

---

# **Review of Best Practices In Mental Health Reform**

**Prepared for the Federal/Provincial/Territorial  
Advisory Network on Mental Health**

---

***1997***

The opinions expressed in this publication are those of the authors and contributors and do not necessarily reflect the official views of Health Canada or the Provincial and Territorial Ministries of Health.

For additional copies, please contact:

Publications  
Health Canada  
Ottawa, Ontario  
K1A 0K9

Tel: (613) 954-5995  
Fax: (613) 941-5366

Ce document est aussi offert en français sous le titre :  
*Examen des meilleures pratiques de la réforme des soins de la santé mentale :*  
*Examen de la documentation*

© Minister of Public Works and Government Services Canada, 1998  
Cat. N° H39-441/1997E  
ISBN 0-662-26947-0

# **Review of Best Practices in Mental Health Reform**

Prepared for the Advisory Network  
on Mental Health 1997

by Health Systems Research Unit  
Clarke Institute of Psychiatry



## *Project Team*

*The following people were responsible for designing  
and conducting this review:*

**Principal Investigator:**

Paula Goering

**Co Investigators:**

Jeanette Cochrane  
Janet Durbin  
Alain Lesage  
Joy Rogers  
John Trainor  
Don Wasylenki

**List of Authors:**

Kathy Boydell  
Dale Butterill  
Jeanette Cochrane  
Janet Durbin  
Paula Goering  
Joy Rogers  
John Trainor

**Research Assistant:**

Daniel Gelinas  
Brenda Gladstone  
Andrea Redford

# Table of Contents

<b>PREFACE</b>	<b>vii</b>
<b>EXECUTIVE SUMMARY</b>	<b>viii</b>
<b>I. Core Services and Supports: Summary of Evidence and Key Elements of Best Practice</b>	<b>ix</b>
Assertive Community Treatment/Case Management	ix
Crisis Response/Emergency Services	x
Housing/Community Supports	xi
Inpatient/Outpatient Care	xii
Consumer Self-Help and Consumer Initiatives	xiii
Family Self Help	xiv
Vocational/Educational Services	xiv
<b>II. Summary of System Reform Strategies</b>	<b>xv</b>
Policy	xv
Governance and Fiscal	xv
Evaluation	xvii
Human Resources	xvii
<b>Next steps</b>	<b>xviii</b>
<b>INTRODUCTION AND METHODOLOGY</b>	<b>xix</b>
<b>Introduction</b>	<b>xix</b>
<b>Methodology</b>	<b>xxi</b>

## **Section I: Core Services in a Comprehensive Mental Health System**

<b>1.</b>	<b>CASE MANAGEMENT/ASSERTIVE COMMUNITY TREATMENT</b>	<b>3</b>
1.1	Introduction & Definitions	3
1.2	Review of Research	6
1.2.1	Reviews	6
1.2.2	Additional Studies	6
1.2.3	Summary of Findings	13
1.3	Research Directions	15
1.4	Discussion	17
1.5	Best Practices: Case Management/Assertive Community Treatment	18
<b>2.</b>	<b>CRISIS RESPONSE SYSTEMS/PSYCHIATRIC EMERGENCY SERVICES</b>	<b>25</b>
2.1	Introduction & Definitions	25
2.1.1	Goals of a CRS	26
2.1.2	Key Functions of a Crisis Response System	26
2.1.3	Components of a Crisis Response System	27
2.1.4	Summary	30
2.2	Review of Research	30
2.2.1	Community-based Services	30
2.2.2	Hospital-based Services	33
2.2.3	Medical Crisis Service versus Hospital Treatment	33
2.3	Discussion	34
2.4	Best Practices: Crisis Response Systems/Psychiatric Emergency Services	34
<b>3.</b>	<b>HOUSING/COMMUNITY SUPPORT</b>	<b>38</b>
3.1	Introduction & Definitions	38
3.1.1	Housing and Mental Health Reform	39
3.1.2	Supported Housing	39
3.2	Review of the Research	40
3.2.1	Reviews	41
3.2.2	Additional Studies	42
3.3	Discussion	47
3.4	Best Practices: Housing/Community Support	49

<b>4.</b>	<b>INPATIENT/OUTPATIENT CARE</b>	<b>56</b>
4.1	Introduction and Definitions	56
4.2	De-institutionalization/Downsizing of Psychiatric Hospitals	57
	4.2.1 Reviews	57
	4.2.2 Additional Studies	58
4.3	Shorter Length of Stay in Hospital	59
	4.3.1 Reviews	59
	4.3.2 Additional Studies	59
4.4	Partial Hospitalization	60
	4.4.1 Reviews	60
	4.4.2 Additional Studies	62
4.5	Home Treatment	63
	4.5.1 Reviews	63
	4.5.2 Additional Studies	63
4.6	Relationship to Primary Care	64
	4.6.1 Primary Studies	64
4.7	Discussion	66
4.8	Best Practices: inpatient/outpatient care	67
<b>5.</b>	<b>CONSUMER SELF-HELP AND CONSUMERS INITIATIVES</b>	<b>73</b>
5.1	Introduction & Definitions	73
5.2	Traditional Self-Help Models in the Mental Health Field	75
5.3	Consumer Initiatives in the Mental Health Field	77
5.4	Discussion	80
5.5	Best Practices: Consumer Self-Help and Consumer Initiatives	82
<b>6.</b>	<b>FAMILY SELF-HELP</b>	<b>87</b>
6.1	Introduction & Definition	87
6.2	Published Literature	89
6.3	Discussion	91
6.4	Best Practices: Family Self-Help	92

<b>7.</b>	<b>VOCATIONAL/EDUCATIONAL SERVICES</b>	<b>95</b>
7.1	Vocational Services: Introduction & Definitions	95
	7.1.1 Employment Preparation Programs	95
	7.1.2 Employment Programs	96
	7.1.3 Supported Employment	97
7.2	Reviews of Vocational Research	99
	7.2.1 Summary of Research Findings	100
	7.2.2 Research Directions for Supported Employment	101
7.3	Educational services	102
7.4	Best Practices: Vocational/ educational Services	103

## **Section II: Mental Health System Reform Strategies**

<b>8.</b>	<b>POLICY</b>	<b>109</b>
8.1	National Context	109
8.2	Policy Themes	110
8.3	Policy Options	111
8.4	Summary	112
8.5	Best Practices: Policy	112
<b>9.</b>	<b>GOVERNANCE AND FISCAL STRATEGIES FOR ACHIEVING MENTAL HEALTH REFORM</b>	<b>115</b>
9.1	Introduction	115
9.2	Needs Based Allocations	116
	9.2.1 Experiences	117
9.3	Strategies for Integration	118
	9.3.1 Single Envelope Funding	118
	9.3.2 Authorities	119
	9.3.3 Experiences	120
9.4	Strategies for Program Reimbursement	122
	9.4.1 Strategies that link funding to individual need	123
	9.4.2 Strategies that link funding to program and system performance	126
9.5	Discussion	128
9.6	Best Practices: Governance and Fiscal Strategies	129



<b>10. EVALUATION</b>	<b>135</b>
10.1 Introduction	135
10.2 Monitoring Performance – Processes and Outcomes	136
10.3 Quality of Life as a Mental Health Outcome	137
10.4 System Evaluation – Structures and Processes	138
10.5 Canadian System Evaluations	140
10.6 Discussion	140
10.7 Best Practices: Evaluation	141
<b>11. HUMAN RESOURCES</b>	<b>145</b>
11.1 Introduction	145
11.2 Redeployment of Staff	146
11.3 Training and Education	147
11.4 Consumers as Providers	148
11.5 Human Resource Development in the Health System	149
11.6 Discussion	150
11.7 Best Practices: Human Resources	150
<b>Appendix A: Federal and Provincial Documents Related to Mental Health Care</b>	<b>153</b>



## PREFACE

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

The Health Systems Research Unit of the Clarke Institute of Psychiatry was commissioned to undertake this body of work, which culminated in three deliverables: *Best Practices in Mental Health Reform: Discussion Paper 1997*, and two background papers *Best Practices in Mental Health Reform: Situational Analysis*, and the present document *Review of Best Practices in Mental Health Reform*. It should be noted that the views expressed in these publications are those of the authors, and do not necessarily represent the views of the ANMH.

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

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

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

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

## EXECUTIVE SUMMARY

The purpose of this literature review is to summarize the evidence that is most relevant to the reform of our mental health systems and to guide the reader to other reviews and resources.

The review has focused upon services and strategies for persons with serious mental illness at the program and system level. It has generally not included research into client-level treatment interventions. The question of interest is how to best organize programs and systems within which efficacious clinical interventions and treatments can be provided.

The nature of the evidence that is used to define ‘best practice’ is somewhat different when one moves from medical treatment research to the effectiveness of programs in community settings. In this review we have whenever possible reported the findings of randomized, controlled studies. But as will become clear, such evidence is not always available, especially with regard to newer service and support modalities. In its absence, the best recent data-based evaluations are described.

In the search for best practices we surveyed published and unpublished evidence-based knowledge about mental health reform initiatives. Articles and documents in French as well as English were appraised for this review. A computer assisted search of PsychLit and MEDLINE databases was conducted. This was supplemented by citations in the literature and by checking our search results with the Psychiatric Rehabilitation Journal and Current Psychiatric Opinion, both of which publish reviews of recent literature on similar topics of interest. In some instances we contacted experts in other jurisdictions for information about unpublished articles or documents.

This review has two parts. The first is concerned with the development of effective services and supports that are components of a comprehensive community support system. It compiles information about current evidence to inform decision making about the different elements of care that should be in place in each local community. Proven and promising approaches to providing individual supports, inpatient/outpatient care, housing, employment and self-help are described. The second part of the review shifts to macro-level or system-wide strategies that foster the widespread implementation of the effective services and supports identified in Section I. Facilitative policy, modified governance and funding mechanisms, evaluation and human resource strategies can all be tools for change. Evaluation of macro-level approaches to system change is difficult but there are some empirical studies that can guide the definition of best practice, as can descriptions of experience in other jurisdictions.

We have examined these two types of practice separately, but they should be applied together. For example, the system strategy of setting clear and measurable targets about shifting resources from hospital to community is successful only if it contributes to an increase in the availability of case management programs or consumer and family initiatives, which then improve the quality of life of their participants. There are not always immediate or visible connections between the two types of

practice, but system practices are ineffective if they do not act through services and supports. At the same time, widespread dissemination of effective services and supports is dependent upon conducive system practices.

If best practices are considered to be **activities and programs that are in keeping with the best possible evidence about what works**, then the studies that are reviewed in this document provide a solid base for the definition of best practices related to mental health reform. There is stronger research evidence for some types of services and supports than others, and in some areas little can be said from this perspective. Still, the adage that we know far more than we do, clearly applies to the provision of community support for those who are severely mentally ill.

The following descriptions of best practice are meant to influence and inform policy rather than dictate specifically what course should be taken. Descriptions of best practice in many ways resemble descriptions of ideal service delivery systems. In the real world it is rare for all the components to be achieved and usually attention is focussed upon selected aspects as targets for change. Incremental progress on multiple fronts is the most typical way in which systems are improved.

## **I. Core Services and Supports: Summary of Evidence and Key Elements of Best Practice**

A balanced and effective service and support system is a central aim of mental health reform. It is meant to consist of programs that involve consumers and their families in the design and delivery of care. The promotion of independence to the fullest extent possible and true community integration are overall goals. Based upon the evidence from the literature such a balanced and effective service delivery system will include the following:

### **Assertive Community Treatment/Case Management**

#### **Research Evidence**

A wide array of rigorous trials have accumulated evidence that:

- demonstrate that Assertive Community Treatment (ACT) programs are superior for improving clinical status and reducing hospitalization

Studies generally support that ACT:

- is a cost-effective alternative to hospitalization with standard aftercare for persons at risk for repeated hospitalization
- produces high rates of client and family satisfaction and no increased burden on families

A smaller body of controlled and uncontrolled studies show that:

- Rehabilitation and personal strengths models are effective in improving social and vocational functioning, and promoting residential stability and independence

**Key Elements of Best Practice**

ACT programs which include the following components:

- assertive outreach
- continuous, round the clock, time unlimited, individual support to people with serious mental illness
- services are predominantly provided in the community as opposed to office-based
- provision of flexible support specifically tailored to meet the needs of each individuals
- involvement of consumers and their families in all aspects of service delivery, including design, implementation, monitoring and evaluation

Programs are provided which serve special needs groups such as those with dual disorders.

Other clinical case management programs are provided to serve clients with less intensive needs.

Clinical case management program models include:

- Rehabilitation model which focuses on improving living skills, is individually tailored to client needs and provides continuous interpersonal support
- Personal Strengths model which focuses on client strengths and identifies or develops community resources and environments where clients can achieve success.

**Crisis Response/Emergency Services**

**Research Evidence**

Non-experimental and descriptive studies suggest that:

- crisis housing provides a viable alternative to hospitalization for persons with SMI
- diversion programs are effective
- crisis centres can serve persons with psychosocial problems

**Key Elements of Best Practice**

Services are established that resolve crises for persons with serious mental illness using minimally intrusive options.

Crisis programs are in place to divert people from inpatient hospitalization.

Evaluation/research protocols are incorporated into crisis programs.

Examples of crisis programs are:

- Telephone crisis services
- Mobile crisis units
- Crisis residential services - e.g. supervised apartments/houses, foster homes
- Psychiatric emergency/medical crisis services in hospitals

## **Housing/Community Supports**

### **Research Evidence**

Quasi-experimental and longitudinal studies show that:

- community residential programs can successfully substitute for long-term inpatient care
- supported housing can successfully serve a diverse population of persons with psychiatric disabilities but support networks need to be monitored
- consumer choice is associated with housing satisfaction, residential stability and emotional well-being

Cross-sectional studies show that:

- consumers prefer single occupancy, choice, and supports when requested

Controlled and non-controlled trials have demonstrated that:

- individuals with severe mental illness, including homeless people, can be housed when provided with assertive case management services

### **Key Elements of Best Practice**

A range of different housing alternatives (e.g. supervised group homes or other residential settings) is provided but there is a shift of resources and emphasis on supported housing.

Supported housing incorporates the following critical elements:

- use of generic housing dispersed widely in the community
- provision of flexible individualized supports which vary in intensity
- consumer choice
- assistance in locating and maintaining housing

- no restrictions on length of time client can remain in the residence
- case management services are not tied to particular residential settings but are available to the client regardless of whether the client moves or is hospitalized

Community residential housing is provided as a substitute for long-term inpatient care.

Housing needs of the homeless mentally ill which include an assertive outreach component are addressed.

## **Inpatient/Outpatient Care**

### **Research Evidence**

Well designed follow-up studies show that:

- Discharge of long-stay patients is associated with improved social functioning over time
- Individuals and families prefer community care to hospitalization
- Clinical and social outcomes are at least as good for discharged patients receiving community care as for matched counterparts remaining in hospital

Numerous controlled trials show that:

- Day hospitalization is less costly than inpatient care with comparable outcomes
- Day hospitalization offers more intensive treatment in a less restrictive and more home-like environment
- Shorter length of stay is generally not associated with increased readmission and achieves similar outcomes to longer stay admissions
- Home-based treatment is an effective alternative to admission for many patients

Preliminary descriptive studies show that:

- Integrating mental health professionals in primary care settings can enhance continuity of care; increase accessibility to mental health services; lead to more efficient use of mental health services; provide new opportunities for continuing education for physicians; and improves communication between mental health services and family practitioners.

### **Key Elements of Best Practice**

- Long-stay patients in Provincial Psychiatric Hospitals are moved into the community with carefully planned transitions to alternative care models.
- Inpatient stays are kept as short as is possible without harmful effects on patient outcomes.
- Partial hospitalization programs are available as an alternative for inpatient admission. Day treatment is an option for those with non-psychotic diagnosis.



- Home treatment programs (that are either assertive community treatment teams or adjuncts to intensive case management) are available as an alternative for inpatient admission.
- New service delivery models that link family physicians with mental health specialists are in place.

## **Consumer Self-Help and Consumer Initiatives**

### **Research Evidence**

While there is variability in the quality of studies conducted to evaluate self-help and consumer initiatives, there is consistency in findings.

- Participation in self-help is associated with
  - ♦ reduced hospitalization
  - ♦ reduced other service use
  - ♦ increased knowledge, information and coping skills
  - ♦ increased self-esteem, confidence, sense of well-being and of being in control
  - ♦ stronger social networks and support
- Compared with professionally led groups, self-help groups emphasize experiential knowledge and social support, and tend to be more spontaneous, unstructured and unconstrained by time.

### **Key Elements of Best Practice**

There are growing numbers of funded organizations that utilise non-service models to engage in:

- mutual support
- advocacy
- cultural activities
- knowledge development and skills training
- public education
- educating professionals
- economic development

Evaluation of the effectiveness of these initiatives that uses appropriate, alternative methods is supported.

The general public and mental health professionals are educated about the value of self-help.

Steps are taken to attract and train strong leaders for self-help groups.

## **Family Self Help**

### **Research Evidence**

Existing research on family self-help is limited in quantity and quality, with single group, cross-sectional study designs frequently used. Study findings associate participation in support groups with:

- increased levels of information among participants
- improved coping skills
- reduced caregiver burden
- improved identity as caregiver
- improved relationship with and ability to support ill relative
- improved emotional support

### **Key Elements of Best Practice**

- Funding is provided to family self help groups (as individual or joint consumer-family initiatives) and they are used as a resource in the planning and evaluation of care delivery.
- Evaluation of the effectiveness of these groups that uses appropriate, alternative methods is encouraged and supported.

## **Vocational/Educational Services**

### **Research Evidence**

There are a number of fairly rigorous studies which demonstrate that:

- People with serious psychiatric illness have the capacity to work
- Employment programs should be encouraged for even the most disabled individuals
- Supported employment is more effective than other employment models
- Supported education enables clients to return to school on a full-time basis

### **Key Elements of Best Practice**

There is a shift from traditional methods of providing vocational services to supported employment which includes:

- continuous, time-unlimited individual support
- attention to client preferences
- a place-train philosophy with on-site job specific skills training

Supported education and social recreational programs are viewed as promising approaches in need of further evaluation.

## II Summary of System Reform Strategies

Best administrative practices for creating an environment conducive to implementing mental health reform encompass policy; evaluation; governance and funding; and human resource planning as follows:

### 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.

### Governance and Fiscal

#### *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 indicates 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 is:

- 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.

## **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.

## **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.

### **Next steps**

This literature review is the first phase of a project to define best practice. The second phase will be a situational analysis of best practices in mental health reform in Canada. The intent is to provide specific examples and applications of best practices from the provinces. In particular, we want to be able to better describe how similar services and supports and system approaches have been fostered and developed as a part of mental health reform.

In a subsequent document, these descriptions will be compiled and discussed. In addition, three best practice strategies will be examined more closely and used as case studies of the process of mental health reform. The situational analysis will be used to illustrate and highlight activities across Canada that are in keeping with our current state of knowledge about mental health reform. They also will be used to identify the key factors and circumstances that facilitate or impede the development of best practices in mental health systems.

A final phase will synthesize the findings from the literature review and the situational analysis to develop promising approaches for mental health reform, appropriate indicators for systems and important characteristics of 'best practice' which lead to improved mental health outcomes.

# INTRODUCTION AND METHODOLOGY

## Introduction

The following document is a compilation of current knowledge about the delivery of services and supports for people with severe mental illness. The widely evident need to identify cost-effective approaches to providing mental health care is created in large part by the radical changes in patterns of care for this population (*Mechanic, 1996*). Deinstitutionalisation has created complex and challenging problems as clients have been dispersed into the community without the necessary services and supports to allow them to function successfully. There is a growing body of research that can be used to address these problems (*Mowbray, 1992*). The purpose of this literature review is to summarize the evidence that is most relevant to the reform of our mental health systems and to guide the reader to other reviews and resources. It is hoped that these findings will be utilized by those who want to improve care for clients and their families.

There are many reasons, pragmatic and ethical, why current reform policies give priority to the needs of the subpopulation with severe mental illness which represent approximately 2% of the general population and 10% of those who have a psychiatric diagnosis (*Offord et.al., 1994*). They have been ill served by past policy initiatives which closed hospitals and reduced beds as a cost cutting exercise, failing to protect the resources and create the directives needed to build adequate community support systems. In the absence of better community support, this subgroup consumes disproportionately high amounts of expensive inpatient and treatment services, with limited benefits to themselves or their families. Governments across North America are now attempting to reform their publicly funded health care systems so that the most needy are provided with humane and fiscally responsible care. Intrinsic to these efforts is the reallocation of existing resources to more effective, communitybased alternatives. Having true systems of care in place should also benefit the population of patients who are less ill or disabled, but their needs will continue, for the most part, to be met by other resources in the primary care and social service sectors.

A focus upon people with severe mental illness does not imply that those with less serious mental health problems are unworthy or less deserving. Growing policy concerns particularly relevant to their care include the relationship between family physicians and psychiatrists (Chapter 4) and the interface between primary and mental health specialty sectors. The reality is that there are many significant populations and topics related to the delivery of mental health services and supports that could not be adequately dealt with in this review. In particular there are a number of special populations with unique needs, e.g. children, elderly, ethno-cultural, under serviced areas, etc. Fortunately there are a number of Health Canada projects that have studied other aspects of mental health (see Appendix A). Some project documents will be highlighted in a report on best practices in Canada that is the second phase of this project. In addition, a final project report will identify issues and topics that require further study.

This literature review has focused on services and strategies at the program and system level. It has generally not included research into client-level treatment interventions. There is an extensive and valuable body of knowledge about the use of medications, individual and group therapy, psychoeducational and rehabilitation techniques that has not been covered. Instead, the question of interest is how to best organize programs and systems within which efficacious clinical interventions and treatments can be provided.

It was not unusual in the past for reviews of this sort to separate the delivery of care into two modes, i.e. traditional hospitalization and alternatives. The latter term was used to denote any and all types of community care that avoided or shortened inpatient stays for those with severe mental illness. Such summaries of controlled research evidence provided positive support for deinstitutionalisation (*Braun et al., 1982; Kiesler, 1982*). In the last decade the questions have shifted from the global one of whether community care is possible, to a number of much more specific ones about **what kinds** of programs work with **which individuals** to achieve a **variety of outcomes**. As better specified and more varied models of providing community care have evolved, it has been helpful to group approaches into a number of different categories depending upon their primary focus, as will be done in this review. Still, there is often considerable overlap between the categories and particularly with programs (such as assertive community treatment) that are multifaceted, their inclusion in one rather than another is somewhat arbitrary.

Although each chapter deals with a different group of services and supports, it is important to note that their provision needs to be integrated. The primary mechanisms for achieving continuity of care are case management at the client level (see Chapter 1) and regional authorities at the program and system level (see Chapter 9). Within both levels there should be a continual cycle of assessing needs, planning and providing care and evaluating results using a partnership model with those who are being served.

Best practices are considered to be *activities and programs that are in keeping with the best possible evidence about what works*. However, the nature of the evidence that is used to define "best practice" is somewhat different when one moves from medical treatment research to the effectiveness of programs in community settings. As Mechanic (1996) states "Health services research is different in that it addresses the implementation of care in the messy world with all of its difficulties." (P.372). Randomized trials are an important tool in mental health services research but they are not always feasible and have limitations (*Conrad, 1994*). Quasi-experimental research designs are thus often used to address questions of effectiveness and outcome. In this review we have whenever possible reported findings of randomized, controlled studies. But as will become clear, such evidence is not always available, especially with regard to newer service and support modalities. In its absence, the best recent data-based evaluations are described.

When evaluating the effectiveness of community health programs there is a general consensus that interventions and outcomes should be broad. This review includes a variety of approaches, e.g. housing and vocational programs together with treatment services. The effectiveness of these services and supports is gauged only in part by their impact upon health status. There is also an expectation that quality of life will improve, i.e. that participants will have a decent place to live, meaningful



occupation and social support. But it must be remembered that the larger societal context can limit or enhance the success of these efforts. In particular, widening disparities in the social and economic environment can contribute to disability and make rehabilitation more difficult. A determinants of health approach (*Health Canada, 1994*) has relevance to all components of the population. Although they are not the subjects of this review, employment, income and housing are all broader social issues that have direct and serious consequences for people with severe mental illness and their families.

This review has two parts. The first (Section I) is concerned with the development of effective services and supports that are components of a comprehensive community support system. It will compile information about current evidence that can inform decision making about the different elements of care that should be in place in each local community. Proven and promising approaches to providing individual supports, hospital-based care, housing, employment and self-help will be described. The second part of the review (Section II) shifts to macro-level or system-wide strategies that are used to create the necessary conditions and incentives to foster the widespread implementation of the effective services and supports identified in Section I. Facilitative policy, modified governance and funding mechanisms, evaluation and human resource strategies can all be tools for change. Their ultimate aim is the improvement of client and family outcomes, but this can only be achieved through their impact upon the organization and implementation of effective services and supports. Evaluation of macro-level approaches to system change is difficult however there are some empirical studies that can guide the definition of best practice as can descriptions of experience in other jurisdictions.

While we have separated our discussion of services and strategies into two parts, they should be applied together. For example, the system strategy of setting clear and measurable targets about shifting resources from hospital to community is successful only if it contributes to an increase in the availability of case management programs or consumer and family initiatives, which then improve the quality of life of their participants. There are not always immediate or visible connections between the two types of practice, but system practices are ineffective if they do not act through services and supports. At the same time widespread dissemination of effective services and supports is dependent upon conducive system practices.

## **Methodology**

The review focuses on the current state of knowledge about efforts to improve the organization, efficiency and effectiveness of mental health systems and the delivery of appropriate care for people with severe mental illness, with an emphasis on community-based services. In the search for best practices we surveyed published and unpublished evidence-based knowledge about mental health reform initiatives. Articles and documents in French as well as English were appraised for this review.

For Section I on core services, a computer-assisted search of PsychLit and MEDLINE databases from 1985 to the present was conducted. This was supplemented by citations in the literature and by checking our search results with the *Psychiatric Rehabilitation Journal* and *Current Psychiatric*

Opinion, both of which do reviews of recent literature on similar topics of interest. In some instances we contacted experts in other jurisdictions for information about unpublished articles or documents.

Key words used in the search varied by service/program area but included terms such as ‘mental health’, ‘mental illness’, ‘psychiatric illness’, and ‘evaluation’, ‘experimental’ plus the relevant program or service-related key words.

Whenever possible, current, rigorous reviews were identified and updated. Where good reviews did not exist, we conducted a search for relevant primary studies which employ experimental or quasi experimental designs or solid qualitative methodology.

In addition to published reviews, we looked at the provincial mental health documents, reviews and reports which were made available to us by the ANMH committee.

Review articles which conformed to the following criteria (*Mulrow, 1987*) were included:

- A well-conceived review always answers a question which should be clearly stated at the beginning of the review.
- The author should outline the search strategies used for identifying relevant articles and state the criteria for inclusion/exclusion.
- The method of appraising information, research designs, implementations and analyses, should be stated. To avoid single-reviewer biases, articles and data assessments should be consensus-ranked by more than one reviewer.
- Information should be systematically integrated using clearly stated methodologies.
- Limitations of the data should be identified.
- Conclusions should be logically ordered summaries of the data.
- Review articles should end by clearly stating existing knowledge about the subject matter, identifying gaps and suggesting future initiatives.

Primary studies were appraised to determine the quality and rigour of their experimental design. Only those that met with accepted standards of research methodology (qualitative and quantitative) were included using criteria as specified in Burns (1989), Forchuk & Roberts (1992), Hall et al., (1994) and Wortman (1994). It is assumed that both types of research can offer valuable information, as long as the method is appropriate to the research question (*Goering & Streiner, 1996*).

Section II deals with mental health systems reform strategies and a different, less scientific methodology was utilized. A computerized literature search was conducted using key words such as ‘mental health reform’, ‘policy’, ‘health care policy’, ‘systems’ and ‘utilization’. However, a great deal of the literature dealing with mental health policy issues is found in government and other unpublished documents. Key articles and documents that analyse and summarize experiences of other jurisdictions were identified. For each of the sub-sections – policy, governance and funding, monitoring and evaluation, and human resources – strategies based on the experiences that were successful in other jurisdictions are discussed with emphasis on the critical issues and lessons learned.

## REFERENCES

- Braun, P., Kochanzky, G., Shapiro, R., Greenberg, S., Gudeman, J.E., Johnson, S., Shore, M.F., (1981) Overview: Deinstitutionalisation of Psychiatric Patients, a Critical Review of Outcome Studies: *American Journal of Psychiatry*, 138(6):736-749
- Burns, N., (1989). Standards for Qualitative Research. *Nursing Science Quarterly*, 2(4):44-52
- Conrad, K.J., (1994) Critically Evaluating the Role of Experiments: *New Directions For Program Evaluation*, No.63
- Forchuk, C. & Roberts, J.,(1992) How to critique qualitative health research articles. Working Paper 92-2, System-Linked Research Unit, McMaster University, Hamilton, Ont.
- Goering, P., Streiner, D.L., (1996) Research Methods in Psychiatry: Reconcilable Differences: The Marriage of Qualitative and Quantitative Methods: *Canadian Journal of Psychiatry*, 41:491-497
- Hall, J.A., Tickle-Degnen, L. Rosenthal, R., & Mosteller, F. (1994). Hypotheses and problems in research synthesis. In H. Cooper & LV Hedges (Eds), *Handbook of research synthesis*. New York: Russell Sage Foundation
- Federal, Provincial, & Territorial Advisory Committee on Population Health (1994) Strategies for Population Health: Investing in the Health of Canadians: Health Canada.
- Kiesler, C.A., (1982) Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy of Mental Patients: *American Psychologist*, 37:349-360
- Mechanic, D., (1996) Emerging Issues in International Mental Health Services Research: *Psychiatric Services*, 47(4):371-375
- Mowbray, C.T., (1992) The Role of Evaluation in the Restructuring of the Public Mental Health System: *Evaluation and Program Planning*, 15:403-415
- Mulrow, C.D. (1987) The medical review article: State of the science. *Annals of Internal Medicine*, 106:485-488
- Offord, D., Boyle, M., Campbell, D., Cochrane, J., Goering, P., Lin, E., Rhodes, A., Wong, J., (1994) *Ontario Health Survey 1990*, Ontario Ministry of Health.
- Wortman, P.M. (1994). Judging research quality. In H. Cooper & LV Hedges (Eds), *Handbook of research synthesis*. New York: Russell Sage Foundation



**S E C T I O N I :**

***Core Services in a  
Comprehensive Mental  
Health System***



# 1. CASE MANAGEMENT/ASSERTIVE COMMUNITY TREATMENT

## 1.1 Introduction & Definitions

During the last decade case management has gained in acceptance and prominence to become a critical ingredient in a community focused mental health system. (*Goering & Wasylenki, 1996*) Early conceptualizations focused on the ability of case management to coordinate a fragmented system of care for people disabled by mental illness. More recently it has come to be viewed as a service which can help disabled people function in the least restrictive, most normal environment and achieve an improved quality of life. Case management is a key component in any strategy to reduce hospital inpatient census.

