
**Why Fund
Addiction and
Mental Health Services**

02/04



Ontario Federation of
Community Mental Health
and Addiction Programs



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INTRODUCTION

Faced with a mounting deficit, and increasing need in all sectors of the Province's health and social service system, the Government of Ontario must identify modest strategic investments that will leverage significant system improvement.

Community mental health and addiction services are uniquely positioned to be those strategic investments. With an appropriately targeted injection of funding, those services can continue to relieve the growing pressure on our more expensive institutional partners, and can assist government in supporting the health care system in times of restraint. They can, if adequately funded, and recognized as a critical component of an integrated health care system, deliver exceptional service to Ontario's most vulnerable people. They can, and have, demonstrated their effectiveness, their cost-effectiveness, and their accountability to both the public and their funders.

In addition community mental health and addiction services need accountability and system models for both the community and institutional sectors, that support effective functioning, cost effectiveness and is outcome based.

Sadly, the budget constraints with which our members have been living for the last twelve years, and the rising demand for services in that same time, have made it increasingly difficult for them to do their job. They are now at the breaking point.

BACKGROUND

The Ontario Federation of Community Mental Health and Addiction Programs ("The Federation") envisions a community mental health and addiction system which is accessible, flexible, comprehensive and responsive to the needs of individuals, families and communities, shaped by many partnerships, respectful of human dignity and rights, and accountable to those it serves. The Federation brings together 215 community mental health and addiction services in the province of Ontario to help members provide effective, and accountable high quality services. We appreciate the opportunity to present to government on a matter of critical importance as it prepares its first budget.

Our members, and the people they serve, are in crisis:

- Provincially funded mental health agencies have had no increase to their base budgets in 12 years.
- Operating budgets for addiction services have risen just 2% in 10 years.
- With inflation, those services have experienced an effective 20% reduction in funding.
- Faced with rising costs and a requirement to maintain a balanced budget, they have been forced to close programs, reduce services and limit access, at the same time as the need for their services has increased dramatically.
- The outcome is:

- longer **WAITING LISTS**
- increased use of other, **MORE EXPENSIVE** institutional services
- increased stress on consumers/clients, **FAMILIES AND COMMUNITIES**
- **INCREASED PRESSURE** on other health and social services, most notably, police and correctional services.
- **INCREASED PRESSURE** on emergency services

That reality stands in stark contrast with the vision articulated by both of the previous two governments.





THE VISION

Previous governments committed to restructuring the province's mental health and addiction systems and to investing in community services. In 1993, then-Minister of Health Ruth Grier released *Putting People First: The Reform of Mental Health Services in Ontario*. That document embraced a vision of the future in which:

- There will be a comprehensive service delivery system.
- People with mental illness will have better access to quality care from an appropriate mix of institutional and community services.
- All components will be integrated and coordinated.

To achieve that goal, the restructuring plan also included a commitment to shifting the funding balance from 21% community service/79% institutional care, to 60% community/ 40% institutional by 2003 – a target that Minister Grier acknowledged, in 1993, was “cautious” in comparison with that set in other jurisdictions.

In 1999, Health Minister Elizabeth Witmer released *Making it Happen*, and reaffirmed the government's commitment to the vision and principles outlined in previous reform documents. Those principles included the following:

- Services will be tailored to consumer needs, with a view to increased quality of life.
- Consumer choice and access to services will be improved.
- There will be continued investments/reinvestments in mental health services to support mental health reform and increase the overall capacity of the mental health system.

That same year, the Ministry released *Setting the Course: A Framework for Integrating Addiction Services in Ontario*. That document, which was intended to guide the development of a comprehensive provincial substance abuse treatment system, embraced the following vision:

“All people in Ontario with an addiction problem will have access to an integrated, client-focused system of evidence-based, cost-effective services to meet their diverse needs as well as the needs of family members and others affected by someone's addiction.”

The report also articulated two overarching goals:

- To ensure that each district of the province offers an appropriate range of addiction services and has access to specialized programs in other parts of the province.
- To ensure that clients have access to appropriate addiction services and, in particular, to ensure that more people have access to services now in short supply.

Now, as then, the Federation is supportive of the vision articulated in those documents and is deeply concerned that it has not yet been realized.





THE REALITY

“In all the years I’ve worked in mental health I’ve never seen such desperation”.

Executive Director, community mental health housing agency, Southern Ontario

“All addiction services in the province are stretched to the limit and are at imminent risk of collapsing under the strain.”

Board President, addiction services agency, Northern Ontario

“My heart is sore. A lifeline is fraying and I am so afraid that it will break.”

