Outcomes and Effectiveness

The Success of Community Mental Health and Addiction Programs

Ontario Federation of
Community Mental Health
and Addiction Programs

Outcomes and Effectiveness

Ontario Federation of Community Mental Health and Addiction Programs

250 Consumers Road, Suite 806
Toronto, Ontario M2J 4V6
Tel.: 416 490-8902

Introduction

The Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP), represents 216 community based organizations. OFCMHAP recognizes that there is a distinct lack of understanding and awareness about the success and effectiveness of the services provided to vulnerable people in the province of Ontario.

This lack of awareness and understanding has resulted in a continued erosion of financial support to the core programs that make up the community addiction and mental health sectors. As a result, most organizations have seen their base budget decline by over 20% since 1992, as their funding has not kept pace with the increased cost of providing services.

To understand the crisis that the addiction and mental health field is facing, it should be recognized that:

- The cost of mental health and addiction problems to the Ontario economy is enormous.
- The number of people affected by mental health and substance use problems is on the rise
- The cost of managing those problems in the community by members of OFCMHAP is significantly less than the alternatives.
- Members of OFCMHAP are unable to offer enough service to many of the people who come to us for help.
- And despite these obstacles the community based addiction and mental health sector can demonstrate the success and effectiveness of the services they provide.

Community based mental health and addiction services, as provided by members of OFCMHAP, are part of a comprehensive package to address the issues facing the health care system in the province of Ontario.

Support, enhancement and expansion of community based programs in the addiction and mental health sector will result in a more effective and efficient health care system.

Acknowledgements

The Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP) would like to thank the following people and organizations for their support and participation in the preparation of this document.

Tim Aubry (University of Ottawa)
Michel Bedard (Lakehead University)
Dale Butterill (CAMH)
Sue Carr (OFCMHAP – PSR Toolkit Project)
Larry Corea (DATIS)
Wendy Czarny (Waterloo Regional Homes for Mental Health)
Maurice Fortin (CMHA Thunder Bay)
Vicky Huehn (Frontenac Community Mental Health Services)
Steve Lurie (CMHA Metro)
Sandy Milakovic (CMHA Peel)
Mike Petrenko (CMHA London)
Ellen Tate (CAMH)
Susan Vincent (DART)
Jeff Wilbee (ADRAO)
Diana Anderson (Regeneration House)

Members of the OFCMHAP Workforce Compensation Committee

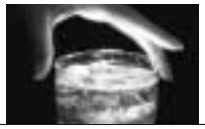
Steve Bransfield
Joanne Campbell
Asta Dvorak
Susan Meikle
Brian Pollock
Harry Spindel
Brigitte Witkowski
Claire McConnell
Fatima Amarshi
Linda Gallacher
David Kelly

Alcohol and Drug Recovery Association of Ontario (ADRAO)

Canadian Mental Health Association – Ontario Division

OFCMHAP Board of Directors

Table of Contents



Findings

Project findings are reported here in relation to the key messages they support. For more detailed information about each of the referenced documents, see *Citations.*

The cost of mental health and addiction problems to the Ontario economy is enormous

- Single et al (1996) estimated the cost of substance abuse to the Ontario economy at $7.02 Billion in 1992, emphasizing that this was a "conservative" estimate and that actual costs could be "significantly higher". Even this "conservative" figure accounted for 2.5% of the Province's GDP or $662 per capita.

- Data from that same study allows for estimation[1] of:

  annual number of **hospitalizations** due to substance abuse in Ontario – 114,481

  annual number of hospital days due to **substance abuse** in Ontario – 1,608,138.

