

## Knowledge Notes

### **System Level Performance for Mental Health in Alberta**

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#### **Objectives**

To measure the effectiveness of the mental health system.

#### **Background**

The Alberta Provincial Mental Health Plan (2004) called for an increased focus on measuring the effectiveness of the mental health system, which the Alberta Mental Health Board (AMHB) was asked to lead.

#### **Method**

Measures were selected from each of the six domains in the Alberta Quality Matrix for Health, using measures specific to mental health.

#### **Results**

##### *Satisfaction*

Client perspectives of satisfaction with services are an important component of measuring the effectiveness of health care programs. Previously-defined regional health authorities assessed at least a portion of their program recipients, and results are consistent with internationally published findings. The majority of clients surveyed indicated they were satisfied with the mental health services that they received. Ratings from over 3,000 individuals or families were reported, with results typically reaching 80% satisfaction. Results are used to inform the cycle of change in program delivery, and regions were encouraged to share the positive ratings with staff as part of the effort to recognize their positive contributions.

##### *Budget*

There are no existing standards in Canada with which to compare Alberta's per capita investment in mental health services. The budget for mental health services across the nine health regions approached \$476 million, or \$140.62 per capita. Measured over time, the per capita amount will indicate whether mental health dollars are protected and keeping pace with the increasing burden of illness attributable to mental disorders. Standards for mental health spending amounts and proportions are necessary, given that there is considerable variation between the nine regions. Comparison to other jurisdictions may reveal insights into establishing minimum investment. Of the regional budgets presented in this exercise, the proportion allocated to community-and facility-

based services is 53% and 47%, respectively. This trend is in keeping with mental health reform in moving towards greater investment in community-based programming. As with other areas of health, a push towards more spending on the front end of the continuum (i.e., health promotion, education, prevention and early intervention) is encouraged.

Many services necessary for recovery-based programs are not funded through health but are essential to a continuum of care (e.g., housing, psychological treatments, rehabilitation). It will be important to measure the cost effectiveness of these as well as other changes in focus for the mental health system.

#### *Effectiveness*

While clients report satisfaction with services, there is little ability to comment provincially regarding the effectiveness of the services provided. This is due largely to the relative scarcity of clinical and functional outcome measurement information provided. In those regions where outcome data was provided, a variety of programs and populations demonstrated measurable clinical improvement following treatment. Outcome measurement activities need to be advanced across the province. Programs that are similar in design and purpose should use comparable evaluation measures. Advancing measurement in this domain should be priority.

#### *Shared Care*

The province is starting to engage family physicians in mental health shared care. This is encouraging, given that more than 500,000 Albertans see a physician each year for mental health problems, and most (over 80%) see a family physician only. To date, around 750 family physicians in the province are involved in some type of shared care arrangement. The type of shared care model and the level of formality in the model vary by region. All regions report that processes are in place to reach family physicians, with varying degrees of success. A particularly encouraging finding is that of the 75 physicians surveyed to date, 80% indicated that their shared care relationship met or exceeded their expectations, and over 70% indicated that their clinical skills had improved. Moving forward, a clearer definition of what is meant by shared care, along with more precise targets and timelines for developing relationships, and a formative evaluation of existing successful models, will assist in advancing this initiative.

#### *Access to Services*

Over the past four years, there was a 24% increase in the number of Albertans accessing a regional mental health service. Considerable accomplishment has been made in the ability of health regions to measure access to select components of the mental health system, especially in the area of children. With respect to the approximately 40,000 Albertans who use community mental health clinics, the median (average) wait was ten days for enrolment into service. However, in approximately 18% of cases, the wait was greater than one month. Wait-times vary with age group, with older Albertans receiving services sooner. Quantifying the wait-times from primary care referral to a specialist, developing subsequent standards and assessing the satisfaction of referral sources are

important future activities. Currently, children are assessed using a standard urgency rating as part of the “Coordinated Access Standards for Children’s Mental Health Services”, which assists in ensuring that those in most urgent need of care are seen first. Developing access standards that include urgency ratings for all populations is a logical next step.

### *Continuity of Care*

Throughout the province, regions have various processes in place to coordinate the discharge of patients from hospitals and to initiate follow-up services, including the use of innovative approaches such as telehealth. Continuity is an important and challenging task within the multiple levels of providers and complexity in mental health service delivery. Failure leads to unnecessary readmission and relapse due to breakdowns in care. It will be important to understand which processes are most effective at maintaining continuity of care and to implement those processes provincially. We will be able to evaluate this domain more comprehensively when it receives the necessary detailed data from Alberta Health and Wellness.

### *Efficiency*

Limited access to appropriate, supportive housing is the foremost barrier to discharging patients from hospital. The result is that patients are staying in hospital beyond what is clinically necessary, contributing to unnecessary costs and creating blockages for those in need of inpatient services (in two regions, 20% of mental health beds were blocked with patients whose condition could have been managed in a less resource-intensive level of care). As housing for the mentally ill is a nationwide issue, stakeholders from various agencies and ministries will need to collaborate to resolve the challenges. Preliminary positive responses to this complex issue have been shown in Mental Health Innovation Fund projects in four regions.

### **Conclusions**

We anticipate that next steps will include refining the measures, implementing standard collection and reporting, determining targets for various measures, and using a consensus approach to identify and implement best practices to facilitate improvements in the performance of the mental health system.