

S E C T I O N I I :
***Mental Health
System Reform Strategies***

8. POLICY

There are a number of critical success factors for mental health reform that are reflected in the official government policies that guide and sanction systems change (*Goering & Cochrane, 1992a*). A clear and committed vision is necessary to consolidate and maintain support. If the underlying assumptions, values and principles for mental health reform are articulated and agreed upon then the implementation of wide scale change, with its inevitable conflicts and disruption, is more likely to succeed.

8.1 National Context

In Canada, it is primarily at the provincial level that policy concerning mental health care is formulated and enacted. There is though some policy development at the federal level that provides a context for provincial actions (*Goering et al., 1994*). In 1988, Health Canada released **Mental Health for Canadians: Striking a Balance** as a set of guiding principles for reviewing mental health related policies and programs. Even though it included a broadened definition of mental health and a focus upon health promotion, there is no inherent contradiction between the policy and the propositions that underlie the creation of ideal systems of care for those with severe mental illness. The policy's three implementation strategies are fostering public participation, strengthening community health services and coordinating public policy. These all are compatible with the provincial policy directions.

The other influential national policy related to mental health reform is the Framework for Support developed by the Canadian Mental Health Association (*Trainor et al., 1992*). This policy component is a conceptual base that has had considerable influence upon thinking and project development across Canada. It has challenged policy makers to expand their horizons beyond the formal service delivery system and to include community development activities aimed at enlisting the meaningful involvement of self-help groups, informal caring networks and community groups. Another valuable attribute of this policy framework is that it keeps the client clearly in the centre. One of the pitfalls of past reform efforts has been as exclusive focus upon changing services and reallocating dollars rather than addressing the perceived needs of consumers (*Anthony et al., 1988*). If the goal of improved quality of life is kept foremost and there is a belief in the potential for rehabilitation and recovery, then health, jobs, housing, friends and income all become relevant outcomes.

8.2 Policy Themes

A review of provincial mental health policy documents found a number of themes that appeared with remarkable consistency across the various provinces (*MacNaughton, 1992*). Priority setting, reallocation of fiscal and human resources, coordination, regionalisation/decentralization, individualization, self-help and consumer and family participation were repeatedly identified as key issues. This does not imply that there are no differences between the provinces as the same theme may be defined and implemented differently from one province to the next. Critical analyses and appraisal of mental health policy has been limited. But there are some notable exceptions, i.e. examinations of social and political dynamics in Ontario (*Simmons, 1990; Wasylenki et al., 1994*) and Quebec (*Boudreau, 1991; Mercier & White, 1994; White & Mercier, 1991*).

The themes that are found in Canadian provincial policy are not dissimilar to those identified by a recent content analysis of 23 mental health position papers in the United States (*Pandiani et al., 1996*). The eight broad policy issues of major importance were: coverage, cost containment, access to services, monitoring quality and outcome, the role of government, coordination and integration of services, consumer orientation and restrictiveness of treatment. Clearly the absence of national health insurance has created a particular set of pressures south of the border, but reforms of public mental health systems in most of the states have much in common with our provinces.

There is some difference of opinion about how much those with severe mental illness benefit from the Canadian national insurance coverage. *Bachrach (1994)* argues strongly that in a culture that endorses universal access to health care and single payer financing it is easier to achieve a high level of comprehensiveness in the provision of mental health services. *Rocheport (1992)* identifies five sources of tension in Canada's mental health care system that are also familiar in American settings and concludes that universal insurance coverage would ameliorate only some of the problems faced by persons with severe mental illness.

There has been much more use of legislation as a means to achieve mental health reform in the United States than in Canada. Mental Health Acts typically transform policies into laws that require reconfigurations of services and allocate set amounts of funds to accomplish the goals of reform. A recent mental health act in Kansas provides an example (*Rapp & Moore, 1995*). The act clarified roles and responsibilities by assigning mental health centres as gatekeepers for state hospitals, funding new community services and identifying those with serious illness as the population of highest priority. It also put in place fiscal mechanisms for containing costs and shifting funding from institutional to community-based care and mandated the representation of consumers and family members on governing boards. Leaders of mental health reform in other states (*Hogan, 1992; Santiago, 1990*) identify the use of legislation and litigation as forces for positive change. In Canada, there has been more emphasis on achieving consensus through community consultations and using officially mandated planning documents to maintain a consistent direction as elected governments come and go.

8.3 Policy Options

Some policies have singled out particular types of service delivery for system-wide development. This has happened most often with regard to case management (*Deci et al., 1995; Essock & Kontos, 1995*) and housing (*Kinsley & Fleming, 1993; Pandiani et al., 1994*). For example, New York state elected to use the implementation of intensive case management as a part of a series of interrelated initiatives designed to create structural changes in its mental health system (*Shern et al., 1989; Surles et al., 1992*). This was seen as playing a strategic role in altering the legal, regulatory and resource base in the mental health environment. It provided a concrete mechanism for assuming responsibility for an identified target population of the most severely disabled, identifying barriers that hamper access to services and initiating a process of leadership development and realignment of decision-making authority. Preliminary findings from a comprehensive evaluation were positive (*Surles et al., 1992*) and a longer term follow-up survey of county mental health directors found the program to be very effective for individual clients (*Landsberg & Rock, 1994*). There was more variability in results assessing system change and cautions are raised about having overly ambitious expectations about any one program initiative when what is required is a truly coordinated approach. Planning for case management needs to be integrated into planning for a system of care that includes hospital and support services (*Wasylenki & Goering, 1993*).

The use of targets or benchmarks within policy documents has gained credence in the past decade (*Goering & Cochrane, 1992b; Nasir, 1995*). The aim has been to tie the overall goals of reform to specific objectives that quantify the magnitude and pace of change in terms that will be meaningful to politicians and the general public. Reductions in the number of inpatients beds is a common approach. There is no scientific method for prescribing the correct number of beds or utilisation rates for a region and it does not make sense to set one standard to be applied uniformly across a province (*Goering & Cochrane, 1994*). But overall bed ratios do provide an indirect indicator of the extent to which a community focused system has been achieved. Since it is possible (and has been quite common) to reduce the number of beds without reallocating human and fiscal resources, it is important to combine bed ratios with other indicators. Setting specific goals for the amount of funding that will be shifted from institutional to community care and the number of new community workers or case managers that will be required are other ways of quantifying a move to more balanced service delivery systems. Examining the experience and plans from other progressive jurisdictions can assist in setting specific targets and providing performance comparisons (*Goering et al., 1994*). Still there must be mechanisms for monitoring progress and negotiating appropriate variations in regional expectations as a part of a larger system wide evaluation strategy (see Chapter 11). The pace of reform will depend primarily upon the political will that is exerted and the fiscal and governance structures that are in place (see Chapter 9).

8.4 Summary

Policy statements are important documents that set the course for mental health reform. The national Canadian mental health policy context broadens the scope of concern beyond the formal service sector so that determinants of population health and community development are included. These directions are compatible with reform policies that give priority to populations with serious mental illness and disability.

There is more commonality than difference across provinces and countries in the mental health policy themes that are currently at the centre of attention. This heightens opportunities to learn from experience in other jurisdictions and there is considerable descriptive and critical analysis available. Legislation may be an underused reform strategy in Canada. System wide service developments and setting targets are policy options that can facilitate change, if they are parts of a coordinated planning and implementation process.

8.5 Best Practices: Policy

Key Elements of Best Practice

There is a free-standing mental health reform policy in place.

The mental health policy is supported by an explicit vision that the various stakeholders are aware of and in agreement with.

The full range of stakeholders, including consumers and families is involved in the ongoing development and evolution of policy.

The policy supports development of services and supports that go beyond the formal mental health system, for example, consumer and family initiatives and informal supports.

The policy defines measurable targets that quantify the magnitude and pace of change for reform.

There is a planned strategy for implementing policy, for example through legislation and through officially mandated planning documents.

Policy covers issues such as priority setting, reallocation of fiscal and human resources, coordination of care, integration of services and supports, consumer and family participation, monitoring quality and outcome.

REFERENCES

- Anthony, W. A., Cohen, M. & Kennard, W. (1990). Understanding the current facts and principles of mental health systems planning. *American Psychologist*, 45(11): 1249-1252.
- Bachrach, L.L. (1994). Reflections on mental health service delivery in Canada: One American's view. In L. L. Bachrach, P. Goering, & D. Wasylenki (Eds.), *Mental Health Care in Canada*. (pp. 87-95). California: USA: Jossey-Bass Inc.
- Boudreau, F. (1991). Partnership as a new strategy in mental health policy: The case of Quebec. *Journal of Health Politics, Policy and Law*, 16(2): 307-329.
- Deci, P. A., Santos, A. B., Hiott, D. W., Schoenwald, S. & Dias, J. K. (1995). Dissemination of assertive community treatment programs. *Psychiatric Services*, 46(7): 676-678.
- Essock, S. M. & Kontos, N. (1995). Implementing assertive community treatment teams. *Psychiatric Services*, 46(7): 679-683.
- Goering, P. & Cochrane, J. (1992a). *Critical success factors for mental health reform lessons learned from other jurisdictions*. Report to Ontario Ministry of Health.
- Goering, P. & Cochrane, J. (1992b). *Briefing note targets and pace of reform*. Report to Ontario Ministry of Health.
- Goering, P. & Cochrane, J. (1994). *Estimating the utilization of inpatient beds in a reformed system of care*. Report to Ontario Ministry of Health.
- Goering, P., Durbin, J., Cochrane, J. & Gehrs, M. (1994). *Essential service ratios in a reformed mental health system: Case management*. Report to Ontario Ministry of Health.
- Hogan, M. F. (1992). New futures for mental health care: The case of Ohio. *Health Affairs*, 69-83.
- Knisley, M. B. & Fleming, M. (1993). Implementing supported housing in state and local mental health systems. *Hospital and Community Psychiatry*, 44(5): 456-460.
- Landsberg, G. & Rock, M. (1994). County mental health directors' evaluation of a statewide intensive case management program: The New York state experience. *The Journal of Mental Health Administration*, 21(2): 193-200.
- MacNaughton, E. (1992). Canadian mental health policy: The emergent picture. *Canada's Mental Health*, 40(1): 3-10.
- Mercier, C., & White, D. (1994). Mental health policy in Quebec: Challenges for an integrated system. In L. L. Bachrach, P. Goering & D. Wasylenki (Eds.), *Mental Health Care in Canada*. (pp. 41-52). California: USA: Jossey-Bass Inc.

