Best Practices in Mental Health

a review of literature

CRP Health Policy & Communications

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In an effort to inform the BCNU’s recently launched Mental Health Initiative, this document summarizes a literature review conducted on best practices in mental health. It utilizes Hsiao’s Control Knob model to conceptualize possible entry points to policy change. These are financing, payment, organization, regulation, and behaviour.

While extensive data was not available to inform mental health specific financing and payment schemes, some themes did emerge. Equity promoting methods of finance, such as social insurance or general revenue, are seen as preferable. The improved quality outcomes of salaried payment formats are also seen positively. Additionally, keeping earmarked funds dedicated to mental health may prevent erosion of mental health services during periods of budgetary restraint.

The most significant regulatory consideration in relation to mental health is in regards to the use of coercion to force treatment. While it is acknowledged as necessary at times, effort should be taken to use it very judiciously and infrequently, as it can have many negative effects.

Organizational terms, the trend in mental health has been towards integrated, collaborative models of care. Structural, or systemic approaches are advocated over individualistic ones.

Behaviourally, staff are asked to think in a holistic way. Not only should the context of the patient be considered, but also the context of the community, and the service agency. The implementation of programs must be thought about in this way too, with attention to follow up, and support for clinicians.

Pertinent trends are summarized in section seven of this document, and provide a slightly more in depth summary of the findings. Throughout the document, dialogue boxes titled “spotlight” highlight the lessons provided by various programs.
1. Introduction

Purpose

This document has been prepared at request of the British Columbia Nurses’ Union (BCNU), in an effort to inform the recently launched Mental Health Initiative. This initiative’s mandate is, in part, to advocate for patients and families and to offer ideas grounded in best practice and evidence and informed by the frontline experience of BCNU’s members.

This document will focus on improving the experiences of Mental Health Consumers (MHC) and families as they travel through the mental health system. While the spotlight will be on innovative, successful programs and approaches from around the globe, the British Columbian (BC) mental health system will form a jumping off point for this discussion. MHCs and their families will be an important part of this document. However, the interventions explored and proposed will be geared at a systemic or structural level. This reflects the province-wide nature of the proposed initiative. Individual interventions will be reviewed, however only from the context of lessons that they provide to the system.

In an effort to generate a broad array of ideas, this literature review has been conducted in a scoping style. This means that the priority for the research phase of this document was to obtain a maximum amount of perspectives to inform the discussion.

Control Knobs for System Change

In understanding structural interventions in healthcare systems, one must start by understanding the ways in which policy normally affects those systems. The most universally utilized model for this is Hsiao’s (2003) “Control Knobs.” In this model, Hsiao (2003) proposes that the healthcare system is controlled by five adjustable policy inputs, which he conceptualizes as control knobs. These are financing, payment, organization, regulation, and behaviour. Each of these has impacts on the mental health system, and varying degrees of data were available on each of these points. The box on the next page provides a brief overview of what each of the five control knobs represents.
Health Care System Control Knobs

Financing. Financing is concerned about the way in which a healthcare system gathers money and resources to fund itself. Some systems do this through insurance schemes, others ask for out of pocket payments from clients, yet others derive their funds from general government revenue.

Payment. Payment is concerned with the way in which the system pays its providers, including nurses, doctors, and support staff. Some payment system examples include salary payments, as most nurses in BC receive. Others include fee-for-service models, which is how doctors in BC are paid.

Organization. Organization refers to the way in which a system organizes its services. This might include issues of integration, strong primary or secondary care focuses, or the way in which data is managed. For example, a decision could be made to create interdisciplinary care teams where MHCs have access to nurses, physicians, and counsellors. This would be an alternative to separate agencies which would independently provide nursing, medical, and counselling services.

Regulation. Regulation refers to ways in which individuals (both MHCs and care providers) are coerced into certain actions, or restrained from others. In the context of MHCs, this is most pertinent in relation to involuntary treatment. More broadly, it may refer safety standard regulations.

Behaviour. This final issue relates to the ways in which we can influence the individual behaviour of care providers and MHCs without the use of coercive measures. This may include things like ensuring that care providers are practicing according to the most recent evidence based practice, or that MHCs are taking better care of their mental health issues before seeking help.

(Hsiao, 2003)

This document will review the available data on each of these control knobs.

Methods

As mentioned previously, this document represents the findings of a scoping review of the literature. Primarily, resources were collected by searching the Simon Fraser University academic library for terms such as “Mental Health,” and “Best Practices.” Once data was analyzed, more focused sampling on key areas was initiated. For example, insufficient initial data was found on the subject of mental health law, and particularly, coerced treatment. Additional research into this area revealed the necessary information. Due to time constraints, this review does not represent an exhaustive exploration of the literature. However, it is felt that the data represented is saturated. This means that additional searches continue to return increasingly high levels of repeating information. Snowball sampling, where references in found articles are explored, was also used.
2. What is Best Practice?

Vanderber (2013) suggests that best practices cannot be viewed as a static, unchanging construct. Instead, four separate perspectives are proposed, which are grounded in different ways of knowing. First, Vanderber (2013) suggests the perspective of research evidence. From this perspective, best practice is interested in what amount of evidence can be weighed against what strength of evidence (Corcoran & Vanderber, 2013). If several large-scale or many small-scale studies show promising results for treatment A, and if the opposing treatment has less evidence, either in total quality or quantity, we can say that treatment A constitutes best practice (Corcoran & Vanderber, 2013).

This is a particularly useful approach to evaluating things like drug regimens, or other individual interventions, because the quality of each study is easier to measure and add up (ex: Sullivan, Antle, van Zyl & Faul, 2009). We can analyze these kinds of studies by looking at the size of the sample, the homogeneity of the control group, and the randomness of assignment to treatment groups. The best quality of study to inform best practices is the systematic review (Yaffe, 2013). This is significantly less possible, however, when discussing interventions which occur on national scales, like policy changes. In this context, homogenous control groups are almost impossible to create, random assignment to treatment groups is unlikely, and size of the sample is pre-determined by the scope of the policy intervention. In short, systematic reviews may not be feasible in this context.