Although there has been widespread implementation of case management, there is no standardized method or definition of the approach. Some programs view case management as a brokerage function which requires little or no direct contact with the client and which involves only coordination and referral of the client to required services. But experience has shown that persons with serious mental illness require more support and direct service provision and need case management which focuses on client needs and explicitly employs a therapeutic relationship. This genre of case management is referred to as **clinical** case management which distinguishes it from the brokerage model. While case management practice can vary, fundamental aspects of the role are building a trusting and respectful relationship with clients and providing constant and ongoing support, even when a client's needs change and cross service settings. Core functions include assessment, planning, linking, monitoring, and advocacy. Beyond this, case management practice are diverse, reflecting the priorities and resources of individual programs. Caseloads vary in size and in terms of client skills and needs.

Table 1.1 outlines the goals and key features of case management practice and is adapted from a report to the Ontario Ministry of Health (*Goering et al., 1994*).



**Table 1.1– Case Management Practice**

<p style="text-align: center;"><b>GOALS</b></p> <ul style="list-style-type: none"><li>★ help individuals with severe and persistent mental illness to achieve the highest level of functioning possible in the least restrictive setting</li><li>★ help individuals obtain needed services from a fragmented health care system</li><li>★ remain a constant and ongoing source of support for people, even when their needs and use of services change</li></ul> <p style="text-align: center;"><b>KEY FEATURES</b></p> <ul style="list-style-type: none"><li>★ development of a caring, supportive relationship between practitioner and individual</li><li>★ emphasis on continuity of care - that is, supports provided as long as needed across service and program settings</li><li>★ flexibility in provision of supports to meet a person's perceived needs and changing needs over time</li><li>★ provision of supports to coordinate a fragmented system of care</li></ul>
---

*Robinson and Toff-Bergman (1989)* surveyed programs in the United States and Canada in order to “clarify the many meanings of case management” (p.11) and to develop a typology of case management practices. The four models they describe, which differ in the basic philosophy of their approaches and in the emphasis they place on the different functions, are presented below.

**Expanded Broker Model:** Has also been called the **generalist** model. It includes assessment, planning, linking and advocating. The case manager assesses needs and deficits and refers the client to appropriate services. The broker model was the first type of case management service provision and has not been widely researched. The outcome evidence from the few studies conducted has been largely negative and for this reason the model cannot be recommended as a ‘best practice’. Other more promising models are briefly described below.



**Rehabilitation Model:** Focus is on improving the client's living skills. Rehabilitation case management begins with a functional assessment to identify skill deficits with the objective of producing a comprehensive rehabilitation plan. Client needs and goals determine which services are provided. Case managers provide continuous interpersonal support, assistance in dealing with crises and accessing needed resources.

**Personal Strengths Model:** This model focuses on clients' strengths rather than disabilities and identifies or develops community resources and environmental situations where clients can achieve success. A strong interpersonal relationship, often defined as a partnership between the case manager and the consumer, is emphasized.

**Full Support Model:** This model, also known as Assertive Community Treatment (ACT), focuses on the reduction and management of symptoms. It combines skill teaching with clinical management and the provision of support. Distinguishing features of this model are case management provided by a multidisciplinary team of professionals, including psychiatrists, social workers, nurses, occupational therapists, vocational specialists, etc.; 24-hour, 7 days a week coverage; assertive outreach; and providing support to clients in the community where they live rather than office-based practice. This model called Training in Community Living (TCL) by *Stein and Test (1980)* and developed by them in Madison, Wisconsin, is the most widely replicated and evaluated model of case management.

The literature in case management reflects considerable confusion when distinguishing among these four models of service delivery. For example, one reviewer included a case management program as an ACT model because it provided support using a team approach, was community-based and had 24-hour availability. Another reviewer called this same service 'intensive case management' because the team was not multidisciplinary and did not provide direct service but referred the clients to specialized services in the community. Although on paper, there are distinct philosophical and structural differences, in practice these differences are often blurred. In actual practice, most programs are hybrids which do not always fit into neat definitional packages.

**Intensive Case Management** reflects certain dimensions of service delivery which although common to the full support model, can also be provided by practitioners of the rehabilitation and personal strengths models: frequency of contact; proactive outreach; small caseloads; 24-hour availability; and community-based practice. An intensive form of case management support is often necessary to maintain in the community those who are at greatest risk of rehospitalization. Intensive case management is geared to high need individuals and gives priority to activities that will prevent hospitalization. Among case management practitioners, there needs to be a subgroup who can provide intensive levels of support.

Whereas most of the research reviewed in this document compares different models of case management with each other or with standard community care, more recently the emphasis has been on delineating the important elements of service delivery and relating specific elements or components to client, family and systems level outcomes. This newer research also investigates program implementation and fidelity of the service components to the goals, objectives and structure of the program.

## 1.2 Review of Research

This section provides a brief summary of the reviews of case management research, followed by abstracts of additional studies not included in the reviews. The chapter concludes with a summary of research findings from both the reviews and the additional studies and recommendations for future research.

### 1.2.1 Reviews

Since 1985 there have been several reviews of the case management research literature, all of these published since 1990. These reviews cover studies published from 1973 until 1995 (see Table 1.2). Most of the investigations have been conducted to determine the efficacy of the full support models of case management. Training in Community Living (TCL), Assertive Community Treatment (ACT), Program in Assertive Community Treatment (PACT) models or modifications of these models as the experimental condition are compared to control or comparison conditions which are described as standard or usual care. Standard care can vary from discharge into the community with little or no follow-up to other forms of clinical case management which differ in some important respect from the experimental condition. Authors who have reviewed ACT, PACT, or TCL<sup>1</sup> models exclusively are *Olfson (1990)*, *Taube (1990)*, *Test (1992)*, *McGrew et al., (1994)*, *Bond et al.,(1995)* and *Burns and Santos (1995)*. Other reviewers (*Chamberlain and Rapp, 1991*; *Solomon, 1992*; *Holloway et al., 1992*; *Rubin, 1992*; *Scott and Dixon, 1995*; *Rapp, 1996*) have included studies in which the experimental conditions were other models of case management – expanded broker or generalist, rehabilitation, and personal strengths. The *Scott and Dixon (1995)* review also includes studies of intensive case management programs which are compared to generalist case management or standard community treatment. The review by *Rapp (1996)* analyses the results of 34 case management studies and makes inferences about the elements of the program models which contribute to positive client outcomes.

### 1.2.2 Additional Studies

The search for research not reviewed above resulted in nine additional investigations of case management using either experimental or quasi-experimental designs, repeated measures or pre-post designs. (See table 1.3 for characteristics of these studies). Three studies reported using randomized control designs (*Aberg-Wistedt et al., 1995*; *Jerrell, 1995*; *Lafave et al., 1996*). Studies by *Wood and Anderson (1994)* and *Sands and Cnaan (1994)* used a matched control design with no random assignment. Four studies employed a repeated measures or pre-post design (*McGrew et al., 1995*; *Dincin et al., 1993*; *Santos et al.,1993*; *McRae et al., 1990*).

---

1 In the following description of the research, TCL, ACT and PACT will be used interchangeably to refer to full support models of case management.

All studies evaluated the ACT approach to case management, and of those using a control group, the comparison was mostly to standard psychiatric care.

These studies and their findings are summarized below. While many studies collected baseline and follow-up data, findings recorded in table 1.3 report significant experimental/control group differences, not longitudinal comparisons.

In a Canadian study by *Lafave et al., 1996*, all clients referred to Brockville Psychiatric Hospital during a 12-month period were randomly assigned to an assertive community rehabilitation program, a team approach modelled on ACT, or to hospital-based case management programs. Clients in the experimental group were supported by a team which included a psychiatrist, nurses, social workers, vocational counsellors and a support worker who was a consumer/survivor. Clients were seen weekly in their homes or other community-based venues. Clients in the control group were admitted to hospital for assessment and individual treatment plans were developed in hospital. After discharge, clients were followed up by hospital staff. After 12 months, patients in both groups were contacted and interviewed by independent consultants.

The study collected data on quality of life, client satisfaction, residential autonomy, symptomatology, hospitalization and community tenure. The mean number of **hospital days** for clients in the experimental group was 16% of the number for the control group: 39 versus 256 days during the study period. In addition, each month, a greater number of ACT clients were **living in the community**. Clients in the experimental group had a higher score on one of the objective measures of quality of life – living situation and felt more in **control over their living environment**.

*McGrew and his colleagues (1995)* conducted a multisite study of ACT teams at 6 Community Mental Health Centers (CMHC) in Indiana. A total of 212 subjects with serious and chronic mental illness were followed for 18 months. This study used a within subject pre-post design. The number of hospitalizations for each patient were compared to data from the two-year period before entry into the program. Data on diagnosis, level of functioning, attitudes and compliance to medication and housing and vocational status were measured at baseline, six, 12 and 18 months post-entry into the ACT programs.

Results showed a significant improvement at five of the six sites. Overall, **hospital use** both in terms of number of admissions and mean number of hospital days decreased significantly. Scores on the **Quality of life and level of functioning** measures increased significantly although the changes were not clinically meaningful. None of the other outcome indicators showed any significant change.

An interesting finding from this study had to do with **program implementation and fidelity** to the ACT model. The authors provide a description of their attempts to implement the program across the six CMHC sites, including details of the training and support of the staff provided prior to, and during the study. Training of the staff at all sites involved two days training in ACT prior to starting, and ½ to 1 day training quarterly throughout the study. The key element was the use of a clinical coordinator who made on-site visits. Contacts with staff were frequent, the coordinator was available for phone or unscheduled site visits, and continuous and time-unlimited follow along. He was also a skilled

clinician who showed by doing and maintained a proactive orientation – heading off problems before they became major.

*Aberg-Wistedt et al., 1995* randomly assigned patients to an ACT-like intensive case management treatment or to a control condition described as “care consistent with normal psychiatric practice in Sweden”. Inpatient and emergency room use data were collected for the two years prior to study entrance and for the two year study period. In addition, data on use of treatment services, quality of life, social network and family burden were collected at baseline and after two years.

The case-managed group had a reduction of 372 inpatient days compared with 166 days by the control group. In addition the experimental group had a reduced **number of emergency room visits** compared to controls, 42 fewer visits during the study period compared to 16. **Quality of life** increased for patients who received treatment from the intensive case management teams. **Family burden** relating to relationship with the psychiatric treatment service providers decreased significantly for relatives of the experimental group.

*Jerrell (1995)* conducted a controlled cost-effectiveness study in which patients were randomly assigned to one of three delivery models of community care. The three models compared were: (i) an adaptation of PACT in which individual caseloads averaged between 15 and 20 clients (ii) a hybrid model which is described as a clinical team approach in which generalist staff provided individual and group treatment with supplementary case management for about 25% of the most unstable clients. Caseloads were large – initially about 35 per therapist then 40-45 as clients stabilized. (iii) an expanded broker model in which clients were linked to all the services covered in their treatment plans and also received support from their case managers. Caseloads averaged about 15-18 clients and case managers worked individually in a community setting. Subjects for the study were severely ill psychiatric patients who were being discharged from their most recent inpatient episode or from lengthy residential treatment and repeated psychiatric emergency visits. Clients were treated and monitored for two years and interviewed every six months after entry to the study. Outcome measures were social adjustment, role functioning, satisfaction with life, use of services, substance use and involvement with the legal system. Diagnostic interviews were also conducted. In addition, the study collected cost of care data for each subject which was based on all mental health services included public and private mental health resources, housing, medication and cost of providing case management services.

Self-reported **social functioning** was not significantly different among the three groups. In general scores did not improve a great deal, although there was an upward trend. Overall, **role functioning** scores were higher for PACT clients than for clients of the other two programs and there was no difference between the clinical team case management and the broker models. PACT clients had higher **symptom** scores on intake than either of the other two groups. Over time there were reductions of symptoms in all three programs.

**Costs:** The intensive broker model was the least expensive to operate over time; PACT was the most expensive. Outpatient mental health costs decreased somewhat for all three models as clients stabilized. Intensive service costs (inpatient, residential, nursing, and emergency services) decreased dramatically in all three models. The greatest reductions were in the PACT and the clinical case management programs.

In conclusion, the PACT model shows somewhat better client psychosocial adjustment and functioning, with reduced costs of intensive mental health care and no differences in the cost of providing outpatient care. These findings occurred despite the fact that the caseloads in this study were higher than usual for PACT model programs. The author notes that the “intensity and structure of these services may be more flexible than was previously thought” (p. 205). This study shows that client needs are more effectively served by multidisciplinary teams and that continuous care teams are best able to control clients’ use of expensive intensive care services.

*Wood & Anderson (1994)*, conducted a follow-up study of two groups of subjects matched for diagnosis, age, sex, marital status and number of hospital admissions. The two study conditions were assertive community case management teams with active participation by the general practice physician or standard outpatient care. There was no random assignment of subjects. General practitioners (GPs) from group practices were added to the assertive community treatment team. The teams held monthly meetings with the GPs to discuss cases. Informal contact between the individual physicians and the members of the team was also encouraged. The GPs developed close working relationships with their respective teams.

Outcomes reported in this paper include total number of **inpatient days**, **day hospital attendance** and length of **time to first inpatient readmission**. The two-year study period data are compared to the two year period before study admission. No attempts were made to investigate the possible benefits of physician participation because the research design did not include another condition of case management without physician participation. However, anecdotal accounts suggest the benefit of including community-based general practitioners in the mental health care of patients. The number of experimental subjects not admitted was higher and the total number of **admission days** lower than among control subjects. In addition, the experimental group remained out of hospital for longer periods of time before first **readmission**.

In a study by *Sands and Cnaan (1994)*, two strategies of community-based case management teams which differed in certain elements were compared. The objective of the study was to determine whether differences in client outcome could be related to the different elements in the method of service delivery. Community Treatment Teams (CTT) were developed to work intensively with patients who were about to be discharged from the State psychiatric hospital which was being closed. At the same time there were intensive case management teams (ICMT) operating out of community mental health centres which provided a somewhat less intensive form of care than the CTTs. Although both programs were modelled on ACT programs, they differed in the structure of the teams and the intensity of the service delivery.

The main differences reported in this study were the staff-client ratios, 1:5 versus 1:20; the number of times clients are seen – at least weekly versus every two weeks; team responsibility for client versus individual case manager caseloads with team backup; and the staff training program - an extensive six-week training versus a shorter three week training program. Thirty clients were randomly selected from patients eligible for the CTT program, i.e. those who were patients in the state hospital or in nursing homes. A matched sample of clients was selected from clients currently being served by the ICMTs. The sample was matched for age, sex, race and psychiatric diagnosis. Because these ICMT clients were already receiving services, random assignment was not possible.

Outcomes measured included rehospitalization, medication compliance, contact with family and friends, use of community services, engagement in recreational activities and housing tenure. Strategies or process measures of the two case management conditions were also investigated as inputs which could be related to client outcomes.

The CTT program provided significantly more face-to-face contacts, more extensive nursing services, and higher annual frequency of follow-up. Clients of the CTT program were more likely to be involved in day treatment and vocational rehabilitation. However, the ICMT clients were more likely to be living independently or with family and friends than the CTT clients.

There were few significant differences between the two groups in other outcome measures. Overall both groups of clients seemed to be doing fairly well: they had stable housing arrangements, frequent contacts with family and friends, and used community and recreational resources. No differences were found in the number of rehospitalizations. The main differences in outcomes were in **medication compliance** – all clients in the CCT group took their medication regularly compared to 79% of the ICMT group; and **functioning** as measured by the Global Assessment of Functioning (GAF) – CCT clients had significantly higher GAF scores after one year.

The major finding in this study was the modest difference between the high and moderate intensity groups. The authors speculate that there may be a “ceiling or saturation effect in case management beyond which increased contact is not productive” (p 455). This raises questions about cost-effectiveness – are the costs of providing more intensive services offset by its benefits? The reduced number of hospital days in the CCT group, although not statistically significant, resulted in a considerable cost saving for that group of clients.

*Santos et al., (1993)* describe an evaluation of the effect of an assertive community treatment program developed for patients in a rural community. Hospital utilization data in the five years before entry into the study, were compared with use during a period of between 4 and 26 months after entry. The assertive treatment program was based on the ACT model.

The mean number of **hospital days** per year, the mean **length of stay** and the mean number of **hospital admissions** were all significantly lower after entry to the program when compared to the five-year period before entry into the program. A **cost analysis** showed an average reduction in costs of 52% per patient per year, taking into consideration the costs of hospital care, traditional care and the cost of the assertive case management program.

The authors describe differences encountered in trying to implement case management programs in rural areas. The factors specific to rural life are mobility, communications, accessibility or availability of resources, and expectations and attitudes towards health and treatment. Additionally, case managers spend a great deal of their time mobilizing and coordinating available community resources and engaging family members and neighbours in carrying out treatment plans, assisting with medication needs, transporting clients to appointments and lending support during emergencies.

The purpose of a study by *Dincin et al., (1993)* was to determine whether state hospital inpatient utilization could be reduced by the introduction of an assertive community treatment team. The authors compared utilization in the target community in the catchment area to the rest of the catchment of the state hospital. Program participants were recruited from patients admitted to the state hospital from the target area. This program was a newly established Thresholds Bridge model based on the principles and methods of assertive community treatment but was modified to meet the objectives of the research. The program emphasized teamwork (no individual caseloads) and focused on clients' basic problems of living (medication, money management and housing). The new program made four changes to the usual assertive treatment approach. First, services were provided for a flexible length of time rather than indefinitely. When providers determined that the client was functioning adequately and had a sufficient support network, a gradual transition was made to less intensive services. The second change was the addition of a liaison worker from the team who monitored hospital admissions from the target area, identified heavy service users, participated in discharge planning and eliminated barriers to hospital discharge (set up medication management services, helped find resources such as funds and housing). Thirdly, a psychiatric consultant provided seven day a week medication monitoring often in the client's home. Finally, there were monthly meetings in which senior representatives from the hospital, from the state and city mental health departments and from the program got together to review service delivery with the goal of improving service and eliminating or modifying obstacles at the systems level.

**Systems level data:** The study conducted two types of pre-post utilization comparisons using routinely collected data. First, the percentage of change in the number of bed days from the baseline year (1986) for the target area were calculated for each of the three following years. In these calculations the target area was its own control. Secondly, the number of bed days for the target area was compared to utilization in the rest of the catchment area. This comparison group served as its own control for the calculation of percentage change in bed days from the baseline. Cost data were also calculated.

**Client level data:** Using each subject as its own control, the study calculated changes in state hospital admissions and number of bed days. Participants' level of functioning was also assessed at study intake and at the point where assertive treatment was withdrawn, or at one-year post index discharge, whichever came first.

**Results:** **Bed days** used for the target area residents decreased by 9% the first year, 15% the second year and 28% in the third year. In the comparison group, the changes were a decrease of 3% in year one, and increases of 6% and 15% in the following two years. The **cost** analysis, taking into account the cost of hospital care and the cost of providing the intensive case management program, showed an

impressive saving for the target area. At the client level, the study found significantly reduced **number of admissions** and number of **bed days** used. In addition, the **level of functioning** was significantly improved during the clients' tenure in the program.

*McRae et al., (1990)* address the question of whether stabilized clients can be transferred to less intensive case management programs or to mainstream psychiatric services. Clients were followed for two years after their involvement in a five year ACT program ended. This study was a modified time series A-B design. In this design, data on the same individuals or group are gathered over an extended period of time before and after the intervention. No control group was available and random assignment was not possible. The five- year intervention in this study has been reported (*Borland et al., 1989*) and reviewed in the Chamberlain & Rapp (1991) review paper discussed above.

In this follow-up study, 69 of the original 72 clients were followed over a two-year period after the intervention ended and patients were carefully linked to existing mainstream services. Many of the patients continued to see the same case manager who had been transferred to Community Mental Health Center (CMHC) staff. However, the case managers were now responsible for caseloads of approximately 50 clients as opposed to the 9 they had carried in the intensive intervention. Another element in the transition was that most of the study clients were more stable than they had been at the beginning of the five-year program and therefore already required fewer case management services than before.

Differences in outcome measures from the period before the patients' transfer to CMHC programs and two years after the transfer are presented. At the end of two years in the mainstream program, 91% of the clients were still **involved in a treatment** program; annualized **hospital admissions** and **hospital days** increased but not significantly; **involuntary admissions** (a measure of patients in difficulty) increased but this also was not significant; there was no difference in the **use of structured residential care**; and the number of case management contacts decreased while the number of CMHC contacts for other services increased - both of these changes were significant. **Cost analysis** of the data revealed an increase in hospital costs which was a function of increased hospital days. Case management costs decreased while mainstream service costs increased. The overall patient care costs decreased by 12% allowing the saved money to be used to treat other patients.

The authors conclude that providing intensive community care for an extended time is effective in breaking the rehospitalization cycle and has long lasting stabilizing effects. The costs of providing mainstream services was 12% lower than the ACT program and did not result in any significant deterioration in patient stability, a finding contrary to that of the earlier Stein and Test study. However, they caution that transition to less intensive care must be handled carefully.



### 1.2.3 Summary of Findings

The findings from reviews and additional studies will be summarized by outcome domain. Not all studies have measured or reported all outcomes.

#### **Hospitalization**

Most studies reviewed have included some measure of hospitalization as an indicator of effectiveness. The most consistent finding of TCL or ACT programs as noted in all reviews is reduced hospitalization, variously defined as number of admissions, number of inpatient days, length of time to readmission. Studies using other forms of intensive case management programs as the experimental condition also report reduced inpatient utilization. Other models of case management have been less successful in reducing inpatient care and in some cases have reported an increase.

#### **Costs**

Three of the additional primary studies conducted a cost analysis of the ACT model and reported reduced service costs for their experimental subjects (*Jerrell, 1995; Santos, et al., 1993; Dincin et al., 1993*). In all cases the high cost of hospitalization was the major factor in the total cost of services and the reduction of hospital use led to impressive cost savings even when the cost of the intervention was taken into account.

The *Taube et al., (1990)* review found that ACT programs were cost-effective alternatives to hospitalization with standard aftercare for persons at high risk for repeated hospitalization, long lengths of stay, or both. The reviewers conclude that intensive case management and community residential care can be a substitute for institutionalization among the seriously mentally ill. They state that further research should assess elements of the programs which are associated with each type of patient outcome, which patient subgroups are best served by the programs, total system costs, cost shifting between payers and the effect of substituting formal care for informal care.

The more recent reviews of ACT programs (*Rapp, 1996; Scott & Dixon, 1995*) concluded that the evidence generally supports lower direct and indirect costs for this type of program. *Scott & Dixon (1995)* summarize the cost findings by stating that “TCL programs are either less costly than comparison conditions or, when more costly, the higher costs may be offset by an increased earning capacity on the part of service recipients. In addition, several studies have shown that the sources of treatment costs change as a result of TCL programming, with a reduction in costs attributable to inpatient care and an increase in structured residential and/or outpatient costs. These shifts are compatible with the program theory underlying the TCL model” (P663).

In contrast to the above studies, *Jerrell & Hu, (1989)* and *Borland et al., (1989)* found no significant cost advantage for their experimental subjects who received ACT case management. Borland and colleagues in their review of costs over five years, found that although the cost of inpatient treatment was reduced, the cost of structured residential care increased and when the cost of the intervention was added there was no cost advantage for the experimental subjects. A follow-up study of Borland’s

patients by *McRae et al., (1990)*, found that when the experimental subjects were returned to standard community care after the initial study, the total costs of treatment were reduced by 12% compared to the costs under intensive case management. *McRae et al.*, suggest that the five years of intensive case management may have had stabilizing effects which lasted after the termination of the treatment.

A cost study of the brokerage model by *Franklin et al., (1987)* reviewed by *Rapp (1996)* found increased hospitalization with corresponding higher costs for the clients receiving the intervention compared to the control group.

### **Clinical Status**

In general, case management models have shown little effect on measures of symptomatology. However, the evidence for symptom reduction is much stronger for ACT programs. In a recent review by *Burns and Santos (1995)*, four of the seven studies using randomized control designs, reported improved clinical status for subjects receiving assertive community treatment.

### **Client and Family Satisfaction**

Many of the studies reviewed have investigated client and family satisfaction with services and family burden. Although the instruments and methods used to study these outcomes differ, the general finding of ACT model research is one of high rates of family and client satisfaction. The studies which investigate family burden conclude that community treatment of psychiatric patients does not increase burden on families.

### **Social Functioning/Community Adjustment**

Community adjustment as measured by social and vocational functioning, residential situation (stability and independent living), medication compliance and quality of life are other important domains which have been investigated. Overall, both ACT and non-Act programs have been successful in improving social functioning and promoting residential stability and independence. Some have shown improvement in vocational outcomes.

### **Other Outcomes**

ACT programs are also effective in maintaining clients in treatment. Use of other community services has not been widely studied in ACT research and the results have been variable. No studies have found a decrease in the use of community-based services. Studies of other types of case management have found a significant increase in the use of community services. These models emphasize linkage with other community services. A study of the brokerage model by *Franklin et al., (1987)* reviewed by *Rapp (1996)* found that while the case managers were very successful in linking clients to other services, there was an increase in hospitalization and no significant differences in quality of life between the case managed group and the controls.

In conclusion, it is evident that all studies found some positive effects of the program model studied. *Chamberlain and Rapp (1991)* conclude that regardless of the intervention and the particular focus of the intervention, the primary focus will be achieved.

### 1.3 Research Directions

The following is a summary of the issues raised by the authors of the reviews.

#### Intervention

Studies need to clearly define and describe the nature of the experimental intervention including all program elements. In this way it will be easier to relate specific elements to outcomes. Failure to describe the intervention fully creates problems when examining outcomes and when comparing across studies. Studies should also monitor the implementation of the intervention and report on the similarities and/or differences between ideal practice and the intervention as practised by the program. *McGrew et al., (1994)* found that fidelity to the original program model can be measured and that increased fidelity was correlated to the outcomes measured by the study. *Taube and colleagues (1990)* suggest that programs should be allowed some time (6 months or more) to mature before starting the study, to make sure that the care provided is more consistent and standardized.

#### Subjects

Although all studies reviewed target the seriously mentally ill, descriptions of the population indicate that different subgroups are being studied, reducing comparability across studies and generalizability. The different subgroups studied include high users of psychiatric inpatient services; high users of outpatient with no prior inpatient use; first episode patients; chronic patients; and high users of emergency services.

#### Control Condition

Most studies use standard community care as the control condition. With improvements in community resources and in general case management services, the difference between experimental interventions and control conditions is diminishing. It is hypothesized that this growing similarity between experimental and control conditions is a key factor in the equivocal findings of many of these studies.

*Taube et al., (1990)* and *Solomon (1992)* state that control conditions should reflect current practice and include case management, mobile treatment teams, etc. and make it possible to determine the cost-effectiveness of adding specific elements of ACT programs such as multi-disciplinary teams, small caseloads, 24 hour availability, individualized treatment and in vivo treatment which are over and above standard community care practices.

The nature of environmental factors such as service and resource availability should also be described as these will have an impact on the differential effect of the experimental condition (*Solomon, 1992*).

### Outcome

The use of different instruments to measure outcomes such as functional status, quality of life or patient satisfaction is problematic when attempting to compare results across studies. Also noted in many of the reviews is the difficulty in achieving experimental effects in the measurement of symptoms, and functional outcomes. *Burns and Santos (1995)* state that "Evidence of differential effects of assertive community treatment on client-level outcomes are incremental rather than dramatic"(p674). This may be attributed to problems of measurement, or to the fact that comparison conditions have improved in the past few years with the dissemination of case management research findings, increased sophistication about community support and the willingness of providers to engage in community-based service delivery. The apparent lack of definitive improvements in 'client-level outcomes' may also be explained by the severity of the illness in the patients under study and the limited gains which can be achieved, particularly during the study periods which typically have short follow-ups.

Most reviewers noted the difficulty in comparing outcomes across studies which arises from different definitions, or ways of reporting outcomes. For example hospitalization has been reported as the mean number of admissions; the proportion of subjects hospitalized; and the mean number of days hospitalized, etc.

In general, the reviewers have concluded that outcomes related to hospitalization have been well researched and that more attention needs to be focussed on functional outcomes, improvement in quality of life, both subjective and objective and in client and family satisfaction with treatment. Other rarely reported factors related to the delivery of services such as staff burnout and turnover rates should be included in future investigations.