- Stevens and Joubert (1998) found that:

  678,000 employed Canadians lost 39,000 person years of work time due to **depression**

  2,000,000 individuals lost an additional 115,000 person years due to "distress".[2]

- The authors stated: "We can thus conclude with fair confidence that the economic burden of mental health problems (in Canada) – both medically treated and not, is $14.4B annually at a minimum. These results show that promoting the mental health of Canadians would be a sound investment, not only to prevent mental health problems, but also to decrease the staggering economic burden associated with them."[3]

[1] Single does not offer a breakdown by province of hospitalization data. Given that Ontario accounts for 38% of the Canadian population, this estimate was developed by multiplying the figures for all of Canada by .38.
[2] Using the same percentage (38%) it might be reasonable to estimate the number of Ontarians affected by depression at 257,640, with a resulting loss of 14,820 person years of work. Similarly, "distress" would affect 760,000 individuals and result in 43,700 lost years of work.
[3] It should be noted that Stevens and Joubert dealt with the impact of depression and "distress" only. No consideration was given to individuals who, as a result of serious mental illness, may have removed themselves from the workforce completely.

- According to Wilkerson (2001), (2002), (2002):

In Canada, the **cost** of mental illness represents nearly 14% of all corporate income.

Households with a **disabled family member** consume, on average, 40% less in goods and services than the average household.

Mental health disorders are one of the 3 leading **causes of disability** in the world today.

Since 1994, depressive disorders have grown 100% as a percentage of short term and long term **disability claims**, 40% as a percentage of Workers' Safety and Insurance Board claims and 55% across all categories of disability-related absences from work.

Stress and mental health –related problems currently represent 40 – 50% of the **short-term disability** claims among employees of some of Canada's largest corporations.

Over the next 20 years, Harvard University and the World Bank foresee depression becoming the **leading source of workdays lost** through disability and premature death. Heart disease will be number two.

The social and personal cost to our communities is even more profound

- Single et al reported (1996) 40,931 deaths due to substance abuse in Canada in 1992 (an estimated 15,554 of them in Ontario). Those 40,931 deaths accounted for 21% of total mortality for the year.

- According to the Canadian Health Network, 10% of adult Canadians report problems with their drinking, and a full 50% report problems with someone else's drinking.

- Wilkerson (2002) reports that the suicide rate is equal to one jumbo jet falling out of the sky every month for a year.

- Health Canada (2002) indicates that:

20% of Canadians will personally **experience** a mental illness in their lifetime

8% will experience a **major depression**

1% will be diagnosed with **schizophrenia**

12% will suffer mild to severe **impairment** as a result of an anxiety disorder

suicide accounts for 24% of all deaths among 15-24 year olds, and 16% among those from 25 to 44.

The number of people affected by mental health and substance use problems is on the rise

- The Office of Applied Statistics (2001) reported that 7.1% of the U.S. population (age 12 and older) identified themselves as "current drug users" in 2001, compared with 6.3% the year prior (2000). The most significant increases were noted among those 12-17 years (from 9.7% to 10.8%), and 18-25 years (from 15.9% to 18.8%).[4]

- According to Stevens and Joubert (2001), youth exhibited the highest distress levels in the population, when they had the lowest levels 20 years ago.

- According to the World Health Organization (Wilkerson, 2002) the average age of onset of the most pervasive and common psychiatric disorders is getting younger.

- Wilkerson (2002) also notes that Canada has the youngest average age of onset for addiction disorders in countries surveyed by the WHO.

[4] U.S.-based data was used because no comparable Canadian study was identified.

The problems from which they suffer can be dealt with effectively in the community

- Leff, Trieman, Knapp, and Hallam (2000) studied more than 1,100 long-stay patients discharged from two psychiatric hospitals in the U.K., following them for up to 13 years. The study concluded that, when provided with appropriate community support, these former patients experienced:

  increased skill in using community facilities

  improved activities of daily living

  increased number of social contacts with "ordinary" members of the public (rather than fellow patients or health service professionals)

  greatly improved quality of life

  significantly fewer restrictions in their living environment

  As a consequence of these improvements, 84% of these individuals expressed a preference for remaining in the community, five years after discharge from hospital.

