



REPORT 1

Mental Health, Mental Illness and Addiction:

Overview of Policies and Programs in Canada

**Interim Report of
The Standing Senate Committee On Social Affairs, Science And Technology**

**The Honourable Michael J.L.Kirby, Chair
The Honourable Wilbert Joseph Keon, Deputy Chair**

November 2004

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The Standing Senate Committee on Social Affairs, Science and Technology

Interim Report on
Mental Health, Mental Illness and Addiction

Report 1
MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION:
OVERVIEW OF POLICIES AND PROGRAMS IN CANADA

Chair

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Deputy Chair

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November 2004

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ORDER OF REFERENCE

Extract from the *Journals of the Senate* for Thursday, October 7, 2004:

The Honourable Senator Kirby moved, seconded by the Honourable Losier-Cool:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on issues arising from, and developments since, the tabling of its final report on the state of the health care system in Canada in October 2002. In particular, the Committee shall be authorized to examine issues concerning mental health and mental illness.

That the papers and evidence received and taken by the Committee on the study of mental health and mental illness in Canada in the Thirty-seventh Parliament be referred to the Committee; and

That the Committee submit its final report no later than December 16, 2005 and that the Committee retain all powers necessary to publicize the findings of the Committee until March 31, 2006.

The question being put on the motion, it was adopted.

Paul C. Bélisle

Clerk of the Senate

SENATORS

The following Senators have participated in the study on the state of the health care system of the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J. L. Kirby, Chair of the Committee

The Honourable Wilbert Joseph Keon, Deputy Chair of the Committee

The Honourable Senators:

Catherine S. Callbeck

Ethel M. Cochrane

Joan Cook

Jane Mary Cordy

Joyce Fairbairn, P.C.

Aurélien Gill

Janis G. Johnson

Marjory LeBreton

Viola Léger

Yves Morin

Lucie Pépin

Brenda Robertson (retired)

Douglas Roche (retired)

Eileen Rossiter (retired)

Marilyn Trenholme Counsell

Ex-officio members of the Committee:

The Honourable Senators: Jack Austin P.C. or (William Rompkey) and Noël A. Kinsella or (Terrance Stratton)

Other Senators who have participated from time to time on this study:

The Honourable Senators Di Nino, Forrestall, Kinsella, Lynch-Staunton, Milne and Murray.

MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION: OVERVIEW OF POLICIES AND PROGRAMS IN CANADA

INTRODUCTION

In February 2003, during the Second Session of the Thirty-Seventh Parliament, the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to study the state of mental health services and addiction treatment in Canada and to examine the role of the federal government in this area. The Senate renewed the mandate of the Committee in the Third Session of the Thirty-Seventh Parliament (February 2004), and then again in the First Session of the Thirty-Eighth Parliament (October 2004).

This mandate reads as follows:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on issues arising from, and developments since, the tabling of its final report on the state of the health care system in Canada in October 2002. In particular, the Committee shall be authorized to examine issues concerning mental health and mental illness;

That the papers and evidence received and taken by the Committee on the study of mental health and mental illness in Canada in the Thirty-seventh Parliament be referred to the Committee, and

That the Committee submit its final report no later than December 16, 2005 and that the Committee retain all powers necessary to publicize the findings of the Committee until March 31, 2006¹.

For the purpose of this study, the Committee adopted a broad approach towards examining mental health, mental illness and addiction in terms of: the prevalence of mental disorders and their economic impact on various sectors of the Canadian society, including business, education and health care systems; relevant federal and provincial policies and programs; mental health strategies in other countries; mental health promotion, mental illness and suicide prevention; mental health related disease surveillance and research; access to and delivery of mental health services and addiction treatment; support to families and caregivers; and the potential for the development of a national action plan on mental health, mental illness and addiction in Canada.

¹ Debates of the Senate (Hansard), 1st Session, 38th Parliament, Volume 142, Issue 7, October 2004.

The Committee's study on mental health, mental illness and addiction includes four reports. The following table provides information on each individual report and the proposed timeframe for publication:

**STUDY ON MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION
INDIVIDUAL REPORTS AND PROPOSED TIMEFRAMES**

Report	Content	Timing
First	Fact-based document providing historical background, overview of service delivery, respective roles of federal and provincial/territorial governments, assessments of policies and programs based on public testimony and literature review	November 2004
Second	International comparative analysis (Australia, Canada, New Zealand, the United Kingdom, and the United States)	November 2004
Third	An issues and options paper summarizing the issues which the Committee will address in its final report and raising options for addressing these issues	November 2004
Fourth	Recommendations for reform	November 2005

This report, which consists of eleven chapters, constitutes the first report by the Committee on mental health, mental illness and addiction. Chapter 1 summarizes the personal stories of one individual living with mental illness and three family members affected by mental illness who candidly shared their experience with the Committee. Chapter 2 provides further information on the impact of mental illness and addiction on affected individuals, their families and caregivers. Chapter 3 examines the issues of stigma and discrimination and their impact on individuals with mental illness and addiction. Chapter 4 defines the various concepts related to mental health, mental illness and addiction. Chapter 5 provides information on the prevalence of mental illness and addiction and their economic impact on Canadian society. Chapter 6 reviews the relationships between mental illness/addiction and work and examines ways to address mental illness and addiction in the workplace. Chapter 7 provides a chronological overview of the development of mental health services and addiction treatment in Canada. Chapter 8 compares the organizational structure and level of integration of the mental health services and addiction treatment system in some provinces and highlights the major differences of all provincial mental health legislation. Chapter 9 provides an overview as well as an assessment of the direct and indirect roles of the federal government in mental health, mental illness and addiction. Chapter 10 provides an overview of the state of research into mental health, mental illness and addiction in Canada. Chapter 11 examines various ethical issues related to mental illness and addiction with a particular

focus on service delivery, research, capacity to consent to treatment, and privacy and confidentiality issues.



PART 1

**The Human Face Of
Mental Illness And
Addiction**

CHAPTER 1: WITNESSES SHARE THEIR PERSONAL EXPERIENCES²

(...) I believe it is time to ask the opinion of service users and mental health experts. And who else but us are the experts in our disorders, needs and problems? We obviously cannot cure ourselves. We are people with a certain ability to think. We need to be heard, and I thank you for doing that.

[Loïse (9:18).]

INTRODUCTION

On February 26, 2003, the Committee embarked on its study on mental health, mental illness and addiction by putting a human face to the issue. More precisely, members of three families affected by mental illness and one individual with mental illness accepted our invitation to speak together about their experiences – how mental disorders affected their lives. These four witnesses came from all over the country with first-hand experience of mental health and addiction issues to tell their stories to the Committee. To make them comfortable enough to talk candidly, the Committee referred to them by their first names only. This chapter provides a summary of their testimony. It illustrates graphically why the study of mental health, mental illness and addiction has become such an emotional cause for the members of the Committee.

Throughout its study, the Committee also received evidence on the lives of many other Canadians affected by mental illness and addiction through public hearings, letters and e-mails. The experience these individuals shared with us is summarized in Chapter 2.

1.1 IN THEIR OWN WORDS

1.1.1 Loïse's Story

Loïse spoke to the Committee about her own experiences with mental health problems, specifically bipolar disorder:

Ten years ago, following the sudden death of my partner in life, I had an episode of manic psychosis. During that phase, you lie, you spend money, and you are sure you have money, and you believe what you're doing, which is out of context. You feel you could save the world during that

² In this report, the testimony received by witnesses printed in the *Minutes of Proceedings and Evidence of the Standing Senate Committee on Social Affairs, Science and Technology* will be hereinafter referred to only by issue number and page number within the text.

period. I had an episode which lasted six months and ended with a suicide attempt. That was followed by four years of depression.

At the emergency department of the hospital where I was taken, it was recommended that I go to a crisis centre. That was the start of nine years of unflinching support from community organizations and four years of continuous fighting to obtain the necessary psychological and pharmaceutical assistance from institutions and psychiatrists.³

She recounted the number of times and the variety of health care professionals to whom she has had to retell her story over and over again:

For years, I had to tell and repeat my life story to the following persons: an emergency nurse, the emergency psychiatrist, a medical assessor at the crisis centre, a psychosocial worker at that centre – they talked about my life history and constantly went back to the traumas, the painful things, and each time I had to start all over from scratch – a psychiatrist at the hospital crisis centre, a social worker at the hospital, an intake officer at the CLSC, a CLSC caseworker, a psychosocial worker at the CLSC and the CLSC family physician. It was extremely painful (...). I don't know how I managed to go on. There were also an assessing psychiatrist on duty at the hospital, six different psychiatric nurses and four different psychiatrists at the outpatient clinic – because they often change – a psychiatrist specializing in mood disorders who had a therapy group, a psychiatrist and three residents, whom she was training at the mood disorder clinic – and, lastly, three years ago, a psychiatrist who is still monitoring me and with whom I feel I have a privileged relationship.⁴

She also talked about there being little or no integration of services and supports and the important role community-based organizations played in her recovery:

With the energy I still have, I have decided to get involved at the community and advisory level on the city's regional health board. If I had not had the community services, I would not be here to speak with you today.

Yes, the institutions eventually helped me, the psychiatrists too, but they could also have killed me by making me relive the awful traumas I had to face. The duplication, rigid parameters and problems of approach at the institutional level must expand, and they have to work with the

³ Loïse (9:19).

⁴ *Ibid.*

community agencies to help the users of those services find the help they need.⁵

Loïse stressed the importance of addressing the stigma and prejudices associated with mental illness and addiction:

Since being diagnosed with my disease, I have lost the esteem of some members of my family. I have had to fight that, and many people have had to do that as well.

(...)

The deep and persistent prejudices that still exist in our society must be addressed on an urgent basis either through media campaigns or by other means.⁶

With respect to the media, she noted particularly:

We organize press conferences for the community sector, for users, to explain the various diseases to people, but no journalists ever come. However, if someone who is mentally ill commits an indictable offence, the headlines read, “Schizophrenic kills wife,” “Manic depressive man abuses his children.” And yet, I’ve never seen, “Cancer patient kills his wife,” or anything like that. In this regard, the media don’t help matters. There is work to be done. In a more educated, specialized population, where there are fewer prejudices, things are better, but it’s still a very serious problem.⁷

1.1.2 Ronald’s Story

Ronald spoke to the Committee about his life with his wife, who suffers from schizophrenia. He spoke about the onset of her disease about a decade after they were married in 1959 to today, and about how ill-equipped he was to help her then. “I had no idea what was going on. I was not familiar with mental illness,” he said.⁸ He explained:

I was married in 1959, and the first disorders began in the 1970s. We already had three children.

(...)

I have accepted my decision to stay with her, for better or for worse.

⁵ Loïse (9:19-20).

⁶ Loïse (9:20).

⁷ Loïse (9:27).

⁸ Ronald (9:20).

At the time, my wife didn't want to be hospitalized because, in her mind, there was no disease. She was not ill. Since the disease did not exist, I had to find a way to have her hospitalized.⁹

Ronald explained to the Committee the processes he went through to try to get help for his wife:

I spoke about the matter with my attending physician, who told me: "There's definitely something wrong with your wife; you should have her examined." But that required papers from two psychiatrists. The attending physician undertook to find two psychiatrists who would sign the papers and have her hospitalized.

Once the papers were signed by the two psychiatrists, she didn't want to go to the hospital. I told her: "You go to the hospital on your own, or the police will come and get you." I had to go get a piece of paper from the judge, and she agreed to be hospitalized.

She was hospitalized for three months and attempted suicide a number of times. Someone stayed in her room 24 hours a day for three months to prevent her from committing suicide. Lastly, she left the hospital under medication. At that time, she was taking neuroleptics (...). The crises gradually disappeared completely. The positive side of the disease, that is to say the hallucinations, religious delusions and so on, disappeared. But what appeared at that point, and what the drugs don't work on, was the negative side of the disease, that is to say the social side, the lack of self-confidence and personal hygiene, the feeling she had that she was worthless and that she was absolutely incapable of succeeding at anything, and so on. It's so subtle because she believes she's good for nothing and a failure; she also can't accept anyone loving her or telling her that she's good and able to succeed; that would be betraying what she actually believes.

She definitely let herself go.¹⁰

He told the Committee that, as his wife's disease progressed "we lost our friends and no longer had any social life, love life or sex life. Ultimately, we no longer had anything."¹¹ Talking about his life with his wife today, he said:

At home, my wife's disease and symptoms have disappeared. The psychiatrist sees my wife once every six months, but things aren't better. The entire negative side of the disease has worsened. Now she hardly ever

⁹ Ronald (9:20-21).

¹⁰ Ronald (9:21).

¹¹ Ronald (9:21).

gets dressed, she has no initiative and she is interested in nothing. She registers for courses in literature and painting, but always drops out. She comes home discouraged.

The children do not come to the house because they cannot cope with the situation.¹²

Ronald felt alone in that there was little support available to help him understand his wife's illness and manage the situation properly:

At the time, I was alone. The situation was difficult, and I had no help. I had to deal with all that. How I managed to get through it all, I don't know. [...] there was no violence. It was more emotional. My wife withdrew from the world. There was very little violence. It occurred on a few occasions. There were some suicide attempts because she had so little self-confidence. But it was very hard on the children.¹³

Ronald also talked about his difficulty in obtaining the medical certificate required for eligibility tax breaks:

(...) at first, the psychiatrist signed a letter for me giving me a tax exemption, but the second one did not do that, and I am no longer entitled to the tax break. That is hard to take. Everyone thinks she's doing well because there's no obvious sign in her everyday life, except for her physical appearance.¹⁴

He talked about a pilot project dealing with individualized care plans which, in his view, can only work with strong collaboration among the various mental health care professionals who are involved:

I remember an experiment that was conducted in which they talked about individual service plans. The mentally ill person was supposed to be the central person, and, around him or her, there was a team, the psychiatrist, the nurse and so on. That didn't work because they weren't able to bring the entire team together.

Now it works in small organizations such as ours, where the nurse agrees to cooperate and the doctor as well.¹⁵

In response to what was happening to his wife and family, Ronald went into volunteer work. Discovering that the best way to help relatives is to set up an organization to take care of individuals with mental disorders, he and other volunteers founded Le Pavois, an

¹² Ronald (9:22).

¹³ Ronald (9:30).

¹⁴ Ronald (9:22-23).

¹⁵ Ronald (9:36).

organization that strives to achieve social reintegration and rehabilitation through work. At Le Pavois, individuals with mental illness re-socialize through office workshops and cooking workshops. Once they have succeeded in a controlled environment, integration officers visit employers and try to find them internships and then jobs. Le Pavois also runs a second-hand clothing store, a photocopying service and a cafeteria at a provincial health and social service center. Ronald also stated:

These social businesses are an intermediate step enabling our members to move from Le Pavois to the actual labour market. We have realized that it is far too stressful for them to go directly into the labour market. Most are incapable of returning to the labour market.¹⁶

1.1.3 Murray's Story

Murray spoke to the Committee about his son, affected by paranoid schizophrenia. On May 28, 2002, while a patient at the Royal Ottawa Hospital, he left the hospital grounds and found his way onto the Queensway (on a lane reserved for buses) where he was struck and killed by a city bus. He described his son prior to the onset of his illness in these words:

Before the onset of his illness, approximately six years ago, our son was an honours student, played in the school band and toured Canada and the United States as a member of it, was a first division soccer player, had many good friends and a wonderful, long-term girlfriend, and was a soul mate to his younger sister. In short, he had just about everything going for him.

Things gradually started to go horribly wrong as he descended into the abyss of slow onset paranoid schizophrenia, the mental health care system and social services system.¹⁷

He described to the Committee a health care system equipped only to respond to crisis:

Invariably, when things really went wrong it was because we could not access the health care system in a timely fashion for reasons of lack of beds, emphasis on community treatment, a missed opportunity for him to go in voluntarily, or shortage of staff and insecure facilities. It seemed impossible to circumvent a crisis. The system only responded to the crisis and only after weeks of drug rebounding, deterioration and many family pleadings and warnings to caregivers. Not once during the many times he was discharged from hospital was he discharged in a stable condition with insight and compliance with medication.¹⁸

(...)

¹⁶ Ronald (9:22).

¹⁷ Murray (9:14).

¹⁸ Murray (9:15).

Even when he was in the hospital there were serious problems to deal with: the failure to obtain service, preparation for certification hearings, doctors meetings, visits to hospitals, Ontario Disability Support Program filings, researching medication and treatment, attendance at support groups, and unsettling telephone calls from our hospitalized son. We worried about his possible flight from the hospital and feared the possibility of long-term brain damage due to the use of inappropriate medications.¹⁹

Murray stated that the lack of services and supports had a serious negative impact on his son. He talked about the stress this placed on the entire family, their social network and finances:

As a consequence, he had unpredictable behaviour, outbursts of frustration and violent behaviour at any time of the day or night. This severely traumatized family members. We feared physical injury to our son and to family members, even while sleeping. We slept in shifts. The physical damage to our home was extensive and costly.

(...)

These fears created high levels of stress over the years [that] combined to result in mental and physical exhaustion, and worse.

There was no such thing as a social life. We could not take him with us because he could not tolerate elevated levels of sensory input for any length of time. We could not leave him at home and a sitter was out of the question.

The pain and suffering of my son's siblings included the loss of an entire university year, the trauma of police incursions into our home and the fear of their brother being injured or killed by police during numerous forced hospitalizations. Our daughter lost a soul mate and our surviving son will spend the rest of his life without his much beloved brother.

This illness (...) limited our opportunity to earn a living. I lost business income and was fired by my employer due to low production. I managed only to maintain my existing client base. I could not gain new clients for three years. I often could not keep planned appointments, as I could not leave the house when my son was at home. I was fearful of arranging appointments in the evenings because I would have to leave my wife and

¹⁹ Murray (9:16).

daughter at home alone with my son. There was a high burn rate of our savings.²⁰

Murray also talked about how frustrated his family was by the restrictions of privacy legislation which did not allow health care providers to share information with them about his son's illness:

Why is it that the medical profession is not allowed to share information with family members when it has been shown that family support is beneficial to the patient? The patient is on meds because his thinking is affected; yet the medical profession believes that sharing information with a family member must be a decision of the patient, who cannot make a reasonable or thoughtful decision.²¹

He stressed the need to find an appropriate balance between the right of the patient to be treated and involuntary treatment:

When it comes to balancing rights with forcing medication, as a parent, you are very concerned about your child's life and well-being, and it is not a question of his rights. He has a right to treatment, and he does not realize he needs it. He has a right to life, although he is incapable of maintaining it himself. It becomes very clear when you reach the point where his life is endangered.²²

Murray raised a question about the appropriate level of government funding for the diagnosis, treatment and research into mental disorders in comparison to other diseases:

My understanding is that both federal and provincial health dollars are to be spent on the health of all Canadians. Why is it that the most vocal and strongest lobby groups get the most money? We have statistics that we can provide on that subject. Meanwhile, these vulnerable people cannot speak for themselves and are left by the wayside. There are no political points to be made in spending money on these groups.

(...)

The rights issue is on our list of things that should be dealt with. It falls outside of the normal legal framework. When dealing with someone who does not have capacity, it is very awkward.

²⁰ Murray (9:15-16).

²¹ Murray (9:18).

²² Murray (9:28).

There are varying degrees of schizophrenia and the people who complain about their rights may have a minor form of the illness and feel that they are being persecuted and dealt with unfairly. It is a difficult issue.²³²⁴

Murray also raised concern about the lack of early intervention for mental disorders in comparison to other illnesses:

What sense does it make when there are many guidelines to determine if your family member has heart disease, depression, diabetes and so on, but there are no guidelines to tell if somebody is suffering from schizophrenia? The schools simply assume there is a drug problem and this leads to long lags in the treatment. Early treatment is critical.²⁵

1.1.4 David's Story

This was the first time David had agreed to share his personal experience with anybody. He stressed that it was not an easy task to recount his story and insisted on the importance of not disclosing his identity:

(...) I want to put a human face on autism by telling you a bit about our family experience. This is the first time I have ever done this. (...) I was told that you wanted to hear a personal story, and that is what I will tell you.

(...)

I will let it all hang out, and that is why I would rather that my identity not be disclosed. Mine is a very personal experience that bares deep personal values and issues. I am not sure whether this presentation will upset me or stabilize me.²⁶

David has a 31-year-old son living with autism. He described his son as follows:

My son is 31 years old. We did not know the extent of his disability until he was 15, which is quite unlike the situation with most people with autism. My son is not classically autistic. He is high functioning; he can speak; he can read; he graduated from high school..²⁷

(...)

²³ Murray (9:28-29).

²⁴ Murray (9:17).

²⁵ *Ibid.*

²⁶ David (9:6).

²⁷ *Ibid.*

My son, Adam, had problems in making friends when he was a young boy. We did not know he was autistic. He did not show autistic symptoms when he was two or three, which is when most people demonstrate their autistic tendencies. We did note he was aggressive, particularly towards strangers, and particularly aggressive toward the friends that his brother Andrew would bring home. People with autism do not like changes. They are resistant to change.

We sensed that school was becoming more stressful for Adam as he became older. When he became 15 years of age, he refused to go to school. Other children gave him a hard time. They made fun of him, and he found recess time to be extremely stressful. He became very agitated and angry. He would go out for walks and would return in a burning rage. He would get so angry that he would break windows and pull out light fixtures in our home.²⁸

David described in detail years of misdiagnosis, inappropriate therapies and the family's eventual discovery of what was wrong with their son. He recalled:

We had no choice but to have him taken to a hospital, where he was admitted and diagnosed incorrectly with bipolar disorder. That was because our medical system did not have the capacity to diagnose autism at the time. It is not much better today. It soon became clear that this diagnosis was not accurate. The children's hospital sedated Adam with medication but did not do anything to resolve his basic problems.

We have gone through a number of traumatic experiences. One was the night we had a call at two o'clock in the morning to tell us that Adam had left the hospital. He had jumped through the window onto the roof and then taken a ladder down onto the ground outside the hospital. By the time we got to the hospital Adam had been found by the police and was being treated for hypothermia. He never explained why he had taken such drastic action to jump out the window and climb out and run on the loose in his pyjamas in the middle of the night, but he frequently expressed his anger at us for putting him in hospital. Later, in his anger, he would pull out light fixtures. He became so aggressive and out of control that at one point we had to have him hospitalized in an adult psychiatric hospital, which was quite inappropriate for him but that was the only option available because it was only the adult psychiatric hospital that had the ability to control his access and to keep him restrained.²⁹

²⁸ David (9:8-9).

²⁹ David (9:9).

David recalled that, had he and his wife had known more about autism, they would have been better able to help their son:

At that time, there was very little understanding of autism in our community, so there were no resources that we could access. Our son was different in the sense that he was not classically autistic. Even if he were born today, he would not have been immediately recognized as having autistic symptoms because he did not portray all of the most common symptoms of autism. He could speak. There seemed to be no physical impairment of his speech.

Had we known what we were dealing with, we would not have wasted so much time. We wasted a large part of his life. I am [ambivalent] in my answer to this one. I asked my wife, "Would we have been better off if we had known what we were dealing with?" At one point, we both agreed that we would not have tried so hard. If we had known our son had a disability, we might not have pushed him so hard, because we did push him. We pushed him to the point where we endangered our health. Much of the stress that came out in his physical violence was, to a large extent, because we were pushing him to do things. That created a situation where we were living in a very dangerous environment in our home. We worried about fires and other dangerous situations. We pushed out the envelope really hard. That is one side of it.

The other side is that, had we known what we were dealing with, we would not have wasted all of this time with family therapy and medications that were more appropriate for people with bipolar disorder. We would have taken a much more intelligent approach to trying to come to grips with our son's problem. We would have sought good advice on how to deal with the problem. The fundamental problem was one of communication.³⁰

David also talked about the fear and anger the family lives with:

Autism is worse than cancer in many ways, because the person with autism has a normal lifespan. The problem is with you for a lifetime. The problem is with you seven days a week, 24 hours a day, for the rest of your life. My wife and I expect to have responsibility for Adam until we die. We lose sleep over what will become of him after we are deceased. Our financial resources are depleted, so our ability to provide for him is limited.³¹

³⁰ David (9:23-24).

³¹ David (9:12).

He spoke about the strain this mental illness has put upon his entire family, including Adam's siblings, on his and his wife's work, on their finances and on their social network:

My son's ability to communicate is limited, which limits his ability to socialize and to work. He has never worked in his life, and his disability has had a profound impact upon his brother Andrew and upon my wife and myself. It was a big cause of concern for my parents and my wife's parents, all of who are deceased.³²

(...)

Up to the point when our problems escalated out of control, we used to entertain friends and associates in our home. We would have them into our home for dinner. We used to reciprocate invitations. We found inviting strangers into our house was hard on both Adam and us. He did not want strangers visiting with us. He has been known to go into the kitchen when my wife has been baking and dump everything on to the floor. That makes it difficult to prepare dinner. The result is, we hardly ever had friends in for dinner. We do not invite them and they do not invite us. Home is not necessarily a haven when living with a person with autism. (...) Having a family member with autism is a lonely, traumatic experience.³³

David also explained how the family copes with the lack of resources for adults with autism:

The problem with autism is that the family has to bear the full burden of responsibility, financially, emotionally and in every other way. Our family is bearing the full burden of this disability. We receive no help financially or medically. Because our son is high-functioning, government requires that he apply for support, sign the documents, and that, when the government decides that there is a renewal required for the application, Adam has to fill this out.

He does not do it. We did have him on a small income support payment, but he was required to reapply. He delayed and he has now been cut off. He does not have the skills required to maintain access to support, but he is too high-functioning to have us appointed as his guardians to act on his behalf. We cannot go on vacation unless Adam's brother is at home. As I mentioned, he is a student at university and is unlikely to be spending much time at home in the future.³⁴

³² David (9:6).

³³ David (9:11).

³⁴ David (9:12).