### Research Design

Most studies reviewed use experimental or quasi-experimental designs but the length of follow-up varies. Reviews all recommend longer follow-up of at least 2 years. The early research of *Stein & Test* showed that after 14 months when patients were discharged from the experimental program they lost most of the gains they had made during their tenure in the TCL treatment intervention. These results argue for indefinite provision of intensive care in order to maintain gains. However, the study by *Dincin and colleagues (1993)* described above, found that with careful transitioning, clients could be successfully maintained in the community with less intensive case management. More research with longer follow-up is required to determine the optimal length of service provision before patients can be discharged into less intensive community care programs.

## 1.4 Discussion

This aspect of service delivery has far more research evidence than do any of the others that are reviewed in this report. In particular, the Assertive Community Treatment model has demonstrated its effectiveness and acceptability to clients and families in multiple trials with various populations. In part, this is because the initial model demonstrated by Stein and Test (1980) was widely disseminated and training programs established. But more importantly, case management is an approach to service delivery that is particularly well suited to the problems created by deinstitutionalisation. It injects continuity of care into a fragmented, unbalanced system. The client has **one** individual or team looking after **all** of his needs **over time** in the **community** rather than multiple specialized helpers providing time limited, office based treatment. There also is a clear fit between the accomplishments of this type of intervention and the goals of mental health reform policy (see Chapter 10).

As the value of the basic approach has been accepted, interest has shifted to understanding better how it works, with whom and what improvements/modifications can be made. The positive findings about case management have contributed to the paradigm shifts that have occurred with regard to the provision of housing, vocational and educational services (see Chapters 3 and 7). The latest round of US federal demonstration model grants have for the most part been combinations of a case management intervention **with** portable approaches to finding employment and housing. The provision of individual support has become the central element of a community support system and the rapid development of case management services can proceed with the benefit of an expanding body of sound evaluation studies.

## 1.5 Best Practices: Case Management/Assertive Community Treatment

### Research Evidence

A wide array of rigorous trials have accumulated evidence that:

- ★ demonstrate Assertive Community Treatment programs are superior for improving clinical status and reducing hospitalization

Studies generally support that ACT:

- ★ is a cost-effective alternative to hospitalization with standard aftercare for persons at risk for repeated hospitalization
- ★ produces high rates of client and family satisfaction and no increased burden on families

A smaller body of controlled and uncontrolled studies show that:

- ★ rehabilitation and personal strengths models are effective in improving social and vocational functioning, and promoting residential stability and independence

### Key Elements of Best Practice

ACT programs include the following components:

- ★ assertive outreach
- ★ continuous, round the clock, time unlimited, individual support to people with serious mental illness
- ★ services are predominantly provided in the community as opposed to office-based
- ★ provision of flexible support specifically tailored to meet the needs of each individual
- ★ involvement of consumers and their families in all aspects of service delivery, including design, implementation, monitoring and evaluation

Programs which serve special needs groups such as those with dual disorders are provided.

Other clinical case management programs are provided to serve clients with less intensive needs.

Clinical case management program models include:

- ★ Rehabilitation model which focuses on improving living skills, is individually tailored to client needs and provides continuous interpersonal support
- ★ Personal Strengths model which focuses on client strengths and identifies or develops community resources and environments where clients can achieve success.

**Table 1.2: Reviews of Case Management/Assertive Community Treatment Studies: Dates and Characteristics**

Review	Type of Review	Years	Number of studies	Types of Models Reviewed	Designs of Reviewed Model
Olfson (1990)	Narrative	1973-89	11	ACT	RCT, Repeated measures
Taube et al., (1990)	Narrative (cost effectiveness)	1982-89	5	ACT	Experimental/quasi experimental
Chamberlain & Rapp (1991)	Narrative	1987-89	6	ACT, Rehab, Generalist & Strengths	Experimental/quasi experimental; RCT, Cohort, matched control
Rubin (1992)	Narrative	1987-91	8	Generalist, Intensive, rehab	RCT, quasi experimental, non experimental
Solomon (1992)	Narrative	1980-90	20	14 ACT, 1 Rehab; 1 personal strength; 5 expanded broker	Experimental, quasi experimental, non experimental
Test (1992)	Narrative	1973-92	8	ACT/TCL	RCT
McGrew et al., (1994) (Fidelity testing)	Quantitative analysis	1982-94	9	Threshold Bridge (PACT adaptation)	Comparison
Bond et al., (1995)	Meta-analysis	1982-93	9	Threshold Bridge (PACT adaptation)	Experimental, quasi experimental, pre-post
Scott & Dixon (1995)	Narrative (review of reviews & new studies)	1990-95	7 review 12 studies	ACT, Intensive CM, Personal strengths model	RCT, matched control
Burns & Santos (1995)	Narrative	1990-94	8	ACT	RCT
Holloway et al., (1995)	Narrative	1980-93	23	10 ACT, 2 broker, 2 personal strengths, 3 rehab, 2 intensive cm, rest not specified	RCT, own controls, control non-random, matched control
Rapp (1996)	Narrative	1980-1995	34	21 ACT, 1 Rehab, 6 broker, 6 strengths	RCT, quasi experimental, non-experimental pre-post



**Table 1.3: Additional Studies of Assertive Community Treatment/Case Management**

<b>Authors</b>	<b>Study population</b>	<b>Method</b>	<b>Program</b>	<b>Results</b>
Santos et al., (1993)	rural, smi, n=23	non-exptl/replicated measures	ACT	Reduced mean number of hospital days, mean length of stay and mean number of hospital admissions; Cost analysis showed 52% cost reduction per patient per year
McGrew et al., (1995)	chronically ill; n=212; 6 CMHCs	non-exptl/replicated measures	ACT	Reduced number of hospital admissions, and mean number of hospital days; quality of life & level of functioning improved
Aberg-Wistedt et al., (1995)	dx schizo/psychotic disorder; n=40	RCT	ACT/standard	Reduction in number of inpatient days and emergency room visits; increased QOL and decreased family burden
Lafave et al., (1996)	smi; n=110 heavy users	RCT	ACT/hospital-based	Reduction in mean number of inpatient days; increased number of ACT clients living in the community; improved living situation and more control over living environment
Wood & Anderson (1994)	SMI; n=120	Individual matched control	ACT/standard	Admission rate and number of inpatient days lower for ACT clients; ACT clients remained in the community longer
Dincin et al., (1993)	SMI; n=66	Within subject/pre-post/comparison group	ACT/Thresholds Bridge vs standard care in comparison areas	System data: reduced number of inpatient days and cost saving for region with ACT team Client data: reduced number of admissions and inpatient days; increased level of functioning for ACT clients
Sands & Cnaan, (1994)	SMI; n=60	Random selection; matched controls;	Comparison of 2 ACT programs with different intensity & structure	More intensive ACT program clients had better medication compliance and higher social functioning scores
Jerrell (1995)	SMI, n=122	RCT	3 models: PACT/expanded broker/generalist team	Overall role functioning higher for PACT clients; reduced cost of intensive care services for PACT & generalist team CM clients
McRae et al., (1990)	SMI; n=69	Follow-up	Transfer of ACT clients to less intensive CM	ACT can break rehospitalization cycle and has long-lasting stabilizing effect; clients can be carefully transferred to less intensive CM

## REFERENCES

- Aberg-Wistedt, A, Cressell, T, Lidberg, Y, Liljenberg, B, & Osby, U. (1995). Two-year outcome of team-based intensive case management for patients with schizophrenia. *Psychiatric Services*, 46(12):1263-1266
- Bond GR, McGrew JH & Fekete DM (1995) Assertive outreach for frequent users of psychiatric hospitals: a meta-analysis. *Journal of Mental Health Administration*, 22(1):4-16
- Borland, A., McRae, J. & Lycan, C. (1989). Outcomes of five years of continuous intensive case management. *Hospital and Community Psychiatry*, 40 (4): 369-376
- Burns BJ & Santos AB. (1995). Assertive Community treatment: an update of randomized trials. *Psychiatric Services*, 46(7):669-675
- Chamberlain R & Rapp, CA. (1991). A decade of case management: A methodological review of outcome research. *Community Mental Health Journal*, 27(3):171-187
- Drake, RE, Mueser, KT, Clark, RE & Wallach, MA. (1996). The course, treatment, and outcome of substance disorder in persons with severe mental illness. *American J of Orthopsychiatry*, 66(1): 42-51
- Dincin, J., Wasmer, D., Witheridge, TF., Sobek, L., Cook, J. & Razzano, L. (1993). Impact of assertive community treatment on the use of state hospital inpatient bed-days. *Hospital and Community Psychiatry*, 44(9): 833-838
- Franklin, JL., Solovitz, B., Mason, M., Clemons, JR., & Miller, GE. (1987). An evaluation of case management. *American Journal of Public Health*, 77(6): 647-678
- 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
- Goering, PN, & Wasylenki, D. (1996). Case management, in Breakey, WR (ed), *Integrated Mental Health Services*. New York and Oxford: Oxford University Press.
- Hood, C., Mangham, C. & Leigh, G. (1996a). *Exploring the links between substance use and mental health: An annotated bibliography*. Health Canada, Ottawa
- Hood, C., Mangham, C. & Leigh, G. (1996b). *Exploring the links between substance use and mental health: A discussion paper*. Health Canada, Ottawa
- Holloway, F, Oliver, N, Collins, E & Carson J. (1995). Case management: a critical review of the outcome literature. *European Psychiatry*, 10:113-128

- Husted, J, Wentler, SA, Bursell, A. (1994). The effectiveness of community support programs for persistently mentally ill in rural areas. *Community Mental Health Journal*, 30(6):595-600
- Jerrell, JM. (1995). Toward managed care for persons with severe mental illness: implications from a cost-effectiveness study. *Health Affairs*, 14(3):197-207.
- Jerrell, JM. & Hu, T. (1989). Cost-effectiveness of intensive clinical case management compared with an existing system of care. *Inquiry*, 26: 224-234
- Lafave, HG, deSouza, HR & Gerber, GJ.(1996). Assertive community treatment of severe mental illness: A Canadian experience. *Psychiatric Services*, 47(7):757-759
- McGrew, JH, Bond, GR, Dietzen, L & Salyers, M. (1994). Measuring the fidelity of implementation of a mental health program model. *J Consulting and Clinical Psychology*, 62(4):670-678
- McGrew, JH, Bond, GR, Dietzen, L, McKasson, M, Miller, LD. (1995). A multisite study of client outcomes in assertive community treatment. *Psychiatric Services*, 46(7):696-701
- McRae, J, Higgins, M, Lycan, C & Sherman, W. (1990). What happens to patients after five years of intensive case management stops? *Hospital and Community Psychiatry*, 41(2):175-179.
- Olfson, M.(1990) Assertive community treatment: an evaluation of the experimental evidence. *Hospital and Community Psychiatry*, 41(6):634-641
- Rapp, CA (1996). The active ingredients of effective case management: A research synthesis. In: Giesler, LJ (ed) *Case Management for Behavioral Managed Care*, National Association of Case Management, Cincinnati, Ohio.
- Robinson, GK & Toff-Bergman, G. (1989). *Choices in case management : current knowledge and practice for mental health*. Mental Health Policy Resource Center, Washington, DC.
- Rubin, A. (1992). Is case management effective for people with serious mental illness? A research review. *Health and Social Work*, 17(2):138-150
- Sands, RG & Cnaan, RA. (1994).Two modes of case management assessing their impact. *Community Mental Health Journal*, 30(5):441-457.
- Santos, AB, Deci, PA, Lachance, KR, Dias, JK, Sloop, TB, Hiers, TG, Bevilacqua, JJ. (1993). Providing assertive community treatment for severely mentally ill patients in a rural area. *Hospital & Community Psychiatry*, 44(1):34-39
- Scott, JE & Dixon, LB(1995). Assertive community treatment and case management for schizophrenia. *Schizophrenia Bulletin*, 21(4):657-668

- Solomon P.(1992) The efficacy of case management services for severely mentally disabled clients. *Community Mental Health Journal*, 28(3):163-179
- Stein, LI & Test, MA. (1980). An alternative to mental hospital treatment. I: Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, 37:392-397.
- Taube, CA, Morlock, L, Burns, BJ, & Santos, AB. (1990). New directions in research on assertive community treatment. *Hospital and Community Psychiatry*, 41(6):642-647.
- Teague, GB, Drake, RE, & Ackerson, TH. (1995). Evaluating use of continuous treatment teams for persons with mental illness and substance abuse. *Psychiatric Services*, 46(7):689-695.
- Test, MA. (1992). Training in community living. In: Liberman, RP (ed) *Handbook of Psychiatric Rehabilitation*. New York, NY: Macmillan Publishing Co., pp 153-170
- Wood, K & Anderson, J. (1994). The effect on hospital admissions of psychiatric case management involving general practitioners: preliminary results. *Australian and New Zealand Journal of Psychiatry*, 28:223-229

# 2.

## CRISIS RESPONSE SYSTEMS/PSYCHIATRIC EMERGENCY SERVICES

### 2.1 Introduction & Definitions

Many persons with severe mental illness are susceptible to stress and face recurrent episodes of psychosis. Others experience crises due to poverty, recurrent unemployment, loss of housing or loss of support networks. Despite the differing origins and manifestations of these crises, hospital emergency rooms are the primary venue for crisis management, and admission or release without follow-up have been common responses. This approach to crisis management has serious limitations. It often leads to unnecessary hospitalization, resulting in negative consequences for the individual and his family and inefficient use of resources. If aftercare is not arranged, opportunities are missed to link new users to appropriate resources or to mobilize existing networks to help manage crisis situations.

Crisis response systems (CRS) have been proposed to provide a more effective approach, both in the short and longer term. Rather than a single service response, a CRS encompasses a range of services integrated across various providers. With its expertise and range of options, a CRS is positioned to resolve crises using minimally intrusive options, particularly for non-compliant persons. A CRS offers backup to community providers, including mental health personnel, family practitioners and police; it provides an important community outreach mechanism by connecting first time users to appropriate services; and it serves as a valuable community relations tool by reassuring members of the community, such as landlords, that persons with severe mental illness will be supported during crises. A CRS is positioned to identify gaps in community resources and advocate for improvements.

The first part of this chapter defines the goals, functions and components of a CRS part of which is adapted from a document written for the Ministry of Health, Ontario. (*Goering & Durbin, 1994*) This will be followed by a discussion of the few research papers dealing with emergency services.

### 2.1.1 Goals of a CRS

The following goals represent a consensus about the purposes of a CRS. For the person-in-crisis, objectives of a CRS are:

- to increase community tenure
- to maximize the person's ability to recognize and deal with situations which may otherwise result in crises
- to increase (improve) the person's network of community supports and use of these supports for crisis prevention

From a system perspective, the goals of a CRS are:

- to provide timely and accessible aid to persons experiencing psychiatric and psychosocial crises
- to provide persons-in-crisis with access to a wide range of crisis options;
- to stabilize persons-in-crisis as quickly as possible, and to assist them to return to their pre-crisis level of functioning

In viewing crisis response as one component of the mental health system, there are additional expectations of a CRS:

- to integrate (or re-integrate) people to the broader system of interventions and supports so that ongoing support is available once the crisis is resolved
- to introduce strategies to prevent crises from developing, and to intervene and resolve crises as early as possible

### 2.1.2 Key Functions of a Crisis Response System

A CRS can be conceptualized as a range of functions to provide appropriate, timely and well-coordinated responses for persons in crisis situations (see Table 2.1). One can conceive of the scope of a CRS as falling into two categories. The first category includes crisis specific functions dedicated to the resolution of crises such as telephone hot-lines, mobile outreach teams, safe beds and emergency rooms. Services in the second category, pre-crisis and ongoing supports, address broader goals of continuity of care and community tenure. Within the first category, functions are ordered as a graduated array, from telephone to medical services, which serve an increasing level of severity/intensity of crisis, require intervention from increasingly specialized individuals and offer support in increasingly restricted environments.

**TABLE 2.1**

#### Crisis Specific Functions

- ★ medical services including inpatient services when other options have been exhausted
- ★ short-term residential placements for crisis stabilization in protective and supportive settings
- ★ mobile crisis outreach which brings assistance to virtually any site in the community where crisis is occurring
- ★ walk-in crisis intervention services
- ★ telephone crisis services

#### Pre-crisis and Ongoing Support Functions

- ★ crisis prevention services such as peer support networks, family support, intensive case management, in-home support programs, etc.
- ★ ongoing supportive services such as case management, natural supports, drop-in centres, housing support, financial support.

### 2.1.3 Components of a Crisis Response System

#### **Telephone Crisis Response**

The telephone is often the first point of contact with the mental health system for a person in crisis or a member of his/her support system. Telephone crisis services need to be available 24 hours per day to provide screening and assessment, preliminary counselling and information and referral. A primary role of telephone crisis personnel is to assess the need for face-to-face crisis intervention services and to arrange for such services when indicated.

#### **Walk-in Crisis Services**

Walk-in crisis services provide face-to-face assessment and crisis intervention. Services typically provided include screening and assessment, crisis stabilization, brief treatment and linking with services. While hospital emergency rooms are used for this purpose, many do not have mental health specialists available or well-defined crisis management procedures in place. The result is that persons

may be admitted unnecessarily or released without follow-up. (The role of E.R.'s in a crisis response system are discussed further in the section on Hospital Emergency/Medical Crisis Services.)

The need for walk-in crisis services has been questioned, in part, because many people who walk in do not require a crisis level of service. Some jurisdictions recommend that community mental health agencies become more active in handling “urgent” situations, perhaps through extended hours.

### **Mobile Crisis Outreach**

Mobile crisis teams are one of the most innovative components of a CRS. The teams intervene quickly, day or night, wherever the crisis is occurring, e.g. private home, boarding home, police station. The mobile crisis team serves persons unknown to the system, is available 24 hours, and provides rapid response. Teams work closely with police forces, crisis hotlines and hospital emergency services. They usually operate out of a community location, e.g. an assertive case management program, crisis centre, multi-purpose community mental health centre, but also can operate out of a hospital. Some teams work 24 hours whereas others operate during nights and weekends, relying on community agencies to handle crises during regular working hours. In some crisis response systems, mobile teams provide preventive support as well as crisis intervention by “checking in” on clients felt to be at risk.

While one of the goals of a mobile crisis team is to link users to community support services, teams vary in this capacity. The linking process is facilitated if the mobile team is part of a community mental health program, e.g., an assertive case management program, or if explicit channels of access have been established between the team and community programs.

### **Crisis Residential Services**

Resolution of a crisis may require separation from the environment. The purpose of residential crisis services is to provide the person-in-crisis with support in a calm, protected, supervised non-hospital setting. During this period the person can restabilize, resolve problems and link with possible sources of ongoing support.

A range of settings for residential crisis support should be available to meet the varying needs and desires of individuals. Residential supports are classified as individual or group. **Individual approaches** serve one or two clients in a particular setting for 10-14 days. Examples include **family-based crisis homes** where the person-in-crisis lives in the family home and receives practical and emotional support from family members. Professional providers usually visit the family home daily to help the client develop a treatment plan and connect with needed services. Family home sponsors are screened and trained. Persons-in-crisis are not placed in family homes if they are considered to be at risk for violent behaviour.

There are other models for providing individual support. In a **crisis apartment**, a roster of crisis workers or trained volunteers provides 24 hour observation, support and assistance to the person-in-crisis who remains in the apartment until the individual is stabilized and linked with other supports. In



a **peer support** model, groups of consumers look after the person-in-crisis in the home of one of their members, providing encouragement, support, assistance and role models in a non-threatening atmosphere. An **in-home support** approach, similar to crisis apartment support, can be considered if separation from the natural environment is not felt to be necessary.

**Group approaches** serve more than two clients. They are generally provided through crisis residences which combine two types of assistance - crisis intervention and residential treatment. Crisis residences offer short-term treatment, structure and supervision in a protective environment which minimizes institutional features. Services depend on the program philosophy but can include physical assessment, psychiatric assessment, daily living skills training and social activities as well as counselling, treatment planning and linking.

Crisis residential services are used primarily as an alternative to hospitalization but can also shorten hospital lengths of stay.

### ***Psychiatric Emergency/Medical Crisis Services***

Hospitals serve as the medical site for the crisis system. Traditionally, mentally ill people whose condition appears to require immediate attention present themselves (or are taken by others) to the emergency departments of general or psychiatric hospitals where they are assessed by a duty physician, given immediate treatment and referred to appropriate care. Mental health reform has forced practitioners and institutions to question sole reliance on this service delivery approach and to re-examine the methods most hospital-based psychiatric emergency services use to assess and treat people in crisis. Recent program development efforts tend to emphasize community-based mobile crisis teams and intensive case management incorporating crisis response capacity.

Over the past decade, many hospital-based emergency services have expanded their crisis response capacities in various ways in an attempt to improve service. Some have developed specially trained multi-disciplinary crisis response teams who assess and provide immediate support to all individuals in emotional crisis who present at the hospital's general emergency department. Others have developed a mechanism whereby a designated non-medical staff member on the psychiatric inpatient unit is called to the emergency department for assessments and crisis intervention. The role of staff psychiatrists in such services is often as back-up consultant, often by telephone. Some psychiatric departments have added **24 hours holding beds** to permit more extended evaluation with a view to referring more individuals to ambulatory services such as urgent care clinics, day hospitals or community support programs. If hospital services are integrated with other components of a CRS, unnecessary hospitalizations can be avoided, necessary admissions proceed as quickly and humanely as possible, length of stay in hospital is minimized, and individuals are linked to support services upon discharge.

### 2.1.4 Summary

Crisis response is a key element of a reformed mental health care system that seeks to avoid unnecessary hospitalization and improve the quality of life for those with severe mental health problems. A crisis response system encompasses a range of functions to provide appropriate, timely and well-coordinated responses for persons in crisis. Crisis specific functions of increasing levels of intensity are as follows: telephone and walk in services, mobile outreach, residential supports and medical services. These functions should be provided within a coordinated network of pre-crisis and ongoing support functions. Assertive case management programs provide a strong base for building a crisis response system that integrates existing resources. Rural applications may differ considerably and both community and hospital programs have a potential role as key players.

## 2.2 Review of Research

Most of the published literature on emergency services has been descriptive in nature. Only one study (*Merson et al., 1992*) meets criteria for an experimental or quasi-experimental design. The others are predominantly evaluation studies with one or two having a comparison group design. Two studies investigated the use of mobile crisis units (*Fisher et al., 1990; Reding & Raphelson, 1995*); the use of crisis housing was evaluated by *Leaman, (1987)* and *Bond et al., (1989)*; two studies looked at hospital based services: 24-hour holding beds (*Gillig et al., 1989*) and an after hours crisis intervention program (*Lambert, 1995*). *Merson et al., (1992)* conducted a clinical trial comparing inpatient hospitalization to care in the community after patients presented to the psychiatric emergency room. The following is a review of these studies which are listed in Table 2.2.

### 2.2.1 Community-based Services

#### **Mobile Crisis Units**

A recent study by *Reding and Raphelson (1995)* looked at the effect on inpatient admissions of adding a mobile psychiatrist to a 24-hour crisis intervention service which had been operating in the region for fourteen years. The psychiatrist was assigned to the unit for one full year. During that year, there was an immediate drop in inpatient admissions to the state hospital with no increase in admissions to other hospitals in the region. After the psychiatrist was withdrawn from the service, admissions rose sharply to the level they were at before the study year. The authors speculate that the ability to make decisions about medications and admissions on the spot and prescribe and administer depot medication or fast acting tranquilizers when necessary was an important element in diverting people in crisis from hospital admissions. The psychiatrist also provided the usual support to family and other caregivers and made frequent calls during the initial crisis period.

*Fisher and his colleagues (1990)* compared state hospital admission rates for counties with and without mobile crisis units in the state of Massachusetts. This study used 1986 data to compare catchment areas in twenty counties with mobile crisis capacity to twenty counties without. They

controlled for as many factors as they could that might differentially effect inpatient utilization such as social stress, community resources, psychiatric beds, etc.. There were no data to describe the structure of the mobile services or how they were integrated with other services. The results of this comparison showed no difference in the number of psychiatric admissions between those counties which had mobile crisis units and those which did not. The authors caution that this negative finding does not provide evidence that mobile units do not work in reducing hospitalization. They state that “the concept is rational and humane” but like all mental health services the efficacy of mobile crisis units needs to be rigorously evaluated.

### **Crisis Housing**

*Leaman (1987)* evaluated a foster home program for patients referred by community mental health agencies and by the hospital Crisis Intervention Center. This was a non-experimental study. All patients who were deemed eligible by staff were referred to the crisis homes. In general, patients who were able to function in an open psychiatric unit, who did not have a history of violence, arson or theft and who were determined by staff to be able to live safely in a family’s private home were accepted into the program. Foster care providers are families living in the community who responded to advertisements in the newspaper. Those chosen to participate were given a four-week clinical orientation which covered medications, communication issues, patient characteristics, suicide assessment and community resources. Patients placed in the homes met daily with a nurse for counselling, medication and assistance with referrals connecting the patients to community resources following the crisis home stay. The evaluation looked at patient satisfaction, psychiatric symptoms and costs. Results of a one-year data collection found that 80% of patients considered for inpatient treatment were diverted to the foster home program at considerable savings (approximately \$224,000 in 1984-85). Patient satisfaction with the program was high (94% were satisfied) and 77% thought that the stay in the crisis home helped them avoid hospitalization. In addition the staff and patients reported significant improvement in clinical status as measured by a psychiatric rating scale.

*Bond et al., (1989)* compared two models of crisis housing provided along with short-term case management as an alternative to hospitalization. The crisis housing programs were part of the Thresholds Bridge organization in Chicago. In addition to crisis housing, the programs provide short-term case management services which continue until housing, income and psychiatric supports are in place. The focus of the short-term case management program is to prevent unnecessary hospitalization and to stabilize housing and income support for the person in crisis. The two programs differed only in the type of crisis housing provided. Bridge West runs an eight bed crisis house with 24-hour supervision and on site assertive service coordination. Bridge South purchases temporary shelter in local hotels and boarding houses and provides less intensive staff coverage, 9 to 5 on weekdays with on-call response at other times. Subjects for this study were consecutive first time admissions, judged by hospital staff to be in acute crisis and appropriate for community care. The study collected data on services provided, client outcomes (rehospitalizations and community functioning) and treatment costs over a four-month period. Both samples stayed in the crisis housing approximately one month. Clients in both settings who had had prior contact with Thresholds Bridge case management used fewer days of the short term intervention than those with no prior contact.

Clients of Bridge South used approximately three times the number of hours of assertive service coordination than the clients of Bridge West. However, the on-site hours of service for Bridge West clients were not included in the calculations. Rates of hospitalization were similar for clients in the two programs. Community functioning (housing, money and medication management) improved for all the clients with little difference between groups. Bridge program, hospital and government assistance costs were calculated and overall between group costs did not differ. The major difference between the two programs was found in the high rate of turnover among staff in the more intensively staffed Bridge West crisis house. Monetary costs of staff turnover were not included in the costs reported.

*Bond et al., (1989)* state that this project is an example of how research can translate into policy decisions. Based on this finding of no difference in client outcomes and the high staff turnover in Bridge West, the decision was made to close the crisis house in the Bridge West program and purchase temporary shelter for clients in that area. The authors reiterate the importance of continuing the short-term assertive coordination and continuing to provide appropriate supports via long term case management programs. In addition, it is essential to monitor and carefully assess the costs and benefits of different program models.

### **Crisis Centre**

A study by *Peladeau and colleagues (1991)* assessed the establishment of a crisis centre in an urban, disadvantaged area in Montreal with a high concentration of psychiatric patients and the presence of a psychiatric hospital. The study examined the socio-demographic characteristics, the services offered and the type of crises that brought individuals to the crisis centre.

The design is descriptive and also used qualitative analysis. The period covered was the first 12 months of operation. Data were gathered from the call registry of all individuals who contacted the centre, assessment forms completed by the centre workers for all users coming for interview, and a report of the intervention completed when the case was closed.

Approximately half of the 457 individuals referred to the centre were assessed (49.2%) while the rest received either support on the phone or were referred to other more appropriate services. More than 71.7% of the centre's clients had an active file at the sector's psychiatric hospital and 43.4% had previously been admitted. Socio-demographic variables indicate that the clients were socially and economically disadvantaged.

Hospital services were the main source of referral (50.9%) which includes 37% from the local psychiatric hospital. Content analysis of the intake interview confirms that most of the crises were psychosocial (family problems, couple problems), with psychiatric crises (relapse, hallucinations, etc.) representing only a small percentage of the problems found. However, more in-depth analysis of the clients' files indicate a frequent depressive reaction to the psychosocial problems, and that 36% had suicidal elements. Psychosocial problems involved issues of loneliness, isolation and poverty. Services offered included short-term sheltered environment at the crisis centre (65.8%), follow-up with emotional or practical support (27.1%) and referral to other settings (12.4%).

An interesting finding of this descriptive study was the predominance of psychosocial crises as the presenting problem.

## **2.2.2 Hospital-based Services**

### **24-Hour Holding Beds**

*Gillig et al., (1989)* investigated the effect of a 24-hour holding area on inpatient utilization. Two psychiatric emergency services, one with a holding unit and one without, were compared. Both services were similar in that they provided the primary emergency evaluation for psychiatric patients in their catchment areas, both were the primary point of entry into a state hospital system, both hospitals were affiliated with a major university medical center, each had enough psychiatric beds so that patients in emergencies could always be admitted and each served in areas with similar community resources. It was hypothesized that the hospital with the holding beds would have lower rates of hospital admissions than the hospital without this service. Data collected over a one month period supported the hypothesis that the availability of a holding area or extended evaluation unit can reduce hospitalization rates. The authors caution that such a unit will be of little benefit if it is used for detaining seriously ill patients for inappropriate lengths of time because inpatient beds are not available. However, if the availability of the holding unit provides staff with the opportunity to do a more effective evaluation of the patient's status it can lead to decisions to refer the patient to more appropriate community care rather than to unnecessary inpatient hospitalization.

