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Canadian Psychiatric Association
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The College of
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Le Collège des
médecins de famille
du Canada

Study on Mental Health, Mental Illness and Addiction in Canada

**Supplementary Submission to the Senate Standing
Committee on Social Affairs, Science and Technology**

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PRIORITIES FOR ACTION

The Canadian Medical Association, Canadian Paediatric Society, Canadian Psychiatric Association, Canadian Society of Addiction Medicine and College of Family Physicians of Canada are pleased to provide a joint supplementary submission to the Senate Standing Committee on Social Affairs, Science and Technology study on mental health, mental illness and addiction in Canada.

This submission provides advice on the areas that we believe require the most immediate attention from the federal government over the short term, and that will have the most direct benefit for those affected by mental illness, poor mental health and addiction.

The four areas are:

- 1. Federal Leadership & Capacity**
- 2. Access Benchmarks and Surveillance Information**
- 3. Best practices in mental illness, mental health and addiction**
- 4. Human resource planning**

This submission also provides recommendations for specific “**priority tasks**” under each of these four general areas.

1. Federal Leadership & Capacity

Federal leadership and capacity must be rapidly and significantly enhanced in order to address the existing deficiencies in the mental health system. This will signal and institutionalize a renewed commitment by the federal government and will ultimately provide support for Canadians impacted by mental illness, poor mental health and addictions.

Federal capacity can be enhanced through one of 3 models: a unit in an existing federal department, a federal arm’s length agency, or a pan-Canadian arm’s length agency.

Model 1: Unit within an existing federal department

Under this option, a new Branch led by an assistant deputy minister (ADM) would be created within Health Canada to provide policy leadership and deliver federal programs and services in the area of mental health, mental illness and addiction. The ADM would have general authority for its management and direction, be answerable to the deputy minister, and work with all other federal departments and agencies to develop and coordinate policies, programs and services in this area.

Model 2: Creation of a federal arm's length Centre for Mental Illness, Mental Health and Addiction

This option would entail the creation of a more independent organization within the purview of the federal government. The 'Centre for Mental Illness, Mental Health and Addiction' would be structured as a federal agency in which decision-making powers are vested in a Board of Directors with a CEO responsible for the daily operations. This Board would be representative of all relevant stakeholders including health providers, health researchers, governments and affected populations. The Centre would remain under the health portfolio, with accountability through the Minister of Health. The Centre's main function would be to deliver federal programs and services, working closely with Health Canada, the Public Health Agency of Canada, Department of Justice and other organizations such as the Canadian Centre for Substance Abuse. While the Centre would provide advice, the responsibility for federal policy development with respect to mental illness and mental health would continue to reside within Health Canada.

Model 3: Pan-Canadian arm's length institute

This option consists of incorporating an Institute as a not-for-profit entity with the federal and provincial governments as shareholders. This model has been used in other areas where federal-provincial collaboration is essential, such as the Canadian Institute for Health Information. As in the previous model, the Institute for Mental Illness, Mental Health and Addiction would have a board, and a CEO. However, instead of direct accountability to the Minister of Health, the institute would be accountable to the Conference of F-P-T Ministers of Health. It would be responsible for delivering pan-Canadian programs and services that are complementary to provincial and territorial mental health/illness programs and services. Policy development responsibilities for mental health, mental illness and addiction would continue to reside with federal and provincial/territorial governments.

Each of the models outlined above has strengths and weakness. It is also possible that we could move from one model to another over time once the system is stabilized. However, for the short term, we contend that Model 1, a dedicated unit within Health Canada, would be the best fit with our objective of enhancing federal leadership and capacity to address mental illness, mental health and addiction issues.

The strength of Model 1 is that by elevating responsibility for mental health /illness issues to the branch level it raises the profile and importance of these issues. This would reinstate and indeed increase the capacity that had existed within Health Canada but was lost through numerous reorganizations and resource reallocations. In addition intra-departmental and inter-departmental synergies can be maximized with this model.

Should this model be chosen, it is important that the federal government demonstrate the kind of collaborative leadership that it has shown in the area of primary care through initiatives funded via the Primary Health Care Transition Fund.*

*The Primary Health Care Transition fund supported provinces and territories in their efforts to reform the primary health care system in addition to supporting various pan-Canadian initiatives to address common barriers. Although the Primary Health Care Transition Fund itself was time-limited, the changes which it supported were intended to have a lasting and sustainable impact on the health care system.