With respect to community-based services and supports for adults affected with autism, David stated:

There are no services for adults with autism, except respite services for those who are lower functioning. Respite means babysitting, and the people who do respite work are paid minimum wage. After school, there is no structure in the life with a person with autism; there is just an abyss. The prospect of employment is remote without a lot of help, and the family has to shoulder the full burden.³⁵

David stressed the importance of recognizing that mental health is as important as physical health and that mental illness should be treated with the same sense of urgency as physical illness. He believes that the federal government should play a major role in achieving this:

There is no difference between someone who has a mental illness and someone who has a physical illness. That is the key question: Are we treating people with mental disorders with the same urgency that we treat people with physical disorders? I do not think we are. That is the fundamental question here. There is an equal public policy role for government in dealing with mental disorders. How do we do that? How do we change the environment out there?

The reality is that a mental disorder does not have a sense of urgency because it is recognized that people with mental disorders will be around tomorrow, whereas people who have heart disorders or cancer have to be treated today because they may not be around tomorrow. That clouds the whole issue. We must do something about it.

One thing we could do — and this is where your committee can play an important role — is for the Government of Canada, with regard to the transferring of funds for mental disorders, to put those funds in a fiscal envelope to be used only for mental disorders. That money cannot be used for anything else.³⁶

1.2 COMMITTEE COMMENTARY

You have to put a human face on it, as the chairman said. I do not know a better way to do that than to have people like the four people at this table stand up and be counted, to say things that are very difficult to say. That is why I think what they have done here today is very courageous.

³⁵ David (9:13).

³⁶ David (9:37-38).

To be honest with you, I do not know another way to do it. People do not understand. Politicians do not understand. They have no understanding of what we go through. How do you provide that understanding? It is only when they have a family member or some relation who has this dilemma that they can relate to it. It is very difficult to understand unless you walk in our shoes.
[David (9:34)]

The Committee very much appreciates the sincere, thoughtful testimony made by David, Murray, Loïse and Ronald. Somehow, just saying thank you to them does not seem to be enough. We appreciate how difficult it was for them to come and talk with us the way they did.

Together, these four witnesses painted a picture for the Committee of the stigma, frustration, fear and anger that affect individuals with mental illness and addiction and their families, of the impact of their diseases on parents and siblings, on their social lives and on their finances. By telling their moving stories, which were very important to the Committee's work, these witnesses helped shed light on many issues such as access to care, lack of communication or collaboration between health care providers, a lack of resources and patient rights and privacy issues. All these issues are addressed in the following chapters of this report. We do so in the hope that our work will ultimately be of help to David, Murray, Loïse and Ronald and to the thousands of people like them across the country.

CHAPTER 2: MENTAL DISORDERS TOUCH THE LIVES OF ALL CANADIANS

*Mental illness hits everyone — rich, poor, male, female —
of every race and creed.
[J. Michael Grass (17:43).]*

INTRODUCTION

One of the reasons behind the Committee's decision to undertake an in-depth study of issues relating to mental health, mental illness and addiction in Canada was recognition by our members of their profound effects on our society: mental illness and addiction affect individual Canadians of all ages in all segments of the population. The initial phase of the Committee's study, that has formed the basis for this report, has only reinforced that recognition.

Perhaps it is a neighbour who has Alzheimer's, a sister who has experienced post-partum depression, a colleague who is on stress leave from work, an uncle struggling with alcoholism, or friends talking about eating disorders, suicidal thoughts, or childhood abuse. It has been estimated that one in five Canadians will be affected at some point during his or her lifetime by a mental illness or addiction. It is difficult to imagine a day going by without *all* of us, knowingly or unknowingly, being in a room, on a bus, at a restaurant, or elsewhere, with someone who has experienced a mental illness or addiction.

This chapter builds on the personal stories of Chapter 1. It describes the impact of mental illness and addiction on individuals, on families and other care providers, as well as on their communities. While seeking to expand the understanding of what it is like to live with a mental disorder oneself or to live with someone affected by one, it also presents other facets of the impact of mental illness and addiction that stretch beyond the borders of families and households to encompass schools, offices and the many other places where Canadians interact.

The focus of this chapter is on individual perceptions. It provides brief glimpses into the lives of some of the many Canadians who live with mental illness and addiction every day. The excerpts are primarily from evidence contained in letters and e-mails sent to the Committee, from public testimony, as well as from a number of site visits by the Committee, supplemented by information drawn from relevant websites. In many instances, the stories are those of loss – loss of jobs, of family, of self-respect – and of struggling to obtain needed care. But there are also positive stories that tell of gains – of knowledge of self and of social, medical and legal services and supports that can help individuals affected by mental illness and addiction to live productive and contributing lives.

The voices are many and fragmented. They come from individuals who use services and providers who give them. They are from mothers who care for children, and husbands who care for wives. They are from teachers who build social and other skills, employers who

adapt their workplaces, and community leaders who work to restore neighbourhoods. They are from people everywhere in Canada.

2.1 INDIVIDUALS LIVING WITH MENTAL DISORDERS

2.1.1 A State of Mind

Many individuals living with mental disorders offered comments on their own mental states, emphasizing particularly the way they are perceived by the larger society to fall under the label “crazy.” One ended a long letter about his precarious, unsettled life with: “(…) and I’m not as crazy as people think I am.”³⁷ Another remembered her first thoughts when diagnosed with a psychosis at age 16 years as: “Oh my God! I can’t be one of those crazy people, with no home, no family, and no life.”³⁸

Even those who have the support of family and friends, who live in comfortable homes with regular meals and clean clothes, and who can access new therapies and the best drugs, talk about their sense of shame and failure, particularly as they see others accomplishing the goals they have set for themselves. They worry about the possible re-emergence of their symptoms. They know that they are viewed differently from other people and feel the loss of being “different”. In the words of one woman, “it’s worse for us because we know what we’re missing.”³⁹

Pat Capponi, author, journalist, speaker and social activist who also refers to herself as a psychiatric consumer/survivor, told the Committee:

*A mental patient is just that in the eyes of many. We are not entitled to be full human beings behind that label, not expected to have basic personalities that mirror those in the greater population, good and bad and everything in between. A schizophrenic is a schizophrenic, and every action is attributed to that disease and not to the underlying nature of the individual.*⁴⁰

Many people associate mental illness and addiction with disgrace; affected individuals are often discredited and, unfortunately, set apart from the rest of society. Sadly, stigma – whether the result of self-stigmatization or public stigmatization – is the cause of much of the distress those individuals with mental illness and addiction experience in their daily lives.

2.1.2 A Perpetual Cycle

Individuals affected by mental illness and addiction pointed out also how the perpetual cycle of problems they confront makes it difficult to integrate themselves into the broader community and to remain there, leading meaningful and productive lives. Pat Capponi told the Committee that medication is often seen as the easiest single solution to the complex

³⁷ Letter from John, no date.

³⁸ Letter from Tara, 28 November 2003.

³⁹ As reported by Pat Capponi, Brief to the Committee, April 2004, p. 2.

⁴⁰ Pat Capponi (7:49).

issues involved, but that this sometimes does little to address the real and continuing underlying concerns:

(...) funding has increasingly gone to keeping discharged patients in chemical straight jackets for the comfort of the mainstream community. If a client is depressed and upset that his life is so narrowly constricted, his medication is increased. If he is fearful of a landlord or unable to sleep in an over-crowded room, his medication is increased. If poverty leaves him hungry and restless, his medication is increased. And if he has the remaining life inside his body to be angry, the dosages will ensure that that anger is forgotten.⁴¹

She also told the Committee about how the gulf between the haves and the have-nots is widening, creating particular difficulties for those living with mental illness and addiction:

More people are using the food banks and so the share for the chronic mental patient has been dramatically reduced. A landlord will rent his house to people who he thinks will be less disruptive than a former mental health patient. People get squeezed out. Shelters prefer to house immigrants or battered women because they will not be seen as potentially disruptive. The stigma about the crazy people that we are exists.⁴²

Again, the stigma associated with mental illness and addiction may deny affected individuals even such basic rights as shelter and housing.

2.1.3 An Uncoordinated State

Individuals concerned with all aspects of mental health and addiction emphasized the need for those living with these conditions to have access to a continuum of services and supports that includes affordable housing and short-term intensive support services for people immediately after their discharge from hospitals, shelters, or jails. But they also stressed that the delivery of these services and supports must be much better coordinated across the entire mental health and addiction “system” and better integrated with the services offered by the broader social sector.

One example illustrating the absence of that coordination involved a patient/client living on welfare with some social security money to rent an apartment as well as meet some other expenses. This person had a relapse, spent 15 days in an acute psychiatric unit, and as a consequence lost both the social security funding and his apartment. As a result, the government had to accommodate him in a more expensive hospital bed until a space in the community became available.⁴³

Another example illustrates where early intervention and subsequent coordinated preventive action could have made a difference. A 25 year old man in Vancouver, in and out of foster

⁴¹ *Ibid.*

⁴² Pat Capponi (7:70).

⁴³ Julio Arboleda-Florez, (11:69).

care and jails since he was 13 years old, was diagnosed for first time with bipolar disorder. While on remand for three months for a break and enter committed to secure money for drugs. He was not tried but released on conditions, but, unfortunately, before long found himself back in jail. One condition of his release was that he continue taking three drugs: Ritalin, an antidepressant and methadone. Taken together these made him “hazy”. He was provided \$28 a week for food and accommodation, and found a small room on the downtown eastside. He could not afford transit, however, and had no support system in place. Within two weeks he had broken his probation after trying to connect with his father who had just been released from William’s Head prison on Vancouver Island.⁴⁴

Older Canadians are affected by many mental health issues that affect both their independence and the sense of control they have over their lives. For example, both for individuals with dementia and many others, a loss of access to transportation can mean the loss of contact with the outside world, of independence and of control. While public transportation may be an option for some, for others, it is simply not available. The Alzheimer Society recounted the stories of two individuals affected by the dementia. Trevor Jones, a career police officer was diagnosed at 57 years of age, while Jesse Roy, whose own mother had died of Alzheimer’s, still lived in her own home and volunteered to help others when, at 77 years of age, she was diagnosed. Among their many concerns, both expressed anxiety particularly about the loss of independence when they lost their driving abilities. Trevor did not trust himself to take public transportation and was forced to rely on his wife and various friends for transportation. Jesse worried that having to give up driving would not only curtail her activities; it would change her living arrangements and require her to move to a care facility.⁴⁵

In all these cases, little or nothing in the way of a support system was available. Support services were either not available or not integrated in such a way as to providing the affected individuals with the desirable continuum of care.

2.1.4 An Underserved State

The provision of adequate services and the ability to access them by those in need was one of the most crucial issues raised by all individuals living with a mental disorder. One young person wrote: “I credit my good health and success in life to a revolutionary treatment approach for youth experiencing their first break with reality...I can say with confidence that early intervention saved my life.”⁴⁶

Her letter went on to note that access to such life-saving programs is limited because they exist primarily only as research models in teaching hospitals:

“Even in Ottawa, the nation’s capital, the First Episode Program is grossly under funded with a waiting list of one year. People suffering their first episode (of psychosis) flounder at best to try and secure treatment. Many are afraid to reach out for help, others plainly

⁴⁴ Fax from Margaret, April 28, 2004.

⁴⁵ Alzheimer Society of Canada, Brief to the Committee, 4 June 2003.

⁴⁶ Letter from Tara, 28 November 2003.

*incapable of doing so because of the effects of the illness itself. Families are left to try and deal with what is an impossible situation.*⁴⁷

The need for early detection and intervention in the field of mental illness and addiction is clear. Early intervention can interrupt the negative course of many mental disorders, lessen long term disability and help to reduce the burden on families and other informal caregivers as well.

2.2 THOSE CARING FOR INDIVIDUALS WITH MENTAL ILLNESS

2.2.1 Parental Fears

Parents are the primary advocates for the interests of children who enter any part of the health care system. When dealing with mental health care, parents confront the reality that their roles as advocates and as providers of care will be a long term one. They must act as a continuous buffer between the affected individual and an often hostile larger community. With young children, parents must seek out for themselves a network of appropriate services and supports both within and beyond the health care sector. The need to exert themselves on behalf of their children often never stops until they themselves are incapacitated by age or illness.

Witnesses told the Committee that many parents fear most what will happen to their children when they can act no longer as their advocates. Phil Upshall, President of the Mood Disorders Society of Canada and the National Director of the Canadian Alliance on Mental Health and Mental Illness, recounted the story of family friends: “My family had two friends who had people with severe mental illnesses, totally incapable of treatment, living with them. The big fear in those families was what would happen to their son or daughter when they go.”⁴⁸

One 76 year old woman wrote the Committee about her many fears for her son who had been institutionalized for psychiatric treatment. She worried about the effectiveness of the treatment and the side effects that she had observed in her son. She wanted an investigation of the living and other conditions he confronted, but could not afford to pay the necessary legal fees out of her monthly pension. She said: “I don’t want to die while my son is a prisoner patient in that place...Because I’ve seen what they do to patients with no living relatives.”⁴⁹

Another mother wrote about her autistic adult son, his problems with sleeping at night and his need for her to be available always, to tuck him in and reassure him so that he could get back to sleep. She wrote:

I worry about Stephen in the long term and short term. Will we ever get any programs in place to help him? What if I get sick? What if my

⁴⁷ *Ibid.*

⁴⁸ Phil Upshall (9:30).

⁴⁹ Letter from Amy, 3 October 2003.

*cancer comes back? What will happen to him ultimately? Who will care for him as I do when I cannot, simply because I won't be here.*⁵⁰

Families are often the principal resource and the sole support available to individuals with mental illness and addiction. Because of the limited resources available in the hospital sector and the community, it is parents who house, care, supervise and provide financial assistance to their affected children. As those who recounted their experience above clearly demonstrated, this can be a source of enormous tension and emotional stress.

2.2.2 Parental Advocacy

Parents are deeply concerned for the welfare of their children when they enter the health care system for the treatment for mental illness. As lay persons, they feel inadequately equipped with the knowledge and resources needed to deal with the many challenges they know lie ahead. They worry about their being an insufficient level of care and that the care that is available may not always be delivered with the sensitivity their loved ones require. They worry about the cost of additional specialized care and of legal advice. Many parents and affected individuals stressed the need of those living with mental disorders to have available to them dedicated advocates to help them gain access to appropriate housing supports, as well as treatment and care.

One mother spoke of her experiences of navigating around obstacles in the current system; she wanted assurances that family members would have a “first right of refusal” to be part of the decision-making team, to obtain information about the affected family member’s diagnosis and treatment, to consider options about the care provided.⁵¹

Some witnesses pointed that children with autism or those suffering from Foetal Alcohol Syndrome and Foetal Alcohol Effects (FAS/FAE) require constant care. They emphasized that many parents and caregivers not only experience social and emotional isolation from family, friends and their communities, but they also carry heavy financial loads as well in their effort to get help. Pam Massad, speaking about FAS/FAE noted that:

*In their attempts to access the required services and supports for their child, many families experience serious financial burdens. Many provinces and territories do not offer financial support for specialized health services, educational supports and legal supports.*⁵²

The father of a three year old son, Steven, diagnosed at the Children’s Hospital of Eastern Ontario (CHEO) on December 8, 2003 to be suffering from autism, wrote about the lengthy and costly experience of trying to obtain appropriate treatment. “It has been now 261 days since then and we are on waiting lists. We have not received either one cent’s worth of medically necessary treatment or financial assistance so far.”⁵³ His e-mail went on to point

⁵⁰ Letter from unidentified woman, February 2003.

⁵¹ Letter from Irene, 7 avril 2003.

⁵² Pam Massad (13:7).

⁵³ E-mail from Andrew, 25 August 2004.

out that the family had resorted to private care out of necessity, and now faced out of pocket costs of about \$50,000 a year.

2.2.3 Parental Survivors

Parents may outlive their troubled children. While survivors of suicide speak of the desperate need to do something urgently to stop their “needless, unspeakable pain,” those who are left behind after successful suicides are devastated by the loss of their loved one. Diane Yackel of the Centre for Suicide Prevention pointed out that each day, there are 10 more families in Canada “whose lives were unalterably changed because a father, a son, a sister, some family member, with some degree of intentionality, chose to die by suicide.”⁵⁴

She recounted the tragic stories of four mothers:

- The first concerned a woman whose two husbands had both died by suicide. “She came to see me at the point in time when her son- her only child – had hanged himself. Several weeks after her son’s death, she was released from her work responsibilities because (quote) ‘she no longer was a productive employee.’”
- Then there was the incapacitated mother. “She was frozen in time, unable to sleep anywhere but on her chesterfield near the front door of her home. This was the chesterfield from which she last saw her son, and from where she heard the gunshot. Perhaps, just perhaps if she stayed there long enough, he might come back through that front door again, and she would have a second chance to stop him from going into his bedroom and shooting himself.”
- And the Aboriginal mother “whose 19 year-old daughter lay down on the railway tracks when life became too difficult for her to go on.”
- And yet another mother, herself a widow, “who discovered and had to cut down the body of her 14 year old daughter hanging in their house.”⁵⁵

It is truly not possible to comprehend and convey the profound anguish of those left in the aftermath of suicide. The central message survivors of suicide have conveyed to the Committee is the need for a comprehensive suicide prevention strategy that includes both early identification of suicidal behaviour and crisis management.

2.3 THOSE PROVIDING MENTAL HEALTH AND ADDICTION SERVICES

2.3.1 Provider Access

In mental health, most of the many gatekeepers to the “system” are health care professionals who deliver treatment; others, however, such as teachers and social workers, also provide access to necessary services and supports. In Canada, access to such services and supports is unevenly distributed. Shortages are evident everywhere, but they are particularly severe in certain parts of the country.

⁵⁴ Diane Yackel (6:47).

⁵⁵ Diane Yackel (6:46).

One brief submitted to the Committee highlighted the hardship afflicted on individuals with mental illness and addiction by restricted access to providers:

In Yukon, for example, there is at present no resident psychiatrist at all. The result is that people are forced to travel far from their homes to receive needed services – a hardship (ironically dubbed “Greyhound Therapy”) that is doubly stressful for someone dealing with a mental health problem.⁵⁶

Providers told the Committee that they can often correlate at least part of the problem faced by individuals with mental illness and addiction with the physical and socio-economic conditions in which they live. One psychiatrist who provides home visits talked about the lives of some of her patients:

A significant number of my patients do not have a method of transportation and we are a large rural community spread over a vast area. Significant numbers of my patients live with many extended family members in inadequate housing; some homes still have dirt floors and no indoor plumbing or source of heating in the winter other than a woodstove.⁵⁷

She also recounted how it took almost six months for an older man with untreated paranoid schizophrenia to develop a relationship with her through his doorway before he felt comfortable enough to invite her inside with him.⁵⁸

These stories point to the need for addressing the special mental health challenges faced by under-serviced rural and remote communities across the country.

2.3.2 Teachers and other School Service Providers

The role of teachers, schools and others in the early detection of mental disorders received considerable attention during the Committee’s hearings. Many witnesses emphasized the importance of schools in early detection so that mental health problems and illnesses can be addressed before they cause lifelong negative effects. Several witnesses made connections between observed problems with reading and writing and psychological distress and/or mental disorders. As Tom Lips from Health Canada pointed out with respect to literacy, “there may be mental health reasons that contribute to illiteracy. As well, there are mental health impacts to being illiterate.”⁵⁹

At the same time, witnesses recognized that, although school remains the place where children spend most of their time and acquire many of their adaptive social skills, the current reality is that the resources available are thinly stretched, making appropriate intervention more difficult to provide. Teachers face larger classes than they used to; this makes the

⁵⁶ Canadian Mental Health Association, Brief to the Committee, June 2003.

⁵⁷ Dr Cornelia Wieman (9:53).

⁵⁸ *Ibid.*

⁵⁹ Tom Lips, Health Canada (11:25).

identification and confrontation of students with more and complicated individual problems extremely difficult. The services provided to schools by nurses, psychologists and social workers have also been significantly reduced. Some treatment approaches are so fragmented that they actually end in the middle of the school year.

Children with Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), and learning disabilities have problems with impulsivity, attention and managing their behaviour. They may also have difficulty reading, distinguishing sounds and understanding the teacher.

The Committee heard that in Toronto the waiting list just for diagnosis in the publicly funded system is 18 months – almost 2 school years. Private access is available within a week or two to those who can afford \$2000 for the services of a psychologist (of which approximately \$300 may be covered by employer-sponsored insurance).⁶⁰

Diane Sacks, President-Elect, Canadian Paediatric Society, pointed out how many children with ADD, ADHD and learning disabilities mask their difficulties until junior high school when they begin to fail:

They fail at a time when, for many, they feel that their bodies are also failing them. They are not strong enough, thin enough or definitely not tall enough. The pressures are enormous. Poor social skills, which go along with this condition, now cause rejection and peer conflicts. How can a failing, “dummy” teen with poor social skills, which is what untreated ADHD looks like, form the peer group we talked about as one the essential tasks of adolescence? He cannot. Self-esteem issues arise. This is directly related to acting out, bullying and problems with the law.⁶¹

The fact that the onset of most adult mental health disorders occurs during childhood points, once again, to the need to devote more resources to early detection and intervention. Schools must be recognized as key players in the provision of mental health services and supports.

2.3.3 Primary Health Care Providers

The Committee was struck by the number of witnesses who talked about the significant breadth and range of services needed. Some pointed to the need for more training for primary care physicians in identifying mental disorders and in securing earlier interventions. Others talked about roles for nurse practitioners, social workers and psychologists. Many insisted upon the need to combine physical and mental care as part of the care continuum, pointing out how too often we treat the mind and the body differently, almost as if they were entirely separate entities.

The Canadian Psychological Association pointed to the particular psychological issues facing different individuals at different stages in their lives, such as:

⁶⁰ Diane Sacks (13:53).

⁶¹ Diane Sacks (13:51).

- a twelve year old who must adapt to a diabetic regimen that involves injections, daily blood testing, and dietary adjustments;
- a middle-aged man having survived a near fatal heart attack whose family members are obliged to modify their behaviours and relationships;
- a family caring for a parent with dementia at home;
- or a mother facing her demise from non-Hodgkin's lymphoma with the prospect of leaving behind two young children.⁶²

In this vein, Dr. Cornelia Wieman, a psychiatrist from the Six Nations Mental Health Services (Ohsweken, Ontario), expressed concerns about adopting a narrow biological approach to mental illness. She provided an example that illustrated why simply prescribing an antidepressant for a patient would have been an inadequate response:

(...) I have a patient who last year lost a son to suicide while he was in police custody. The same year, she was diagnosed with kidney cancer and underwent to removal of her kidney by surgery. Her youngest daughter, aged 14, has coped with her brother's suicide by engaging in extremely risky behaviour including engaging in substance abuse, unprotected sexual activity and staying away from the home for days at a time. This woman has been on medical leave from work, which has caused a great deal of financial stress. She also has several extended family members living in her home. She is a widow with few social supports.

Using this patient as an example, it would be unrealistic of me to simply prescribe her an antidepressant medication and reassure her that over time she will feel better. However, by prescribing her an antidepressant as well as activating a number of psychosocial supports, including counselling, and after working with her quite intensively over the period of a year at our clinic, she is finally feeling better. She returned to full-time employment this month.⁶³

She also pointed out that as a fee-for-service physician, she only gets paid for direct patient contact and not for time spent conferencing with other service providers about shared clients.

The discussion the Committee had with these witnesses suggests that we must re-think the way we address mental illness in relation to physical illness. We must also address the appropriate balance between a narrowly defined biomedical approach and psychosocial intervention. Appropriate incentives must be developed to ensure that health care providers can devote the time required to address the specific, usually time-consuming needs of individuals affected by mental illness and addiction.

⁶² Sam Mikail and John Service, [*Presentation to the Commission on the Future of Health Care in Canada*](#), Ontario Psychological Association, 11 April 11 2002.

⁶³ Dr. Cornelia Wieman (9:54).

2.3.4 Provider Distress

Mental health professionals face their own anxieties. They are not always able to address the needs of their patients and their families as fully as or in ways they would like. In some instances, this is the result of a lack of sufficient resources; in others, they are aware that diagnosing a mental illness may require them to treat the individual and their family differently than if the problems were physical in nature.

One paediatric specialist spoke about gains made in the methods for diagnosing many childhood conditions and the insufficiency of research into methods for prevention and treatment. She observed that the search for appropriate services can become a major undertaking when:

(...) services that provide treatment are seriously underfunded and leave families scrambling for the few spaces that are available. Fragmentation of services mean these families and their primary care provider must look for new options almost on a yearly basis.”⁶⁴

Other providers pointed out that it was not that long ago that treatment methods and attitudes we now find reprehensible were standard practice. For example, Dr. Michel Maziade, Head, Department of Psychiatry, Faculty of Medicine, University Laval (Quebec), stated:

In the 1950s and up until the late 1960s, psychoanalysis was very prevalent and everything was environmental. It is as if the brain did not exist at all. If you look at papers published at that time, all those disorders – schizophrenia, autism, and manic-depressive disorders – were the fault of the mother. It was always because the mother was lacking in education.

(...)

In those days, we accused people. I am a practising child and adolescent psychiatrist and I did that myself as a resident in the early 1970s. I was giving the parents the diagnoses for this terrible disorder and instead of providing support to them, as one would if their child had a cardiac disorder, I was accusing them because I was suggesting that they go to psychotherapy to help the child, because something was missing in the relationship. That was terrible.⁶⁵

2.4 MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION AT WORK

2.4.1 Workplace Secrets

⁶⁴ Dr. Diane Sacks, President-Elect, Canadian Paediatric Society, Brief to the Committee, May 2003, p. 1.

⁶⁵ Dr. Michel Maziade (14:32).

In some workplaces, individuals with mental illness or addiction may have access to some assistance in dealing with their problems, but with or without these supports, they may still feel compelled to keep their personal struggle hidden. All too often, the fear of losing one's job or of being stigmatized by one's colleagues is enough to prevent individuals living with a mental disorder from seeking treatment. The Committee heard that it is common for employees to blame themselves and remain silent when they become depressed or unable to meet their employers' expectations because of a mental health or substance abuse problem.

