Bringing Services

For Mental Illnesses

“Out of the Shadows”

First steps towards a coherent policy for
British Columbians
with psychiatric illnesses.

A. Donald Milliken
MB, MSHA, FRCPC

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Executive Summary.

In this paper, the author identifies:

- Some background factors in the development of the Province's mental health system, and reasons for its deficiencies;

- Modern information on the importance of the public health burden of psychiatric illnesses, both on their own and as complicating factors which adversely effect the mortality and morbidity rates of other illnesses;

- The benefits to be achieved by the proper organization of care;

- Identifies how the Mental Health and Addictions Branch of British Columbia's Ministry of Health, together with the Health Authorities are planning for and addressing the needs of the patients and the system of care, and

- Makes two recommendations which, if implemented, would establish greater effectiveness of care, greater efficiency of the system so the patient receives the correct supports at the appropriate time in his or her recovery, as well as greater public accountability for the monies spent.

British Columbia's Conversation on Health.

In the February 2006 Throne speech [1] important questions were asked about our province's health care system:

- What does the principle of "universality" mean?
- What does the principle of "accessibility" mean?
- What does "comprehensive" and "portable" mean?
- How should we define concepts like "reasonable access" to "medically necessary" services?

When later inaugurating BC's Conversation on Health, Premier Gordon Campbell added three further topics:

- What do the principles of the Canada Health Act really mean?
- How can we improve health care delivery to live up to those principles?
- How can we ensure that our system is sustainable for British Columbians in the long term?

This very important discussion is especially poignant for British Columbians with mental illnesses. Words like "universality", "accessibility", "comprehensive" and "reasonable access" are foreign to the reality which faces many such persons -- and their families and friends. At the time when their abilities to sort through organizational challenges are compromised by illness, these individuals are faced with a care system that is patchwork, haphazard and structured without adequate attention to the real needs of those who are the supposed focus of the endeavour. Too many organizations chant "putting patients first" as a mantra without substance.

Persons with psychiatric illnesses should experience care
- at the same level,
- with the same degree of sophistication, and
- the same degree of evidence-based care,

as any other person with an illness of equivalent disability.

In discussions such as this, patients disabled by psychiatric illnesses all-too-often do not receive the acknowledgment that their level of illness and disability warrants. Because the illnesses themselves reduce the sufferer's capacity to advocate on their own behalf, their needs are not thought about, but remain out of sight – buried in the shadows.

[1] Second Session of the Thirty-Eighth Parliament of the Province of British Columbia

This author, Dr. Donald Milliken, is a medical doctor whose training and specialty lies in the care of patients with serious psychiatric and mental illnesses, and who has spent over 30 years working with such patients. In addition to his specialty psychiatric training, he holds a Master's Degree in Health Administration from the University of Colorado. In addition to his clinical practice, he has always held a variety of leadership and administrative positions responsible for the organization of care to this patient population, including appointments as the Chief of Psychiatry at the Misericordia Hospital, Edmonton (7 years), the Clinical Director of Forensic Services at the Alberta Hospital Edmonton (7 years) as well as the Chief of Psychiatry and Director of Psychiatric Services in Victoria, BC (8 years). He has been a consultant to the Alberta and British Columbia governments, as well as the formation of the Mental Health Commission of Canada. His professional colleagues have elected him as President of the Alberta Psychiatric Association, the British Columbia Psychiatric Association and the national Canadian Psychiatric Association.

In this "conversation", it is important to ensure that the treatment, recovery and supportive ongoing care needs of those who face such illnesses are considered. , Services for this group of patients must be at a level that is the equivalent of that provided to patients with physical illnesses with similar levels of disability is recognised.

> "In the end, we will remember not the words of our enemies, but rather the silence of our friends."
>
> Martin Luther King

Historical background.

Modern Canada has a long history of minimizing or ignoring the needs of the mentally ill. The Hospital Insurance and Diagnostic Services Act (1957), the precursor to the Canada Health Act, sets it out clearly when it states that, for the purposes of federal funding and cost-sharing

> *"hospital" includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include*
>
> *(a) a hospital or institution primarily for the mentally disordered*…"
>
> Hospital Insurance and Diagnostic Services Act (1957)
> Canada Health Act (1984)

This exclusion effectively eliminated the majority of then psychiatric patients from sharing in the increased Federal-Provincial transfer payments that led the development

of Canada's health system through the 60's and 70's. In contrast to every other branch of medicine, care for the great majority of those with psychiatric illnesses was left entirely to the provincial governments, with none of the federal support for the upgrading of facilities or services provided to other conditions.

Not surprisingly, this made it much more attractive for provinces to invest dollars in the other, non-psychiatric areas of hospital and health care, where such investments would be matched by the federal government.

A simple example lies in the increase in nurse staffing per 100 patients. In 1961, mental hospitals started out with a very much lower nurse to patient ratio than general hospitals. Over the next 15 years, while the numbers of nurses increased in both types of institutions, the increase in nurses per patient in general hospitals was **three times** that for patients in mental hospitals.