Client, addiction services agency, Eastern Ontario

“Without high support for psychiatric and physical problems, she (my client) could die.”

Case Manager, community mental health housing agency, Southern Ontario

Those comments reflect the level of concern in the system about the future of the province’s mental health and addiction programs. A survey of Federation members in 2002 concluded the following:

- Almost half of the people who need mental health or addiction services in Ontario must wait for 8 weeks or more - an eternity in the lifetime of a person, a family or a community struggling with a serious mental health or addiction problem.
- For a significant number of programs (18%), the waiting time can be a year or longer.
- Eighty percent of respondents have had to close programs temporarily to cope with fiscal pressures. Twenty-five percent of them are closing programs permanently.
- Almost three quarters of our members have lost valuable staff to higher paying jobs outside our sector.
- When people leave, we often can’t afford to replace them. Some of these positions have been lost permanently.
- When we do hire, we have trouble attracting experienced staff because we can’t offer competitive salaries.
- As a result, we often hire trainees who, once experienced, find more lucrative positions elsewhere.

Data from the Drug and Alcohol Registry of Treatment (DART) indicates that:

- Since 1996, 233 beds or 12% of residential addiction treatment capacity has been lost in Ontario. Withdrawal Management services has seen a similar loss in capacity.
- In some communities, people must wait as long as:

- **4 MONTHS** to be assessed for addiction services
- **5 MONTHS** for admission to a day or evening treatment program

¹ DART is a province-wide information service that provides free, round-the-clock access to current information about Ontario’s addiction services. A proposal to provide a similar service for the mental health system was submitted to the provincial government in May 2002. In the absence of such an information service, we are unable to provide comparable data for mental health services.





- **ALMOST 6 MONTHS** for admission to a residential service.

In the mental health system, the “cautious” ten-year target set in 1993 is nowhere in sight. Rather than the 60/40 balance identified in Putting People First, community mental health and addiction services account for just 34% of the total provincial mental health budget, with institutional services still responsible for the remaining 66%.

Those statistics are alarming. However, they pale in comparison with the situations in which three of our member organizations currently find themselves:

CASE STUDIES

Addiction Services, Northwestern Ontario

In June 2003, the only addiction psychiatrist in Northwestern Ontario, licensed to prescribe methadone, announced that he was leaving the community. The 96 patients who had depended on him for treatment would be left without a physician to prescribe their medication. The service community rallied and a local hospital reallocated some of its mental health resources to temporarily create a methadone clinic. This health care provider reallocated 2 case managers, and sessional fees to fund essential medical services. Three physicians and a psychiatrist completed the training necessary for methadone licensing. In October 2003, the Ministry of Health and Long-Term Care provided \$50,000 in one-time funding to support the program for six months.

Though the crisis for these 96 individuals was averted, the existing resources do not begin to address the needs of more than 500 identified opiate dependent individuals living throughout Northwestern Ontario who are in need of Methadone Maintenance treatment.

For the community, the complex needs of individuals struggling with opiate dependency contribute significant strain on already overtaxed resources.

Consider this:

- The absence of comprehensive methadone maintenance services² results in:

- increased **STREET TRAFFICKING**
- increased **CRIME** such as pharmacy break-ins (Pharmaceutical break ins are three times higher in 2003 compared to 2002 statistics with 80% of the break-ins resulting in theft of opiate and narcotic medications)
- increased **INCARCERATIONS**
- multiple **EMERGENCY** room visits

² Best Practices – Methadone Maintenance Treatment (Health Canada) indicates that integrated, comprehensive services (including medical care, other substance use treatment, counseling and support, mental health services, health promotion, disease prevention and education, linkages with other community based services and supports, outreach and advocacy) are required.





- multiple **IN-PATIENT ADMISSIONS** to both general and psychiatric hospitals
 - increased **LENGTH OF STAY** in Withdrawal Management Services (commonly known as “detox centres”)³
 - longer **WAITING LISTS** for Withdrawal Management beds for non-methadone users⁴
-

