A Case for more Proximity Services in Mental Health[1]

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ABSTRACT:

Objective: *To illustrate the level of financing (public or private) of mental health services, while assessing the contribution of community mental health organizations in Quebec, particularly in Montreal.*
Methods: *Analysis of financial statements and statistics on mental health funding in Quebec. Analysis of the contribution of 29 community organizations based on interviews and studies of annual reports.*
Results: *On a per capita basis, mental health accounts for 5% of total healthcare expenditures with 10% of these mental health resources allocated to community organizations. Programs most publicly financed: hospitalization, outpatient services, and residential services. The least publicly financed, rehabilitation services, socio-professional integration and daytime activities, are offered by community organizations.*
Discussion: *Community organizations are offering services that would normally be part of a balanced public mental healthcare approach geared towards recovery and proximity services. We make a case for increased funding in order to develop more proximity services based on close partnerships between community organizations and the public sector.*

KEY WORDS:

Mental health, community, healthcare, outpatient, residential services

INTRODUCTION

In Canada, both public and private sectors provide mental health services. Regardless of whether the funding comes from public or private sources, a balance must be achieved between more cost-intensive treatments, such as hospitalization, and less cost-intensive services such as community outreach (Cuffel, Regier, 2001). Most patients require the least costly services whereas the severely mentally ill require higher cost services. According to Thornicroft and Tansella (2003), the components of a balanced mental healthcare system include: (1) Primary care – the fulcrum of mental healthcare (15% of the general population). Providing medication and psychotherapy have been shown to be partly effective for the most common mental disorders (ex. anxiety and depression) with occasional referrals to specialized services; (2) Specialized outpatient care (1-2% of the population), generally provided by multidisciplinary community mental healthcare teams or a specialized disease/treatment

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program (ex. first-onset psychosis and intensive home care programs). The organization of this type of specialized care is mostly found in university-based areas; (3) Occupational, daytime, social reintegration and rehabilitation services (0.5% of the population); (4) Acute hospital care (0.3% of the population); (5) Long-term hospital and residential care (0.2% of the population) (Lesage 2010; IHE, 2014). According to the Canadian Institute for Health Information, the mean length of stay on psychiatric inpatient units in Canada is 12 days (CIHI 2012).

In a balanced mental healthcare system, available resources are related to the capacity to meet the needs of the severely mentally ill (Andrews, Henderson, 2006; Fleury, Piat, Grenier, Bamvita, Boyer, Lesage, Tremblay, 2010; Knapp, Chisholm, Leese, Amaddeo, Tansella, Schene, Thornicroft, Vazquez-Barquero, Knudsen, Becker, 2002). In the last decades, there have been successful closures and downsizing of psychiatric hospital beds in Organization for Economic Co-operation and Development (OECD) countries. Indeed, discharged long-stay in-patients who have access to adequate community care programs have shown good outcomes (Tansella,Thornicroft, 2003). Nevertheless, there has been a system management failure to properly fund, develop and coordinate community services (Tansella, Thornicroft, 2003). Occupational, daytime, social re-integration and rehabilitation services are particularly vulnerable (Holloway 2010). The senatorial committee that funded the Mental Health Commission of Canada came to the same conclusions (Kirby, Keon, 2006). In the province of Quebec, there has been a failure to deploy evidence-based intensive home care teams, proposed in the 2005-2010 mental health action plan. No more than 30% of the home care teams needed to deliver treatment and rehabilitation to the severely mentally ill have been put in place (Delorme 2009).

In the area of community-based services, non-governmental organizations (NGOs) have played an important role in the development of the mental healthcare system. New services and new models of rehabilitation with a "patient-first" approach have been developed in community practices and these recovery approaches and values have been progressively adopted by public services (White, Mercier, 1991). These NGOs are considered essential to the public system and the Quebec government aims to allocate 10% of its mental healthcare system budget to them (RACOR 2009).

According to a recent study by the Institute of Health Economics (IHE 2010), the total Canadian spending ratio for mental health is between 5% and 6% of the overall health budget in provincial and territorial jurisdictions (IHE 2007: 48-49). The ratio of mental health expenditures to total health expenditures is a useful indicator that allows a comparison in terms of spending, between different provinces and countries. Data from the World Health Organization (WHO 2005) shows that, in comparable countries, this ratio ranges from 6.4% in Australia to 11% in Sweden, New Zealand and the UK. In terms of public spending, the figure for the US is 8.1%, putting it higher than that of Canada and Quebec. This ratio does not take into consideration the prevalence of mental illness or the burden of diseases where mental disorders like depression overcome other diseases. According to the 2010 Global Burden of Disease Study, mental and behavioural disorders account for almost a quarter (23%) of years of life lost due to disability and 13% of years lost due to disability and premature mortality (i.e. disease burden) in Canada (IHME, 2013).