- Nasir, H. (1995). *Considerations in planning psychiatric bed targets*. Report to Alberta Health.
- Pandiani, J. A., Edgar, E. R. & Pierce, J. E. (1994). A longitudinal study of the impact of changing public policy on community mental health client residential patterns and staff attitudes. *The Journal of Mental Health Administration*, 21(1): 71-79.
- Pandiani, J. A., Murtaugh, M. & Pierce, J. (1996). The mental health care reform debate: A content analysis of position papers. *The Journal of Mental Health Administration*, 23(2):217-225.
- Rapp, C. & Moore, T. D. (1995). The first 18 months of mental health reform in Kansas. *Psychiatric Services*, 46(6):580-585.
- Rocheffort, D. A. (1992). More lessons, of a different kind: Canadian mental health policy in comparative perspective. *Hospital and Community Psychiatry*, 43(11):1083-1090.
- Santiago, J. M. (1990). The evolution of systems of mental health care: The Arizona experience. *American Journal of Psychiatry*, 147(2):148-155.
- Shern, D. L., Surles, R. C. & Waizer, J. (1989). Designing community treatment systems for the most seriously mentally ill: A state administrative perspective. *Journal of Social Issues*, 45(3): 105-117.
- Simmons, H. (1990). *Unbalanced: Mental health policy in Ontario (1930-1989)*. Toronto: Wall & Thompson.
- Surles, R. C., Blanch, A. K., Shern, D. L., & Donahue, S. A. (1992). Case management as a strategy for systems change. *Health Affairs*, 1:151-163.
- Trainor, J., Church, K., Pape, B., Pomeroy, E., Reville, D., Tefft, B., Lakaski, C. & Renaud, L. (1992). Building a framework for support: Developing a sector-based policy model for people with serious mental illness. *Canada's Mental Health*, 40(1):25-29.
- Wasylenki, D. A., & Goering, P. N. (1993). Implementing case management systems: A Canadian experience. In M. Harris & H. C. Bergman (Eds.), *Case Management for Mentally Ill Patients: Theory and Practice*. (pp. 199-216). Pennsylvania: USA: Harwood Academic Publishers.
- Wasylenki, D., Goering, P. & Macnaughton, E. (1994). Planning mental health services: Background and key issues. In L. L. Bachrach, P. Goering & D. Wasylenki (Eds.), *Mental Health Care in Canada*. (pp. 31-40). California: USA: Jossey-Bass Inc.
- White, D. & Mercier, C. (1991). Coordinating community and public-institutional mental health services: Some unintended consequences. *Social Science and Medicine*, 33(6):729-739.

9. GOVERNANCE AND FISCAL STRATEGIES FOR ACHIEVING MENTAL HEALTH REFORM

9.1 Introduction

The mental health system is often described as complex, fragmented and confusing. Hadley (1996) discusses how changes in methods of financing mental health services have contributed to the complexity and disarray that now plagues the system. His concern is echoed by Nasir (1994) who argues that lack of fiscal and management integration among the major sectors providing mental health care is seriously undermining delivery of quality care and progress in mental health reform. Mental hospitals, psychiatric units in general hospitals, community mental health services and physician services operate in virtual isolation from each other. As a result each sector is driven by its own agenda, leading to fragmentation, lack of continuity and cracks in the system for patients, and an absence of accountability.

The mental health care system spends a disproportionate amount of resources on institutional care. In Canada, the portion of the provincial mental health budget that is spent on community support services averages 13%, and ranges from 3.1% in Manitoba to 46% in New Brunswick (*Nasir, 1994*). This imbalance derives, in part, from the fact that spending on users of mental health services did not follow individuals into the community during de-institutionalization. In other words, the monies saved from bed reductions did not resurface in expanded community programs. This issue is emerging again with hospital restructuring and downsizing. As *Rachlis and Kushner (1994)* note “mental health resources are under constant threat from acute care poaching” (p 266). Unless strategies are put in place to protect mental health spending in institutions, hospitals will be tempted to use unspent mental health funds to meet other budget priorities. *Dreezer (1996)* acknowledges this problem and urges immediate identification and freezing of mental health dollars in the institutional sector. This can be followed by implementation of fiscal strategies that move mental health dollars into the community.

The challenge of implementing mental health reform is being faced by jurisdictions across Canada, United States and Europe. Other sections of this document focus on the services that comprise a reformed mental health system, and report evidence of best practices. In this section we identify methods that can be used to create an organizational infrastructure conducive to delivery of these best practices. In particular we will review governance and funding strategies to protect mental health resources, encourage transfer of funds from institution to community and an expansion of community care, increase continuity of care for users, and move to more cost-effective care delivery. Much of the material in this chapter is drawn from Nasir’s comprehensive review of fiscal restructuring tools and case studies (1994) and a review of structures for coordinating mental health care (*Goering et al., 1996*). Other sources are cited as used.

Rigorous evaluations are not feasible in service systems research but many jurisdictions have recorded markers of change over an extended period of time or identified comparison systems in order to assess progress and success. This section does not offer a comprehensive literature review but for each strategy examples of implementation experiences and findings are given.

While many of the fiscal and governance strategies discussed in this report have been identified as key elements and components of a public sector managed care system, (*Hogan et al., 1994*), we will not directly discuss the managed care concept. Our wish is to focus on tools and methods that can advance the specific objectives of mental health reform.

9.2 Needs Based Allocations

The two most common funding strategies used in health care today - global budgets and fee-for-service (FFS) - are driven mainly by provider preferences and past utilization of services rather than by current need. These methods are criticized for favouring the status quo and perpetuating inequities. Typically hospitals receive a global budget (based on past budgets) which is adjusted upward to reflect rates of inflation, new programs and new capital expenses. More recently, annual budget adjustments have been downward but still are indexed to the hospital's current budget. This approach does not take into account changes in need for services of both current hospital users and residents of the surrounding community. The FFS system which accounts for most physician reimbursement has other limitations. Until recently levels of reimbursement were open-ended in most jurisdictions, resulting in a rapid escalation in costs of physician services. FFS encourages high volume and incorporates few controls or incentives regarding where providers practice, who they serve and what they provide. Under FFS the nature of care provided is influenced by provider availability and preferences, factors that are not necessarily linked to population needs for health care (*Hughes, 1991; Nasir, 1994*).

A needs-based approach to funding strives to relate resource allocations to characteristics of populations served on the basis of health risks and morbidity. (*Nasir, 1994*) In this approach the estimation of need is relative. For example a jurisdiction with higher rates of psychiatric disorder can be deemed to have greater need and to require more resources. A needs-based approach is considered to be more efficient because services can be aligned with need. It is more equitable because resources are directed to where the need is greatest, regardless of availability of providers and past patterns of use. Fiscal allocations based on need can be used to establish the mental health funding pool for a specific area or to tie program funding levels more closely to individual need. However, planners still face the challenge of translating predictions of need into estimates of necessary services.

The validity of needs-based allocations in practice depends on what indicators can be collected to define need and how they are used. Often indicators are combined into a single measure such as a patient severity rating or area index that is used to rank areas or patients into groupings based on relative need. Indicators commonly used to assess individual need include diagnosis, age, medical complications, immediate risk, symptom severity, chronicity, social stability and level of functioning

(*Stoskopf & Horn, 1992; Lyons et al., 1995*). These can be obtained from clinician report, medical records or patient self-report.

Indicators of area need such as prevalence of disorder or disability are direct measures that are obtained from epidemiological surveys. To avoid the expense and time required to conduct such surveys, methods are developing that use social indicators as indirect or proxy measures of need. Variables such as age, gender, marital status and ethnicity (socio-demographic); and income, education, unemployment and poverty (socio-economic/deprivation) are felt to link with actual need but can be obtained from existing data bases (e.g., government census data) at much less cost than survey data. One problem of using social indicators to model need is that methodologies produce different results and vary in levels of accuracy.

9.2.1 Experiences

Lesage and colleagues (1996) used several needs assessment approaches to evaluate current distribution of staff among seven community psychiatric clinics in Montreal, Quebec. They assessed relative need within each clinic catchment area using prevalence data obtained from an epidemiological survey, utilization data and a model of utilization using social indicator data. In addition, patient populations in two clinic areas were compared using a case control study. The final social indicator model included variables related to dimensions of poverty, unemployment, occupational skills, social isolation and ethnic background. Staff allocations based on these three needs estimates were compared to actual staffing patterns.

Differences were found between predicted and actual distribution of staff, with each estimate of need yielding different results. Lesage concludes that a socio-economic indicators model of utilization represents an interesting and inexpensive planning tool and produces estimates of resource allocation that are consistent with sensible distribution of human resources. However, decisions about actual resource allocation should consider both empirical data and input from local practitioners and users. None of the needs assessment methods adequately reflected the severity of cases evidenced in the case control study.

Ciarlo et al., (1992) developed and assessed a number of indirect needs estimation models. They used measures of diagnosis, dysfunction and demoralization obtained from a Colorado state-wide survey as the need standard to be predicted. Most models provided some increase in accuracy over an assumption of no difference in need across subareas. The strongest model was based on only two indicators - percentage of persons in poverty and percentage of divorced males. The researchers conclude that any jurisdiction currently not using a social indicator or other type of indirect needs assessment model could probably improve accuracy of service planning by incorporating an indirect needs estimation technique.

Ontario recently incorporated area need into a methodology to distribute a Community Investment Fund of \$20 million among six planning regions in the province. The purpose of the Fund was to increase regional base funding for supporting individuals with severe mental illness in anticipation of

reductions in inpatient care. It was expected that the enhanced funding base combined with future reallocated inpatient resources would help each region to develop a comprehensive community support system. In dispensing the funds there was an attempt to recognize regional differences and inequities. The allocation methodology incorporated a number of regional factors, including population need (i.e., total population, distribution of ethnic and aboriginal populations), current resources (i.e., per capital mental health spending, inpatient bed ratios), and service delivery costs (e.g., geographic size, rural population) (*Ontario Ministry of Health, 1994*).

At a program level, capitation grants and prospective payment are examples of reimbursement structures that try to link program funding levels to needs of individuals served. These are discussed in detail in the next section.

9.3 Strategies for Integration

The existence of silos in funding and management of mental health care has allowed each sector to focus on its own growth and prosperity, without taking into account broader systems issues and consumer needs. Jurisdictions are most strongly positioned to break down the solitude of the different sectors and create more integrated mental health care if the following are implemented:

- a single funding envelope that integrates diverse mental health funding streams; and
- a single organization or authority responsible for management of mental health care within a defined area.

9.3.1 Single Envelope Funding

Integrating funding streams is a necessary condition for achieving progress in mental health reform. Evidence from other jurisdictions indicates that reform efforts are compromised if funding for hospital and community services, at a minimum, are not combined. One benefit of having a combined envelope is that fiscal levers can be used to increase integration of hospital and community care. For example, bonuses for reducing hospital bed use below a baseline target rate can be channelled into development of a stronger community service system. The resulting inter-dependence of hospital and community sectors promotes service innovation and benefits the consumer who can move more freely between settings and levels of support. Because funding is combined within one envelope, fiscal management is centralized and accountability clearly defined. Creation of a single funding envelope realizes another benefit by requiring all mental health funding to be explicitly identified. A clearly defined resource base should be easier to protect, and easier to protest if it is felt to be inadequate.

At a minimum, the funding envelope should integrate spending for general hospital inpatient psychiatric services, psychiatric facilities, specialty psychiatric facilities and community mental health programs. Spending for mental health services delivered by physicians is a significant component of the mental health purse but there are no jurisdictions in Canada or the United States that have isolated this funding and put it under the control of a separate mental health authority.

While major changes in how doctors are reimbursed for mental health care need to be made in conjunction with broader reforms in physician payment, there are small scale strategies that can be deployed now. *Dreezer (1996)* suggested using fiscal incentives to encourage more psychiatrists and other physicians to work with individuals, families and caregivers involved with chronic mental illness. Alternatives to FFS such as sessional fees and various salaried options could be made more available to physicians. The Business Plan recently published by the Ontario Ministry of Health promises an expansion of alternative payment plans for physicians and implementation of new funding models. Currently one in 10 physicians in Ontario is paid through an alternative method (Ontario Ministry of Health, 1996).