- People with opiate dependency require medical support to either taper their drug use or to establish a methadone maintenance regime. The nearest medically supported withdrawal management service is 14 hours away, by bus. Potential patients disembark at the bus stations which are frequently located in close proximity to bars. Many clients do not find their way to the withdrawal management centres.
- Of the 96 people currently receiving services through the clinic:
- 70% have medical complications, ranging from asthma (1%) to hepatitis (31.9%)
- 89% have concurrent psychiatric disorders
- Opiate use is rising dramatically, especially among professionals. Too embarrassed and ashamed to be forthright with their family doctors and unable to secure more medications, these professional people begin buying opiates off the street at a cost of 25 to 40 dollars per pill. These honest citizens may resort to stealing to support their addiction. Their lives become chaotic and unmanageable. Often unable to work, erratic in their behaviours, their family life and financial security rapidly deteriorate. Child welfare services frequently become involved. Within a matter of a few short months, they are no longer recognizable to their families or themselves.
- Providing comprehensive service to the 500 people in this community in need of methadone maintenance treatment would cost \$1.5 million per year. Failure to provide that service will result in costs to the health and social service system of \$22 million per year.⁵
- The local addiction treatment system could, if adequately funded, provide additional services to clients of the clinic. More than a decade of inadequate funding has eroded the staffing resources and available services. One service provider has lost 7 of 50 full time equivalent staff positions over the last 7 years. Referrals have increased by 20% in that same period. In an effort to deal with its own fiscal crisis, the agency closed its residential programs for six weeks in 2003. Waiting lists for essential residential services currently range from two to four months.

Community Mental Health Housing Program, Southern Ontario

This high support housing program opened its doors in May 2000 to 30 of Ontario’s most severely disabled people. To meet their complex needs, the program entered into a unique partnership - contracting with another service provider for the nursing care required to address residents’ unstable medical conditions, while the program itself provided the support necessary for them to cope with serious mental illness. Prior to their admission to the program, all of the residents had been long-term in-patients in provincial psychiatric hospitals. Although many of them had tried repeatedly, none had been able to manage in other housing

³ Detoxification from Methadone takes five to seven days, compared with the 24-48 hours required for non-opiates

⁴ At present, local Withdrawal Management Services turn away between 25 to 50 people per month as a result of current capacity levels

⁵ Wall, Rehm, Brands, etc...(2000) estimated that, for each person addicted to opiates followed in the study, the average health and social costs are about \$44,000 per person.





programs. Ranging in age from 41 to 69, the program's clients have been ill for 27 years, on average. In addition to their psychiatric diagnoses:

- nine residents have diabetes
- eight have a history of addiction
- six have a developmental delay
- six have been ordered into treatment by the Ontario Review Board
- five have arthritis
- three have Chronic Obstructive Pulmonary Disease
- three have seizure disorders
- one resident has cancer

Despite the severity of their conditions, residents have fared remarkably well since entering the program, developing a sense of community, supporting each other, and achieving goals that would otherwise have been unattainable. Perhaps most importantly, they have spent very little time in hospital, saving the health care system over \$4,400,000 in 2002 alone¹¹.

Soon, however, this facility may be unavailable. The private sector partner is in receivership. The mortgage holder offered to sell the building to the agency at a price significantly under market value, and the city offered substantial financial support. The agency planned to expand its much needed service and found another not-for-profit organization to occupy the surplus space¹². The Ministry did not approve the plan, nor did it approve additional funding for services that had been provided by the private sector partner. Despite an intensive search for an alternative facility, the agency has not yet been able to find another viable option. Even if it does, without 24 hour nursing support, program staff will be unable to take the most medically fragile residents with them. The program has been given notice to vacate on or before May 31, 2004.

Aware of their precarious living situation, residents have become increasingly anxious. They are placing extraordinary demands on staff, who have observed signs of stress-related decompensation and an increase in aggressive and socially inappropriate behaviour, among normally well-controlled clients.

The government has a choice: It can spend \$59 per day to support residents in the home to which they have become accustomed, or many times that for the alternatives:

- \$80-\$90 per day for a hostel bed
- \$117 per day for residence in a Long-Term Care facility
- \$137 per day for incarceration
- \$500 per day for psychiatric hospitalization

The choice should be obvious.

¹¹ Calculation is based on the number of days each resident would have spent in hospital had they not been admitted to the residence, multiplied by the hospital per diem, minus the cost of their residency in the program during the year.

¹² Instead of the \$125,000 that is the norm for supportive housing, this arrangement would have added 61 units at a per unit cost of \$26,000.





Community Mental Health Program, Eastern Ontario

For many years this agency has been recognized by consumers, colleagues and the MOHLTC for the excellence of its services and the efficiency of its administration. Given that reputation, the Ministry has been quick to call upon the agency to assume sponsorship of struggling programs, originally administered by other organizations. Under their new leadership, those programs have thrived. When funding was made available to develop new programs in areas identified by the Ministry as priorities, the agency volunteered once again, adding 4 programs to its portfolio in 3 years.