Nurses per 100 beds:

Year	Mental Hospitals	General Hospitals
1961	5.97	41.23
1975	16.70	71.31
Change in staffing numbers	10.73	30.08

Statistics Canada data.

Part of the mental hospital increase came from the 30% mental hospital bed reduction during this time; in contrast, general hospital beds increased by almost 35%. **The increase in total numbers of general hospital nurses was over 14 times the increase in mental hospital nurses: persons with mental illnesses did not receive the same level of support.**

Over the next decades, the same approaches continued. Combining data from the Canadian Hospitals Association and the Canadian Institute of Health Information, BC showed a loss of **almost 40%** of its rated bed capacity for patients with psychiatric illnesses during the period 1990 to 2002.

These changes in institutional care were not accompanied by alternative programs to address the needs of the sufferers, nor the requirements for a whole system. Financial efficiency was divorced from clinical efficacy. Institutional downsizing was not matched with equal investments in community care, whether in general hospitals, community mental health agencies or clinics, or other supportive services. Thus, the clinical effects of the financial decisions were disastrous for the mentally ill.

In 1964, less than a decade after the Hospital Insurance Act was introduced, the Hall Commission stated:

"Of all the problems presented before the Commission, that which reflects the greatest public concern, apart from financing of health services generally, is mental illness – case finding, diagnosis, treatment and rehabilitation."
"…Treatment of the mentally ill has been for too long characterized by callousness and neglect."

Despite such sentiments, the 1984 Canada Health Act continued the same exclusionary clauses, continuing to isolate patients with serious psychiatric illnesses from the mainstream of federal healthcare funding.

Faced with this reality, and like many other provinces, British Columbia has never produced a consistent, coherent and effective policy to ensure that mentally ill patients receive services at a level equivalent to those offered to physically ill patients with an equivalent level of disability.

The results were predictable. As the recent Senate of Canada report "Out of the Shadows at Last" comments

"Mental illness, in general, is not often treated with the same degree of seriousness as physical illness… Achieving equity would mark an important step in combating the stigma …and the discrimination against people living with [mental illness]."

"Quite simply, mental health services and addiction treatment are under-funded in relation to their prevalence and the economic burden of illness they impose.

However, calculating exactly which level of government, through what department, funds which services at what level, is no simple task.

There are multiple sources of funding with little joint interministerial collaboration.

None of this funding is dedicated expressly to mental illness and addiction and there is no accountability for the use of public funding for mental health or addiction treatment."

This quotation does not state the clear tragedy of these administrative decisions.

> **The Tragedy of Mental Illness:**
>
> The available evidence suggests that a properly organised system of care, providing for the clinical needs of the patients at the appropriate location, and in a timely manner, will produce a better clinical result, at no greater cost to the system, than the current system of disorganised, haphazard and ad-hoc care.
>
> Decades of poor clinical stewardship has produced a system that does not provide good results for the patients or for public accountability.

THE PUBLIC HEALTH BURDEN OF PSYCHIATRIC ILLNESS: what everyone needs to know.

Because psychiatric illnesses

- are a serious public health problem,
- are an unrecognised, "invisible" disability,
- have significant problems of access to services,
- have significant problems of availability of appropriate services (even where there is some access), and
- lack generalised standards for care between the various health authorities,

the plight of the mentally ill in our community deserves to be addressed in this Conversation.

> "…prevalence of mental disorder was generally higher than that of any other class of chronic conditions. This was striking in light of research documenting that mental disorders have greater effects on role functioning than many serious chronic physical illnesses"
>
> The WHO World Mental Health Survey Consortium

[2] Prevalence, Severity and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys: JAMA, 2004, 291, 2581-2590

Our neighbours, our relatives, our friends.

Throughout the developed world, the estimates of the incidence of mental illnesses in communities are the same: about 20% (1 in 5) will experience a significant mental illness at some point throughout their life. For many of these, the illness will start in youth or young adulthood. Without proper, accessible and well organized treatment, the disabilities can be prolonged, and the effects can last a lifetime.

Mental illness affects 1 in 5 persons.

Because we marry and live in families, this means that about 1 in 3 families will have a relative with, or who will develop, a serious mental illness.

Add friends and acquaintances, and the individual with mental illness is known to us all.

They are out of sight

- because of their shame,
- because of our prejudice, and
- because of society's stigma.

Traditionally, persons with psychiatric illnesses have been kept (or sent) "out of sight". This has prevented a true awareness of the public health burden produced from these diseases. In the 1990's, however, this naivety was shattered by the comprehensive studies, sponsored by the World Bank and Harvard University, on the disability burden of various diseases in the world.

The public health burden.

The "disability burden" of an illness on society is made up of two components:

- Years of life lost due to premature death (the agreed definition being that of death before the age of 75 years), and
- Years of life lived with a burden of illness.

