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MENTAL HEALTH SERVICES

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STUDY: BRITISH COLUMBIA TOPS EVERY STATE IN QUALITY OF MENTAL HEALTH SERVICES

Province's per capita costs lower than those in eight states

WASHINGTON, D.C.-- Mental health services for individuals with serious mental illnesses are better in the Canadian province of British Columbia than they are in any one of the 50 American states, according to a report released today by the Public Citizen Health Research Group.

The report, the first ever to measure the differences between Canadian and American mental health services, also found that British Columbia was rated as high or higher than any American state and twice as high as 40 states in each of the five categories making up the overall rate: hospital care, outpatient care, rehabilitation, housing, and children's services.

Meanwhile, the province delivers its superior services at a per capita cost lower than those in eight U.S. states, according to the study.

The study was carried out in March 1993 by Dr. E. Fuller Torrey of the Public Citizen Health Research Group staff in collaboration with Dr. Douglas A. Bigelow, Director of Clinical Services, Alcohol and Drug Programs, British Columbia Ministry of Health and Dr. Nicholas Sladen-Dew, Associate Medical Director of the Greater Vancouver Mental Health Service Society.

The results were presented at the annual meeting of the National Alliance for the Mentally Ill in Miami, Fl.

The study rated services in the province on a 0 to 5 scale. British Columbia's total score was 21 out of a possible 25 points. The results were compared to a 1990 survey of the 50 states (E.F. Torrey et al., Care of the Seriously Mentally Ill: A Rating of State Programs), in which Vermont ranked highest of the states with 17 points, followed by New Hampshire and Rhode Island (16 points), Connecticut and Ohio (15 points), and Colorado (14 points).

British Columbia would rank 9th in per capita costs ($58.87 in comparable U.S. dollars) behind New York ($118.34), Massachusetts ($83.91), Michigan ($73.73), Connecticut ($72.81), Alaska ($72.24), Maine ($67.29), New Hampshire ($63.37), and Maryland ($61.21). The average per capita cost for all 50 states in 1990 was $48.35. [See table, attached.]

When both quality of services and cost of services are considered, British Columbia (21 points; $58.87 per capita) is delivering services that are twice as good at the same cost as Pennsylvania (10 points, $56.85 per capita), almost twice as good at half the cost as New York (12 points, $118.34 per capita), and three times as good at 25 percent more than Indiana (7 points, $47.05 per capita).

The study did not attempt to compare British Columbia to the other Canadian provinces, or other Canadian provinces to the United States.

The report cites three principal reasons for the relative superiority of services for seriously mentally ill individuals in British Columbia over any of the states:

1) Single source funding: The Canadian single-payer system has much lower administrative costs, no cost shifting, and better continuity of patient care than the United States. In the United States the responsibility for funding and bill-paying is divided among state, local and federal government. Despite the fact that the federal government in Canada contributes approximately 40 percent of the cost, all responsibility for the care of mentally ill individuals in Canada is fixed at the provincial level.

(more)

2) Clearer mandate: In British Columbia, individuals with serious mental illnesses (e.g. schizophrenia, manic-depressive illness) are given greater priority for services than they are in the United States.

3) More comprehensive: In British Columbia, services such as housing and rehabilitation are considered to be more integral to mental health services than they are in the United States.

"There is no question that average persons with a serious mental illness are better off in British Columbia than they are in any American state," said Dr. Torrey. "Although far from perfect, the services there are better organized, more equitably distributed, and of higher quality.

"Until the United States adopts a single-payer system, it will lag woefully and dangerously behind Canada in providing services for the seriously mentally ill."

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Public Citizen, founded in 1971, is a nonprofit consumer advocacy organization with more than 150,000 members. The Public Citizen Health Research Group was founded by Dr. Sidney Wolfe and Ralph Nader in 1972.

Copies of the study, Quality and Cost of Services for Individuals with Serious Mental Illnesses in British Columbia Compared to the United States, are available for $10.00 from Public Citizen, Publications Dept., 2000 P St. NW, Suite 650, Washington, D.C. 20036.