Individuals tend to keep personal issues to themselves sometimes with negative consequences for their future employment as well as their well-being. These stories were brought to the Committee's attention. For example:

Michael Koo, 34, says he was devastated when his coworkers complained in a performance evaluation that he wasn't pulling his weight. But Koo says he didn't feel comfortable explaining that a major depression was the reason for his low productivity. "My thought was, 'I can't afford to let them know what was going on, 'cause I'll lose my work'," he recalls, adding that stress leaves were associated with shame.

Jane, a 30-year-old biologist, says she never discussed her clinical depression with her employer because she was afraid of losing respect. "People in the workplace want to be dealing with consistent and reliable colleagues," she says. "Being perceived as being vulnerable to depression limits how much people feel they can invest in you." Although she hid her depression, Jane says she lost all credibility with her company when her work began to suffer. "I would fall short on my commitments and was unable to justify my inability to produce according to expectations," she explains.⁶⁶

These stories underline the importance of increasing awareness in the workplace about mental illness and addiction. An important step will have been taken once workplace managers have better knowledge of mental illness and addiction; they will be more willing to and capable of offering accommodation to those workers suffering from mental illness and addiction.

2.4.2 Workplace Successes

Individuals living with chronic mental illnesses have struggled to create a place for themselves in the workforce. Although traditional vocational rehabilitation has been available for decades, the development of "survivor" businesses is relatively recent. Pat Capponi outlined the struggle of the Ontario Council of Alternative Businesses to develop opportunities for chronic psychiatric patients in neighbourhoods where ratepayers, local politicians and businesses were hostile. She told the Committee that:

Our community began to see that there were possibilities out there for us. We began to have role models and leaders. We were achieving, breaking myths and assumptions about who and what we were, and we were forming a community. Chronic psychiatric patients showed commitment

⁶⁶ According to information from <http://www.heretohelp.bc.ca/>.

in reporting to work on time. In acquiring new skills, lasting friendships were created and people grabbed every opportunity to learn from each other's experiences.⁶⁷

Work makes an important contribution to the process of recovery. Employment may reduce the frequency and severity of episodes of acute illness by providing structure, the opportunity for social connections and a fuller life. Regular remuneration also helps to reduce dependence on social assistance and the needs of individuals for mental health services and supports.

2.5 PEOPLE LIVING WITH MENTAL ILLNESS WHO ARE UNDER FEDERAL RESPONSIBILITY

2.5.1 Veterans

Concerns about the care of Canadian veterans took the Committee to Ste.-Anne-de-Bellevue Hospital in Quebec, the only facility for veterans still administered by Veterans Affairs Canada. Like many older Canadians, veterans prefer to stay at home as long as possible before entering long-term care facilities. By the time they enter such facilities, they can be quite frail. At Ste. Anne's anywhere from 50 to about 80 per cent of the residents are affected by some form of dementia. The loneliness and boredom experienced by many patients in such facilities are often exacerbated by mental disorder.

Bernard Groulx, Chief Psychiatrist at Ste. Anne's, outlined some of the specific issues encountered in caring for patients suffering from dementia:

These patients have severe problems. They wake up at night; they are disoriented in space, time and people; incontinent; they are emotionally unstable; they are hyperactive; frequently aggressive; have delusions and hallucinations; show a variety of agitated behaviour.⁶⁸

Specialized nursing approaches are essential to ensure a reasonable quality of life for these patients. The nursing staff at the hospital has to support families as well as the residents. A nurse at Ste. Anne's Hospital said: "I work a lot with the families, especially with Alzheimer's. I have to communicate with the families, make them comfortable and help them to understand the disease. (...) I support everything they have to go through, the hard times."⁶⁹

2.5.2 Inmates

Inmates in federal correctional services fall under federal responsibility. Recent trends indicate that the proportion of the population of federal offenders with mental health and substance abuse problems is growing, even though overall prison admissions and

⁶⁷ Pat Capponi (7:48).

⁶⁸ Bernard Groulx, Brief on Psychiatric Care at Ste. Anne's Veterans Hospital, provided to the Committee on 7 May 2003.

⁶⁹ Sarah Tyrrell, [Nurses – Always There For You: Caring For Families](#), Veterans Affairs Canada, 2002.

institutional population have been in decline. Some, such as women and Aboriginal peoples, have particular needs.

Within Correctional Services Canada, the need for mental health treatment is acknowledged:

Mental health treatment for offenders is required if we want to reduce the disabling effects of serious mental illness in order to maximize each inmate's ability to participate electively in correctional programs; to help keep the prison safe for staff, inmates, volunteers and visitors; and to decrease the needless extremes of human suffering caused by mental illness.⁷⁰

Officials from the department also talked about the need to deal with offenders who require specialized mental health intervention in order to reduce the “revolving door” phenomenon:

There is what we call a revolving door between corrections, both federal and provincial, but also the community, where often people who are afflicted with mental health disorders find themselves in the criminal justice system. While mentally disordered offenders are often less likely to reoffend — including violently — they are more likely to return to prison due to a breach of their release conditions — often as a result of inadequate support while they are in the community.⁷¹

This points to the need to develop better links between the federal and provincial governments and between the justice and the mental health service/support systems. Correctional Service Canada must do more to prevent the “revolving door” phenomenon.

2.5.3 First Nations and Inuit

Questions were raised concerning the inadequacy of access to individual counselling services for First Nations and Inuit patients under Health Canada's Non-Insured Health Benefits (NIHB) counselling program. The NIHB program supports clients “in crisis” or those who cannot access counselling through out-patient clinics funded by the province or who cannot pay for private counselling. But limited incomes, combined with transportation and access issues, mean that many individuals fall through the cracks.

According to Dr. Cornelia Wieman:

Presently, my patients can access individual counselling through the Non-Insured Health benefits program. (...) However, (...) the limit is 15 sessions with the possibility of renewing for a further 12. A total of 27

⁷⁰ Françoise Bouchard, Director General, Health Services, Correctional Service Canada (7:53).

⁷¹ Françoise Bouchard (7:54).

sessions for many people is not sufficient to help them adequately address their mental health concerns.⁷²

Clearly, the NIHB program must be revised so as to better reflect the mental health needs of First Nations and Inuit peoples.

2.6 COMMITTEE COMMENTARY

Even with our somewhat broader look at the lives of individuals affected by mental illness and addiction the Committee is acutely aware that the preceding excerpts from the evidence received have only scratched the surface of what is a very large problem. It is impossible to fully enumerate the many groups of Canadians who are affected by mental illness and addiction and to portray fragments from all their lives.

In the remainder of this report the Committee has gathered together the evidence it has heard over the past 18 months. This is the first step in coming to grips with the enormous challenges that lie before us in developing a set of recommendations to improve the quality of life of those who are living with, and those who are directly or indirectly impacted by, mental illness and addiction. This includes all of us.

⁷² Dr. Cornelia Wicman (9:55).

CHAPTER 3: STIGMA AND DISCRIMINATION

3.1 INTRODUCTION

In the course of its hearings, the Committee heard from many witnesses about the enormous importance of addressing head on the problem of the stigmatization of, and discrimination against, individuals living with mental disorders. There was considerable discussion concerning how best to reduce stigmatization and combat discrimination, as well as over how to understand the relationship between these two phenomena.

There was widespread agreement on the absolutely central place occupied by these issues in considering how to improve access to and the delivery of mental health services and to enhance the mental health of Canadians more generally. Ms. Heather Stuart, Associate Professor, Community Health and Epidemiology, Queen's University, put it well in her testimony to the Committee:

We are in a community mental health model right now and so stigma and discrimination are the crux of the issue for us. They are our major barriers to the treatment of mental illness in our modern day. We expect, when we put people into the community, that the community will want them and nurture them. This is not happening.⁷³

The first section of this chapter looks at how to define the two phenomena, stigma and discrimination, how they are related, and some of the factors that contribute to their stubborn persistence. The second section explores the impact of stigma and discrimination on individuals living with mental disorders in order to better understand why many have described it as being worse than the burden of illness itself. The third section discusses the options and strategies that have been suggested to combat the stigmatization of individuals living with mental disorders and to reduce the discrimination they face. A section devoted to Committee Commentary concludes the chapter.

3.2 DEFINING STIGMA AND ITS RELATIONSHIP TO DISCRIMINATION

Two questions pervade the discussion of stigma and discrimination:

1. How does the stigmatization of individuals living with mental disorders relate to the discrimination they face?
2. Why is it so hard to change attitudes and reduce discrimination?

We will examine the second question in Section 3 of this chapter. As for the relationship between stigma and discrimination, some witnesses contended that the term stigma itself

⁷³ Second Session, 15:10.

tends to focus our attention on the wrong thing, and that it should be discarded in favour of talking in terms of discrimination. This was the view expressed by Ms. Nancy Hall, Mental Health Consultant:

I come from the school that calls it what it is, which is discrimination. In any of the other disability organizations in which I am involved, they do not use the word "stigma." It is a polite term. They use the word "discrimination." To me, discrimination is when someone with a mental illness is systematically treated differently from someone who does not have a mental illness.⁷⁴

The Committee nonetheless feels it is important to try to get a handle on what is meant by stigmatization. Although the relevant literature does not yield a single, universally-accepted definition that encompasses all the dimensions of this complex phenomenon,⁷⁵ stigma has variously been defined "as a sign of disgrace or discredit, which sets a person apart from others,"⁷⁶ and as "stereotypes that reflect a group negatively."⁷⁷ Ms. Bronwyn Shoush, Board Member, Institute of Aboriginal Peoples' Health, Canadian Institutes of Health Research, suggested to the Committee that:

...stigma might be seen as a veil over a person that prevents others from focusing on that person. There needs to be a way to lift that veil and take a look at the person and not see only things that are different about him or her.⁷⁸

Witnesses generally agreed that stigmatization involved attitudes, while, as Ms. Stuart said, "... the action is discrimination."⁷⁹ Dr. Julio Arboleda-Florèz, Professor and Head, Department of Psychiatry, Queen's University, put it this way:

...discrimination exists, but it is different from a stigma. A stigma concerns our attitude toward particular groups. Discrimination is a denial of legal entitlements that we all ought to be able access.⁸⁰

The connection between stigma and discrimination has been described in the literature as involving a number of overlapping elements that come together to form a continuum linking the development of negative stereotypes to actual discriminatory behaviour towards people with mental illness. Three key steps have been identified in this process:

1. Labelling or stereotyping

⁷⁴ Second Session, 16:3.

⁷⁵ Bruce G. Link and Jo C. Phelan, "On Stigma and its Public Health Implications," Background Paper, National Institute of Health Stigma Conference.

⁷⁶ Peter Byrne, "Stigma of mental illness and ways of diminishing it," *Advances in Psychiatric Treatment* (2000) Vol. 6, p. 65.

⁷⁷ Patrick Corrigan and Robert Lundin, *Don't Call Me Nuts*, Recovery Press, 2001.

⁷⁸ Second Session, 16:10.

⁷⁹ Second Session, 15:27.

⁸⁰ Second Session, 11:70.

2. Developing prejudice
3. Practicing discrimination

Researchers have also distinguished between public stigmatization (ways in which the general public reacts to a group based on stigma about that group) and self-stigmatization (the reactions which individuals turn against themselves because they are members of a stigmatized group).⁸¹ The following table provides an overview of the three components involved in the process of stigmatization of individuals living with mental disorders.

THREE LEVELS OF PSYCHOLOGICAL STRUCTURES THAT COMPRISE PUBLIC AND SELF-STIGMATIZATION

	Public Stigmatization	Self-Stigmatization
<i>Stereotype:</i>	Negative belief about a group, e.g. dangerousness, incompetence, character weakness	Negative belief about the self, e.g. character weakness, incompetence
<i>Prejudice:</i>	Agreement with belief and/or negative emotional reaction, e.g. anger, fear	Agreement with belief Negative emotional reaction e.g. low self-esteem, low self-efficacy
<i>Discrimination: Behaviour response to prejudice</i>	e.g., avoidance of work and housing opportunities	e.g., failure to pursue work and housing opportunities

Source: Amy C. Watson and Patrick W. Corrigan, “The Impact of Stigma on Service Access and Participation,” a guideline developed for the Behavioural Health Management Project.

The development of stereotypes is a key part of the process of stigmatization of, and discrimination against, people with mental illness. Stereotyping involves using selective perceptions to place people in categories and exaggerating the differences between these various groups⁸² (“them and us”). As with racial prejudice, stereotypes also make people easier to dismiss and, in so doing, the stigmatizer maintains social distance. In this regard, Ms. Hall also told the Committee that:

...as [a] Mental Health Advocate, nine out of ten people told me that once their diagnosis was acknowledged, once they were open about their diagnosis, people treated them systematically differently.⁸³

Stigmatizing stereotypes can be so strong that stigmatized people are thought to “be” the thing they are labeled. For example, some people speak of persons as being epileptics or schizophrenics rather than describing them as having epilepsy or schizophrenia. This is revealing with regard to mental illness because it is different for other diseases. A person *has* cancer, heart disease or the flu — they are one of “us,” a person who just happens to be

⁸¹ Amy C. Watson and Patrick W. Corrigan, “The Impact of Stigma on Service Access and Participation,” a guideline developed for the Behavioural Health Management Project.

⁸² Byrne (2000), *op. cit.*

⁸³ Second Session, 16:16.

beset by a serious illness. But the person *is* a “schizophrenic.” Thus the whole person is stigmatized,⁸⁴ as Ms. Pat Capponi told the Committee:

*A mental patient is just that in the eyes of many. We are not entitled to be full human beings behind that label, not expected to have basic personalities that mirror those in the greater population — good, bad and everything in between. A schizophrenic is a schizophrenic and every action is attributed to that disease and not to the underlying nature of the individual or his circumstances. A person who is bitter and angry or who is addicted to crack or other drugs does something terrible and a chorus of voices is raised against all who carry the same label.*⁸⁵

There are a number of stereotypes that are commonly identified in the literature as being widely held about persons with serious mental illness. These include:

1. People with mental illness are dangerous and should be avoided.
2. People with mental illness have brought their problems upon themselves and are to blame for their disabilities since they arise from weak character.
3. They are incompetent or irresponsible and require authority figures to make decisions for them.
4. They are viewed as childlike and needing parental figures to care for them.
5. Poor prognosis: the view that there is little hope for recovery from mental illness.
6. Disruption in social interaction: the view that people with mental illnesses are not easy to talk to and have poor social skills.
7. People with mental illness are not as intelligent as others.

However, a very recent (June 2004) scientific survey of public perceptions of mental illness that was undertaken in Houston, Texas, (the first of its kind in a major metropolitan area)⁸⁶ produced some interesting and encouraging findings, that the study’s authors believe are representative of mainstream attitudes in the United States as a whole. In the words of the study:

The data indicate that an overwhelming majority of the public at large has come to believe that mental illness is essentially a physiological disorder that ought to be treated like any other physical illness. Only a

⁸⁴ Link and Phelan, *op. cit.* Also, Keith Brunton, “Stigma,” in the *Journal of Advanced Nursing*, No. 26, 1997.

⁸⁵ Third Session, 7:49.

⁸⁶ *Public Perceptions of Mental Illness: A report to the Mental Health Association of Greater Houston* by Stephen L. Klineberg, Ph.d., Rice University (June 2004).

*tiny minority continues to believe that mental illness can be attributed to any sort of morally relevant defect of character.*⁸⁷

*Moreover, by 56 to 31 percent, more than half of Harris County residents believe that most people being treated for mental illness are able to live a normal life. A clear plurality (47 percent) would not be concerned if they discovered that a person under treatment for a mental illness were living in their neighborhood, and a majority (by 51 to 42 percent) would be willing to pay higher taxes to improve access to mental health services in the Houston area.*⁸⁸

3.2.1 Self-Stigmatization

Self-stigmatization can be defined fairly easily. It is simply agreeing with the negative attitudes about mental illness and turning them against oneself. Persons living with mental illness who believe that other people devalue and reject people with mental illness will most likely fear that this rejection will be applied to them personally. Such a person may wonder, “Will others think less of me, reject me, because I have been identified as having a mental illness?” Then, to the extent that it becomes a part of their worldview, that perception can have serious negative consequences. Expecting and fearing rejection, people who have been hospitalized for mental illnesses may act less confidently, be more defensive, or they may simply avoid a threatening contact altogether.⁸⁹

Self-stigmatization takes the form of “I am” statements such as the following:⁹⁰

- *I really am unable to care for myself.*
- *I’m dangerous and could snap at any minute.*
- *I’m no different than a child.*
- *I can’t handle responsibility.*
- *Don’t give me money. I’ll only blow it.*
- *I’m a bad person.*
- *Who would want to live next to a person like me?*
- *Everyone can plainly see I’m weird.*
- *I’m not worth the investment of time and resources.*
- *I have a weak personality.*
- *I am not able to do...*

Self-stigmatization has a broad and deleterious impact on the person with mental illness, and can worsen the course of his or her disorder. Persons who self-stigmatize are likely to have

⁸⁷ *Ibid.*, p. 27.

⁸⁸ *Ibid.*, p. 28.

⁸⁹ Bruce G. Link, Elmer L. Struening, Sheree Neese-Todd, Sara Asmussen, Jo C. Phelan, “The Consequences of Stigma for the Self-Esteem of People With Mental Illnesses,” *Psychiatric Services*, Vol. 51, No. 12, December 2001.

⁹⁰ Corrigan and Lundin, *op. cit.*

more problems and disabilities with their mental illness than people who do not internalize statements like those above. One reason is that people who self-stigmatize have poor self-esteem, and with the deprivation of self-esteem comes a loss of hope. Not only do such people believe they are not worthy of respect now, they believe things will not change in the future.⁹¹ Ms. Rena Scheffer, Director, Public Education and Information Services, Centre for Addiction and Mental Health, told the Committee that:

On an individual level, stigma not only leads to low self-esteem, isolation and hopelessness, but all of those characteristics also have been found to be predictors of poor social adjustment, so people end up in an endless cycle of poorer quality of life.⁹²

People with diminished self-efficacy due to self-stigmatization are less likely to apply for jobs or apartments (“Someone who is mentally ill like me can’t handle a regular job!”).⁹³ Other people with mental illnesses try to avoid discrimination by simply concealing their illness. In doing so, however, they can incur more stress from the continuous fear of being discovered, from endangering their mental health by tending not to take time off even when they need it, and from remaining ineligible for appropriate accommodations for their disability that might have made their working lives easier and more enjoyable.

Self-stigmatization is also one of the factors that contributes to the fact that many people with diagnosable mental disorders do not seek treatment. When people fear being identified and labeled as having a stigmatizing condition, they may then delay or avoid seeking treatment. According to Ms. Scheffer:

Estimates are that two-thirds of people who require treatment for a mental illness do not seek help, largely because they are either unaware of the symptoms or because of the stigma associated with the illness or its treatment.⁹⁴

Dr. Richard Brière, Assistant Director of the Canadian Institutes of Health Research Institute of Neurosciences, Mental Health and Addiction offered the following analogy to the Committee:

People who need help often do not seek help because they are ashamed of what happens to them. If we can do something about the stigma attached to mental illness, you will have people bragging about it the way they do about heart disease, saying, “Well, I had a bypass.” People will tell their friends about that, but many people will not talk about their mental illness problem.⁹⁵

⁹¹ *Ibid.*

⁹² Second Session, 16:20.

⁹³ Watson and Corrigan, op. cit.

⁹⁴ Second Session, 16:19.

⁹⁵ Third Session, 6:55.

Families of individuals living with mental disorders can also take on board the fear of stigmatization, with potentially serious consequences. In her brief to the Committee, Ms. Stuart referred to a case in which a mother whose daughter's mental health was deteriorating initially avoided treatment out of fear that her daughter would be branded as "crazy" by medical personnel. Ultimately, the police had to intervene when the daughter's worsening condition degenerated into a full-blown crisis.⁹⁶

Stigma is not a new phenomenon. In fact, stigmatization of people with mental disorders has persisted throughout history.⁹⁷ In this regard, Ms. Scheffer, in her brief to committee, referred to the renowned sociologist Erving Goffman who pointed out that the word stigma in the original Greek was used "to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier."⁹⁸ While the exact content of the mythology that contributes to the stigmatization of people with mental illness has no doubt changed in the intervening millennia, it is striking the extent to which the term still describes a situation in which the person being stigmatized is being set apart (and de-valued) because of certain behavioural or physical traits.

In general, given the significance of the phenomenon of stigma, the Committee agrees with Mr. John Arnett, Head, Department of Clinical Health Psychology, Faculty of Medicine, University of Manitoba, who argued that the process of stigmatization itself has a real and profound impact on individuals living with mental disorders. This is how he put it in his testimony:

We know that stigmatization is characterized by bias, distrust, stereotyping and so on. It frequently reduces an individual's access to resources and opportunities for housing and jobs and ultimately leads to low self-esteem, isolation and hopelessness. There is no question that this occurs in many cases independently of the limitations that may be imposed by the mental health disorders themselves. In other words, stigmatization seems to have an independent capacity to do this.⁹⁹

3.2.2 The Role of the Media and the "Attribution of Dangerousness" to Individuals Living With Mental Disorders

One factor that has often been cited as contributing to the persistence of stigmatization of persons with mental disorders is media coverage. About a third of people identify the media — including print, radio, television, and internet-based news, advice, entertainment and advertising — as their main source of information about people with mental illnesses.¹⁰⁰ Unfortunately, the media often reinforces myths and stereotypes about people with mental

⁹⁶ Brief to the Committee, May 14, 2003, p.3.

⁹⁷ *Mental Health: A Report of the Surgeon General* of the United States, 1999. Also, Paul E. Garfinkel and David S. Goldbloom, "Mental health — getting beyond stigma and categories," *Bulletin of the World Health Organization*, 2000.

⁹⁸ Brief to the Committee, May 28, 2003, p. 3.

⁹⁹ Second Session, 16:7.

¹⁰⁰ *Discrimination Against People with Mental Illnesses and their Families: Changing Attitudes, Opening Minds*, A Report of the BC Minister of Health's Advisory Council on Mental Health, April 2002.

illnesses. Analysis of ways in which film and print represent mental illness have shown that, in particular, two of the stereotypes of persons with mental disorders are spread by these sources: people with mental illness are “homicidal maniacs who need to be feared”, and they are “childlike and need to be protected by parental figures.”¹⁰¹

Content analyses of American television have shown that over 70% of major characters with a mental illness in prime time television dramas are portrayed as violent; more than one fifth are shown as killers.¹⁰² The typical newspaper depiction of individuals with mental illnesses shows them to be psychotic, unemployed, transient, and dangerous—not as productive members of a family or community. Similar studies of newspapers in Canada and Britain have shown that stories featuring violent acts by people living with mental disorders appear more frequently and are given greater prominence than articles containing a more positive portrayal.¹⁰³

Negative conditioning towards people with mental disorders that encourage stigmatization may begin at an early age. The first study of children’s television programming in New Zealand and the U.S., published in 2000, concluded that “the frequent and casual use of fundamentally disrespectful vocabulary such as crazy, mad, nuts, twisted, wacko or loony demonstrated for children that such expressions are acceptable or even funny.”¹⁰⁴ The researchers responsible for this study actively looked for, but were unable to identify, any positive attributes associated with those who were depicted as mentally ill, nor did they find any understanding of the suffering that mental illness involves.

Some of the stereotypical depictions of people with mental illness that occur regularly in the media include the following: rebellious free spirit; violent seductress; narcissistic parasite; mad scientist; sly manipulator; helpless and depressed female; and comedic relief.¹⁰⁵ Most often such characters have no identity outside of their stereotypical “crazy” behaviour, and are primarily identified by an inferred mental illness.

At the centre of media accounts and public misperceptions is the attribution of a propensity for violence to individuals living with mental disorders. For example, 88% of participants in focus groups conducted by the Ontario Division of the Canadian Mental Health Association in the early 1990s believed that people with a mental illness “are dangerous or violent.”¹⁰⁶ Not only is this a persistent problem, but it would appear that it is getting worse over time. In the United States, attitudes toward mental illnesses have apparently become more infused with concerns about violence associated with these illnesses. Thus, between 1950 and 1996,

¹⁰¹ Corrigan and Lundin, *op. cit.*

¹⁰² Sampson, Stephanie “Countering the Stigma of Mental Illness”, online newsletter of the Anxiety Disorders Association of America (ADAA), May-June 2002. Accessed on March 11, 2004 at http://www.adaa.org/aboutADAA/newsletter/2002_stigma.htm.

¹⁰³ Scott Simmie, *The Last Taboo* (Toronto: McClelland & Stewart, 2001) p. 304.

¹⁰⁴ Wilson, Claire, Raymond Nairn, John Coverdale and Aroha Panapa, “How Mental Illness is Portrayed in Children’s Television” *British Journal of Psychiatry* (2000) 176, p. 442.

¹⁰⁵ Dara Roth Edney, “Mass Media and Mental Illness: A Literature Review” (Canadian Mental Health Association, Ontario Division, 2004) p. 3.

¹⁰⁶ Scott Simmie *Out of Mind: An Investigation Into Mental Health* (Toronto: Atkinson Charitable Foundation, 1999) p. 65.

the proportion of Americans who describe mental illness in terms consistent with violent or dangerous behaviour nearly doubled.¹⁰⁷

According to the U.S. Surgeon General this attribution of a propensity towards violence on the part of individuals living with mental disorders is a key factor in explaining the persistence of stigmatizing attitudes:

*Why is stigma so strong despite better public understanding of mental illness? The answer appears to be fear of violence: people with mental illness, especially those with psychosis, are perceived to be more violent than in the past.*¹⁰⁸

It is important to note that this fear of violence rests on what is largely a misperception of the facts. In the words of a Health Canada sponsored study, “there is no compelling scientific evidence to suggest that mental illness causes violence”.¹⁰⁹ Some American studies have argued that at most 4% of all violent incidents have any connection to mental illnesses.¹¹⁰ At the very least this strongly suggests that public fears are largely misplaced, although they are clearly widespread.