Different illnesses will have different total burdens, as well as burdens composed of vastly different ratios of these two components.

Heart Attack:
If 10 people have a heart attack at the age of 65;
of those 10, 5 (50%) die instantly;
of the remaining 5, 50% (2.5 persons) are disabled and die at the age of 70,
and 50% (2.5 persons) live a normal life and die later than 75 years,

then the "disability burden" for this group will be

5	x (75 years - 65 years) =	50 years lost due to premature death
2.5	x (75 years – 65 years) =	25 years lost due to combined disability and early death
2.5	x (75 years – 75 years) =	0 years of life lost by this subgroup

for a total of 75 years (for these 10 people).

Major Depression:
If 10 people have a major depression starting at the age of 30;
of those 10, 1 dies from the illness at 30 years;
of the remaining 9, all live to 75 years,
but are disabled 50% of the time,

then the "disability burden" of this group will be

1	x (75 years – 30 years) =	45 years lost due to early death
4.5	x 50% of (75 years – 30 years) =	202.5 years lost due to disability
9	x (75 years – 75 years) =	0 years of life lost for this subgroup

for a total of 247.5 years (for these 10 people)

The Recorded Mortality Rate:
For this example the premature mortality rate (recorded in the death statistics) for heart attacks would be 7.5 and that for suicide is 1.

The 9 living with depression will have a lifespan that is shorter than the standard. However, their early deaths with other identified causes, such as heart attacks, will, in the death statistics, then increase the apparent burden from these physical illnesses and not reflect the true burden caused by depression.

Burden of Premature Death:

There are no figures for the burden of "years lived with disability" in BC. The Coroner's Service does, however, provide figures both for the death rate from various conditions, as well as a calculation of the years lost due to premature death.

Death may occur as a direct result of the psychiatric illnesses. For 10 to 15% of patients who suffer from schizophrenia or major depression, the outcome is fatal and directly related to the illness process.

The 2005 figures give the absolute numbers of persons dying prematurely (under 75 years) from heart disease as 1,134, from HIV as 144, from diabetes 375, and from motor vehicle accidents 326.

The suicide figure was 367.

MORTALITY RATES BY SELECTED CAUSES OF DEATH
BRITISH COLUMBIA, 2005

	PYLL (Age Under 75 Years)					Mortality (All Ages)		
Cause of Death	No. of Deaths	Total PYLL	Percent of PYLL	Average PYLL	PYLLSR	No. of Deaths	Percent of Deaths	ASMR
- HIV disease	144	3,975	2.1	27.6	0.94	145	0.5	0.31
- Malignant neoplasm of female breast	344	5,635	2.9	16.4	2.24	570	1.9	1.93
- Diabetes mellitus	375	4,503	2.3	12.0	0.94	1,021	3.4	1.78
- Ischemic heart diseases	1,134	12,585	6.5	11.1	2.55	4,361	14.5	7.20
External causes of death	**1,236**	**38,954**	**20.1**	**31.5**	**9.89**	**1,654**	**5.5**	**3.42**
- Motor vehicle accidents	326	12,075	6.2	37.0	3.18	369	1.2	0.84
- Suicide	367	11,293	5.8	30.8	2.80	403	1.3	0.87
All causes	**11,497**	**193,693**	**100.0**	**16.8**	**45.34**	**30,033**	**100.0**	**52.52**

No PYLL - Potential Years of Life Lost, denotes the total number of years of life lost from an established life expectancy (75 years).
PYLLSR - PYLL Standardized Rate per 1,000 standard population (Canada 1991 Census).
ASMR - Age Standardized Mortality Rate per 10,000 standard population (Canada 1991 Census).
[1]Other causes includes undetermined and pending.
Total percentage may not add up to 100 due to rounding. Non-residents are excluded.

However, the Potential Years of Life Lost (PYLL) for suicide was approximately the same as that for ischaemic heart disease (11,293 vs. 12,585), even though the death rate for heart disease was almost three times that of suicide (1,134 vs. 367 for suicide).

The "years of life" lost through suicide alone is almost **three times that of HIV**, **double that of breast cancer** or **more than double that from diabetes**, although the latter two have recorded death rates similar to that for suicide – but at different stages of the individual's life.

This is not a one-year phenomenon: BC's Vital Statistics branch documents "Observable Deaths" from 1995 to 1999, and gives the PYLL by district. Everywhere we look: -- province-wide or by region, the years of life prematurely lost from heart disease and from suicide are approximately the same.