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British Columbia Compared to the Most Highly Rated States in Services for Individuals with Serious Mental Illnesses

Rating on Quality of Services (total points out of 25)		Per Capita Cost, 1990 (in U.S. dollars)	
British Columbia	21	New York	118.34
Vermont	17	Massachusetts	83.91
New Hampshire	16	Michigan	73.73
Rhode Island	16	Connecticut	72.81
Connecticut	15	Alaska	72.24
Ohio	15	Maine	67.29
Colorado	14	New Hampshire	63.37
New York	12	Maryland	61.21
North Carolina	12	British Columbia	58.87
Wisconsin	12	New Jersey	57.16
Utah	11	Pennsylvania	56.85
		Minnesota	55.44

(All other states had 10 points or less)

Quality and Cost of Services for Individuals with Serious Mental Illnesses in British Columbia Compared to the United States

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Table of Contents

Abstract....................................2
Methods.....................................5
Results.....................................8
Hospitals...................................9
Outpatient & Community Support..............11
Housing.....................................17
Children's Services.........................19
Total Score.................................20

Discussion..................................21

Tables

(1) Comparison of British Columbia with best of the United States........................27

(2) Per capita cost of mental health services...29

References..................................30

Abstract

Objective: The quality and cost of services for individuals with serious mental illnesses in the Canadian province of British Columbia (3.2 million people) were compared to the 50 states.

Methods: A survey of selected psychiatric facilities, data from the Ministry of Health, and information from families and consumers were assessed using methods similar to those used in a 1990 survey which rated services for individuals with serious mental illnesses in the 50 states. Separate scores were given for hospitals outpatient, rehabilitation, housing, and children's services.

Results: Despite having some significant problems, British Columbia still scored higher than any single state in the United States and more than twice as high as 40 states on the quality of services. The Greater Vancouver Mental Health Services, covering 600,000 people, is especially impressive. On cost per capita, British Columbia ranked 9th among the states. When quality and cost are combined British Columbia, compared to New York State, appears to be delivering services almost twice as good at approximately half the cost. Measures such as readmission rates, diagnostic caseloads of mental health centers, percent of homeless who are seriously mentally ill, and suicide rates support the superiority of services in British Columbia

over the United States. There are recent indications, however, that British Columbia's services may be deteriorating.

Conclusions: Probable reasons for the superior services in British Columbia include single source funding, a stronger mandate to treat seriously mentally ill individuals, and a more comprehensive approach. It is concluded that the Canadian health system, as implemented in British Columbia, has definite advantages for individuals with serious mental illnesses.

The Canadian health care system was implemented in the 1960s to provide universal coverage for all Canadians. All hospital and physician bills are paid by a single source payer, the provincial government, although the government does not own the hospitals and most physicians are not government employees. Citizens are given health cards which can be used to obtain services from any physician or hospital although access to medical specialists must be through referral by a general practitioner. The system is financed by taxes with approximately 40 percent of the funds coming from the federal government. As long as they meet broad federal guidelines for services, each of the ten provinces may implement its own program and there are differences between them; for example, Quebec is the most decentralized, and Saskatchewan is the only province that covers the total cost of all prescription drugs for everyone.

Despite widespread interest in the Canadian health care system among American health analysts and planners, comparatively little has been written about Canadian psychiatric services. The few studies which do exist suggest that the Canadian system focuses more resources on individuals with serious mental illnesses, uses hospitalization less frequently, provides better rehabilitation for discharged patients, and has lower administrative costs (1-3); however it also appears to share many shortcomings with its American counterpart (4).

Public psychiatric services in the United States have been criticized for failing to treat individuals with serious mental illnesses, resulting in high rehospitalization rates (5); large numbers of seriously mentally ill individuals in jails (6), prisons (7), and among the homeless population (8); and increasing episodes of violent behavior by mentally ill individuals when they do not receive treatment (9). Comparing American and Canadian psychiatric services provides an opportunity to better understand the strengths and weaknesses of each system and to incorporate whatever can be learned into the ongoing debate about health care reform. For this reason we undertook a survey of psychiatric services in one Canadian province, British Columbia, and compared their quality and cost to a previous survey done for each of the fifty states (10).

Methods

British Columbia was selected for the study because of existing psychiatric care data bases which have been used in the past to compare British Columbia to Oregon (3) and the city of Vancouver to Portland (2). It is not known how representative British Columbia is of the other Canadian provinces although it is known to spend a greater proportion of its provincial mental health budget on services in the community than any province except Saskatchewan (4, 11).