To this end, Vanderber (2013) provides us with three other possible ways of looking at best practices. These are assessing the practitioner’s opinions, assessing the practice setting to see how the interventions work in the “here and now,” and finally, looking at general action plans that have been built with context in mind. Indeed, even when looking at individual interventions, it is necessary for best practice research pay close attention to the context in which the studied practice is likely to be applied (Corcoran & Vanderber, 2013). Issues such as individual MHC needs, organization values, and environmental strengths and barriers form part of the understanding of context (Regehr, Stern & Shlonsky, 2007).
Evidence Based Practice

A focus on context and practice driven information, however, should not exclude research from informing what best practices mean. What counts as admissible evidence in the judgement of best practices has changed and grown through time. Including research evidence in determining what best practices ought to be is foundational to good policy making (Corcoran & Vandiver, 2013; Manthey & Goscha, 2013). Despite this, research has consistently shown that, when it comes to health practice, the evidence base is frequently not considered (Glasgow, 2009; Gotham, 2004; Lehman, 2010). In fact, one study estimates the time for new research to reach the practice setting as 17 years from time of publication (Institute of Medicine, 2001).

Even once programs that are evidence informed are created, best practice approaches are difficult to maintain. A phenomenon that shall be termed Evidence Based Practice Drift, or EBP Drift, has been a documented occurrence in mental health programs. Most commonly noted in ACT model programs (discussed later in this paper), EBP Drift refers to the gradual departure from established best practices over time (Bond, 1991). In the case of well established methods of delivering programs, fidelity is the concept used to measure adherence to established approaches.

Spotlight: Evidence Based Practice

In the state of Kentucky, public mental health settings have begun using an integrated algorithm for deciding which medication would be most beneficial for which patients. In function, this appears to have eliminated much of the guesswork that physicians would have previously relied on. Additionally, it has integrated the best practice evidence into an easy to use tool, meaning that clinicians can access this information easily and effectively. Positive patient outcomes have been noted as a result of the introduction of this algorithm (Sullivan, Antle, van Zyl & Faul, 2009).

Implications: Because this program was piloted in a facility to which other facilities could be compared, and the intervention was a relatively discrete and well-defined, patient outcomes could easily be compared to a control facility, or the patient outcomes prior to the intervention. As such, this intervention is amenable to research evidence, and standardized testing should be pursued as the basis for informing best practices.

Furthermore, the study draws attention to the importance of knowledge translation tools for encouraging clinicians to follow best practices.
Recently at the Crossroads Unit, an inpatient adolescent forensic psychiatry centre, an extreme example of adherence to a treatment model was reported on. Under the rubric of adhering to the Attachment Model, an approach seen very positively in the research literature, the facility avoided the use of isolative techniques which are commonplace at many forensic institutions. The Attachment Model is based on the concept that building strong relationships with the MHC is invaluable to their recovery. The literature, in general, supports the use of this approach. The lack of isolation and safety techniques at the centre was subsequently explained as an effort to conform to this theoretical model of care. Unfortunately, this has lead to extreme safety issues for nurses, who have been repeatedly assaulted and traumatized. Adherence to the attachment model was so strict, that even the well evaluated use of consequences for unacceptable behaviour was abandoned, potentially endangering the MHC's recovery process. The CBC article covering this piece reports that nurses' insight into the problems of the facility has largely been ignored (CBC, 2014).

**Implications:** Despite the Attachment Model being very well evaluated in the literature, it had not been evaluated in a setting exactly like the Crossroads Unit. As a result, unintended negative consequences for both nurses and MHCs were apparent. An over-attention to the evidence base, without engaging the context of the situation, meant that the overall program was effectively not in line with best practices.
Since society started to address the issue of mental illness, mechanisms to treat patients against their will have been in place (Floyd, 2013). Coerced treatment of mental illness can take many forms. Most commonly, it refers to forced intra-muscular (IM) injections of medication, seclusion in an isolated room, physical restraint, and involuntary admission to a facility (Haw, Stubbs, Bickle, & Stewart, 2011). It can refer to either inpatient or outpatient treatment. Most jurisdictions in the United States, for example, have legislative frameworks in place for both inpatient and outpatient settings (Segal, 2012).

While laws permitting coercive treatment are meant to help patients, there are extensive examples of past abuses to coercive laws (Assembly Interim Committee on Ways, Means, Subcommittee on Mental Health, 1966). In fact, coercion in mental health has been described as a tool of detainment and social control (Arya, 2012). To this end, regulatory frameworks stipulating exactly when, where, and how MHC can be coerced into treatment is a central discussion under the topic of regulation in mental health best practices.

### Global Practices of Coerced Treatment

There is great debate about the efficacy of coerced treatment. Several pieces of literature suggest that coerced treatment has outcomes similar to voluntary treatment. Swedish involuntary patients undergoing addictions treatment, for example, are said to have the same success rate as voluntary patients (Lundren, Brannstrom, Armelius, Chassler, Moren, & Trocchio, 2012). Since these patients would have been unlikely to initiate or sustain treatment by themselves, this is seen as a positive outcome.

Similarly, in a case study of a private addictions treatment centre in Florida, voluntary and involuntary patients had similar rates of successful completion (Sweeney, Strolla, & Myers, 2013). Interestingly, no data was available about follow up or relapse rates in this case. In a United States study, prison inmates who were ordered to a drug treatment group were found to, sometimes, continue in the group even after their order to do so had expired. This has been interpreted...
as a positive outcome for coerced treatment (Farabee, Prendergast, & Anglin, 1998).

One study went as far as to link the ability to coerce mental health patients to decreased homicide rates. Segal (2012) suggests that in jurisdictions with broad certification criteria and effective mental health systems that can act on those criteria, homicide rates were lower when controlling for other social factors. Despite potential ecological fallacy in this study, this is certainly a promising finding in favour of coercive treatment.

Despite all this, the efficacy of coerced treatment remains highly contested. In the field of addictions, coerced treatment is associated with extremely high rates of relapse (Hall, et al., 2012). Whether the patient's buy-in is a pre-requisite to successful rehabilitation from addiction has been called “the great question” of the field (Sweeney, Strolla, & Myers, 2013).