		Potential Years of Life Lost (Age under 75)	
		Observed Deaths	Total PYLL
PROVINCIAL TOTAL	Ischaemic Heart Disease	8402	85541
	Suicide	2307	75528
	Motor Vehicle Accident	1849	73786
Capital	Ischaemic Heart Disease	702	6591
	Suicide	206	6498
	Motor Vehicle Accident	62	6950
Simon Fraser / Burnaby	Ischaemic Heart Disease	971	9798
	Suicide	252	8245
	Motor Vehicle Accident	146	5947
Vancouver / Richmond	Ischaemic Heart Disease	1312	13490
	Suicide	438	14025
	Motor Vehicle Accident	181	6593

Extracted from "Health Status Indicators in British Columbia, Birth-Rate and Mortality Statistics 1995-1999".
Note: "Observed Deaths" are for those below age 75, and differ from the total number of deaths.
All data extraction and calculations done by BC Vital Statistics.

How can this be? If the actual rates of death are so different, how can the rates of years of life lost be so similar?

The explanation lies in the age at death. Depression, schizophrenia, and accompanying suicide strike at our nation's young adults. Students pursuing higher education; workers trying to establish careers; mother giving birth to their families; these are the groups that fall victim to these illnesses, and when they die from their illness, these deaths are early, premature in every sense of the word.

And when these illnesses lead not to death, but to disability, then the burden is truly prolonged.

Burden of Disability.

There are no BC or Canadian figures on the burden of disability for these illnesses.

From the international literature, however, we can find figures for comparable economies to ours.

The US Surgeon General states that this burden is significant south of the border:

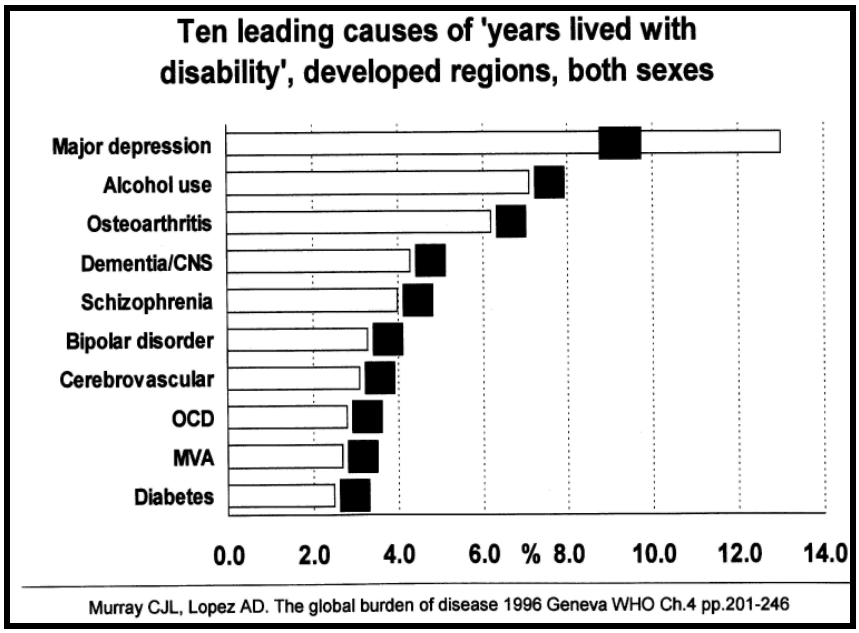
Mental Disorders Are Disabling

	% of Disease Burden
All cardiovascular disorders	18.6
All mental illness	15.4
All malignant disease (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infections and parasitic disease	2.8
All drug use	1.5

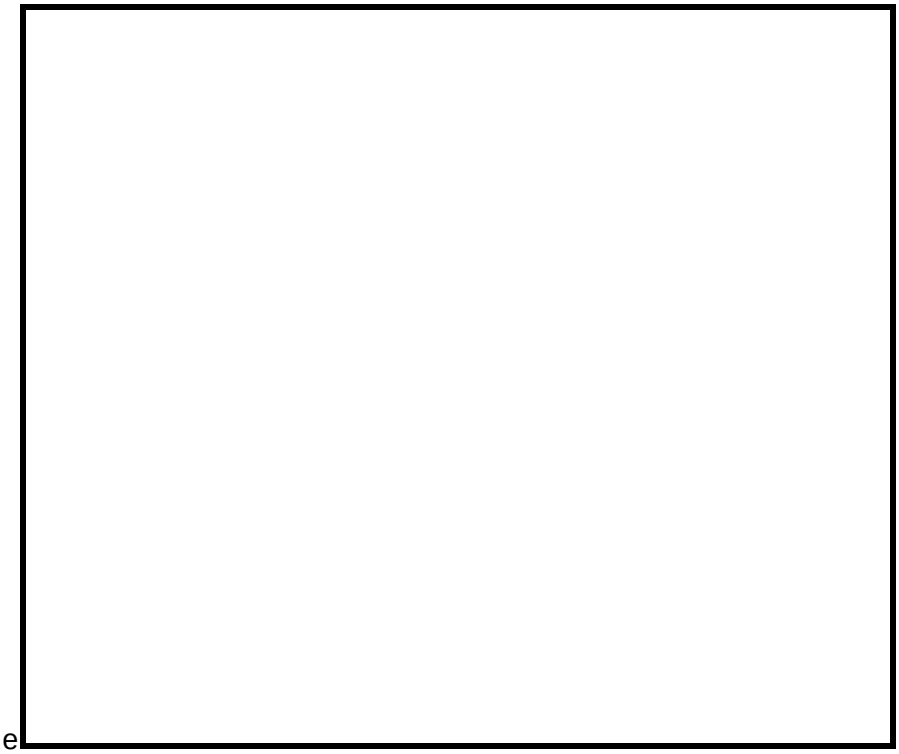
Mental Illnesses account for 15.4% of the overall years of life lost to major illnesses in our country. The mental illness disease burden ranks second only to heart disease, and is greater than all forms of cancer added together.