To compare psychiatric services in British Columbia to the states, the senior author spent two weeks in March, 1993,

surveying selected psychiatric facilities across British Columbia. The facilities visited included those identified by families and Ministry of Health officials as providing good services as well as those said to be having problems. Facilities were included from Vancouver (20 percent of total provincial population), Vancouver Island (18 percent), and the Okanagen-West Kootenay-East Kootenay rural area (15 percent). Except for a single group home, no facilities were visited in the Fraser Valley-North Shore region (33 percent), Burnaby (5 percent), or the North (9 percent). The senior author was given access to all available published and unpublished Ministry of Health data including comparative diagnostic data for patients in all mental health centers.

Data was collected as much as possible to coincide with the 1990 survey of state services for individuals with serious mental illnesses (Care of the Seriously Mentally Ill: A Rating of State Programs) (10). The British Columbia survey was therefore restricted to these same diagnostic groups (schizophrenia, manic-depressive disorder, severe depression, and related disorders) and no effort was made to assess services for individuals with other diagnoses. To solicit information on services from consumers and their families, a letter was sent to the British Columbia Schizophrenia Society requesting its members to submit information on a confidential basis; 26 individual and 2 group replies were received representing a total of approximately 50 individuals.

Cost data for British Columbia was obtained for the same year (1990) using the same data collection forms as state data recently published by the National Association of State Mental Health Program Directors (12). To facilitate comparisons, Canadian dollars were stated in terms of U.S. dollars by utilizing an exchange rate of $1.00 U.S.= $0.83 Canadian. The collection of comparable cost data was helped immeasurably by the fact that one of the authors (D.A.B.) has worked on mental health cost data both for British Columbia's Ministry of Health and for Oregon's Department of Human Resources.

The quality of services for seriously mentally ill individuals in British Columbia was evaluated using the same categories as the 1990 survey of the states: hospitals, outpatient and community support, rehabilitation, housing, and children's services. The evaluation also utilized the same 0 (worst) to 5 (best) scoring system for each of the categories as defined in the 1990 survey (10). In addition the evaluation and scoring was done by the same principal scorer (E.F.T.) as was the 1990 survey.

In making comparisons it is useful to remember that British Columbia's population of 3.2 million places it in the same population category as states such as Colorado, Connecticut, and Oklahoma (all 3.1-3.3 million). The population of Vancouver and Richmond, B.C., served by the Greater Vancouver Mental Health Services (GVMHS), is 600,000 which is similar to cities such as Memphis (610,000), Washington, D.C. (607,000), and Boston (574,000).

Results

Inpatient psychiatric services in British Columbia take place in the 900-bed Riverview Hospital and in 742 psychiatric beds in general hospitals with units ranging from 9 to 83 beds. Outpatient services are delivered by 60 mental health centers. Of British Columbia's 373 psychiatrists, 87 percent are concentrated in the urban areas of Vancouver and Victoria; the majority work independently on a fee-for-service, which is equivalent to private practice in the United States, and are reimbursed by the Ministry of Health at $90 per hour. A minority work in 3.5 hour time blocks called "sessions" in hospitals or mental health clinics and are reimbursed between $64 and $76 per hour. The mean annual net income of psychiatrists in British Columbia in 1991 was approximately $100,000 US compared to a mean annual net income of psychiatrists in the United States of $127,600 (13). There are 2,517 psychiatric nurses working in British Columbia; some have training as R.N.s and others have a Diploma of Associate in Psychiatric Nursing. Psychiatric nurses play a significantly larger role and psychiatric social workers a smaller role than in the United States.

Under the Ministry of Health's Medical Services Plan psychiatrists are reimbursed for both medical services and psychotherapy by means of a simple 4 inch by 8 inch claim form. General practitioners are also reimbursed for psychotherapy which they do much more commonly than their American counterparts.

Psychotherapy and counseling by psychologists and psychiatric social workers are not reimbursed under the Medical Services Plan although some counseling is provided by psychologists and social workers in social service facilities and schools administered by the Ministry of Social Services and the Ministry of Education. In addition private psychotherapy and counseling in which the individual pays the entire cost is available in urban areas.

Hospitals in British Columbia (4 points):

For psychiatric hospitals British Columbia scored 4 out of 5 points, as did Colorado, Nebraska, New Hampshire, and Utah (Table 1). Inpatient psychiatric services are generally of high quality both in Riverview Hospital and in the psychiatric units of general hospitals. Because psychiatrists are concentrated in the urban areas of Vancouver and Victoria, rural hospitals rely heavily on general practitioners to provide psychiatric care. One program which has partially ameliorated this situation is a pairing of psychiatric units in Vancouver hospitals with psychiatric units in 20 rural hospitals. For example, Cranbrook Regional Hospital, covering a rural area of 65,000 people 500 miles east of Vancouver, has a modern 20-bed unit staffed by a psychiatrist and 3 general practitioners; once a month a psychiatrist from Vancouver's Shaughnessy Hospital visits for consultation and education.