The use of coercion is highly context driven, however seems to be less related to the patient’s needs and more related to the social environment. For example, regional differences exist in the most common types of coercive interventions used. While the UK is more likely to use chemical sedation with forced IM injections, the Netherlands is more likely to use seclusion rooms (Haw, Stubbs, Bickle, & Stewart, 2011).

The Codes of Coercion in Mental Health

The debate to decide when a person becomes certifiable is not new. As such, the topic has seen legal statutes formed in many jurisdictions to attempt to provide pragmatic answers to the question posed by this review. Although sometimes criticized as unclear, as in the case of Finland (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011), these provide mental health systems with their understanding of what constitutes a justifiable cut-off point for who is, and isn't certifiable. There is significant regional and international variation in these laws (Segal, 2012).

One such variation is whether or not drug abuse or addiction is seen as a legitimate mental health diagnosis that warrants certification. Drugs are included in certification legislation in many places including Florida (Sweeney, Strolla, & Myers, 2013) and Sweden (Lundren, Brannstrom, Armelius, Chassler, Moren, & Trocchio, 2012). Arya (2012) however indicates that very often drug-related disorders are excluded from certification systems. Further complicating matters is that these realities are not always perfectly defined in law. For example, BC has no formal, codified exclusion of addiction from the certification legislation (Legislature of British Columbia, 1996). However, BC clinicians tend to interpret the province’s Mental Health Act as meaning that addictions are excluded. As such, BC hospitals rarely accept psychiatric certifications on the basis of substance use.
Another major variation is whether the certification process is kept within the medical disciplines or whether it is routed through the court system. In Florida, an order from the court is required to initiate treatment. Such orders are usually requested by family members or the public prosecutor (Sweeney, Strolla, & Myers, 2013). What’s more, if a patient doesn’t comply with the order, they are found to be in contempt of court and can be imprisoned for up to 6 months (Sweeney, Strolla, & Myers, 2013). In the Netherlands, a health care provider who is providing care to the patient first initiates coercive treatment. However, such an order must immediately be reviewed by the court system (van der Post, Peen, & Dekker, 2014). In BC, the Mental Health Act allows for actions almost entirely devoid of court-based oversight, however the option to seek a judicial review is reserved for the MHC (Legislature of British Columbia, 1996). It is possible that court system oversight may provide additional protection to the patient by enforcing due process. Due Process is, according the WHO, a minimum standard for ethical implementation of coerced treatment (Porter, Arif, & Curran, 1986).

Advocacy organizations have also weighed in on the issue of broad or narrow certification criteria. The National Alliance for the Mentally Ill (NAMI) favours broader criteria, based on the belief that by the time a patient is a danger to themselves or others, the intervention is too late. They would prefer criteria that would allow for early intervention so that the patient would not have to become a danger to themselves or others before treatment begins (Public Policy Committee of the Board of Directors, the NAMI Department of Public Policy, Research, 2004). On the other hand, the Blazelon Centre for Mental Health Law argues that broader commitment standards encroach dangerously on civil liberties of MHCs. They suggest that other, less invasive but more costly interventions are possible. Because of this, they argue that expanding the criteria for certification unjustly targets MHCs for failures of the system (Bazelon Center for Mental Health Law, 2004).

Finally, some studies focus on the actual criteria used to judge whether an individual is certifiable. Segal (2012) notes that a major issue is in whether the criteria are narrow or broad. Segal (2012) defines narrow criteria as limited to the patient posing a risk to themselves or others. In the context of the United States, Segal (2012) notes that this criterion is universally present in the legislation of all US states and the District of Connecticut. Broader criteria, such as those permitting certification to protect the individual’s health, can also be found but are not as universal, at least in the case of the US (Segal, 2012). In Sweden, certification criteria demand that the patient require treatment (Lundren, Brannstrom, Armelius, Chassler, Moren, & Trocchio, 2012). In BC, the relevant legislation requires that individuals either be a risk to themselves or others or that treatment have likelihood to help (Legislature of British Columbia, 1996). In practice, these two criteria are often conflated as both being necessary, rather than either of them being necessary.
The Reality of Coercion in Mental Health

In many cases, law codifies exactly when and how someone can be compelled to receive treatment against their will. Despite this, coercion is not always used as intended by the relevant legislation (Minkowitz, 2006).

The Amsterdam Study of Acute Psychiatry (ASAP) is a large-scale investigation attempting to build predictive models for who is at risk of coercive mental health treatment (van der Post, Peen, & Dekker, 2014). Interestingly, it has been finding that social factors, rather than clinical indicators, are the best at predicting who is likely to be coerced into treatment (van der Post, Peen, & Dekker, 2014).

“Factors other than the characteristics of the [patients] themselves are associated with the use of compulsory care on them...(p 662)” (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011). While this quote refers to a study of adolescents only, it effectively summarizes the findings of several studies in this field.

The greatest predictive factors turned out to be limited social networks and first generation immigrant background (van der Post, Peen, & Dekker, 2014), second generation immigrant background (Lundren, Brannstrom, Armelius, Chassler, Moren, & Trocchio, 2012), and gender, in that women appear to be over represented in coercive treatment (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011).

Local mental health service availability was also seen as a predictive factor for coercive treatment. There is some debate about whether the availability of inpatient beds may increase certifications (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011). In Finland, administrative regions with more mental health inpatient capacity seem to accept a higher rate of people to coerced treatment. These regions, however, also have characteristically higher rates of social problems (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011). There is less debate about the role that outpatient and community services play in levels of involuntary treatment. Fewer supports in the community are broadly associated with higher rates of involuntary admission (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011; Fakhoury & Priebe, 2002; Priebe, et al., 2005; Korkeila, Lehtinen, & Tuori, 1998; Romansky, Lyons, Lehner, & West, 2003).