Because the needs of people with severe mental illness are broad, an ideal envelope also would contain funding for social welfare services. For example the Robert Wood Johnston Program on Chronic Mental Illness (RWJP/CMI), described in more detail in the next section on authorities, included Department of Housing and Urban Development (HUD) housing certificates in its allocations. This additional funding helped program participants access more independent and better quality housing. Improved living conditions were associated with greater residential stability, reduced use of hospital and reduced service needs (*Newman et al., 1994*).

9.3.2 Authorities

The benefit of having a combined envelope is most fully realized if a single body or **authority** is responsible for dispensing funds and organizing services for a defined area. Earlier reform efforts in mental health care focused on developing stronger community support systems and shifting the locus of care from hospital to community. While more community programs have resulted, service organization is generally fragmented and responsibility is diffused. Currently attention is focused on improving the service system infrastructure to address these problems. Mental health authorities have emerged as a promising vehicle for organizing administrative, clinical and fiscal aspects of care delivery to create a more integrated system of care (*Schinnar et al., 1992; Goldman et al., 1994*).

A mental health authority is a public, non-profit organization that manages all aspects of care to meet the mental health and possibly social welfare needs of persons living in a defined geographic area (*Shore & Cohen, 1990; Goldman et al., 1990*). An authority can be a newly formed organization or an existing organization with expanded responsibilities – e.g., county mental health boards in Wisconsin. While an authority can be a direct provider of services, more often it is a regulator, contracting delivery of services to local providers and monitoring their performance. This purchaser/provider separation minimizes potential for conflict of interest but distances managers from the providers of care (*Agus & Baron, 1995*). Because an authority is a centralized point of responsibility with clearly delineated relationships to providers and funders, accountability is enhanced.

An authority can use multiple tools to achieve administrative, fiscal and clinical integration. Examples of administrative tools include information systems for planning services and monitoring performance, housing and bed registries to monitor availability, referral agreements to formalize

program linkages, and training to increase skills and promote shared values among providers. Fiscal strategies for program reimbursement (see next section) can be used to shift resources into the community and encourage the programmatic links necessary to improve continuity of care. Clinical mechanisms for forging links across programs include case management, continuous treatment teams and crisis response systems. Primary goals are to divert or shorten hospitalization, connect discharged consumers with community services, increase engagement of the target population and minimize the fragmentation that allows people to “fall through the cracks”. Other chapters in this report review best practices for implementing these various clinical services.

While authorities are expected to improve cost effectiveness in the longer term, initially they increase administrative costs. Authorities can take years to implement as they overcome myriad political, legal and professional hurdles. Opposition from local providers who fear losing influence and autonomy can be considerable. In the RWJP projects, many sites spent years trying to obtain control over state mental hospital budgets (*Mechanic, 1991; Goldman et al., 1990*).

9.3.3 Experiences

The success of mental health authorities and single funding envelopes for implementing reform has been assessed to a limited degree in Canada and widely in the United States. This section includes reports from many American jurisdictions although we recognize that the unique Canadian health care context needs to be considered when applying American experiences to Canada.

New Brunswick is near the end of a ten year program for mental health reform. A provincial Mental Health Commission, administered by a provincial board and seven regional boards, was established by legislation to oversee reform implementation. The Commission was given control over all mental health resources. A recent evaluation by independent consultants (*PGF, 1994*) documents their progress. From 1990 to 1995 spending on community services in New Brunswick increased from 12% to 46%, beds in psychiatric hospitals dropped from 695 to 360 and admissions declined from 1305 to 371. The consultants identified several areas for further work, including improving communication and coordination between different system components and clarifying mandates and roles.

New Brunswick has just dismantled the Commission (at an annual saving of approximately \$500,000), and established a separate Mental Health Division within the Ministry of Health and Social Services that is advised by various provincial and local advisory committees. The Division directly manages 13 Community Mental Health Centres, funds seven regional hospital psychiatric units, and two psychiatric hospitals through yearly purchase of service contracts, and provides program grants to consumer, family and not-for-profit volunteer groups. The separate mental health funding envelope still remains but local authority over spending has been lost (*Lajeunesse et al., 1995; Allard, 1996*).

Greater Vancouver Mental Health Services (GVMHS) is internationally recognized as a comprehensive and effective system for providing mental health services to clients with serious mental illness. Single envelope funding has given GVMHS flexibility in developing, administering and operating an integrated system of programs that are responsive to community demands. There is one administrative agency responsible for the operation of a variety of services. Central to the program are nine mental health teams staffed by providers from a range of health disciplines, including medicine, that deliver services to defined catchment areas. The teams link with a continuum of services also offered by GVMHS that include assessment, mobile crisis response, safe beds, housing and vocational support. The only aspect of the system which has not been fully integrated is general and provincial hospital services. The downsizing of Riverview and the establishment of regional mental health boards is now addressing this issue (*Bigelow et al., 1994*).

In the **Robert Wood Johnston Program on Chronic Mental Illness**, nine cities throughout the United States received funds to develop community-wide systems of care for persons with chronic mental illness. Each city was expected to create a public mental health authority that would improve continuity of care, move funds to meet consumer needs, develop a range of housing options and enhance the range of available rehabilitation programs. The initiative began in 1986 and was accompanied by a comprehensive national evaluation project. Evaluators found that authorities could be successfully established, increasing centralization, coordination and continuity of care. Yet outcomes for program users did not improve. This negative finding may reflect methodological limitations in the evaluations. Alternatively, it may demonstrate that structural changes are important but do not obviate the need to expend more public funds to ensure that high quality clinical and social programs are available to persons with chronic mental disorders (*Morrissey et al., 1994; Shore & Cohen, 1994; Lehman et al., 1994; Okin, 1995*).

Wisconsin was one of the first jurisdictions in the United States to implement authorities and combine hospital/community funding. In each county an authority was mandated to organize delivery of care, including inpatient services, for people with severe mental illness. The hospital portion of each county's resource allocation was based on an index year of inpatient use, and authorities could use fiscal incentives to encourage less hospital use below the index year. Monies not spent on hospitalization remained with the authority and could be used to develop better community supports, but authorities were required to pay for overuse of hospital beds. Within 10 years, Dane County's expenditures for inpatient care accounted for only 9% of the mental health budget. Over 75% of chronically mentally ill persons were living in independent settings, hospital admissions had dropped and the readmission rate was only 25%. The rate of spending on inpatient care reported by Dane County may be artificially low because authorities were not charged for nursing home care where many people with mental illness were referred. The other 55 county mental health boards in Wisconsin achieved less impressive results, despite having similar systems. This reinforces the need for local stakeholder participation and support, even when structures are in place to support a system shift to community-based care (*Nasir, 1994*).

Michigan provides an example of a jurisdiction where authorities were implemented but not uniformly given control over an integrated funding envelope. Full management boards (similar to

local authorities) were allowed to either enter into performance contracts for purchase of hospital services or receive free inpatient care but relinquish control over hospital budgets. Compared with the Dane County authority, these Boards, in aggregate, were less successful in transferring funding from hospitals to the community – 50% of mental health funding still goes to inpatient care (*Nasir, 1994*). Nasir hypothesizes that those who opted out of the contracts were heavy hospital users.

In 1989, the **State of Washington** shifted responsibility for managing and delivering local mental health programs to county governments. Thirty-seven counties formed 14 Regional Service Networks (RSNs) which received a block grant of community and residential mental health funds, and additional funding for expansion of crisis, case management and housing services. Spending for state and community hospital use was added later. In 1993, the State developed a series of performance contracts with the RSNs pertaining to system goals such as increased community tenure, movement to independent living, engagement of homeless mentally ill, increased involvement in school or work and access for under-served groups. The State allocated new funds to develop a consumer-centred information system that attached service, demographic and outcome information to each system user, and allowed monitoring of system performance. Early findings were positive. After two years of operation, 16% more consumers were receiving services in the community and there were major improvements in continuity of care (i.e., discharged patients were linked faster and more often to community services). After the performance contract for state hospital use was implemented in 1993, the state hospital census dropped by nearly 300 beds (*Brown et al., 1994; Hanig & Gilman, 1995*).

The **State of Kansas** implemented a Mental Health Reform Act in 1991 that transferred control over state hospital admissions to community programs, established a new service to screen and divert consumers from hospitalization, set state hospital bed targets and increased funding for community programs. An evaluation of the first 18 months of implementation indicated that state level systems change can decrease state hospitalization, increase utilization of community services and improve quality of life for people with severe and persistent mental illness (*Rapp & Moore, 1995*).

9.4 Strategies for Program Reimbursement

Financing mechanisms are a powerful tool for shaping how health services are delivered. For example, fee-for-service (FFS) is a reimbursement method that encourages high volume, office-based care for problems that reflect provider priorities and preferences. If jurisdictions are to successfully implement mental health reform they need to use fiscal strategies that promote cost containment, transfer of resources from institutional to community care, priority to those in greatest need and better service for neglected populations. Reimbursement strategies can be broadly grouped into those that are linked to individual need and those linked to aggregate program and system performance. Strategies can use positive incentives (rewards) or negative incentives (penalties) to bring about the desired changes. They can link funding to an individual procedure, an episode of care or a period of time. Each strategy has strengths and limitations, and jurisdictions need to select those that are most likely to succeed in their environment. The following discussion outlines the most promising strategies for implementing reform and research evidence regarding their performance.

9.4.1 Strategies that link funding to individual need

Prospective Payment

Prospective payment is an approach to funding that moves the consumer to the centre of the financing policy. The level of payment for services rendered to an individual during an episode of care or defined period of time is determined before services are actually provided. Reimbursement rates are based on the illness characteristics and anticipated needs of the consumer, and are independent of the actual cost of providing service. Prospective payment is aimed at cost containment, and uses rewards and risk to encourage efficiency. Providers in prospective payment contracts can retain unspent revenues but bear the loss if costs exceed income (*Dickey & Cohen, 1993*).

The problem with implementing prospective payment in mental health is that efforts to establish reimbursement rates suffer from our inability to model how patient characteristics relate to service use. Since the advent of the Medicare Prospective Payment System (PPS) for reimbursing U.S. hospitals in the early 1980s, research on creating patient groups which can be expected to have similar care needs (and therefore a similar level of reimbursement) has flourished. Yet our capacity to predict patient service needs remains limited (*Frank & Lave, 1985; Mitchell et al., 1987*). If payment rates do not accurately reflect actual care costs, good providers are financially penalized and practices that undermine care are promoted – for example skimming (i.e., selecting more healthy, cheaper-to-treat patients), manipulation (i.e., recording information that places a patient in a higher reimbursement category) and under-servicing. Utilization review is a strategy used in environments where prospective payment is the basis for funding allocations. In hospitals UR can be applied to assess the appropriateness of clinical decisions and provide feedback to providers for future practice (*Yank, Hargrove & Davis, 1992*).

Prospective payment can also be applied to users of ambulatory services if appropriate methods for determining levels of prepayment can be developed.

Experience with Prospective Payment

In the United States the **Prospective Payment System** or PPS is the predominant tool for funding hospital services. While psychiatry has been excluded from the Medicare prospective payment plan because classification tools for setting patient reimbursement rates are felt to be inadequate, private insurers and managed care organizations are actively seeking better tools for determining psychiatric patient reimbursement. Many private companies are vying for this portion of the health care market.