One particularly impressive inpatient facility is Venture, a 20-bed short-stay (average: 9 days) large attractive house in

Vancouver which was built specifically to be an unobtrusive psychiatric inpatient unit. It is an integral part of the GVMHS system with joint staffing, shared patient charts, and excellent continuity of inpatient-outpatient care. Burnaby, a suburb of Vancouver, also provides good inpatient-outpatient coordination because its 25-bed inpatient facility is administratively integrated with outpatient care.

These examples are exceptions, however. Most inpatient psychiatric units in British Columbia are administered completely separately from mental health centers and the lack of coordination between the two is one of the major deficiencies in the province's mental health system. For example, in Vancouver a GVMHS outpatient team can expect to have a discharge summary the day following a patient's discharge from Venture which is part of the GVMHS system. But if the patient was hospitalized on the psychiatric unit of Vancouver General Hospital, a discharge summary may not become available for three months. In some rural towns professionals cooperate and hospital-mental health center coordination is good; in other towns such as Trail the professionals do not cooperate and coordination is severely impaired.

Another major problem affecting inpatient care is the increasingly stringent criteria required in British Columbia for involuntary psychiatric admissions. Although the Mental Health Act still permits "need-for-treatment" as a criterion for involuntary admissions, civil rights activists have effectively

abolished its use. As a result, the number of seriously mentally ill individuals among the homeless population and in jails is slowly increasing. There is also no outpatient commitment law, as is available in the majority of states although it is little used. Insuring that discharged patients continue to take their medication can also be affected through "extended leave" provisions of hospital discharges; although this was used in the past and is still theoretically possible in British Columbia, it is currently rarely used.

Clozapine, a new but very expensive antipsychotic, is widely available and there are no fiscal restrictions on its use; however, British Columbian psychiatrists appear to be less enthusiastic than are their American counterparts regarding its efficacy.

Outpatient and Community Support in British Columbia (5 points)

For outpatient and community support services, British Columbia scored 5 out of 5 points; only 3 states scored as many as 4 points (Table 1). Outpatient services are exemplary in British Columbia, especially in Vancouver where GVMHS appears to provide better outpatient care than is available in any urban area in the United States. GVMHS began in 1972 as part of Dr. John Cumming's "Vancouver Plan" for mental health services and consists of 9 multidisciplinary teams, each with approximately 25 members, its own catchment area, and its own global budget. Together they serve a total of 600,000 people. The city is

ethnically diverse with 40 percent of the population speaking English as a second language, and teams in highly ethnic neighborhoods have developed culturally-appropriate services, e.g. Chinese language groups, Punjabi mental health workers.

GVMHS has an active caseload of 4,700 adults and children and evaluates 7,000 new referrals each year (14). Of the active caseload 72 percent have been previously psychiatrically hospitalized; 70 percent have schizophrenia, major affective disorder, or an organic psychosis as a primary diagnosis (15). GVMHS views serious mental illnesses as its most important mandate; in fact it has been criticized by some community groups for focusing too exclusively on serious mental illnesses and not allocating sufficient resources to eating disorders, personality disorders, and other diagnostic categories. Staff turnover at GVMHS is very low by American standards; between 1973 and 1988 the annual turnover was 2 percent for social workers and 4 percent for psychiatric nurses.

GVMHS contracts with non-profit organizations for some services and delivers other services directly. Especially difficult patients are followed by a multi-service network which coordinates treatment from corrections, forensic services, social services, alcohol and drug abuse services, and mental health (16). Another interdisciplinary program, the inter-ministerial project, provides intensive case management for 50 seriously mentally ill individuals who also have been arrested. GVMHS also operates an outreach program for the Vancouver City Jail and a

store front drop-in center (The Living Room) which is open daily to serve individuals who are homeless.