The idea that the main predictors of involuntary treatment are social, rather than medical, is reinforced by regional differences in coercion that cannot be accounted for by epidemiology or legislative frameworks. Instead, it is suggested that these differences are explained by demographics and mental health systems (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011). Not only are there regional differences in hard rates of involuntary treatment, but there also seem to be variation in what types of coercive treatments are preferred. For example, Sweden, Australia and the UK lean towards the use of chemical restraint through
involuntary IM injections. In the Netherlands, on the other hand, seclusion seems to be the preferred treatment (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011). It is theorized that this may be based on the work culture of the treating clinicians, rather than the needs of MHCs (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011).

One of the most common diseases responsible for involuntary admission is schizophrenia, which is understood to be a primarily biogenetically driven disorder that does not have a cure (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011). Since the use of coercion is justified as a part of treating a patient’s illness, it seems odd that the main predictors of the use of coercion would be social or cultural. Indeed, if schizophrenia is a medical or genetic disorder, and coercion is used to treat it, one would expect predictors for the treatment to be primarily biogenetic or clinical. Two solutions to this are readily visible: either the disease is more socially generated than is commonly believed, or there is a confounder that predisposes certain social groups and not others to being coerced into treatment, independently of clinical state. What’s more, involuntary treatment is also initiated to treat other, more socially derived conditions including conduct disorders, suicidal ideation, and substance abuse (Siponen, Valimaki, Kaivosoja, Marttunen, & Katiala-Heino, 2011).

A proponent of involuntary treatment may argue that, because schizophrenia is incurable, and is sometimes associated with violence, we must coerce patients to protect society from harm. This argument falls apart if the causes of the mental health violence are just as social as any other kind of violence and hence preventable by addressing social conditions rather than the coercion and oppression of the mentally ill.

One predictor of involuntary treatment stands out from the other social causes. This is that a history of previous involuntary treatment predisposes an individual to additional involuntary treatment (van der Post, Peen, & Dekker, 2014). This would seem to suggest that regardless of whether coercion is applied on a biological or social basis, the individuals making the decisions show signs of inter-rater-reliability.

**Implications**

Even when discussed optimistically, the use of coercive treatment is seen as a course of last resort (Lundren, Brannstrom, Armelius, Chassler, Moren, & Trocchio, 2012). Given that coercive treatment seems to be determined more by social environment than a patient’s medical situation, that its efficacy remains highly questionable, and that there are significant negative outcomes associated with it, it is safe to conclude that coercion should only be used extremely judiciously, and in the absolute minimum of cases possible. The criterion of harm to others seems to be the most universally justifiable for the initiation of coercive treatment, although the argument that we would want to pre-empt actual harm to others, and intervene earlier, is sound. Looking outside of healthcare, it may be that patients who cause harm to others may end up
in the criminal justice system. Diverting them away from jail and towards treatment, which may correct the illness that caused them to cause harm, seems logical. Despite these reasons to use coercion, it would seem beneficial to limit the degree to which the experience itself is coercive. Acknowledging patients’ voices could be a part of this. In their study, Floyd (2013) was able to find workable suggestions from patients who had experienced coercion. Namely, they wanted less involvement from the police, and a promotion of communication between the clinicians and the patient during certification. An effort to disambiguate legislation should be undertaken, in order to reflect best practices. Evidence would seem to suggest that a focus on harm to others, rather than focusing on the diagnosis (chemical dependence vs other mental illness) should be used. While British Columbia’s legislation is consistent with world standards, ensuring that clinicians have a suitable understanding of its content will also be important.
Financing & Payment

Financing

Financing is concerned with how a health system generates money and other resources for its use, and can include such things as general revenue or social insurance (Roberts, Hsiao et al., 2004). It bears mentioning, however, that due to significant equity issues amongst the MHC population, financing models which are highly redistributive and focussed on equity are seen as preferred approaches.

Generally, the most equity focused method of financing is general taxation revenue (Roberts, Hsiao et al., 2004). In this model, taxes which are collected are pooled, and a budget is created upon which health services can draw. It tends to be the most equitable because the taxation approach can be tailored to progressively affect higher income earners (Roberts, Hsiao et al., 2004). A common problem with this approach entails the possibility of governmental change. If a new government which doesn't prioritize healthcare is elected, budgetary changes may lead to financial pressures on the system (Roberts, Hsiao et al., 2004). A major concern with this is that because mental health tends to have a lower political, and arguably medical priority than other parts of the healthcare service, like emergency care or intensive care, generalized financing coupled with budgetary restrain will often mean significant cuts to mental health (dos Anjos Oliveira & Garcia, 2011).

A slightly less redistributive approach is the social insurance model. Here, the government operates an insurance fund which is mandatory for all citizens. The revenue stream is seen as somewhat shielded from political changes, promoting some stability in healthcare funding (Roberts, Hsiao et al., 2004). These systems tend to be, in most part, a flat tax that is based on population. This removes possible revenue from corporate taxation, and is generally less redistributive (Roberts, Hsiao et al., 2004).

BC’s model of financing is a hybrid between general revenue and social insurance. Unfortunately, some of the potential benefits of both approaches are not realized. While the Medical Services Plan (MSP), BC’s socialized insurance provider, does collect a relatively flat fee from most citizens, funds are not
earmarked for health, but rather enter general revenue, before a new general budget item reassigns money to MSP in order to make payments. While those living in significant poverty are excluded from having to make payments, middle income earners are not. This means that an average family that is economically struggling to support a mentally ill child would not be shielded from having to make MSP payments. Positively, income generated by MSP is supplemented through other revenue such as corporate taxation.

Most importantly, moves towards less redistributive models of financing should be avoided at all cost. Direct out of pocket payments, and private insurance models would almost certainly reduce access to services for individuals who need them most (Roberts, Hsiao et al, 2004). Any effort towards earmarking funds to be used specifically for mental health would be seen as positive, and would likely help reduce the volatility associated with general revenue funding (Roberts, Hsiao et al, 2004).

**Payment**

Approaches to payment are as important as financing. Payment is concerned about how money is provided to clinicians. Varying models include budget and salary, fee-for-service, or capitation. In relation to mental health in the British Columbian context, the question we must ask is what is the most important deliverable of the healthcare system? Different payment approaches possess different benefits and drawbacks. A chart is presented on the following pages defining the various benefits and drawbacks of each payment model.