There is, however, evidence that suggests that people who do not receive treatment for their mental illness, or who have concurrent disorders (that is, individuals who have a mental disorder as well as a substance abuse disorder) are more likely to be violent than the general population. Still, there is very little risk of violence or harm to a stranger from casual contact with an individual who has a mental disorder and the overall contribution of mental disorders to the total level of violence in society is exceptionally small.¹¹¹ In this regard, Ms. Scheffer commented that, “as a predictor of violence, mental illness ranks far behind other risk factors like age, gender and history of violence or substance abuse.”¹¹²

And Ms. Hall noted:

*...the sad thing is that actually people with mental illness are more at risk of self-harm. In my province, a person a day commits suicide. Even though the reality is that they are more at risk of doing harm to themselves, the public perception is that they are indeed a danger to others, which simply is not the normative truth...*¹¹³

Ms. Jennifer Chambers, Empowerment Council Coordinator, Centre for Addiction and Mental Health, also shared the following insight with the Committee:

107 Sampson, op. cit.

108 Surgeon General, *ibid.*

109 Julio Arboleda-Florez, Heather L. Holley, and Annette Crisanti *Mental Illness and Violence: Proof or Stereotype*, Health Canada, 1996, p. x.

110 Simmie, op. cit., p. 49.

111 *Ibid.*

112 Second Session, 16:21.

113 Second Session, 16:16.

One difficulty of shifting the discussion of the association between people in the mental health system and violence is the circular reasoning that happens. If a particularly violent crime is committed people say, “Oh, that person is sick, psycho, weird,” so there is no way to get outside the debate, even if they were not considered to have any particular mental or emotional disturbance before committing the act.¹¹⁴

The influence of media accounts can be enormous, both for the public in general and for those living with mental illnesses. One British study found that over 20% of the people they interviewed were more inclined to accept the media portrayal of people with mental illnesses as being prone to violent behaviour than they were to believe the reality they encountered in their own interaction with people living with mental disorders. An example was given of a young woman who lived near a mental hospital just outside Glasgow, Scotland, that has since closed. She had worked there as a volunteer and mixed with the patients. She told the researchers:

The actual people I met weren't violent — that I think they are violent, that comes from television, from plays and things. That's the strange thing — the people were mainly geriatric — it wasn't the people you hear of on television. Not all of them were old, some of them were younger. None of them were violent — but I remember being scared of them, because it was a mental hospital — it's not a very good attitude to have but it is the way things come across on TV, and films — you know, mental axe murders and plays and things — the people I met weren't like that, but that is what I associated them with.¹¹⁵

The same study concluded that the most powerful negative effect seemed to be in the area of self-stigmatization. As one interviewee put it: “You see a programme and it shows a very bad image of what it feels like yourself and then you think, ‘What are my neighbours going to think of it?’”¹¹⁶

3.2.3 Stigmatization of Mental Health Providers

Not only do individuals living with mental disorders suffer from misrepresentation in the media, but so too do mental health practitioners. One study indicated that since the mid-1960s, only three films portrayed therapists sympathetically (*Good Will Hunting*, 1997; *Ordinary People*, 1980; and *I Never Promised You a Rose Garden*, 1977). In every other instance, mental health practitioners were portrayed in one or more of the following ways: neurotic, unable to maintain professional boundaries, drug- or alcohol-addicted, rigid, controlling, ineffectual, mentally ill themselves, comically inept, uncaring, self-absorbed, having ulterior

¹¹⁴ Second Session, 15:14.

¹¹⁵ Greg Philo, “Changing Images of Mental Distress” Chapter 4 of *Media And Mental Distress*, edited by Greg Philo (Longman: 1996), accessed at <http://www.gla.ac.uk/Acad/Sociology/mental.htm> on March 11, 2004.

¹¹⁶ *Ibid.*

motives, easily tricked and manipulated, foolish, and idiotic.¹¹⁷ Such portrayals tend to convey the idea that helping others is an unworthy vocation requiring little skill or expertise.

Witnesses repeatedly indicated that stigmatization affects those who provide care and services to individuals living with mental disorders. Dr. Gail Beck, Acting Associate Secretary General, Canadian Medical Association, remarked that, “I regularly hear jokes that I am not a real doctor. That is not related to what I do in practice; it is related to the fact that there is a stigma and discrimination about the kind of illnesses that I treat.” And Dr. Rémi Quirion, Scientific Director of the Canadian Institutes of Health Research Institute of Neurosciences, Mental Health and Addiction, told the Committee that:

*Psychiatrists are still stigmatized compared with the other types of doctors. It is still often seen more as an art than a science. This needs to change. We need to make sure that the young students will be stimulated to go into psychiatry.*¹¹⁸

According to Ms. Manon Desjardins, Clinical Administration Chief, Adult Ultra Specialized Services Division, Douglas Hospital, recruiting medical students to the field remains a problem:

*In universities, it is still far more prestigious to go for cardiac, surgery, [or] intensive care rather than psychiatry or geriatrics. Geriatrics and psychiatry are seen to be at just about the same level: they are not very attractive.*¹¹⁹

Ms. Maggie Gibson, Psychologist, St. Joseph's Health Care London, also pointed to the fact that the stigmatization of individuals living with mental disorders affects the whole range of service providers in the mental health field:

*With respect to the issue of family and caregiver stress, I want to comment on the issue of stigma — in particular the neglected stigma associated with using long-term care services. We would benefit greatly from a cultural shift that takes a compassionate and pragmatic approach to identifying the best care options for both older people and their family members and allow for dependency, when it is part of the system. Systems that allow for dependency without devaluing people go a long way to improving mental health.*¹²⁰

¹¹⁷ *Ibid.*, p. 5.

¹¹⁸ Second Session, 14:29.

¹¹⁹ Second Session, 14:124.

¹²⁰ Second Session, 17:15.

3.3 THE IMPACT OF STIGMATIZATION AND DISCRIMINATION

As noted earlier, for many people living with severe mental disorders, the stigmatization and discrimination they confront can be as important a source of distress as the illness itself. Ms. Stuart put it this way:

In the context of mental illness, consumers will describe stigma as worse than having a mental illness. It is perceived to be a second dimension of suffering, almost a second level of disease that they have to cope with that is more debilitating and disabling than the mental illness they suffer. You can well imagine some of the consequences of stigma. You are denied social standing and rights and social entitlements. You are actively discriminated against. We have to focus on the discrimination.¹²¹

Her insistence on the need to deal with the discrimination that is the concrete result of stigmatizing attitudes was a recurring theme during the Committee's hearings. Mr. Patrick Storey, Chair, Minister's Advisory Council on Mental Health, Province of British Columbia, insisted to the Committee that:

...we need to recognize discrimination against people with mental illness and their family members as just as unacceptable as other forms of discrimination. We need to devote the same energy to its elimination that we devote to the elimination of other forms of discrimination.¹²²

In this same vein, Mr. John Service, Executive Director, Canadian Psychological Association, told the Committee about hearing a speech by "a young congressman from Rhode Island by the name of Kennedy"¹²³:

He conceptualized the discrimination against people with mental illnesses in the United States as the same kind of discrimination experienced by Black people and by women in the 1950s and 1960s. He said it is the same system, and that we can correct it in the same way. He says you solve that systemic discrimination by doing what we know works in discrimination, which includes things like significant financial investments to turn the system and for affirmative action.¹²⁴

There are many ways that discrimination affects individuals living with mental disorders. They are routinely excluded from social life and can even be denied a variety of civil rights others take for granted. They are often denied basic rights in the areas of housing, employment, income, insurance, higher education, criminal justice, and parenting, among others.¹²⁵ People with mental illnesses also face rejection and discrimination by service

¹²¹ Second Session, 15:10.

¹²² Second Session, 15:6.

¹²³ Mr. Service is referring to Patrick Kennedy, the youngest of three children of Senator Edward M. Kennedy, who has represented the First Congressional District of Rhode Island since 1994.

¹²⁴ Third Session, 5:38.

¹²⁵ B.C. Report, *op. cit.*

providers in both the mental health and physical health care systems and discrimination by policy makers and the media.

Professors Bruce Link and Jo Phelan of Columbia University have proposed a useful way of dividing these different manifestations of discrimination into two broad categories: direct discrimination and structural discrimination.¹²⁶ In her testimony, Ms. Stuart offered a similar distinction, that between overt discrimination and “acts of omission”:

More insidious is that you may neglect to do something just by virtue of the fact that you think something is not important. You may have a negative attitude or put something on the back burner. I like to think there is as much or more damage done by those acts of omission, at every level of policy or government. We can focus on overt discrimination, and there are certainly huge issues there, but I would like to see it go farther than that. I would like to see the acts of omission addressed as well. If we could get at the stigma and the attitudes that underlie both of those things, we might be in a better position. I recognize that that is difficult to do. Sometimes the actions are easier to address.¹²⁷

3.3.1 Direct Discrimination

Direct discrimination refers to the standard way of conceptualizing the connection between labelling/stereotyping and discrimination. It points to direct discriminatory behaviour on the part of the person who holds the stereotyped beliefs. Direct discrimination occurs most obviously when a person in a powerful role withholds an opportunity.¹²⁸ Landlords do not rent an apartment to someone because he or she was in a psychiatric hospital. Employers fail to offer a job interview because the person with mental illness has not worked recently.

The evidence indicates that this form of discrimination occurs with some regularity in the lives of people who are stigmatized. For example, in a Canadian survey of people with mental illnesses, half said the area in their life most affected by discrimination was housing. Research shows that a person’s status as a psychiatric patient means he or she is less likely to be leased an apartment.¹²⁹

There remains a considerable amount of discrimination in the workforce, by both employers and co-workers, towards people with mental illnesses. Surveys show that employers and workers still feel justified distrusting and discriminating against people with mental illnesses. As a result, people with serious mental illness, such as schizophrenia and related disorders, have the highest rate of unemployment and underemployment of all people with disabilities, at a rate of around 90%.¹³⁰

¹²⁶ Link and Phelan, *op. cit.*

¹²⁷ Second Session, 15:27.

¹²⁸ Corrigan and Lundin, *op. cit.*

¹²⁹ B.C. Report, *op. cit.*

¹³⁰ See Chapter 6, below.

A number of surveys have consistently found that anywhere from one-third to one-half of people with mental illnesses report being turned down for a job for which they were qualified after their illness was disclosed, or had been dismissed from their jobs, and/or forced to resign as a result of their mental illness. Surprisingly, the figures are not dramatically lower for employment of individuals living with mental illness within mental health agencies or for volunteer positions both inside and outside the mental health field.¹³¹

Not only do families of people with mental illnesses have to cope with the financial, practical and emotional stressors of caring, but they face a kind of ‘discrimination by association.’ They have to deal with strained relationships with other family members or friends, fear, violence, anxiety, conflict, lowered self-esteem, and guilt. Discrimination against family members often stems from misconceptions about the family’s role in the causes of mental illness.¹³²

3.3.1.1 Discrimination Within The Health Care System

The importance of dealing with discrimination against individuals living with mental disorders within the health care system itself was raised by numerous witnesses. There is much evidence, Canadian and international, that mental health professionals and health professionals in general can be among those who show discriminatory attitudes and behaviour toward their own clients. People with mental illnesses frequently note that their views are neither listened to, nor respected, and that mental health workers tend to focus on clinical issues of care to the exclusion of social issues. Studies have identified a lack of respectful treatment by GPs and emergency room clinicians as the most common complaint among people with mental illnesses.¹³³

This is a somewhat puzzling phenomenon, as Ms. Stuart remarked:

*Why are health care workers so stigmatizing? They are among the most knowledgeable people on mental illness that we have in our society. They are invariably identified as the people who are the worst offenders.*¹³⁴

Other witnesses concurred that the problem was widespread. Mr. Storey told the Committee:

*In the discussions we had with people with mental illness, it was remarkable that they all had stories to tell of mistreatment in emergency rooms, as well as hospitals generally. Even when they were presenting complaints of a physical nature, they were treated as mental patients.*¹³⁵

¹³¹ B.C. Report, *op. cit.*

¹³² *Ibid.*

¹³³ *Ibid.*

¹³⁴ Second Session, 15:24.

¹³⁵ Second Session, 15:6.

Dr. Jim Millar, Executive Director, Mental Health and Physician Services, Nova Scotia Department of Health, also pointed to hospital emergency rooms as a place where discrimination occurs, telling the Committee that:

One only needs to visit the local emergency room to see stigmatization by health care providers. Mental health clients wait the longest. Their privacy is violated. Their concerns are not dealt with appropriately.¹³⁶

This seemingly widespread discrimination within the health care system has many negative consequences for people in need of help. Ms. Pat Capponi pointed to the lack of trust that ensues:

We have learned that we cannot depend on those working within the system to advocate for us. We cannot even expect them to see us as full individuals behind our obscuring labels.¹³⁷

3.3.2 Structural Discrimination

However, discrimination against people with mental illnesses and their families is not limited to overt acts of discriminatory behaviour by one person directed at another. It can also take the form of what Link and Phelan call structural discrimination.

To see what they mean, suppose that because it is a stigmatized illness, less funding is dedicated to research on schizophrenia than for other illnesses and less money is allocated to adequate care and management. As a consequence, people with schizophrenia are less able to benefit from scientific discoveries than they would have been if the illness they happened to develop were not stigmatized. To the extent that the stigma of schizophrenia has created such a situation, a person who develops this disorder will be the recipient of structural discrimination regardless of whether or not anyone happens to treat him or her in a discriminatory way.

There are many ways in which this kind of structural discrimination based on stigmatization can occur. Stigma may influence access to treatment by creating undesirable conditions in treatment settings that make seeking help far less desirable than it would otherwise be. For example, there exists a fear of people with psychosis that is out of proportion to the actual risk that people with psychosis pose. To the extent that this fear increases recourse to the use of guards, locked wards, searches and the like, stigma produces very negative circumstances in the treatment environment that could easily make people want to avoid those settings.

Structural discrimination can also be manifested in the general levels of funding that are made available for research and treatment of mental illnesses (see Chapter 9, below). Moreover, within the health care community in general, mental health professionals often feel treated as second-class citizens by their professional peers, and mental health services,

¹³⁶ Third Session, 7:18.

¹³⁷ Third Session, 7:51.

programs and research themselves still tend to be given a lower priority than physical health care issues.

3.4 REDUCING THE IMPACT OF STIGMA AND DISCRIMINATION

There are both individual and community- or socially-based approaches to reducing the impact of stigma and discrimination. On the one hand, individuals with mental illness can seek out strategies that allow them to cope with, or contest, the stigmatization and discrimination they encounter. On the other hand, socially- or community-based strategies can be developed to attempt to reduce the overall extent and impact of stigmatization and discrimination. In this section we will concentrate almost exclusively on the latter, but, before doing that, a few words on individual approaches are in order.

Broadly speaking, the literature identifies three strategies that are available to individuals living with mental illness:

1. They can attempt to completely conceal their illness from others with whom they interact;
2. They can practice selective avoidance, limiting their social interaction to people they know to be non-stigmatizers;
3. They can attempt to educate everyone with whom they come into regular contact about the nature of their illness.

As noted earlier, maintaining secrecy about one's mental illness can have many negative consequences. According to one study that explored the value of all these individual approaches, it is not just the first strategy listed above that can be counter-productive. Rather, the study concluded unequivocally that all three were harmful and that "using these methods made rejection more likely."¹³⁸

Given the difficulties associated with these strategies based on individual action it would seem clear that, if there is to be progress in reducing both stigma and discrimination, some form of community or socially based intervention will be necessary. This follows from the fact that both stigma and discrimination are thoroughly social phenomena. They rely on the propagation of myths about individuals living with mental disorders within the institutions of society (schools, workplaces, the media, etc.), and take hold in discriminatory practices that can be enshrined or condoned by law and by tradition.

There is, however, likely no simple or single strategy to eliminate the stigma associated with mental illness.¹³⁹ In the first place, stereotypes such as those that sustain the stigmatization of people with mental illness are complex phenomena. They have components that are somewhat changeable but they also have some that are fiercely resistant to change.¹⁴⁰

¹³⁸ The study was conducted in 1991 by Link, Mirotnik and Cullen and reported on by Keith Brunton in his article "Stigma," *op. cit.*, p. 894.

¹³⁹ Surgeon General, *op. cit.*

¹⁴⁰ B.C. Report, *op. cit.*

As noted earlier, the persistence over time of pervasive stigma attached to mental illness, despite growing knowledge and public awareness of the nature of these disorders, raises an important question with regard to the efficacy of education alone to reduce the effects of stigmatization on the lives of people with mental illness. Stigma was expected to abate with increased knowledge of mental illness, but just the opposite occurred: stigma in some ways intensified over the past 40 years even though understanding improved.¹⁴¹

Since stigmatizing opinions are not always closely related to the extent of knowledge about mental illness in general, it follows that campaigns to reduce stigma must be carefully planned and probably have to do more than simply increase knowledge of the stigmatized conditions.¹⁴² One hypothesis that has been advanced to explain why information alone is unlikely to eliminate stigmatizing attitudes holds that stigmatizers need a new emotional experience rather than, or in addition to, a new explanatory model, before they would be likely to call into question any stereotypes they may have taken on board.¹⁴³

Thus, the effectiveness of mass advertising campaigns in reducing stigma and discrimination has been challenged.¹⁴⁴ This is how Ms. Stuart put it:

*With respect to anti-stigma interventions, how do we stop stigma and discrimination? We are learning from the World Psychiatric Association work that one size does not fit all. It is a waste of time and energy to embark on a large, public education campaign that is designed to improve literacy as an anti-stigma intervention because segments of the population have different views. They understand their risks differently depending on the diagnostic group.*¹⁴⁵

Results are more promising when media campaigns are backed by ongoing community-based education and action. The general consensus internationally seems to be that public education campaigns are most effective when they are locally based and focused on the anxieties of their target groups.¹⁴⁶ In Ms. Stuart's words:

*We are now talking about more focused and targeted interventions. We have had the best success in all of the things that we have tried by going into high schools and working with young people because they are more malleable.*¹⁴⁷

Reducing stigma will therefore require campaigns that are carefully focussed and targeted to specific audiences. Two recent articles indicate that such carefully targeted campaigns can

¹⁴¹ Surgeon General, *op. cit.*

¹⁴² Arthur H. Crisp, Michael, G. Gelder, Susannah Rix, Howard I. Meltzer and Olwen J. Rowlands, "Stigmatisation of people with mental illness," Royal College of Psychiatrists, 2000.

¹⁴³ Rahman Haghghat, "A unitary theory of stigmatization," *British Journal of Psychiatry*, No. 178, 2001.

¹⁴⁴ Heather Stuart and Julio Arboleda-Flórez, "Community Attitudes Toward People With Schizophrenia," *Canadian Journal of Psychiatry*, No. 46, 2001.

¹⁴⁵ Second Session, 15:12.

¹⁴⁶ Peter Byrne, "Psychiatric Stigma," *British Journal of Psychiatry*, No. 178, 2001.

¹⁴⁷ Second Session, 15:12.

indeed alter attitudes towards people living with mental health disorders. An evaluation of mental health awareness workshops directed at secondary school students in Britain concluded that “educational workshops with young people can have a small but positive impact on students’ views of people with mental health problems.”¹⁴⁸ An assessment of another British effort directed at police officers also indicated that workshop programs had a positive impact on attitudes, and that “targeting a group in the work-place provides the opportunity to challenge negative stereotypes while addressing specific work-based training needs, thus creating a more favourable learning environment for addressing attitudes and behaviours.”¹⁴⁹

One leading anti-stigma researcher, Otto F. Wahl, Professor of Psychology at George Mason University in Fairfax, Virginia, put it this way: “If we are going to truly eradicate stigma, we need to have a more concrete, practical and personalized understanding of its effects – that is, how stigma makes people feel and how it affects treatment and recovery.”¹⁵⁰

One possibility would therefore be to explore destigmatizing strategies that provide forums for the expression of fears that exist amongst the target group, in which people can ask questions and communicate their worries.¹⁵¹ According to Ms. Stuart:

When we talked about targeting things, we were trying to target experiences. We figured out we had to get them at an emotional level. We had to make them aware that their whole system of beliefs was somehow ill-founded. One of the best ways to do that was to construct situations in which people who have a mental illness could meet people who have perhaps never met someone with a mental illness, under controlled and constructive kinds of situations. They would talk about their mental illness. They would convey factual information, but more important, they would convey information at a human level. That is what made the difference.¹⁵²

Indeed, it is contact with people with mental illness that appears to yield the best prospects for improving attitudes about mental illness. There is research that shows that members of the general public who are more familiar with mental illness are less likely to endorse prejudicial attitudes.¹⁵³ In this respect, Ms. Scheffer told the Committee that:

¹⁴⁸ Vanessa Pinfold, Hilary Toulmin, Graham Thornicroft, Peter Huxley, Paul Farmer and Tanya Graham, “Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools” in the *British Journal of Psychiatry* (2003), 182, p. 344.

¹⁴⁹ Vanessa Pinfold, P. Huxley, G. Thornicroft, P. Farmer, H. Toulmin, and T. Graham, “Reducing psychiatric stigma and discrimination: Evaluating an educational intervention with the police force in England,” *Journal of Social Psychiatry and Psychiatric Epidemiology* (2003) 38, p. 343.

¹⁵⁰ Sampson, *op cit.*

¹⁵¹ Haghghat, *op. cit.*

¹⁵² Second Session, 15:24.

¹⁵³ Watson and Corrigan, *op. cit.*

*The most promising strategy for impacting negative perceptions is increasing contact with mentally ill persons. No other strategy has been shown to be more effective.*¹⁵⁴

This conclusion was further reinforced by the results of the Houston area survey of public perceptions of mental illness referred to earlier. Its authors wrote that:

*We have been struck continually throughout these analyses by the dominating importance of personal knowledge in shaping public attitudes toward mental health issues. When respondents were asked if they knew of “anyone among your friends or family who has been diagnosed with a mental illness, including clinical depression,” the 38 percent who answered in the affirmative were consistently and significantly more likely than the 62 percent without such personal experience to support both corporate and tax policies to ensure access to mental health services, to be unconcerned upon learning of a neighbor being treated for a mental illness, and to believe that most people undergoing treatment for mental illness are able to live a normal life.*¹⁵⁵

However, recent research also suggests that the way in which contact with individuals living with mental disorders takes place may have a bearing on the extent to which stigmatizing attitudes are challenged. A study by researchers at the University of Chicago Center for Psychiatric Rehabilitation¹⁵⁶ reached a number of interesting conclusions. In the first place, the researchers confirmed previous work that showed that contact with individuals living with mental disorders “yields significant change in attitudes about mental illness.”¹⁵⁷ As well, and contrary to their original expectations the researchers did not find any noticeable difference in the extent of the impact of the contact when contact was via videotape rather than *in vivo*.

However, they did find that stereotypes were not called into question when the contact with the person living with serious mental illness highlighted the symptoms of that illness rather than the possibility of recovery. Moreover, they concluded that their research offered a plausible explanation for why many health care providers remain vulnerable to embracing stigmatizing attitudes. In their words:

Meeting a person with mental illness whose symptoms and other problems are highlighted is not likely to challenge one’s stereotype. This may be one reason why mental health service providers are likely to endorse the stigma of mental illness so highly. Treatment providers, especially inpatient clinicians, largely interact with people with mental

¹⁵⁴ Second Session, 16:21.

¹⁵⁵ *Op. cit.*, pp. 20-22.

¹⁵⁶ Rebecca R. Reinke, Patrick W. Corrigan, Christoph Leonhard, Robert K. Lundin and Mary Anne Kubiak, “Examining Media’s Use of Contact on the Stigma of Mental Illness,” unpublished manuscript (n.d.), submitted to the *Journal of Nervous and Mental Disease*.

¹⁵⁷ *ibid.*, p. 10.

*illness when they are acutely ill, a status which is likely to confirm the stereotype rather than challenge it. Most of these people are frequently discharged before recovery is evident so that the treatment provider does not have an experience that disconfirms the stereotype.*¹⁵⁸

Ms. Scheffer also suggested that the most effective strategy “in creating understanding and acceptance is a comprehensive health promotion approach combined with a social marketing approach” that would “raise awareness, encourage seeking help and promote positive understanding.”¹⁵⁹

Mr. Service indicated that stigma can be reduced as a result of the successful treatment and care of individuals living with mental disorders. He told the Committee that:

*Stigma is reducing significantly in certain populations. It is the populations who can access and use the service who do not have a problem because their neighbour, their friend, brother or cousin have accessed services and had a good experience. That is how you break down stigma. In our business that is also one of the best referrals. It is not from another professional, it is from somebody saying, “I went to see Mr. Service and he did not a bad job so you might want to try him out.” That is how you get most of your referrals and that is how you break down stigma.*¹⁶⁰

The need to involve individuals living with mental disorders in all aspects of efforts to eliminate stigma and discrimination, was further emphasized by witnesses. Ms. Chambers recommended to the Committee that:

*a national education program...directed and delivered by survivors, should be launched to challenge the devastating prejudice and discrimination that exists in our community.*¹⁶¹

Ms. Capponi pointed to the broad anti-stigmatizing impact of facilitating the participation of individuals living with mental disorders in meaningful and productive undertakings:

We began to tackle poverty and powerlessness directly through the creation of psychiatric-survivor-run businesses. Led by my sister Diana, who had battled mental illness and heroin addiction, they lobbied and developed survivor businesses in the Province of Ontario — a radical departure from traditional vocational rehabilitation. Our community began to see that there were possibilities out there for us. We began to have role models and leaders. We were achieving, breaking myths and assumptions about who and what we were, and we were forming

¹⁵⁸ *Ibid.*, p. 11.

¹⁵⁹ Second Session, 16:21.

¹⁶⁰ Third Session, 5:48.