In Canada global budgets are still the predominant form of hospital reimbursement but initiatives that link funding to volume and nature of patients served are emerging. In Ontario, the Hospital Funding Reform Project is developing methods for adjusting hospital global budgets based on patient and facility characteristics. Reimbursement for patient care in a hospital is prospectively calculated, based on the patient case mix in a previous year and expected costs of treating patients in each case mix group. More recently hospital characteristics have been incorporated into the funding methodology (*Lave et al., 1992; Joint Policy and Planning Committee, 1995a*). The difference between hospital

actual costs and expected costs is the basis for making budget adjustments. Refining budgets based on case mix does not work well in psychiatry because of the limited accuracy of the Case Mix Group (CMG) classification system (*Joint Policy and Planning Committee, 1995b*). This limitation has been recognized by the Ministry of Health which, in partnership with the Ontario Hospital Association, is currently investigating more effective approaches for funding and managing hospital psychiatric services.

The **Province of Alberta** is using a diagnosis-based classification system for funding inpatient care. Thus far, psychiatric hospitals have been excluded. A recent study concluded that a funding system based on the Refined Group Numbers (RGNs) classification system used in Alberta would result in inequitable funding for psychiatric discharges, with specialty facilities being substantially underfunded (*Wellock, 1995*).

Capitation

Capitation is a needs-based form of prospective payment wherein providers receive a preset fee per enrollee in exchange for delivery of a defined range of services in a specified period of time. Capitation plans strive to link reimbursement rates to the expected needs of enrollees so that providers are not penalized for accepting more ill, lower functioning individuals into the plan. Because the fee remains fixed regardless of the patient's level of use of services, the provider assumes risk and responsibility for costs exceeding the capitated amount (*Dickey & Cohen, 1993*).

Capitation has numerous advantages. It is a powerful device for consolidating fragmented funding streams including hospital and community resources, and linking funding to user need. Because services must be delivered within a fixed budget, capitation promotes substitution of less costly services for more expensive ones and use of preventive interventions to avoid more intensive care later. Because total spending is determined in advance, budgets can be controlled and contained. If a capitation plan is non-profit, savings can be redirected to development of more community services. Capitation can be used to encourage providers to serve neglected populations by setting higher rates for the care of these individuals. In contrast to environments where there is close monitoring of all care decisions (ie., managed care programs), capitation offers providers and consumers more freedom and flexibility in service choices. Capitation centralizes responsibility for service delivery, thus consolidating and clarifying accountability.

While capitation is the most comprehensive of strategies for linking reimbursement to individual need, it has serious vulnerabilities. The main danger of capitation is under-service. Because the care period for reimbursement is usually one year, providers tend to focus on immediate spending control rather than longer term health care management. Prevention is given little priority and services may be withheld to control expenses. Systems can be implemented to monitor under service but they are difficult to develop and costly to operate. A further limitation is that we lack understanding about how to calculate payment rates that accurately reflect the resources needed to treat patients with different illness and demographic characteristics. As a result providers may be unwilling to take on users with more complex needs for fear of inadequate reimbursement. Few administrators have the

technical expertise to negotiate agreements and work out the complicated arrangements for risk-sharing that capitation entails (*Lehman, 1987; Nasir, 1994; Okin, 1995*).

The vulnerability of capitation plans to under-service is a particular concern in mental health care. There are fears that private capitation plans will imitate other private insurance programs, imposing limits on allowed inpatient days and outpatient visits, and excluding rehabilitation services. As a result, people with chronic mental illness will be under-served or excluded from participating (*Lehman, 1987; Sharfstein et al., 1993; Hughes, 1996*). Yet, if pitfalls can be avoided, capitation affords many advantages. A number of jurisdictions have set up pilot projects to assess effectiveness of separate, publicly funded capitation programs with mandated minimum standards for people with chronic mental illness. Results have been encouraging.

Experiences with Capitation

Integrated Mental Health, Inc. (IMH) was a non-profit corporation established in Upper State **New York** to administer a capitation program for people with serious mental illness who were heavy users of hospital services. Multiple funding streams were integrated within IMH to make single capitation payments possible. Each of several community mental health centres (CMHCs) received a budget allocation from IMH determined by the number of enrollees and their projected respective levels of need. The Centres assumed responsibility for care of all rostered persons. Direct mental health services were generally provided by the Centre, with other services such as housing, social or rehabilitation services purchased from other local agencies. The CMHC also paid for use of acute and long-term hospitalization.

An evaluation compared individuals randomized into either the capitation program or a control group which received traditional mental health care. Capitation was successful in transferring heavy uses of inpatient services into the community and increasing use of less costly services. Consumers in the capitation project used fewer hospital services and more case management than those in the control condition at a lower overall cost. There were no group differences in functioning or level of symptomatology. A number of implementation difficulties were encountered, including defining capitation rates and establishing an information system for monitoring. Questions were raised about the appropriateness of capitation for all persons with serious mental illness as many criteria were applied to selection of participants for this project. For this reason, it was suggested that capitation programs target clearly defined groups (*Reed et al., 1994; Dickey & Cohen, 1993; Cole et al., 1994*).

Rhode Island implemented a partial capitation program to move long-term users out of the state hospital. Local mental health authorities were offered a fixed rate per annum to arrange for a patient's discharge and community treatment. Unlike full capitation plans, the authorities were not held financially responsible if rehospitalization was required. The program was successful in shifting funds from hospital to community mental health budgets, focusing care on seriously disabled consumers and providing individualized treatment and support. After seven years, all clients in the transfer program were living in community settings and more than \$7 million had been transferred annually to community programs. Levels of functioning and community tenure improved in the majority of consumers (*Nasir, 1994*).

Two sites in **California** were chosen to implement and test the effectiveness of an integrated service agency that combined capitation with assertive continuous treatment. Participants were screened for program eligibility (i.e., required a DSMIII-R diagnosis, substantial functional impairment and eligibility for public assistance) and then randomly assigned to the capitation program or usual county mental health services. After 12 months, those in the capitation programs had spent less time in hospital, were less likely to have dropped out and were more likely to work for pay. It was felt that the integrated service delivery model and flexibility of capitated funding increased access to vocational programming for consumers and contributed to the program's success in that area. Group differences were not found in symptomatology, number of friends, independent living, self-esteem and quality of life (*Chandler et al., 1996*).

Leff and colleagues (1996) compared outcomes over time of persons with severe mental illness who were randomly assigned to capitated and fee-for-service (FFS) programs in **Arizona**. They found that more disturbed persons had better outcomes under capitation than under FFS in symptom levels and social conflict while less disturbed persons had equal or poorer outcomes. Leff suggested that providers reimbursed under capitation are motivated to appropriately serve highly disturbed individuals in order to avoid expensive hospitalizations, but feel they can under serve less disordered persons without dire consequences.

Vouchers

This method gives purchasing rights directly to individuals by providing them with vouchers to buy needed services. While the voucher system should enhance consumer choice and provider competition, in practice there are rarely enough providers to realize either of these benefits. To use vouchers optimally, consumers need to judge quality and compare alternative providers but serious mental illness can interfere with decision-making capacity. Some consumers have difficulty pacing their use of vouchers and may run out or have vouchers left at the end of the period of coverage (*Frank & Goldman, 1989*).

In the **Robert Wood Johnson Program on Chronic Mental Illness**, individuals were given housing vouchers from HUD that allowed them to choose their own housing. Evaluators found that this funding served as a conduit to more independent living, more affordable housing and improved housing conditions for program participants (*Newman et al., 1994*).

9.4.2 Strategies that link funding to program and system performance

Performance Contracts

In contrast to strategies that link funding to individual care, **incentive or performance contracts** tie payments to aggregate measures of program performance to promote goals such as improved quality, contained costs, new service development and increased care for previously neglected populations. Financial incentives can be awarded for meeting performance targets and penalties imposed if targets are missed. Contracting can flag ineffective providers through close monitoring of performance if

consensus is reached on appropriate delivery and outcome measures. In mental health reform there has been progress in defining system targets (such as institutional/community spending ratios, hospital bed targets) but opinion still varies on what constitutes program success (see chapter on evaluation). With uneven progress and relapse common among people with severe mental illness, programs need protection against poorer outcomes.

Contracting is more likely to realize innovation and increased competence in programs when there is competitive bidding but, among programs that serve people with serious mental illness, there is often a lack of multiple bidders. If competition leads to frequent changes in recipients of contract awards, there will be a disruption in continuity of care for consumers. Contracts that impose strong penalties can create pressures to under-serve in order to meet preset targets (*Frank & Goldman, 1989*).

Experiences with Performance Contracts

Wisconsin used performance contracts successfully to reduce spending on inpatient care. Local mental health authorities, managing a combined hospital and community envelope, were given responsibility for purchasing hospital services for their patient population. If bed use fell below a preset rate they were reimbursed for the difference but if use exceeded the target, they paid the additional costs. Monies saved by decreasing inappropriate hospital use could be used to create or expand community mental health programs. As reported earlier this system worked well in Dane County but was less effective in other counties in Wisconsin. The **Ohio Plan** used a similar approach of allowing local boards to gain control over funds previously spent on inpatient care. Between 1982 and 1992 state psychiatric hospital census declined from 4375 to 2450 and community mental health spending increased from \$54 million to \$128 million (*Nasir, 1994*).

The State of **Texas** successfully used incentive contracts to reduce state mental hospital inpatient use even though state hospital funding was not contained in the local funding envelope. Local mental health authorities received a bonus for each day of hospital care in actual experience that fell below a preset baseline level. Penalties were not applied if bed use exceeded the targeted amount. This initiative resulted in a \$20 million transfer from the state hospital budget to community mental health centres in the first two years of the program and a 19% reduction in average daily census (*Nasir, 1994*).

New York State used financial incentives to encourage improved discharge planning and early patient linkage. Hospitals received a “bridging fee” for successfully linking a Medicaid patient with outpatient services within 10 days of discharge, and eligible outpatient providers were offered a 40% premium above base Medicaid fees-for-services provided during the first 30 days after discharge (*Mechanic, 1991*). **Washington State** worked with stakeholders and a technical work group to develop outcome measures and incorporate them into funding contracts with county mental health authorities or RSNs. Funding was tied to performance related to consumer engagement, community tenure, residential status, daily activity and parity for under served, domains which the state information system was able to monitor (*Hanig & Gilman, 1995*).

Grants

Grants are lump-sum transfers of resources, usually from government to non-profit providers, to deliver a specific type of service. They tend to be simpler vehicles for program reimbursement than performance contracts because they set fewer criteria and require less reporting (*Frank & Goldman, 1989*). Their advantage is that administration costs are kept low and providers have flexibility in how they deliver care. *Bigelow & McFarland (1994)* support use of less expensive forms of fiscal management, arguing that strategies such as peer review, site visiting and continuing education can be used to improve and monitor quality of care.

9.5 Discussion

The history of trying to create a system of care for the severely mentally ill can be traced for decades, since deinstitutionalization began releasing great numbers of individuals into communities ill-prepared to provide adequate substitute care. Earlier efforts focused on creating a stronger system of community services and supports that met basic needs and provided treatment and rehabilitation. More recently, concerns about fragmentation among diverse services have spurred efforts to improve coordination and service integration. Clinical coordinating mechanisms such as case management have achieved some success in improving coordination at the individual level but have not achieved system-wide change. More recently a number of jurisdictions have implemented separate mental health authorities that control a consolidated funding envelope to advance the goals of mental health reform and achieve a more integrated system of care. In many cases implementation of authorities has led to the desired structural changes of transferring more funds to community and increasing continuity of care, but as the Robert Wood Johnston Program discovered, systems still need adequate financing and service quality requires ongoing attention.