US Surgeon General, 1999

Murray and Lopez in their studies supported by the World Bank, Harvard University and the WHO, also clearly outlined the community burden from years lived with disability:



For females of working age, the figures are even more striking: 6 of the top 10 causes of disease burden (including both death and disability) have mental health components.



Depression is now recognised as the “leading cause of illness in the United States for individuals age 15 to 44”. [3] Although similar BC and Canadian data are not available, what evidence there is supports the idea that psychiatric disability is prevalent amongst young adults, and when present, can be long lasting.

About one third of the claimants from private employee insurance programs in Canada have psychiatric or mental disabilities. In contrast, about three quarters of all the payments made are for psychiatric illnesses. When such illnesses are present, they last longer and are more disabling that physical ones in the same population.

> This level of disability affects not only the individual patient or worker, but also his or her family members and friends. If a working mother is disabled from normal daily activities because of her illness, this will affect her husband, her children, and the family grandparents, all of whom may have to take on increased family rearing responsibilities for a long time.

The burden is high, and not limited to the individual patient.

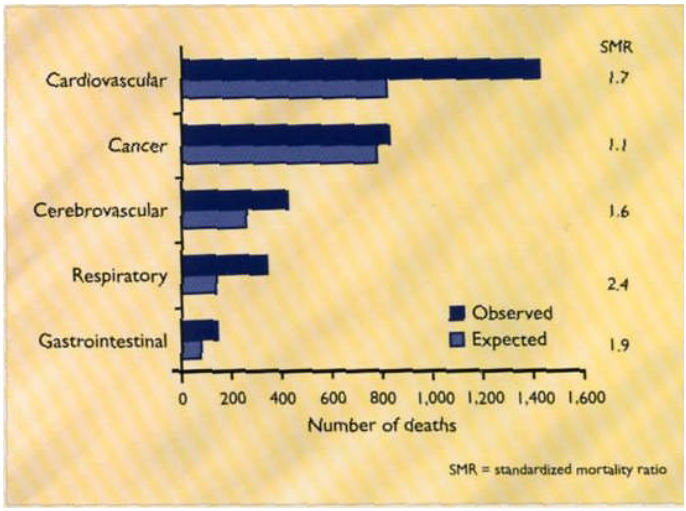
[3] Hoff, Timothy: Associate Professor of Health Policy and Management, University at Albany School of Public Health, Sept. 2, 2007

Indirect Death and Physical Illness as a Consequence of Psychiatric Illness.

Where the illnesses are not immediately fatal, but are disabling, this also can have a real, but hidden effect on later mortality.

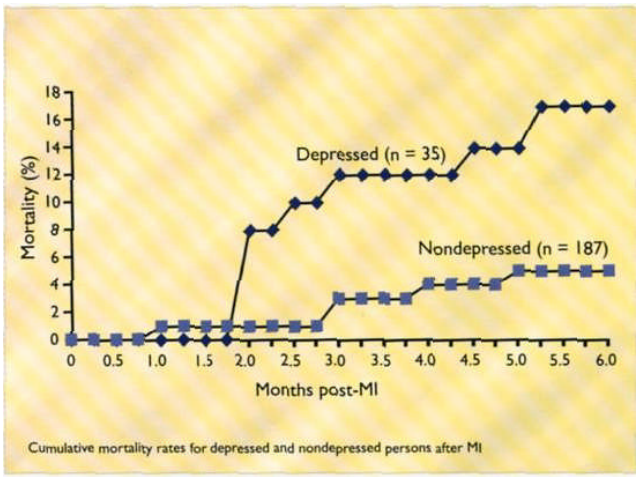
In Sweden, the presence of depression increases the mortality ratio for many other illnesses.