- Carroll (1997) reports that the effectiveness of certain treatment approaches for alcohol and other drug use disorders is comparable to that for other chronic disorders, such as diabetes or asthma

The cost of managing those problems in the community is significantly less than the alternatives

- Based on results from a study of over 1900 residents from 368 mental health facilities in England and Wales, Knapp, Chisholm, Astin, Lelliot and Audini (1997) concluded:

  The costs of hospital care are significantly greater than the costs of care in the community in all 8 geographic areas studied.

Considerable sums of **money could be saved** if people inappropriately accommodated in hospital were to move to community based services.

- Leff., Trieman, Knapp and Hallam (2000) also concluded that community-based care is more cost-effective than hospital care.

- McCrone, Chisholm and Bould (1999) state that: "shifting the emphasis from hospital to community care results in a decrease in the cost of care, despite the cost of implementing new programs".

- Carroll (1997) reports that each dollar spent on the treatment of alcohol use disorders saves between $4 and $12 in long-term societal, economic and medical costs.

- In a recent Ontario study, Rush, and Aitken-Harris (May 2000) assessed the clinical status of 162 individuals during receipt of withdrawal management services and at discharge. Based on client report, they concluded that, if withdrawal management services had not been available:

  5% of clients indicated they would likely be in **jail**

  11% reported they would be in **hospital.**

- Rush and Aitken-Harris thus concluded that withdrawal management services are providing an alternative to the use of more expensive medical and correctional services.

- Rush, Hobden, Aitken Harris and Shaw Moxam (2000) suggest that by two years following treatment for substance use there are significant declines in the use of health services, resulting in considerable cost savings to the overall health care system.

- Latimer (2001) reported on outcomes from a study of 41 clients receiving the services of an ACT team at the Douglas Hospital, Montreal:

  Annual hospital days per client were **reduced** from 97 to 21.

  Emergency room and outpatient visits were also **reduced**.

  Net annual **savings** in treatment cost were estimated at $390,000.

- Forchuk (2002) studied outcomes related to incorporation of a Transitional Discharge Model into 13 in-patient psychiatry wards. This model has two significant features – a more flexible role for in-patient staff, allowing them to create a "bridge' for patients into the community, and a formalized partnership between mental health consumer organizations and service providers. Forchuk found that:

"Transitional clients" used $4,400 less in **hospital services** than the control group in year following discharge.

A subgroup of transitional clients described as "lonely" used $20,3000 **less in hospital services**.

Adding the transitional component to in-patient units resulted in total **cost savings** of $12M for 390 clients.

The investment in community support programs is paying off

Preliminary findings from the Community Mental Health Evaluation Initiative (2002) indicate that people with serious and persistent mental illness (including those who are homeless) are showing significant improvement in their community functioning, quality of life, functioning, symptoms, use of substances, and are experiencing fewer crises and days in hospital.

Some of the people we see are very disabled

Clients who are recipients of the intensive community support services studied through the CMHEI are, for the most part, significantly disabled with a serious mental health disease. Early results show that both of the service models under study hold promise for helping these disabled clients to decrease their reliance on institutional care and improve their quality of life.

We are unable to offer enough service to many of the people who come to us for help

- The Health Systems Research and Consulting Unit (2002) , reporting on Ontario's Community Comprehensive Assessment Projects indicate that, in all regions of Ontario:
- Less than 50% of mental health consumers receive the appropriate level of care.

There is **inadequate capacity** in the system to meet the needs of people who require level 3 or 4 care.[5]

Areas of **highest need** include vocational and social support, housing and income support.

At the same time, there are many people in hospital who would not need to be there were more community based alternatives available

The Health Systems Research and Consulting Unit (2002) found that about 3% of those who were receiving in-patient treatment actually required it, based on their clinical/functional need. The percentage of those mandated to receive treatment as in-patients was not reported.

People who do receive our services benefit from them

- Projects involved in the Community Mental Health Evaluation Initiative (CMHEI) are finding that clients experience fewer symptoms, lower rates of drug abuse and better overall functioning. They require less frequent hospitalization and visit the emergency room less often.
- Both qualitative and quantitative data from CMHEI projects focused on consumer/survivor and family initiatives indicate that those projects have positive impacts on members and the community.
- Rush, Hobden, Aitken Harris and Shaw Moxam (2000) found that 88.7% of addiction clients surveyed felt "moderately" or "very" positive about the service they had received.