Concerns have been raised that creating separate authorities isolates mental health care, making funding more vulnerable to cutbacks and distancing mental from physical health care. Yet separate authorities are powerful structures for implementing mental health reform. Many believe that integration with health should only be considered after a stronger, more mature reformed mental health system has been established.

Allocating mental health resources on the basis of need should lead to more equitable and appropriate reimbursement but jurisdictions need to experiment with appropriate methodologies. While capitation and prospective payment are reimbursement methods that strive to link funding to individual need, they need to be applied carefully as they have many pitfalls. Performance contracts that offer awards and penalties are closer to current funding strategies and have been used successfully in many places to shift resources to the community and increase continuity of care. Better technical tools are needed to support implementation of these various funding approaches – for example, systems for classifying patients into groups that require similar levels of care, methodologies for estimating the proportion of a general hospital budget that is spent on mental health care, and models that can predict need using social indicator data.

9.6 Best Practices: Governance and Fiscal Strategies

Research Evidence

Empirical evidence from system evaluations indicate that:

- ★ Needs-based resource allocation is more effective in matching resources to local consumer needs than approaches based on historical funding levels and provider behaviour.
- ★ Local mental health authorities and single funding envelopes can create more integrated mental health delivery systems, shifting resources from institutions to community, expanding community services and increasing continuity of care.
- ★ Funding strategies that attach reimbursement to individuals have many advantages but are still limited by our capacity to calculate appropriate rates of reimbursement, monitor performance and develop/manage provider contracts.
- ★ Performance contracts can be used to reduce hospital use and shift resources into community supports.

Evidence from controlled and uncontrolled trials indicate that:

- ★ Despite implementation problems, non-profit capitation programs for people with severe mental illness can successfully direct care to a neglected population, reduce hospital use, increase use of community supports and lower overall treatment costs.

Key Elements of Best Practice

At a provincial level there are:

- ★ leadership which has an explicit and shared vision with all stakeholders for how the reformed system should be organized and what outcomes are desirable for people
- ★ a strategy that includes creating decentralized structures for managing local mental health care delivery
- ★ monitoring responsibility (e.g., through allocations, standard setting, audits)
- ★ separate, single funding envelope that combines various funding streams for delivery of mental health care
- ★ legislation or policy directives to preserve the mental health reform strategy and envelope
- ★ capacity to develop joint initiatives with other government departments

At a regional and/or local level there is a mental health authority in place that:

- ★ serves as a clear point of responsibility for people with serious mental illness.
- ★ controls a single, combined envelope for funding mental health care
- ★ has responsibility for planning, organizing and monitoring services and supports, and dispensing funds
- ★ uses clinical, administrative and fiscal mechanisms to achieve more integrated delivery of care.

Funding allocations for particular geographic areas are linked with unique characteristics and needs of area residents.

Reimbursement mechanisms (e.g., performance contracts, capitation) are used to promote program and systems change. The needs of the consumer are always central in this process.

There is a strategy to rebalance spending and increase the proportion of total mental health funds spent on community services and supports.

A consumer-centred information system supports decision-making in planning, funding and managing the system.

Policy and legislative mechanisms preserve the mental health envelope and prevent losses due to downsizing in the institutional sector.

REFERENCES

- Agus, D., & Baron, S. T. *The development of a local mental health authority*. (unpublished)
- Allard, C. Ministry of Health, New Brunswick (Personal Communication)
- Bigelow, D. A., & McFarland, B. H. (1994). Financing Canada's mental health services. *New Directions for Mental Health Services*, 61, 63-72.
- Bigelow, D.A., Sladen-Drew, N. & Russell, J.S. (1994). Serving severely mentally ill people in a major Canadian city. *New Directions for Mental Health Services*, 61, 53-62.
- Brown, L., Cox, G. B., Jones, W. E., Semke, J., Allen, D. G., Gilchrist, L. D. & Sutphen-Mroz, J. (1994). Effects of mental health reform on client characteristics, continuity of care and community tenure. *Evaluation and Program Planning*, 17(1), 63-72.
- Ciarlo, J. A., Tweed, D., Shern, D. L., et al., (1992). I. Validation of indirect methods to estimate need for mental health services. *Evaluation and Program Planning*, 15, 115-131.
- Cole, R., Reed, S., Babigian, H., Brown, S. & Fray, J. (1994) A mental health capitation program: I. Patient outcomes. *Hospital and Community Psychiatry*, 45(11), 1090-1096.
- Dickey, B. & Cohen, M. (1993). Changing the financing of state mental health programs: Using carrots, not sticks, to improve care. *Administration and Policy in Mental Health*, 20(5), 343-355.
- Dreezer, S. Health Consultant, Toronto (Personal Communication)
- Frank, R. G., & Lave, J. R. (1985). A plan for prospective payment for inpatient psychiatric care. *Hospital and Community Psychiatry*, 36(7), 775-776.
- Frank, R. G., & Goldman, H. H. (1989). Financing care of the severely mentally ill: Incentives, contracts, and public responsibility. *Journal of Social Issues*, 45(3), 131-144.
- Goering, P., Cochrane, J., & Durbin, J. (1996). "Structures for co-ordinating mental health care in Toronto," Report to Metropolitan Toronto District Health Council.
- Goldman, H. H., Morrissey, J. P., & Ridgely, M. S. (1990). Form and function of mental health authorities at RWJ foundation program sites: Preliminary observations. *Hospital and Community Psychiatry*, 41(11), 1222-1230.
- Goldman, H. H., Morrissey, J. P., & Ridgely, M. S. (1994). Evaluating the Robert Wood Johnson Foundation Program on Chronic Mental Illness. *The Milbank Quarterly*, 72(1), 37-45.

- Hadley, T. R., Muijen, M., Goldman, H., & Shepherd, G. (1996). Mental health policy reform and its problems in the UK: Deja vu. *Current Opinion in Psychiatry*, 9(2), 105-108.
- Hanig, D. A., & Gilman, W. (1995). A consumer-centered information system. Washington state's experience. *New Directions for Mental Health Services*, 66, 75-85.
- Hughes, J. (1991). How well has Canada contained the costs of doctoring? *JAMA*, 265(18), 2347-2351.
- Hughes, W. (1996). The case for parity in mental health insurance through a single-payer plan. *Psychiatric Rehabilitation Journal*, 20(1), 33-36.
- Hoge, M. A., Davidson, L., Griffith, E. E. H., Sledge, W. H., & Howenstine, R. A. (1994). Defining managed care in public-sector psychiatry. *Hospital and Community Psychiatry*, 45(11), 1085-1089.
- Joint Policy and Planning Committee. (1995a). Replacing peer groups with adjustment factors. DP3-2.
- Joint Policy and Planning Committee. (1995b). Final recommendations of an activity measurement working group regarding the evaluation of CIHI's psychiatric CMGs. RD2-5.
- Lajeunesse, R., & Ross, K. (1995). Mental health system restructuring in Alberta and New Brunswick: A presentation to the Canadian Mental Health Association Ontario Division Executive Director's Network.
- Lave, J. R., Jacobs, P., & Markel, F. (1992). Transitional funding: Changing Ontario's global budgeting system. *Health Care Financing Review*, 13(3), 77-84.
- Leff, H. S., Lieberman, M., Mulkern, V. and Rabb, B. (1996). Outcome trends for severely mentally ill persons in capitated and case managed mental health programs. *Administration and Policy in Mental Health*, 24(1), 3-23.
- Lehman, A. F. (1987). Capitation payment and mental health care: a review of the opportunities and risks. *Hospital and Community Psychiatry*, 38(1), 31-38.
- Lehman, A. F., Postrado, L. T., Roth, D., McNary, S. W., & Goldman, H. H. (1994). Continuity of care and client outcomes in the Robert Wood Johnson Foundation program on chronic mental illness. *Milbank Quarterly*, 72(1), 105-122.
- Lesage, A. D., Clerc, D., Uribe, I., Cournoyer, J., Fabian, J., Tourjman, V., VanHaaster, I., & Chang, C. (1996). Estimating local-area needs for psychiatric care: a case study. *British Journal of Psychiatry*, 169, 49-57.

- Lyons, J. S., O'Mahoney, M. T., Doheny, K. M., Dworkin, L. N., & Miller, S. I. (1995). The prediction of short-stay psychiatric inpatients. *Administration and Policy in Mental Health*, 23(1), 17-25.
- Mechanic, D. (1991). Strategies for integrating public mental health services. *Hospital and Community Psychiatry*, 42(8), 797-801.
- Ontario Ministry of Health. (1994). Guidelines for the Allocation of the Community Investment Fund.
- Mitchell, J. B., Dickey, B., Liptzin, B., & et al., (1987). Bringing psychiatric patient into the medicare prospective payment system: Alternatives to DRGs. *American Journal of Psychiatry*, 144(5), 610-615.
- Morrissey, J. P., Calloway, M., Bartko, W. T., & et al., (1994) Mental Health authorities and service system change: Evidence from the Robert Wood Johnson Foundation Program on Chronic Mental Illness, *Millbank Quarterly*, 72(1), 49-80.
- Nasir, H. (1994). *Mental health and health care resource allocation*. Report to Alberta Health.
- Newman, S. J., Reschovsky, J. D., Kaneda, K., & et al., (1994). The effects of independent living on persons with chronic mental illness: An assessment of the section 8 certificate program component of the program on chronic mental illness. *The Milbank Quarterly*, 72(1), 171-198.
- Okin, R. (1995). Testing the limits of de-institutionalization. *Psychiatric Services*, 46(6), 569-574.
- Ontario Ministry of Health. (1996). Business Plan, Publications Ontario.
- PGF Consultants, Inc. (1994). The Status of mental health reform in New Brunswick.
- Rapp, C. A., & Moore, T. D. (1995). The first 18 months of mental health reform in Kansas. *Psychiatric Services*, 46(6), 580-585.
- Reed, S. K., Hennessy, K. D., Mitchell, O. S., & Babigian, H. M. (1994). A mental health capitation program: II. Cost-benefit analysis. *Hospital and Community Psychiatry*, 45(11), 1097-1103.
- Schinnar, A. P., Rothbard, A. B., & Hadley, T. R. (1992). A prospective management approach to the delivery of public mental health services. *Administration and Policy in Mental Health*, 19(4), 291-308.
- Sharfstein, S. S., Stoline, A. M., & Goldman, H. H. (1993). Psychiatric care and health insurance reform. *American Journal of Psychiatry*, 150, 7-18.
- Shore, M. F., & Cohen, M. D. (1990). The Robert Wood Johnson Foundation program on chronic mental illness: An overview. *Hospital and Community Psychiatry*, 41(11), 1212-1216.

- Shore, M. F., & Cohen, M. D. (1994). Introduction. *The Milbank Quarterly*, 72(1), 31-35.
- Stoskopf, C., & Dadakis Horn, S. (1992). Predicting length of stay for patients with psychoses. *Health Services Research*, 26(6), 743-766.
- Wellock, C. M. (1995). Is a diagnosis-based classification system appropriate for funding psychiatric care in Alberta? *Canadian Journal of Psychiatry*, 40(9), 507-513.
- Yank, G. R., Hargrove, D. S., & Davis, K. E. (1992). Toward the financial integration of public mental health services. *Community Mental Health Journal*, 28(2), 97-109.