Emergency psychiatric services for GVMHS are provided by Car 87, an unmarked police car staffed jointly by a specially-trained officer and a psychiatric nurse who respond to emergency psychiatric calls from 5 P.M. to 3 A.M. each night. A psychiatrist is on back-up call and can be summoned as needed. GVMHS teams alert Car 87 staff about possible problems (e.g. a potentially suicidal individual) at the end of each work day. As soon as the Car 87 staff evaluates a patient, it telephones a summary to an answering machine for the appropriate GVMHS team; when the team convenes the following morning it plays back the tape of the previous night's contacts.

Several measures suggest that GVMHS outpatient services are more effective than comparable services in the United States. A collaborative project between one GVMHS team (Broadway South) and Riverview Hospital followed up patients discharged from the hospital. It found that over a one-year period 18 percent of the patients had to be rehospitalized and 5 percent were arrested. For comparison purposes, in Illinois 30 percent of discharged patients are rehospitalized within 30 days (17) and in one study in Ohio 32 percent of discharged patients were arrested within 6 months (18).

GVMHS also undertook an extensive study of Vancouver to identify every seriously mentally ill individual in the inner city who was not currently receiving psychiatric services (19); a

total of only 200 such individuals were located. Based upon 10 years experience in working with mentally ill homeless individuals in Washington, D.C., a city of similar size, the senior author estimates that at least three times more such individuals would be found in a comparable survey. A study was also done in 1991 to assess the percentage of seriously mentally ill individuals among Vancouver's single homeless population (20); only 8 percent were found to qualify for a diagnosis of schizophrenia or bipolar disorder by psychiatric exam and another 4 percent by past history although, as noted, above, the percentage is increasing; comparable data from American studies have found that 30 to 35 percent of homeless individuals have schizophrenia or bipolar disorder (8). Finally a study of suicides among GVMHS patients with a diagnosis of schizophrenia found the rate to be approximately 2 percent over a 9 year period (2); this is half the rate reported in comparable American studies (22).

In addition to GVMHS which serves Vancouver, good outpatient services can be found in many other areas of British Columbia. In letters received during the survey, consumers and families reported outreach by mental health centers much more frequently than are reported by consumers and families in the United States; e.g. a mother in a rural area wrote that "after the patient goes home from the hospital a nurse visits the home once a week." In Victoria an Intensive Community Support Team was recently begun using the Dane County, Wisconsin (PACT) team model for 40

seriously mentally ill outpatients. Also in Victoria a nurse-social worker team responds to psychiatric emergencies from 3 p.m. to 1 a.m. each night. Even in a rural hospital such as in Cranbrook there is an extensive day program for 80 outpatients.

Provincial data from the Ministry of Health indicates that on the average 60 percent of patients seen in British Columbia's 60 mental health centers are seriously mentally ill, although this proportion varies by region. Data obtained by survey questionnaire from American community mental health centers suggest that no more than 40 percent of their outpatients are seriously mentally ill and even this may be an overestimate since the surveys were highly selective with less than half of the surveyed centers responding (23, 24).

Rehabilitation in British Columbia (4 points)

For rehabilitation services for individuals with serious mental illnesses, British Columbia scored 4 out of 5 points,as did 4 states (Table 1). Rehabilitation programs in British Columbia are stronger for individuals who are more disabled and weaker for individuals who are less disabled. For the more disabled the Broadway Industries workshop for severely disabled individuals in Vancouver is a model program and has received many awards. It accommodates approximately 70 individuals per month and has developed over 600 product design lines to allow one or more severely disabled individuals to be involved in production. Its high quality crafts are sold at several locations in the

city. Other impressive programs are the Widget Factory, a combination workshop and recreation program in Vancouver, and Community Explorations, a day program for 17 seriously mentally ill individuals with concurrent mental retardation in Victoria. Many rural communities also have rehabilitation programs for the more disabled; for example Cranbrook has a Living Skills Program at the Mental Health Center and an exemplary used clothing store called Clothes Encounters of the Kids Kind, utilizing mentally disabled individuals to repair clothing, and Nelson has a Therapeutic Work Program in which participants make muffins and sell them to local restaurants.

There are said to be 25 clubhouses in British Columbia but in fact most of them are day programs. A true clubhouse, based on the model of New York's Fountain House, includes being open seven days a week as well having housing and vocational rehabilitation components. A few British Columbia have achieved this and others are moving in this direction. An example of a good clubhouse is the Coast Foundation Clubhouse in Vancouver which serves 80 to 100 members each day. Even the town of Trail, a rural community of 10,000 persons, has a clubhouse-day program serving 40 members.