### **After-Hours Crisis Intervention**

*Lambert (1995)* describes an after hours crisis intervention service staffed by psychiatry residents in a Veteran's Affairs hospital emergency department. The program operates between 5:00 and 11:30 pm and offers medication, family interventions and referral to outpatient services. An evaluation of this service concluded that in the first year of operation, the number of inpatient admissions in the time period covered by the service decreased by 34% and resulted in significant cost savings.

## **2.2.3 Medical Crisis Service versus Hospital Treatment**

In the only randomized clinical trial that we were able to find, *Merson et al., (1992)* compare the outcomes of patients randomly assigned to an early intervention community service (EIS) or to standard hospital treatment (HS). The EIS has an open referral system, is able to respond to all referrals within three days but does not provide 24-hour coverage. Assessments are carried out in the patient's home and a case manager is assigned to each patient to coordinate all aspects of the patient's care and management. One hundred patients presenting to the psychiatric emergency department at a London (UK) teaching hospital over a 14-month period were randomly assigned to a multi-disciplinary community-based team or to standard hospital treatment. The researchers who conducted the assessment interviews and questionnaires were blind to the allocation of the patients. Data were

collected on bed utilization, psychiatric symptoms, social functioning, personality status and satisfaction with treatment. Assessments were carried out at two, four and 12 weeks after randomization and repeated measures analysis was conducted. Results showed greater satisfaction with services, reduced inpatient utilization and somewhat improved clinical status for patients assigned to the community-based treatment condition. The reduced use of inpatient beds resulted because length of stay was shorter for EIS patients than for those receiving standard hospital treatment.

## 2.3 Discussion

This chapter has provided a description of the components of a comprehensive crisis response system and a summary of the sparse research literature. It is evident from our literature search that few evaluations of crisis services have been conducted and the reported outcomes of these studies must be treated with caution due to generally weak research designs. There is almost no evidence supporting the efficacy of different crisis interventions. For example, *Geller et al., (1995)* conducted a US survey of mobile crisis services and found that although these services have been widely accepted and implemented, no systematic evaluations have been carried out.

Compared to service areas such as case management, vocational supports and treatment services, components of a crisis intervention system have been poorly studied either as individual programs or as necessary parts of the system.

## 2.4 Best Practices: Crisis Response Systems/Psychiatric Emergency Services

### Research Evidence

Non-experimental and descriptive studies suggest that:

- ★ crisis housing provides a viable alternative to hospitalization for persons with SMI
- ★ diversion programs are effective
- ★ crisis centres can serve persons with psychosocial problems

### Key Elements of Best Practice

Services are established that resolve crises for persons with serious mental illness using minimally intrusive options.

Crisis programs are in place to divert people from inpatient hospitalization.

Evaluation/research protocols are incorporated into crisis programs.

Examples of crisis programs are:

- ★ Telephone crisis services
- ★ Mobile crisis units
- ★ Crisis residential services, e.g. supervised apartments/houses, foster homes
- ★ Psychiatric emergency/medical crisis services in hospitals

**Table 2.2: Studies of Crisis Response System Components**

<b>Authors</b>	<b>Component of CRS studied</b>	<b>Study population</b>	<b>Method</b>	<b>Results</b>
Merson et al., (1992)	Community care vs inpatient	patients with SMI presenting at ER	RCT	Greater satisfaction with services; reduced inpatient utilization
Bond et al., (1989)	Comparison of 2 crisis housing alternatives	patients with SMI presenting at ER	non random, 4 month follow-up	Clients in unsupervised housing used more services; staff turnover was high in supervised crisis house; otherwise no differences found
Lambert (1995)	After hours crisis intervention	Patients presenting to a VA ER	evaluation	Reduced hospitalization and costs
Gillig et al., (1994)	24 hour holding beds; compared 2 hospitals, one with and one without	Patients presenting to ER	comparison groups	Reduced hospitalization rates
Reding & Raphaelson (1995)	Mobile Crisis Unit/effect of adding psychiatrist	SMI patients in crisis	Retrospective evaluation	Adding a psychiatrist to mobile unit reduced hospitalization
Fisher et al., (1990)	Mobile Crisis Units	40 counties; 20 with MCUs & 20 without	Comparison; review of admission rates	No differences between counties in rates of hospitalization
Leaman (1987)	Crisis homes	all patients admitted	program description/evaluation	Improved clinical status; patient satisfaction was high; considerable cost savings
Peladeau et al., (1991)	Crisis centre	all clients referred	descriptive; quantitative/qualitative	Most of the presenting problems were psychosocial

*ER = Emergency room SMI = seriously mentally ill VA= Veteran's Affairs hospital (USA)*



## REFERENCES

- Bond, GR, Witheridge, TE, Wasmer, D, Dincin, J, McRae, SA, Mayes, J & Ward, RS. (1989). A comparison of two crisis housing alternatives to psychiatric hospitalization. *Hospital and Community Psychiatry*, 40(2):177-183.
- Fisher, WH, Geller, JL, Wirth-Cauchon, J. (1990). Empirically assessing the impact of mobile crisis capacity on state hospital admission. *Community Mental Health Journal*, 26(3):245-253
- Geller, JL., Fisher, WH, McDermeit, M. (1995). A national survey of Mobile Crisis Services and their evaluation. *Psychiatric Services*, 46(9):893-897.
- Gillig, PM, Hillard, JR, Bell, J, Combs, HE, Martin, C & Deddens, JA. (1989), The psychiatric emergency service holding area: Effect on utilization of inpatient resources. *American Journal of Psychiatry*, 146(3):369-372.
- Goering, P & Durbin, J. (1994). *A Background Paper for Mental Health Reform in Ontario*, Ontario Ministry of Health.
- Lambert, M. (1995). Psychiatric crisis intervention in the general emergency service of a Veterans Affairs hospital. *Psychiatric Services*, 46(3):283-284
- Leaman, K. (1987). A hospital alternative for patients in crisis. *Hospital and Community Psychiatry*, 38(11):1221-1223.
- Merson, S, Tyrer, P, Onyett, S, Lack, S, Birkett, P, Lynch, S. & Johnson, T. (1992). Early intervention in psychiatric emergencies: a controlled clinical trial. *The Lancet*, 339:1311-1314.
- Peladeau, N., Mercier, C., Couture, L (1991) Les centres de crise et les services de sante mentale: l'experience du sud-ouest de Montreal. *Sante Mentale au Quebec*. 26 (2), 267-288.
- Reding, GR., & Raphelson, M. (1995) Around-the-clock mobile psychiatric crisis intervention *Community Mental Health Journal*, 31(2): 179-190

# 3.

## HOUSING/COMMUNITY SUPPORT

### 3.1 Introduction & Definitions

With de-institutionalization, increasing attention has focussed on the housing and community support needs of people with serious and persistent mental illnesses. During the earlier phases, most former psychiatric patients who were unable to cope with independent living were placed in nursing homes, foster homes, and board and care facilities. Many of these settings operated on a for-profit basis and were not designed or funded to meet the rehabilitative needs of residents. Over time and in a rather unplanned fashion at first, an array of residential alternatives evolved.

*Trainor et al., (1993)* separates community housing for people with psychiatric disabilities into two overall categories: custodial models and alternative housing models. The former tend to be larger facilities with little or no programming. The latter include group homes, half-way houses, cooperatives and supported housing (which features support services that are separate from the housing itself and focuses on helping people live in the 'normal' community). Alternative housing programs tend to be fairly small and offer rehabilitative and community support services.

During the 1970s and 1980s, what has become known as the linear residential continuum became the most widely accepted conceptual framework in the field of residential services (*Ridgway & Zipple, 1990*). In this paradigm clients are placed in residential treatment/support programs that best meet their current needs. Ideally, as they become stabilized and rehabilitated they move from more restrictive/intensively staffed settings to gradually less restrictive alternatives that offer less service. The goal is to achieve a high enough level of functioning to move out of the residential services continuum into independent living.

Widespread adoption of this model led planners and providers in most mental health systems to try to systematically develop a comprehensive continuum of residential programming options. However, few communities were able to accomplish this costly and complex task satisfactorily. And, as *Ridgway and Zipple (1990)* point out in their overview, “a common language or nomenclature has failed to emerge, and there is no broad consensus on what constitutes an ideal continuum” (p. 13). The category of “group home” alone came to subsume a heterogeneous range of for-profit and not-for-profit congregate living models. Only some of these incorporate treatment/rehabilitation employing different philosophies, approaches and intensities.

Another barrier to advancement is that historically the mental health field viewed housing as a social/welfare problem not related to treatment, the main focus. Social welfare and public housing systems countered with the argument that specialized residential programs should come under the

purview of mental health (*Carling & Ridgway, 1987*). This debate still surfaces occasionally in times of funding cutbacks.

### **3.1.1 Housing and Mental Health Reform**

The mental health reform movement with its focus on community-based care and consumer involvement brought with it new approaches and philosophies about housing for people with psychiatric disabilities. Advocating for greater availability of safe, decent and appropriate housing and community supports has become a priority for service providers, family organizations and consumers alike. Factors contributing to the growing sense of urgency about housing include the large numbers of mentally ill individuals among the homeless; the decreasing availability of safe and affordable housing stock for this population in many communities; and recent constraints in funding for all types of mental health services. The finding of preference studies wherein consumers give top priority to meeting basic needs for housing has also been an important mobilizing force.

The outcome of these systems-level concerns and pressures has been a large-scale paradigm shift from a reliance on the residential services continuum to a strong emphasis on what has become known as the supported housing model. Today, many experts view the supported housing approach as a key element of mental health reform. The significant changes in philosophies and service directions have been shaped by results of research into consumer preferences for housing; the effectiveness of innovative methods of community-based care (eg., psychiatric rehabilitation approaches, case management, mobile crisis teams) and the experiences of mental health professionals and those working with the developmentally handicapped and the infirm elderly.

*Ridgway and Zipple (1990)* point out that this paradigm shift is an enormous transition marked by a “reorganization of values, perspectives and meaning” (p. 27) which challenges the status quo, threatens vested interests and will necessarily involve a complex process of change for the existing system of facility-based residential services. However they also warn against wholesale acceptance of the new approach without thorough evaluation of its effectiveness.

### **3.1.2 Supported Housing**

Based on the principle of community integration, the supported housing model incorporates the following critical elements: the use of generic housing widely dispersed in the community; the provision of flexible individualized supports at varying levels of intensity and times; consumer choice; and assistance in locating and maintaining housing. Housing is primarily the place where clients live, not a treatment setting. Hence there are no restrictions on how long consumers can stay in their residences and they are not required to participate in program activities. Services are not tied to particular residential settings but rather are made available on an ongoing basis regardless of whether the individual moves to another residence or is hospitalized. This approach is commonly referred to as ‘de-linked services’.

Experts agree that a program is **not** supported housing if **only** residential program settings such as group homes and other staffed facilities are used, or if clients are expected to move if their functioning improves or deteriorates (*Hogan & Carling, 1992; Livingston et al., 1991*).

Some supported housing programs are more consumer-directed than others. One example is the Supportive Housing Program (SHP) in Winnipeg, Manitoba, developed by the CMHA and funded by the Manitoba Department of Health as a demonstration project (*Chipperfield & Aubry, 1990*). The SHP helps people with mental health problems to set up a cooperative living arrangement of their own choice and provides them with support as needed.

Supported housing and intensive case management services are integrally intertwined in some programs. The Thresholds Bridge Program in Chicago, established in the late 1970s, serves over 500 people at any one time and offers a range of housing options. Influenced by the assertive community treatment model developed by Stein and Test in Wisconsin, Thresholds Bridge is one of a number of examples of the combined service approach. Most of these programs (which are also discussed under the case management section of this review) are directed specifically towards individuals at high risk for hospitalization and/or homelessness (*Witheridge, 1990*).

The terms “supported” and “supportive” housing are often used interchangeably when discussing housing and supports for consumers of mental health services (*CMHA, 1995*). In the following review we use the term “supported” unless investigators have explicitly used “supportive” to describe the housing approach under study.

### 3.2 Review of the Research

People with psychiatric disabilities live in a broad and eclectic array of community-based housing. Given the multi-faceted nature of client and housing variables and the transitional state of this field, the fact that gaps exist in scientific knowledge about the benefits and shortcomings of various housing options should not be surprising.

While the literature contains numerous articles examining different aspects of the experiences and outcomes of residents in specific settings or models, the designs and methods of most studies are weak, limiting our ability to draw inferences from results. A host of variables associated with the resident, the housing model and the particular facility may exert an impact on housing outcomes. These are seldom controlled for in designing investigations or in analysing findings. Most important, rigorous experimental designs such as random assignment are seldom possible and comparison groups are rarely used. Thus few conclusions about relative effectiveness can be made. In reviewing and discussing the evidence, we have chosen therefore to err on the side of inclusiveness. In general, both the reviews and the primary studies included here have less than rigorous designs and methods. Most of the reported findings that follow should be used only to identify possible effects and important avenues for future research.

### 3.2.1 Reviews

The literature contains a number of overviews dealing with various aspects of housing and related community supports (eg., *Cook et al., 1996; Carling, 1990; Fields, 1990; Ridgway & Zipple, 1990*). These reviews summarize studies that examine the housing preferences of consumers as well as the experience and impact of living in various housing options. The four review articles which are selected for more detailed discussion (see Table 3.1), while not rigorously conducted according to our pre-stated criteria, have a research focus and expand our knowledge base in this area.

*Tanzman (1993)* summarizes key findings from 23 consumer preference studies conducted in the United States and in Ontario. The studies found that people with psychiatric disabilities prefer to live in their own apartments or houses, and prefer not to live with other consumers of mental health services. They want support from mental health staff to deal with emotional upsets and crises, to help find housing, and to assist with budgeting money. Inadequate financial and material resources was cited as the greatest barrier to consumers living in the housing of their choice.

*Cournos (1987)* focuses on evidence about the effect of environmental factors on the course of serious mental illness in individuals living in a range of residential programs including foster homes and various congregate living program models but not supported housing. Most studies reviewed, albeit deficient in their designs and methods, report environmental variables to be more powerful predictors of outcome than client characteristics. These variables include central community location; opportunities for autonomy; moderate expectations for functioning; and avoidance of a rigid, demanding environment with overly intense supervision.

*Trainor et al., (1993)* examines evidence about which environmental variables appear to enhance adaptation and increase community tenure. These include the involvement of residents in planning within the facility; consumer choice of activities; and a normative, home-like environment. The most widely reported finding is the superiority of smaller facilities in fostering adaptation and increasing community activity and resident satisfaction. *Trainor et al., (1993)* and *Cournos (1987)* both cite findings that suggest patient diagnosis may be a factor in resident responses to activity. For example, those with a diagnosis of schizophrenia may respond negatively to increased activity while those without such a diagnosis tend to respond more positively.

Although two reviews (*Carling, 1990; Trainor et al., 1993*) suggest that changing residence because of limits on residential length of stay may expose individuals to a higher risk of exacerbation of illness, this view does not seem to be backed up by strong research evidence. Similarly, research examining the impact of admission requirements seems to be lacking, although *Trainor et al.*, recommend less restrictive admission criteria.

The most broadly based review was written by a widely recognized expert in this field, *Paul Carling (1993)*, and subsumes research studies and policy analyses carried out over a 15-year period. It does not specify search methods or criteria for inclusion. The author notes that empirical knowledge about residential program models is generally “hampered by methodological problems” (p441) and that few studies meet basic criteria of experimental design. The reviewer does not attempt a critical appraisal

of the strength of the evidence of individual studies cited. *Carling*, along with the other reviewers, concludes that community-based residential treatment/care is as effective or more effective than hospital-based care in achieving outcomes such as use of community services and supports, and finding and keeping employment. However, he questions whether the studies provide much evidence that transitional residential programs promote community integration. *Carling* cites the results of an earlier review (*Carling & Ridgway, 1987*) as providing strong evidence that the housing needs of many special needs groups (including the psychiatrically disabled, the poor and the developmentally disabled) are similar; that support needs are critical factors in determining tenure in housing choices; and that housing problems relate more to economic and social factors than to disability. Regarding the supported housing model, *Carling (1993)* concludes that although initial indications from outcome studies suggest that it may compare favourably with other approaches, much more research is needed. For example, he notes findings that involuntary placement in supported housing results in greater risk for certain outcomes such as re-hospitalization than does client selection of this option.

The *Trainor et al., (1993)* review suggests that relying mainly on the supported housing model may not be advisable, particularly in jurisdictions where community supports are scarce and fragmented or not easily accessible. Referring to findings that the severely impaired who are living in the community and do not have intensive case management services may be at greater risk for a range of adverse outcomes, they question whether the demands of supported housing may be too great for some individuals who require high levels of support. The importance of finding and keeping decent, safe and affordable housing appears to be critical to community adjustment. However, more research both quantitative and qualitative, with stronger research designs, and more involvement of residents in evaluations is needed. Research priorities include: the relative effectiveness and impact of different living arrangements on social support, community integration and other outcomes; the role of individual choice, control and autonomy in predicting success; and consumers' capabilities, both as individuals and consumer groups, to manage their own symptoms and lives and support each other.

### 3.2.2 Additional Studies

Table 3.2 describes key features of selected additional studies. Because of the inherent limitations of the available research, our criteria for inclusion are generous. The studies included have quasi-experimental or longitudinal designs; adequate descriptions of sample and setting(s); descriptions of methods and approach to analysis; have been published since 1990 and are not included in the reviews. Several investigations have been mounted by Canadian researchers who appear to be in the forefront of scientific work currently being carried out in this important field.

#### **Community-Based Residential Programs**

Three longitudinal studies involving various program models provide further evidence that some but not all types of settings can be a successful substitute for longer-term inpatient care.

*Okin et al., (1995)* carried out a follow-up assessment of 53 people with long-term psychiatric problems discharged from a state hospital (after an average length of stay of 11.5 years) into four

structured, well-staffed group homes. A mean of 7.5 years after discharge, 57% continued to live in structured community residential settings, 28% had moved to independent living and only 16% had returned to institutions. Although 55% were readmitted at least once during this period, there was a significant increase in cognitive functioning and improvement in social functioning; 94% expressed a preference for life in the community; and a majority viewed their quality of life as improved. Somewhat surprisingly, those with lower levels of functioning and higher symptom levels at discharge did not require more hospitalization. For the investigators, another unexpected finding was that daily living skills did not improve significantly over time.

*Hawthorne et al., (1994)* used a single group, retrospective repeated measures design to evaluate two publicly funded and well-staffed residential treatment programs. Residents were individuals with severe and persistent mental disorders with a history of repeated hospitalizations and repeated failures at attempts to live in the community. The programs used a psychosocial rehabilitation model that emphasized supportive relationships and individualized treatment plans. After one year in the program, residents were more likely to be employed and living independently, and less likely to be homeless. There was a significant reduction in mean number of hospital and crisis centre admissions during the program year compared with the two-year period prior to entry. There was no correlation between outcome and various demographic factors or diagnosis.

In Montreal *Hodgins et al., (1990)* conducted a two year follow-up study of two groups of former inpatients receiving outpatient services. One group lived in four adjacent 20 unit apartment buildings which housed only hospital outpatients that were supervised by an on site worker. These residents were matched and compared with a control group who were living independently. Standardized measures were administered during resident interviews at six-month intervals for two years. At 24 months, hospital files were reviewed. Contrary to expectations, the two groups did not differ in readmission rates or length of time in hospital. However the experimental group reported experiencing more stress which was attributed to living in close contact with other consumers. Supervision in the buildings was low, consisting primarily of crisis management with little attention focused on building social support or life skills training. The authors attribute the lack of group differences in the study to the low level of supervision in the apartments, which were functioning more as mini asylums than as supported environments. Other studies also have linked grouping patients in aftercare facilities to poor outcomes and have stressed the importance of attending to environmental factors when housing individuals with chronic mental illness (*Cournos, 1987; Hellman et al., 1985*).

### **Supported Housing Studies**

*Livingston and colleagues (1991)* use a longitudinal design to evaluate 10 supported housing demonstration projects funded by the National Institute of Mental Health. While projects varied in how they implemented supported housing, most used apartments or housing scattered throughout the community and implemented low caseload, out-of-office teams to provide support (i.e., similar to ACT model). Availability of supports ranged from 24 hours daily to traditional office hours. Overall, the evaluation found that supported housing can successfully serve a diverse population of persons with severe psychiatric disabilities, including individuals with challenging behaviours. After program

entry, use of hospitals and crisis services declined and housing stability increased for most participants who were very satisfied with their housing situation. Housing stability was better for those who were living in a household of their choice and had fewer symptoms. Sources and levels of social support remained unchanged as did symptom levels. Only 30% of clients were employed and many incomes were inadequate to adequately cover transportation, clothing and social activity costs.

In a Canadian study, *Boydell and Everett (1992)* use both qualitative and quantitative methods to investigate adaptation of people with long-term psychiatric disabilities to living in a type of supported housing. Participants lived in a residence consisting of 14 bachelor units and support was provided as needed. The study examined the residential milieu, changes in resident support networks and level of staff-tenant contacts after one year. Both staff and tenants reported that the residential milieu emphasized independence, relationships and personal growth. Tenants came to define as freedom what initially appeared to be staff abandonment, and were learning how to deal with personal and practical problems. Although no increase in informal social networks was found, residents began to rely on staff more as supports than as supervisors. As a result there was a decrease of 60% in staff time spent on service delivery. The authors conclude that residents were adjusting well to their independent living situations. They may need more support initially until they become comfortable with their independence.

In another Canadian study *Nelson et al., (1997)* uses a longitudinal design to compare non-equivalent groups of 52 consumers living in supportive apartments (SA), 30 in group homes (GH) and 25 in board and care homes (BCH). In the SA model, support is tied to specific locations but the amount and type of support provided by staff is negotiated on an individual basis. The hypotheses tested were: SA and GH residents would report fewer housing concerns; GH and BCH residents would report more staff support; SA and GH residents would report higher levels of resident control and democratic decision-making (SA more than GH); and SA and GH residents would show more improvement over time. Outcomes included measures of personal empowerment, community integration and quality of life, as well as open-ended questions about what changes residents had experienced. An initial and one year follow-up interview were conducted.

All three groups had few housing concerns. This finding was surprising because, in the BCH option there were more residents, fewer had their own rooms, and there was less control over decision-making. One explanation for the lack of difference is that the BCHs included in the study were more physically and socially desirable than most. Residents from the two congregate living situations reported more social support and less emotional abuse than SA residents, more of whom also felt isolated and thought their relationships had deteriorated over the year. Similar findings have been reported by other researchers in studies not included here because of weaker designs (*eg., Pomeroy et al., 1992*). This finding indicates that loss of support can be a cost of having more control and freedom in SAs. Providing adequate support to consumers who want more choice and control in their housing remains a challenge.

Residents in all three housing models reported relationship problems with living companions which may reflect lack of choice in housemates. All three groups improved over time on staff-rated instrumental role involvement but the SA and GH groups showed greater improvement in



independent functioning. No improvement was found for any of the groups on subjective quality of life indicators.

Qualitative data provide stronger support for SAs and GHs compared to BCHs. Answers to the open-ended questions were quantified to obtain frequency data. A large portion of SA and GH residents reported at least one positive change in themselves over the study period (eg., improved social skills, self esteem, greater community involvement) compared to less than half of BCH residents. The three groups were similar in improved health and emotional well-being. Overall the residents of SAs and GHs tended to be more growth oriented than BCH residents who appeared to be less concerned with change and more satisfied with their lives. This may reflect the life stage of BCH residents who were older, less educated, less independent in function and had lived in their settings longer. The authors acknowledge this non-equivalence of groups as a study limitation.

Another analysis of the same study (*Nelson et al., in press-b*) examines the relationship between various housing characteristics and dimensions of community adaptation. After controlling for demographic variables and prior adaptation, significant predictors of community adaptation included the number of living companions, housing-related concerns and having a private room. Indicators of adaptation were positive and negative affect, mastery and independent functioning. Although other investigators have reported similar findings (eg., *Baker & Douglas, 1990; Newman et al., 1994*), the stronger design of this study adds weight to the effect of certain housing characteristics on outcome.

A number of other investigations of supported housing not included because of their cross-sectional designs (eg., *Pyke & Lowe, 1996; McCarthy & Nelson, 1993; Chipperfield & Aubry, 1990*) report improved quality of life and personal growth over time. Findings about perceived social support and relationships with other tenants vary. Reports suggest that some respondents feel isolated and miss the company of staff. It is possible that results depend highly on a range of factors related to the particular target group, setting or program model.

The **case management literature** provides another perspective for evaluating the success of consumers living in non-residential housing situations. Most intensive case management programs place a strong emphasis on helping clients to find and maintain housing – this is the ‘support’ aspect that is so crucial to supported housing – and most provide support to consumers regardless of where they live. Many housing programs that shift to a supported housing model retrain staff to be case managers rather than housing supervisors. Evidence from rigorous trials and other studies reported in Chapter 1 indicates that consumers with serious mental illness can improve in a number of life areas and live successfully in various types of community housing when supported by assertive community treatment and other case management services. While these findings support the feasibility and success of supported housing, the comparison condition usually was standard community care, not residential care.

Studies have examined the impact of providing **housing vouchers** to recipients of case management. The Robert Wood Johnston Program on Chronic Mental Illness (RWJP/CMI), described in more detail in Chapter 9, included federal government 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*).

### **Programs for Housing the Homeless**

The special housing and other needs of the homeless mentally ill have been the focus of increasing attention over the past decade. For a comprehensive overview of research and services for homeless mentally ill persons, the reader is referred to wide-ranging reviews of the state of knowledge by *Dennis et al., (1991)* and *Hamid et al., (1993)*. Each contains sections dealing with the housing needs and provisions of this population. Even more comprehensive and up-to-date, but unpublished reviews of issues and intervention programs have been carried out by The Workgroup on Homelessness and Social Isolation of the Metropolitan Toronto District Health Council (1995) and by the Mental Health Programs and Services Group, Ministry of Health, Ontario (1995).

All reviewers conclude that the needs of the homeless mentally ill are diverse and complex. There are strong indications of the benefits of employing an outreach service model and of addressing the multiple needs of this population in a comprehensive and flexible manner. Evidence suggests that a wide range of housing options with varying degrees of supervision and support is needed. Research also suggests that highly structured settings may not be appropriate and that extended follow-up is particularly important with this group. One evaluative study of five outreach programs for the homeless (*Barrow et al., 1991*) found that although two-thirds of clients obtained housing during the six month follow-up, only half remained housed throughout this period.

Perhaps the most important large-scale initiative directed towards this target group involves five research demonstration projects jointly sponsored by the US departments of Health and Social Services and Housing and Urban Development (*Centre for Mental Health Services, 1994*). The goal was to test the effectiveness of a variety of approaches to providing mental health treatment, housing and support services to homeless adults with serious mental illness. Three projects offering case management and housing were mounted in Boston, Baltimore and San Diego and two in New York City. All projects used a rigorous research design in which individuals were assigned randomly to either experimental or comparison groups. A total of 896 people received services from the projects.

Twelve months later, most projects reported increased use of community mental health services often coupled with a decrease in symptoms and a dramatic decrease in inpatient hospitalization (e.g., in the Baltimore project, the number of inpatient days were reduced by 50%). A significant number of participants were helped to find and maintain community-based housing. All projects helped participants to access financial aid. Four projects successfully used formerly homeless people with severe mental illness either as paid or volunteer staff. Almost all participants reported improvements in their lives after involvement in these projects. Substance abuse was found to be a major factor in housing loss for this population.

More demonstration programs with evaluative components are being initiated and some of these are now reporting results of considerable interest for future program development. An NIMH-funded research demonstration based in two Michigan communities (*Bybee et al., 1994*) is one such example.

It utilizes a team of mental health workers to reach out to this target group with a view to housing them in independent residences of their choice, helping them with income needs and to obtain a range of rehabilitative and support services. The evaluation at four and 12 months examined residential status, residential experiences, functioning, and use of mental health and shelter services before and after enrolment in the project.

At both time points, over 80% of participants had spent some time in a permanent residence, but the number who remained in their first permanent residence declined from 42% at four months to 15% at 12 months. Between the two time points, substantial movement occurred. At 12 months, 60% of those who had been homeless or in a treatment facility at four months were in supervised dependent housing. Baseline client functioning measures (hostile/psychotic cluster descriptors) appeared to predict residential outcome at four months but were no longer significant predictors by 12 months. This suggests that some more difficult clients may still achieve positive residential outcomes over a longer time period. Another analysis of the same study (*Mowbray et al., 1993*) provides support for the use of implementation data in evaluations. In this case, client 'engagement' was operationalized and found to be an intermediate predictor of outcome.

A recent Canadian study by *Goering et al., (1997)* involves an assertive case management service for homeless mentally ill individuals which is linked with two men's and four women's hostels. Eight case managers provide intensive services to caseloads of approximately 15 clients each. This longitudinal study, using a single group, pre/post design, followed 55 clients over an 18-month period. Results demonstrate that initial gains in social functioning and symptom reduction found at the nine month point can be maintained and continued over time. Most clients spent the last nine of those months in one housing setting. Those with a stronger alliance with their worker improved faster, had fewer symptoms and better social functioning at 18 months.

### 3.3 Discussion

The results of recent primary studies of community-based residential programs reinforce the conclusions of *Carling (1993)* and others that ample evidence exists showing that community-based care is equally or more effective than long-term care in inpatient facilities and that further research in this area is largely unnecessary. A growing body of research from diverse perspectives substantiates the value of the supported housing model. Findings show that:

- supported housing is preferred by consumers, in part because it allows choice to be exercised
- supported housing can serve a wide variety of individuals with severe mental illness, including homeless individuals
- assertive case management programs can successfully support individuals in various housing arrangements

Despite this support, experts caution that a wholesale move away from other residential program models towards funding only the supported housing approach would appear to be premature.