[5] Level 3 is defined as "intensive community support: up to daily". Level 4 care is "residential treatment"

Those same individuals showed positive outcomes at six-month follow up in terms of:

significant reductions in alcohol, cocaine and cannabis use

improvements in self-esteem and self-confidence.

Our members can demonstrate success

- Wendy Czarny, Executive Director, Waterloo Regional Homes for Mental Health, (Czarny 2002), reports an 89% reduction in the average amount of time people spend in hospital before and after becoming involved in her supportive housing program.[6]

- Vicky Huehn, Executive Director, Frontenac Community Mental Health Services in Kingston, (Huehn 2002), notes a 60% reduction over 8 years in the total length of time spent in hospital as a result of involvement in another of our housing programs in Eastern Ontario.[7]

- Steve Lurie, Executive Director, CMHA Metro, (Lurie 2002), 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.

- Sandy Milakovic, Executive Director, CMHA Peel, (Milakovic 2002), reports that her agency provides community support through club house services, court support, outreach and support networks for people, who would otherwise spend much of their time in hospital, for less than $5000 per year, on average.

In 1993 the Provincial Government committed to shifting the balance from hospital to community care

In 1992/93 Ontario spent 21% of the mental health budget on community services and 79% on institutional care. With the release of *Putting People First*, government committed to shifting that balance to 80% community/20% institutional by 2003.

[6] 2001/02 data tracked 120 consumers, each of whom spent 37.9 days in hospital (on average) the year prior to program involvement and 8.3 days in the year following admission to the program.
[7] Total # of days spent in hospital in 1994/5 was 1,124. By 2001/02 hospital days had been reduced to 451.

AND YET ...

In late 2002, we are far from achieving that goal

According to a recent survey of Federation members (Ontario Federation of Community Mental Health and Addiction Programs 2002):

- Most of the Federation's 212 member organizations have experienced a net decrease in provincial funding for core programs of 20% when taking into account the increased cost of operations since 1992.
- As a result of those fiscal constraints, the majority of organizations have had to reduce service to clients.
- That service reduction has put clients at increased risk for hospitalization, homelessness, incarceration or harm to themselves or others - the very outcomes they are dedicated to avoiding.
- 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 half of the people who need our services 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.

The Drug and Alcohol Registry of Treatment (2002) reports that:

- Since 1996 Ontario has lost almost 10% of residential addiction treatment beds (from 2003 beds to 1817) and over 14% of withdrawal management beds (from 627 beds to 535).
- 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

almost 6 months for admission to a residential service.

- For some groups of people, the only appropriate service available is hundreds of miles from home:

> Residential addiction services for youth are located in Thunder Bay, while people with concurrent disorders must **relocate** to St. Thomas if they require residential care. Those programs are often unable to accommodate local residents because they have **reached capacity** with clients from elsewhere in the province.

Our people are our most valuable asset

Despite this, respondents to the Federation survey (2002) report that:

- Almost 3/4 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 permanently lost.
- 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.

The future looks even bleaker...

Half of the Federation's member organizations anticipate cutting service further in the next two years – it's the only way they can make ends meet.

General observations

The following general observations should be noted:

- Research related to the outcomes and cost-effectiveness of community mental health services has been underway in some other jurisdictions (most notably Great Britain) for over a decade. For the most part, these findings are extremely positive. Since the British policy framework and service delivery structures are different from those of Ontario, however, caution should be exercised in generalizing those findings.

- Much of the current mental health research compares outcomes derived from ACT(T)-like programs with those of Intensive Case Management or other program types. Given that it is not the intent of this paper to compare one community mental health approach to another, findings from that research are not reported here.

- A great deal of mental health research is currently underway in Ontario – through the Community Mental Health Evaluation Initiative (CMHEI) and the Comprehensive Assessment Project (CAP).