In this context, charitable organizations play an important complementary role. According to the Canada Revenue Agency, the sector of health and social services (including religious donations) accounted for 70% of all private donations in 2007 (Hall, Lasby, Ayer, Gibbons, 2009). In 2008-2009, the biggest foundation specializing in mental health in Montreal gave $1.7 million, which is equivalent to 7% of all resources allocated to community mental health organizations in Montreal during that year. Over the years, this foundation has concentrated its funding on direct support of proximity services by community organizations in order to reach the severely mentally ill and fill some of the gaps in services.

As part of a mandate given to our group of researchers by a private foundation, this study provided an opportunity to study the level of financing (public or private) of mental health services

in Quebec. It was possible to interview the key players of 29 Montreal community organizations partly funded by this private foundation. It showed what services were made possible by the grants and identified the future needs and challenges of these organizations. Finally, the study provided the opportunity to assess the contribution of community mental health organizations to a balanced mental healthcare system.

1. Methods

To better understand the level of financing of mental health organizations, the authors conducted a thorough analysis of statistics and financial statements provided by the Ministry of Health and Social Services in Quebec.

To assess the role of community mental health resources, an analysis of reports and documentation provided by organizations receiving donations from a major private foundation was conducted. Interviews were performed with the 29 recipients who received the most significant amount of funding from this organization over the past five years. All of the organizations surveyed received funding from the private foundation. These recipients, who are all located in Montreal, Quebec, specialize in mental health and represent three different areas of focus: research, public services and community organizations.

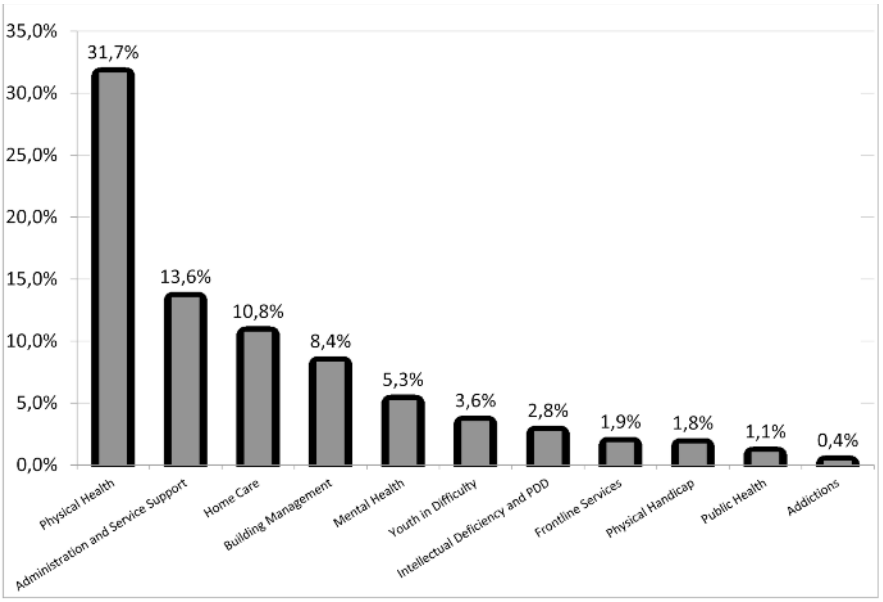
The aspects covered in the interviews are as follows: the quality of the relationship with the foundation, the quality of the relationship with other donors, the direct services made possible by the donations, the future needs of the organization and of the mental health sector.