The same leadership principles apply to reform of the mental health system in that while there are common problems and solutions across Canada there are also the needs of specific communities which must be addressed individually.

Of immediate priority for this unit are initiatives to reduce stigma and to address the mental health needs of First Nations and Inuit Peoples.

Stigma Reduction

A stigma reduction strategy is an on-going function that must be core to the activities of the federal government. Stigma involves thoughts, emotions and behaviours, thus a comprehensive approach includes interventions to target each of these dimensions at both the individual and population level.

The strategy should include aspects of:

- Public awareness and education to facilitate understanding about the importance of early diagnosis, treatment, recovery and prevention;
- Enhanced provider/student education and support;
- Policy analysis and modification of discriminatory legislation;
- Support for a strong voluntary sector to voice the concerns of patients and their families;
- Exposure to positive spokespeople (e.g. prominent Canadians) who have mental illness and/or addiction in order to highlight success stories;
- Researching stigma.

The stigma associated with mental illness in children can hinder early identification and intervention and places them on a damaging path of suffering and pain. The effective treatment and community reintegration of people with mental illness and/or addiction will not only improve the lives of those directly affected but will also work to reduce stigma in the long term.

First Nations and Inuit Peoples

All people with mental illness and/or addiction have a right to programs and services that facilitate recovery and/or improve their quality of life. It is clear that the First Nations and Inuit peoples of Canada experience mental illness, addiction and poor mental health at rates exceeding that of other Canadians. Individual, community and population level factors contribute to this including socioeconomic status, social environment, child development, nutrition, maternal health, culture and access to health services. The urgent need to work with these communities, and identify the structures and interventions to reduce the burden of mental illness and addiction is critical to the health and wellness and future of First Nations and Inuit peoples. Enhanced federal capacity should be created through First Nations and Inuit Health that will provide increased funding and support for First Nations and Inuit community mental health strategies. The establishment of a First Nations and Inuit Mental Health Working Group that is comprised of First Nations and Inuit mental health experts and accountable to First Nations and Inuit leadership is essential for the success of this initiative. Both expert and resource supports are integral elements to facilitate and encourage culturally appropriate mental health strategies and programming in these communities.

We believe that as a population, the First Nations and Inuit peoples should be the priority for the federal government in the provision of much need treatment and support.

Priority tasks:

- A. Establish a Mental Health, Mental Illness and Addiction Branch at Health Canada.
- B. Implement a Stigma Reduction Strategy
- C. Improve the capacity of First Nations and Inuit peoples to address the mental health needs of their communities in a culturally appropriate manner.

2. Access Benchmarks and Surveillance Information

Access to services, both public and private, currently acts as a barrier to treatment and recovery from mental illness, poor mental health and addiction. Promotion of collaborative care models along with better coordination of services would greatly improve the quality of care received. Governments must facilitate integration and access to these services.

Recently, the Supreme Court decision in the case of *Chaoulli and Zeliotis vs Quebec* struck down two provisions in Quebec’s health insurance legislation that prohibit Quebec residents from purchasing private insurance for insured health services. This decision suggests that if Canadians wish to keep their “single-tier” system of universal, first dollar public coverage for health care, then governments must ensure that needed services are available to all Canadians at the time and to the extent of need, including mental health services. Governments must provide timely access to essential services within the public system in order to maximize potential for recovery and quality of life.

With the support of the federal government, and on behalf of the medical community, we (CMA, CPA, CPS, CSAM, CFPC) can coordinate and implement a process to develop medically acceptable wait time benchmarks for access to mental illness and addiction care for children and adults. The outcome of this process would be to provide all governments with performance goals to strive for in providing timely access to mental illness and addiction services.

With the establishment of benchmarks we will be able to measure how the system is performing. A basic mental illness surveillance system exists and the primary dissemination product is “A Report on Mental Illness in Canada”. However, there is agreement that the current information is limited for several reasons:

- There is limited data in the system regarding mental health, addiction and many mental illnesses;
- The quality of the data in the system has not been validated for many mental illnesses and addictions;
- Not all data sources have been accessed for the surveillance system;
- Since many supports and services for mental illness and addictions lie outside the formal health system, the collection of these data has not been possible with current constraints;
- There is a need for a broader dissemination system.

An expanded mental illness surveillance system should work closely with other chronic disease surveillance initiatives to ensure that indicators of common interest are obtained collaboratively and in an efficient manner.