  Preliminary findings from the CMHEI projects indicate **positive outcomes** from various types of community mental health services. Private communication with some researchers suggests that final outcomes may be even stronger than reported, but that caution is required given these studies are not yet complete.

  CAP data will be extremely valuable for purposes of this project. Preliminary results suggest strong support for one of the central theses of this paper – i.e. that there is **inadequate capacity** in Ontario's community mental health system to deliver the level of support required by people with significant needs. A summary report, scheduled for publication by mid December 2002, will include detailed analysis of regional and provincial data.

- Similarly, access to the MOHLTC's fiscal pressures survey would be invaluable in demonstrating the impact of fiscal constraints on the addiction system. Whether survey results will ever be made public, given the sensitivity of that data, remains to be seen.

Background

In August 2002, the Ontario Federation of Community Mental Health and Addiction Programs (the Federation) contracted with Johnston Consulting to research and develop a report that demonstrates the effectiveness and outcomes of the community mental health and addiction sectors."

Project deliverables

Project deliverables were defined as follows:

1. Review of the literature with respect to the effectiveness of community mental health and addiction programs as measured by:

---

community tenure

mortality

criminal justice system involvement

clinical status

functional status

employment status

housing status

financial status

quality of life

physical health status[8]

---

2. Key informant interviews (10) with leaders of agencies that provide community mental health and addiction services and can demonstrate their effectiveness through data analysis and/or anecdotes.

3. Development of a rationale for enhanced funding for community mental health and addiction programs, based on the information obtained through #s 1&2.

[8] These measures were selected due to their inclusion in the Mental Health Accountability Framework recently released by the Ministry of Health and Long-Tem Care. Although assessment of service outcomes against these criteria was seen as the ideal, it became apparent as this project progressed that there is not yet a great deal of research available that addresses those measures specifically. Consequently, the project, and this document, was re-focused to emphasize outcomes for which there was support available – either in the literature or anecdotally.

Project process

This report is the final stage of the following process:

- The Research Consultant identified 75 documents with potential relevance to the project.
- Based on a brief scan of all the documents, the Principal Consultant undertook a detailed review of 50 abstracts, presentations, reports and full-text articles containing specific data related to cost, outcomes and cost-effectiveness of community mental health and addiction programs.
- The Principal Consultant contacted 15 key informants for additional information:

  Tim Aubry (University of Ottawa)

  Michel Bedard (Lakehead University)

  Dale Butterill (CAMH)

  Sue Carr (OFCMHAP – PSR Toolkit Project)

  Larry Corea (DATIS)

  Wendy Czarny (Waterloo Regional Homes for Mental Health)

  Janet Durbin (Centre for Addiction and Mental Health)

  Maurice Fortin (CMHA Thunder Bay)

  Vicky Huehn (Frontenac Community Mental Health Services)

  Steve Lurie (CMHA Metro)

  Sandy Milakovic (CMHA Peel)

  Mike Petrenko (CMHA London)

  Ellen Tate (CAMH)

  Susan Vincent (DART)

  Jeff Wilbee (ADRAO)

- The Principal Consultant developed a series of key messages, each supported by findings from the literature and/or information obtained from key informants. Those key messages were presented to the Federation Board of Directors on October 25, 2002.
- Based on input from the Board, the Principal Consultant revised the key messages and prepared this document.

CITATIONS

1. Eric Single, Lynda Robson, Xiodie Xie, & Jurgen Rehm. *The Costs of Substance Abuse in Canada: Highlights of a major study of the health, social and economic costs associated with the use of alcohol, tobacco and illicit drugs.* Canadian Centre on Substance Abuse, 1996

2. Thomas Stephens and Natacha Joubert. *The Economic Burden of Mental Health Problems in Canada.* Chronic Diseases in Canada, Volume 22, No, 1-2001. www.hc-sc.gc.ca/hpb/lcdc/publicat/cdic/cdic221/cd221d_e.html