2. Results

2.1 Analysis of statistics and financial data

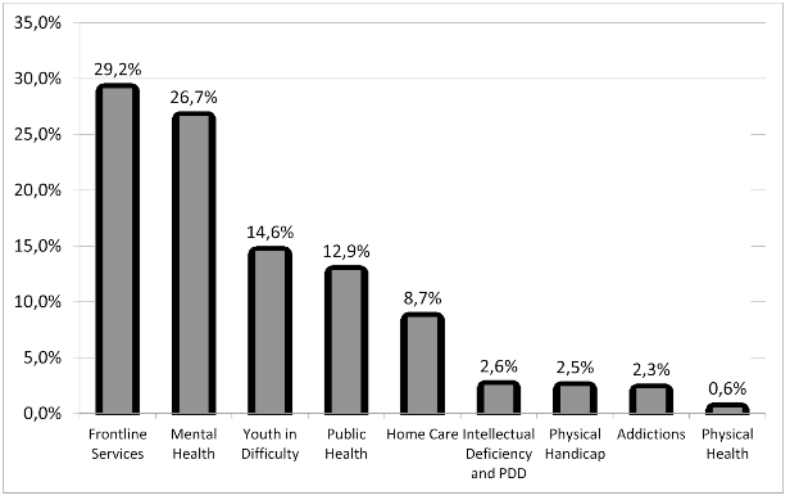
The analysis of the statistics and financial data provided by the Ministry of Health and Social Services (MSSS) shows expenditures in programs such as physical health, mental health, frontline services, addictions, youth services and public health. Furthermore, these expenditures can be calculated on a per capita basis and by administrative region indicating the proportion of funds directed towards mental health. Figure 1 shows the result of this analysis for Montreal in 2008-2009.

Figure 1: Percentage of expenditure by sector of activity in Montreal, 2008-2009



In addition to funding public services, the government allocates funding to community organizations in various sectors. Figure 2 shows the percentage of government spending in community organizations by sector of activity in Montreal.

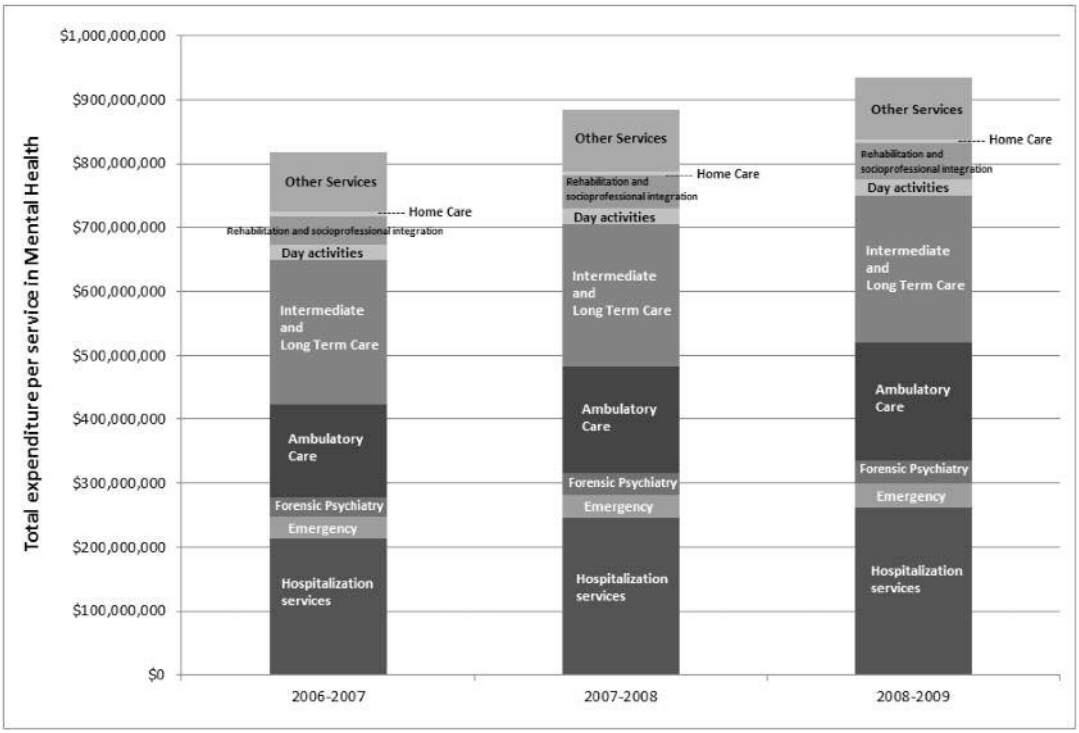
Figure 2: Percentage of community organization expenditure by sector of activity in Montreal, 2008-2009



