July 29, 2013

MENTAL HEALTH'S EXPANDED ROLE IN A TRANSFORMED HEALTHCARE SERVICES DELIVERY SYSTEM

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The big search for who is in the 5 percent of "high-users" of healthcare services has found that mental health and addictions clients are among the highest right across the province. It makes sense that they show up as "high-cost generators" in other parts of the system. We've known about the underfunding for mental health for years.

It seems that the only time anything improves for the mental health sector is when -- from time to time -- a Minister of Health steps in, and simply makes it happen. Poof! The Minister can be like the fairy godmother, when they decide something is a priority.

While I often rant and rave about politics in healthcare, the fact is “values” and “political beliefs” drive both health policy, and directly influences how our health services delivery system behaves.

Because of my background and experience as a speech-writer for Ministers of Health from all three political parties, I always focus on people's values. “Values” were certainly what drove Health Minister **Larry Grossman** in the early 1980’s, when I served as his Chief-of-Staff.

Respect, compassion, dignity, human rights, and community service were values that were instilled in Larry by his family from the start. Larry would recall how, as a young boy waking up each morning, he would hop out of bed and tiptoe around refugees who had been taken in for the night by his parents in the aftermath of 1956 Hungarian Revolution. He understood what was expected of him: he was to “add value” to the world by being in service to the communities of which he was a part.

When he arrived as Minister of Health in 1981, Grossman was clearly a star cabinet minister in the government of **Bill Davis**. As Minister of Industry, he had been innovative and bold in his efforts to support the transformation of Ontario’s economy from its traditional industrial base to the underpinnings of what has now evolved into the knowledge economy.

As a cabinet minister, Grossman was visionary, highly strategic and courageous. He was determined to make a difference in the world that he inherited.

By his third day as Minister of Health, Grossman had exchanged his pinstriped suits for blue jeans and a T-shirt as he toured Parkdale with ex-psychiatric patient activist, **Pat Capponi** – who today is a successful Canadian writer.

Pat Capponi did not give Mr. Grossman a nice safe ministerial tour. In the late 1970s, the provincial government had closed thousands of institutional psychiatric beds – in part due to budget constraints, in part due to changing treatment patterns – but they had no, or very few, support programs in the community.

Releasing thousands of patients with only a packet of pills and a pat on the bum had produced a major crisis in downtown Toronto. Deplorable living conditions and what coroner juries called "death by therapeutic misadventure" were the results of government policies that had no vision and no strategy for the traditional "poor cousin" of Ontario's health care system: the mental health care sector.

Shaken by Pat Capponi's real-world tour of Parkdale's Kafkaesque boarding houses, and by his conversations with the ex-psychiatric patients he met, Grossman vowed he would transform the provincial mental health system – and in particular, provide dignity, respect, and meaningful support for those who needed it, where they needed it.

As he dug deeper and learned more about mental health issues over his first several months at the Ministry of Health, Grossman began to develop a much more comprehensive approach that was based on the advice of the mental health reform advocates that he surrounded himself with.

Steve Lurie, Aileen Meagher, Brian Davidson, Mary Ellen Polak, Ron Ballantyne, Dr. Tyrone Turner and numerous front-line support workers collaborated with Grossman and his staff to craft policies and programs that would enable the system to evolve to meet the changing needs of the people it was intended to serve.

Within 18 months of his arrival at the Ministry of Health, Grossman had a new *Mental Health Act* focused on patients' rights; a **Psychiatric Patient Advocate Office**; a major commitment to develop supportive housing for people with chronic mental health issues; an expansion of community-based mental health and support programs that sky-rocketed from $17 million per year to $75 million in just 18 months; a strategy for the devolution of the Provincial Psychiatric Hospitals; and, a commitment for $100M in capital to replace the old Whitby Psychiatric Hospital with Ontario Shores.

In the olden-days, that was a lot of money -- and a lot of rapid change.

But what Grossman understood was that money and laws alone would not "fix" the system: what was needed was a fundamental shift in the way we think about mental health – within the mental health system itself, and among the public.

For the public, Grossman, through his partnership with the provincial arm of the *Canadian Mental Health Association*, sponsored large-scale award-winning radio and television commercials that appealed for public support for the reintegration into the community of fellow citizens who had experienced a mental health problem.

Grossman understood that the real struggle for shifting attitudes would be in the mental health care system itself – among administrators and mental health professionals. That is why he placed special emphasis on the role of the **Psychiatric Patient Advocate Office**

(PPAO) as the key leverage point in the system. Grossman wanted the PPAO to have a profound impact on the culture (thinking & behavior) that had evolved within the system.

"Our challenge," said Grossman, "is to change the very culture of the system. We need to help administrators, professional practitioners, and Ministry of Health officials to change the way in which they think about mental health and patients' rights."

So, here we are – 30 years later. Did the *Psychiatric Patient Advocate Office* achieve its intended purpose? Has supportive housing proven effective? Did the community mental health sector rise to the challenge? Did it build the internal capacity to transform, grow and evolve? Did the provincial psychiatric hospitals successfully devolve and evolve? Did Larry Grossman's values-based mental health sector reform strategy work?