*Bachrach (1994)* argues convincingly that “there is no single kind of housing that can effectively meet the needs of all long-term mental patients” (p203) and a full array of housing options is needed (*see also Lesage & Morrisette, 1993*). As stated by *Fields (1990)*, it is not yet clear what proportion and which of the psychiatrically disabled in both longer-term and acute institutions can be served effectively by the supported housing model. Equally important, more information is needed about the range of support services required for various client groups so that the real costs of this approach can be analysed. Experts urge policy makers and planners not to embrace supported housing because it appears to be a cost-cutting approach and then to underfund its supportive aspects (*Cook et al., 1996; Carling, 1993*). Experience suggests that if necessary support components are not made available and/or not funded appropriately, supported housing is likely to turn into another version of the custodial living arrangements of the past.

The need to develop and use reliable and valid methods and tools to assess various aspects of this complex field of research is recognized in the literature (*Goldman et al., 1995*). Recent research demonstrates the benefits of involving consumers and families in the design and method of housing investigations, thus contributing valuable information not otherwise available. For example *Boydell (1993)* successfully used consumers in data collection and interpretation.

In 1990, *Carling* set out an evaluation research agenda for consideration which remains equally valid today. He proposed that the following step-by-step approach be taken in evaluating supported housing:

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

### 3.4 Best Practices: Housing/Community Support

#### Research Evidence

Quasi-experimental and longitudinal studies show that:

- ★ community residential programs can successfully substitute for long-term inpatient care
- ★ supported housing can successfully serve a diverse population of persons with psychiatric disabilities but support networks need to be monitored
- ★ consumer choice is associated with housing satisfaction, residential stability and emotional well-being

Cross-sectional studies show that:

- ★ consumers prefer single occupancy, choice and supports when requested

Controlled and non-controlled trials have demonstrated that:

- ★ individuals with severe mental illness, including homeless people, can be housed when provided with assertive case management services

#### Key Elements of Best Practice

A range of different housing alternatives (e.g. supervised group homes or other residential settings) is provided but there is a shift of resources and emphasis on supported housing.

Supported housing incorporates the following critical elements:

- ★ use of generic housing dispersed widely in the community
- ★ provision of flexible individualized supports which vary in intensity
- ★ consumer choice
- ★ assistance in locating and maintaining housing
- ★ no restrictions on length of time client can remain in the residence

case management services are not tied to particular residential settings but are available to the client regardless of whether the client moves or is hospitalized

Community residential housing is provided as a substitute for long-term inpatient care.

Housing needs of the homeless mentally ill which include an assertive outreach component are addressed.

Evaluation/research protocols are incorporated into housing programs.



**Table 3.1: Reviews of Housing-Related Studies: Dates, Characteristics**

<b>Review</b>	<b>Type of Review</b>	<b>Years</b>	<b># Studies</b>	<b>Focus</b>	<b>Remarks</b>
Cournos (1987)	Narrative	1954-86	32	Environmental Factors - Residential Programs	No description of search methods. No assessment of design, methods of studies or strength of evidence.
Carling (1993)	Narrative	1977-93	124	All Housing Models	Large database but no description of search methods or assessment of strength of evidence. Research and policy analysis included.
Trainor et al., (1993)	Narrative & Survey	1975-92	22	Alternative Housing	Less rigorous assessment of evidence
Tanzman (1993)	Narrative	1986-92	26	Consumers Housing Preferences	Methods, sample and inclusion criteria described.

■ ■ ■ ■ ■  
**Table 3.2: Additional Studies**

Authors	Study Population (n)	Program Models	Design/ Method	Outcome				
				Tenure	Client	Staff	Family	Cost
<b>Community-based Residential</b>								
Hodgins et al., (1990)	112	Supervised apts/indep. living	Matched sample	x	x			
Hawthorne et al., (1994)	104	Residential treatment homes	1 yr follow-up	x	x			
Okin et al., (1995)	72	4 group homes	1 yr follow-up	x	x			
<b>Supported Housing</b>								
Boydell & Everett (1992)	14	Supported housing	1 yr follow-up (qualitative & quantitative)		x	x		
Nelson et al., (1995)	34	Supportive housing apartments	Pre-Post test		x			
Nelson et al., (in press)	107	Boarding/group/supportive housing	1 yr follow-up		x			
<b>Combined Housing/Case Management Programs</b>								
Galster et al., (1992)	82	various models of case management & housing	2.5 years					x
<b>Programs for Homeless Mentally Ill</b>								
Cohen et al., (1994)	130	Outreach, housing	3 years	x	x			
Bybee et al., (1994)	139	Outreach, housing	12 months	x	x			

## REFERENCES

- Bachrach, L.L. (1989). The legacy of model programs. *Hospital and Community Psychiatry*, 40(3): 234-235.
- Bachrach, L.L. (1994). Residential planning: concepts and themes. *Hospital and Community Psychiatry*, 45:202-203.
- Baker, F. & Douglas, C. (1990). Housing environments and community adjustment of severely mentally ill persons. *Community Mental Health Journal*, 26:497-505.
- Barrow, S.M., Hellman, F., Lovell, A.M., Plapinger, J.D., & Struening, E.L. (1991). Evaluating outreach services: Lessons from a study of five programs. Neal L. Cohen, (Ed.) *Psychiatric outreach to the mentally ill. New directions for mental health services*, No. 52: The Jossey-Bass social and behavioral sciences series, Jossey-Bass Inc, Publishers, San Francisco, p. 29-45.
- Boydell, K. (1993). The Dundas-Osler project: A multi-support model of independent living for people with long-term psychiatric backgrounds. *National Mental Health Policy Reporter*, p. 5-6.
- Boydell, K., & Everett, B. (1992). What makes a house a home? An evaluation of a supported housing project for individuals with long-term psychiatric backgrounds. *Canadian Journal of Community Mental Health*, 11(1):109-123.
- Bybee, D., Mowbray, C.T., & Cohen, E. (1994). Short versus longer term effectiveness of an outreach program for the homeless mentally ill. *American Journal of Community Psychology*, 22:181-209.
- Canadian Mental Health Association, Ontario Division. (1995). *Respecting housing and support. Policy Document*.
- Carling, P.J. & Ridgway, P. (1987). Overview of a psychiatric rehabilitation approach to housing. In *Psychiatric Rehabilitation: Turning Theory into Practice*. Anthony WA & Farkas M (eds), Baltimore: Johns Hopkins University Press.
- Carling, P.J. (1990). Supported housing: An evaluation agenda. Special issue: Supported housing: New approaches to residential services. *Psychosocial Rehabilitation Journal*, 13: 95-104.
- Carling, P.J. (1993). Housing and supports for persons with mental illness: Emerging approaches to research and practice. *Hospital and Community Psychiatry*, 44:439-449.
- Center for Mental Health Services, Substance Abuse and Mental Health Services Administration., & U.S. Department of Health and Human Services. (1994). *Making a difference: Interim status report of the McKinney research demonstration program for homeless adults with serious mental illness*.



- Chipperfield, S., & Aubry, T. (1990). The supportive housing program in Winnipeg. *Psychosocial Rehabilitation Journal*, 4:91-94.
- Cohen, C., Onserud, H. & Monaco, C. (1993). Outcomes for mentally ill in a program for older homeless persons. *Hospital and Community Psychiatry*, 44(7): 650-656
- Cook, J.A., Pickett, S.A., Razzano, L., Fitzgibbon, G., Jonikas, J.A., & Cohler, J.J. (1996). Rehabilitation services for persons with schizophrenia. *Psychiatric Annals*, 26:97-104.
- Cournos, F. (1987). The impact of environmental factors on outcome in residential programs. *Hospital and Community Psychiatry*, 38:848-852.
- Dennis, D.L., Buckner, J.C., Lipton, F.R., & Levine, I.S. (1991). A decade of research and services for homeless mentally ill persons: Where do we stand? Special Issue: Homelessness. *American Psychologist*, 46:1129-1138.
- Fields, S. (1990). The relationship between residential treatment and supported housing in a community system of services. *Psychosocial Rehabilitation Journal*, 13:105-113.
- Galster, GC., Champney, TF., & Williams, Y. (1994) Costs of caring for persons with long-terms mental illness in alternative residential settings. *Evaluation and Program Planning*, 17(3): 239-248
- Goering, P., Wasylenki, D., Lindsay, S., Lemire, D., & Rhodes, A. (1997). Process and outcome in a hostel outreach program for homeless clients with severe mental illness. *American Journal of Orthopsychiatry*, 67(4): 607-617
- Goldman, H.H., Rachuba, L., & Van Tosh, L. (1995). Methods of assessing mental health consumers' preferences for housing and support services. *Psychiatric Services*, 46:169-172.
- Hamid, W.A., Wykes, T., & Stansfeld, S. (1993). The homeless mentally ill: Myths and realities. *The International Journal of Social Psychiatry*, 38:237-254.
- Hawthorne, W.B., Fals-Stewart, W., & Lohr, J.B. (1994). A treatment outcome study of community-based residential care. *Hospital and Community Psychiatry*, 45:152-155.
- Hellman, I., Green, L, Morrison, T. & Abramowitz, S. (1985). Organizational size and perceptions in a residential treatment program. *American Journal of Community Psychology*, 13, 99-105.
- Hodgins, S., Cyr, M., & Gaston, L. (1990). Impact of supervised apartments on the functioning of mentally disordered adults. *Community Mental Health Journal*, 26:507-516.
- Hogan, M.F. & Carling, P.J. (1992). Normal housing: A key element of a supported housing approach for people with psychiatric disabilities. *Community Mental Health Journal*, 28:215-226.

- Lesage, A. & Morrisette, R. (1993). Residential and palliative needs of persons with severe mental illness who are subject to long-term hospitalization. *Canada's Mental Health*, 41(2):12-17.
- Livingston, J.A., Gordon, L.R., King, D.A., & et al., (1991). *Implementing the supported housing approach: A national evaluation of NIMH supported housing demonstration projects*.
- Mental Health Programs and Services Group (1995). *People who are homeless and have mental health problems: A selective review of the literature*. Ministry of Health, Ontario.
- McCarthy, J., & Nelson, G. (1993). An evaluation of supportive housing: Qualitative and quantitative perspectives. *Canadian Journal of Community Mental Health*, 12:157-175.
- Mowbray, C.T., Cohen, E., & Bybee, D. (1993). The challenge of outcome evaluation in homeless services: Engagement as an intermediate outcome measure. *Evaluation and Program Planning*, 16:337-346.
- Nelson, G., Hall, G.B., & Walsh-Bowers, R. (1998). The relationship between housing characteristics, emotional well-being and the personal empowerment of psychiatric consumer/survivors: *Community Mental Health Journal*. 34(1): 57-70
- Nelson, G., Hall, G.B., & Walsh-Bowers, R. (1997). A comparative evaluation of supportive apartments, group homes, and board-and-care homes for psychiatric consumer/survivors. *Journal of Community Psychology*. 25: 167-188
- 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.L., Borus, J.F., Baer, L., & Jones, A.L. (1995). Long-term outcome of state hospital patients discharged into structured community residential settings. *Psychiatric Services*, 46: 73-78.
- Owen, C., Rutherford, V., Jones, M., Wright, C., Tennant, C., & Smallman, A. (1996). Housing accommodation preferences of people with psychiatric disabilities. *Psychiatric Services*, 47: 628-632.
- Pomeroy, E., Cook, B. & Benjafield, J. (1992). Perceived social support in three residential contexts. *Canadian Journal of Community Mental Health*, 11(1):101-107.
- Pyke, J., & Lowe, J. (1996). Supporting people, not structures: Changes in the provision of housing support. *Psychiatric Rehabilitation Journal*, 19:5-12.
- Ridgway, P., & Carling, P. J. (1987). *Strategic Planning in Housing and Mental Health*. Monograph Series on Housing and Rehabilitation in Mental Health.

- Ridgway P., & Zipple A.M. (1990). The paradigm shift in residential services: From the linear continuum to supported housing approaches. Special Issue: Supported housing: New approaches to residential services. *Psychosocial Rehabilitation Journal*, 13: 11-31.
- Segal, S.P., & Kotler, P.L. (1993). Sheltered care residence: Ten-year personal outcomes. *American Journal of Orthopsychiatry*, 63: 80-91.
- Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal*, 31:139-152.
- Tanzman, B. (1993). An overview of surveys of mental health consumers' preferences for housing and support services. *Hospital and Community Psychiatry*, 44(5): 450-455
- Trainor, J.N., Morrell-Bellai, T.L., Ballantyne, R., & et al., (1993). Housing for people with mental illnesses: A comparison of models and an examination of the growth of alternative housing in Canada. *Canadian Journal of Psychiatry*, 38:494-501.
- Witheridge, T. F. (1990). Assertive community treatment: A strategy for helping persons with severe mental illness to avoid rehospitalization. In, Cohen NL (ed) *Psychiatry takes to the streets: Outreach and crisis intervention for the mentally ill*. New York: Guilford Press.
- Workgroup on Homelessness and Social Isolation. (1995). *Homelessness, social isolation and mental health reform "meeting the needs"* Report to the Metropolitan Toronto District Health Council.

# 4.

## INPATIENT/OUTPATIENT CARE

### 4.1 Introduction and Definitions

The past three decades have seen sweeping changes in traditional hospital-based mental health care. Psychiatric hospitals have been downsizing, realigning their resources to emphasize community-focussed care, and changing their role from long-term asylum to specialized tertiary care. General hospital psychiatric units are being used increasingly to provide acute care for people with serious and persistent psychiatric disorders. Length of inpatient stay in acute care settings has been decreasing steadily and hospital-based service delivery modalities have been changing. For example, the use of partial hospitalization has been expanding and new approaches to emergency and outpatient care and home treatment are being used.

This section focuses on the current state of knowledge about these critical elements of mental health reform. Table 4.1 lists and describes the reviews that form the basis of our assessment. The most rigorously conducted review examines the effectiveness of services for the severely mentally ill (*Hargreaves & Shumway, 1990*) and covers treatments, treatment programs and treatment settings. The authors include only published controlled studies and reviews of these studies.

Some reviews listed here deal with one or more aspects of mental health care and/or a particular target population. *Pfeiffer et al., (1996)* take a rigorous scientific approach in their review of the social, psychological and psychiatric correlates of outcome for discharged psychiatric patients. Their focus is the impact of various treatment and community-based approaches. *Caton and Galnick (1987)* examine length of hospitalization. Rosie and his colleagues (*Rosie et al., 1995; Rosie, 1987*) and *Hoge et al., (1992)* review the literature on partial hospitalization.

Because of the multi-faceted nature of this area, the findings of reviews and additional primary studies will be brought together and summarized under separate headings for each component. Criteria for including research studies here are: a longitudinal, comparative or pre-post test design and clear description of the sample, methods and analyses, all of which meet acceptable methodological standards.

## 4.2 De-institutionalization/Downsizing of Psychiatric Hospitals

### 4.2.1 Reviews

There is strong research evidence that a variety of community-based model programs are capable of providing care for the seriously mentally ill which is as effective and sometimes more effective than traditional hospital-based care (*Olfson & Goldman, 1996; Nasir, 1993; Hargreaves & Shumway, 1990*). Several studies demonstrate that hospital admissions can be averted and re-admission rates reduced through the use of alternative models of community-based care. The reviewers cited here also point to evidence about the importance of continuous coordinated care as opposed to episode-based care.

In a similar vein, in reviewing the literature on discharge of long-stay patients, *Hargreaves and Shumway (1990)* conclude that it is associated with improved social functioning over time. They note, however, that studies fail to show differences between institutionalized and discharged groups in psychiatric symptomatology.

The most comprehensive and careful approaches to the evaluation of planned closure of mental hospitals and implementation of community care have been conducted in the UK by a research team from the University of Kent. These include the Care in the Community Demonstration Programme involving 28 projects in various communities (*Knapp et al., 1990*), and the closure of Friern and Claybury hospitals in northeast London (*Anderson et al., 1993*). Data about these initiatives continue to be gathered and analysed. Many papers have been published and findings of their more recent investigations are outlined below. As summarized by *Marks (1992)*, these and other examinations of de-institutionalization find that while community care for the seriously mentally ill may not make a major difference in terms of clinical or social outcomes, individuals and families appear to prefer it, improvements in quality of life result, and it seems to be cheaper.

*Knapp et al., (1990)* caution that the Care in the Community demonstration projects show some evidence of skimming – ie., experimental subjects were, as a group, less dependent than the hospital average. The implication is that effective rehabilitation of future groups from the same hospitals may be more difficult and costly. *Marks* notes a hazard of experimental program development – that if anything untoward such as a suicide occurs, considerable media attention may be attracted. This can jeopardize research and innovation.

The issue of economics is addressed by *Nasir (1993)* who critically examines the relatively small body of knowledge comparing the cost benefits/cost effectiveness of community services over traditional hospital care. Noting that this area of research is very complex and that much more research still needs to be done, he reports that findings to date suggest that community care is less costly. However, *Nasir* concludes that it is too early to know whether this advantage is retained over time and urges researchers to be more rigorous and inclusive in their approach to cost measurements.

### 4.2.2 Additional Studies

*Knapp et al., (1995)* report on an analysis of the prediction of community care costs in a sample of former longer-stay inpatients involved in the closure of the two British psychiatric hospitals discussed above. Personal characteristics as measured in hospital were found to explain 35% of the variance in costs of community care. Costs were higher for the unmarried, younger-aged, and those with higher levels of psychiatric symptoms and sparser social networks. Diagnosis had no relationship to either use or costs of community care. The large, still unexplained portion of the variation is thought to be linked to changes in level of individual need during the year. Nevertheless, these findings could be used to assist planners to predict the service and fiscal needs of target groups for discharge from long-term care facilities.

Another economic analysis of data from the same project (*Hallam et al., 1994*) reports that one year post-discharge, half of the sample of the first five cohorts of hospital leavers were living in highly supported residential care and more than 40 community services were used as well. Accommodation costs were found to comprise 85% of the total costs. The remaining 15% of costs were borne by local agencies, resulting in increased budgetary pressures and higher staff caseloads.

*Anderson et al., (1993)* found that, for a cohort drawn from this same population of former inpatients after one year in the community, clinical and social outcomes were at least as good as their matched counterparts who remained in hospital. As well, there was no significant change in their mental state and social disabilities, they had more diverse social networks, lived in less restrictive circumstances, and preferred living in the community.

*Lawrence et al., (1991)* report results of a quasi-experimental study which evaluated the effect, over seven years, of a change in service provision involving planned expansion of community resources. One catchment area of the Care in the Community Project began to treat the mentally ill in a general hospital psychiatric unit, stopping admissions to the mental hospital. People living in the neighbouring catchment area continued to be treated in a traditional mental hospital. No significant change over time in patterns of bed use was found in the experimental area except for an increase in very short-term admissions. This was despite steady expansion in community services. Findings are viewed as support for the hypothesis that an irreducible number of individuals will always need inpatient care, however comprehensive the community resources. The authors warn that a move away from larger mental hospitals may only produce time-limited cost savings through moving out old long stay patients and selling the real estate.

*Bandeira et al., (1994)* reported results of an assessment of a Canadian hospital-based rehabilitation program for a long-stay target group that have some relevance here. The program differed from usual practices in that a multi-disciplinary team used an “in Vivo” skills teaching approach, with intensive community treatment and crisis intervention provided upon discharge. This quasi-experimental study compared outcomes, at discharge and after three years of those involved with the rehabilitation program with a matched sample of patients discharged from other units in the same hospital. The experimental group demonstrated fewer symptoms, more living skills, were living in less controlling supervised residences and did not show an increase in their level of care needs, in contrast to the

comparison group. The investigators conclude that discharge with intensive follow-up can ensure a better transition to the community for long-stay patients in psychiatric hospitals.

## 4.3 Shorter Length of Stay in Hospital

### 4.3.1 Reviews

Debate about optimum length of stay in hospital has been fuelled both by mental health reform philosophies and by the need to cut hospital costs. As noted by *Caton and Gralnick (1987)* the trend over time is towards shorter hospitalizations. However average length of stay still varies considerably, tending to be affected greatly by type of hospital and by the policies and practices of physicians. They report that only one of six controlled studies reviewed show any increase in readmission rates for shorter-term length of stay subjects and most studies find no differences in outcomes.

*Pfeiffer et al., (1996)* report that diverse opinions persist among researchers and reviewers of the evidence about the benefits of shorter-term treatment in improving client outcomes. They employed a more analytical approach in assessing the evidence, hypothesizing that longer length of stay would correlate with more favourable outcome. Seven of thirteen studies reviewed supported this prediction, four did not find a significant relationship and two supported the benefits of short-term hospitalization. When findings were combined using an integrated approach which took into account sample size and time to discharge, length of stay showed no significant relationship to outcome.

Research findings to date do not warrant doing away entirely with longer-term hospitalization. In discussing directions for research, reviewers cite findings demonstrating the importance of documenting other features of inpatient care, and taking client variables such as severity of illness into account rather than just assessing outcome on the basis of number of days in hospital. They also urge more standardized definitions of 'brief hospitalization' and note the absence of consensus on what constitutes its critical lower limit.

### 4.3.2 Additional Studies

*Appleby et al., (1993)* examined whether duration of hospital stay affects the rate and rapidity of readmission for those with a diagnosis of schizophrenia. Data on 1500 patients from 10 state hospitals were gathered from 18 months after initial discharge. While the magnitude of the effect was small, shorter stay patients (14 days or less) had a greater likelihood of being rehospitalized within 30 days of discharge than those treated for longer periods.

*Swett (1995)*, concerned about findings suggesting that short length of stay may be associated with increased likelihood of readmission, conducted a prospective study of 189 consecutive admissions to an acute admissions unit to examine factors predicting readmission within 30 days. High scores at discharge on the BPRS scale thought disorder factor along with a high number of former admissions were significant predictors. The authors suggest using this scale and information about past

hospitalizations as a tool to help plan for provision of extra support for such individuals. Length of stay did not predict readmission within 30 days.

An uncontrolled pre-post test study by *Schneider and Ross (1996)* produced data suggesting that 'ultra-short hospitalization' (as defined by a targeted length of stay of three days) in a community hospital psychiatric unit can be effective for the severely mentally ill. Over a two-year period, 69% of admissions to designated short-term beds were discharged directly back to the community. Readmission rates for these individuals were almost the same as those from the traditional inpatient service where the average length of stay was 16.9 days (14.6% compared to 15%). Concluding that the program is well received by patients, clinicians and community agencies, the authors endorse its adoption as a 'best practice' for many people with severe and prolonged mental illnesses.

A recent Canadian study by *Edward-Chandran et al., (1996)* compared average length of stay (ALOS) and readmission rates before and after planned efforts to reduce length of stay at one of two hospitals examined. The readmission rate at this hospital rose during the first year but then fell again. While the two hospitals originally had similar ALOS, the rate at the experimental hospital, over a three-year period, dropped from 25 to 16 days over all diagnostic groups.

## 4.4 Partial Hospitalization

### 4.4.1 Reviews

Partial hospitalization is an attempt to combine the advantages of intensive treatment with the advantages of keeping individuals in their home environment. The term covers a range of often poorly differentiated models of ambulatory treatment programs (referred to in the British literature as 'day care'). In various settings, the period of hospitalization may be during the night, the day, evening hours and weekends.

*Rosie (1987)* divides partial hospitalization into categories according to function. Day hospitals diagnose and treat acutely ill individuals who would otherwise be inpatients, and provide intensive rehabilitation for those who need more treatment than can be supplied by outpatient services. Day treatment programs are often more diverse in function, treating both those in some degree of remission from acute illness and those in transition from inpatient or day hospitalization to outpatient programming. Some day treatment programs are directed towards specific target groups (such as substance abusers or adolescents). Day care programs focus on longer-term maintenance and rehabilitation of those with chronic, disabling disorders. They are sometimes but not always located at hospitals.

In reviewing earlier research about all of these modalities, *Rosie* concluded that "the validity of the day hospital as an economical, effective treatment alternative for a substantial number of acutely ill patients is firmly established by well-designed, well-controlled, and replicated studies" (p. 1297). These conclusions continue to be supported by *Olfson and Goldman (1996)*. *Rosie* recommends more



research aimed at improving criteria for selection of individuals for either inpatient care, day hospital, day treatment or day care. *Olfson and Goldman (1996)* cite evidence that non-dangerous patients, females and those with acute rather than chronic conditions can be effectively served by day hospitals.

*Rosie (1995)* pointed to the paucity of research into day treatment programs despite their suitability for controlled studies. At that time he viewed research into the effectiveness of day care centres as exploratory but suggestive of their potential benefits in maintaining and rehabilitating the chronically mentally ill. He pointed out findings supporting the greater involvement of family members in programming.

In a recent review, *Rosie et al (1995)* emphasize the importance of treatment-patient matching. They cite findings that intensity and type of treatment must be geared to client level of disturbance and the need for containment. They also recommend careful attention to referral sources. They note that under-utilization continues to be a problem for partial hospitalization programs and urge nurturing good relationships and close links with clinicians, inpatient programs and emergency units.

*Hoge et al., (1992)* conducted a comprehensive review of the literature on partial hospitalization, and discuss American service and policy directions in this field. These authors conclude that fairly strong research evidence supports the effectiveness of day hospitals but that findings about day treatment or day care programs are ambiguous. They state that the lack of a clear definition for partial hospitalization impedes advances in knowledge and practices. Indeed, their own review lumps together studies of all three service models. They also report the criticisms of others regarding day treatment and day care programs - ie that longer-term involvement in day care encourages dependency and seldom involves goal-directed treatment or focused rehabilitation; that day treatment programs (which typically have a length of stay of 3-6 months) may not be as effective for those with severe mental disorders; that length of stay in day hospitals is frequently longer than would have occurred in a typical inpatient unit; and that continuity of care is impeded by moving people from an outpatient to an inpatient service and then to a day hospital.

The reviewers urge researchers not to focus on comparing inpatient care with day hospitalization, but rather on comparing the effectiveness of day hospitalization and intensive outpatient interventions. They query whether, in the case of individuals with severe and persistent mental disorders, day treatment should be replaced by assertive community treatment programs.

*Rosie et al (1995)* challenge the conclusions of *Hoge et al.* They continue to support the day treatment program model, asserting that day treatment needs to be differentiated from rehabilitation; that the programs reviewed by Hoge et al., were mostly rehabilitative; and that day treatment is contra-indicated for those with a diagnosis of schizophrenia.

*Olfson and Goldman (1996)* conclude that partial hospitalization programs can be effective. They view reimbursement/funding problems and a general unfamiliarity on the part of psychiatrists with this program model as barriers to expansion of this approach.

#### 4.4.2 Additional Studies

*Davidson et al., (1996)* report results of a randomized controlled study which assigned 197 individuals requiring hospitalization to either inpatient care or an experimental day hospital program. Those admitted to this intensive 30-day program were simultaneously admitted to a community-based crisis home. Follow-up at two, five and 10 months post discharge indicated that 83% of those admitted to inpatient care met inclusion criteria for the experimental day hospital program. No differences between groups were found on any measures of symptoms, functioning, quality of life or service satisfaction. The only significant difference was in the area of cost-direct costs of the day program were 80% of those in the inpatient unit.

The investigators also examined differences in the two environments. The day program environment was found to be more home-like, offering more intensive treatment in a less restrictive setting. They speculated that the lack of differences in outcomes may be less related to the nature of the settings than to the long-term nature of the disorders being treated.

*Nienhuis et al., (1994)*, in a randomized controlled trial conducted in the Netherlands compared day hospital treatment integrated with community care to hospital treatment. They found the experimental treatment to be feasible with 3 - 4 out of 10 patients with major psychiatric disorders needing acute admission. One and two-year follow-ups showed no differences between group in outcomes which included burden on families, service costs, medication levels, patterns of admission and outpatient care. The experimental group had higher numbers of contacts with the commonly used ambulatory service, thus more continuity of care. They and their families were significantly more satisfied with services.

Day hospital patients had longer episodes of treatment and higher service utilization suggesting greater compliance but perhaps also more dependency on mental health care. Findings suggest that this type of day treatment is more effective for those with schizophrenia than for those with affective disorders. The authors conclude that day hospital treatment is desirable and preferable to inpatient hospitalization because it involves less stigma and is less disruptive of participation in community life.

## 4.5 Home Treatment

### 4.5.1 Reviews

Home treatment programs aim to avert admission to acute care psychiatric settings by having a mental health professional provide intensive therapy and support to people experiencing acute episodes of illness in their own homes. Over the past two decades, numerous experimental home treatment programs have been initiated and subjected to evaluation by investigators studying the assertive community treatment (ACT) model. As a consequence, considerable literature addressing this treatment approach has developed. Many of the demonstration model home treatment programs have been launched and/or coordinated by hospital-based mental health professionals.

An up-to-date review of this literature is provided in *Breakey (1996)* who concludes (*as do Marks 1992; Hargreaves & Shumway, 1990*) that there is persuasive evidence of the effectiveness of this approach. Results of evaluations of the ACT model are documented in the chapter dealing with case management.

### 4.5.2 Additional Studies

A paper by *Wasylenki et al., (1997)* describes the establishment and evaluation of a Canadian home treatment program developed as a collaborative project involving several agencies. The Home Treatment Program for Acute Psychosis is a partnership between the Clarke Institute of Psychiatry (CIP) and the Home Care Program for Metropolitan Toronto (HCPMT). Services are provided by the St. Elizabeth's Visiting Nurses, the Visiting Homemakers Association and HCPMT social workers and coordinators. After an extensive training period, the program was implemented. Clients of CIP who required admission, were offered the choice of receiving treatment in their homes. In urgent cases, services were started immediately. Otherwise, within 48 hours visiting nurses, homemakers and social workers began to provide intensive support. A psychiatrist was available for back-up support. Once the client was stabilized, care reverted back to the psychiatrist-case manager team at the Clarke. Interviews and questionnaires were administered to clients and caregivers at baseline, termination and at three-month follow-up. Evaluation of the program included attitudes towards home and hospital treatment; impact on family or other caregivers such as boarding home operators; client and caregiver satisfaction; illness or symptom severity measures; organizational factors necessary to implement the program; and direct costs of providing care compared to inpatient costs.