All that time however, they were faced with one inescapable fact – there had been no increase to the base budget for their 4 original programs in 12 years, and they were grossly under-funded. Thanks to extraordinary personal sacrifice on the part of staff, they managed nonetheless to balance the budget every year - staff worked harder and longer to fill the vacuum left by colleagues whose positions were eliminated, and accepted salaries far below a competitive level. The Executive Director chose not to take a Board-approved compensation increase in order to redirect funds to service provision. When all else failed, they subsidized core programs¹³ with surplus from newly funded programs that weren't yet fully operational. In short, they did whatever was necessary to avoid reducing service. This year, however, with all programs fully staffed, they have no surplus to redirect, and no option but to eliminate some of the services on which their consumers have come to rely.¹⁴

Faced with a potential \$400,000 deficit in 2003/04, and the expectation from the MOHLTC that it will balance the agency's budget, the Board of Directors has concluded that it must take the following steps:

- Eliminate five of the current 11 Full Time Equivalent (FTE) staff positions in the Residential program
- Eliminate 3.6 FTEs of the total 9 in the Day Centre program
- Eliminate 1 FTE of 5 in the Community Support program

Loss of those positions will have a profound effect on the agency's ability to deliver service:

- Residents of nine residential homes will have reduced access to staff on weekends.
- A residence that currently provides 24 hour on-site staff support will be reduced to staff on call overnight.
- The Drop in centre and other programs, which have operated for 36 hours a week, will be reduced to 15 hours per week.
- Thirty fewer clients will have access to community support/case management services.

Overnight, the agency waiting list will grow exponentially. Within days, or weeks, the people who are turned away will make additional demands on the system's already overburdened crisis and emergency services.

If this situation is not addressed immediately, the agency's 2004/05 deficit will balloon to \$644,000 – requiring the further elimination of 2 positions in each of the Residential and Centre programs, and rotating unpaid leaves of absence for the organization's few remaining administrative staff.

Three case studies and three communities at risk. There are many more – some of which, like the example below, have implications for the entire province.

¹³ The agency informed the MOHLTC of this financial management strategy in its 2002/2203 Operating plan

¹⁴ Demand for those services has grown dramatically. The case management program alone has experienced a 63% increase in 2 years. The social rehabilitation program provided service for 11.6% more people in 2002/03 than in 2000/01.





CONCURRENT DISORDER SERVICES

People with co-occurring mental health and addiction problems (“concurrent disorders”) are, by definition, dually afflicted. With a decision recently taken by a major healthcare institution, they have also fallen victim to poor system planning.

From its opening in 1985, the program offered specialized residential treatment for people with concurrent disorders. Mandated to provide tertiary care for both the region and the province, almost 50% of the program’s referrals (2001/02, 2002/03) come from areas of the province outside the region in which the facility is located.

As part of Ontario’s mental health reform process, the program was transferred to another institution. That organization determined that it could make the best use of its scarce resources by modifying the program model to reduce the emphasis on residential care, and by restricting admission to people referred from within the region. That decision may, as the institution suggests, be in the best interests of the local community, its clients/consumers and its service providers. However, it is clearly not in the best interest of those who have come to rely on this program as a provincial resource. With few other similar programs currently available in Ontario, and with no immediate plans to create additional residential services for this population, the closure of these beds will represent a significant loss of capacity for the entire province.

We are gravely concerned about the impact of this decision on people with concurrent disorders. We are equally concerned about the lack of consultation prior to the decision. Ontario’s vision of “an integrated, client-focused system of ... services” will never be achieved if planning continues in isolation. We must act together, with all our partners, to ensure the kind of “seamless” service to which we are all committed. The Federation and its members are eager to do so, and must be given that opportunity.

EFFECTIVENESS

We know that our services are effective. Studies of community mental health programs, both here and abroad, have demonstrated the following:

- People with serious and persistent mental illness (including those who are homeless) show significant improvement in their community functioning, quality of life, symptoms, and use of substances when involved in community mental health programs. They experience fewer crises, require less frequent hospitalization and visit the emergency room less often. (Community Mental Health Evaluation Initiative, 2002)
- The cost of hospital care is significantly greater than the cost of care in the community. (Leff, Trieman, Knapp, and Hallam, 2000, McCrone, Chisholm and Bould, 1999)
- Across Ontario, fewer than 50% of mental health consumers receive the appropriate level of care:
 - 76% of the people in Whitby who need community mental health services, and 63% of those in the Northeast region, are receiving **LESS HELP THAN THEY NEED.** (Health Systems Research and Consulting Unit, 2002)
- It is a lack of alternative settings and supports, rather than level of functioning, that puts and keeps individuals in hospital. In order to avoid the over-provision of this most expensive and restrictive type of care, it is necessary to develop a range of community supports. (Health Systems Research and





Consulting Unit, 2002)

Our members themselves can demonstrate success:

- Vicki Huehn, Executive Director, Frontenac Community Mental Health Services in Kingston, notes a 60% reduction over 8 years in the total length of time consumers spent in hospital as a result of involvement in that agency's housing program.
- Wendy Czarny, Executive Director, Waterloo Regional Homes for Mental Health, reports an 89% reduction in the average amount of time people spend in hospital before and after becoming involved in her supportive housing program.
- Steve Lurie, Executive Director, CMHA Metro, can demonstrate a decrease in total hospitalization costs from \$1,358,136 to \$172,692 for 56 people receiving comprehensive case management services in Toronto.