As the chart demonstrates, payment systems are highly complex and choosing from amongst them requires careful consideration of what outcomes are desired. In many cases, hybrid models are employed in order to attempt to merge the benefits of several different approaches. This document is primarily concerned with the quality of care for MHCs and their families in the BC setting. To this end, clinicians on salary and budgeted systems seem best suited to the task (Roberts, Hsiao et al, 2004).
## For Clinicians

<table>
<thead>
<tr>
<th>Model</th>
<th>Benefits</th>
<th>Setbacks</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>Clinicians paid a standard amount regardless of how many patients they see.</td>
<td>Tends to increase the amount of time spent with each patient, and individual quality of care</td>
<td>No incentive for efficiency, prone to backlogged systems.</td>
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<tr>
<td></td>
<td></td>
<td>No incentive for efficiency, prone to backlogged systems.</td>
<td>Nurses and most NPs in BC are remunerated by salary models</td>
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<tr>
<td>Fee-for-service</td>
<td>Clinicians paid for each patient interaction.</td>
<td>Tends to greatly boost efficiency, incentivizing practitioners to perform as many services per day as possible</td>
<td>Tends to reduce the time with the patient, incentivizing shorter meetings to fit more clients in. The model is prone overtreatment, because it incentivizes more treatments.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Physicians and some NPs in BC are remunerated with a fee-for-service approach. Inpatient nursing care would be very difficult to adjust to this payment model, but not impossible, particularly as a hybrid model.</td>
</tr>
<tr>
<td>Capitation</td>
<td>Clinicians paid a regular amount for each individual registered to their care, regardless of whether they need treatment at that moment or not.</td>
<td>Connects providers’ financial risk to client outcomes. As such, this model incentivizes positive patient outcomes.</td>
<td>The model incentivizes seeing the patient less frequently, and as such is prone to undertreatment.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Capitation is not used in BC, however is used in Washington state and has an extensive history in Europe. Inpatient nursing care would be very difficult to adjust to this payment model, but not impossible, particularly in long term settings.</td>
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<tr>
<td>Model</td>
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<tr>
<td>Budgeted</td>
<td>Facilities receive a preset amount of money, likely based on the community’s needs and the size of the facility.</td>
<td>Tends to promote quality of care, extends the amount of time a MHC is associated to a facility. Least bureaucracy.</td>
<td>Most BC hospitals and mental health clinics operate based on budgets.</td>
</tr>
<tr>
<td>Fee-for-service, length-of-stay</td>
<td>Facility receives funds per patient, multiplied by the time spent in care.</td>
<td>Fairly compensates facilities for staff time, one of the most expensive expenditures in healthcare.</td>
<td>Tends to extend patient stays and does not compensate specialized treatments, meaning less treatment happens in a given amount of time.</td>
</tr>
<tr>
<td>Fee-for-service, admission</td>
<td>Facility receives funds per patient, per episode.</td>
<td>Provides financial incentive for efficiency.</td>
<td>Promotes undertreatment and premature discharge.</td>
</tr>
<tr>
<td>Fee-for-service, intervention based</td>
<td>Facility receives funds per patient, multiplied by the patients needs using a grading index which determines the severity of a patient’s needs.</td>
<td>Likely the fairest method of treatment.</td>
<td>Incredibly difficult to establish sufficient coding systems to accurately reflect the costs of each patient. Associated with massive bureaucracy which can impact the efficiency of a system.</td>
</tr>
<tr>
<td>Capitation</td>
<td>Facility receives funds per individual registered to their care, regardless of whether they are in need of treatment or not.</td>
<td>Incentive to keep patients away from facilities, and hence to provide better treatment and health promotion.</td>
<td>Often based on competitive contracts which can undermine total system efficiency. Relatively high level of bureaucracy.</td>
</tr>
</tbody>
</table>

adapted from (Roberts, Hsiao et al, 2004)
Section five of this document will explore the ways in which mental healthcare systems are organized, and the way in which staff and clients interact with those systems. These two points constitute the final considerations of Hsiao’s (2003) health system control knobs. Rather than organizing this section according to the traditional control knobs, organization will be guided by findings of the literature review. Three primary themes emerged from the literature: barriers, staffing, and integration. These will be discussed in turn.

### Barriers to Effective Mental Health Systems

As this document is meant to inform a process that has, as its goal, ameliorative change to the mental health system, a relevant body of research are the well documented barriers to change and implementation of new programs. As discussed previously, one major change barrier is a lack of balance between paying attention to relevant literature, and paying attention to the context of the proposed change. Even before understanding the context of the community, the organizational climate and culture of the providing organization must be understood (Patterson, Wolf, & Dulmus, 2012). Organizational culture is seen as having a major impact on how programs are chosen, implemented, and ultimately, how effective they are (Hemmelgarn, Glisson, & James, 2006). Glisson (1996) identifies ideological defensiveness as a major downfall to mental health program implementation. Instead, Glisson (1996) argues for effective support to staff during transition processes, to help diffuse defensiveness about established practices. Singer & Greeno (2013) advise against the use of standardized manuals universally throughout a system. In their words, unless a “manualized” program is created specifically for a certain practice environment, the experience of implementing what would otherwise be considered a well evaluated program is akin to a meeting of “Bambi and Godzilla.” Singer & Greeno (2013) don’t abandon the idea of systematized evidence informed programs, however. They recommend that program implementation should be undertaken by larger organizations rather than individual practitioners. They feel that larger organizations may have the capacity to appropriately inform practice through the evidence base.
FIVE WARNING SIGNS OF DE-ADOPTING BEST PRACTICES

Lack of resources
Lack of external support
Problems attracting and retaining qualified staff
Practice doesn’t match organization’s skills or values
Practice is perceived as temporary
Practice is too difficult to implement

-(Massatti, Sweeney, Panzano, & Roth, 2008)