There are good vocational rehabilitation programs for less disabled individuals but they are comparatively rare. In Vancouver they include the Kitsilano Workshop and Gastown Industries and in Victoria there is Laurel Enterprises. Other impressive programs include a training program for psychiatric aides in the town of Salmon Arms which has included individuals

who have been seriously mentally ill, and a Partnership Education Program in Victoria which four seriously mentally ill individuals are employed full time by the provincial Ministry of Health to give talks to government agencies, mental health professionals, social workers, police officers, judges, and high school classes regarding the nature of mental illness and what it is like to be mentally ill.

A major problem with developing vocational programs for less disabled individuals in British Columbia is that such persons often lose money by participating in the programs. The equivalent payment for Supplemental Security Income (SSI) in the United States is called HPIA in British Columbia and is currently $606 (U.S. dollars) per month; few entry-level jobs pay that much.

<u>Housing</u> in British Columbia (5 points)

For housing programs British Columbia scored 5 out of 5 points; only four states scored as many as 4 points (Table 1). Although most seriously mentally ill individuals and their families complain about the lack of affordable housing in British Columbia, by American standards the housing look very good. For example Vernon, a town of 30,000 in the Okanagan Valley, has a total of 130 places for seriously mentally ill individuals in family care homes, group homes, supported independent living facilities, apartments, and community care facilities and regularly cannot fill them all. GVMHS manages housing for 1100 individuals in Vancouver but still has an active waiting list of

300 more. The commitment of GVMHS to housing is exemplified by the fact that it employs a half-time housing inspector out of its own funds to regularly inspect the housing units under its jurisdiction for compliance with building and safety codes.

Another impressive feature of housing for seriously mentally ill individuals in British Columbia is how few such individuals live with their families and how many live independently. In Kelowna, a town of 70,000, only 5 percent live with their families. In Trail, a town of 10,000 persons, not a single one of the 40 clubhouse members lives with their families. Most live in their own apartments while others live in facilities such as McBride Manor, a very attractive 9-person transitional house that invites all its "graduates" back for dinner once a week.

Vancouver and Victoria have also made extensive efforts to provide housing for seriously mentally ill individuals who are homeless. For example, Lookout in Vancouver is a combination shelter-apartment complex built specifically for this purpose and funded jointly by GVMHS and the Ministry of Social Services. It has 42 shelter beds and separate rooms (with sink) for 39 permanent residents built around a courtyard. Streetlink in Victoria is similar with 55 shelter beds, 26 individual apartments, and a medical clinic in the basement. Even at Vancouver's Portland Hotel, a rundown 66-room residential hotel with many individuals with serious mental illnesses, GVMHS provides 3 full time staff outreach workers.

A factor that has impaired the development of additional housing for seriously mentally ill individuals in British

Columbia who smoke is the price of cigarettes. Currently costing $5 (U.S.) a pack and going up, cigarettes consume a substantial percentage of the disposable income of individuals who are heavily addicted to nicotine. Consequently many mentally ill individuals elect to live in cheap, rundown motels or hotels rather than in better housing which cost more in order to save their money for cigarettes.

<u>Children's Services</u> in British Columbia (3 points)

Services for seriously mentally ill children in British Columbia scored 3 out of 5 points, the same as 6 states and no state scored higher (Table 1). These services are reasonably good but not as good as the adult services. Many of the services are provided in collaboration with the Ministries of Education and Social Services. In Vancouver, GVMHS has a multidisciplinary family treatment team consisting of 2 child psychiatrists, a family therapist, a speech pathologist, a special education teacher, and 3 child care counselors, which provides daily therapeutic group programs and home visiting. A new parent-infant project specifically targets seriously disturbed children under the age of two-and-one-half, and a school liaison program provides some counseling services within city schools.

Outside of Vancouver psychiatric services for seriously mentally ill children are integrated with those for adults but face a chronic problem of lack of trained personnel. To partially ameliorate that problem an outreach program for child and adolescent services, similar to that for adults, pairs child psychiatry services in Vancouver hospitals with hospitals in 28

rural areas. Personnel from the Vancouver hospitals visit the rural hospital on a regular basis for assessment, consultation and education; for example, the Children's Hospital is responsible for visiting Dawson Creek, Campbell River, and Prince George, while University Hospital is responsible for Prince Rupert, Queen Charlotte Islands, and, Cranbrook.