During the 18-month study period, 34 episodes of home treatment were completed involving 27 clients. The mean length of the episodes was 28 days. No client who was offered home treatment refused and in approximately half the cases no family caregivers were involved. The evaluation showed that attitudes towards home treatment were positive, symptoms were reduced, family burden decreased, satisfaction with treatment was high and home treatment was preferred to hospital treatment. Analysis of direct service costs showed that home treatment was significantly cheaper than inpatient care at the Clarke (\$139.78 per diem vs \$637.00 per diem). The Home Treatment program

continues to operate and has extended its client base to include several general hospitals and a provincial hospital in the Metropolitan Toronto area.

Despite strong research evidence and the fact that mental health policies have shifted towards community care, home-based treatment programs for the mentally ill which include home visits by psychiatrists are still uncommon in North America. In contrast, many psychiatrists in the UK and other parts of Europe reportedly make domiciliary visits (*see Kates et al., 1991*). *Reding et al., (1994)*, who studied attitudes and practice patterns of community mental health psychiatrists throughout Michigan, note that the home treatment model is dependent on psychiatrists visiting the home. They found that, contrary to expectations, psychiatrists in community mental health centres were no more likely to treat their patients at home than those with hospital-based practices.

## 4.6 Relationship to Primary Care

Outpatient care in general medical settings is covered by *Olfson and Goldman (1996)* whose chapter addresses advances in mental health services research. Discussing the considerable amount of mental health care provided by primary care physicians, findings are cited that the mentally ill who are seen by them tend to be less severely impaired than those seen by mental health specialists; that their mental health visits tend to be shorter in duration; less often include therapeutic listening; and more commonly result in prescription of a medication. Other research finds that primary care patients with mental disorders often escape detection and that physicians vary widely in their level of interest, training and skill in treating psychiatric disorders. The authors note however that much of the related research has been done in the UK, and mostly with those suffering from mild to moderate affective disorders. Much remains to be learned about which mental disorders are best treated in which sector.

### 4.6.1 Primary Studies

*Ferguson et al., (1992)* describe results of a follow-up study of a new program in the UK which featured the transfer of psychiatric out-patient work into a community primary care setting. The program involves close cooperation between a multi-disciplinary psychiatric team and primary care physicians and is part of an integrated system of care including a day hospital and community-based support programs. The experimental community service was compared to a conventional hospital-based outpatient service, and found to be at least as effective in delivering psychiatric outpatient care. No differences in client outcomes were found. Compared to the traditional service, there was more frequent use of day hospitals, wider involvement of all members of the psychiatric team and evidence of willingness to maintain follow-up contact over time. No differences in diagnoses or symptom levels were found between the two client populations. Cost comparisons were not carried out.

*Wilkison et al., (1995)* report results of an evaluation of another innovative outpatient service for people with severe and long-term mental illness featuring an integration of mental health specialist and primary care providers. The program is situated in a semi-rural setting in the UK where access to psychiatrists is limited. A mental health professional (non-medical) was assigned to each primary

practice team, with the psychiatrist acting primarily as a consultant. Over the two-year follow-up period, patients remained relatively stable, with slight improvements in symptoms and social performance. Most continued on psychotropic medications and maintained therapeutic contacts. Only two of 34 patients were admitted to hospital, compared to 11 who had been admitted on more than five occasions prior to the study. The investigators conclude that such an approach is feasible in a semi-rural setting and is capable of helping individuals maintain stability and community tenure. They also note that the consultant psychiatrist played only a minor back-up role in direct clinical service provision but was essential in his role of developing, implementing and providing consultation to the team. Generalizability of findings are limited because there was no control group, and the sample was small and individuals were relatively well.

**Kates and colleagues (1992)** report on a pilot study in Hamilton, Ontario which explores the acceptability and perceived usefulness of case review discussions involving psychiatrists and family physicians. Staff psychiatrists from a community mental health centre met family physicians in their offices on three or four occasions over a six month period to discuss management and referral of patients with psychiatric problems. The nature and outcomes of meetings are recorded and satisfaction of participating physicians assessed. Family physicians were positive about the program which provides advice on case management, informs them about community resources, identifies patients who can benefit from psychiatric consultation and facilitates referrals to more specialized psychiatric treatment. Kates notes that more flexible options for psychiatrist reimbursement are needed to implement family physician support programs on a wider scale.

Another program described and evaluated by **Kates et al., (submitted)** addresses the benefits of integrating mental health care within primary care. The program involves the use of mental health counsellors (mostly social workers and psychiatric nurses) working collaboratively with family physicians who work in Health Service Organizations (HSO). Counsellors are permanently attached to each HSO. Psychiatric consultants visit every one to three weeks as needed. Counsellors are available to see patients and/or provide the physicians with advice about resources or management techniques and make referrals to community programs and services. If necessary, patients can be referred to the visiting psychiatrist who will see the patient and provide the physician with further advice and support and who is available by telephone in case of crises. Consultant psychiatrists are available for direct case consultation with limited follow-up; indirect services where the patient is discussed but not seen; and to provide educational opportunities for the family physicians.

The internal evaluation process contains a comprehensive database which tracks demographic, treatment, and outcome data for each client and is able to construct a longitudinal record to monitor patterns of care and utilization.

After a year of operation the program showed a nine-fold increase in the number of patients (from 374 in the year prior to program initiation to 3,291) receiving mental health care. No-show rates were 8% compared to the rates for out-patient clinics which range from 18 to 60%. The authors suggest that patients would rather receive care in their family doctor's office than attend a mental health clinic which still carries some stigma. Collaboration between the physician, the psychiatrist and the counsellors, with the physician maintaining involvement with the patient, facilitates continuity of

care. Referrals to outpatient mental health clinics by participating physicians were 45% lower in the year following the initiation of the program. The authors attribute this to improved assessments which resulted in fewer but more appropriate referrals.

The authors conclude that integration of mental health services in primary care settings improves communication between mental health services and family physicians; enhances continuity of care; increases accessibility; leads to more efficient use of mental health services; provides innovative approaches to physicians continuing education to increase their skills and comfort level; provides new opportunities for patient education; and is well received by patients and providers.

### 4.7 Discussion

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

With regard to length of inpatient stay, there seems to be general support for shorter hospitalization. However, much remains to be learned about how short is optimum – or too brief and for which groups of people; and about factors that influence re-admission rates. One could speculate that the effectiveness of short inpatient stays rests heavily on the availability of community-based care and support and the linkages between these services and inpatient units. However, more comparative evaluation studies need to be conducted in order to provide evidence-based support for this hypothesis.

In discussing directions for partial hospitalization programs, *Nestadt (1996)* concludes that there is probably sufficient evidence supporting the effectiveness of day hospitals. Nevertheless, this method of treatment remains peripheral to the mainstream of psychiatric practice, being influenced more by individual and local program innovations than by traditions in the field of psychiatry. However, in the US, interest in such programs continues to grow, such that the American Association for Partial Hospitalization has developed standards and guidelines for them.

*Hargreaves and Shumway (1990)* recommend more systems-level research to identify the most cost-effective ways to organize entire service systems. They also point out that, because much of the care of mental disorders is carried out by primary health care providers, this area deserves more attention by researchers, program developers and policy makers. The promising results of evaluative work (eg., *Ferguson et al., 1992; Kates et al., submitted*) highlight the importance of developing and assessing new service delivery models which feature cooperation between mental health practitioners and primary care settings.

## 4.8 Best Practices: inpatient/outpatient care

### Research Evidence

Well designed follow-up studies show that:

- ★ Discharge of long-stay patients is associated with improved social functioning over time
- ★ Individuals and families prefer community care to hospitalization
- ★ Clinical and social outcomes are at least as good for discharged patients receiving community care as for matched counterparts remaining in hospital

Numerous controlled trials show that:

- ★ Day hospitalization is less costly than inpatient care with comparable outcomes
- ★ Day hospitalization offers more intensive treatment in a less restrictive and more home-like environment
- ★ Shorter length of stay is generally not associated with increased readmission and achieves similar outcomes to longer stay admissions
- ★ Home-based treatment is an effective alternative to admission for many patients

Preliminary descriptive studies show that:

- ★ Integrating mental health professionals in primary care settings can enhance continuity of care; increase accessibility to mental health services; lead to more efficient use of mental health services; provide new opportunities for continuing education for physicians; and improves communication between mental health services and family practitioners.

### Key Elements of Best Practice

Long-stay patients in Provincial Psychiatric Hospitals are moved into the community with carefully planned transitions to alternative care models.

Inpatient stays are kept as short as is possible without harmful effects on patient outcomes.

Partial hospitalization programs are available as an alternative for inpatient admission. Day treatment is an option for those with non-psychotic diagnosis.

Home treatment programs (that are either assertive community treatment teams or adjuncts to intensive case management) are available as an alternative for inpatient admission.

New service delivery models that link family physicians with mental health specialists are in place.



***Table 4.1 Reviews of Hospital-based Care Studies***

<b>Review</b>	<b>Topic</b>	<b># Studies</b>	<b>Methodology</b>
Pfeiffer et al., (1996)	Outcome of Hospitalization	54 longitudinal studies	Search methods stated, critical appraisal conducted
Rosie et al., (1995)	Day Treatment	approx 18 + reviews	No search methods, criteria or appraisal
Nasir (1993)	Alternatives to hospital care	approx 15	Study designs & methods discussed, no search methods
Hoge et al., (1992)	Partial hospitalization	30 + reviews	No search methods or inclusion criteria. Good appraisal
Hargreaves & Shumway (1990)	Services efficacy	45 controlled studies + reviews	Inclusion criteria & methods discussed
Knapp (1990)	Downsizing of hospitals	8 of 28 demonstration model sites for people with MH problems	Review or compilation of data from 8 sites
Avison et al., (1987)	Outcome of hospital care	33 longitudinal studies	Search methods, criteria stated
Caton & Galnick (1987)	Length of hospitalization	30 studies + reviews	No search methods or criteria stated; appraisal
Rosie (1987)	Partial hospitalization studies	10 longitudinal studies	No search methods or inclusion criteria stated



**Table 4.2: Additional Research**

<b>Author (year)</b>	<b>Issue studied</b>	<b>Research Method</b>	<b>Results</b>
Appleby et al., (1993)	Length of stay	Chart review of 1500 patients	Patients with shorter stays more likely to be rehospitalized within 30 days of discharge
Swett (1995)	Predictors of readmission	Prospective study of 189 consecutive admissions	High score on thought disorder scale on discharge, number of previous admissions were predictors
Edward-Chandran et al., (1996)	Average length of stay (ALOS)	Comparison of 2 hospitals	ALOS at hospital with planned efforts at reduction fell from 25 to 16 days
Schneider & Ross (1996)	Ultra short LOS (3 days)	Compares patients discharged from ultra short stay beds to those from traditional LOS beds for readmission rates	69% of ultra short patients were discharged into community; readmission rates comparable
Davidson et al., (1996)	Day hospital	RCT; patients requiring hospitalization randomly assigned to day hosp. or inpatient	No difference at follow-up between groups on symptoms, functioning, quality of life or service satisfaction; direct cost of day program was 80% of inpatient costs
Neinhuis et al., (1994)	Day hospital	RCT; 2 year follow-up; patients assigned to day treatment with community care or inpatient care	Exper. group & families more satisfied; more contacts with community services; day tx less disruptive; No group differences in family burden, costs, medication levels, patterns of admission, etc
Wasylenki et al., (in press)	Home treatment	Evaluation; 18 month study of 34 episodes of home-based tx; 3 month follow-up	Attitudes toward home tx positive; symptoms reduced; family burden decreased and satisfaction high. Direct treatment costs were significantly lower than inpatient care
Ferguson et al., (1992)	Primary Care	Experimental community primary care service compared to hospital-based outpatient care	No differences in patient outcomes; exper. clients used more day hospital services; wider involvement of psychiatric team & more willingness to maintain follow-up contact
Wilkinson et al., (1995)	Primary Care	Semi-rural setting; non-med mental health prof assigned to each primary practice team; 2 year follow-up of clients; no control group	Patients remained stable; slight improvement in symptoms & social function; rate of inpatient admissions decreased dramatically
Kates et al., (1992)	Primary Care	Description of pilot study using case reviews of GP patients with a psychiatrist	GPs were positive about program; received advice about management, learned about community resources; and facilitated referrals for specialized treatment
Kates et al., (submitted)	Primary Care	Evaluation of program integrating mental health services into primary care setting	Increased accessibility; enhanced continuity of care; more efficient utilization of mental health services

## REFERENCES

- Anderson, J., Dayson, D., Wills, W., Gooch, C., Margolius, O., O'Driscoll, C., Leff, J., (1993) The TAPS Project.13: clinical and social outcomes of long-stay psychiatric patients after one year in the community. *British Journal of Psychiatry*, 162(suppl19):45-56
- Appleby, L., Desai, P.N., Luchins, D.J., Gibbons, R.D., Hedeker, D.R., (1993) Length of stay and recidivism in schizophrenia: a study of public psychiatric hospital patients. *American Journal of Psychiatry*, 150(1):72-76
- Bandeira M, Lesage AD, Morissette R & Granger (1994) Evaluation de l'efficacite long terme de la reinsertion sociale de patients psychiatriques. *Sante mentale au Quebec*, XIX(2), 178-190.
- Bigelow, D.A., McFarland, B.H., Gareau, M.J. & Young, D.J.(1991). Implementation and effectiveness of a bed reduction project. *Community Mental Health Journal*, 27(2)125-133
- Breakey, W.R. (ed)(1996) *Integrated Mental Health Services*. New York, NY: Oxford University Press, Inc.
- Burns, T., Beadsmoore, A., Bhat, A.V., Oliver, O. & Mathers, C. (1993). A controlled trial of home-based acute psychiatric services. I: Clinical and social outcome. *British Journal of Psychiatry*, 163:49-54
- Burns, T., Raftery, J., Beadsmoore, A., McGuigan, S. & Dickson, M. (1993). A controlled trial of home-based acute psychiatric services II: treatment patterns and costs. *British Journal of Psychiatry*, 163:55-61
- Caton, C.L.M.& Gralnick, A. (1987). A Review of issues surrounding length of psychiatric hospitalization. *Hospital and Community Psychiatry*, 38(8):858-863
- Clarke Institute Consulting Group (1994). *Essential Service Ratios in a Reformed Mental Health System: Case Management*. submitted to Ministry of Health, Ontario.
- Davidson, L.D., Tebes, J.K., Rakfeldt, J. & Sledge, W.H. (1996). Differences in social environment between inpatient and day hospital-crisis respite setting. *Psychiatric Services*, 47(7):714-720
- Edward-Chandran, T., Malcolm, D. & Bowen, R.C. (1996). Reduction of length of stay in an acute care psychiatric unit. *Can J Psychiatry*, 41:49-51
- Ferguson, B., Cooper, S., Brothwell, J., Markantonakis, A. & Tyer, P. (1992). The clinical evaluation of a new community psychiatric service based on general practice psychiatric clinics. *British Journal of Psychiatry*, 160: 493-497

- Hallam, A., Beecham, J., Knapp, M. & Fenyo, A. (1994). The costs of accommodation and care. Community provision for former long-stay psychiatric hospital patients. *European Archives of Psychiatry and Clinical Neuroscience*, 243(6):304-310
- Hargreaves WA & Shumway M. (1990). Effectiveness of services for the severely mentally ill. in Taube, C.A., Mechanic, D., Hohman, A.A., (eds) *New Directions for Mental Health Services*, San Francisco, Jossey-Bass Publishers
- Hoge, M.A., Davidson, L., Hill, W.L., Turner, V.E. & Ameli, R. (1992). The promise of partial hospitalization: a reassessment. *Hospital and Community Psychiatry*, 43(4):345-354
- Kates, N., Webb, S. & LePage, P. (1991). Therapy begins at home: the psychiatric house call. *Canadian Journal of Psychiatry*, 36(9):673-676
- Kates, N., Craven, M., Webb, S., Low, J. & Perry, K. (1992). Case reviews in the family physician's office. *Canadian Journal of Psychiatry*, 37(2), 2-6.
- Kates, N., Craven, M., Crustolo, A.M., Nikolaou, L. & Allen, C. (submitted) Integrating mental health services within primary care: a Canadian program. *General Hospital Psychiatry*
- Knapp, M., Cambridge, P., Thomason, C., Beecham, J., Allen, C. & Darton, R. (1990). Lessons from a demonstration programme. *Care in the Community Newsletter*, 9:1-39,340-347
- Knapp, M., Beecham, J., Fenyo, A. & Hallam, A.M. (1995). Community mental health care for former hospital in-patients: predicting costs from needs and diagnoses. *British Journal of Psychiatry*, 166(27):10-18
- Knapp, M., Beecham, J., Koutsogeorgopoulou, V., Hallam, A., Fenyo, A., Marks, I.M., Connolly, J., Audini, B. & Muijen, M. (1994). Service use and costs of home-based versus hospital-based care for people with serious mental illness. *British Journal of Psychiatry*, 165:195-203
- Lawrence, R.E., Copas, J.B. & Cooper, P.W. (1991). Community care: does it reduce the need for psychiatric beds? A comparison of two different styles of service in three hospitals. *British Journal of Psychiatry*, 159:334-340
- Marks, I.M., Connolly, J., Muijen, M., Audini, B., McNamee, G. & Lawrence, R.E. (1994). Home-based versus hospital-based care for people with serious mental illness. *British Journal of Psychiatry*, 165:179-194
- Marks, I. (1992). Innovations in mental health care delivery. *British Journal of Psychiatry*, 160:589-597
- Nasir, H. (1993). Mental health: a move towards community-based services. Paper prepared for the Alberta Mental Health Strategic Planning Initiative, Alberta Mental Health Division

- Nestadt, G. (1996). Partial hospitalization. in Breakey, WR (ed), *Integrated Mental Health Services*, New York & Oxford:Oxford University Press.
- Nienhuis, F.J., Giel, R., Kluiters, H., Ruphan, M. & Weirsmas, D. (1994). Efficacy of psychiatric day treatment: course and outcome of psychiatric disorders in a randomised trial. *Eur Arch Psychiatry Clin Neurosci*, 244:73-80
- Olfson M. & Goldman, H.H. (1996). Mental health services research, in Breakey, WR (ed), *Integrated Mental Health Services*, New York & Oxford:Oxford University Press.
- Pfeiffer, S.I., Malley, D.S. & Shott, S. (1996). Factors associated with outcome of adults treated in psychiatric hospitals: a synthesis of findings. *Psychiatric Services*, 47(3):263-269
- Reding, K.M., Raphelson, M. & Montgomery, C.B. (1994). Home visits: psychiatrists' attitudes and practice patterns. *Community Mental Health Journal*, 30(3):285-296
- Rosie, J.S. (1987). Partial hospitalization: a review of recent literature. *Hospital and Community Psychiatry*, 38(12):1291-1299
- Rosie, JS, Hassan, FAA., Piper, W.E. & Joyce, A.S. (1995). Effective psychiatric day treatment: historical lessons. *Psychiatric Services*, 46(10):1019-1026
- Schneider, S.E. & Ross, I.M. (1996). Ultra-short hospitalization for severely mentally ill patients. *Psychiatric Services*, 47(2):137-138
- Swett, C. (1995). Symptom severity and number of previous psychiatric admissions as predictors of readmission. *Psychiatric Services*, 46(5):482-485
- Wasylenki, D., Gehrs, M., Goering, P., & Toner, B. (1997). A home-based program for the treatment of acute psychosis. *Community Mental Health Journal*. 33(2): 151-162
- Wilkison, G., Piccinelli, M., Falloon, I., Krekorian, H., McLees, S., (1995) An evaluation of community-based psychiatric care for people with treated long-term mental illness. *British Journal of Psychiatry*, 167:26-37

## 5. CONSUMER SELF-HELP AND CONSUMERS INITIATIVES

### 5.1 Introduction & Definitions

Self-help is an attempt by people with a problem to take control over the circumstances of their lives. In the words of a consumer of psychiatric services:

I have been labelled mentally ill and told I would never hold a job. I have been hospitalized in the state institutions and lived in residential programs. I have slept on the street and foraged in dumpsters. I have felt alone and lost, with no way back to mainstream America. The self-help movement gave me a roadmap - through community organizing... I realize that the only road to justice for people with psychiatric diagnoses was through collective action. This is also the most direct route to giving people a feeling of control over their own lives...from my own experience in the system, I came to believe that this is what people recovering from mental illness need most (*Rogers, 1996*).

Self-help is founded upon the principle that people who share a disability have something to offer each other which cannot be provided by professionals. Self-help groups have been recognized for the enormous benefits they provide to members, their families and society. These groups make low-cost or no-cost resources available to vast segments of the population coping with developmental disabilities, chronic conditions and other afflictions (*Borman et al., 1982*).

Significant expansion has occurred in the number of self-help and mutual support groups for all types of individuals and all types of problems, including serious mental illness (*Mowbray, 1992*). Over the past two decades, there has been tremendous growth in the number of self-help groups and organizations for people who have experienced a mental health problem (*Segal et al., 1993, 1994, 1995*), who increasingly refer to themselves as “consumers” or “survivors”. The mental health self-help movement is composed of many different types of groups. *Chamberlin (1990)* notes that there are groups whose members promote the illness metaphor (e.g. National Depressive and Manic-Depressive Association, Schizophrenia Society of Canada); groups whose members promote self-help in conjunction with treatment for illness (e.g. Recovery, Inc.); groups whose members see themselves as consumers (e.g. the National Mental Health Consumers' Association); and groups who see themselves as liberationists (e.g. National Association of Psychiatric Survivors). In Canada, the National network for Mental Health is a broad-based self help network for consumers and survivors of mental health services. As self-help groups have expanded, *Emerick (1990)* notes that support for their activities by mental health systems and foundations has also increased. (For a history of the mental patient self-help movement and a structural typology of groups in the movement, see *Emerick, 1989*).

Mutual aid and self-help groups are congruent with the premises of the Canadian Framework on Health Promotion, involving self-care, mutual aid, and healthy environments (*Epp, 1986*). Consumer/survivor self-help groups have also been recognized as important sources of informal aid in the Framework for Support developed by the Canadian Mental Health Association (*Trainor et al., 1992; Trainor et al., 1993*). Many provincial reform policies explicitly recognize the importance of self-help and consumer initiatives, and there is an increasing commitment of resources to their development and operation. Self-help can mean either helping oneself **without** the assistance of others or helping oneself **with** the assistance of others. This review focuses on the second meaning, as it occurs formally in self-help groups. In addition, this review does not focus on the burgeoning literature on consumer involvement as members of boards and committees or as employees of service agencies. For an overview of the range of consumer involvement in Canada see *Ward (no date)*.

Despite the considerable body of literature on self-help groups, confusion persists regarding what constitutes a self-help group and, as a result, definitions often remain unclear. *Rootes and Aanes (1992)* attempt to address this in their outline of seven criteria for defining the self-help group and differentiating it from other types of groups, such as advocacy or support groups. They indicate that self-help groups are distinguished by their supportive and educational aims; focus on a single life-disrupting event; have the primary purpose of supporting personal change; are anonymous and of a confidential nature; have voluntary membership, member leadership, and absence of a profit orientation. In a Canadian Council on Social Development publication, *Romedor (1990)* offers the following definition:

Self-help groups are small, autonomous and open groups that meet regularly. As a result of a personal crisis or chronic problem, members share common experiences of suffering and meet each other as equals. The primary activity of these groups is personal mutual aid, a form of social support that focuses on the sharing of experiences, information and ways of coping. In addition to personal change, members often engage in activities directed to social change. Group activities are voluntary, and essentially free of charge (pp. 32-33).

These groups draw upon the experience of members to provide support, information, coping skills, problem solving and advocacy. Group members are empowered to take control of their lives, support others, and develop positive attitudes about themselves and their conditions (*Fine et al., 1995*). Self-help groups offer the opportunity to provide support as well as receive support and to develop friendships, which are important for well-being and self-esteem (*Constantino & Nelson 1995; Reissman, 1990*). Self-help is generally conceptualized as being free of professional involvement but *Lavoie and Stewart (1995)* note that professionals may play important roles in groups at different stages of their development. While the above approaches to defining self-help groups cover some organizations, they are clearly too narrow for the current range of consumer and survivor groups that go beyond self-help to include consumer-run business, advocacy, education of the public and professionals, to name a few (*Trainor & Tremblay, 1992*). *Ward (no date)* encompasses this broader range of activity in a three-part typology of consumer involvement that includes taking more control

within the formal mental health system, advocating for change within the system, and empowering consumers outside the system.

The first part of this review focuses on the historical roots of self-help which contribute to the current self-help movement and which are reflected in such groups as Recovery, Inc. and Grow, which date from the 1930's and 1950's respectively (*Galanter, 1988; Lee, 1995; Omark, 1979; Powell, 1975*). According to *Zimmerman and his colleagues (1991)*, the main goal of these self-help organizations is to integrate members back into the community without interfering with the mental health system or threatening the role of professionals. These traditional and conservative national organizations adopt some form of the 12-step "alcoholics anonymous model".

More recent self-help programs are developed and operated primarily by consumers of services themselves. The second part of the review focuses on this more recent version of self-help programs. Self-help promotes the role of mentally disabled people as active consumers who determine which services will best meet their needs (*Segal et al., 1993*). Although most professionals are familiar with the idea of self-help, many are not cognizant of the expanded notion of direct action by consumers. Self-help, which is clearly not a service, has typically been regarded in a positive, but marginal way. This view is now beginning to change (*Trainor & Tremblay, 1992*). There is a growing recognition of the value of collective efforts by people who have used the mental health system. The second part focuses on programs which typically support an expanded range of activities that include, but usually go beyond, the traditional self-help group. These other activities include advocacy, operating drop-in centres, and educating the public and professionals. These groups emphasize consciousness-raising and the empowerment of people with psychiatric histories.

Participation in self-help groups is voluntary and members value the informality of groups, minimal bureaucracy and shared control. In this environment random assignment and formal data gathering often are not appropriate and not accepted (*Mowbray, 1992*). Preferred research strategies tend to be participatory, using cross-sectional designs and member report. The material summarized in this chapter ranges from descriptive studies of group processes to evaluations with matched comparison groups. While the quality of the evidence is variable, the consistency of findings adds to their strength.

## 5.2 Traditional Self-Help Models in the Mental Health Field

**Recovery, Inc.** is a voluntary, non-profit association for mutual aid. The organization was established in 1937 by Abraham Low, a Chicago psychiatrist who believed that his patients could learn to exercise control over their thoughts and impulses and that this control would give them the ability to manage their psychiatric problems better. The group does not discuss members' psychiatric therapies and medications and is supportive of the value of professional treatment.

Low's techniques are implemented by means of a format applied in weekly two-hour local group meetings, each led by a peer leader and attended by an average of 12 members. Members may continue to participate in a local group for as long as they choose, and all meetings of all groups use

the same format. This includes readings or an audiotape by Dr. Low followed by patient presentations and then open exchange among members. The giving of examples is very important in demonstrating how Recovery works (*Lee, 1971*). A detailed description of the historical development, basic functions, member roles and problems of the Recovery method can be found in *Weschler's (1976)* case study.

**Galanter (1988)** found that men and women who participated in Recovery reported less nervousness, tension and depression after joining the group. Long-term members who were leaders reported a diminished need for professional psychotherapy and medication and were indistinguishable from a probability sample of community members on self-reported measures of general well-being. Respondents included 201 Recovery Inc. group leaders who had been members for at least seven years, 155 short-term members and 195 control subjects who represented a probability sample from the community. **Omark (1979)** found that people who join programs like Recovery remained committed for many years and often were highly dependent.

Another self-help group for consumers of mental health services is **GROW International**, a twelve-step mutual help program designed to assist its members in preventing, or recovering from, mental illness. GROW began in 1957 in Sydney, Australia, when a handful of formerly hospitalized psychiatric patients attending Alcoholics Anonymous (AA) established their own support group (*Zimmerman et al., 1991*). Through structured weekly group meetings, various other functions, and extensive consumer authored literature, GROW encourages the development of support networks and helps members adjust to community living.

In a study of GROW's impact, 31 GROW members with a history of chronic and severe psychiatric problems were matched with comparably disabled non-participants using archival data from the Illinois State Department of Mental Health (*Kennedy, 1989*). The two groups were matched on the basis of twelve variables, including demographic data and history of hospitalization prior to participation in GROW. GROW members were found to be hospitalized for fewer days over a 32-month period (49 vs. 134 days), than their non-participating counterparts.

**Toro et al., (1987)** found that GROW groups were significantly different from psychotherapy groups on 9 of 10 perceived social climate dimensions from the 90-item Group Environment Scale. The mutual help members perceived that their groups had more active leaders, greater group cohesion, more structure and task-orientation, and fostered more independence.

**Toro and colleagues (1988)** documented a naturally occurring quasi-experiment that examined the impact of professional involvement on perceived social climate and observed verbal behaviour in GROW. Participants were members of 22 GROW groups that were led either by a mental health professional or an indigenous member/leader. Results suggested that the professional leaders, despite their special training and their personal support of mutual help methods, may have behaved in ways consistent with a more formal, professional approach, perhaps discouraging behaviours that they thought were less psychologically relevant and making members feel less comfortable in the group. They recommend that professionals exercise caution when collaborating with mutual help groups to avoid professionalising them.



### 5.3 Consumer Initiatives in the Mental Health Field

This second group of self-help programs have a shorter history than the traditional models. Despite its nearly 30-year history, and its significant growth during the 1980's, the mental health consumer self-help movement has received little attention from the media or the social sciences and thus is a largely unknown entity (*Emerick, 1989*). Although the movement is composed of hundreds of groups that claim to provide serious alternatives to the mental health system, very little systematic research has been done on this progressive social movement as a social movement. This is surprising in light of the current general interest in the self-help movement worldwide. There have however been a number of important studies which examine the outcome of recent consumer initiatives.