One of the most critical issues emerging from the literature on access to mental healthcare is stigma. It is often conceptualized as an individualistic phenomenon. For example, Kondrat (2012) has found that due to MHCs’ experiences of stigma, many feel that they are not worthy of receiving treatment, and as such, do not seek it. It creates one of largest barriers for accessing health interventions. As important as this perspective is to understand, it is equally important to take a global view stigma, and how it is generated. In many cases, MHCs report feeling concerned about being judged by their care providers, particularly when first interacting with the system. They report feeling concerned that instead of their issue being conceptualized as a health problem, it may instead be seen as an issue of deficient self-care (Dickerson et al, 2006). Indeed, independent studies can verify alarming levels of stigma towards MHCs amongst care providers, particularly ones in a medically oriented primary care practice (Goldberg et al, 2007). In addition to restricting access to initial healthcare services, the perception of stigma has the ability to reduce the efficacy of treatment that is already in progress. MHCs often feel that they cannot ask their service provider to alter their medication regimen, even if they are experiencing severe side effects which require treatment (Gianfrancesco, Grogg, Mahmoud, Wang, & Nasrallah, 2002). This is all not altogether surprising, given that many primary care providers and other medically based clinicians feel that they do not have the adequate training to address mental health issues in their practice (Leigh, Steward, & Mallios, 2006). Training, or the integration of psychiatric clinicians into medical settings, is indicated. Additionally, system wide and society wide efforts to diffuse and eventually eradicate mental health stigma would be an important part of improving access.
Additional issues further complicate the matter of access to care. It has been found that not speaking a language in which mental healthcare is provided completely eliminates one’s chances of accessing most mental healthcare (Voelkel, LeCroy, Williams, & Holschuh, 2013). More generally than this, Voelkel et al. (2013) address the issue of culturally appropriate services. Although the access issues aren’t as stark as they are with language, cultural fit accounts for a great deal of the MHC’s ability to utilize a service. Voelkel et al. (2013) encourage us to consider a broad definition of culture, including one that encompasses income disparities. Services oriented toward medium and high income earners are unlikely to effectively engage MHCs living in poverty, and vice versa. To this end, culturally safe and specific services are advised (Voelkel et al, 2013).

Staff, the Foundation of Mental Health Services

The literature clearly establishes the primacy of the client’s relationship to their primary care provider as essential. A good working relationship, sometimes referred to as a therapeutic alliance, has been correlated with patients spending more time in treatment, and having a higher quality of life (Kondrat, 2012). What’s more, the issues of stigma discussed above can be mitigated by an effective case manager. An ineffective case manager can, in fact, exacerbate these issues and stand as a barrier to care (Kondrat, 2012). Nurses serving in the case management role require adequate time, mentorship and training in order to be effective (Kondrat, 2012). Unfortunately, a lack of organizational attention to burnout and compassion fatigue is also well documented in the literature. Overwhelming case loads and a lack of administrative supports have been seen as exacerbating these problems (Newell & MacNeil, 2010). While there may often be a perception that issues like compassion fatigue do not have direct patient outcomes, evidence connects patient’s subjective experiences of feeling “cared for” to better clinical outcome indicators (O’Hare & Sherrer, 2009). What’s more, human resourcing challenges, including inadequate staffing, have been directly tied to organizations’ inability to implement best practices (Manthey & Goscha, 2013).

The Right Place at the Right Time: Integration in Mental Health

Lack of coordination is seen as a fundamental issue in mental health services. Issues of geography are often seen to arbitrarily divide systems. Financial lack of integration can lead to administrative problems of equity between regions or disease groups. Organizational issues such as the sharing of data can lead to additional bureaucracy and time in providing services, and finally, strict focus on certain symptom groups and not others create inequity in services to certain MHC groups (Druss & Newcomer, 2007). Integration is generally thought of on two axis; vertical, and horizontal. Vertical integration refers to integration occurring between different levels of care, including primary, secondary, and tertiary, however often to do with the same symptom and disease grouping, or with the same service type. Horizontal integration on
the other hand refers to integration between different service types, different disease processes or even geographical integration (Conrad & Dowling, 1990). An example of vertical integration may be a program for schizophrenics of a particular region that integrates data sharing between community care, hospital, and long term facilities. Horizontal integration could be represented by an interdisciplinary team that provides medical, psychiatric, and counselling services to mental health patients more broadly. Both vertical and horizontal integration are achievable simultaneously, and can create their own issues in mental health.

One key issue of integration that emerges in the literature is that of medical services integrating to mental health services (Miller, Druss, Dombrowski, & Rosenheck, 2003). This is likely the result of funding structures sometimes being separated into differing streams (Brekke et al, 2013). While dedicated funding to mental health services is seen as positive, as discussed previously, measures should be taken to ensure that this does not preclude integration with health services. Physical illnesses, for example, are often overlooked in patients who are being treated for psychiatric reasons (Brekke et al, 2013). Part of this lack of integration has been identified as a training issue, where many mental health professionals lack the skills to identify critical physical illnesses (Brown, 1998). Preventative physical treatments, such as screenings of vaccinations, often take a back seat to immediate mental health symptoms. This in part leads to high levels of chronic illness, resulting in concerning co-morbidities and costs to the system (Bazelon Center for Mental Health Law, 2004).

Lack of training also exists amongst medical primary care providers in addressing psychiatric issues (Leigh, Stewart & Mallios, 2006). This is a particular problem in sub-urban or rural settings, where primary care providers may be more responsible for the care of MHCs, without access to specialized services.