¹⁶¹ Second Session, 15:16-17.

community. Chronic psychiatric patients showed commitment in reporting to work on time. In acquiring new skills, lasting friendships were created and people grabbed every opportunity to learn from each other's experiences. We were successfully attacking the stigma within and without the mental health system where millions of dollars spent on elaborate advertising campaigns had failed.¹⁶²

Several witnesses also pointed to the importance of learning from other communities that have had to confront issues relating to stigma and discrimination. Ms. Scheffer pointed to some of these in her testimony:

If we look to other groups who have suffered the effects of social stigma, like the gay and lesbian community or those with AIDS or cancer, they have successfully ended or minimized stigma by creating widespread change in attitudes.¹⁶³

And Mr. Brian Rush, Research Scientist, Social Prevention and Health Policy, Centre for Addiction and Mental Health, noted in the same vein:

The mental health field could learn a lot from the developmental disability field and the kind of investment it might take to support people in the community, which would still save money in addition to providing people with dignity, respect and a choice to live in the community and not in psychiatric institutions.¹⁶⁴

Ms. Shoush reminded the Committee that different communities will have their own distinctive approaches to helping individuals living with mental disorders, and that is therefore essential to adapt efforts to these varying realities. She told the Committee that:

Aboriginal communities would say that they have a different world view and that the community is the focus. They believe that the community unit deserves to be the focus of concern and that information to help the community be whole and well should be available and shared.¹⁶⁵

3.4.1 The Need for a National Strategy

Although it is clear that there will not be a miracle solution to the problems of stigma and discrimination, and that efforts to reduce their impact will have to be carefully tailored to many different circumstances, several witnesses also insisted on the importance of having a national mental health strategy. Mr. Phil Upshall, President, Mood Disorder Society of Canada, put it this way:

¹⁶² Third Session, 7:48.

¹⁶³ Second Session, 16:20.

¹⁶⁴ Third Session, 8:28.

¹⁶⁵ Second Session, 16:26.

The move towards a federal national strategy would be incredibly anti-stigmatizing. It would be a leadership model that would say to the rest of Canada, "This is something to which we need to pay attention." It would say to the rest of the provincial premiers and their health ministers that this is something that we will finally take seriously.¹⁶⁶

This view was supported by Dr. Blake Woodside, Chairman of the Board, Canadian Psychiatric Association, who told the Committee:

The first thing is to make mental health a public priority, so a declaration by the federal government that a national action plan for mental health was being developed would be a huge step in the right direction. Out of that would fall a wide variety of public educational activities that would help combat this discrimination and stigma.¹⁶⁷

Witnesses also argued that it was important to modify the *Canada Health Act* so that it placed physical and mental illness on an equal footing. This is not the case today since, for example, the *CHA* explicitly excludes psychiatric hospitals from its purview. Thus, Dr. Sunil Patel, President, Canadian Medical Association, pointed out:

Simply put, how are we to overcome stigma and discrimination if we validate these sentiments in our federal legislation? The CMA firmly believes the development of a national strategy and action plan on mental health and mental illness is the single most important step that can be taken on this issue...¹⁶⁸

The CMA proposed a number of measures that would redress this situation, including, as Dr. Patel outlined:

...amending the Canada Health Act to include psychiatric hospitals; adjusting the Canada Health transfer to provide for these additional insured services; re-establishing an adequately resourced federal organizational unit focused on mental illness and mental health and addictions;¹⁶⁹

For his part, Dr. Paul Garfinkel, Chair, Mental Health Working Group, Ontario Hospital Association, and President and Chief Executive Officer, Centre for Addiction and Mental Health, stressed the enormous symbolic value of reforming the *CHA*:

I think changing the Canada Health Act would be hugely powerful from a symbolic point of view. It would be saying that we are correcting a wrong. We did not understand mental illnesses years ago and now we

¹⁶⁶ Third Session, 9:34.

¹⁶⁷ Third Session, 5:26-27.

¹⁶⁸ Third Session, 5:11

¹⁶⁹ *Ibid.*

*realize that they are like any other form of human pain and suffering. That would be dramatic.*¹⁷⁰

Mr. Service also insisted on the significance of not treating mental health, mental illness and addictions as if they were fundamentally different from other health issues:

*If we conceive of mental health, mental illness and addictions as part of and central to the operations of the entire health system, we then make an extremely important structural change that brings mental illness into prime time as opposed to it being ghettoized over here with just the “crazy people” that nobody has to really deal with or the “worried well” for whom we have no time to deal with.*¹⁷¹

Ms. Chambers stressed to the Committee that in order to assist individuals living with mental disorders to take full advantage of their rights, it was necessary also to provide specific resources at the national level. She told the Committee:

*I would like to emphasize that hand-in-glove with the idea of educating people, it is important to have a national mental health legal advocacy resource that is accountable to consumers. It is not just prejudice in the general community, but particularly prejudice and discrimination in the mental health system itself — it is allowed under the law — that needs addressing. It is critical to have both those pieces involved.*¹⁷²

3.4.2 The Need for Policy Reform

In general, witnesses suggested that policy can be easier to change than attitudes, and that every effort should be made to do so. This is how Ms. Stuart put it:

*We are hoping that a third generation of research may focus on the kinds of social structure that ... really perpetuate social inequity and discrimination — the structures and organizations, the policies and the programs that make this happen. It is difficult to change attitudes but you can change policies much more easily.*¹⁷³

In this vein, Dr. Patel called for a “review of federal health policies and programs to ensure the mental illness is on par, in terms of benefits, with other chronic diseases and disabilities.”¹⁷⁴ Mr. Storey gave the following illustration of the kinds of change that he feels are needed:

¹⁷⁰ Third Session, 5:32.

¹⁷¹ Third Session, 5:37.

¹⁷² Second Session, 15:26.

¹⁷³ Second Session, 15:10.

¹⁷⁴ Third Session, 5:11.

A number of policy changes are required in addition to protecting the actual dollars for mental health. Medical billing schedules and procedures, extended health benefits, pension plans, et cetera, do not recognize the special features and challenges of mental illness and create unnecessary obstacles to recovery and health. For example, in British Columbia, a family doctor can bill for only four counselling sessions per patient per year; yet, most people with depression go to see their family doctor. Though antidepressant medication is a helpful adjunct, alone it is not sufficient to help people deal effectively with that sometimes debilitating condition. Doctors are not in a position to provide the help required for a person in a depression.¹⁷⁵

Finally, the need to adjust policy to changing social circumstances was stressed by Ms. Capponi:

There are more mentally ill people on the streets not because of a preference, but because the gulf between the haves and have-nots is getting wider and wider. More people are using the food banks and so the share for the chronic mental patient has been dramatically reduced. A landlord will rent his house to people who he thinks will be less disruptive than a former mental health patient. People get squeezed out. Shelters prefer to house immigrants or battered women because they will not be seen as potentially disruptive.¹⁷⁶

3.4.3 Addressing the Issue of Violence

However, many believe that the most likely reason for the increase in stigma in recent years is related to the exaggerated attribution of a propensity to commit acts of random violence to people living with serious mental illness. There is a perception that an increasing number of violent crimes are committed by individuals with severe psychiatric disorders.¹⁷⁷

Witnesses suggested that a starting point for counteracting this exaggerated attribution of dangerousness to individuals living with mental disorders is to recognize what the best science tells us. Mr. Arnett summed up the essence of this for the Committee:

...there does appear to be some increased risk of violence from those with mental illnesses. It is wise to acknowledge that. This occurs particularly with those with severe mental illness and is magnified significantly when the individuals are also substance abusers.¹⁷⁸

¹⁷⁵ Second Session, 15:7.

¹⁷⁶ Third Session, 7:70.

¹⁷⁷ Treatment Advocacy Center, "Briefing Paper on Stigma and Violence," accessed at: <http://www.psychlaws.org/BriefingPapers/BP9.htm>.

¹⁷⁸ Second Session, 16:8.

Because incidents of violence do occur, some authors believe that a reduction in stigma against people with mental illness is unlikely to take place until there has been a reduction in violent crimes committed by them.¹⁷⁹ They argue that it is necessary to avoid the kind of situation in which the average commuter riding a bus to work will face an anti-stigma poster proclaiming that “mentally ill persons make good neighbours” while simultaneously reading a newspaper article detailing the most recent violent act committed by a mentally ill person.

3.4.3 The Media and Efforts to Reduce Stigma and Discrimination

There are no ready-made strategies available for reducing inaccurate and stigmatizing portrayals of people with mental illnesses in the media, and for encouraging the media themselves to contribute actively to the destigmatization of mental illness.

One example of an initiative directed specifically at altering the portrayal of people with mental disorders in the media was a petition which criticized media coverage of mental illness signed by three thousand psychiatrists in Britain in April 1995. Among their proposals, they called for “a major debate to take place particularly within the media, within broadcasting and the press, to question the persistent replication of stigmatizing and false images of psychiatric illness.” They also encouraged “the making of programmes which give a fair and accurate account of mental health issues [and asked] that the broadcasting and print industries produce codes of conduct to guide journalists in this area.”¹⁸⁰

In Australia a National Media Strategy was undertaken, where the government worked directly with the media to promote more positive messages about mental health and suicide prevention. The Australian media strategy operates in journalism schools and universities, where journalists are taught how they should approach these issues when reporting them to the community so as not to stigmatize individuals living with mental disorders.

Research also points to the importance of highlighting stories of successful recovery that, if they are presented properly, can both educate and entertain audiences. Some examples of positive media portrayal and discussion of mental health issues include:¹⁸¹

- The September 2001 issue of *Rosie* magazine, which focused on depression.
- The 1997 film *As Good as It Gets*, starring Jack Nicholson. In this film, Nicholson plays a romantic lead who has obsessive-compulsive disorder. The film accurately portrays the symptoms of this disorder and, even more encouragingly, shows the character, with the assistance of therapy and medication, winning the woman of his dreams and learning to live with and control his illness.
- The television series *Monk*, which debuted in 2002. The main character is a private detective named Adrian Monk suffering from obsessive-compulsive disorder. Played by Tony Shalhoub, Monk is given a realistic and respectful treatment, according to the National Alliance for the Mentally Ill (NAMI).

¹⁷⁹ *Ibid.*

¹⁸⁰ Philo, op. cit.

¹⁸¹ Roth Edney, op. cit., p. 9.

The struggle for more accurate and positive representation of mental illness and of the mentally ill in the mass media is often thought to be analogous to the struggles of other minority and disenfranchised groups. In the opinion of Greg Philo of the Glasgow Media Group, “the media will not change until there is a movement that demands it.”¹⁸²

3.5 COMMITTEE COMMENTARY

Overall, the evidence suggests that combating stigma and discrimination requires a multi-pronged effort. Any campaign to change attitudes will have to convey a complex message and be sustained over a long period of time, while rooting out the many forms of discrimination will require great determination and perseverance.

The Committee believes that there is a strong case to be made that each of the key phenomena, stigma and discrimination, must be tackled in appropriate ways. The battle can and must be waged on both fronts simultaneously. Campaigning and educating people to challenge stigmatizing attitudes should go hand in hand with resolute opposition to discrimination in whatever form it is perpetrated against individuals living with mental disorders. The Committee notes the success of other stigmatized groups in campaigning to reduce stigma and discrimination, and the real benefits this has yielded.

A number of key elements stand out from the testimony the Committee heard and the evidence it considered. First, the Committee sees much merit in the argument that the very fact of having a national mental health strategy (over and above the concrete elements of that strategy) will contribute to the struggle against stigma and discrimination. A national mental health strategy would focus public attention on mental health issues in unprecedented ways. Its adoption would indicate to people that the federal, provincial and territorial governments attach as much importance to fostering the mental health of Canadians and treating the mental illnesses that afflict them as they do to promoting the physical health of the population.

As part of establishing the parity of mental and physical health, and illness, the Committee took note of the suggestion that the *Canada Health Act* be opened to remove existing disparities. During its two-year study of the acute care sector, the Committee was wary of proposals to re-open the *CHA* because of the difficult debate that this would engender over which services should or should not come under the purview of the *Act*. However, with regard to this particular issue, the Committee feels that the option of modifying the *CHA* should be seriously examined, because of its potentially enormous symbolic value.¹⁸³

Several elements stand out to the Committee as warranting inclusion in national efforts to reduce stigma and discrimination. First, it will be necessary to find ways of countering the attribution of an exaggerated propensity to violence to people living with serious mental illness. Second, efforts to reduce stigma and discrimination must be carefully targeted to maximize their effect. Moreover, the involvement of people living with mental disorders in the conception, design and delivery of these campaigns is essential to their success. It is also

¹⁸² *Ibid.*

¹⁸³ These issues are discussed in greater detail in Chapter 10, below.

important to demonstrate the possibility of recovery and to promote better mental health in order to encourage changes in attitudes towards people living with mental illness.

Finally, the Committee took note of the persistence of stigmatization and discrimination within the health care system in general, and even within the mental health care system itself. There are thus two levels at which it is necessary to work within the overall health care community. First, it is necessary to diminish the stigmatization of mental health workers within the broader health care community so that the structural discrimination that afflicts the mental health sector can be eradicated. Second, it is necessary to work with all health professionals to promote more positive perceptions of people living with mental illness.



PART 2

**The Prevalence and
Consequences of
Mental Illness and
Addiction**

INTRODUCTION

The terms and concepts related to mental health, mental illness and addiction are not easy to define. Different countries have adopted differing terminology and, within countries, professionals and lay groups, organizations and associations often utilize different conventions in defining and describing key concepts relevant to mental health, mental illness and addiction. Consequently, one concept may be referred to by a variety of terms, while some terms will hold different meanings for different groups. Even within Canada, some terms have multiple meanings that are applied inconsistently, often creating confusion.

A respectful, common language to discuss mental illness and mental health is lacking between disciplines and sectors.

[Phil Upshall, President, Canadian Alliance on Mental Illness and Mental Health, Brief to the Committee, 18 July 2003, p. 8.]

This chapter defines the various concepts **used throughout the report** related to mental health, mental illness and addiction. It is divided into nine sections related to: mental health and mental illness (Section 4.1); major mental disorders (4.2); substance use and addiction (4.3); co-morbidity, concurrent disorders and dual diagnosis (4.4); suicidal behaviour (4.5); services and supports (4.6); chronic disease management (4.7); promotion, prevention and surveillance (4.8) and, individuals with mental illness/addiction and recovery (4.9).

4.1 MENTAL HEALTH AND MENTAL ILLNESS

Mental illness undermines mental health, but mental health is more than simply the absence of illness. It is a fundamental resource of all human beings and an essential component of all health.

[Tom Lips, Health Canada (11:7)]

Mental health is defined as the capacity to feel, think and act in ways that enhance one's ability to enjoy life and deal with challenges.¹⁸⁴ Expressed differently, mental health refers to various capacities including the ability to: understand oneself and one's life; relate to other people and respond to one's environment; experience pleasure and enjoyment; handle stress and withstand discomfort; evaluate challenges and problems; pursue goals and interests; and, explore choices and make decisions.

⁽¹⁸⁴⁾ Health Canada, Mental Health Promotion Unit, *Mental Health Promotion: Promoting Mental Health Means Promoting the Best of Ourselves – Frequently Asked Questions*.
http://www.hc-sc.gc.ca/hppb/mentalhealth/mhp/e_faq.html.

Good mental health is associated with positive self-esteem, happiness, interest in life, work satisfaction, mastery and sense of coherence. It is well recognized that good mental health enables individuals to realize their full potential and contribute meaningfully to society.¹⁸⁵

By contrast, *mental health problems* refer to diminished capacities – whether cognitive, emotional, attentional, interpersonal, motivational or behavioural – that interfere with a person’s enjoyment of life or adversely affect interactions with society and environment. Feelings of low self-esteem, frequent frustration or irritability, burn out, feelings of stress, excessive worrying, are all examples of common mental health problems.¹⁸⁶ Over the course of a lifetime, every individual will be likely, at some time, to experience mental health problems such as these. Usually, they are normal, short-term reactions that occur in response to difficult situations (e.g., school pressures, work-related stress, marital conflict, grief, changes in living arrangements) which people cope with in a variety of ways, employing internal resilience, family and community support, etc.

Mental health problems that resolve quickly, do not recur and do not result in significant disability do not meet the criteria required for the diagnosis of a mental illness. *Mental disorders* or *illnesses* generally refer to clinically significant patterns of behavioural or emotional function that are associated with some level of distress, suffering (even to the point of pain and death), or impairment in one or more functional areas (e.g., school, work, social and family interactions).¹⁸⁷

A widely used definition of mental illness or mental disorder is taken from the American Psychiatric Association's Diagnostic and Statistical Manual, Fourth Edition. (...) It is a definition that allows for the possibility of either biological or psychological causes of illness. It excludes normal reactions to stressful situations.
[Tom Lips, *Health Canada* (11:9)]

There are many different forms of mental disorders. They vary widely in terms of the course and pattern of illness, the type and severity of symptoms produced and the degree of disability experienced. An individual may have only one or may have repeated episodes of illness separated by long periods of wellness. While some mental disorders are episodic or cyclical in nature, others are more persistent with lengthy or frequently recurring episodes. Individuals with persistent illnesses usually require long term treatment and support.

4.2 MAJOR MENTAL DISORDERS

In Canada, the classification of mental illnesses follows either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, or the International Classification of Diseases (ICD), Mental Health Section, published by the

¹⁸⁵ Canadian Alliance on Mental Illness and Mental Health, *A Call for Action – Building Consensus for a National Action Plan on Mental Illness and Mental Health*, Discussion Paper, 2000, p. 7. (<http://www.mooodisorderscanada.ca/camimh/index.htm>)

¹⁸⁶ Thomas Stephens *et al.*, “Mental Health of the Canadian Population: A Comprehensive Analysis,” *Chronic Diseases in Canada*, Vol. 20, No. 3, 1999.

¹⁸⁷ Canadian Psychiatric Association, *Youth and Mental Illness*, not dated.

World Health Organization.¹⁸⁸ Each of the two classification systems lists more than 300 mental disorders that can be diagnosed; these are often grouped together on the basis of similarities in their symptoms or patterns of illness.

The complete list of mental disorder diagnoses is available in the DSM and ICD manuals. Some of the major groupings of mental disorders include: mood disorders (depression and bipolar disorders), anxiety disorders (generalized anxiety disorder, phobias, panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder), psychotic disorders (schizophrenia and schizoaffective disorder), eating disorders (anorexia nervosa and bulimia), personality disorders, pervasive developmental disorders (autism and Asperger's disorder), attention deficit and disruptive behaviour disorders, and cognitive disorders (dementia and delirium from a variety of causes).¹⁸⁹ Substance use disorder is also included within the classification of mental disorders. In this report, substance use disorders are discussed in a separate section in order to highlight their importance and relationship to addiction.

Mood disorders include both major depressive and bipolar disorders. *Major depressive disorder* (also referred to as unipolar depression) is characterized by one or more depressive episodes lasting at least two weeks. The core symptom is a sustained depressed mood (different than normal feelings of sadness) and/or a marked decrease in pleasure from or interest in usual activities. This is accompanied by four or more other symptoms characteristic of depression such as disturbance, fatigue or loss of energy, appetite and weight loss or gain, decreased ability to concentrate, think, and make decisions, and recurrent thoughts

When we talk about mental disorders, it is important to mention that the most prevalent of these are anxiety and depressive disorders. (...) The third major area is substance abuse (...). What that means is that these disorders are highly prevalent. In contrast, you will also be hearing about major psychiatric disorders, such as schizophrenia, bipolar affective disorder, and in adolescent children, and possibly in adults, autistic disorders. These are clearly major mental disorders.

[Dr. Alain Lesage, Canadian Academy of Psychiatric Epidemiology (11:12)]

of death. Females have higher rates of major depression than males by a ratio of 2:1. *Bipolar disorder*, classically known as manic depressive illness, is a mental illness associated with dramatic mood swings ranging from mania to depression. Mania, a condition recognized since antiquity, is characterized by at least a week of an altered mood state of euphoria, lability or irritability. Like depression, it is associated with a number of other related symptoms, often as the mirror image of depression, including a marked increase in energy, decreased need for sleep, elevated self-esteem, and a propensity for risky activities. Bipolar disorder usually begins in early adulthood; the average age of onset is around 18-24 years,

¹⁸⁸ The DSM classification system addresses psychiatric disorders only, and no other illness or disease categories. The DSM that is in common usage at the present time in Canada is a revision of the fourth edition (DSM-IV-TR) and it is anticipated that the fifth edition (DSM-V) will soon be released. ICD-10, the tenth edition of the ICD system, which addresses all disease areas and health conditions, is currently being adopted across Canada, replacing ICD-9, which until recently has been the standard diagnostic system in Canadian hospitals and health care organizations. Both the DSM and ICD classification systems are updated regularly by experts in an effort to refine diagnostic accuracy and incorporate new research evidence.

¹⁸⁹ Canadian Mental Health Association, [Mental Illnesses](#), pamphlet, not dated.

although it can sometimes start in childhood or as late as the 40s or 50s. Men and women are equally affected.¹⁹⁰

Anxiety disorders may take many forms. They include: generalized anxiety disorder, specific phobias, panic disorder (with or without agoraphobia), obsessive-compulsive disorder and post-traumatic stress disorder. *Generalized anxiety disorder* is defined by a protracted period (i.e., over 6 months) of anxiety and worry that is accompanied by other symptoms such as muscle tension, fatigue, poor concentration, insomnia, and irritability. *Phobias* reflect marked fear of certain things (such as animals, insects, heights, elevators, etc.) or situations (social phobia); exposure to the object of the phobia, either imaginary, on video or in real life, invariably elicits intense anxiety which may include a panic attack. *Panic disorder* is diagnosed when an individual has experienced a number of unexpected panic attacks – periods with sudden onset of intense fear or discomfort, often associated with palpitations, rapid breathing, and a sense of impending doom – coupled with worries about further attacks. *Obsessive-compulsive disorder* involves either or both obsessions or compulsions which the individual recognizes as excessive or unreasonable. Obsessions consist of persistent, intrusive, inappropriate thoughts, ideas, impulses or images that cause marked anxiety or distress. Compulsions refer to repetitive behaviours (such as hand washing) or mental acts (such as counting) that sometimes occur in a ritualistic way or in response to an obsession. *Post-traumatic stress disorder* involves re-experiencing a traumatic event through dreams and recollections, avoiding stimuli reminiscent of the event, emotional numbing, and a heightened level of arousal; it occurs following a traumatic event in which the person experienced or witnessed threatened or actual physical harm (such as rape, child abuse, war/battle, or natural disaster). Overall, anxiety disorders affect men and women equally; they tend to begin early in life (during childhood or adolescence) and often persist for many years.¹⁹¹

Schizophrenia is a mental illness that typically emerges in late adolescence and early adulthood. Classically, it has often been a chronic, severe and disabling long term disorder. In the last decade, systematic efforts at earlier detection and comprehensive biopsychosocial intervention offer hope for a different trajectory for this often long term illness. Decades of genetic, brain imaging, and other lines of research support a biological model of schizophrenia, although its cause remains unknown. It seriously affects a person's thinking, causing hallucinations (such as hearing voices when there is no one there), delusions (fixed false beliefs such as the fear that strangers are following the ill person or wanting to hurt him/her), a loss of contact with reality and disrupted work and social interactions. The disease often begins slowly; once it has taken hold, it usually manifests itself in cycles of remission and relapse. Men and women are affected by schizophrenia with equal frequency.¹⁹²

Eating disorders involve serious disturbance in eating behaviours. While some cases of eating disorders will resolve themselves spontaneously or with treatment during adolescence, others

¹⁹⁰ According to information from the Internet site of the Mood Disorders Society of Canada (<http://www.mooddisorderscanada.ca/>).

¹⁹¹ According to information from the Internet site of the Anxiety Disorders Association of Canada (<http://www.anxietycanada.ca/>).

¹⁹² British Columbia Schizophrenia Society, *Basic Facts About Schizophrenia*, April 2002.

may become chronic conditions. Some long term follow-up studies reveal death rates of up to 18% in affected individuals. The most common eating disorders include anorexia nervosa, bulimia nervosa and binge eating disorder. *Anorexia nervosa* is characterized by low body weight (under 85% of expected weight), intense fear of weight gain even when markedly underweight, an inaccurate perception of body weight or shape, denial of thinness, and an intense emphasis on weight as a yardstick of self-evaluation. *Bulimia nervosa*, by contrast, most commonly occur in individuals of normal body weight. It is characterized by recurrent episodes of gorging, followed by compensatory activities to eliminate the ingested calories (such as self-induced vomiting, abuse of laxatives or diuretics, intensive exercise, etc). It shares, with anorexia nervosa, however, many of the core psychological preoccupations with weight and shape. *Binge eating disorder* is a newly recognized condition featuring episodic uncontrolled consumption of food, without the compensatory activities of bulimia nervosa. Eating disorders usually arise in adolescence and affect females disproportionately.¹⁹³

Personality disorders include a number of disorders that vary considerably in their characteristics and patterns of behaviour.¹⁹⁴ However, they all share the following characteristics: an enduring pattern of inner experience and behaviour that deviates from the expectations of society and behavioural patterns that are pervasive, inflexible and stable over time, creating distress or impairment.¹⁹⁵ Some forms of personality disorder result in suffering that primarily affects the individual (e.g., avoidant personality disorder, characterized by feelings of extreme discomfort and intense self-criticism in social circumstances, leading to marked loneliness and isolation despite intense longings for social contact). Other forms of personality disorder may not only cause distress to the individual, but also produce profound harm to others and incur substantial cost to society (e.g., antisocial personality disorder, a pervasive pattern of disregard for and violation of the rights of others that often includes repeated criminal activity, impulsive violent behaviour, deceitfulness and lack of remorse.) The onset of personality disorders usually occurs in adolescence or early adulthood, but they can also first manifest themselves in mid-adulthood. In contrast to the mental illnesses described previously, personality disorders are more intimately linked to the affected person's individual temperament and character.¹⁹⁶

Autism is a mental disorder which emerges in childhood and which, for some affected individuals, may be an incapacitating and life-long disability. Generally, autistic individuals display the following: impaired ability to engage in social interaction; impaired communication skills; and specific behavioural patterns (e.g., preoccupation, resistance to change, adherence to non-functional routines and stereotyped and repetitive behaviours). Developmental delay or abnormality in interaction, language and play is evident before 3 years of age in affected individuals. Autism may be accompanied by other disabling conditions, such as seizures or significant cognitive (intellectual) delays.¹⁹⁷ The symptoms and deficits associated with autism, however, may vary. For example, some individuals with

¹⁹³ United States Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, p. 167.