While mental health is largely represented in the community sector, the expenditure on a per capita basis is very low. In Montreal, the per capita spending of community agencies, including mental health organizations, is of $52.71. Montreal's funding per capita therefore ranks sixth out of 16. The lowest in Quebec is $38.20 for the Laurentian region and the highest is $125.96 for the Gaspé-Magdalen Islands region. According to the 2011 census of Statistics Canada, Montreal is the most populous city in Quebec with a population of more than 1.8 million. Quebec City is a distant second with a population of 516,622. Quebec City's per capita funding is similar to that of Montreal at $56.51, ranking it eighth out of 16. It could be argued that, with a greater proportion of socially deprived areas (Lesage, Clerc, Uribé, Cournoyer, Fabian, Tourjman, Van Haaster, Chang, 1996) as well as a disproportionate number of homeless and mentally ill homeless in Montreal (MHCC, 2011), the needs in Montreal would require a greater proportion of funding than what is allotted currently.

The overall budget allocated to community mental health organizations in Montreal for 2008-2009 was $26.7 million, or about 10% of the mental health budget. In Quebec, mental health funding is directed towards a wide range of services including hospitalization, emergency services, ambulatory care and home care. It appears to be particularly unbalanced in the areas of home care, rehabilitation, socio-professional integration and daytime activities (see Figure 3). The areas that receive less public funding are generally those covered by community organizations and these activities are supported, for the most part, by private funds.

Figure 3: Mental health expenses in Quebec, by type of service

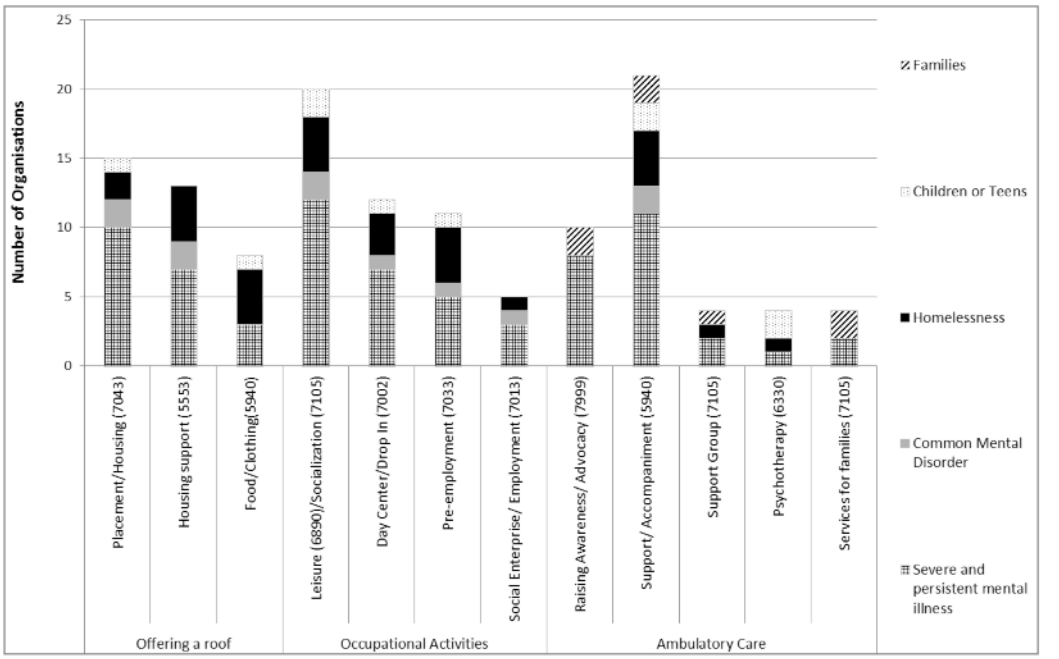


2.2 Analysis of 29 organizations receiving funds from a private foundation

Of the 29 organizations that were interviewed, 25 were community organizations and 4 were hospitals. All four hospitals used the private funds for special projects that were deemed to be innovative. Meanwhile, 20 out of 25 community organizations used the donations to cover operational expenses such as salaries, rent and utilities. The remaining five community organizations, usually larger in size, used the funds for special projects such as offering psychotherapy to homeless teens and developing specialized housing for the mentally ill. For the most part, the donations were used for providing direct services though several organizations were also involved in new projects, research and teaching (16 out of 29 organizations provide internship opportunities for college and university students, particularly social work students).

