Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Hon. Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON M7A 2C4

August 16, 2017

RE: Stable Peer Support Funding for Individuals Being Discharged From Psychiatric Facilities

Dear Eric,

RNAO appreciates your ongoing leadership to improve the health and well-being of all Ontarians through *Patients First: Action Plan for Health Care*[1], and the *Open Minds, Health Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*.[23] We are writing to you today about the need for stable peer support funding for individuals being discharged from psychiatric facilities.

RNAO was delighted when you addressed nursing leaders from across the province on Feb. 23, 2017, at the Registered Nurses' Association of Ontario's (RNAO) Queen's Park Day, and reminded us that "we can't have health without mental health." Indeed, we applaud the government's investments in mental health programs and services within the 2017 Budget,[4] as well as subsequent announcements to address the opioid crisis,[5] and respond to First Nations youth suicides in northern Ontario.[6]

To further the province's objective of improving health outcomes and commitment to health system transformation that is evidence-based, person-centred, equitable, and cost effective, RNAO recommends stable provincial peer support funding for individuals being discharged from psychiatric units. This model was brought forward and supported by RNAO's membership as a resolution at our 2016 Annual General Meeting and is consistent with the findings recommendations of the Mental Health Commission of Canada.[7]

Ontario was making significant headway in that area with the implementation of The Transitional Discharge Model (TDM) - an evidence-based "made-in-Ontario" peer support model that has been in practice since 1992. TDM's purpose is to support successful transition and reintegration of individuals discharged from psychiatric facilities with a mental illness. Two features of TDM are: 1) the overlap of hospital and community staff until a therapeutic relationship is established with a community care provider; and 2) support from a trained peer

who has lived experience of making the transition to community.[8] Preliminary evaluations of TDM in Ontario found reductions in length of hospital stay, reduced hospital readmissions, improved quality of life, and improved social relations.[9] [10] [11] [12] In 2004, the Scottish Parliament declared TDM as a best practice due to the dramatic reduction in readmission rates when implemented in Scotland.[13] [14] A two-year provincial study (2011-2013) funded by the Council of Academic Hospitals of Ontario (CAHO) examined nine hospitals implementing TDM. Results found a reduced average length of stay of 9.8 days, [15] and as shown in Appendix 1, savings from TDM were $2,907,416 per site annually. If the TDM continued to be implemented just across the participating wards at the nine hospitals, the potential savings were estimated to be $31,360,000 per year in hospital days.[16]

Despite these positive results, many of the implementation sites were closed once the CAHO research study was completed due to lack of funding. Or, as the *London Free Press* described the closures at London Health Sciences Centre, "It's cheap, effective-and out of cash."[17] Not only were the savings that were anticipated by continuing the pilot implementation projects lost, there was a wasted opportunity to scale up TDM across Ontario as a standard of care. If TDM was implemented province-wide, the estimated potential net savings in hospital days would be $632,201,920.[18] While these monetary savings are significant, the real value of TDM is helping vulnerable people undergoing a complex transition process when they are at increased risk of suicide following in-patient hospital discharge.[19] [20] [21]

The lead researcher for the CAHO TDM study, Cheryl Forchuk, notes, "The greatest impediment to implementation has been the inadequate funding of the peer support aspect of the model."[22] The Mental Health and Addictions Leadership Council (MHALC) identifies the following four components of a person-centred system: accessible; high-performing; equitable; and recovery orientated.[23] Partnering with people who have lived experience is an essential element in the transformation from a biomedical-orientated system into a person-centred system. MHALC describes a "truly recovery-oriented system as follows":

> In such a system the individual is viewed, not simply as a passive recipient of care, but as an engaged partner in their own recovery. Likewise, there is a broadly shared belief - held by individuals, families and caregivers - that treatments and supports are not an end in themselves but, rather, part of the journey toward recovery, with self-sufficiency as the final goal. Thus, recovery speaks to the importance to all people of leading a meaningful life as part of the community, to have a home, a job, friendships and community connections, and to contribute.[24]

Stable funding for peer support coordinators through mental health consumer survivor initiatives is a cost effective way to: support patients being discharged from psychiatric facilities; create job opportunities for people with lived experience who can share their journey of recovery; and promote cultural change of organizations, systems, and society towards an authentic recovery orientation.

In keeping with the goal of Patients First, improved health outcomes and system cost-savings, RNAO urges the provincial government to reinstate the TDM in the nine initial sites, with the goal towards implementation across the entire province.

Thank you for considering this evidence in support of the Patients First agenda.

With warm regards,

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer, RNAO

Appendix 1: Cost of Transitional Discharge Model (TDM) Implementation and Expected Savings (per site, annually) Across Nine Hospitals in Ontario[25]

Costs for TDM Implementation (per site, annually)		
Item	Description	Amount
Peer support Coordinator salary	1 FTE (37.5 hours per week for 52 weeks) $25.45/hour + benefits = $30.73/hr	$59,924
Peer support Coordinator training	$1,000 honorarium per trainer $1,200 for trainee for 5 days of training	$2,200
Peer support mileage	$500/month for travel to clients and volunteers	$6,000
Volunteer training	50 volunteers for 5 days of training $30 materials + $20 food/person/day = $130 per volunteer	$6,500
Volunteer recognition activities & activities with patients	Includes gift certificates, etc. so that support workers and patients can do activities together	$5,000
	Total Costs	$79,624
Savings from TDM (per site, annually)		
Item	Description	Amount
Reduction in length of stay (LOS)	Reduction in LOS = 9.8 days/discharge Cost of stay in hospital = $800/day Average discharges across all sites = 381 Savings = reduction in LOS x cost per day x Number of discharges	$2,987,040
	Total Savings	
Return on Investment (Total Savings - Total Costs) (per site, annually)		$2,907,416

List of participating hospitals and consumer/survivor (CSI) or peer support programs[26]

Participating Hospitals	**Participating Consumer/Survivor Initiative Organizations/ Peer Support Programs**
Centre for Addiction and Mental Health	Centre for Addiction and Mental Health Peer Support (Toronto)
Hôpital Montfort	Psychiatric Survivors of Ottawa
London Health Science Centre	Connect for Mental Health Inc. (London)
Providence Care	Mental Health Support Network South East Ontario
Baycrest	Krasman Centre (Richmond Hill)
St. Joseph's Healthcare Hamilton (SJHH)	Patient and Family Collaborative Support Services (SJHH), Hamilton
St. Joseph's Health Care London	Can-Voice (London)
Thunder Bay Regional Health Sciences Centre	People Advocating for Change Through Empowerment (Thunder Bay)
Ontario Shores (non-CAHO hospital)[27]	CMHA Durham (Oshawa)

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