Integrating housing services into mental health treatment is also seen as a hallmark of best practices (Padgett, Stanhope, & Henwood, 2011). The “Housing First” model has been exalted as one of the best approach for achieving positive client outcomes. In the context of this model, importance is placed on the key social determinant of housing, acknowledging that many MHCs encounter housing difficulties (Padgett, Stanhope, & Henwood, 2011). Transitional housing programs have also received positive attention in peer reviewed literature. Transitional housing provides aggregated services at the housing location to support the client’s movement from one housing setting to another. Particularly good results have been noted in transitioning MHCs from a hospitalized inpatient setting to standard housing through transitional housing programs. In one study, rates of rehospitalisation fell dramatically between a group that was discharged to transitional housing in comparison to a control group that went directly to standard housing (Uttaro et al, 2013). It should be noted that universal time limits on stays in transitional housing were associated with a higher rate of return to hospital. Transitional housing length of stay should be determined on a case by case basis (Uttaro et al, 2013).
Integrated health services must be designed with collaboration in mind. Indeed, policy decisions, and not staff culture, should be seen as the primary determinant of collaborative service delivery (Armstrong & Evans, 2010). Collaboration also requires the right balance of autonomy and accountability. Armstrong & Evans (2010) suggest that without any autonomy, clinicians are unlikely to take sufficient agency in their practice to truly collaborate. On the other hand, accountability structures which require collaboration are also seen as necessary. In all this, it is important not to miss the client’s voice, and acknowledge that collaboration should extend to the level of the client. Including the MHC in the process of making treatment choices wherever possible will help foster a therapeutic alliance that is likely to promote better patient outcomes (Kondrat, 2012). Client involvement should be clearly outlined in agency policy to promote follow through and establish boundaries within the therapeutic alliance. Again, autonomy should be granted to practitioners to establish client involvement, however practitioners must be accountable to ensure that clients are involved (Kondrat, 2012).

Spotlight: The Clozaril Spectrum Clinic

Certain psychotic MHCs who do not respond to treatment with standard antipsychotic medication may be treated with clozapine. Clozapine is an atypical antipsychotic medication, which has a low, but significant likelihood of triggering severe agranulocytosis, a clinical emergency. While clozapine has this very significant setback, it is also for some MHCs a very effective antipsychotic agent. Because of the significant risk, clozapine requires close follow-up with regular blood work. Unfortunately, follow up isn’t always possible, particularly if a client isn’t invested in care.

As a trial, the Clozaril Spectrum Clinic was established to see if clozapine could be safely administered in the context of a highly horizontally integrated team which featured nurses, social workers, and other associated disciplines. Results from the Clozaril Spectrum Clinic were amazing, both in terms of patient involvement in the mitigation of risks associated to clozapine, but also in terms of overall outcomes, which were seen as highly superior to other treatment models (Nisbet, Dulmus, Greyber, & Langa, 2010).

Implications: While it was the dangerous nature of the drug that prompted the Clozaril Spectrum Clinic’s design, it was its integrated, interdisciplinary, and collaborative nature that allowed for success. These approaches could be exported to other programs.
6. Lessons from the Clinical Setting

Significant time has been spent reviewing the structural themes that emerged from the literature review, informing Hsiao’s (2003) control knob model of healthcare systems. The literature from the field, however, is highly grounded in practice. This section will review studies from the clinical setting, and draw upon them to inform greater system change. This section will highlight select populations of interest. The populations were chosen based available and current literature. They should not be taken as an exhaustive list of all possible populations, nor should the literature associated to each population be seen as an exhaustive amalgamation of evidence for that field. Instead, this section is meant to serve as a cross-sectional snapshot of current research, and inform the reader of the general direction of the advancements in mental health policy.

Adolescents

Because adolescents' worlds and histories are somewhat smaller than adult patients', it is possible to analyze health interventions on a more microcosmic scale. For example, Montgomery, Kim, Springer, and Learman (2013), in a discussion of successful approaches to working with delinquent adolescents, concede that the majority of the work tends to be focused on ameliorating the social circumstances of child. Family life, school, and social groups are examined for structural influences that are causing the MHC to act out. As these structures are somewhat more manageable than adult issues such as career and civic engagement, it is possible to change the MHCs' material circumstances, and make major improvements (Montgomery et al, 2013).

Adolescents are more likely than adults to experience significant short and long term consequences if they do not receive timely treatment, however, adolescents have a low adherence rate to treatment in general (Block, Gjesfeld, & Greeno, 2013). Qualitative studies show that adolescents are concerned with stigma in the same way as their adult counterparts. They are particularly concerned with autonomy in their lives and their treatment. This manifests, in part, with a distinct desire for confidentiality from their parents (Block, Gjesfeld, & Greeno, 2013). Addressing low adherence rates and desires for autonomy are seen as possible. Involving youth in both guiding their own care (Matarese, Carpenter, Huffine, Lane, & Paulson,
It is important to note that in caring for a MHC family member, caregivers can experience the same burnout and compassion fatigue experienced by service providers. It is hence important to provide supports to the family not only to support the MHC, but also to support the mental health of the family (MacNeil & Jaggers, 2013). Families can be supported through participation in conferences, training (Koroloff, Jivanjee, Slaton, Schutte, & Robinson, 2004), or psychological approaches like the “banking positives” method (MacNeil & Jaggers, 2013).

**Hoarding**

A particular interest in both research and lay media has developed over the phenomenon of hoarding. Individuals who struggle with a hoarding disorder rarely seek services, however pose a significant risk to themselves and the public health of their living environment (Bratiotis et al, 2013). Only about 20% of hoarders are connected with mental health services at the time their condition becomes apparent, meaning that for the most part, individuals are not receiving appropriate support (Bratiotis et al, 2013).

The state-of-the-art framework for addressing issues of hoarding has been termed a “Hoarding Task Force,” (Bratiotis, 2012). This is an interdisciplinary team of mental health professionals, city inspectors, fire marshals, cleaners and other relevant service providers that are connected in order to cross-refer, and collaborate on cases. They are generally led and coordinated by community mental health services, and...
as of 2012, 75 such teams existed in the United States (Bratiotis, 2012, Bratiotis et al, 2013). This approach has been highly successful, strongly mitigating the risks of hoarding in larger cities (Bratiotis, 2012, Bratiotis et al, 2013). Approaches to hoarding highlight the importance of interdisciplinary collaboration, and its effectiveness.