Standardized mortality ratios for women with unipolar depression (Sweden 1973-1995) [4]



Similar data exists for patients who have had a heart attack

Mortality rates among depressed and nondepressed patients who have survived to hospital discharge after a myocardial infarction [5]

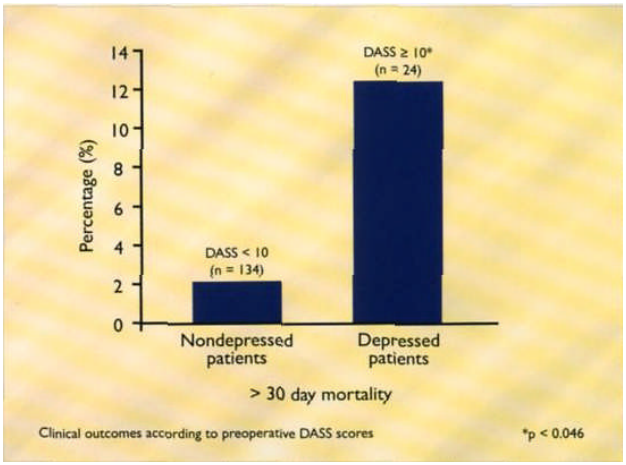


[4] Osby U et al. Arch Gen Psychiatry 2001; 58: 844

[5] Frasure-Smith N, Lesperance F, Talajic M. Depression following myocardial infarction. Impact on 6 month survival. JAMA 1993; 279: 181901825, cited by Darby, Carolynne

or who have undergone open-heart surgery:

Mortality rates among depressed and nondepressed patients undergoing CABG [6]



In our system of counting, such deaths will be recorded as due to the heart disease, with the important effects of the mental disability hidden.

Bipolar disease.

This illness affects 5% of the adult population.

The standardized all-cause mortality rate amongst bi-polar patients is increased approximately 2-fold. The total number of excess deaths is highest for natural causes.

If this illness develops in a 25 year old woman, she may lose 12 years of good health, 14 years of productivity and 9 years in life expectancy (because of cardiovascular and other medical problems).

[6] Adapted from Baker RA et al. ANZ J Surg 2001;71:139 by Darby, Carolynne

Proper Care is Essential.

Notwithstanding the public health importance of these illnesses, and the immediate effect such illnesses have on the lives of many people, the evidence is that many sufferers are not receiving anything that would be considered as modern and effective treatment.

In 1990, Murray and Lopez, as part of their Global Burden of Illness study made the following estimations:

Estimated proportions of cases receiving treatment (1990)

Disorder	Region *EMEs
Unipolar MDE	0.35
Bipolar (cases)	0.35
Schizophrenia (cases)	0.80
OCD (cases)	0.15
Panic Disorder (cases)	0.25

Global Burden of Disease, Lopez and Murray, WHO 1996 p417 Annex Table 4
*EMEs – Established Market Economies

More modern data do not show any significant improvement; in the US, the proportion of persons who are receiving treatment according to the most minimal of guidelines is 33%,[7] in Australia 35%[8]. According to a study published in 2005, of those who suffered from disabling major depression in Atlantic Canada, 24% received care that was regarded as minimal[9]. Care for the rest fell below this most minimal of standards!

[7] Twelve-Month Use of Mental Health Services in the United States: Results from the National Comorbidity Survey Replication: Wang et al: Arch Gen Psychiatry; 2005, 62, 629-640
[8] The Burden of Major Depression Avoidable by Longer-Term Treatment Strategies; Vos et al: Arch Gen Psychiatry 2004; 61: 1097-1103
[9] Unmet Need for the Treatment of Depression in Atlantic Canada: Starkes JM, Poulin CC, Kisely SR: Can J. Psychiatry 2005; 50: 580-590

The tragedy is that proper care could reduce the burden of illness:

Scope of Need: Treatment Makes a Difference

Disorder	Disability Weight		% reduction with treatment
	Untreated	Treated	
Unipolar MDE	0.600	0.302	50%
Schizophrenia	0.627	0.351	44%
OCD	0.129	0.080	38%
Bipolar	0.583	0.383	34%
Panic	0.173	0.091	47%

Global Burden of Disease, Lopez and Murray, WHO 1996

Although this Murray and Lopez data is rather old, similar information comes from Australia, where Professor Gavin Andrews says, after carefully tracking patients (and their costs) through the medical system there, that properly organized care would cost no more per patient than the current disorganised, crisis-driven, often emergency based, ad hoc care that the patients are receiving, and would produce a better result, both for the patient and for society.

How does BC approach this problem?

In its first mandate, the current government started some efforts to address these problems.

- The Premier, Mr. Gordon Campbell, emphasised the need for good care in many public statements, including how mental illness touched his own family;
- The government established a Secretary of State for Mental Health;
- It established a provincial depression strategy advisory committee, and
- It established a provincial anxiety disorders strategy advisory committee.
- The Premier has continued to speak about the importance of this topic.

Unfortunately, these initial efforts have not produced substantive change.

Funding.

Researchers at the University of Western Ontario have shown that, of all the provinces, only BC and New Brunswick had a decline in the total dollars spent on psychiatric services (institutions and community) between 1994-95, and 1998-99. For New

Brunswick, the reduction was a very small amount.[10] Only BC had a reduction in expenditures for community psychiatric expenditures – at a time when the government of the day was propounding a "Closer to Home" philosophy!