10. EVALUATION

10.1 Introduction

The monitoring and evaluation of mental health reform is seen as a critical element of system change in most planning documents and there has been a recent proliferation of articles and reports focused upon the measurement of mental health outcomes (*Atkinson, 1996; Burlingame et al., 1995; Butler, 1994; deBruyn, 1992; Jenkins, 1990; Marks, 1996; Mirin & Namerow, 1991; Wells, 1991*). Evaluation in this context is a type of applied research which uses quantitative and qualitative data-based activities to answer policy related questions.

Research studies which assess the effectiveness of particular approaches using controlled methods have been reviewed in the previous section to identify best practices. The focus of such studies is upon explanation and prediction. Scientific evidence from such research extends theory and focuses upon understanding causal relationships. It is a critical element of system reform, and government support for such studies is necessary to build our knowledge base. Recent federal documents have outlined the basic elements of conducting field evaluations of programs for the treatment of schizophrenia (*Goeree, 1994*) and provided specific examples of their application (*Goeree, 1996*). The principles and techniques that are described are applicable to most community service and support programs.

The focus of this discussion shifts to the evaluation of service performance in uncontrolled conditions that is conducted for administrative, accountability, policy and planning purposes. The current interest in evaluation of mental health outcomes is driven by multiple factors (*Cochrane & Goering, 1992*). Concern about the rising cost of providing mental health care and widespread reform efforts have heightened the importance of developing mechanisms to collect outcome data and monitor the effects of change. The monitoring of hospital and community services and supports is necessary in order to assess whether mental health policy and plans are being implemented successfully. Are the needs of the target population being met? Where should resources be allocated? Are initiatives operating as intended? What impact are they having? Mental health program administrators and practitioners also need outcome data to guide their efforts and modify their practice patterns so that they are as effective and efficient as possible in providing care for their clients.

10.2 Monitoring Performance – Processes and Outcomes

A recent review of the literature on monitoring performance, prepared for the Alberta Health Mental Health Services Branch (*Forth & Nasir, 1996*), provides a comprehensive discussion of conceptual models, reviews levels of measurement, and various mental health outcomes measures. Forth and Nasir outline how conceptual models can link operationally defined **needs, target populations, goals, inputs, intervention processes, outputs** and **expected outcomes**. They stress that program and system evaluations are dependent upon the specification of how particular inputs and processes can be expected to produce relevant short-term or process outcomes and how these in turn lead to long-term or ultimate outcomes. When such a conceptual model is articulated, it provides a basis for selecting specific measures of the various dimensions and for considering how they are interrelated. Key aspects of performance can then be continuously monitored and fed back to stakeholders for continuous quality improvement. Characteristics of good measures are defined and the importance of having a comparative base (i.e. control groups, process standards, benchmarks) by which to interpret and judge outcomes is emphasized.

The practical aspects of performance monitoring are described in Part II of the above review. There are different stakeholder groups who need performance data and the selection of measures must take their information needs into account as well as feasibility and ethical acceptability. Four levels of measurement are defined as follows:

Client: At the client level, measures provide information about the client's clinical and functional condition; whether the intervention was safe, ethical and appropriate; and the client's level of satisfaction. Client **satisfaction and quality of life** have become especially important measurement domains.

Program: Program level measures document the **critical pathways and processes** that clients follow from the time the case is opened, to the time it is closed. Measures should be chosen for their presumed relation to client outcomes.

System: System performance measures provide information about whether the service system as a whole is **balanced, integrated, community-based, consumer-driven, accessible, efficient, and cost effective**. System performance measures should be able to capture those performance dimensions that are unique to system, such as coordination of care among agencies, the cumulative community impact of broad-based structural interventions, as well as aggregated client outcome and agency performance data.

Population: Population health monitoring uses broad population statistics (for example, mortality and life expectancy rates, self-reported health status) as **indicators** of general population health. These provide a barometer of general community and societal wellbeing. (*Forth & Nasir, 1996*)

Various measures for each of these levels are summarized in tabular form in the appendices of the report. The authors conclude that the area of client and program outcome measurement is relatively well developed but that the task of linking client, program and system performance needs to be addressed. The need for measures that relate cost to effectiveness and benefits is recognized (*see also Beecham et al., 1991; Clark et al., 1994; Hafner & an der Heiden, 1991*). They point out that the systematic measurement of mental health system performance is in its infancy with the most common measures currently in use relying upon hospital and service utilisation data as proxies of system change. Given that the health status of a population is determined by many other factors besides a good quality mental health system, strategies at this level will require intersectoral (health, education, environmental, etc.) collaboration and action.

Another literature review on monitoring performance and mental health outcomes has been prepared by the Mental Health Outcome Information Centre for the Nova Scotia Department of Health (*Carlson et al., 1994*). The authors note a discrepancy in the literature between the amount of attention given to defining outcomes and to using them to monitor performance. They focus their attention upon reports and practices that have immediate applicability rather than potential promise. Benchmarking in the Total Quality Management literature refers to a process of identifying best performance which can then be replicated by other providers (*Anderson & Rivenburgh, 1992*). The authors identify this use of outcome data as having the greatest likelihood of immediate benefit for mental health services. The type of outcome data to be gathered is classified in terms of health status, value of services and factors that predict progress. Problems of measurement across the lifespan are highlighted. Methods of assessment, their advantages and disadvantages are summarized. The bulk of this review is a summary of various instruments that might be used to assess outcomes grouped into those that assess health status and those that diagnose the nature of disorder. Instruments suitable for children and adolescents are separated from those for adults. Recommendations for a developmental process for a system wide outcome information system are proposed.

10.3 Quality of Life as a Mental Health Outcome

Although there is wide agreement that quality of life is a central client outcome, measurement of improvement has proved difficult. There is considerable diversity of opinion about conceptual definitions, a proliferation of instruments (*Lehman, 1996; Nelson et al., 1995*) and ongoing difficulties with finding clinically significant differences between treatment groups and documenting change over time. A report recently published by Health Canada provides an overview of these issues and an extensive inventory of assessment instruments (*Atkinson & Zibin, 1996*). There is evidence that subjective perceptions of satisfaction with life domains are generally skewed toward the positive and relatively impervious to change (*Cheng, 1988; Myer & Diener, 1996*). This has led some to shift the emphasis concerning client outcome to more objective status measures (Rapp et al., 1988). A recent International Association of Psychosocial Rehabilitation Services project attempts to operationalize generic status measures (e.g. employment, education, hospitalization, residence etc) in a standardized manner so that cross program comparisons are facilitated (*Arns, 1995*).

10.4 System Evaluation – Structures and Processes

A policy background paper prepared for the Ministry of Health in Ontario focuses on evaluation at the system level (*Cochrane & Goering, 1992*). Examples of system evaluation strategies and structures from other jurisdictions are presented and key questions which have been formulated to guide the evaluations are summarized, as are conclusions and implications for Ontario. Two main approaches to the evaluation of systems of care are considered. The first relies on an **internal** capacity to generate information and analyse it to achieve quality assurance and manage services in accordance with desired goals (*Hogan & Essock, 1991*). The second creates and supports **external** monitoring and evaluation by stakeholder groups with a vested interest in holding providers and management accountable and/or by investigators with interests and technical expertise in health services research. Elements of these two approaches receive varying emphasis from one jurisdiction to another.

The structure and process of evaluation of mental health reform in **Ohio** is provided as an example of a comprehensive strategy that included both internal and external components. (This description is based upon a site visit, review of documents and interviews with key informants.) Evaluation was legislated by the Mental Health Act passed in 1988 which called for the establishment of an independent Study Committee on Mental Health Services and focused the research capacity within the state Department of Mental Health on the evaluation of change. Because of the importance of assessing the impact of the Mental Health Act, the Department of Mental Health allocated over \$2.5 million in federal and state funds over two years to evaluate the impact of the act.

Internal capacity in Ohio is centered in a very busy Program Evaluation and Research Office which acts as a granting office, offers technical assistance to county boards, and conducts research. A comprehensive information system which reports on hospital and community services was established early in the reform process. Regular reports of key performance indicators were published as statistical notes and widely distributed. This means that data comparing the performance and costs of various hospitals and county boards was readily available to various stakeholder groups. In addition, at the county board level, evaluation plans formed a part of the annual mental health plans that were reviewed before funds were allocated. Boards began requiring that all contract service providers develop and use meaningful outcome studies, reporting information on client functioning and satisfaction at mid and year end.

External evaluation capacity was fostered through two channels. One was the awarding of research grants to university investigators on the basis of priorities set by a “framing of the questions” exercise which involved various stakeholder groups in setting a research agenda. There was a steady growth in the number of studies that are focused on topics of direct interest and relevance to government and the broader community. The second was the establishment of the Study Committee with a mandate to determine whether the goals of the legislation had been met and to evaluate its effect on funding and the provision of services. The study committee met for five years, utilizing data from multiple sources including analysis of the management information database, public forums and site visits. Preliminary and final reports played an important role in documenting the positive impact of system's reform and

identifying the pressing problems that still needed attention (*Study Committee on Mental Health Services, 1993*).

Ohio is not the only state that has implemented a comprehensive approach to evaluation of mental health reform. Recent reports of similar efforts in Kansas and Washington are reported in the literature (*Gilchrist et al., 1994; Hanig et al., 1994; Rapp & Moore, 1995*) and summarized in the review by *Forth and Nasir (1996)*. These reports are encouraging, not only because of their generally positive findings, but because they demonstrate that it is possible to implement macro level approaches to the evaluation of system change that are feasible and involve extensive input from family and consumers (*Brower et al., 1994*). Although these types of projects are restricted in their ability to address scientific research questions (like those included in the Robert Wood Johnson multi-site study), they do provide us with valuable knowledge about the broad impact of “organic community support systems” (*Bachrach, 1982*) and about desired mechanisms for public accountability.

In a review of the experiences of other jurisdictions, *Cochrane & Goering (1992)* identified a number of common elements necessary for developing mechanisms for evaluating and monitoring mental health reform. It is clear that there needs to be leadership and accountability for the effectiveness of mental health services at the provincial level. Mental Health reform legislation should require the establishment of a comprehensive system monitoring and evaluation program and the creation of a centre or a body which reports to the legislature (or Ministry) and which is responsible for facilitating, overseeing and coordinating the evaluation of mental health reform.

Mechanisms need to be developed for the regular evaluation of all mental health programs and services; the development, implementation and review of quality assurance and evaluation procedures; and the development and implementation of a consistent, reliable, responsive, useful, credible, mental health information management system. Finally, a critically important element which should not be overlooked is the guarantee of a sufficient research and evaluation budget that is protected from major inflationary inroads and budget cuts.

It is of interest to note the role that management information systems have played in the system wide evaluations. They are consistently used to provide information about the utilisation of services so that questions about **who** is receiving **what** from **whom** can be answered and changes over time recorded. But their utility is quite different from what was envisaged in the 1970s when program performance measurement systems were initiated. These were comprehensive approaches that tried to develop standardized approaches to measuring program objectives, service delivery and outcomes that could be applied across an entire state or nation (*Ciarlo & Windle, 1988*). Few applications of such comprehensive systems were implemented. *Mowbray (1992)* uses this as an example of the failure of evaluation to have an impact. The lack of clear agreement and specification of objectives and reliable data to measure those objectives and an absence of any political payoff for developing them are seen as fundamental problems. There also has been a clear shift to more local, micro level approaches to accountability with the growth of managed care and third party payment. A more common approach now is to keep to a minimum the amount of standardized common data that is required at a macro level, supplementing it with special data collection targeted to particular issues, and encouraging local

authorities to develop their own performance measurement systems that link into the centralized system. A good example of this is found in Washington State where a client centered computerized system was developed in short order, in response to legislated mandate, with considerable diversity still present at the regional level (*Hanig & Gilman, 1995*).