Among addiction services:

- Each dollar spent on the treatment of alcohol use disorders saves between \$4 and \$12 in long-term societal, economic and medical costs (Carroll, 1997). If withdrawal management services are not available:

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- 5% of clients indicated they would likely be in **JAIL**
 - 11% reported they would be in **HOSPITAL**
(Rush and Aitken-Harris, May 2000)
-

- 88.7% of addiction clients surveyed felt “moderately” or “very” positive about the service they had received. Those same individuals showed positive outcomes at six-month follow up in terms of:

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- **SIGNIFICANT REDUCTIONS** in alcohol, cocaine and cannabis use
 - **IMPROVEMENTS** in self-esteem and self-confidence
(Rush, Hobden, Aitken Harris and Shaw Moxam, 2000)
-

- Because Withdrawal Management beds have been so significantly reduced, many clients turn to hospitals, and to emergency departments in particular, when they need help. (Kahan and Dean, 2003)
- Very conservative estimates suggest that alcohol-related problems account for between 10% and 30% of all Emergency Room visits (Kahan and Dean, 2002)
- In 1999/00, 8.06% of the 41,746 referrals to Ontario's residential Withdrawal Management Services came from hospital Emergency Departments. (Kahan and Dean, 2002)





ACCOUNTABILITY

Bill 8, 2003¹⁵, which has received first reading and been referred to committee, would require “health resource providers” (including hospitals) to enter into an accountability agreement with the Minister of Health and Long-Term Care. That agreement would permit the Minister to issue compliance directives and impose sanctions in the event of non-compliance. Until that Bill is passed, health care institutions are under no specific legislated obligation to account for the billions of dollars of public money they spend.

For community mental health and addiction programs, those accountability mechanisms are already in place. The Transfer Payment Agreement (TPA) that each agency must sign requires that the agency:

- ensure that funds are only used for the purposes set out in the annual Operating Plan
- not make any changes to the Operating Plan without the prior written consent of the Ministry.

The TPA also grants the Minister these powers, among others:

- to impose additional terms and conditions on the use of funds, as it considers appropriate
- to inspect and copy financial and non-financial records on 24 hours notice and conduct a full or partial audit of any kind
- to terminate the agreement immediately under specified circumstances

These mechanisms, the active involvement of service recipients in organizational decision making, and our members’ strong connections with their communities, ensure that community mental health and addiction programs are accountable to government, for the public money they spend; to the people they serve, for the quality of their services; and to their community, for enhancing its quality of life.

System tools such as DATIS, Catalyst, and the Psychosocial Rehabilitation Tool Kit all form the building blocks needed by the government to ensure effective outcomes, quality services and accountability to the people of Ontario.

¹⁵ An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health services accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector and to amend the Health Insurance Act





CONCLUSION

Like the present government, the Ontario Federation of Community Mental Health and Addiction Programs is committed to enhancing the health of Ontarians, while ensuring that the health system remains viable and financially sustainable, long into the future. We know that our member organizations play a critical role in service provision to people with mental health and addiction problems. We believe that, with the appropriate resources, we can play an equally valuable role in creating a comprehensive health system for Ontario. We offer these final observations:

- Tertiary care centres, which have been the focus of so much public concern, cannot function effectively without the services our programs provide. Hospitals themselves have urged government to invest in community-based services, because they cannot meet the needs of their patients without a continuum of services and supports in the community.
- Our services are effective in their outcomes, cost effective in their use of public funds and immensely valuable to the people they serve.
- With a 20% decline in capacity over the last 12 years, our members have been severely handicapped in their efforts to serve their communities and to contribute to the reform of Ontario's health system.

It's true that opportunities have been lost – it's also true that it's not yet too late to undo the damage inflicted over the last twelve years. By making a small strategic investment in community mental health and addiction services now, the Government will reduce the pressure on acute care services and save significant money later. We are part, and a significant part, of the solution to Ontario's current economic crisis.





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