Table 7 Reported operating expenditures on psychiatric hospitals and community based psychiatric services (in millions) by province 1994-1995

Year	Canada	NF	PEI	NS	NB	QC	ON	MB	SK	AB	BC
Community Psychiatric Services											
Late 1980s	8.31	1.18	1.03	--	7.80	10.00	---	---	11.904	17.97	---
1994-1995	81.05	--	1.51	42.90*	14.87	252.73*	144.16	9.80*	30.75	30.09	208.00
1998-1999	113.08	7.71	7.49	45.20*	17.44	515.55*	210.82	28.13*	35.69	62.58	200.89
Per capita expenditures on community-based psychiatric services											
Late 1980s	6.97	2.07	7.92	---	10.99	1.53	---	---	11.73	7.59	---
1994-1995	26.08	---	11.21	45.93	19.62	34.68	13.18	8.67	30.39	14.40	56.68
1998-1999	35.90	13.17	54.65	48.23	23.12	70.32	18.43	24.70*	34.78	21.41	50.15
Total expenditures on psychiatric services (institutions and community)											
Late 1980s	---	---	9.03	144.30	52.00	910.00	1016.00	200.00	29.70	176.96	155.43
1994-1995	321.51	---	----	61.68	39.26	853.50	559.35	53.74	50.79	----	832.26
1998-1999	285.41	32.75	----	66.39	38.95	890.00	768.28	73.53	60.44	202.54	435.82
Percentage of total expenditures on community based psychiatric services											
1994-1995	39.2	---	---	69.6*	37.9	29.6	25.8	18.2	60.5	---	32.9
1998-1999	43.8	21.9	---	68.1	44.8	57.9	27.4	38.3	59.1	30.9	46.1

Health and Welfare Canada 1990 (6) Population Data: Statistics Canada Mental Health Statistics (16-20)
Population Statistics are from Statistics Canada. Mortality – Summary List of Causes 1994 (appendix 3) (21)
*Estimates calculated by the authors

When account is taken for inflation, wage increases, etc., this reduction in actual dollars spent translates into an even greater reduction in clinical services available at the front line for patients in distress.

In BC, while funds for community psychiatric services were decreasing, so also was the total identified bed count for psychiatric patients.

[10] Sealy, P & Whitehead, PC: Forty Years of Deinstitutionalization of Psychiatric Services in Canada: An Empirical Assessment. Can. J. Psychiatry (2004), 49, 249-257.

Beds Used for Psychiatric Care / 100,000 population

	1990	2002	Change
Canada:	**96.5**	**72.5**	**-25%**
Nova Scotia	62.3	30.7	-51%
Quebec	**141.2**	**156.3**	**+11%**
Ontario	86.1	44.1	-49%
Manitoba	**93.9**	**59.5**	**-37%**
Alberta	73.0	47.6	-35%
B.C.	**74.9**	**46.7**	**-38%**

Regretfully, this reduction in both arms of care – community services and in-patient bed supports -- appears to have continued. At the health authority level, while funds have been pumped into other areas of health care delivery, the past 5 years have seen further cutbacks in services available for clinical care in mental health, often in response to budget overruns from other parts of the system. No health authority has increased its bed capacity for acute care psychiatric patients: virtually all the global changes that we have been able to identify have been to reduce the amount of total resources.

What makes this especially pernicious is that these changes are hidden. For example, hospitals no longer officially allocate beds to particular services or particular functions, so there is no externally identified capacity for any service. In theory, this promotes flexibility at the local level. However, this change also means that independent organizations such as the Canadian Institute for Health Information (CIHI) can no longer track changes in the available acute care bed base for psychiatric patients.

When medical services are overrun with winter infections, then beds on wards that are nominally surgical can be pressed into service. However, this sharing has a built in warning system: when surgeries have to be cancelled, questions get asked. This public warning system does not exist for acute care psychiatric beds, permitting health authorities to reduce the local allocation of beds to psychiatric patients without much – or any – public discourse.

Combined with the various ways in which federal funding for psychiatric services is provided to the provinces outside the Canada Health Act, but rather through block funding for social programs, it then becomes impossible for a citizen to quickly and easily identify

- how much of the total health care budget is being spent for the care of patients with psychiatric illnesses;
- whether the downsizing of Riverview – the greatest reduction in in-patient resources for any group of medically ill patients – has been accompanied by an equivalent dollar increase in the expenditures by the various local health authorities for the patients so transferred;
- whether there has been a dollar growth in the community services that ensures those patients who now have no beds are properly cared for;
- whether there has been a dollar growth in the local community and general hospital psychiatric services to accommodate the needs of those patients who now do not get admitted to Riverview, and instead are left to whatever care they can find in their local community.

One can only agree with Senator Michael Kirby when he says that park benches and jails have become the new institutions for the seriously mentally ill.

Absence of published strategic planning.

Reducing beds and reducing community resources at the same time does not make any common sense. How can this come about?