Forensics

For the purposes of this paper, forensics refers to criminality in the context of mental illness. Severe mental illness is over-represented in the prison population (Lamberti, Weisman, & Faden, 2004; More & Hiday, 2006; Steadman, Osher, Robbins, Case & Samuels, 2009; Torrey, 1995). This could be accounted for by one of two constructs, or a mixture of both. First, individuals living with mental illness are predisposed to other social issues including poverty, substance use, and precarious housing, which are themselves correlated to criminality (Frank & McGuire, 2010). Second, that mental illness is itself coming to be conflated with criminal behaviour, particularly outside of the supported context. For example, an individual dealing with schizophrenia may be identified as causing a public disturbance (Teplin, 1983). In either case, it is believed that the recent increases in the imprisoned mental health population are as a result of a process known as transinstitutionalization. This is seen as a by-product of the deinstitutionalization movement. The theory suggests that, now that many MHCs don't have access to the protection of asylums, many bounce between the community, inpatient psychiatric treatment, and

**Spotlight: Assertive Community Treatment**

One of the most exciting treatment models that has emerged in the last decade is Assertive Community Treatment, or ACT. This model is based on the idea that a comparatively narrow service provider to MHC ratio, paired with a strong yet small interdisciplinary team can have significant advantages. The model draws on concepts of providing wrap-around services that meet most of the MHC's needs, including housing and a very high level of support. Despite the initial cost of implementing such a program, it has been identified as incredibly cost efficient. This is because in treatment of MHCs who frequently use the emergency department, this approach has been able to divert a significant amount of hospital interactions. The same is true for MHCs with frequent contact with the criminal justice system. Most importantly, ACT style programs report excellent patient outcomes as well (Lamberti, Weisman, & Faden, 2004)

**Implications:** While ACT is incredibly promising for treatment of individuals with significant struggles with street entrenchment, substance use, criminal involvement, and very severe mental illnesses, it should not be confused as appropriate for all mental health treatment, as it would likely be too involved for many patients. ACT’s success with integrated, holistic and collaborative care should be extrapolated to other programs where possible.

Addressing this issue is similar to preventing inpatient hospitalization, described above. In fact, contacts with the criminal justice system are positively correlated to mental health emergency room visits (Constantine et al, 2011). It is well established that access to community mental health services reduces arrest rates (Domino, Norton, Morrissey, Thakur, 2004; Morrissey, Cuddeback, Cuellar, & Steadman, 2007). The process of criminalization often begins in youth, and is more firmly in place in adulthood, therefore services should be geared towards strong interventions for youth (Banks, Pandiani, & Boyd, 2009). Because criminal incarceration is, similarly to coerced hospitalization, based more closely on social factors than current clinical state (Case, Steadman, Dupis, & Morris, 2009), interventions should focus on social determinants such as housing, poverty, and social support networks (Ringhoff, Rapp, & Robst, 2012). Established best approaches to forensics call to attention our need to focus on social determinants, and take into account processes such as deinstitutionalization.
This section is a synthesis of the evidence presented above, reducing the concepts into succinct trends in the field. It will serve as a unified presentation of the key developments in mental health best practices.

The mental health paradigm is shifting towards a holistic perspective. As our understanding of mental illness grows, we have come to see the problems associated with it in a much more holistic way. Mental illness is no longer understood simply as a constellation of psychiatric symptoms, but rather, as a dynamic picture of the Mental Health Consumer’s (MHC’s) life. To this end, it is important to consider the MHC’s housing, family, social support network, and other pertinent determinants. This is particularly important against the backdrop of deinstitutionalization, which for better or for worse, has generated an immense shift in mental health policy.

The evidence indicates that best outcomes for MHCs aren’t attained simply by offering the newest medications and the latest blood tests. Structural, as well as individualistic, approaches are necessary to solve to problems that MHCs face today. Promising evidence is coming to light about approaches such as Housing First, which prioritizes housing access ahead of other, more traditional psychiatric treatment. While we know that a strategy to reduce poverty is unlikely eliminate hallucinations for a schizophrenic individual, we know that it is likely to significantly reduce their chances of coerced hospitalization, and criminal arrest. Not only can this in itself be seen as a positive patient outcome, but it additionally frees up resources to other MHCs who may need them urgently.

We now know that an integrated and interdisciplinary team is the heart of an effective mental healthcare system. The approach of dividing different disciplines, such as nurses, physicians, social workers and counsellors has not served patients well. It has created a fragmented system that is difficult to navigate for the MHC and discouraging to the family. Primary care providers who either have a mental health professional on their team, or have sufficient training to coordinate care effectively are more likely to produce better outcomes for MHCs. Conversely, mental health care providers who have access to medical staff on their team, or sufficient training, are less likely to miss
critical, preventable health issues. Avoiding an over-reliance on bio-medical approaches, and involving either counselling training or counselling staff is also a direction with a critical need for expansion in mental health services.

While coercion is at times a necessary, justifiable approach in mental health care, it is clearly associated with highly negative patient outcomes. In developing systems for managing coerced patients, attention to ensuring efficacy, humaneness, and protection of due process is critical. Closely monitoring the system for how policy is implemented is important to understand possible differences between prescribed and actual practice.

How a mental health program is implemented is as important as its design. We now understand that the best designed program which doesn’t have a well-developed implementation strategy is not well designed at all. A program or project must not only be based on the best empirical research available; it must also consider the context of the organization in which the program will be launched, and the MHC’s social environment. Even once changes are implemented, the phenomenon of Evidence Based Practice Drift may occur, where practices are slowly changed or abandoned on account of limited follow up from the implementation. Change and best practices should not be conceptualized as overhauls that occur from time to time. Instead, best practice, informed by both evidence and context, should become a cornerstone of organizational culture.
8. Conclusion & Next Steps

This review should not be seen as an exhaustive review of all literature. Instead, it has provided a brief overview of the mental healthcare system, its components, relevant problems and successes found through an extensive review of the literature. Each field in mental health could easily be explored in this depth again, as could each individual practice. Initiating specific change will require discussion with front line workers, MHCs, and key community partners to build context based consensus going forward.

While further research is warranted, this document is meant to inform the BCNU’s Mental Health Initiative. A discussion paper, which connects the best practice findings to the goals of the organization, would likely provide a fruitful point to engage in further deliberations on this subject.
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