Priority Tasks:

- A. Federal government financially support the coordination and implementation of a process to develop wait time benchmarks for accessing mental illness and addiction services developed by the CMA, CPA, CPS, CSAM, CFPC.
- B. Creation of an enhanced mental illness surveillance system to produce:
 - Information about the prevalence and incidence of mental illnesses, addiction and risk factors at the national, provincial/territorial and regional level.
 - Progress on improving the availability and accessibility to services.
 - The availability and accessibility of community resources to support people with mental illness and addiction.
 - Progress on improving the availability and accessibility to community resources.
 - Information about the cost of mental illness, poor mental health and addiction to people with the conditions, their families and the health system.
 - Wait list information for mental health services.

3. Best practices in mental illness, mental health and addiction

There are numerous interventions that are effective for various mental illnesses and addiction but ensuring optimal use of effective interventions in the real world has been a challenge. Several factors including lack of use by physicians, failure to prescribe or implement in the recommended manner, costs associated with treatment, and undesirable side effects limit the effectiveness of proven therapies for individual patients. A key element in our capacity to prevent and offer treatment for mental illness and addiction rests with the application of evidence or the promotion of best practices. Therefore we are proposing a pan-Canadian program that can facilitate knowledge exchange across disciplines to optimize outcomes for this population.

We are aware that there is currently an initiative led by the Public Health Agency of Canada to establish a Consortium of Best Practices for Chronic Disease prevention. The goal of the Consortium is to create a Pan-Canadian forum for knowledge exchange between governments, researchers, non-governmental organizations and consumers. This initiative is a positive step and should be closely aligned with our proposed program for mental illness, mental health and addiction. The program we are proposing would go further than just prevention, to include treatment and policy alternatives, both within and outside the health domain.

The program would serve to enhance best practice approaches through activities such as:

- Development of a clearing house to hold evidence-based information for mental illness, mental health and addiction by searching, reviewing and summarizing the current literature and web resources;
- Identification of gaps in knowledge, and gaps between evidence and practice;
- Development of tools to promote best practices relating to mental illness, mental health and addiction, such as the Canadian Collaborative Mental Health Initiative Tool Kit.

Priority Task:

- A. Establish a program to specifically promote inter-disciplinary best practices in prevention, treatment, community interventions and social supports across the continuum of research, policy, to support practice for evidence-based decision making in the area of mental health, mental illness and addiction.

4. Human resource planning

Improving access to specialized and primary mental health diagnostic and treatment services with psychosocial community services that support early intervention, prevention of further disability, rehabilitation, improvement of quality of life and recovery should be considered a fundamental underlying goal of a pan-Canadian action plan.

Several initiatives are currently under way in various parts of the country to enhance collaborative approaches to care among health care providers and to better integrate primary and secondary health care services. However, these efforts are taking place in a context of relative shortage of addiction specialists, psychiatrists, paediatricians, family physicians and other mental health care professionals.

Family doctor and specialist shortages and changing practice patterns have created serious gaps in the availability of mental health services for many Canadians. Health human resource planning needs to consider and address functionally sub-specialized areas of practice as growing numbers of family doctors are moving into these areas, for example general practice psychotherapy and addiction medicine. Health human resource planning must also continue to ensure sustainability of current initiatives and continued access to care.

Early interventions in general and with children specifically are critical to preventing long term disability and minimizing the devastating impact of mental illness. There are far too few mental health professionals to help children, insufficient resources allocated to support their mental health needs, and inadequate research being conducted to fill the gaps in knowledge which exist in this area. We believe that improving the mental health of Canada's children, including strategies that increase the amount of health providers with expertise in this area must be a priority for the federal government.

Priority Tasks:

- Establish a pan-Canadian mental health human resource infrastructure responsible for collecting data, monitoring, conducting research, reporting, and making recommendations related to Canada's ongoing mental health human resources needs, with a priority focus on children's services, in order to ensure a sustainable supply of health human resources;
- Introduce toolkits to assist health practitioners and consumers to implement best practices in collaborative care and develop new models of care in the area of mental health;
- Support the evaluation of new models of care in achieving patient centred objectives and improving outcomes;
- Increasing research capacity and resources in the area of children's mental health.

Conclusion:

Again, our organizations, representing the medical community, appreciate the opportunity to submit to the Committee further elaboration on key initiatives to ensure federal leadership is taken. We want to thank the committee not only for seeking our advice but also for bringing national attention to issues related to mental illness, mental health and addiction.