Although a Mental Health and Addiction Branch exists within the Ministry of Health, there are no published goals or objectives to plan for services in a systematic way. Rather, the government website comments that the actual services are delivered through the various local health authorities.

A review of the performance agreements published on the websites of the respective health authorities is no better.

- Both the Vancouver Island and Interior Health Authorities offer the following two goals for Mental Health and Addictions:

Mental Health and Addictions:

Proportion of persons (aged 15–64) hospitalized for a mental health or addictions diagnosis who receive community or physician followup within 30 days of discharge.

Readmission rates for patients admitted to acute care with a mental health or addictions diagnosis

Note that the goals are only to set target proportions. Achieving the targets to be set out will occur later!

- Vancouver Coastal Health Authority had no mention of these problems in its performance agreement, although it is stated to be included in the 2006 / 2007 agreement.
- The Northern Health Authority does not offer a copy of its agreement on the web.
- Neither does Fraser Health, although it does report a "favourable" budget item of $4.0 million in its "Residential Services and Mental Health and Addiction portfolios. Presumably "favourable" means money not spent on patient care. The question then arises: "favourable" from whose point of view?
- The "BC Mental Health and Addiction Services", an agency of the Provincial Health Services Authority has a 2004 Strategic Plan that was updated in 2005, but not since.

Thus, there is no evidence that the Mental Health and Addictions Branch is showing leadership either in developing its own plans for the needs of citizens with serious mental illnesses, or in demanding accountability from those organizations that it lists as providing the services.

The Mental Health and Addictions Branch has no psychiatrist in an advisory or leadership role: indeed, there is no psychiatrist in-house consultant with any formal, consistent and permanent role attached to the Branch.

It can be argued that specific consultations can be arranged by the Ministry for any clinical question. The problem is not one of getting answers to the questions that are asked, but rather one of knowing what questions to ask, and when the answers need follow-up. Any business which attempted to manage itself without input from both the customers and the skilled and knowledgeable senior staff would quickly face serious problems: the apparent lack of forethought and sound clinical planning reflects this.

Recommendations:

I limit my recommendations to the subject I know best: the system for the prevention of psychiatric illnesses in our Province, and the support and care of those who face such serious and disabling psychiatric illnesses.

The current system has been hampered by decades of neglect, interspersed with occasional expressions of interest which have then been difficult to translate into sustained improvement and the building of a sound clinical system of care.

When I, as a psychiatrist, ask the questions of

- whether the system is doing what it should be doing to be effective, and
- whether the system is doing it in a fiscally prudent and efficient manner,

answers cannot be found in any data at the provincial level.

Yet these are essential questions which must be answered.

Many things need to be done to improve this situation.

However, rather than offer multiple separate recommendations, which if implemented in a piecemeal fashion would not address the needs of a comprehensive system-wide improvement process, there are two essential changes in the way that our system is organised that must occur before either efficacy or efficiency can be established.

Recommendation 1:

Good stewardship of public funds means that we must readily know how much is being spent on the topic in question.

To further this, I offer the following recommendation:

Recommendation 1:

that

- the Auditor-General of British Columbia, in consultation with appropriate medical and psychiatric professionals and / or organizations, undertake a comprehensive review of the total amounts received and spent by the provincial treasury for the care of persons with serious mental health and addiction problems;

- That the Auditor-General of BC establishes a straightforward and understandable system of tracking the monies spent on services for the prevention, treatment and rehabilitation of patients from psychiatric illnesses in a manner that will be comparable from one year to the next, and which will enable citizens to readily see the changes as they occur.

Recommendation 2:

Good stewardship of the use of public funds means that the funds must be used in a way that is clinically sensible, and directed towards agreed-upon ends. Historically, planning for care and other supportive services has been segmented instead of systemic. It has been reactive to the most recent suggestions for cost reductions. The search for financial efficiencies within each separate silo has completely replaced any understanding of the enduring needs for good care, support, housing and recovery - directed interventions that are a fact of our patient's lives.

To make the system focus on the needs of those who struggle with these illnesses, independent of the needs of administrators and bureaucrats for "efficiency without efficacy", input from those who use the system and those who work in the system must be brought into the evaluative process in a meaningful way.

Recommendation 2.

that

- A Provincial Mental Health Commission (PMHC) be established and funded;
- That the PMHC have a membership of not more than 10;
- That the membership includes representatives of the Mental Health and Addictions Branch of the Ministry of Health; the Health Authorities; the University Department of Psychiatry; the BC Psychiatric Association; other independent advocacy and patient representative organizations;
- That the representatives of the Ministry and Health Authorities combined not form a majority of the members of the Provincial Commission;
- That the Chairman not be a governmental or health authority representative, and
- That the PMHC reports annually to the Legislature on the state of mental health services in British Columbia.

If these recommendations are followed, the first steps will have been taken towards a coherent policy for British Columbians with psychiatric illnesses.

Respectfully submitted,

A. Donald Milliken
MB, MSHA, FRCPC.