As someone who worked with Mr. Grossman on his various strategic initiatives, I feel close enough to his thinking to say that if Larry were alive today, he would be very proud of how the mental healthcare sector has indeed transformed to become more patient-focused and more effective.

But I can also with some confidence predict that if Larry were with us today, immediately after applauding and celebrating everyone who had contributed to the very real successes of the mental health advancements, he would ask the following probing questions: *"Are we as consumer/survivor-focused as we ought to be?"* "*Are we truly accountable for designing and delivering services that are grounded in the perspectives of consumer/survivors?"*

Grossman understood in his <u>head</u>, <u>heart</u> and <u>gut</u> why *supportive housing* needed to be a major part of mental health reform. Today, we have about 173,000 people living with mental illness who are vulnerably housed or homeless. The wait list in Toronto alone is over 5,000 -- which means a 2-3 year wait for housing if you are homeless!

The provincial auditor has called for Ontario to develop more supportive housing. We now know that for every $2 spent on high needs individuals, $3 are saved in reduced hospital and justice system costs. That's a real good R.O.I.

In the community sector, an **ACT Team** (Assertive Community Treatment) and rent supplement costs just $21,000 per year -- compared to $100,000 to keep someone in a hostel; $140,000 to keep someone in a jail; and, less than 10% of the cost of one year of hospitalization. Hello? Why aren't we expanding these proven programs?

On a recent tour of an example of a "fully-integrated mental health services support system" at **CMHA Durham** -- I saw the impact of systems thinking and innovation that can occur at the service delivery level of community mental health. CEO **Linda Gallacher** and her team have developed a stunning example of integrated community services that addresses people's needs in a high-quality cost-effective way that also prevents costs elsewhere in the system.

Here is a model!

According to the *Canadian Institute of Health Information* one admission to hospital for bipolar disorder or schizophrenia can cost between $8,000 and $12,000 -- while case management costs just $6,000. Case management can also reduce hospitalizations by 50%, according to the *Community Mental Health Evaluation Initiative* studies.

Given what the government has now just learned from the first 25 *Health Links* about the numbers of mental health and addictions patients in the top 5 percent of health system users, there is now a clear and compelling business case for the sector to grow by at least 4% per year, for the next 3 years. That is, 12% over the next three years.

If Grossman were alive today, his values of service, and his attention to evidence, and to business case assessment, would have him saying bluntly: "we are just not doing good enough." What we need, he would say, are “leveraged investments” in community supports and housing. He could make the business case to cabinet as to why we need to shift resources in the healthcare system from institutions, to community services.

While all that chaos builds up, and as the OHA seeks to find a new CEO to lead the hospital sector's vision for our future health system, is it still possible to increase some community health service delivery budgets, when there is such overwhelming pressure to decrease spending?

That’s where Ministers come in. They can make it possible. In mental health, for example, an investment of just $160 million per year would add less than 1/3 of 1% to health spending annually -- and it would generate cost savings in the medium term, due to reduced hospitalizations.

Best practices suggest that community support services need to be put in place first, and then shift resources out of the hospital sector.

Tory health critic **Christine Elliott** – who is Deputy Leader of her party, and a passionate advocate for mental health – says “we are currently operating our health system on an outdated, reactive model based on acute episodes of illness. We need to transition to a twenty-first century model-of-care. In their policy paper, the PC’s commit to “treat mental health as <u>equal</u> in importance to physical health.”

Having lived though 7 years of minority government under the Government of **Bill Davis** – in which Ontario was also undergoing massive deindustrialization as a result of the Free Trade Agreement – I know that the pressure on our Minister of Health is to “keep a lid on it”. It is the Ministry and Minister's job to "keep a lid on healthcare -- with no new money."

But you really can’t "keep a lid on". Indeed, that is in fact bad strategy.

Pressure will be coming from the hospitals and the doctors over the next few years of minority government to at least maintain the existing funding. While the government talks about "shifting from institutional to community-based service delivery", the funding shift really has not happened yet, and the OHA have yet to develop and roll-out their advocacy campaign. Interesting times ahead.

What is needed today on the mental health file, is a dollop of "Ministerial vision and values". How about it **Deb Matthews**? You have demonstrated a passion for eveidence-based decision-making. Why not invest 4% more per year over the next three years by redeploying resources from institutional care, to highly leveraged sectors like community mental health, home support, illness prevention, Community Health Centres, independent living and supportive housing?

These strategic investments of 12% over the next three years would certainly produce significant cost savings for our total system, in the medium and longer-term -- and it will also help to off-set the impact of lower hospital budgets.

What is missing is a cohesive plan for the next three to five years that shifts resources to the community by first flowing money to the community to build their services, and then -- and only then -- reducing hospital budget. Without such a plan, at the local LHIN-level, the status quo remains entrenched, or consumers get caught in the gap. What are required for our healthcare system to succeed is vision, a strategy, and courage.

If **Larry Grossman** were still with us, he would remind us of the core values that must drive our thinking and behaviour – the values of respect, compassion, dignity, community service, and human rights. Then he would explain to us how in fact … we could be doing much better!

FORWARD THIS BLOG TO COLLEAGUES WHO ARE INTERESTED IN HEALTH SYSTEM REFORM.