The range of activities included in "direct services" is wide. In relation to activities described in Figure 3, community organizations offer services falling in the category of "placement/housing, housing support and food/clothing." Other activities are rehabilitation and socio-professional integration such as "day-centre/drop-in, pre-employment, employment and leisure/socialization." Lastly, "support/accompaniment, raising awareness/advocacy, support groups, psychotherapy, home care and services for families" would fall into the Figure 3 categories of home care and ambulatory care. Figure 4 shows the number of organizations offering the various types of services, for different types of clientele.

Figure 4: Number of organizations and types of services classified according to Quebec Ministry of Health and Social Services AH-471 financial centres of activities, offered for each type of clientele



2.3 Future needs and challenges

In assessing the usefulness of donations from private foundations, the researchers also wanted to evaluate the future needs and challenges of the 29 organizations and whether the services as they are today, were sustainable. The results illustrated in Figure 5 show eight different categories of future needs. The most commonly expressed was the consolidation of existing services.

Consolidation – precariousness

This refers to the need to strengthen the organization by hiring competent employees, training staff, renovating existing premises and working to maintain partnerships and existing services. For many organizations, current operations are precarious, often based on non-recurrent funding; they have difficulty attracting and retaining staff and struggle to maintain their activities. It is therefore not surprising that 20 of the 29 organizations mentioned consolidation as their greatest challenge. One of the major problems cited by community organizations related to the funding of the operating budget (rent, utilities and salaries). Access to funds for operating expenses is a major concern for many community organizations as foundations often prefer funding special projects.

Aging clients

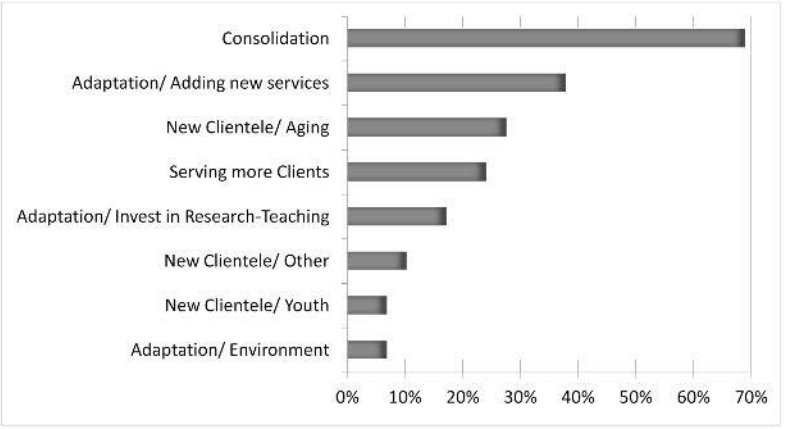
Other future challenges expressed were the need to adapt to a changing environment and in many cases, an aging population. The clientele currently receiving services is aging and presents with the physical problems that come with aging and being medicated for long periods of time. As indicated by some authors (Chwastiak, Tek, 2009), patients with chronic mental illnesses like schizophrenia can die up to 25 years earlier than the general population, the most common cause of death being heart disease, cancer and chronic lung diseases. As stated by some authors (Jeste, Wolkowitz, Palmer, 2011) "Compared with the overall population, individuals with schizophrenia

have accelerated physical aging, with increased and premature medical comorbidity and mortality". The physical condition of aging mentally ill patients places an added burden on existing mental health services, which are required to assist and support their clients in accessing the wide range of medical and psychiatric care needed. Most mental health community organizations are also not equipped with wheelchair access or with facilities for people with problems related to mobility.

New services (including housing)

Some organizations were preoccupied with increasing their services in order to serve more clients. In fact, in many cases, there are significant waiting lists and the demand exceeds the supply of community- based mental health services. In other cases, the agencies mentioned they wished to add new services to better meet the needs of their clients. Housing is a concern that emerged frequently in the interviews. As shown in Figure 4, several organizations offered housing services. The others all have partnerships with organizations offering a roof or shelter. While housing is a major factor in the recovery of people with mental illness, it remains difficult to access (Felx, Piat, Lesage, Côté, Cadorette, Corbière, 2012). Access to affordable housing is a challenge for people suffering from mental illnesses who are often at a socio-economic disadvantage. The need for housing being omnipresent and growing, many organizations mentioned the need to add new housing services or adapt existing services in order to keep up with current and future demand. Figure 5 presents an overview of the different needs identified by the 29 organizations.

Figure 5: Categories of future needs and challenges as expressed by the 29 organizations interviewed.