3. Bill Wilkerson. Business and Economic Roundtable on Addiction and Mental Health. *Business Reinvestment in the Emotional Health of its People. Summary of remarks to the Provincial Forum*. September 24, 2001

4. Bill Wilkerson. Business and Economic Roundtable on Addiction and Mental Health. *Mental Health – The Ultimate Productivity Weapon. Summary of remarks to the Industrial Accident Prevention Association Conference and Trade Show*. April 22, 2002

5. Bill Wilkerson. Business and Economic Roundtable on Addiction and Mental Health. *Summary of remarks to the Annual Meeting of the Industrial Accident Prevention Association of Ontario.* April 22, 2002

6. Canadian Health Network. Substance Use/Addictions/FAQs/Question #1. http://canadian-health-network.ca/faq-faq/substance_use_addictions-toxicomanie/1e.html

7. Health Canada. *A Report on Mental Illness in Canada.* Ottawa, October 2002

8. Office of Applied Statistics. SAMHSA. *Highlights – Volume 1 – 2001. Summary of Findings, 2001 National Household Survey on Drug Abuse*

9. Julian Leff, Noam Trieman, Martin Knapp and Angela Hallam. *The TAPS Project: A report on 13 years of research, 1985-1998.* Psychiatric Bulletin (2000) 24, pp. 165-168

10. Kathleen Carroll. *New Methods of Treatment Efficacy Research: Bridging Clinical Research and Clinical Practice.* Alcohol Health and Research World, Vol. 21, Nov. 4 1997, pp.352-359

11. Knapp, M.; Chisholm, D.; Astin, J.; Lelliot, P.; Audini, B. *The Cost Consequences of Changing the Hospital-Community Balance: the Residential Care Study.* Psychological Medicine. Cambridge University Press, Vol. 27(3) May 1997, pp.681-692

12. Paul McCrone, Daniel Chisholm and Martin Bould. *Costing Different Models of Mental Health Service Provision*. Mental Health Research Review 6, May 1999, pp.14-17

13. Brian Rush and Julie Aiken Harris. Drug and Alcohol Treatment Information System (DATIS). *Client Satisfaction and Outcomes Within Ontario's Withdrawal Management Centres: Results of a Provincial Pilot Study.* May 2000

14. Brian Rush. Karen Hobden, Julie Aitken Harris and Raquel Shaw Moxam. Drug and Alcohol Treatment Information System (DATIS). *Client Outcomes Within the Ontario Substance Abuse Treatment System: Results of a Provincial Pilot Study.* June 2000

15. Eric Latimer, Anne Crocker, Celine Mercier, Helen Cunnungham, Youcef Oudahi and Andrea Martin. *Exportability of the assertive community treatment model to Canada: Initial outcomes of a high fidelity program.* Abstract # 29979 for the APHA Conference: October 2001

16. Cherlyl Forchuk, Kathleen Hartford, Ake Blomquist, Mary-Lou Martin, Lilian Chan and Allan Donner. *Therapeutic Relationships: From Hospital to Community* http://publish.uwo.ca/~forchuk/tr/summary.htm

17. Community Mental Health Evaluation Initiative (Multi Site Study). *Main Messages and Individual Project Summaries.* March 26, 2002.

18. Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health. *Toronto-Peel Comprehensive Assessment Project: Presentation to the Toronto-Peel Mental Health Implementation Task Force.* August 29, 2002

19. Wendy Czarny – Waterloo Regional Homes for Mental Health. *Personal Correspondence.* October 2002

20. Vicky Huehn – Frontenac Community Mental Health Services. *Personal Correspondence.* October 2002

21. Steve Lurie – CMHA Metro. *Personal Correspondence.* October 22, 2002

22. Sandy Milakovic – CMHA Peel. *Personal Correspondence.* October 22, 2002

23. Ontario Federation of Community Mental Health and Addiction Programs. *A System under Pressure; Community mental health and addictions services shrinking.* 2002

24. Susan Vincent, the Drug and Alcohol Registry of Treatment. *Personal Correspondence.* October 23, 2002