In Ontario, 36 **Consumer/Survivor Development Initiative (CSDI)** projects designed to tap the skills, knowledge and commitment of consumers of mental health services, are currently in receipt of funds. Six are cooperative business, one is a provincial business council which provides support to current and new consumer businesses, and 28 are generic consumer/survivor organizations which typically have a local or regional mandate to organize consumers/survivors and develop a series of activities and initiatives which reflect their interests. One organization is diagnostically focused and is unique in having both consumer/survivor and family members. All of the organizations are required to be democratically operated, independent, and with the exception of the mixed group noted above, to be consumer/survivor controlled. The policy structure of the initiative and the ways in which Ontario created a framework is articulated in the 1993 CSDI Operations Guidelines.

Although CSDI utilizes non-service models based on self-help and mutual aid, the projects are able to engage in a range of activities which include, but go beyond, typical self-help groups. In a survey of activities carried out by the 36 consumer/survivor organizations, seven basic areas of activity emerged. These were: **mutual support**, (developing and maintaining self-help groups and offering peer support); **advocacy**, (advocating for better mental health and related services); **cultural activities**, (pursuing a range of artistic and cultural activities); **knowledge development and skills training**; **public education**; **educating professionals**; and, **economic development**, (developing and operating small community-based businesses).

*Trainor et al., (1995, 1996)* describe a large-scale multi-method study of CSDI projects, using both qualitative and quantitative methods. The study focused on CSDI programs, both rural and urban. In one component of the study a representative sample of 194 members of CSDI organizations listed the various mental health services they had used for an equivalent period of time before and after becoming members. All figures were then standardized to one year before and after joining a CSDI group. Results indicated that service use in all categories dropped after joining a CSDI group. The most significant declines in usage were found in in-patient use (48 vs. four days) and crisis services. Admissions to hospitals for psychiatric reasons also dropped from a mean of three admissions to a mean of 0.6 admissions. Out-patient visits and private physician visits were also significantly reduced.

In a larger sample of more than 600 members, respondents reported increased contacts with other people (both consumer/survivors and non-consumer/survivors) as a result of their membership in CSDI. An increased sense of self-respect and dignity was also reported as were skills for dealing with others. CSDI membership also affected self-confidence, feelings of being in control, coping and feeling that choices were available. The main factor which respondents cited as helping them cope was the knowledge they had gained about various aspects of mental illness, including available services, resources, their rights, and the nature of the illness itself. This knowledge resulted in feelings of control over their lives. Another factor which appeared to help members cope was the awareness that there were other people who shared similar problems.

From the perspective of dealing with their mental health problems, respondents were asked to give their overall ranking of the helpfulness or harmfulness of CSDI groups and the various components of the formal service system. In addition to their consumer/survivor organization, study participants ranked community mental health services, general hospital services and psychiatric hospital services. CSDI groups were ranked as significantly more helpful than any of the other components of the mental health system.

*Trainor and Tremblay (1992)* examined consumer/survivor run businesses that feature as key players people who have used the mental health system themselves. Cooperative businesses are set up in such that those involved are employees rather than clients. There is little or no input from professional staff. Results indicate that involvement of these programs is associated with a reduction in the use of mental health services such as inpatient hospitalization.

**The Self-Help Connection** was funded by the Health Promotion Directorate, Health and Welfare Canada, and sponsored by the Canadian Mental Health Association, Nova Scotia Division, from December 1, 1987 to March 31, 1993. The focus of this project is on community self-help and health promotion. The process of developing this project is documented as well as the important principles involved. Self-help is now firmly established in Nova Scotia involving over 400 groups and organizations. During the last five years, this organization has helped build a strong, self-help constituency that is influencing health planning, policy and delivery. The project demonstrated the importance of individuals creating the capacity to manage their own health and to address the barriers to health in the social-political environment (*Bayers, 1993*).

In order to facilitate an open-ended exploration of key issues involving the effectiveness of self-help at the Self-Help Connection, *Warner (1992)* used a personal interview process. A large majority of the participants felt their health had improved over the course of their involvement in the group and thought that the group was a major factor in this improvement. Respondents from eight self-help groups indicated that the groups were helpful in learning practical techniques or information, contributing to personal growth and providing productive activity and meaning for life. The self-help experience was rated as most helpful with respect to gaining knowledge and coping skills relevant to specific problems, and with respect to the support and sharing which is imbedded in the self-help process.

**Chamberlin et al., (1996)** surveyed members of six self-help programs in various parts of the United States in order to increase an understanding of users of such programs, their demographics, their perceptions of how such programs affected their quality of life and their satisfaction with the programs. The study used a Participatory Action Research Paradigm, with an advisory committee of persons who had used such programs and with the intention of developing an evaluation methodology that could be replicated in future studies of user-run programs.

Results indicated that respondents reported positive or highly positive effects of self-help on their general satisfaction with life (78.4%) and on how successful their life has been (72.1%). Self-help participation increased positive feelings by “a fair amount” or “a great deal” for 88.1% of respondents and it helped 88.1% of respondents “get the things they want out of life” by “a fair amount” or “a great deal.” When asked what effect self-help had on their housing, financial and social situations, 77% of participants said it had some or highly positive effect. Respondents reported feeling more positive about themselves as a result of self-help, having more respect for themselves, feeling more productive and capable, feeling better about themselves and being able to recognize their strengths.

In their evaluation study, **Mowbray and Tan (1993)** focused on six consumer-operated drop-in centres serving a combined total of 1,445 consumers, funded as demonstration projects by the Michigan Department of Mental Health. Structured interviews of consumer-users of these centres indicated that the program was meeting its objectives of serving people with serious mental illness and of creating an environment promoting social support and shared problem solving. Levels of satisfaction were uniformly high and there were very few differences across centres. The overall results from the consumer-run projects were successful, indicating the productivity and diversity of services possible from consumer groups.

**Edmunson et al., (1984)** found that 40 discharged psychiatric patients who were randomly assigned to participate in a self-help program (Community Network Development) required half as much re-hospitalization 10 months after discharge as a comparable group of 40 ex-patients who did not participate in the self-help component. Patients who took part in the self-help program also reported one-third as many patient days of rehospitalization (7 vs. 25 days) as non-participants.

Research has begun to focus on the therapeutic components of self-help groups that are of greatest benefit to participants with mental health issues. A recent Canadian study by **Caron and Bergeron (1995)** examines a partnership self-help group for social reintegration of discharged psychiatric patients that involves consumers and professionals. They asked participants to identify the elements of the group they considered to be of greatest value for their re-integration into the community. Elements rated highest by participants were: emotional support from professionals; hearing other participants share feelings about their return to the community; receiving information from professionals about symptoms; and expressing feelings about their return to the community. Aspects of the self-help group related to group objectives (e.g., to facilitate the transition between psychiatric in-patient unit and the community) were rated higher in importance than simple participation in group activities. After two years nearly 60% of participants have not been rehospitalized and, among the others there has been a significant reduction in hospitalization days.

**Kurtz (1990)** examined the use of the Client Satisfaction Questionnaire as part of an evaluation of a mental health self-help organization, the Manic Depressive and Depressive Association of Chicago. As expected, correlations between satisfaction ratings and length and intensity of involvement showed that longer membership and higher involvement were related to higher satisfaction.

**Kaufman et al., (1993)** document the establishment of nine consumer-operated drop-in centres as part of a statewide initiative to promote consumer involvement by the Pennsylvania Office of Mental Health. They describe some of the programs and services developed by the centres and present results of a survey of consumers' use of and satisfaction with services. During the six month survey period, a total of 478 consumers used services; average daily attendance at each centre was 28. Most centres had one paid position supplemented by heavy use of volunteers. Most projects had collaborative relationships with a few providers who maintained a low profile in daily operations. Interviews and focus groups revealed that consumers were highly satisfied with the drop-in centres. Many stated that they liked the centre's relaxed atmosphere and social activities. Several consumers stated that the projects gave them a chance to interact with people who had similar mental health problems.

**Segal et al., (1995)** examined the characteristics of long-term members of two self-help agencies. These were managed and staffed by mental health clients and intended to serve homeless persons with serious mental illness. The authors examined why individuals sought help from the agencies and how they differed from clients of community mental health agencies. They found a higher proportion of the persons served were homeless and had a dual diagnosis of mental disorder and substance abuse. The agencies were used primarily for social support and material assistance. Twenty-eight percent were receiving psychiatric counselling elsewhere, with most starting counselling after becoming a member of the self-help agency. The results demonstrated that the programs were serving the intended audience, primarily filled material and psychosocial functions, and were able to link members with medical and therapeutic services.

In a Canadian study, **Constantino and Nelson (1995)** found that many people who have studied self-help groups have asserted that the culture or ethos of self-help is very different from that of professional help. They also concluded that self-help is based on experiential knowledge and emphasizes social support; and helping activities are more spontaneous, unstructured, and unconstrained by time. In their own study, they examine the relationship between self-help groups and professionals in the field of mental health.

## 5.4 Discussion

Until recently there has been little systematic evaluation of the effect of self-help groups. Research on self-help approaches for individuals with mental illness lags behind advocacy for and even operation of such programs (*Mowbray and Tan, 1993*). Early research is mostly descriptive, for example, presenting and typing various self-help approaches (*Kurtz & Chambon, 1987; Zinman, 1986*), describing members of self-help groups (*Young and Williams, 1988*), or how mental health professionals feel about or interact with mutual support groups for psychiatric patients (*Emerick, 1990*). Yet a small but growing body of studies are evaluating the experiences and outcomes of

individuals who participate in self help and consumer initiatives. Findings have consistently been positive. Self-help programs have evolved and proliferated with participants finding them effective in solving significant personal issues. Both satisfaction and improved coping skills are reported as direct results of group membership as are lower anxiety levels (*Kauffman, 1995*). Several studies have documented significant reductions in hospital stays following involvement in self-help groups. One of the main reasons self-help is successful is the immense sense of relief people experience when they find that they are not alone in their suffering (*Everett et al., 1995*).

Current evidence is supportive of the principle that self-help, in its broadest form, should be part of any mental health reform strategy. In order to operationalize this principle a number of actions are required. Public education on the availability and benefits of self-help should be a priority in order to raise self-help as a community health option. Effort is needed to reverse the trend of self-help being a last resort for persons seeking assistance in a relevant problem area. Training about self-help should be incorporated into the curricula of graduate training programs in the mental health professions. There is also a need for professionals to stay abreast of new developments in self-help on an ongoing basis. There needs to be more intersection between members of self-help groups and professionals. Results from the Self-Help Connection in Nova Scotia (*Warner, 1992*) suggest that strong leadership may be a key ingredient to group effectiveness. A major element of policy efforts to facilitate self-help groups should involve steps to attract and train strong leaders.

A number of important issues related to self-help and consumer initiatives require further study. *Gotlieb (1995)* suggests assessing their longer-term, more lasting effects using a more judicious selection of outcomes. The focus should be less on distal outcomes of symptomatology and role performance and more on lived experience and quality of life. *Segal et al., (1994)* provide an extensive list of critical research questions that focus on the attraction of self-help support and its place in the broader service system. *Mowbray (1992)* recommends a more structured process of replication and reimbursement of nontraditional services. She emphasizes the need for developing alternative evaluation methodologies and instrumentation that respect the values of self-help, yet have scientific acceptability. Improved consumer input in research also is needed.

The potential relevance of participatory research as well as other qualitative methods in the evaluation of self-help groups has been recognized, primarily because of the active involvement of participants. *Chesler (1991)* argues that the participatory paradigm is congruent with research pertaining to mutual aid groups. As a result, the potential of this methodological approach to self-help research should be explored and tested. Given that one of the hallmarks of self-help is to honour people's individual experiences, qualitative methods are appropriate to allow their voices to be heard.

## 5.5 Best Practices: Consumer Self-Help and Consumer Initiatives

### Research Evidence

While there is variability in the quality of studies conducted to evaluate self-help and consumer initiatives, there is consistency in findings.

Participation in self-help is associated with:

- ★ reduced hospitalization
- ★ reduced other service use
- ★ increased knowledge, information and coping skills
- ★ increased self-esteem, confidence, sense of well-being and of being in control
- ★ stronger social networks and support

Compared with professionally led groups, self-help groups emphasize experiential knowledge and social support, and tend to be more spontaneous, unstructured and unconstrained by time.

### Key Elements of Best Practice

There are growing numbers of funded organizations that utilise non-service models to engage in:

- ★ mutual support
- ★ advocacy
- ★ cultural activities
- ★ knowledge development and skills training
- ★ public education
- ★ educating professionals
- ★ economic development

Evaluation of the effectiveness of these initiatives that uses appropriate, alternative methods is supported.

The general public and mental health professionals are educated about the value of self-help.

Steps are taken to attract and train strong leaders for self-help groups.

---

## REFERENCES

- Bayers, L. (1993) *Final report on the self-help connection project*. Nova Scotia: The Self-help Connection.
- Borman, L.D., Borck, L.E., Hess, R., & Pascal, F.L. (Eds.) (1982) Helping people to help themselves: Self-help and prevention . *Prevention in Human Services*, 1(3).
- Caron, J. & Bergeron, N. (1995) A self-help partnership group for people who have experienced psychiatric hospitalization: An exploratory study. *Canada's Mental Health*, 43(2): 19-28.
- Chamberlin, J., Rogers, S., & Ellison, M.L. (1996) Self-help programs : A description of their characteristics and their members. *Psychiatric Rehabilitation Journal*, 19(3): 33-42.
- Chamberlin, J. (1990) The ex-patients' movement: Where we've been and where we're going. *The Journal of Mind and Behaviour*, 11(3): 323-336.
- Chesler, M.A. (1991) Participatory action research with self-help groups: An alternative paradigm for inquiry and action. *American Journal of Community Psychology*, 19(5): 757-768.
- Constantino, V. & Nelson, G. (1995) Changing relationships between self-help and mental health professionals: Shifting ideology and power. *Canadian Journal of Community Mental Health*, 14(2): 55-70.
- Edmunson, E., Bedell, J.R. & Gordon, R.E. (1984) The Community Network Development Project: Bridging the gap between professional aftercare and self-help. In: A. Gartner and F. Reissman (Eds.) *The Self-Help Revolution*. New York: Human Sciences Press, pp.195-203.
- Emerick, R.E. (1995) Clients as claims makers in the self-help movement: Individual and social change ideologies in former mental patient self-help newsletters. *Psychosocial Rehabilitation Journal*. 18(3):17-35.
- Emerick, R.E. (1990) Self-help groups for former patients: Relations with mental health professionals. *Hospital and Community Psychiatry*. 41(4):401-407.
- Emerick, R.E. (1989) Group demographics in the mental patient movement: Group location, age and size as structural factors. *Community Mental Health Journal*, 25(4): 277-300.
- Epp, J. (1986) *Mental Health for Canadians: Striking a Balance*. Minister of National Health and Welfare, Ottawa.
- Everett, B., Martin, N., & Moore, P. (1995) You are not alone. *Canadian Journal of Community Mental Health*, 14(2): 91-100.

- Fine, R., Hammett, C., Sernick, D., & Steinhouse, K. (1995) The self-help clearinghouse of Metropolitan Toronto: Reflections on seven years of survival and beyond. *Canadian Journal of Community Mental Health*, 14(2): 113-121.
- Galanter, M. (1988) Zealous self-help groups as adjuncts to psychiatric treatment: A study of Recovery Inc. *American Journal of Psychiatry*, 145(10): 1248-1253.
- Gottlieb, B.H. (1995) Research on mutual aid and social support: Progress and future directions. *Canadian Journal of Community Mental Health*, 14(2): 229-234.
- Kaufman, C.L. (1995) The self-help employment center: Some outcomes from the first year. *Psychosocial Rehabilitation Journal*, 18(4): 145-162.
- Kaufman, C.L., Ward-Colasante, & Farmer, (1993). Roles for mental health consumers in self-help group research. *Journal of Applied Behavioural Science*, 29(2): 255 -271.
- Kennedy, M. (1989) *Psychiatric hospitalization of GROWERS*. Paper presented at the Biennial Conference on Community Research and Action, East Alnsing, Michigan.
- Kurtz, L.F. (1990) Measuring member satisfaction with a self-help association. *Evaluation and Program Planning*, 13: 119-124.
- Kurtz, L.F., & Chambon, A. (1987) Comparison of self-help groups for mental health. *Health and Social Work*: 275-283.
- Lavoie, F., & Stewart, M. (1995) Mutual-aid groups and support groups: The Canadian context. *Canadian Journal of Community Mental Health*, 14(2): 5-12.
- Lee, D.T. (1995) Professional Underutilization of Recovery Inc. *Psychiatric Rehabilitation*, 19(1): 63-70.
- Lee, D.T. (1971) Recovery, Inc.: Aid in transition from hospital to community. *Mental Hygiene*. 55(2):194-198.
- Mowbray, C.T., & Tan, C. (1993) Evaluation of an Innovative Consumer-run service model: Drop-in center. *Innovations and Research*, 1(2): 19-24.
- Mowbray, C.T. (1992) The role of evaluation in the restructuring of the public mental health system. *Evaluation and Program Planning*, 15: 403-415.
- Omark, R.C. (1979) The dilemma of membership in Recovery Inc., a self-help ex-mental patients' organization. *Psychological Reports*, 44,3(2): 1119-1125.
- Powell, T.J. (1975) The use of self-help groups as supportive reference communities. *American Journal of Orthopsychiatry*, 45(5): 756-764.



- Reissman, F. (1990) Restructuring help: A human service paradigm for the 1990s. *American Journal of Community Psychology*, 18(2):221-230.
- Rogers, J. (1996) Community organizing: Self-help and providing mental health services. *The Journal of the California Alliance for the Mentally Ill*, 6(3).
- Romeder, Jean-Marie, and contributors. (1990) *The self-help way: Mutual aid and health*. Ottawa: Canadian Council on Social Development.
- Rootes, L.E. & Aanes, D.L. (1992) A conceptual framework for understanding self-help groups. *Hospital and Community Psychiatry*, 43(4): 379-381.
- Segal, S., Silverman, C. & Temkin, T. (1994) Issues in Self Help Agency Research. *Innovations and Research*, 3(1): 47-49.
- Segal, S.P., Silverman, C., & Temkin, T. (1995) Characteristics and service use of long-term members of self-help agencies for mental health clients. *Psychiatric Services*, 46(3): 269-274.
- Segal, S.P., Silverman, C., & Temkin, T. (1993) Empowerment and self-help agency practice for people with mental disabilities. *Social Work*, 38(6): 705-712.
- Toro, P.A., Reischl, T.M., Zimmerman, M.A., Rappaport, J., Seidman, E., Luke, D.A. and Roberts, L.J. (1988) Professionals in mutual help groups: Impact on social climate and members' behaviour. *Journal of Consulting and Clinical Psychology*. 56(4):631-632.
- Toro, P.A., Rappaport, J. And Seidman, E. (1987) Social climate comparison of mutual help and psychotherapy groups. *Journal of Consulting and Clinical Psychology*. 55:430-431.
- Trainor, J., Shepherd, M., Boydell, K.M., Leff, A. and Crawford, E. (1995) *The Consumer/Survivor Development Initiative: Evaluation of a Provincial Initiative*. Report submitted to the Ontario Ministry of Health, September 1995.
- Trainor, J., Shepherd, M., Boydell, K.M., Leff, A. and Crawford, E. (1996) Consumer/Survivor initiatives: A case study. Manuscript submitted to *Psychiatric Rehabilitation Journal*, July 1996. Available from E. Crawford, CSRU, Queen Street Mental Health Centre, 1001 Queen Street West, Toronto, Ontario, M6J 1H4.
- Trainor, J., & Tremblay, J. (1992) Consumer/survivor businesses in Ontario: Challenging the rehabilitation model. *Canadian Journal of Community Mental Health*, 11(2): 65-77.
- 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): 25-32.

Trainor, J., Pomeroy, E., & Pape, B. (1993) *A new framework for support for people with serious mental health problems*. Published by the Canadian Mental Health Association.

Warner, A. (1992) *Participants' views on the impact of self-help on health*. Nova Scotia: The Self-Help Connection.

Ward, J. *Consumer involvement in the mental health field*. Report submitted to Health Canada

Weschler, H. (1976) The self-help organization in the mental health field: Recovery Inc., a case study. In: G. Kaplan and M. Killiliea (Eds.) *Support Systems and Mutual Help*, New York: Grune and Stratton, 187-212.

Young, J., & Williams, C.L. (1988) Whom do mutual-help groups help? A typology of members. *Hospital and Community Psychiatry*, 39: 1178-1182.

Zimmerman, M.A., Reischl, T.M., Seidman, E., Rappaport, J., Toro, P.A., & Salem, D.A. (1991) Expansion strategies of a mutual help organization. *American Journal of Psychiatry*, 19(2): 251-278.

Zinman, S. (1986) Self-help: the wave of the future. *Hospital and Community Psychiatry*, 37: 213.

# 6.

## FAMILY SELF-HELP

### 6.1 Introduction & Definition

Organized family advocacy is a comparatively recent phenomenon in mental health (*Mannion et al., 1996; Sommer, 1990*). By comparison, families of the mentally retarded have been well-organized, highly visible and politically effective for more than 50 years. Until recently, an impediment to a strong family movement has been stigma directed towards parents as possible etiological agents in their child's illness. Many mental health professionals give lip service to the importance of families and their organizations (*Hatfield, 1994*). Since the late 1970s, the family support movement has flourished at a phenomenal pace (*Battaglino, 1987*).

Almost 60% of families of the mentally ill are estimated to be operating as primary caretakers with no relief or respite and little guidance or support (*Hatfield, 1979, 1994*). Despite this reality, families receive virtually no systematic support or recognition of their role (*Pomeroy & Trainor, 1991*). Surveys of families coping with the discharge of a family member from inpatient psychiatric units shows that they feel unprepared (*Gantt et al., 1989*). They expect information, support and guidance about what will be helpful to their family member, but they often report that these expectations are not met. As a result, families have begun advocating support services for themselves. Families have formed local and national self-help and advocacy organizations (*Hatfield, 1991*).

In the family literature, self-help groups are more frequently referred to as support groups where dialogue, self-disclosure and encouragement among group members is promoted. Family support groups are recognized as being a service targeted directly at meeting the needs of informal carers (*Mitchell, 1996*). These groups are usually attended by a variety of family members who engage in unstructured discussions regarding their experiences of coping with their ill relative. As *Pomeroy and Trainor (1991)* state, “they provide an irreplaceable sanctuary for family members battered by the broader community experience of having a mentally disordered relative”.

The first organized family group seen as part of the current movement was Parents of Adult Schizophrenics formed in 1973 in San Mateo County, California. The idea spread quickly and within six years there were seven affiliated groups in California under a new name, Families for the Mentally Disabled. Subsequently, several groups adopted an alternative name, Families for Mental Recovery. In 1979, groups from across the United States met in Madison, WI, to form the **National Alliance for the Mentally Ill (NAMI)**. NAMI was conceived seventeen years ago in the tradition of self-organized parents' groups for handicapped and chronically ill children. NAMI is generally regarded as the most effective families organization in the world. From its beginning, members viewed NAMI as a self-help organization that should retain its autonomy from professional dominance (*Hatfield, 1991*). Earlier parent organizations heavily involved professionals and

expressed doubts that highly emotional families were capable of running an organization. NAMI is devoted to improving and expanding clinical and support services for the severely mentally ill, increasing research and improving the training of mental health professionals to meet the needs of this client population (*McLean, 1990*). From the outset, advocacy on a national level was a priority for the organization and NAMI has been referred to as one of the most powerful lobbying forces in health care (*McLean, 1990*). Local AMIs focus their efforts more on their own immediate concerns, such as service needs in a particular location. They are concerned almost entirely with mutual assistance and support which take place in “caring and sharing” sessions (*Sommer, 1990*). One affiliate group is AMI-Quebec, formed in 1976 as a mutual support group for parents of persons with chronic schizophrenia and affiliated with NAMI in 1984.

**The Schizophrenia Society of Canada (SSC)**, often known as the Friends of Schizophrenics and soon to be renamed the **Schizophrenia Society of Ontario**, is likely the most significant player amongst the various family organizations in the country. In addition to family support groups, other major activities now include public information, advocacy and research. Support of research is a major priority for the Schizophrenia Society. The Alberta “Out of Darkness” campaign established a Research Chair at the University of Calgary. The British Columbia group has undertaken a joint campaign with the University of British Columbia to set up a similar Chair for their campus.

**The Ontario Friends of Schizophrenics (OFOS)** began in 1979 when a group of families gathered in the basement of a church in Oakville to learn more about schizophrenia and to provide support to one another (*OFOS Advocate, Spring 1996*). OFOS currently has forty chapters throughout the province. They are a mainstay of family support and education to those with a loved one with schizophrenia. The group adheres to a fairly strict biological, especially genetic, view of the causes of schizophrenia. As their expertise developed, chapters have expanded their role to meet additional local needs based on available resources. They advocate for both persons with the disease and families; increase public awareness and knowledge; and raise funds to increase research into the cause and cure for schizophrenia.

A number of family organizations exist in Saskatchewan, including **Friends and Relatives of the Mentally Ill**, a generic group not based on diagnosis. This group led to the development of a model initiative, a Family Advisory Committee to the provincial Canadian Mental Health Association. This six member committee acts in an advisory capacity to the provincial Board, monitoring policies and programs of mental health services to ensure that consumer and family issues are addressed and advocating on behalf of and with consumers to promote empowerment of persons suffering from mental illness.

The **Society for Depression and Manic Depression (D/MD)** has evolved as an organization with both consumer and family membership and has provincial associations in Manitoba and Ontario. The evolution of interests and activities of D/MD groups in both provinces is typical of those of other family organizations such as the Schizophrenia Society of Canada. They began with self-help/mutual aid and then broadened out into public education and advocacy efforts. Although research is an area that the Ontario groups and provincial association are interested in promoting, it is not a major

concern relative to other activities. The Manitoba group has been involved in the evaluation of a self-help program which they founded.

## 6.2 Published Literature

Most published literature on family self-help or support groups in the mental health field is descriptive and anecdotal in nature, documenting the development and functioning of groups (*Sommer et al., 1984; Kassis et al., 1992*) and describing how support groups enable families to cope with the patient's symptoms at home (*Kane et al., 1990*). There has been little attempt at quantification or hypothesis testing, and a dearth of comparative studies or longitudinal research on single organizations (*Mannion et al., 1996*).

It is also important to note that in our computer search, numerous articles emerged using the key words family mutual aid, family self-help and family support. Most of these articles were, however, family programs within the formal mental health service system. The following summarizes the articles describing family self-help groups that are primarily run and organized by family members rather than professionals.

**Battaglino (1987)** reports that family members are turning to each other to find an atmosphere of support and understanding, released from the blame and scrutiny that immobilized them for so long. Their seriously neglected needs are being met, not by professionals, but by each other. People tend to participate in self-help groups only after they have exhausted all familiar problem-solving resources and approaches. This author reports on an affiliate of NAMI, the Staten Island Alliance for the Mentally Ill, primarily through a profile of participants. She found that members of this self-help group developed a sense of cohesiveness in a relatively short time and that many members felt a sense of family within the group. Members guided each other through the mental health system and the financial and medical bureaucracies involved. Some members have taken active roles in the political arena and have lobbied with legislators for budget increases and legislative changes.

**Gidron et al., (1990)** examined differences in stress and coping patterns between participants and non-participants in a self-help group for parents of the mentally ill in Israel. Parents reported coping patterns that tended to be both more active and interactive. They also reported greater concerns around psycho-social issues than non-participants.

**Mitchell (1996)** conducted a qualitative study to examine the influence of family group organization on perceived benefits. Six groups for caregivers in Great Britain, which varied in their links with service providers and generic or specific focus, were compared. Participants in all groups were satisfied with information and emotional support received. Groups with high professional involvement were less successful at helping caregivers develop a positive self-identify (as a caregiver) but were better at facilitating contacts between carers and other providers. Where there was less staff involvement, groups tended to be more sociable and less structured. Mitchell argues that caregivers would benefit from having variety in available support groups but would be better able to

make informed choices if there was more information on the strengths and weaknesses of the various group types.

**Twigg and Atkin (1994)** found that contact with carers is not only a source of mutual support and information for families, but can also be influential in forming a self-identity as a carer. They stated that the question of self-identity was important for the carers own sense of well-being and esteem and that this can lead to carers being more assertive in seeking and accepting service support.

**Mannion et al., (1996)** study supported the assumption that family members with certain demographic characteristics are more likely to join support groups. Their results indicated that members are more likely to have higher education levels than non-members. In addition, more parents joined support groups than did siblings, spouses or adult children. The idea that participation in a support group positively affects certain key variables in the member's adaptation to mental illness in a relative is mostly supported by their results. Members reported more extensive adaptive coping and less subjective burden than did non-members.

A random sample of 30 members of a non-diagnostic-specific family support organization in Ontario, **Family Association for Mental Health Everywhere (FAME)**, were interviewed regarding the impact of their membership in the organization (**Boydell et al., 1994**). More than 80 percent of respondents indicated that their involvement had helped them to continue caring for their ill relative. Involvement in FAME positively affected their ability to provide support in the treatment area, community living, and in activities of daily living. Families were asked to rate the helpfulness of various community services on a scale of one to 10, one being the least helpful and 10 being the most helpful. The mean score on the helpfulness scale was highest for FAME, followed by community mental health centres, private psychiatrist/physicians, other family groups, psychiatric hospitals, and general hospitals.