10.5 Canadian System Evaluations

Province-wide, comprehensive evaluation strategies are less evident in Canada where instead there have been a number of interesting and valuable initiatives focused upon sub-components of the larger system. For example, British Columbia's strategic Mental Health Plan (1992) recommended that Research and Evaluation and Information systems be two of the major organizational areas. Formal evaluation was to be a consistent component of all mental health programs and specific studies were suggested to assess the functional level and quality of life of patients before and after their transfer from Riverview Hospital to the community. An integrated and comprehensive information system was to be completed within five years. A formal collaborative agreement between the Department of Psychiatry at the University of British Columbia and the Mental Health Services Division was expected to provide a vehicle for conducting research and evaluation related to reform. There are a number of studies underway that focus upon the Riverview population, and some progress has been made with regard to information system development, but the university-provincial liaison was not established.

The evaluations that have examined the Greater Vancouver Mental Health Service (*Bigelow et al., 1994; Beiser et al., 1985; Fuller-Torrey et al., 1993*) provide valuable evidence about a system of care for an entire metropolitan area. Still, as is true across Canada, ongoing evaluation of programs in rural areas and smaller communities is neglected and the interrelationship of the various geographic regions and levels of service needs to be monitored and assessed.

10.6 Discussion

Increased attention to the evaluation of performance at all levels, i.e. client, program, system and population, is evident in the number of reports and articles that focus upon this topic. There is especially an emphasis upon incorporating more measurement of outcome into routine practice and incorporating measurement of costs into assessments of performance. A wealth of instruments and scales are available and a number of inventories provide a guide to their selection and use. To facilitate the development and maintenance of systematic and reliable evaluation protocols, it is essential to involve individuals who have received extensive formal training in research and evaluation methodologies. The importance of defining clear and well specified conceptual models as a basis for all evaluation efforts cannot be underestimated.

10.7 Best Practices: Evaluation

Key Elements of Best Practice

Provincial or regional level:

- ★ There is leadership and accountability for monitoring the effectiveness of mental health services at the provincial level.
- ★ There is a comprehensive program in place for monitoring and evaluation. This program could be part of Mental Health reform legislation.
- ★ There is use of both internal and external evaluation mechanisms (to satisfy needs for monitoring and for new knowledge development).
- ★ Consumers, families and the full range of stakeholders have ongoing input and participation in evaluation planning.
- ★ There is regular monitoring of all mental health programs and supports according to preset goals, performance measures (benchmarks and targets) and time lines.
- ★ Assessment occurs at different levels - for example at the consumer, program, system and/or population level.
- ★ There is a useful information system that has common and local elements.
- ★ There is a sufficient, protected evaluation budget.

Program level:

- ★ Consumers, families and the full range of stakeholders have ongoing input and participation in evaluation planning.
- ★ There are methods of monitoring process and outcomes on a routine basis.
- ★ There are mechanisms for feeding results back to stakeholder groups for continuous quality improvement.
- ★ Program evaluation plans and information systems comply with broader evaluation strategies and also meet program needs.
- ★ Program funding is sufficient to support evaluation activities.

REFERENCES

- Arns, P.G. (ed)(1995). *A Toolkit for Measuring Psychosocial Rehabilitation Outcome*. International Association of Psychosocial Rehabilitation Services.
- Atkinson, M.J. & Zibin, S. (1996). *Quality of life measurement among persons with chronic mental illness: A critique of measures and methods*. Health Directorate, Health Promotion and Programs Branch, Health Canada.
- Bachrach, L.L. (1982). Assessment of outcomes in community Support systems: results, problems and limitations. *Schizophrenia Bulletin*, 8(1):39-60.
- Beecham, J., Knapp, M. & Fenyo, A. (1991). Costs, needs and fiscal outcomes. *Schizophrenia Bulletin*, 17(3):427-433.
- Beiser, M., Shore, J., Peters, R. & Tatum, E.(1985). Does community care for the mentally ill make a difference? A tale of two cities. *American Journal of Psychiatry*, 142(9):1047-1052
- Bigelow, D.A., Sladen-Dew, N. & Russell, J.S. (1994). Serving the severely mentally ill. in Bachrach, L.L., Goering, P., Wasylenki, D. (eds) *Mental Health Care in Canada: New Directions for Mental Health*. Jossey-Bass Publishers: San Francisco.
- Brower, L., Durand T.M. & Allen, D.G. (1994). Mental health reform: client and family member perspectives. *Evaluation and Program Planning*, 17(1):81-92.
- Butler, S.F. (1994). The assessment of outcome and value of psychiatric hospital treatment. *New Directions for Mental Health Services*, 63:83-94
- Burlingame, G.M., Lambert, M.J., Reisinger, C.W., Neff, W.M. & Mosier, J. (1995). Pragmatics of tracking mental health outcomes in a managed care setting. *The Journal of Mental Health Administration*, 22(3):226-236.
- Carlson, R., McGrath, P. & Sweet, S. (1994). Collecting useful outcome information on mental health services: a literature review. Report prepared for the Nova Scotia Department of Health, Halifax: *Mental Health Outcome Information Centre*.
- Cheng, S. (1988). Subjective quality of life in the planning and evaluation of programs. *Evaluation and Program Planning*, 11:123-134.
- Ciarlo, J.A. & Windle, C. (1988). Mental health program evaluation and needs assessment. In H.S. Bloom, D.S. Cordray, & R.J. Lights (eds) *Lessons from selected program and policy areas: New Directions for Program Evaluation*, San Francisco: Jossey-Bass.

- Clark, R.E., Teague G.B., Ricketts, S.K., Bush, P.W., Keller, A.M., Zubkoff, M. & Drake, R.E. (1994). Measuring resource use in economic evaluations: determining the social costs of mental illness. *The Journal of Mental Health Administration*, 21(1):33-41.
- Cochrane, J. & Goering, P. (1992). The Evaluation of System Reform. Report to the Ontario Ministry of Health.
- de Bruyn, T. (1992). *Quality Care and Outcome Indicators in the Mental Health Field: A Guide to the Literature*, Health Canada.
- Forth, C. & Nasir, H. (1996). *Mental Health Outcomes: A Review of Literature*. Report prepared for Alberta Health, Area Services Division, Mental Health Services Branch.
- Fuller-Torrey, E.F., Bigelow, D.A. & Sladen-Dew, N. (1993). Quality and cost of services for seriously mentally ill in British Columbia and the United States: *Hospital and Community Psychiatry*, 44(10):943-950.
- Gilchrist, L.D., Allen, D.G., Brown, L. et al., (1994). A public-academic approach to designing a state mental health program evaluation. *Evaluation and Program Planning*, 17(1):53-61.
- Goeree, R. (1994). *Evaluation of Programs for the Treatment of Schizophrenia: A Health Economic Perspective*. Health Canada.
- Goeree, R. (1996). *Evaluation of Programs for the Treatment of Schizophrenia: Part II A Review of Selected Programs in Canada*. Health Canada.
- Hafner, H. & an der Heiden, W. (1991). Evaluating effectiveness and cost of community care for schizophrenic patients. *Schizophrenia Bulletin*, 17(3):441-451.
- Hanig, D., Perry, R.D. & Johnson, S.S.(1994). Mental health reform in Washington State: the first steps. *Evaluation and Program Planning*, 17(1):37-42.
- Hanig, D.A. & Gilman, W. (1995). A consumer-centered information system: Washington State's experience. In Stein, LI & Hollingsworth, EJ (eds). *New Directions for Mental Health Services*, no. 66. San Francisco: Jossey-Bass.
- Hogan, M.F. & Essock, S.M. (1991). Data and decisions: can mental health management be knowledge-based? *Journal of Mental Health Administration*, 18(1):12-20.
- Jenkins, R. (1990). Towards a system of outcome indicators for mental health care. *British Journal of Psychiatry*, 157:500-514.
- Lehman A. F. (1996). Measures of quality of life among persons with severe and persistent mental disorders. *Social Psychiatry & Psychiatric Epidemiology*, 31:78-88.

- Marks, I. (1996). A computerized system to measure treatment outcomes and cost. *Psychiatric Services*, 47(8):811-812.
- Mirin, S.M. & Namerow, M.J. (1991). Why study treatment outcome? *Hospital and Community Psychiatry*, 42(10):1007-1013.
- Mowbray, C.T. (1992). The role of evaluation in the restructuring of the public mental health system. *Evaluation and Program Planning*, 15:403-415.
- Myers, D.G. & Diener, E. (1996). The pursuit of happiness. *Scientific American*, 27(5):70-72.
- Nelson, G., Wiltshire, C., Hall G.B., Peirson, L. & Walsh-Bowers, R. (1995). Psychiatric consumer/survivors' quality of life: quantitative and qualitative perspectives. *Journal of Community Psychology*, 23:216-233
- Rapp, C., Gowdy, E., Sullivan, W. & Wintersteen, R. (1988). Client outcome reporting: the status method. *Community Mental Health Journal*, 24(2):118-133.
- Rapp, C.A. & Moore, T.D. (1995). The first 18 months of mental health reform in Kansas. *Psychiatric Services*, 46(6):580-585.
- Strategic Mental Health Plan for British Columbia. (1992). Mental Health Services Division, Ministry of Health, British Columbia.
- Study Committee on Mental Health Services (1993). *The Result of Reform: Assessing implementation of the Mental Health Act of 1988*. Ohio Department of Mental Health.
- Wells, K. B. (1991). Outcomes research and mental health policy: advances in 1990-1991: *Current Opinion in Psychiatry*, 4:801-805.

11. HUMAN RESOURCES

11.1 Introduction

Human resource issues under Mental Health Reform pose complex problems and require innovations in thinking about the deployment and training of mental health personnel. The following review highlights the critical human resource issues identified by various jurisdictions and the approaches used to resolve them. Empirical research findings are not available in the literature to inform this discussion but descriptions of process and identification of problems with recommendations are available in reports and papers. These serve as the basis for this brief overview of human resource issues (see references).

Several important questions help to focus the discussion on human resources under Mental Health Reform. What new services will be provided and what are the skills involved? How should the work force be reorganized and what will it look like? Where will the jobs be and who will do the work? (*Premier's Council, 1994*). Hyde, in writing about human resource development, stresses the direct link between human resource planning and development and the quality and efficiency of program implementation (*Hyde, 1989*). The success of Mental Health Reform is then largely dependent upon good analyses of the human resource problems and the creation of viable strategies to manage them.

The shift in services from institutionally-based to community-based and the concomitant changes in treatment philosophy under Mental Health Reform represent the two major adjustments for the work force as a whole. A whole range of issues is associated with the transfer of resources into the community or redeployment. In the second area the changes in treatment philosophy require that workers prepare for new roles through training and reskilling programs. In each area of redeployment and training, there are specific system and program level concerns.

11.2 Redeployment of Staff

In most jurisdictions the shift to community- based service provision under Mental Health Reform occurs along a given time line, e.g., ten years. It usually takes as a benchmark for reallocation of resources, the transfer of approximately 50 percent of institutional resources to the community. In any system, this represents significant numbers of people whose working lives are affected. The literature shows that issues pertinent to redeployment are uniformly similar across jurisdictions. At the **macro/governmental level** the concerns most commonly identified are:

- differences in levels of compensation between institutional and community workers
- lack of transferability of pension and other benefits
- loss of seniority in cases where workers are coming from a unionized environment
- concerns of **regulated** health professionals that discipline specific work will be replaced by generic/multiskilled workers resulting in loss of provider accountability.