¹⁹⁴ Personality disorders include: borderline, antisocial, histrionic, narcissistic, avoidant, dependent, schizoid, obsessive-compulsive, and schizotypal personality disorders.

¹⁹⁵ Paula Stewart, *A Report on Mental Illnesses in Canada*, Health Canada, October 2002, p. 70.

¹⁹⁶ Paula Stewart (2002), pp. 72-73.

¹⁹⁷ Autism Treatment Services of Canada, *What is Autism?*.

autism function at a relatively high level, with speech and intelligence intact, while others are developmentally delayed, do not speak, or have serious language difficulties.¹⁹⁸ Autism tends to be three-to-four times more common in males than females.

Attention Deficit Disorder (ADD) and *Attention Deficit Hyperactivity Disorder (ADHD)* are terms used to describe patterns of behaviour that appear most often in school-aged children. They adversely affect the learning process by reducing the child's ability to pay attention. Children with these disorders are inattentive, overly compulsive and, in the case of ADHD, hyperactive. They have difficulty sitting still, attending to one thing for a long period of time, and may seem overactive. ADD and ADHD are diagnosed 10 times more often in boys than in girls.¹⁹⁹ The attention deficits associated with these disorders may persist throughout childhood and adolescence into adulthood, whereas the symptoms of hyperactivity and impulsivity tend to diminish with age. Although many children with ADD and ADHD ultimately adjust, a higher proportion than in the population of unaffected individuals are more likely to drop out of school and fare more poorly in their careers later. As they grow older, some teenagers who have had severe ADHD since middle childhood experience periods of anxiety or depression. They may also be vulnerable to problems with substance abuse and antisocial behaviour.²⁰⁰

Alzheimer's disease is an organic brain disorder that leads to the loss of mental and physical functions. Together with a number of other illnesses including, for example, Parkinson's disease and Huntington's disease, it is classified as a degenerative disease of the central nervous system. Alzheimer's disease is the leading cause of dementia. Several changes occur in the brain of the affected individuals, notably a progressive loss of neurons from the cerebral cortex and other areas. Consequently, a person with Alzheimer's disease has less brain tissue than a person who does not have the illness; the shrinkage continues over time, affecting how the brain functions.²⁰¹ Memory loss is the most prominent early symptom of Alzheimer's disease, often followed by a slow deterioration of cognitive functions and personality features and physical capacity. Some individuals experience hallucinations, delusions, seizures and aggressive behaviour. Alzheimer's disease affects both men and women equally.²⁰²

Although not classified as mental disorders, *Fetal Alcohol Syndrome* and *Fetal Alcohol Effects (FAS/FAE)* are major birth defects leading to disturbance in brain function. Damage to fetal brain development is caused by the effects of the mother's drinking alcohol during pregnancy. Infants with FAS/FAE display irritability, jitteriness, tremors, weak suck reflexes, problems with sleeping and eating, failure to thrive, delayed development, poor motor control and poor habituation. In childhood, problems such as hyperactivity, attention problems, perceptual difficulties, cognitive deficits, language problems and poor motor coordination are common. In adolescence and adulthood, the primary difficulties are memory impairment, problems with judgment and abstract reasoning and poor adaptive

¹⁹⁸ National Institute of Mental Health, *Briefing Notes on the Mental Health of Children and Adolescents*, United States, not dated. (www.nimh.nih.gov).

¹⁹⁹ Canadian Mental Health Association, *Children and Attention Deficit Disorders*, Pamphlet Series, not dated.

²⁰⁰ US Surgeon General Report (1999), p. 144.

²⁰¹ Canadian Alzheimer's Disease Centre, <http://www.alzheimercentre.ca/english/default.htm>.

²⁰² Sonya Norris, *Alzheimer's Disease*, PRB 02-39E, Library of Parliament, 2 October 2002.

functioning. Some common secondary disabilities, characteristic of adolescents and adults with FAS/FAE, include easy victimization, unfocused and distractable behaviour, difficulty handling money, problems in learning from experience, trouble understanding consequences and perceiving social cues, low frustration tolerance, inappropriate sexual behaviours, substance abuse and trouble with the law.²⁰³

4.3 SUBSTANCE USE AND ADDICTION

It is important to distinguish between substance use, abuse and dependence. Psychoactive substance use is very common. Abuse is less common and dependence affects only a minority of people who use psychoactive substances. The level of severity of consequences is higher for those with abuse and even higher for those with dependence.

[Dr. David Marsh, Centre for Addiction and Mental Health (16:44)]

According to Health Canada, *substance use* includes the use of any of a range of psychoactive substances – i.e., substances that have an effect on a person’s mental state – including alcohol, non-prescription and prescription drugs, illicit drugs, solvents and inhalants. Patterns of use may range from abstinence, to occasional or regular use, to frequent heavy use, to full-blown substance abuse.²⁰⁴

Substance use disorders, which are considered to be mental disorders under both the DSM and the ICD, refers to a habitual pattern of alcohol or drug use that results in significant problems in work, relationships, physical health, financial well-being, and other aspects of a person’s life. Substance use disorders encompass two sub-categories: substance abuse and substance dependence.²⁰⁵ *Substance abuse* refers to a maladaptive pattern of use despite the affected person’s knowledge of the negative consequences associated with such use. *Substance dependence* is characterized by a loss of control, preoccupation with and continued use of substance(s) despite its negative consequences.²⁰⁶

Dependence can be physical, psychological, or both. *Physical dependence* consists of tolerance (needing more of the substance for the same effect). *Psychological dependence* is present when a person perceives an intense need to use the substance in order to function effectively or in particular situations. The degrees of dependence range from mild to severe, the latter being characterized as addiction.²⁰⁷

²⁰³ Fred J. Boland et al., *Fetal Alcohol Syndrome: Implications for Correctional Service*, Correctional Service Canada, July 1998.

²⁰⁴ Colleen Hood, Colin Mangham, Don McGuire and Gillian Leigh, Exploring the Links Between Substance Use and Mental Health, Section I (“A Discussion Paper”) and Section II, (“A Round Table”) Health Canada, 1996, p. 44. (<http://www.hc-sc.gc.ca/hecs-sesc/cds/publications/index.htm>)

²⁰⁵ Health Canada, *Best Practices – Concurrent Mental Health and Substance Use Disorders*, 2002, p. 8.

²⁰⁶ *Ibid.*, pp. 89-90.

²⁰⁷ BC Partners for Mental Health and Addictions Information, “What is Addiction?”, The Primer – Fact Sheets on Mental Health and Addiction Issues, (<http://mentalhealthaddictions.bc.ca/>).

Addiction implies uncontrollable use of one or more substances, associated with discomfort or distress when that use is discontinued or severely reduced. Addiction may also describe certain other behavioural problems, such as *compulsive* or *pathological gambling*, which can be considered a process rather than a substance addiction. Research to date suggests that pathological gambling may progress in stages similar to those in alcoholism.²⁰⁸

In this report, we often use the term “addiction” to refer to the broad field of substance abuse. The *addiction treatment system* encompasses treatment, services and supports for those suffering from substance abuse and substance use disorders.

4.4 CO-MORBIDITY, CONCURRENT DISORDERS AND DUAL DIAGNOSIS

Co-morbidity simply denotes that two or more illnesses affect the same individual, whether two different mental disorders, two physical illnesses or a mental disorder and a physical illness. In this report, the concept of *co-morbidity* refers to the occurrence of a mental illness together with a physical illness. For example, epidemiological data show that 25% of arthritic patients have co-morbid depression or anxiety; there is a high level of co-morbidity between cancer, diabetes, respiratory problems, hypertension or migraine and some mental disorders. The interactions of physical and mental illnesses are, however, very complex.²⁰⁹

The term *concurrent disorders* most commonly refers to individuals who suffer from a mental illness and a substance use disorder at the same point in time. The relationships between mental illness and substance use are not straightforward. On the one hand, mental health problems/illnesses may act as risk factors for increased substance use (e.g., increased anxiety may lead to increased reliance on alcohol) and, on the other, substance abuse may act as a risk factor for increasing mental health problems/illnesses (e.g., problematic alcohol use may be a risk factor for depression). In other situations, a shared causal explanation may apply in which both disorders are promoted by a third factor such as genetic predisposition or family environment. Research indicates, however, that, in some circumstances, mental illness and substance use disorder occur independent of each other.²¹⁰

In general terms, the “concurrent disorders” population refers to those people who are experiencing a combination of mental/emotional/psychiatric problems with the abuse of alcohol and/or another psychoactive drugs. More technically speaking, and in diagnostic terms, it refers to any combination of mental health and substance use disorders, as defined for example on either Axis I and/or Axis II of DSM-IV.

[Brian Rush, Ph.D., CAMH, Brief to the Committee, May 2004, p. 2.]

In this report, *dual diagnosis* refers to individuals who have a mental health problem or illness together with developmental disability (formerly referred to as “mental retardation”). Because there are difficulties in diagnosing mental illness in a person with developmental disability, dual diagnosis is often unrecognized (undiagnosed) and untreated. Affected

²⁰⁸ Health Canada (1996), p. 30.

²⁰⁹ Paula Stewart (2002), p. 22.

²¹⁰ Health Canada, [Best Practices – Concurrent Mental Health and Substance Use Disorders](#), 2002.

individuals have complex and challenging needs and are certainly among the most vulnerable members of the Canadian population. They are more likely to experience abuse (more particularly sexual abuse), neglect and exploitation than other Canadians. They often “fall through the cracks.”²¹¹

4.5 SUICIDAL BEHAVIOUR

The term *suicidal behaviour* encompasses completed suicide (death by suicide), attempted suicide (including intentional self-inflicted harm) and suicidal ideation (thinking about suicide). Suicidal behaviour is often the consequence of a number of factors that have interacted, including acute stressors and negative life events (e.g., bereavement, loss of employment, separation, illness), symptoms associated with an acute episode of mental illness or substance use disorder (e.g., psychosis, depression, intoxication), personality characteristics, social and/or economic circumstances.

While not itself a mental disorder, suicidal behaviour is highly correlated to mental illness and addiction. Studies indicate that more than 90% of suicide victims have a diagnosable mental illness or substance use disorder.²¹² Suicide is the most common cause of death of individuals with schizophrenia. Suicide also accounts for 15% to 25% of all deaths among individuals with severe mood disorders.²¹³ Addiction often predisposes to suicidal behaviour by intensifying a depressive mood swing and by reducing self-control.²¹⁴

The presence of mental health problems is probably the single most important predictor of suicide. Accordingly, approximately 90% of suicide cases meet the criteria for a psychiatric disorder, particularly major depression, substance use disorders and schizophrenia. However, it is only a minority of people with these diagnoses that will eventually commit suicide indicating that a psychiatric disorder may be a necessary, but insufficient risk factor for suicide.

[Dr. Gustavo Turecki, Brief to the Committee, 21 April 2004, p. 1.]

4.6 SERVICES AND SUPPORTS

Traditionally, mental health care in the formal health care system has encompassed primary, secondary and tertiary care. Primary mental health care, i.e., first-line services, traditionally included simple diagnostic procedures, basic treatment, and referral to more specialized services as needed. A great deal of attention has been directed to enhance the capacity of primary mental health care given that it is now recognized that a large proportion of the population should receive services for mental health problems in this sector of the health care system. Secondary care is more specialized care that provides more extensive and

²¹¹ Canadian Mental Health Association – Ontario Division, *Dual Diagnosis: People with Developmental Disability and Mental Illness – Falling Through the Cracks*, Fact Sheet, 1998.

²¹² BC Partners for Mental Health and Addictions Information, “Suicide: Follow the Warning Signs”, *The Primer – Fact Sheets on Mental Health and Addictions Issues*.

²¹³ According to data from the Canadian Mental Health Association – Ontario Division (<http://www.ontario.cmha.ca/>).

²¹⁴ The Merck Manual on Diagnosis and Therapy, “*Suicidal Behaviour*”, Section 15, Chapter 190.

complicated procedures and treatment; it may be provided within hospitals, clinics or office-based practices, on an inpatient or outpatient basis. Tertiary care is generally defined as specialized interventions delivered by highly trained professionals to individuals with problems that are particularly complex and difficult to treat in primary or secondary settings. In the mental health system, tertiary care also refers to the long term care that has historically been provided in large psychiatric hospitals to individuals with persistent mental disorders. Research and teaching activities are also undertaken within tertiary care institutions.

In this report, it is recognized that many and diverse services and supports are required by those who experience mental illnesses and substance use disorders and, as such, they are provided by numerous professional and non-professional service providers and organizations. These services and supports extend beyond those provided in the traditional mental health care system. A Canadian review of best practices suggests the need for the following core mental health and addiction services and supports²¹⁵:

- *Case management* refers to the constant ongoing support provided to individuals with mental illnesses/substance use disorders to help them obtain the services they need. The case manager assesses needs, identifies skill deficits and refers the individual to providers of the appropriate services. Case management is intended to help patients/clients to develop skills for daily living, enhance their community tenure and prevent hospitalization. *Assertive Community Treatment (ACT)* is acknowledged to be the most appropriate model of case management to provide services to those with severe and persistent mental illnesses and concurrent disorders. In the ACT model, case management is provided by a multidisciplinary team in the community where the individual lives rather than in an office-based practice or an institution. The team involves psychiatrists, family physicians, social workers, nurses, occupational therapists, vocational specialists, etc., and is available to the patient/client 24 hour a day, 7 days a week.
- A wide range of *inpatient and outpatient services* are needed, including: counselling; psychotherapy; individual and group therapy; partial hospitalization (day treatment programs); acute home treatment (as an alternative to acute hospitalization); specialty services in both the community and psychiatric units/facilities; forensic psychiatry; and shared care. *Shared mental health care*²¹⁶ is of particular interest. This refers to a broad spectrum of collaborative activities between primary health care providers and psychiatrists or other mental health care providers; some have a strong clinical focus, integrating mental health services into primary health care settings, while others offer creative educational programs to primary health care providers through collaboration among academic departments.
- *Community supports, including housing, vocational services, supported education and supported employment* are important components of the spectrum of services required by individuals with mental disorders. It has been demonstrated that the availability of such community supports can substantially improve outcomes. It is recognized that

²¹⁵ Health Canada, [Review of Best Practices in Mental Health Reform](#), prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, 1997.

²¹⁶ The College of Family Physicians of Canada and the Canadian Psychiatric Association, [Shared Mental Health Care in Canada – A Compendium of Current Projects](#), Spring 2002.

individuals with mental illness have the capacity to work and that employment programs should be encouraged for even the most disabled of individuals. Similarly, supported education programs enable individuals to return to school on a full-time basis. Evidence also suggests that community residential programs can successfully substitute for long-term inpatient care. Thus, a range of different housing alternatives (e.g. supervised group homes or other residential settings) should be provided.

- *Mental health crisis/emergency response* provides a broad range of services to address the widely varying manifestations of acute mental health/substance use. There are five essential components to the crisis response/emergency service: telephone crisis lines, mobile crisis outreach, walk-in crisis stabilization services, crisis residential (non-hospital) services, and hospital-based psychiatric emergency services.
- Most importantly, there should be a strong focus on *initiatives by individuals with mental illness and addiction and their families*: The involvement of individuals who themselves have had mental illness/addiction problems in the planning, delivery, management, evaluation and reform of mental health services and supports has led to the development of a wide range of consumer/family initiatives that provide information, education, training, self-help, mutual aid and peer support. More importantly, significant strides have been made in this domain with the recent development of consumer based businesses as a means to promote self fulfillment and a reduce dependence on social services.

In this report, the *mental health system* refers to the broad range of services and supports available to individuals with mental illness. Similarly, the *addiction system* describes the entire range of services aimed at preventing or reducing/treating substance abuse, substance use disorders and problematic gambling.

4.7 CHRONIC DISEASE MANAGEMENT AND SELF-MANAGEMENT

Chronic disease management is a relatively new approach that has been shown to be very effective in the long term treatment of diseases. The approach is based on the "Chronic Care Model" used by a United States national program called Improving Chronic Illness Care (ICIC) based in Seattle, Washington, at the MacColl Institute for Healthcare Innovation at the Group Health Cooperative of Puget Sound.²¹⁷

Chronic disease management rests on evidence-based clinical guidelines and protocols and involves many health care professionals and administrators throughout all sectors of the health care system that share a common vision and collaborating on several

Chronic disease management as an approach to mental health and addictions care emphasizes assisting individuals to maintain independence and to maintain optimal health through prevention, early detection, and management of chronic mental disorders and substance use disorders.

[Ministry of Health Services, British Columbia, Brief to the Committee, 9 September 2003, p. 7.]

²¹⁷ For more information, please go to the ICIC Website (<http://www.improvingchroniccare.org/>).

initiatives in parallel. This approach contrasts with the model of treating a care episode as a single event – a visit to a health care provider. In Canada and the United States, chronic disease management has been applied with great success to many chronic diseases, such as diabetes, arthritis and even asthma; it is now being contemplated for application to mental illness and addiction. Chronic disease management emphasizes community based care and aims to foster independence and fulfillment.²¹⁸

An important element of chronic disease management is the active participation of affected individuals themselves in the management of their illnesses on a day-to-day basis. This participation of patients/clients is usually referred to as self-management. The concept of *self-management* does not mean that individuals deal with their illnesses or disorders on their own. It is a process that enables the individual to develop the knowledge, attitudes and skills necessary to manage his/her illness or disorder and to make improved use of existing health services and supports in order to access help when it is needed.²¹⁹

4.8 PROMOTION, PREVENTION AND SURVEILLANCE

The goal of mental health *promotion* is to provide information to the public to raise and enhance awareness and understanding of mental health issues, reduce stigma and promote positive mental health. Mental health promotion also includes education and training of human resources in the formal mental health/addiction system.

The concept of mental health literacy is often used in the context of mental health promotion. *Mental health literacy* refers to the knowledge, beliefs and abilities that support the recognition, management or prevention of mental illnesses or substance use disorders. A high public level of mental health literacy makes early recognition of and appropriate intervention in mental illnesses and substance use disorders more likely. It is also effective in reducing stigma.²²⁰

Mental health literacy refers to knowledge and beliefs about mental disorders, which assist in the recognition, management or prevention of mental health and substance use problems, and mental and substance use disorders. Mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking.

[Ministry of Health Services, British Columbia, Brief to the Committee, 9 September 2003, p. 9.]

Prevention is categorized as *primary prevention* when directed at averting a potential mental health/substance use problem; *secondary prevention* is directed at early detection and includes the appropriate intervention to prevent or delay onset or mitigate a mental health problem;

²¹⁸ Mental Health and Addictions, Ministry of Health Services, Government of British Columbia, *Brief to the Committee*, 9 September 2003, p. 7.

²¹⁹ BC Partners for Mental Health and Addictions Information, “Mental Health and Addictions Information Plan for Mental Health Literacy”, [The Primer - Fact Sheets on Mental Health and Addictions Issues](#), British Columbia.

²²⁰ *Ibid.*

tertiary prevention is directed at minimizing disability or avoiding relapse in a successfully treated, stable patient/client.

Surveillance usually refers to the ongoing systematic collection, analysis and interpretation of health-related data used to determine the occurrence of diseases, assess relevant needs and evaluate effectiveness of policies and programs. Currently, Canada has no national surveillance system for tracking mental illnesses and substance use disorders.²²¹

4.9 INDIVIDUALS WITH MENTAL ILLNESS/ADDICTION AND RECOVERY

As described at the outset of this chapter, no commonly accepted language and terminology exist to describe all concepts and issues in the field of mental illness and addiction. There is little agreement in regard to the most respectful and appropriate terms to identify those individuals who themselves have experienced a mental illness or substance use disorder. Some individuals have very strong feelings about the language used in view of the societal stigmatization and pejorative labelling that is far too commonly encountered by individuals with mental illness and addiction.

Traditionally, individuals with mental illness and addiction being cared for by physicians are called patients. Other health professionals often refer to such individuals as *clients* or service users. The individuals may describe themselves by a number of terms, commonly consumers and survivors. Consumers usually refer to individuals with direct experience of significant mental health problems or mental illnesses who have used the resources available from the mental health system. Some individuals have chosen to refer themselves as survivors, a term that they feel acknowledges their strength in coping with mental illness and/or addiction. In this report, the Committee uses the terms *individuals with mental illness and addiction* or *patient/client*.

Individuals with mental illness and addiction often talk about recovery. *Recovery* is not the same thing as being cured. For many individuals, it is a way of living a satisfying, hopeful, and productive life even with limitations caused by the illness; for others, recovery means the reduction or complete remission of symptoms related to mental illness.

Recovery is a journey, rather than a destination. It is an active, ongoing, highly individualized process through which a person is encouraged to assume responsibility for his or her life, often in collaboration with friends, families, peers and professionals.

Each person's recovery is unique. No two people will have the same path or use the same measures to mark the success of their recovery. The real test for recovery is when people feel that they have recovered and are living a quality of life that is not dominated by their past situation or their current symptoms and stresses.

[Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs, Ontario, December 2002, p. 28.]

²²¹ Paula Stewart, *The Development of a Canadian Mental Illnesses and Mental Health Surveillance System: A Discussion Paper*, prepared for the Canadian Alliance on Mental Illness and Mental Health, 1999 (unpublished).

In the field of mental health, recovery is a personal process of overcoming the negative impact of mental illness despite its continued presence. In the field of addiction, recovery describes an abstinence-based approach to substance use disorders, such as those practiced by Alcoholics Anonymous and Narcotics Anonymous. The recovery concept presupposes that, with the appropriate treatment and supports in place, individuals with mental illness and addiction can take charge of their lives, create new goals and aspirations, and engage in society as productive citizens.²²²

²²² Provincial Forum of Mental Health Implementation Task Force Chairs, [*The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario*](#), December 2002, p. 21.

CHAPTER 5: PREVALENCE AND COSTS

Mental disorders are not the exclusive preserve of any social group; they are truly universal. Mental and behavioural disorders are found in people of all regions, all countries and all societies.

[WHO (2001), p. 23.]

INTRODUCTION

Mental illness and addiction are common, affecting about 1 in 5 Canadians during their lifetimes. They affect individuals of all ages, women and men, in all cultures and income groups. They are prevalent in all regions, both rural and urban. They have a huge economic impact, not only on the individual and his/her family, but also on the health care system, the broader social system, the workplace and society as a whole.

If mental illness were an infectious disease, it would constitute an epidemic in Canada. The number of people affected is overwhelming (...).

[Phil Upshall, President, Canadian Alliance on Mental Illness and Mental Health, Brief to the Committee, 18 July 2003, p. 4.]

To plan adequately and organize the delivery of needed services and supports and to develop sound public policy on mental health, it is essential to properly assess the prevalence and economic burden of mental illness and addiction. In this chapter, existing information on the prevalence and the economic cost of mental illness, addiction, pathological gambling and suicide in Canada is reviewed. Where data are available, some international comparisons are also presented.

Section 5.1 provides information on the prevalence of mental illnesses, substance use disorders and pathological gambling. Section 5.2 reviews the prevalence of suicidal behaviour. Section 5.3 examines the prevalence of mental illness and addiction in specific population groups, including Aboriginals, homeless people and inmates. Section 5.4 provides data on the economic burden of mental illness and addiction in Canada. Finally, the Committee makes some commentary and concluding remarks in Section 5.5.

5.1 PREVALENCE OF MENTAL ILLNESSES, SUBSTANCE USE DISORDERS AND PATHOLOGICAL GAMBLING

Canada does not collect, in a systematic manner, national data on the mental health status of Canadians, nor the extent of any particular mental illness.

[Phil Upshall, President, Canadian Alliance on Mental Illness and Mental Health, Brief to the Committee, 18 July 2003, p. 6.]

Data on *prevalence* provide estimates of the proportion of individuals in a population who suffer from an illness or a disorder. Prevalence rates differ depending on whether they refer to individuals who have a disease at a certain point in time (point prevalence), during a period of time (period prevalence – usually a year), or throughout their lifetime (lifetime prevalence).

Currently, there is no national database capable of providing precise information on the prevalence of all mental disorders for all age groups in Canada. Often, the best estimates are derived from epidemiological studies reported in the literature. However, the 2002 Canadian Community Health Survey (CCHS), Cycle 1.2 on Mental Health and Well-Being, carried out by Statistics Canada, provided for the first time prevalence rates for some mental illnesses, substance use disorders and pathological gambling. These are described below.

The Statistics Canada mental health survey that was published in the fall was an excellent start. That was the first population based survey of mental illnesses ever done in this country. Can you imagine if 2003 were the year of the first survey of heart disease or cancer in this country? That would be appalling. We need a better surveillance system.

[Dr. Blake Woodside, Chairman of the Board, Canadian Psychiatric Association (5:19)]

5.1.1 Canadians Aged 15 Years and Over

According to the CCHS (see Table 5.1), 1 out of every 10 Canadians aged 15 and over – about 2.6 million individuals – reported symptoms of substance use disorders during the past year. The rates were similar for men and women as for men: some 1.4 million of women reported symptoms consistent with mental illnesses and/or substance use disorders (or 10%) of men.

Mental illnesses and addictions know no boundaries. They can strike at any age and in any population.

[Canadian Psychological Association, Brief to the Committee, 2003, p. 5.]

There were, however, gender differences by type of disorder. Mood disorders and anxiety disorders were more common among women (6%) than men (4%), while substance use disorders were more common in men (4%) than women (2%).