Total Score for British Columbia (21 points)

Utilizing the same scoring system for quality of services as was used for the 1990 survey of the 50 states (10), British Columbia scored 21 points total. In the 1990 survey Vermont scored the highest (17 points), followed by New Hampshire and Rhode Island (16 points), Connecticut and Ohio (15 points), Colorado (14 points), New York, North Carolina, and Wisconsin (12 points) and Utah (11 points) (Table 1). All other states scored 10 points or less. Therefore if British Columbia was an American state, the quality of its services for individuals with serious mental illnesses would rank first, 29 percent better than the next highest state (Vermont) and more than twice as good as the 40 lowest-ranked states.

Cost of Services

As described above, the cost of services for mentally ill individuals in British Columbia in 1990 was calculated as much as possible to be comparable to the 1990 cost figures for each U.S. state (13). The per capita cost for British Columbia was $58.87

U.S. dollars ($70.93 Canadian). If British Columbia was an American state, this would place it 9th behind New York ($118.34), Massachusetts ($83.91), Michigan ($73.73), Connecticut ($72.81), Alaska ($72.24), Maine ($67.29), New Hampshire ($63.37), and Maryland (61.21). New Jersey ($57.16), Pennsylvania ($56.85), and Minnesota ($55.44) spend just slightly less per capita than does British Columbia (Table 2). When scores for quality of services and per capita costs are both considered, it appears that British Columbia (21 points, $58.87 cost) is delivering twice as good services at the same cost as Pennsylvania (10 points, $56.85 cost), almost twice as good services at half the cost of New York (12 points, $118.34 cost), and three times as good services at 25 percent more as Indiana (7 points, $47.05 cost).

Discussion

It is useful to speculate how British Columbia is able to provide better services than any American state for its seriously mentally ill citizens and do so at a cost comparable to most U.S. states. Furthermore it accomplishes this within a medical care system in which everyone is covered, in contrast to the United States in which approximately 15 percent of the population (37 million people) is not covered by any form of health insurance. There are at least three reasons for the superiority of services in British Columbia.

1) Single Source Funding: Despite the fact that Canada's

federal government contributes 40 percent of the cost of British Columbia's health care system, the federal contribution comes virtually without strings attached. All fiscal decisions are made at the provincial level or, in cases like GVMHS which is given a global budget by the province, at the local level. There are no incentives for local or provincial officials to shape services to fit any particular mold in order to qualify for more federal funds because the federal payment is fixed; this contrasts sharply with the current situation in the United States where state mental health officials spend much time attempting to shift costs to federal programs such as Medicaid and Medicare.

At a practical level, single source funding results in much less paperwork and significantly lower administrative costs. One of the most striking features of British Columbia's mental health system is the smaller size of patients' charts in both inpatient and outpatient facilities, and the fact that most staff appeared to be interacting with patients rather than writing on charts. Although little research has been done in the U.S. on the cost of extra staff, forms, and meetings which are necessary to justify reimbursement for categorical funding sources such as Medicaid, such costs are clearly substantial; for example the cost of a Joint Commission on Accreditation of Health Care Organization (JCAHO) accreditation survey, necessary to qualify for some federal payments, was calculated at $326,784 at one psychiatric hospital (25).

Another important advantage of single source funding is that it permits a greater degree of programming which is driven by

patients' needs rather than reimbursement eligibility. While attending staff meetings regarding the planning of new services, the senior author noted an absence of discussion of reimbursement eligibility in sharp contrast to similar meetings in the United States. Within the limits of their global budgets, mental health centers in British Columbia have much more autonomy to shape their programs to local needs than do mental health centers in the states.

2) Clearer mandate: Another reason for the comparative success of British Columbia's services for individuals with serious mental illness is its clearer mandate to serve this population. This is seen most clearly in Vancouver where GVMHS has been criticized by some community groups for its almost exclusive emphasis on serious mental illnesses, but it is also seen in many of the rural mental health centers.

This does not mean, however, that individual psychotherapy and counseling for less serious mental illnesses is not available in British Columbia. There are in fact large numbers of psychiatrists in Vancouver and Victoria whose practice consists almost exclusively of psychotherapy with individuals who do not have serious mental illnesses. Among the top 50 fee items reimbursed to physicians under the province's Medical Services Plan in 1990-1991, "prolonged visit for counseling" was 7th highest ($16,577,724) and "individual psychotherapy per hour" was 9th highest ($14,622,805) (U.S. dollars) in gross payments (26) although these categories are broad and may also include activities such as medication checks. However such

reimbursements were given exclusively to psychiatrists and other physicians because non-physicians are not eligible for reimbursement for these services under the Medical Services Plan.