Proposed solutions to these obstacles to change are:

- adjust compensation levels using the principle of ‘equal pay for equal work’. This requires investment in job evaluation
- maintain comparable benefits
- provide job security commitments for those being transferred and alternative placements for staff unable to make the transfer (*Goodrick, 1990*)
- ensure practice standards are developed for new classes of workers and provider accountability is assured
- ensure the role of mental health professionals under mental health reform is defined

The time-frame, pace and magnitude of redeployment should be clearly articulated and negotiated, if necessary, at the governmental level. Determining the size of the workforce involved, the role attrition will play and the impact of governing legislation on plans for redeployment is important. Recently a survey was conducted in Ontario for the Health Sector Training and Adjustment Program that assessed the human resources patterns in the health care field and the activities and resources dedicated to training in preparation for health care restructuring (*Health Sector Human Resources, 1996*). All agree that adequate funds must be allocated to cover the costs of redeployment.

Redeployment at the **program level** involves problems and actions of a different sort. Programs can facilitate change by attending to process variables in employer/employee transactions. Building partnerships, using open communication styles, recognizing the threat experienced by workers, and providing supportive and innovative work environments contribute substantially to the success of the redeployment task. Human resource plans and implementation agreements that detail the specific conditions under which redeployment will take place are common as is the **voluntary** reassignment

of staff. Some organizations negotiate partnership agreements with community service providers that allow for the exchange of staff between inpatient and community services.

11.3 Training and Education

The reorganization of the workforce to do different types of work, e.g., case management, using new models of care, e.g., psychosocial rehabilitation, in community settings, requires careful attention to the preparation and retention of workers for these new roles. Training, education and reskilling initiatives are fundamental to the implementation of Mental Health Reform. Strongly emphasized in the training are the values under Mental Health Reform.

Responsibilities at the **macro level** in this area are:

- clear articulation of values of Mental Health Reform
- establishment of provincial training standards and core curriculum
- identification of attitudes, skill sets and knowledge bases for key Mental Health Reform roles, e.g., case management and crisis intervention
- provision of training funds
- assistance in the development of a structure for delivering training by identifying trainers and developing linkages within professional schools and community colleges to provide **generic skills** that enhance workforce flexibility and adaptability

An example of case management training in Ontario is the Humber College Post Diploma Certificate Case Management Course developed by the International Association for Psychosocial Rehabilitation, Ontario Chapter. The course, in operation since 1990, runs for 15 weeks and is open to students of diverse academic backgrounds, consumers and family members. Students work in a range of mental health and social service settings. The course focuses on the application of psychosocial rehabilitation principles to case management. It has been adopted by other communities in the province.

At the **program level** managers are providing opportunities for the assessment of the learning needs of employees, cost-effective training programs and mechanisms for helping employees with the change process. Organizations and jurisdictions involved in training recommend that training programs use the principles of adult learning and offer the program through a mix of experiential, didactic and in vivo methods, e.g., placements in community settings. Matching the backgrounds of the trainees with the characteristics of the community setting eases acceptance of new roles for institutional workers.

An excellent example of an organization-based course is the St. Thomas Psychiatric Hospital case management education and training program. Using the *Case Management Training Resource Guide (1993)* framework developed by the Mental Health Case Management Association of Ontario and

enhancing it with the addition of training modules, the course was initially designed for psychiatric hospital workers and then expanded to community mental health workers and consumers. The program is currently being evaluated by a local university.

Perhaps the greatest single training barrier for professionally trained institutional workers is the perception that the carefully cultivated discipline specific training valued by the professions will be lost in the change to a more generic role focus. Under Mental Health Reform workers on the whole are expected to provide services using a psychosocial perspective and from a community-based location. That is not to say that the specialized training of psychologists, nursing, social work and occupational therapy is not needed and does not have a place. What it means is that the field will expand to include non-professionally trained workers and those from the professions will be expected to incorporate new methods into their practices.

Integral to the success of training is the importance of respecting the skills and abilities of those undergoing training and recognizing the vast opportunities for skill transfer to the community. Organizations have started to recognize the benefit in making it easier for workers to move between the nonprofessional and professional sectors as the mental health field opens to non-credentialed workers and consumers. At the same time the field needs to ensure practice standards are in place and can be monitored in order to ensure provider accountability.

11.4 Consumers as Providers

The employment of consumers as providers of mental health care is a relatively recent phenomenon which has received some attention from prominent researchers in the field. A recent study by *Solomon et al., (1995)* investigated the use of consumers as case managers in a PACT model program to deliver care to seriously mentally ill patients. Using an experimental design, clients were randomly assigned to two teams, one composed exclusively of consumer case managers and the other made up of professionals. The results show that consumer case managers were equally successful at forming strong working alliances with clients and promoting positive outcomes.

Mowbray and Colleagues (1996) examine the issues created by employing consumers as peer support specialists for a research demonstration project designed to expand vocational services offered by case management teams. They found that peer support specialists (PSS) were highly positive about the benefits of their service. They described several positive outcomes in clients' job successes. They found that the identification factor in which one peer can offer another sympathetic understanding of mental illness - something which is often defined out of professional-consumer relationships - may add a special form of support and perhaps intimacy that can lower the social distance between provider and recipient with positive results.

Woodside and Cikalo (1995) describe a collaborative research project carried out by consumers and mental health professionals to learn what activities are meaningful for clients. The research team found the experience empowering, with consumer researchers discovering new skills and confidence,

and professionals appreciating the knowledge, skills and perspective brought by the consumers. Traditional power relationships between professionals and consumers were shifted during this project

Manning and Suire (1996) discuss factors which affect consumers' success as employees of mental health programs. The authors interviewed consumer case manager aides for information about the "bridges and roadblocks" encountered in their work. These factors include issues around orientation to the job; support from peers and supervisors; clear role expectations including the level of autonomy or involvement in decision-making and opportunities to work independently; empowerment through being treated like other employees and increased awareness of capabilities; the stigma of mental illness which interfered with their relationships with other staff and excluded them from some legitimate work activities; and agency policies which reduced stress and promoted job security including job sharing, flexible hours and a team approach with back up. Manning and Suire conclude by stating that by attempting to overcome the obstacles encountered by consumers in work situations "professionals and co-workers can facilitate new consumer employees' entry into the job market and provide the support they need at a very stressful time of transition. In turn, consumer employees can bring innovative and unique skills and perspectives to the mental health service system" (p 943).

11.5 Human Resource Development in the Health System

The focus of our discussion is human resource issues under Mental Health Reform yet the Health System too is undergoing rapid and significant change, much of which is mirrored in the smaller mental health system. The background paper prepared by the Health System Renewal Working Group on Human Resources refers to human resources being caught up in the 'tangle of reform' (*Background Information, 1996*). Shifts in emphasis in health care policy to primary care, increased community care, prevention and health promotion require new skill sets and in some cases new classes of workers. The larger system is struggling with regulation, remuneration and deployment of these new or 'renewed' workers. The changes too have implications for educational institutions, employers and the consumers of health care. The increased accountability required by the government and the public demands that workers and their employers prove that they are working efficiently and effectively. This emphasis requires the incorporation of best practice methods, the development of excellent information systems and the application of evaluation methodologies for services provided. This represents an enormous challenge to the whole system.

In another document, *Integrated Health Human Resources Development (1995)*, several issues and barriers to more integrated human resources are identified. Those relevant to mental health include: limited linkages between planners, policy makers and human resources development; consumer and provider resistance to change; competition among provider groups; current discipline focused educational models; and limited knowledge regarding the human resources requirements under reformed health care. They recommend collaborative and integrated action among all stakeholders in the areas of human resources planning, training /education and management.

11.6 Discussion

Jurisdictions across North America learned that attention to human resources in preparation for Mental Health Reform is essential to its successful implementation. Redeployment strategies and training frameworks are the key elements of human resource planning and much can be learned from the experiences of others to date. This brief summary has provided an outline of the complex problems that will be encountered in attempts to reorganize mental health services and shift resources from institutional settings to the community. Underlying the effectiveness of these strategies is the importance of political will to work through the complexities involved and a shared vision across all sectors.

11.7 Best Practices: Human Resources

Key Elements of Best Practice

There is a labour strategy to facilitate redeployment of staff that:

- ★ addresses issues such as the impact of collective agreements, loss of seniority, differences in levels of compensation;
- ★ clearly articulates the time frame, pace and magnitude of redeployment;
- ★ allocates adequate funds to cover the costs of redeployment.

There is a training strategy for developing the skilled labour force needed to implement mental health reform that includes both training and reskilling initiatives.

There are strategies in place to enhance consumer involvement as providers - e.g., through training, by including experience as an employment criterion.

References

- Building A Stronger Foundation: Component 1 Health Human Resources in Community-Based Care: A Review of the Literature.* (1995) Report for the Federal, Provincial and Territorial Deputy Ministers of Health. Unpublished Document.
- Goodrick, D. (1990) *National Technical Assistance Centre For Mental Health Planning. State's experience in transferring financial and staff resources from inpatient to community mental health service systems.* Unpublished Document.
- Health Sector Training and Adjustment Program. (1996). *Health sector human resources in Ontario: Result's from HSTAP'S survey.* Unpublished Document.
- Health System Renewal Working Group on Health Human Resources. (1996). *Background Information.* Unpublished Document.
- Hyde, P., Harrison, J. & Woody, D.L. (1989). *Concept paper: Human resources development.* Unpublished Document. Ohio Department of Health.
- Implementation Strategy Subcommittee for Building Support For People. (1990) *A Plan for Mental Health in Ontario: A Mental Health Training Network for Ontario: Discussion paper.* Unpublished Document.
- Canadian Association of Occupational Therapists, Canadian Dietetic Association, Canadian Nurses Association, Canadian Physiotherapy Association (1995). *Integrated Health Human Resources: Pragmatism or Pie in the Sky.* Unpublished Document
- International Association of Psychosocial Rehabilitation Services/Mental Health Case Management Association of Ontario Partnership. (1995). *Case management training initiatives in Ontario: Two model programs.* Unpublished Document.
- Manning, S.S. & Suire, B. (1996). Consumers as employees in mental health: Bridges and roadblocks. *Psychiatric Services*, 47(9):939-943.
- Mental Health Case Management Association of Ontario. (1993) *Case management training resource guide.* Unpublished Document.
- Ministry of Health. (1994). *Labour Strategy Work Group Report.* Unpublished Document.
- Mowbray, C.T., Moxley, D.P., Thrasher, S., Bybee, D., McCrohan, N., Harris, S., & Clover, G. (1996) Consumers as community support providers: Issues created by role innovation. *Community Mental Health Journal*, 32(1): 47-67.

Premier's Council on Health, Well-being and Social Justice. (1994). *Medium-term labour adjustment issues in the health and social services sectors: Initiating a debate*. Unpublished Document.

Solomon, P., Draine, J., & Delaney, MA. (1995). The Working Alliance and Consumer Case Management. *Journal of Mental Health Administration*, 22(2):126-134.

Woodside, H. & Cikalo, P. (1995). Collaborative research: Perspectives on consumer-professional partnerships. *Canada's Mental Health*, 43(1): 2-6.