TABLE 5.1

**ONE-YEAR PREVALENCE OF MENTAL DISORDERS AMONG CANADIANS
AGED 15 YEARS AND OLDER, 2002**

	Total		Males		Females	
	Number (000's)	Rate (%)	Number (000's)	Rate (%)	Number (000's)	Rate (%)
Unipolar Depression	1,120	4.5	420	3.4	700	5.5
Bipolar Depression	190	0.8	90	0.7	100	0.8
Any Mood	1,210	4.9	460	3.8	750	5.9
Panic Disorder	400	1.6	130	1.1	270	2.1
Agoraphobia	180	0.7	40	0.4	140	1.1
Social Phobia	750	3.0	310	2.6	430	3.4
Any Anxiety	1,180	4.7	440	3.6	740	5.8
Alcohol Dependence	640	2.6	470	3.8	170	1.3
Illicit Drug Dependence	170	0.7	120	1.0	50	0.4
Any Substance Use	740	3.0	540	4.4	200	1.6
Total – Any Disorder	2,600	10.4	1,190	9.7	1,410	11.1

Statistics Canada, "Canadian Community Health Survey: Mental Health and Well-Being", *The Daily*, 3 September 2003.

The CCHS found that adolescents and young adults aged between 15 and 24 were more likely to report suffering from mental illnesses and/or substance use disorders than other age groups. In this age group, 18% reported having experienced mental illness and/or substance abuse, compared to 12% of those aged 25-44, 8% of those aged 45-64, and 3% of seniors 65 and over.

The CCHS survey was limited in the range of mental disorders observed in the Canadian population. This contrasts with the National Survey of Mental Health and Well-Being undertaken in Australia in 1997. The Australian survey covered a wider range of anxiety and affective mood disorders. It also distinguished between the harmful use of, and dependence on, alcohol and drugs. The Australian government also plans a survey of low prevalence psychotic disorders, such as schizophrenia.²²³

(...) we need to see co-occurring addiction and mental health problems as the norm, not the exception. To detect the presence of one problem should lead us to the assumption that the other is present unless it is determined otherwise.

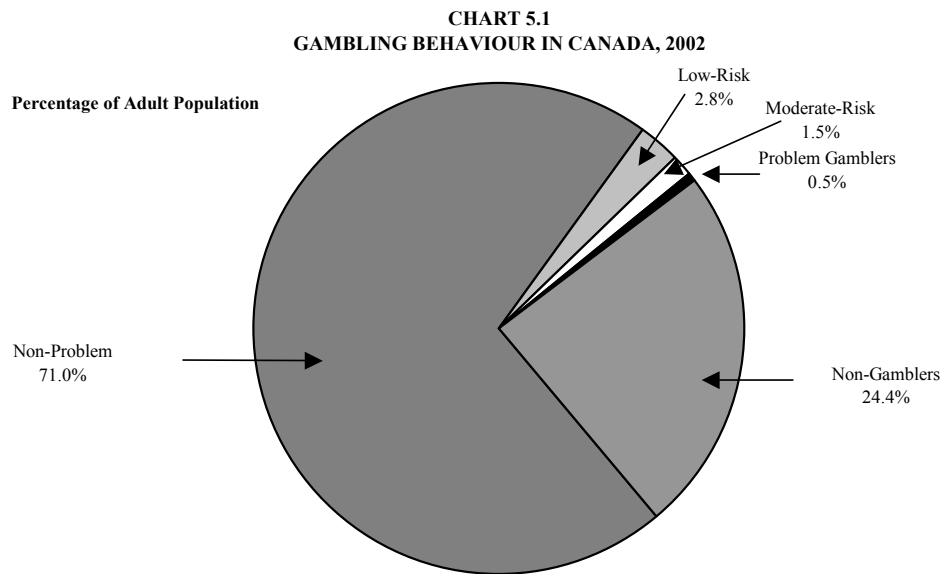
[Wayne Skinner, CAMH, Brief to the Committee, May 2004, p. 2]

²²³ The Australian's National Survey of Mental Health and Well-Being covered the following anxiety disorders – panic disorder, agoraphobia, social phobia, generalized anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder – and the following affective disorders – depression, dysthymia, mania, hypomania, bipolar disorder. In addition, it surveyed alcohol use

It is unfortunate that the CCHS survey did not correlate or cross-tabulate data in order to evaluate the prevalence rates of concurrent disorders (mental illness co-occurring with substance use disorder) among Canadians aged 15 and over. The insufficiency of the information on the prevalence of concurrent disorders creates obstacles to better understanding them and to the effective planning and development of appropriate services and supports for those affected. The design of the National Survey of Mental Health and Well-Being of Adults in Australia permitted an assessment of both concurrent disorders and co-morbidity (defined as the presence of both mental disorders and physical conditions).

In contrast to the Australian survey, the CCHS survey did provide information on problem or pathological gambling.²²⁴ Some 1.2 million Canadians (or 5% of the adult population) in 2002 were estimated to have the potential to become problem gamblers or were so already (see Chart 5.1). 700,000 Canadians were at low risk (2.8%), some 370,000 individuals were at moderate risk (1.5%) and 120,000 were already problem gamblers (0.5%). Men (8%) who gambled were significantly more likely than women (5%) to be at-risk or problem gamblers. At-risk and problem gamblers were also, on average, younger than non-problem gamblers (40 versus 45) and less well educated (8% versus 5%).

Where there is gambling, there will be people with a problem.
[Katherine Marshall and Harold Wynne, "Fighting the Odds", p. 5.]



Katherine Marshall and Harold Wynne, "Fighting the Odds", *Perspectives on Labour and Income*, Statistics Canada, Catalogue No. 75-001-XIE, Vol. 4, No. 12, December 2003.

disorders and drug use disorders in terms of both harmful use and dependence. For more information, visit the website of the Australian Bureau of Statistics.

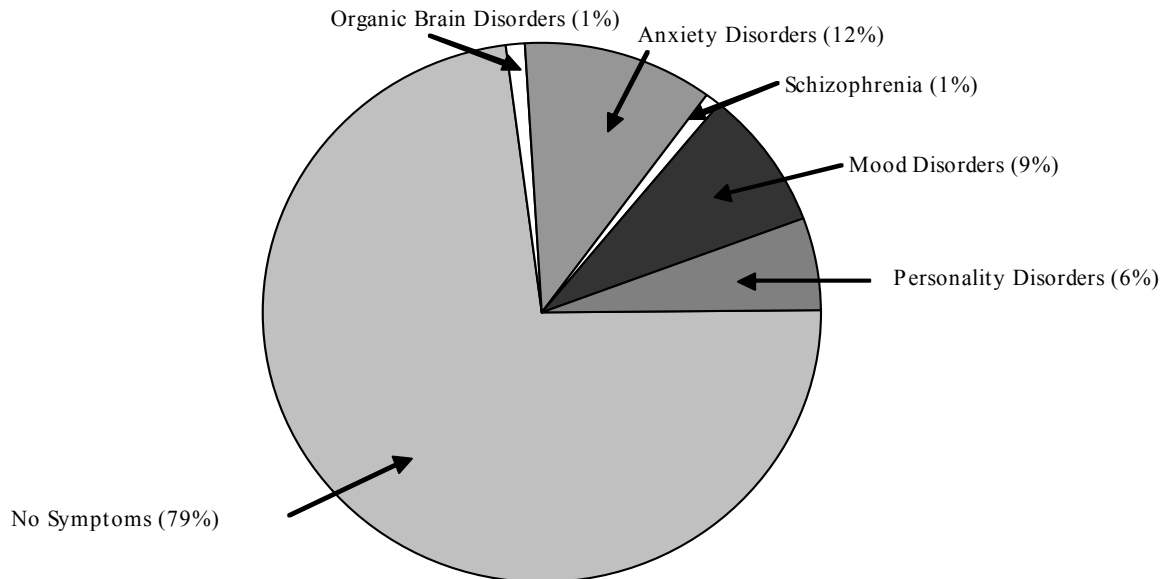
(<http://www.abs.gov.au/Ausstats/abs@.nsf/0/3F8A5DFCBECAD9C0CA2568A900139380?Open>).

²²⁴ Data on gambling are analyzed in details by Katherine Marshall and Harold Wynne in "Fighting the Odds", *Perspectives on Labour and Income*, Statistics Canada, Catalogue No. 75-001-XIE, Vol. 4, No. 12, December 2003, pp. 5-13 (<http://www.statcan.ca/>).

Interestingly, the survey suggested a link between pathological gambling, mental illness and substance abuse. More precisely, 42% of problem gamblers reported a high or extreme level of stress in their lives; 24% of them reported having had a major clinical depression; and 15% reported being dependent on alcohol. The survey also found that 18% of problem gamblers had contemplated suicide in the past year.

Lifetime prevalence rates for mental illnesses and substance use disorders in Canada are based on various epidemiological studies. Data compiled by Paula Stewart and her colleagues (October 2002), showed that nearly one in five Canadian adults (21% of the population or 4.5 million individuals) will personally experience a mental illness in their lifetime.²²⁵ Chart 5.2 illustrates the lifetime prevalence of mental illness among Canadian adults as derived from epidemiological studies.

CHART 5.2
MENTAL ILLNESSES IN CANADA: LIFETIME PREVALENCE AMONG ADULTS



Nota: Percentages may not add up to 100% as individuals may have symptoms in more than one category. Based on data provided by Paula Stewart et. al., *A Report on Mental Illnesses in Canada*, October 2002.

As illustrated above, anxiety disorders and mood disorders are the most common mental illnesses among Canadian adults; they affect 12% and 9% of adults respectively. Schizophrenia affects about 1% of the Canadian population. Dementia associated with Alzheimer’s disease and organic brain disorders which are the result of physical disease or injury to the brain (e.g., AIDS dementia complex and vascular dementia), also affect some 1% of Canadian adults. Between 6% and 9% of adults in Canada suffer from personality disorders.

²²⁵ Paula Stewart et al., [A Report on Mental Illnesses in Canada](#), published by Health Canada, October 2002.

Similar rates of prevalence are found worldwide. With respect to point prevalence, the World Health Organization (WHO) reported in 2001 that mental illness and addiction at any point in time affect about 10% of the adult population – or some 450 million individuals worldwide.²²⁶ In terms of lifetime prevalence, the WHO reported that, throughout their lifetime, more than 25% of individuals develop one or more mental illnesses.²²⁷ The WHO also estimated that, throughout the world, one in four families has at least one member currently suffering from a mental illness or addiction.²²⁸

With respect to one-year prevalence rates, the WHO World Mental Health Survey Consortium found that mental disorders are highly prevalent in both developed and less developed countries, although there is substantial cross-national variation; the prevalence is low in Asian countries in particular. Anxiety disorders are the most common mental illnesses, with mood disorders next. Broken down by the degree of severity, a substantial proportion of disorders were classified as mild; smaller proportions of the samples were considered serious or moderate disorders, although they were often associated with significant impairment in carrying out usual activities.²²⁹

5.1.2 Children and Adolescents (0 to 19 Years of Age)

Based on various epidemiological studies, Charlotte Waddell and Cody Shepherd (October 2002) estimated overall and disorder-specific prevalence rates of some mental disorders in children and adolescents in British Columbia. Table 5.2 extrapolates from these rates to estimate the number of children and adolescents in Canada who may be affected by mental disorders.

The overall prevalence of mental illness in Canadian children and adolescents, at any given point in time, is about 15%. This translates into approximately 1.2 million of children and adolescents who experience mental illness and/or addiction of sufficient severity to cause significant distress and impaired functioning. The most common are anxiety (6.5%), conduct (3.3%), attention deficit (3.3%), depressive (2.1%) and substance use (0.8%) disorders.

²²⁶ World Health Organization, *Mental Health : New Understanding, New Hope*, 2001, p. 23.

²²⁷ *Ibid.*

²²⁸ WHO (2001), p. 24.

²²⁹ The WHO World Mental Health Survey Consortium, “Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys”, *Journal of the American Medical Association*, Vol. 291, No. 21, 2 June 2004, pp. 2581-2590.

TABLE 5.2

PREVALENCE OF MENTAL DISORDERS IN CHILDREN AND ADOLESCENTS^(a)

MENTAL DISORDER	PREVALENCE RATE (%)	APPROXIMATE NUMBER
Anxiety Disorder	6.5	513,780
Conduct Disorder	3.3	260,842
ADHD	3.3	260,842
Depressive Disorder	2.1	165,990
Substance Abuse	0.8	63,234
Pervasive Developmental Disorder	0.3	23,713
Obsessive-Compulsive Disorder	0.2	15,809
Schizophrenia	0.1	7,904
Tourette's Disorder	0.1	7,904
Eating Disorder	0.1	7,904
Bipolar Disorder	less than 0.1	less than 7,904
ANY DISORDER	15	1,185,645

(a) Based on a population estimate by Statistics Canada of 7,904,300 children and adolescents (aged 0 to 19 years) in July 2002.

Source: Adapted from Charlotte Waddell and Cody Shepherd, *Prevalence of Mental Disorders in Children and Youth*, Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, University of British Columbia, October 2002.

An important fact that is not captured in the table is the presence of two or more mental disorders occurring together. For example, an Ontario Child Health Survey reported that amongst children and adolescents who experienced a mental disorder, over two-thirds (68%) of them had two or more mental disorders. Similarly, a recent study of adolescents with substance use disorders found that over three quarters (76%) had concurrent anxiety, mood or behaviour disorders.²³⁰

Dr. Joseph H. Beitchman, Psychiatrist-in-Chief, Hospital for Sick Children (Toronto), stressed in his brief that most adult mental disorders begin or originate in childhood or adolescence; they are serious, lifelong illnesses.²³¹ This underscores the need for early detection and intervention. It also highlights that the best opportunities for prevention and reduction in the emergence of new cases are in childhood and adolescence. As pointed out by Charlotte Waddell et. al. (2002): “Good-quality epidemiological information is essential for developing sound public policies to improve children’s mental health.”²³² It is interesting to note that the National Mental Health Strategy adopted by the Commonwealth, State and Territory governments of Australia called for a child and adolescent survey to be undertaken

²³⁰ Data quoted in Charlotte Waddell et. al., *Child and Youth Mental Health: Population Health and Clinical Services Considerations*, Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, University of British Columbia, April 2002, p. 15.

²³¹ Dr. Joseph H. Beitchman, Psychiatrist-in-Chief, Hospital of Sick Children (Toronto), Brief to the Committee, 30 April 2003, p. 7.

²³² Charlotte Waddell et. al., “Child Psychiatric Epidemiology and Canadian Public Policy-Making: The State of the Science and the Art of the Possible”, *Canadian Journal of Psychiatry*, Vol. 47, No. 9, November 2002, pp. 825-832.

as well as their National Survey of Mental Health and Well-Being of Adults. Such a study has never been done in Canada.

5.1.3 Seniors (65 Years and Over)

The CCHS survey, as reported above, found that, during the past year, some 3% of Canadians aged 65 and over (or some 107,283 seniors) reported symptoms associated with the five mental disorders and the two substance dependencies surveyed. The one-year prevalence rate was 1.8% for unipolar disorder, 0.2% for panic disorder, 0.9% for social phobia and 0.4% for agoraphobia. Mental illnesses and substance use disorders were more prevalent among women (3.2%) than men (2.5%). The survey also found that about 2% of Canadian seniors reported having had suicidal thoughts in the past twelve months.

Other information was presented to the Committee on the prevalence of mental disorders among Canadian seniors:

- The incidence of depression in seniors in long term care settings is three to four times higher than in the general population. The prevalence of mental disorders among nursing home residents is extraordinarily high, between 80% and 90%. The prevalence of psychosis ranges from 12% to 21% depending on how psychotic symptoms are measured.²³³
- Alzheimer's disease and related dementias currently affect more than 360,000 Canadians, including 1 in 13 over the age of 65 and 1 in 3 over 85 years of age. Women are more affected by the disease than men.²³⁴
- Estimates suggest that 25% to 50% of seniors who abuse or misuse alcohol also suffer from mental disorders.²³⁵
- The incidence of suicide among men 80 years old and over is the highest of all age groups (31 per 100,000 population).²³⁶

5.1.4 Canadian Forces²³⁷

The more than 83,000 CF members (Regular Force and Reserve) are doubly concerned by [mental disorders] as they are exposed not only to the problems of a "normal" life, but also to those of a high-risk career.

[National Defence, [Statistics Canada CF Mental Health Survey: A "Milestone"](#), 2003.]

²³³ Dr. David Conn, Co-Chair, Canadian Coalition for Seniors Mental Health, Brief to the Committee, 4 June 2003, p. 4 and p. 6.

²³⁴ Alzheimer Society of Canada, Brief to the Committee, 4 June 2003, p. 3.

²³⁵ Margaret Gibson, Department of Psychology, University of Western Ontario, Brief to the Committee, 4 June 2003, p. 2.

²³⁶ Dr. David Conn (4 June 2003), p. 5.

²³⁷ National Defence, [Statistics Canada CF Mental Health Survey: A "Milestone"](#), 2003.

The CCHS included a separate mental health survey of the Canadian Forces (CF). It found a one year prevalence rate of 7.6% and a lifetime rate of 16.2% for unipolar depression within the CF regular force; the comparable prevalence rates for reservists were respectively 4.1% and 9.7%. In the regular forces, the prevalence rate of social phobia is 3.6% (one year) and 8.7% (lifetime), and 2.3% and 7.1% for the reservists. The one year and lifetime prevalence of Post Traumatic Stress Disorder is 2.8% and 7.2% for members of the regular forces and 1.2% and 4.7% for reservists. The one year and lifetime prevalence of general anxiety disorder is 1.8% and 4.6% for members of the regular forces and 1.0% and 2.9% for reservists. The comparable prevalence of panic disorder is 2.2% and 5.0% in the regular forces, and 1.4% and 3.3% in reservists. The one year prevalence rate for alcoholism is 4.2% and the lifetime prevalence rate is 8.5% for the regular forces; the rates are respectively 6.2% and 8.8% for reservists.

5.1.5 FAE/FAS and Dual Diagnosis

The prevalence of Fetal Alcohol Syndrome and Fetal Alcohol Effects (FAS/FAE) in Canada has not been properly evaluated. Based on worldwide prevalence rates, Health Canada estimated that there were some 341,901 individuals with FAS/FAE in Canada in 2001. The prevalence rates of FAS/FEA in some communities, particularly among Aboriginal Canadians, are higher than the national average.²³⁸

At least one baby a day in Canada is born with fetal alcohol syndrome, FAS, a disability that will have repercussions for the child, his or her family and the community for the individual's entire life. FAS is the leading cause of preventable birth defects and developmental delays in Canada. It is more common than Down's Syndrome.

[Pam Massad, Health Canada (13:5)]

As described in Chapter 4, dual diagnosis refers to individuals who have a mental health problem or illness together with developmental disability (formerly referred to as “mental retardation”). Because of the difficulty of diagnosing mental illness in individuals with developmental disability, dual diagnosis is often unrecognized and untreated. Data indicate that between 1% and 3% of Canadians have moderate or severe developmental disability. Conservatively estimated, 30% of these individuals also have mental illness; some researchers estimate the prevalence as high as 50% to 60%.²³⁹

5.2 PREVALENCE OF SUICIDAL BEHAVIOUR

One in twenty-five Canadians will attempt suicide during their lifetime. [Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, University of British Columbia, At-a-Glance Suicide Facts]

²³⁸ Health Canada, *Fetal Alcohol Spectrum Disorder*, Brief to the Committee, 30 April 2003.

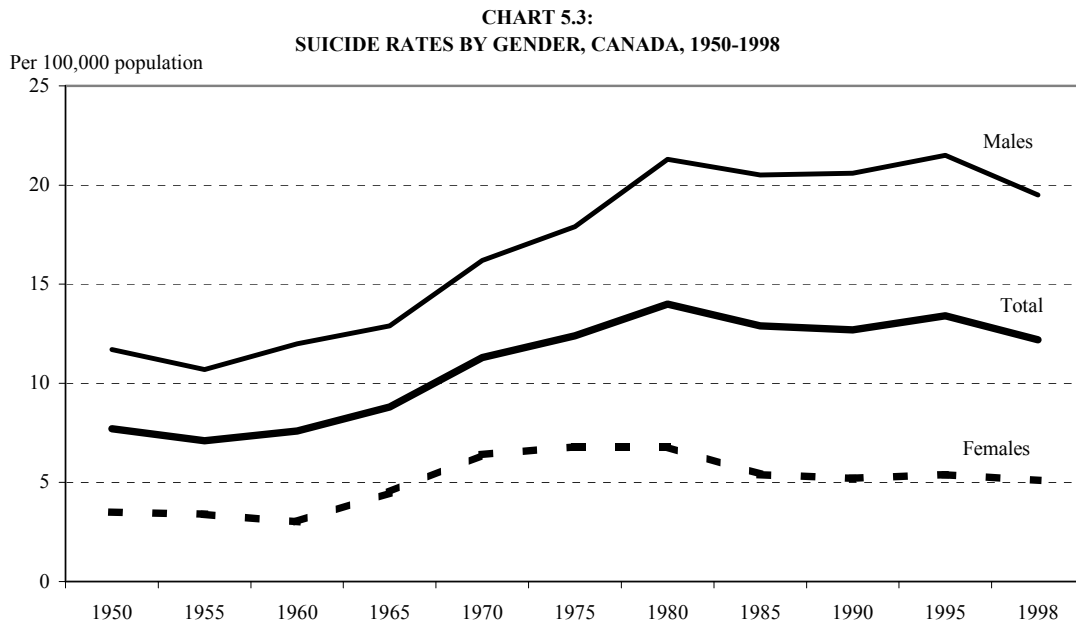
²³⁹ Canadian Mental Health Association – Ontario Division, *Dual Diagnosis: People with Developmental Disability and Mental Illness – Falling Through the Cracks*, Fact Sheet, 1998.

As discussed in Chapter 4, the concept of suicidal behaviour is broad, encompassing completed suicide (death by suicide), attempted suicide (including intentional self-inflicted harm) and suicidal ideation (thinking about suicide). This section presents recent data on the extent of suicidal behaviour in Canada and provides some international comparisons.

Suicide is a “stoppable” problem. It is an action, not an illness. (...) Moreover, attempted suicides, where the individual’s actions have been non-fatal – are like the submerged unseen base of an iceberg.
[Diane Yackel, Centre for Suicide Prevention, Brief to the Committee.]

5.2.1 Completed Suicides

Chart 5.3 shows that suicide rates in Canada rose sharply from 1950 to the early 1980s, with a peak in 1983, after which the rates remained more or less stable, with a slight decrease between 1995 and 1998 (latest year for which data are available).



Source: Economics Division, Parliamentary Research Branch, Library of Parliament, March 2004. Data from the World Health Organization (2003).

In 1998, 3,699 Canadians took their own lives. The distribution by age group is shown in Chart 5.4. Suicide represented 2% of all deaths in Canada in 1998.

Looking at the epidemiology of suicide we realize that suicide is an important problem from the public health perspective. It ranks among the 10 top causes of death for individuals of all ages.

[Dr. Gustavo Turecki, Director, McGill Group for Suicide Studies, McGill University (:)]

TABLE 5.3

NUMBER OF SUICIDES AND SUICIDE RATES BY AGE GROUP AND SEX,

CANADA, 1998

AGE	NUMBER OF SUICIDES	SUICIDE RATES (PER 100,000)
-----	--------------------	-----------------------------

GROUP	TOTAL	MALES	FEMALES	TOTAL	MALES	FEMALES
5-14	46	30	16	1.2	1.5	0.8
15-24	562	457	105	13.5	21.6	5.1
25-34	701	568	133	13.7	22.1	5.2
35-44	895	713	182	19.0	30.3	7.7
45-54	672	513	159	19.2	29.0	9.2
55-64	366	296	70	15.5	25.9	5.8
65-74	260	201	59	14.9	26.7	6.0
75+	197	147	50	16.5	31.6	6.9
TOTAL	3,699	2925	774	12.2	19.5	5.1

* Per 100,000 population.

Source: World Health Organization, *Suicide Prevention – Country Reports and Charts*, Geneva, 2003.

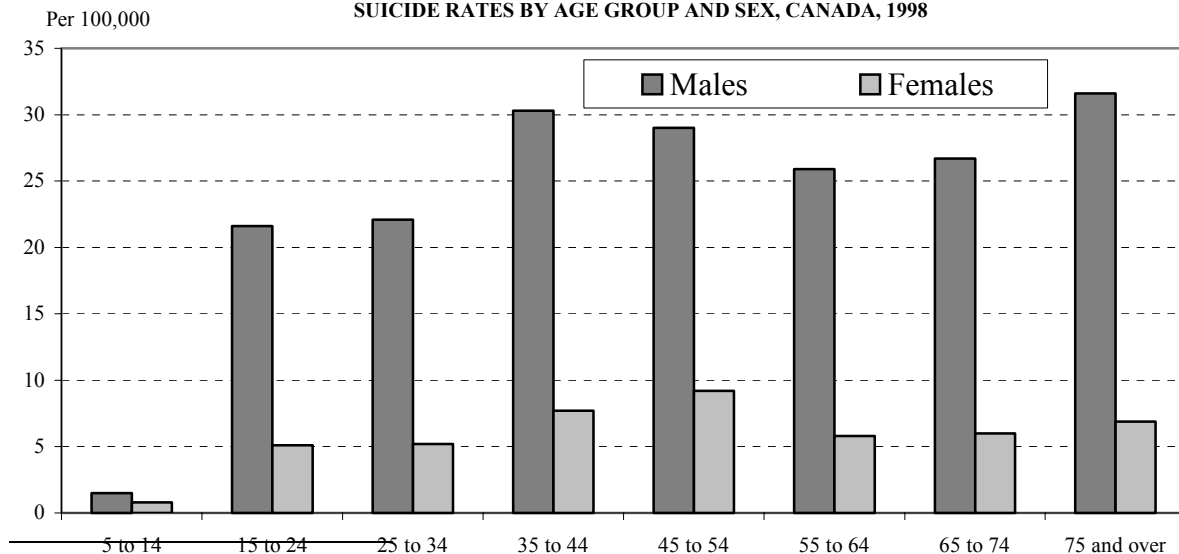
In every age group, males had a higher suicide rate than did females (see Chart 5.4); approximately four men committed suicide for every woman who did so.