CONCLUSION

Financial resources allocated to mental health services in the public healthcare system in Quebec and Canada are lower than those allocated in most industrialized countries. In Quebec, non-governmental community organizations partly financed by the managed care system receive 10% of the province's total mental health budget. Our interviews with these organizations, which concentrate on direct rehabilitation services, indicate that they are insufficiently and precariously funded and insufficiently supported by public managers. They provide services that are not covered by the public sector, despite the fact that they are essential to a balanced mental health system with proximity services, working towards the rehabilitation and recovery of the severely mentally ill. At times, the support of private foundations can conceal the significant underfunding of the organizations providing the aforementioned essential rehabilitation and recovery services to patients and their families.

This confirms the harsh judgement of the 2006 Canadian senatorial committee, which, for the first time since the creation of the Canadian universal public managed care system in the 1960s, considered "de facto" mental healthcare a non-system of care. "The tragedy is not that so many people suffer from mental disorders, the tragedy is that we do not do what we know works" (Kirby, Keon, 2006). This illustrates the gaps in types of services in Canada as compared to other countries like the UK and Australia, whose services were also assessed by the Canadian senatorial committee (Kirby, Keon, 2006). This is related to the underfunding of the whole system in comparison with these other countries, a cause for the failure of the proximity care system identified by Tansella and Thornicroft in their health evidence network report (2003).

This study is limited by the fact that it does not allow for a comparison of the past and present budgets of mental health and community organizations. It does not address the growing pressure on the system's public and community organizations to deliver more with decreasing resources. Our assessment of community organizations was limited to those sampled in Montreal and those funded by this private foundation, which is a bias in itself. On the other hand, even though these 29 agencies may not be a representative sample of all mental health community organizations, their range of actions and sizes appear typical of the majority, and their claims are consistent with reports from other Quebec researchers (White, Mercier, 1991; Grenier, Fleury, 2009).

This study also illustrates that the financing of community organizations, which play an essential role in supporting the efforts of the public sector, draws from the private sector. These community organizations follow best practices when working with the mentally ill and are recognized by university teaching institutions that send their trainees to them. However, the field of mental health attracts few private donors due to the stigma surrounding this cause (Thornicroft 2006) and is therefore much less successful at obtaining funds than children's health causes or other illnesses such as cancer.

This phenomenon has important policy implications for health leaders who must decide how to better support the community sector, while knowing that it is an essential partner in mental health. From this study, we make a case for offering more proximity services in mental health, something which should be done in the context of a partnership of voluntary community organizations and the public sector. An increase in overall funding and support in mental health is required to fulfill the promise of proximity community care for the mentally ill and their families. Everyone involved, including public sector professionals, community organization activists, family and consumer representatives, the private and political sectors should form an alliance in each province, similar to the Canadian Alliance for Mental Health and Mental Illness (see http://www.camimh.ca/). This organization successfully lobbied for the creation of the Mental Health Commission of Canada, but did not succeed in increasing funding for mental health in Canada, nor within the provinces. Such alliances, based on enhancing all citizenship participation and public accountability, were recently successful in the socially stigmatised health area of AIDS (McCoy, Labonte, Orbinski, 2006). We suggest that it might very well be the case with mental health as well.

RÉSUMÉ :

Objectifs : *Cette étude vise à illustrer le niveau de financement des services publics et privés en santé mentale ainsi qu'évaluer la contribution des organismes communautaires en santé mentale à Montréal.*

Méthodes : *Une analyse des états financiers et des statistiques du financement en santé mentale au Québec a été réalisée. La contribution de 29 organismes communautaires a été évaluée, basée sur des entrevues et des rapports annuels.*

Résultats : *Les dépenses en santé mentale représentent 5 % des dépenses totales en santé, de ce montant 10 % sont alloués aux organismes communautaires. Les programmes les plus financés sont l'hospitalisation, les services ambulatoires et les services résidentiels. Les moins financés sont la réadaptation, les services d'intégration socio-professionnelle et les activités de jour qui sont tous offerts par des organismes communautaires.*

Discussion : *Les organismes communautaires offrent des services qui devraient faire partie d'une approche équilibrée de services en santé mentale, orientée vers le rétablissement et les services de proximité. Cette étude présente des arguments en faveur du financement accru des services de proximité, basés sur un partenariat entre le secteur communautaire et le secteur public.*

MOTS-CLÉS :

Santé mentale, organismes communautaires, réseau de la santé et des services sociaux, services ambulatoires, services résidentiels

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