3) More comprehensive: A third probable reason for the comparative success of British Columbia's services for individuals with serious mental illnesses is its more comprehensive approach to the problem. This is seen especially in housing which is integrated into the community psychiatric programs much more strongly than it is in the United States. For example the fact that an urban mental health agency such as GVMHS hires its own housing inspector, or that rural mental health centers frequently construct housing units in conjunction with the British Columbia Housing Authority, is not at all unusual in British Columbia but would be so in the states. This more comprehensive approach may also be partially attributable to the single source funding in which patients' needs are more important than reimbursement eligibility.

Despite the fact that British Columbia offers services for individuals with serious mental illnesses which are superior to any American state, it nevertheless has significant deficiencies in its programs. The most important of these defficiencies, alluded to in the preceding program descriptions are: 1) the lack of coordination between inpatient and outpatient services; 2) the failure to use involuntary hospitalization when needed; 3) the paucity of vocational rehabilitation programs for less

severely impaired patients and the HPIA disincentive to return to work; 4) the lack of quality affordable housing for everyone who needs it; 5) the paucity of adequate children's services; 6) the geographical concentration of psychiatrists in Vancouver and Victoria; 7) the payment scheme whereby psychiatrists doing "sessions" in mental health centers are paid less than those doing private fee-for-service; and 8) the lack of coordination between overlapping programs funded by different ministries. Looked at from this perspective, it appears that services for seriously mentally ill individuals in British Columbia have not achieved excellence in an absolute sense, but rather in comparison to services in the United States.

Of even greater concern are indicators that services for seriously mentally ill individuals in British Columbia are deteriorating. It is becoming increasingly difficult to find a hospital bed for mentally ill individuals who need inpatient care, and the number of seriously mentally ill individuals among the homeless population and in jail appears to be increasing. There are also increasing constraints on the Ministry of Health's budget and British Columbia physicians have threatened to strike because of reimbursement caps imposed by the provincial government (27). The proposed solution for many of these problems is decentralization of medical (including psychiatric) services to 20 regional boards with 100 community health councils reporting to them. This decentralization is already in process (28).

Despite these problems, it appears that at this time individuals with serious mental illnesses are substantially better off in British Columbia than they are in any state in the United States. The most common criticism leveled at the Canadian health care system by American observers has been the restricted availability of diagnostic high-technology equipment and waiting lists for some surgical procedures; neither of these criticisms are relevant to the diagnosis and treatment of serious mental illnesses. Therefore for individuals with these illnesses there appears to be substantial advantages to the Canadian system, at least as it has been operationalized in the province of British Columbia.

Table 1: Comparison of British Columbia with the best of the states on a scale of 0 points (worst) to 5 points (best)

Category	State/Province	Points
Hospitals		
	British Columbia	4
	Colorado	4
	Nebraska	4
	New Hampshire	4
	Utah	4
Outpatient and Community Support		
	British Columbia	5
	Ohio	4
	Rhode Island	4
	Vermont	4
Rehabilitation		
	British Columbia	4
	Connecticut	4
	New Hampshire	4
	Rhode Island	4
	Vermont	4
Housing		
	British Columbia	5
	Connecticut	4
	New Hampshire	4
	Rhode Island	4
	Vermont	4
Children		
	British Columbia	3
	Alaska	3
	Maine	3
	North Carolina	3
	New York	3
	Ohio	3
	Vermont	3

Total Points

British Columbia	21
Vermont	17
New Hampshire	16
Rhode Island	16
Connecticut	15
Ohio	15
Colorado	14
New York	12
North Carolina	12
Wisconsin	12
Utah	11

All other states had 10 points or less.

Table 2: Per capita cost of mental health services for 1990 in British Columbia compared to the American states with the highest costs (12)

	Per Capita Cost, 1990
New York	118.34
Masschusetts	83.91
Michigan	73.73
Connecticut	72.81
Alaska	72.24
Maine	67.29
New Hampshire	63.37
Maryland	61.21
British Columbia	58.87 *
New Jersey	57.16
Pennsylvania	56.85
Minnesota	55.44

* $70.93 Canadian dollars = $58.87 U.S. dollars.

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