In a focus group conducted as part of the above study, family members had the following to say about their involvement in FAME:

*You go to meetings and you keep learning. You pick up things. Oh yes, maybe that will work for my daughter or a friend of mine.*

*It's a release. It's a release, temporarily, anyway. Until the next onslaught anyway. At least it accomplishes that.*

*When I started coming to the group, I was very shy. I'm not a talkative person. I listen more. For me to come here and talk with you people is a big change for me. I can talk about it more. When I see parents are having a hard time like I did at the beginning, I know more, and I can talk about it more and this helps me. I can help my daughter now.*

Other studies have noted such potential benefits as a reduction in the general sense of burden felt by family members, improved relationships with the mentally ill family member, and an increase in the information on the illness and on coping strategies to address their stresses (*Potasznik & Nelson, 1984; Medvene & Krauss, 1989; Biegel & Yamatani, 1986; Shapiro et al., 1983*). The support of such groups enhance self-esteem and helps families to identify and affirm their rights. It also provides the power to affect service provision.

### **6.3 Discussion**

The primary outlet for families' dissatisfaction with the mental health system has been the development of mutual support groups that began as a way of getting and giving the emotional nurturance that had been missing (*Bernheim, 1990*). Some families prefer support such as self-help and advocacy groups to more traditional interventions such as family therapy (*Gidron et al., 1990; Spaniol & Zippel, 1988*). Benefits to carers from attending support groups are well documented in the literature. Evidence from existing studies associates self-help participation for families of the mentally ill with positive effects. For example, preliminary work done with FAME (outlined above) has indicated that membership in support groups reduces burden and keeps families as allies with mental health professionals. Family support groups can meet members' social needs as well as their needs for hope and support (*Mannion et al., 1996*).

Funding families to support their voice and to reduce their burden has been called for as part of mental health reform strategies. It is a fact that families do care for their mentally ill relatives. Families need to be seen as important and equal stakeholders in the overall social process of supporting people with mental illness (*Pomeroy & Trainor, 1991*).

## 6.4 Best Practices: Family Self-Help

### Research Evidence

Existing research on family self-help is limited in quantity and quality, with single group, cross-sectional study designs frequently used. Study findings associate participation in support groups with:

- ★ increased levels of information among participants
- ★ improved coping skills
- ★ reduced caregiver burden
- ★ improved identity as caregiver
- ★ improved relationship with and ability to support ill relative
- ★ improved emotional support

### Key Elements of Best Practice

Funding is provided to family self-help groups (as individual or joint consumer-family initiatives) and they are used as a resource in the planning and evaluation of care delivery.

- ★ Evaluation of the effectiveness of these groups that uses appropriate, alternative methods is encouraged and supported.



## REFERENCES

- Battaglino, L. (1987) Family empowerment through self-help groups. *New Directions for Mental Health Services*, 34: 43-51.
- Berheim, K. (1990) Principles of professional and family collaboration. *Hospital and Community Psychiatry*. 41(12): 1353-1355.
- Biegel, D.E., & Yamatami, H. (1986) Self-help groups for families of the mentally ill: Research perspectives. In M. Goldstein, (Ed.), *Schizophrenia: Family, Patient and Professional, A New Partnership*. Washington, D.C., American Psychiatric Press, Inc.
- Boydell, K.M., Trainor, J., & Gladstone, B.M. (1994) *A study of the impact of a families support group*. Unpublished study available from the first author, 1001 Queen Street West, Toronto, Ontario, M6J 1H4.
- FAME (The Family Association for Mental Health) (1989), *Executive Summary*. (Submitted by Bill Sande - Chairperson, FAME.) Etobicoke:
- Gantt, A.B., Goldstein, G., and Pinsky, S. (1989) Family understanding of psychiatric illness. *Community Mental Health Journal*. 26(6): 483-496.
- Gidron, B., Guterman, N.B., & Hartman, H. (1990) Stress and coping patterns of participants and non-participants in self-help groups for parents of the mentally ill. *Community Mental Health Journal*, 26(6): 483-496.
- Hatfield, A.B. (1994) Developing collaborative relationships with families. In A.B. Hatfield (ed.), *Family Interventions in Mental Illness*. New Directions for Mental Health Services. No. 62, San Fransico, Jossey-Bass Publishers.
- Hatfield, A.B. (1991) The national alliance for the mentally ill: A decade later. *Community Mental Health Journal*, 27(2): 1991.
- Hatfield, A.B. (1991) The National Alliance for the Mentally Ill: A decade later. *Hospital and Community Psychiatry*, 27(2): 95-103.
- Hatfield, A.B. (1979) Help-seeking behaviour in families of schizophrenics. *American Journal of Community Psychology*, 7: 563-569.
- Kane, C.F., DiMartino, E., & Jimenez, M. (1990) A comparison of short-term psychoeducational and support groups for relatives coping with chronic schizophrenia. *Archives of Psychiatric Nursing*, 4(6): 343-353.

- Kassis, J.P., Boothroyd, P., & Ben-Dror, R. (1992) The family support group: Families and professionals in partnership. *Psychosocial Rehabilitation Journal*, 15(4): 91-96.
- Mannion, E., Meisel, M., Solomon, P., and Driane, J. (1996) A comparative analysis of families with mentally ill adult relatives: Support group members versus non-members. *Psychiatric Rehabilitation Journal*, 20(1): 43-50.
- McLean, A. (1990) Contradictions in the social production of clinical knowledge: The case of schizophrenia. *Social Science and Medicine*, 30(9): 969-985.
- Medvene, L. & Krauss, D. (1989) Casual attributions about psychiatric disability in a self-help group for families of the mentally ill. *Journal of Applied Social Psychology*, 19:1413-1430.
- Mitchell, F. (1996) Carer support groups: the effects of organizational factors on the character of groups. *Health and Social Care in the Community*, 4(2), 113-121.
- OFOS Advocate: Quarterly Newsletter of the Ontario Friends of Schizophrenics. (1996) Spring.
- Pomeroy, E., Trainor, J. (1991) Families of people with mental illness: Current dilemmas and strategies for change. *Canadian Mental Health Association*.
- Potasnik, H., & Nelson, G. (1984) Stress and social support: The burden experienced by the family of a mentally ill person. *American Journal of Community Psychology*, 12: 589-607.
- Shapiro, R., Possidente, S.M., Plum, K.C., & Lehan, A.F. (1983) The evaluation of a support group for families of the chronically mentally ill. *Psychiatric Quarterly*, 56: 276-285.
- Sommer, R. (1990) Family advocacy and the mental health system: The recent rise of the Alliance for the Mentally Ill. *Psychiatric Quarterly*, 56(4): 276-285.
- Sommer, R., Williams, P., & Williams, W.A. (1984) Self-survey of a family organization. *Psychiatric Quarterly*, 56(4): 276-285.
- Spaniol, L., and Zipple, A. (1988) Family and professional perceptions of family needs and coping strengths. *Rehabilitation Psychology*, 33(1): 37-45
- Twigg, J. and Atkin, K. (1994) *Carers and services: a review of research*. HMSO, London.

# **7. VOCATIONAL/EDUCATIONAL SERVICES**

## **7.1 Vocational Services: Introduction & Definitions**

Over the past few decades there have been significant changes in the way vocational services for persons with psychiatric disorders have been organized and delivered. Until recently, most discharged patients did not move directly from hospital to a job but rather progressed through a series of interlocking programmatic steps which were related to the overall goal of work restoration and tailored to each individual's needs and resources. Now, however, there is greater recognition that because not everyone follows the same path and the progression is not always orderly (illness symptoms may recur unexpectedly), flexible and adaptive systems are important. Programs aimed at placing individuals more quickly into actual jobs and providing flexible levels of support for longer periods of time are the most promising new developments in the field. However, it should be noted that most of the evidence comes from the United States which has had significantly lower unemployment rates than Canada. Attempts to place clients into competitive employment depends not only on the efficacy of the program model but also on the economic context.

The first section of this chapter is a conceptual description of employment programs derived from a report by *Cochrane et al., (1990)* which was produced for Health Services and Promotion Branch, Health and Welfare Canada. The next section will review the published research which has investigated the relative merits and effectiveness of different employment and education models.

### **7.1.1 Employment Preparation Programs**

Historically, services developed which focused on preparing clients for employment, prior to placement in the community. These programs are briefly described.

#### **Work Adjustment Training Programs**

Work adjustment training programs are aimed at assisting patients who have lost, or who never acquired, the fundamental work skills and habits necessary to obtain and hold a job in competitive employment. Deficit areas in job-related performance skills may include such problems as lack of punctuality, lack of motivation to work, inappropriate dress or behaviour and inability to interact effectively with co-workers and supervisors (*Anthony et al., 1983; Church & Pakula, 1984*). Typically, work adjustment training programs are offered in sheltered hospital-based or similar settings. Such programs may, however, also be situated in community settings where acquisition of skills through daily living is the main focus.

### **Career Counselling Programs**

Career counselling programs for psychiatric clients have traditionally been neglected in the vocational process although their relationship to successful vocational outcome is significant. Experts believe that outcome will be poor if the client has not been involved in formulating career decisions, since commitment and investment in the goal need his or her input (*Anthony et al., 1983; Hursh & Anthony, 1983*). The emphasis should be on helping the client set realistic career goals congruent with his or her level of skill and degree of impairment. Anthony and colleagues (*Danley & Anthony, 1987*) have developed an approach they call the Choose-Get-Keep model. This model, which will be described more fully in the section on Supported Employment, encourages career planning, typically in career counselling sessions.

### **Career Placement Training Programs**

These programs are aimed at helping clients develop effective job seeking and marketing strategies. Clients are taught to identify their skills and career goals and in addition, to learn presentation and interviewing techniques. There is some support in the literature for the idea of career placement training (*Anthony et al., 1983; Church & Pakula, 1984*).

## **7.1.2 Employment Programs**

### **Sheltered Workshops**

These programs combine training and employment in community or hospital settings. Traditional sheltered workshops typically solicit factory contract work which is carried out in a segregated and protected environment. Newer alternatives to this are non-profit organizations often started by health professionals and affiliated with rehabilitation agencies. These organizations obtain contracts and employ clients to carry out the work. The programs are intended to help clients develop a work history and learn how to get along with others (*Lang & Cara, 1989*).

Some work programs which fall under the general rubric of sheltered employment are initiatives developed by consumers. These programs are described in the chapter on Consumer and Family Involvement.

### **Cooperatives**

The Fairweather Lodge program, which combines housing and work using a cooperative model, has been replicated a number of times in the U.S. It involves a group of former psychiatric patients living together and selling various services such as maintenance or gardening. This model is also quite common in Italy (*Mosher & Burti, 1989*).

## **Home Employment**

Cottage industries employing people working at home on a piece-work basis have been developed for other target groups such as the developmentally handicapped. The first report of the use of this vocational program model for the psychiatrically disabled who want to work but are unable or unwilling to participate in either sheltered or competitive work describes a program developed in Hamilton, Ontario (*Kates et al., 1989*).

### **7.1.3 Supported Employment**

Supportive employment (SE) represents a more recent focus in the rehabilitation field. Its philosophy is that all people, regardless of the severity of their disability, can do meaningful, productive work in normal (as opposed to sheltered) work settings – if they so choose, and if they are provided with access to a range of ongoing supportive services. Most supported employment programs have four basic components: job placement, job-site training, ongoing monitoring and follow-up. Supported employment was first defined in the 1980s and included the following features:

- clients work for pay
- they work as regular employees in integrated settings
- they receive flexible and ongoing support

*Bond (1996)* outlines four vocational rehabilitation models which have influenced the development of the SE model.

1. **Job coach model** of supported employment: These originated in Virginia as a place-then-train approach. Clients were placed individually at work sites with job coaches who provided intensive on-site training and time-unlimited support. First targeted towards people with developmental disabilities this approach has been successfully used for persons with psychiatric disabilities.
2. **The Club House and Transitional Employment:** These programs were developed for people with serious mental illness by Fountain House, a psychiatric rehabilitation program in New York. Transitional employment (TE) programs provide time-limited assistance to clients who experience difficulty in making the transition from sheltered, non-competitive work situations to the open employment market. Transitional employment focuses on strengthening work-related skills by first providing pre-vocational training which is followed by supported placements in industrial and commercial settings within the open market. Placements range from minimal to total supervision, and may be fully or semi-integrated into the company's work environment. Placements are most often entry-level positions, consistent with the goal of facilitating behavioural work adjustment skills. The placements are usually time-limited, with clients who are capable of moving on into work in the competitive job market. The clubhouse model is similar to SE in its emphasis on community employment as a normalizing experience, and the assumption that clients usually need help in finding a job and support for maintaining the job.

The differences are that TE positions are temporary and that they are controlled by the club house.

3. **Assertive Community Treatment:** This model has been fully described in the chapter on case management. Employment has always been considered an integral part of the treatment plan and most ACT teams include a vocational services specialist. Vocational services in ACT have evolved over time and have not been adequately researched. Like supported employment, ACT emphasizes unlimited support and providing skills training in environments in which they are to be used.
4. **Choose-Get-Keep:** This model was developed by Anthony and associates in Boston (*Danley & Anthony, 1987*) as part of the psychiatric rehabilitation program. It emphasizes extended exploration of career options before community placement. The basic elements of this model are client choice in selecting, obtaining and maintaining jobs. The focus on client choice and preferences have become essential characteristics of the SE approach.

In SE programs both entry and non-entry level jobs (some of which may have career ladder possibilities) are considered because participants are involved in identifying work that fits in with their interests, aspirations and abilities. No empirical data are available on the population best served by supportive employment programs (*Anthony & Blanch, 1987*). It is thought that a wide variety of persons can be considered appropriate for placement. Some agencies exclude those who are thought to be capable of going from transitional employment straight into competitive settings without supports. Others believe that SE is for those who function too well for TE, but not well enough to make it alone in the job world.

Supported employment differs from transitional employment (TE) in certain basic ways. In SE the training occurs after the job placement rather than before as in TE and other traditional vocational rehabilitation efforts. Training on the job is believed to reduce the possibility of inappropriate or irrelevant job skills training and maximize the fit between the client and the job. Another major difference between SE and TE is that on-the-job support in SE continues indefinitely. Some authors have noted that clients who are terminated from a time-limited support tend to regress (*Anthony et al., 1986*). Therefore it is likely that some clients will need to have many years of support in order to achieve maximum vocational success.

## 7.2 Reviews of Vocational Research

In the past five years there have been three comprehensive reviews of the vocational rehabilitation research. These are summarized below. (Table 7.1)

The first of these by *Bond (1992)* provides a brief overview of the past, present and future of vocational programming for persons with severe psychiatric illness. He also reviews 24 studies of traditional vocational models conducted between 1963 and 1986 and selected studies of more recent transitional employment and supported employment models. The inclusion criteria for the studies are random assignment or a close approximation, an explicit vocational component in the experimental condition and reporting of vocational outcomes for individuals with psychiatric illness. Experimental programs included hospital vocational programs, halfway houses (eg Fairweather House which provides a structured setting for living, employment and peer support), sheltered workshops, vocational counselling, job clubs, assertive community treatment, and psychosocial rehabilitation centres (eg Fountain House - TE programs).

This review shows that vocational programs have succeeded in placing and maintaining clients in jobs. The results suggest that clients will be helped to maintain community employment as long as they continue to receive intensive supports. However, there is no evidence that the programs prepare clients for future competitive employment outside the support provided by the program. Studies of sheltered workshops have shown them to be ineffective for psychiatric patients, particularly with regards to making the transition to competitive employment. Hospital-based programs, however, have illustrated the fact that even institutionalized patients have the capacity to work and that employment programs are possible and should be encouraged for discharged long-term patients.

Prior work experience was found to be a predictor of future employment. It is felt that clients with prior work experience could benefit from higher expectation programs. On the other hand, there was a subgroup of patients with little prior work experience for whom the vocational programs had little effect. These individuals might be helped to achieve employment after attending “supported education” programs.

This review includes research on current vocational models. However the more recent review by *Bond et al., (1996)* will be used to provide a more up-to-date and comprehensive description of the effectiveness research of these models .

*Lehman (1995)* reviewed studies of vocational rehabilitation programs focusing on outcomes for persons with schizophrenia. Lehman’s review summarizes findings from a meta-analysis of 19 studies conducted between 1955 and 1985 (*Bond, 1986*), a subsequent review by *Bond (1992)* and then reviews additional studies conducted between 1992 and 1993.

The main research question in this review is whether vocational interventions of any kind have an effect on vocational or employment outcomes of persons with schizophrenia. There is very little discussion of the relative effectiveness of different models of vocational interventions on outcomes. In general the studies reviewed found a positive impact of vocational programs on paid employment,

job starts, full-time employment, duration of employment and earnings. Despite this there is no evidence that these programs have been helpful in preparing clients “for future competitive employment outside the support provided by the rehabilitation program” (*Bond, 1992, p250*). These findings appeared to hold for the subset of persons with schizophrenia when the data were re-examined by Lehman.

The most recent review is by *Bond et al., (1996)*. This review was limited to studies of employment programs labeled as SE which examined outcomes for persons with serious mental illness. The settings, program features, sampling strategies and research designs were diverse. The designs of the 14 studies reviewed included seven descriptive, one quasi-experimental and six experimental. Control conditions in the quasi-experimental and experimental studies included sheltered worksites, referrals to the Vocational Rehabilitation (VR) system (the usual system), traditional day treatment with brokered VR, and prevocational services before SE. These studies were published between 1988 and 1996.

Although the SE models and the study designs differed, *Bond et al., (1996)* found that all these studies provided positive evidence for the SE model in relation to the traditional vocational models. Among the experimental and quasi-experimental studies, the mean rate for obtaining employment was 49.8% (range=29.4% to 76.4%) compared to a mean of 20.6% (range=5.9% to 40.3%) for clients in the control condition. Hours employed and wages earned were also better for the experimental subjects. In addition to the finding of increased competitive employment, the research produced evidence in favour of basic SE principles. Results suggest that it is not enough just to provide case management, or skills training or prevocational training without also focusing on obtaining competitive employment. A second finding from at least four of the studies was that clients who were placed directly into jobs with training and support had higher rates of employment than those who had extended prevocational preparation. The third finding was that integrating clinical and vocational approaches leads to better results than brokering the two services. Referral to VR services had almost no impact on clients’ rate of employment. Studies also found that attending to clients’ preferences leads to greatly improved outcomes. Two of the studies reported that clients held their jobs almost twice as long as those in non-preferred work settings and reported higher levels of satisfaction.

### 7.2.1 Summary of Research Findings

One of the most basic findings is that most people with serious psychiatric illness have the capacity to work and that employment programs should be encouraged for even the most disabled and institutionalized individuals. Most of the employment and vocational preparation services studied have been effective in helping clients obtain and maintain jobs.

However, traditional programs and services appear to be less effective in helping clients achieve competitive employment. The more recent alternatives, particularly the various supported employment models, have produced superior outcomes when compared to more traditional models. The most critical elements for the success of these programs are continued, time-unlimited support, attending to



client preferences and the place-train philosophy which involves the provision of on-site job specific skills training.

### **7.2.2 Research Directions for Supported Employment**

The authors of the above reviews have suggested further areas in the field of supported employment which require more investigation:

- The issue of how long to provide employment support and the best types of support have not been adequately studied. Studies have shown that clients who receive long-term and continuous support keep their jobs longer than those receiving intermittent or short-term support.
- Attention needs to be paid to the process of accessing SE services. Traditionally professionals have decided when clients are ready for vocational rehabilitation. This goes against current thinking which says that consumers have the right to decide which services they need and research findings which suggest that if clients are given adequate information about programs and services they will be able to make appropriate choices.
- Once access is assured, researchers should investigate the characteristics that lead to retention in the SE program. Studies commonly report high dropout rates. The support of a multidisciplinary case management team has been shown to increase retention. Bond and colleagues speculate that this occurs because services are time unlimited, readily available, include assertive outreach and are sensitive to fluctuations in the client's clinical condition. Closely related to this is the issue of duration of employment. The few studies which have looked beyond a two-year follow-up suggest that longer periods of support will lead to higher employment rates. Job stability and satisfaction with the job are related areas which have not been carefully examined.
- Another little studied process is that of job development. Programs which require the client to take responsibility for finding a job do not appear to be satisfactory for most individuals with SMI. Staff roles and responsibilities in helping clients to find jobs and in the interview process, need to be clarified. The issue of disclosure, contact between staff and employers and employers' obligations to make accommodations for SMI employees also require thoughtful study.
- Cost-effectiveness studies of vocational programs are needed which take into consideration the perspectives of clients, families, society and health systems.
- Methodological considerations: *Bond et al., (1996)* reiterate the necessity of conducting controlled experimental studies, providing complete descriptions of the experimental, and control conditions, defining specific elements of the programs, implementation criteria and staffing.

### 7.3 Educational services

The development of educational programs for persons with mental illness is a relatively recent occurrence. Since the first onset of serious mental illness usually occurs in young adults, disruption of normal developmental tasks often results. Educational and career plans are frequently interrupted when, as is often the case, the young person drops out of school.

#### Psychiatric Rehabilitation Through Education

A growing body of evidence suggests that the psychiatrically disabled are capable of learning a variety of skills despite sometimes severe and continuing symptomatology, and that skills acquisition in such areas as vocational preparation, community living and coping with daily activities can result in functional improvements (*Anthony et al., 1983*). Especially for younger clients, the use of non-stigmatizing, more familiar environments is thought to be important in encouraging them to take advantage of opportunities to develop such skills. Thus, programs employing a learning/teaching model in a classroom setting have been set up in post-secondary educational settings such as community colleges in various parts of Canada and the United States (*Unger, 1989*). Although such programs are believed to be beneficial, no controlled studies have been conducted to link the intervention to reportedly favourable results.

#### Supported Education

Supported education programs have been developed which facilitate a return to the appropriate educational level (*Housel & Hickey, 1993; Cook & Solomon, 1993*). These programs attempt to ease the transition from hospital to college, maintain educational and career aspirations and enhance self-esteem. One such program was developed and evaluated at an inpatient setting in New York state. *Hoffmann and Mastrianni (1993)* investigated the efficacy of supported education (SE) by comparing two treatment settings which were comparable in every way except that only one of them included a SE program. The SE program provides opportunities for patients to participate in educational activities as an integral part of their treatment program. The patients take part in individually tailored academic activities with a neighbouring university or community college or a continuation of studies at the person's home institution. These activities are supported by the therapists and other treatment team members. The subjects of this study were seriously mentally ill inpatients aged 18 to 24 at two private hospitals. The experimental group comprised 68 patients who participated in the SE program at one of the hospitals from the initiation of the program until they were discharged. The control group (n=63), matched for age, prior education and hospitalization was selected from the institution without a SE program. Both groups were interviewed after discharge from hospital to obtain information about their post discharge activities. Areas of inquiry included housing, college and work activities, educational aspirations and experiences, and nature of follow-up care received. Recipients of the SE program were significantly more likely to return to college, and more SE returned to school on a full-time basis. The transition from hospital to school was reported as difficult by both groups, but was somewhat less difficult for the SE group. The SE group also retained significantly higher

educational aspirations than control subjects. The control subjects were more likely to be living in supervised housing or to be involved in day treatment programs. The authors find the results of this preliminary research to be encouraging in that the SE program enabled patients to re-enter settings that “are more normative for their age”(p119).

## 7.4 Best Practices: Vocational/ educational Services

### Research Evidence

There are a number of fairly rigorous studies which demonstrate that:

- ★ People with serious psychiatric illness have the capacity to work
- ★ Employment programs should be encouraged for even the most disabled individuals
- ★ Supported employment is more effective than other employment models
- ★ Supported education enables clients to return to school on a full time basis

### Key Elements of Best Practice

There is a shift from traditional methods of providing vocational services to supported employment which includes:

- ★ continuous, time-unlimited individual support
- ★ attention to client preferences
- ★ a place-train philosophy with on site job specific skills training

Supported education and social recreational programs are viewed as promising approaches in need of further evaluation.



***Table 7.1: Reviews of Vocational Studies***

<b>Authors</b>	<b>Type of Review</b>	<b>Years</b>	<b>Number of Studies reviewed</b>	<b>Types of Models</b>	<b>Design of Reviewed Studies</b>
Bond (1992)	Narrative	1963-1986	24	Various	RCT, quasi experimental
Lehman (1995)	Narrative (related to schizophrenia)	1955-1993	?	Various	not specified
Bond et al., (1996)	Narrative	1988-1996	14	Supported employment compared to other models	6 experimental; 1 quasi 7 descriptive

## REFERENCES

- Anthony, WA, Howell, J. & Danley, KS. (1983). Vocational rehabilitation. Adapted from a chapter in: *The Chronically Mentally Ill: Research and Services*. Jamaica, NY: SP Medical and Scientific Books.
- Anthony, W.A., Cohen, M.R. & Danley, K.(1986): The psychiatric rehabilitation model as applied to vocational rehabilitation. In J. Ciardiello & M. Bell (eds) *Vocational Rehabilitation of Persons with Prolonged Mental Illness*. Baltimore Md: John Hopkins University Press.
- Bond, GR(1992). Vocational rehabilitation, in *Handbook of Psychiatric Rehabilitation*. (ed) Liberman, RP. New York: Macmillan.
- Bond, GR, Drake, RE, Mueser, KT, & Becker, DR.(1996). Supported Employment for people with severe mental illness: A review. *Psychiatric Services*, in press.
- Buckley, L.R.(1981). Partial employment for persons with chronic mental illness. *Canada's Mental Health*, 29:10-12.
- Church K & Pakula, A. (1984). Employment opportunities for people labeled as psychiatrically disabled. A discussion paper submitted to the Disabled Persons Directorate, Employment and Immigration Canada by CMHA.
- Cochrane, J, Rogers, J & Goering, P (1991). Vocational Programs and Services in Canada. *Canadian Journal of Community Mental Health*, 10(1):51-63.
- Cochrane, J, Rogers, J & Goering, P (1990). *Employment for persons with a history of mental illness: problems and benefits - A critical literature review*. Report submitted to Health Services and Promotion Branch, Health and Welfare Canada.
- Cook, JA & Solomon, ML. (1993). The Community Scholar Program: An outcome study of supported education for students with severe mental illness. *Psychosocial Rehabilitation Journal*, 17(1):83-97.
- Danley, KS & Anthony, WA. (1987). The Choose-Get-Keep model: Serving severely psychiatrically disabled people. *American Rehabilitation*, 13(4):27-29.
- Deacon, S., Dunning, R.E. & Dease, R. (1974). A job clinic for psychotic clients in remission. *American Journal of Occupational Therapy*, 28:144-147.
- Hoffmann FL & Mastrianni, X. (1993). The role of supported education in the inpatient treatment of young adults: A two-site comparison. *Psychosocial Rehabilitation Journal*, 17(1):109-119.

- Housel, DP & Hickey, JS. (1993). Supported education in a community college for students with psychiatric disabilities: The Houston Community College Model. *Psychosocial Rehabilitation Journal*, 17(1):42-50.
- Hursh, N. & Anthony, W.A.(1983). The vocational preparation of chronic psychiatric patients in the community. In: I. Barofsky and R.D. Budson (eds.), *The Chronic Psychiatric Patient in the Community: Principles of Treatment*. New York: SP Medical and Scientific Books, pp. 205-239.
- Kates, N., Woodside, H., Gavin, D., et al., (1989). Home Employment: A Work Alternative for Persons who are Mentally Ill. *Psychosocial Rehabilitation Journal*, 12(4):66-69.
- Lang, S.K. & Cara, E.(1989). Vocational integration for the psychiatrically disabled. *Hospital and Community Psychiatry*, 40(9):890-892.
- Lehman, AF (1995). Vocational rehabilitation in schizophrenia. *Schizophrenia Bulletin*, 21(4):645-656.
- Mosher, L.R. & Burti, L.(1989). *Community Mental Health: Principles and Practice*. New York, New York: Norton.
- Unger, KV. (1989) Psychiatric Rehabilitation through Education: Rethinking the Context. In: M.D. Farkas and W.A. Anthony (eds.), *Psychiatric Rehabilitation Programs*. Baltimore, The John Hopkins University Press, 132-161.

**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., Surlles, 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.
- Surlles, 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-serve 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 Resoruces: 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.

## Appendix A:

### Federal and Provincial Documents on Topics related to Mental Health Care

#### Dual Disorders

Hood, C., Mangham, C., McGuire, D. & Leigh, G. (1996). *Exploring the links between substance use and mental health: I. An annotated bibliography*. Health Canada, Ottawa.

Hood, C., Mangham, C., McGuire, D. & Leigh, G. (1996). *Exploring the links between substance use and mental health: II. A detailed analysis*. Health Canada, Ottawa.

#### Mental Illness and the Criminal Justice System

Milstone, C. (1995). *The mentally ill and the criminal justice system: Innovative community-based programs*. Mental Health Division, Health Services Directorate, Health Programs and Services, Health Canada.

#### Health Promotion

Jonah, N (1996). *A guide to the literature on the effectiveness of prevention of mental health problems for those at risk*. Mental Health Unit, Health Care and Issues Division, Health Canada [draft].

Arboleda-Florez, Holley, H. & Crisanti, A (1996). *Mental health and violence: proof or stereotype?* Health Promotion and Programs Branch, Health Canada.

Ristock, J & Grieger, L (1996). *Joining together against violence: An agenda for collaborative action*, Canadian Mental Health Association.

## **Continuing Care/Long-term Care**

Future directions in continuing care. (1992) Report of the Federal/Provincial/Territorial Subcommittee on Continuing Care, Health Services and Promotion Branch, Health Canada.

Proceedings from the Invitational Symposium. Continuing Care/Long-term Care (Feb 8, 1995). Health Service Systems Division, Health Programs and Services Branch, Health Canada.

## **Evaluation**

Planning for health: Toward informed decision-making. (1993). Report of the project team on emerging trends in the organization and delivery of health care services. Health services Directorate, Health and Social Programs Branch, Health Canada.