According to Langlois and Morrison (2002), suicide was the leading cause of death for men in the age groups between 25 to 29 and 40 to 44, and for women between the ages of 30 to 34. For the three age groups from 10 to 14, 15 to 19 and 20 to 24, it was the second leading cause of death for both sexes, surpassed only by motor vehicle accidents.²⁴⁰

I am sure you will agree that taking one's own life at 14 or 15, while thousands or even millions of people fight against death every day, remains a paradox. Suicide among young Canadians is a serious problem that should be made a priority.

[Dr. Johanne Renaud, Centre hospitalier Sainte-Justine (13 :13-14)]

CHART 5.4
SUICIDE RATES BY AGE GROUP AND SEX, CANADA, 1998

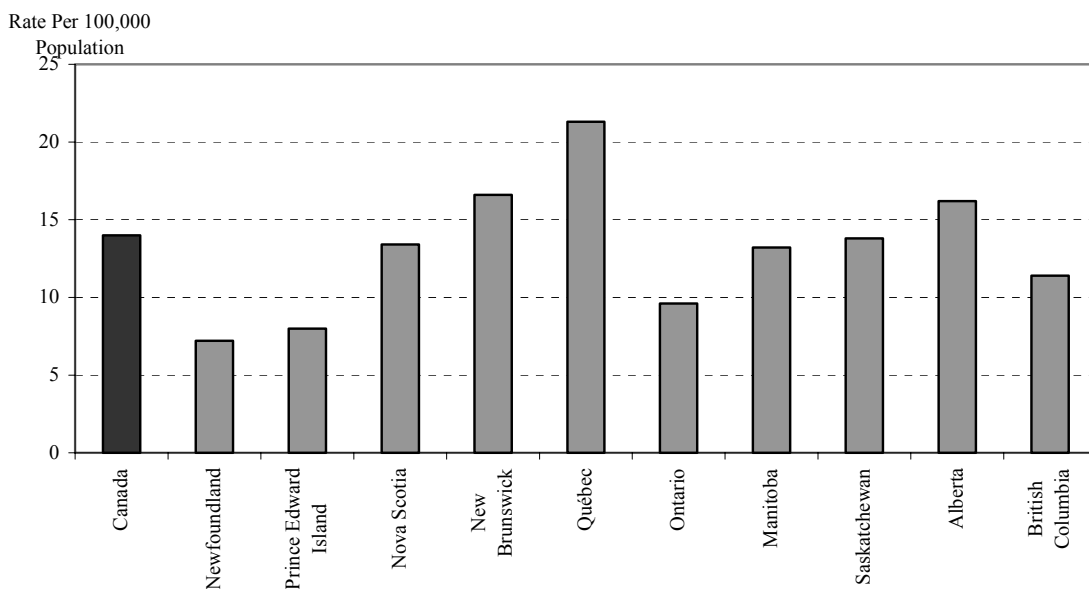


²⁴⁰ Stéphanie Langlois and Peter Morrison, "Suicide, Deaths and Suicide Attempts," *Health Reports*, Statistics Canada, Catalogue 83-003, Vol. 13, No. 2, January 2002. Data from the World Health Organization (2003).

Langlois and Morrison (2002) also demonstrated large provincial differences in suicide rates. In 1998, Québec had the highest age-standardized suicide rate (21.3 suicide deaths per 100,000 population)²⁴¹, significantly above the national average of 14.0 suicide deaths per 100,000. New Brunswick and Alberta also exceeded the national average (16.6 and 16.2 suicide deaths per 100,000 respectively). Newfoundland, Prince Edward Island, Ontario and British Columbia reported rates significantly below the national average (see Chart 5.5).

According to WHO data, Canada's suicide rate for the entire population ranks 9th among 12 industrialized countries (see Chart 5.6). Age-standardized suicide rates range from a low of 7.5 per 100,000 population in the United Kingdom to a high of 22.5 in Finland. The suicide rate in Canada (12.2 per 100,000 population) is higher than that in the United States (10.7 per 100,000). It is important to note that international comparisons must be interpreted with caution as the methods for certifying the cause of death vary from one country to another.

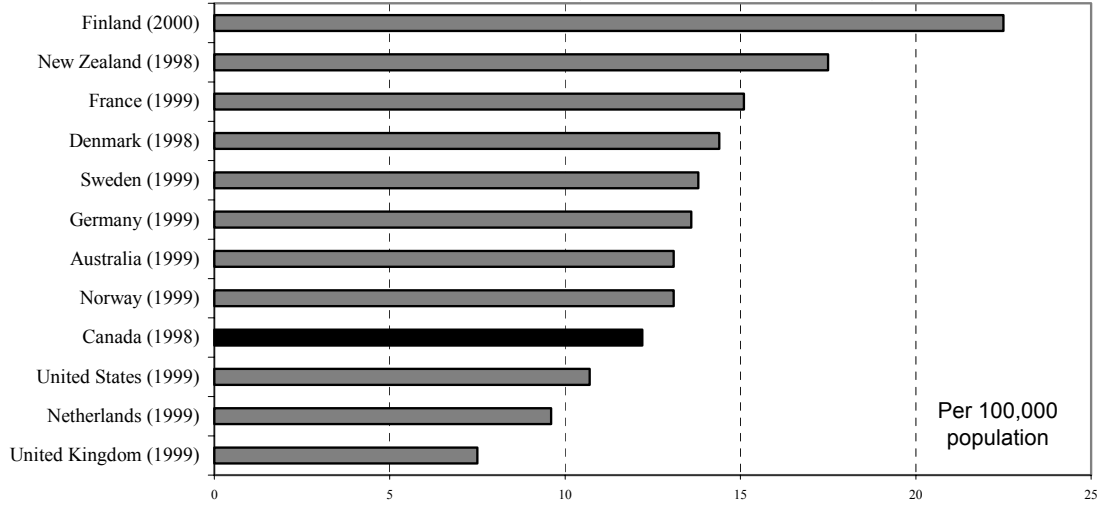
CHART 5.5
AGE-STANDARDIZED SUICIDE RATES IN CANADA BY PROVINCE, 1998



Source: Stéphanie Langlois and Peter Morrison, "Suicide Deaths and Suicide Attempts", *Health Reports*, Vol. 13, No. 2, January 2002.

²⁴¹ With the exception of the territories.

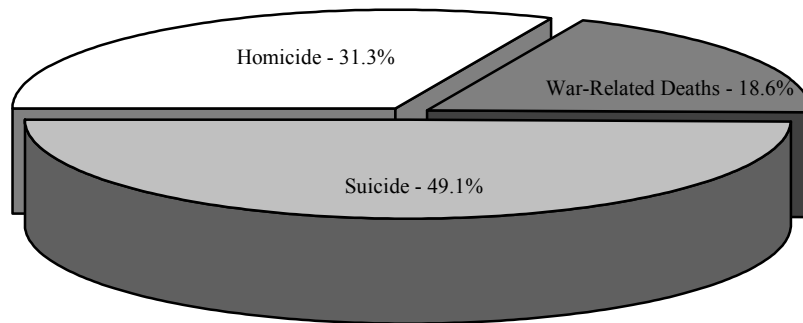
**CHART 5.6:
AGE-STANDARDIZED SUICIDE RATES, SELECTED COUNTRIES, 1998 TO 2000**



Source: Economics Division, Parliamentary Research Branch, Library of Parliament, March 2004. Data from the World Health Organization (2003).

Estimates from the WHO indicate that suicide is the leading cause of violent deaths worldwide, greater than homicide or war-related deaths (see Chart 5.7).

**CHART 5.7:
ESTIMATED VIOLENCE-RELATED DEATHS WORLDWIDE, 2000**



Source: World Health Organization, *World Report on Violence and Health*, Geneva, Table 1.2, October 2002, p. 10.

5.2.2 Attempted Suicides

While we know that the number of attempted suicides exceeds that of completed suicides, it is difficult to determine their number exactly. The World Health Organization estimates that there are as many as 20 attempts for every suicide death. In Canada, hospitalization rates are used as a measure of attempted suicides.

In 1998-1999, a total of 23,225 hospitalizations of Canadians aged 10 or older were related to attempted suicide and intentional self-inflicted injuries. Female hospitalization rates for attempted suicide were consistently higher than for males, except for the group 75 years and over (see Table 5.4). The hospitalization rate for attempted suicide among females peaked at age 15 to 19. Male hospitalization rates for attempted suicide were highest at ages 20 to 29 and 30 to 44. Hospitalization for attempted suicide was less common at older ages.

TABLE 5.4

HOSPITALIZATIONS FOR ATTEMPTED SUICIDE BY AGE GROUP AND SEX, CANADA, 1998-1999
(Rate Per 100,000 Age-Specific Population)

AGE GROUP	TOTAL	MALES	FEMALES
10 to 14	40.8	15.5	67.5
15 to 19	152.2	87.3	220.8
20 to 29	117.9	98.0	138.4
30 to 44	118.3	97.6	139.3
45 to 59	68.3	55.1	81.3
60 to 74	25.0	24.7	25.2
75 and over	21.0	27.6	17.2

Source: Stéphanie Langlois and Peter Morrison, "Suicide Deaths and Suicide Attempts", *Health Reports*, Statistics Canada, Catalogue 82-003, Vol. 13, No. 2, January 2002.

5.2.3 Suicidal Ideation

According to the CCHS, about 3.7% of Canadians aged 15 years and over had suicidal thoughts during the previous year (see Table 5.5). Women were slightly more likely than men to contemplate suicide (3.8% versus 3.6%). Suicidal ideation occurred three times more often among Canadians aged between 15 and 24 than those aged 65 or older (6.0% versus 1.7%).

TABLE 5.5

PERCENTAGE OF CANADIANS WHO HAD SUICIDAL THOUGHTS IN THE PAST 12 MONTHS, 2002

AGE GROUP	SUICIDAL THOUGHTS (%)
Total, 15 Years and Over	3.7
Men	3.6
Women	3.8
15-24 Years	6.0
Men	4.7
Women	7.3
25-64 Years	3.6
Men	3.7
Women	3.4
65 Years and Over	1.7
Men	1.3
Women	n.a.

n.a.: Not available due to extreme sampling variability.

Source: Economics Division, Parliamentary Information and Research Services, Library of Parliament, March 2004. Based on data from the [Canadian Community Health Survey, Cycle 1.2, Mental Health and Well-Being](#), 2002.

5.3 SPECIFIC POPULATION GROUPS: ABORIGINAL PEOPLES, HOMELESS PEOPLE AND INMATES

Although mental disorders affect individuals of all genders, ages and cultures, and in all occupations, educational and income levels, it appears that the prevalence in some population groups is higher than in others. This section provides information on the prevalence of mental illness among Aboriginal peoples, homeless people and inmates.

5.3.1 Aboriginal Peoples

There is a significant amount of missing information in respect of the range of mental health problems [among Aboriginal Canadians]. There have been no studies to date that have really used up-to-date psychiatric epidemiological methods to estimate the range of psychiatric disorders in Aboriginal communities. Instead, we have health surveys that ask some general questions about people's understanding of their problems, their experience and their sense of what the dominant problems are. [Dr. Laurence J. Kirmayer, Department of Psychiatry, McGill University, Proceedings (9:41)]

Although data on the prevalence of psychiatric disorders among Aboriginal peoples are quite limited, there is a consensus in the general literature that Aboriginal communities suffer significantly higher rates of mental illness, addiction and suicidal behaviour than the general population. What follows is a summary of key case studies and relevant findings.

- The Aboriginal Healing Foundation reported in 2003 on the mental health profiles of residential school survivors in British Columbia. Mental illness was indicated in all but two of the 127 case files examined. The most common mental disorders were post-traumatic stress disorder (64.2%), substance use disorder (26.3%) and major depression (21.1%). Half of those with post-traumatic stress disorder also had concurring mental disorders including substance use disorder (34.8%), major depression (30.4%); and, dysthymic disorder, a chronic form of depression (26.1%).²⁴²
- A 2002 report by Statistics Canada, which examined the health of the off-reserve Aboriginal population, found that Aboriginal peoples who live off-reserve were 1.5 times more likely than the non-Aboriginal population to have experienced a major depressive episode in the previous year. About 13% of the off-reserve Aboriginal population had experienced a major depressive episode in the year before the survey, compared with 7% for the non-Aboriginal population, suggesting that Aboriginal

²⁴² Aboriginal Healing Foundation, [*Mental Health Profiles for a Sample of British Columbia's Aboriginal Survivors of the Canadian Residential School System, Research Series*](#), Ottawa, 2003.

peoples living in urban areas may experience feelings of alienation, isolation, marginalization and cultural dislocation.²⁴³

- The Flower of the Two Soils Project (1993) examined the relation among academic performance, psychosocial variables and mental health in Aboriginal children aged 11 to 18 years at several sites in the United States and Canada. The Canadian locations included parts of Manitoba and British Columbia. Among Aboriginal respondents, the most frequent diagnoses were disruptive behaviour disorders (22%), substance use disorders (18.4%), anxiety disorders (17.4%), affective disorders, including depression (9.3%), and post-traumatic stress disorder (5.0%). Almost half of the children with behaviour and affective disorders also reported concurrent substance use disorders.
- The 1996 Report of the Royal Commission on Aboriginal Peoples found that the suicide rate of Aboriginal Canadians was roughly three times that of the general population. Amongst Aboriginal adolescents, suicide occurred roughly five to six times more frequently than for their non-Aboriginal counterparts. The Commission reported that suicide was the leading cause of death among males aged 10 years to 49 years.²⁴⁴
- A study by Chandler and Lalonde (1998), in which they surveyed 196 Aboriginal communities in British Columbia over a five-year period, found wide variation across communities in the prevalence of suicidal behaviour. Communities with some measure of self-government had the lowest rates of suicide. They also found that land claims and education were the second and third most important factors in predicting low suicide rates in Aboriginal communities.²⁴⁵

Experts in the field suggest that, while many of the causes of mental illness, addiction and suicidal behaviour in Aboriginal and non-Aboriginal communities may be similar, there are added cultural factors in Aboriginal communities that affect individual decision-making and suicidal ideation. These cultural factors include past government policies, creation of the reserve system, the change from an active to a sedentary lifestyle, the impact of residential schools, racism, marginalization and the projection of an inferior self-image.²⁴⁶

5.3.2 Homeless Peoples

Measuring the prevalence of homelessness and the personal characteristics and state of the health of homeless persons presents significant challenges. The “Pathways to Homelessness Project” in the City of Toronto attempted, over an 18-month period, to estimate the prevalence of mental illness and addiction among people who are homeless. Key findings about lifetime prevalence rates included:

²⁴³ Statistics Canada, “Health of the Off-Reserve Aboriginal Population”, *The Daily*, 27 August 2002.

²⁴⁴ Royal Commission on Aboriginal Peoples, *Choosing Life: A Special Report on Suicide Among Aboriginal Peoples*, 1995.

²⁴⁵ J.J. Chandler and C. Lalonde, “Cultural Continuity as an Hedge Against Suicide in Canada’s First Nations”, *Transcultural Psychiatry*, Vol. 35, No. 2, 1998, pp. 191-219.

²⁴⁶ Laurence J. Kirmayer, Gregory M. Brass and Caroline L. Tait, “The Mental Health of Aboriginal Peoples: Transformations of Identity and Community”, *Canadian Journal of Psychiatry*, Vol. 45, September 2000, pp. 607-616.

- Approximately 66% of homeless persons had a lifetime diagnosis of mental illness. This was 2-3 times the rate in the general population.
- About 66% of homeless persons had a lifetime diagnosis of substance abuse (of alcohol, marijuana and cocaine in particular), 4-5 times the rate in the general population.
- Some 86% of homeless persons had either a lifetime diagnosis of mental illness or substance abuse, 2-3 times the rate in the general population. In other words, only 14% of homeless persons exhibited no symptoms of either mental illness or substance abuse.
- Some 75% of homeless persons in every diagnostic category of mental illness also had substance abuse disorders.
- The lifetime prevalence rate of severe mental illness (psychotic disorders, including schizophrenia) was 5.7%, and that of mood disorder was 38%.
- Some 22% of homeless persons claimed that either mental illness (4%) or substance abuse (18%) was the reason for their becoming homeless.
- In the year immediately prior to becoming homeless, 6% of homeless persons had been in a psychiatric institution, 20% had received services for substance abuse, 25% had received psychiatric outpatient services, and 30% had spent time in police stations or jails.²⁴⁷

(...) contrary to popular misconceptions, only a small proportion of the homeless population suffers from schizophrenia, (...) affective [mood] disorders are much more common.

[Bill Cameron, Director General, National Secretariat of Homelessness, Brief to the Committee, 29 April 2004, p. 2.]

A causal relationship between homelessness and mental illness/addiction remains difficult to establish because mental disorders can lead to homelessness, but they can also be caused by homelessness given the traumatic impact of being destitute and living on the streets.

5.3.3 Inmates

Research studies are confirming that those with serious mental health problems are being “trans-institutionalized”: Canadian prisons have replaced former psychiatric hospitals or wards.

[Canadian Mental Health Association, Brief to the Committee, June 2003, p. 21.]

The prison population is another group in which mental illnesses and substance use disorders are more prevalent than in the general population. A study by Boe and Vuong

²⁴⁷ Mental Health Policy Research Group, [Mental Illness and Pathways into Homelessness: Proceedings and Recommendations](#), Toronto, 1998. Similar findings are reported by Stephen W. Hwang, “Homelessness and Health”, in [Canadian Medical Association Journal](#), Vol. 164, No. 2, pp. 229-233, 23 January 2001.

(2002) showed that, between 1997 and 2001, the percentage of new offenders with a diagnosis of mental illness on admission into federal custody rose from 6% to 8.5%, an increase of 40%. During the same period, the number of new offenders being prescribed medication to treat mental illness on admission increased by 80%, from approximately 10% to 18%.²⁴⁸

Data from Moloughney (2004) suggested that a high proportion of inmates have substance abuse problems on admission, with drug abuse being more commonly identified than alcohol abuse (see Table 5.6). His study showed that on average, some 3% of inmates were identified with a mental disorder at intake, with higher proportions in female (from 2.5% to 8.6%) than in male (from 1.4% to 3.3%) inmates. An average of 7% of male and female inmates were identified on psychological assessment as in need of immediate attention. Some 31% of female inmates and 15% of male inmates reported emotional or mental health problems at intake, and overall, 14% of inmates were under recent psychiatric or psychological treatment prior to incarceration. Substantial proportions of inmates (21% female and 14% male) had attempted suicide in the preceding 5 years.

Literature on offenders with mental disorders has shown that they are...

- more vulnerable to arrest because of their behaviour
- more likely entangled in a cyclical pattern of recurrent and brief encounters with both the mental health and criminal justice system
- found in both provincial and federal correctional systems as well as under the care of provincial health systems in specialized forensic facilities

[Correctional Service Canada, Brief to the Committee, April 2004, p. 3.]

There are no data from recent national studies that provide prevalence rates for specific mental disorders among federal inmates. The latest data are from 1988 for federal male inmates and 1989 for federal female inmates (see Table 5.7). Female inmates had substantially higher prevalence of all mental disorders than male inmates, with the exception of antisocial personality disorders.

²⁴⁸ Roger Boe and Ben Vuong, "Mental Health Trends Among Federal Inmates", *FORUM on Corrections Research*, Vol. 14, no. 2, May 2002.

TABLE 5.6

PROPORTION OF INMATES IDENTIFIED AT INTAKE WITH MENTAL HEALTH PROBLEMS, 2002

	MALE			FEMALE		
	Min.	Med.	Max.	Min.	Med.	Max.
Alcohol Abuse	34.3	45.8	42.1	29.3	49.4	69..6
Drug Abuse	36.4	51.2	51.4	40.1	67.5	78.3
Appears mentally disordered	1.4	2.9	3.3	2.5	4.4	8.6
Emotional/mental health requiring immediate attention	4.4	7.3	7.6	6.8	15.4	17.1
Reporting emotional/mental health problems	11.4	15.7	13.6	17.08	40.4	37.1
Recent mental health intervention/hospitalization	10.6	14.5	15.3	12.2	24.7	19.6
Shows signs of depression	9.0	9.7	9.4	8.8	16.2	2.2
Previous suicide attempt(s)	9.5	14.5	16.4	10.9	23.4	41.3
May be suicidal	3.4	5.2	5.5	2.7	5.8	6.5

Nota: Min., Med. And Max. refer to minimum, medium and maximum security.

Source: Brent Moloughney, "A Health Care Needs Assessment of Federal Inmates in Canada", *Canadian Journal of Public Health*, Vol. 95, Supplement 1, March-April 2004, p. S37.

TABLE 5.7

LIFETIME PREVALENCE (%) OF MENTAL DISORDERS AMONG FEDERAL INMATES, CANADA

DISORDER	MALE (1988)	FEMALE (1989)
Major Depression	13.6	32.9
General Anxiety Disorder	31.9	19.7
Psychosocial Dysfunction	19.6	34.2
Antisocial Personality Disorder	57.2	36.8
Alcohol Use/Dependence	47.4	63.2
Drug Use/Dependance	41.6	50.0

Source: Correctional Service Canada, Brief to the Committee, April 2004, p. 9.

No studies have been done to determine if the prevalence rates of mental illnesses and substance use disorders among federal inmates have changed over time. Officials from Correctional Service Canada are of the view, however, that, based on recent trends, the percentage of the federal inmate population with mental health problems and disorders is growing, even though overall prison admissions and the institutional population counts are in decline.²⁴⁹

²⁴⁹ Correctional Service Canada, Brief to the Committee, April 2004, p. 13.

5.4 ECONOMIC BURDEN OF MENTAL ILLNESS, ADDICTION AND SUICIDE

5.4.1 The Cost of Mental Illness

According to Stephens and Joubert (2001), the economic burden of mental illnesses (substance use disorders were not included in their study) in Canada was estimated to be \$14.4 billion in 1998; direct health care costs amounted to \$6.3 billion, and indirect costs related to lost productivity and premature death totalled \$8.1 billion.²⁵⁰ The relative magnitude of the major cost components is given in Table 5.8. Hospital care represented by far the largest direct cost, at \$3.9 billion (26.9%) of the total burden of mental illness.

TABLE 5.8

ECONOMIC BURDEN OF MENTAL ILLNESSES IN CANADA, 1998

Cost Component	In Millions of Dollars	Percentage of total
Direct Costs (Health Care)⁽¹⁾:	6,257	43.5
▪ Medications	642	4.5
▪ Physicians	854	5.9
▪ Hospitals	3,874	26.9
▪ Other Health Care Institutions	887	6.2
Indirect Costs (Lost Productivity):	8,132	56.5
▪ Short Term Disability ⁽²⁾	6,024	40.6
▪ Long Term Disability	1,708	11.9
▪ Premature Death	400	2.7
Total	14,389	100.0

(1) This category also includes \$278 million in professional costs for social workers and psychologists incurred as a result of depression or distress.

(2) Attributable to depression and distress only.

Source: Thomas Stephens and Natacha Joubert, "The Economic Burden of Mental Health Problems", *Chronic Diseases in Canada*, Vol. 22, No. 1, 2001.

The principal indirect cost component was the value of short term disability, estimated at \$6.0 billion, or some 40.6% of the total economic burden. The authors stressed that their data under-estimated the true situation due to the limitation of their dataset (only depression and distress were included were covered in their survey).

In 1998, mental illnesses accounted for 4.9% of the overall cost (direct and indirect) of disease in Canada. As such, they ranked seventh among all diseases, behind cardiovascular diseases (11.6%), musculo-skeletal diseases (10.3%), cancer (8.9%), injuries (8.0%), respiratory diseases (5.4%) and diseases of the nervous system (5.2%).²⁵¹ Mental illnesses were second only to cardiovascular disease in terms of direct health care costs alone.²⁵² In

²⁵⁰ Thomas Stephens and Natacha Joubert, "The Economic Burden of Mental Health Problems", *Chronic Diseases in Canada*, Vol. 22, No. 1, 2001.

²⁵¹ Health Canada, *Economic Burden of Illness in Canada, 1998*, Government of Canada, 2002.

²⁵² *Ibid.*

terms of indirect costs, mental illnesses ranked fourth as the main cause of long term disability, behind musculo-skeletal diseases, diseases of the nervous system and cardiovascular diseases.²⁵³

A joint study by the World Health Organization, the World Bank and Harvard University – *The Global Burden of Disease Study* – estimated that mental illness, including suicide, accounts for 10.5% of the total burden of disease worldwide. Their projections show that this proportion could increase to almost 15% in 2020.²⁵⁴ This study developed a single measure to allow comparison of the burden of disease across many different disease conditions. This measure, called the Disability Adjusted Life Year (DALY), reflects the number of years of healthy life lost due to premature death or disability. The study revealed that in established market economies, unipolar major depression ranks only second to ischemic heart disease in terms of DALYs. In comparison, cardiovascular disease and alcohol abuse rank 3rd and 4th respectively in terms of leading sources of DALYs. Schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder also contribute significantly to the total burden of illness as measured in terms of DALYs.²⁵⁵

In its 2001 report, the WHO stressed that the economic burden of mental illness is wide-ranging, long lasting and huge – but remains largely underestimated. In particular, in addition to meeting the expenses of treatment, the burden for families in which one member suffers from a mental illness ranges from economic difficulties to emotional reactions to the illness, from the stress of coping with disturbed behaviour, to the disruption of household routine and the restriction of social activities.²⁵⁶

5.4.2 The Cost of Substance Abuse

The total cost (direct and indirect) of alcohol abuse was estimated at \$7.5 billion in Canada in 1992, while the cost of illicit drug abuse amounted to some \$1.2 billion (see Table 5.9). The largest economic costs of alcohol abuse were \$4.1 billion for lost productivity due to illness and premature death, \$1.4 billion for law enforcement and \$1.3 billion in direct health care costs. Similarly, the greatest cost associated with illicit drug abuse was lost productivity due to illness and premature death (\$823 million), followed by law enforcement (\$400 million) and direct health care costs (\$88 million).

²⁵³ *Ibid.*

²⁵⁴ The information on The Global Burden of Disease is well summarized by the National Institute of Mental Health, *The Impact of Mental Illness on Society*, January 2001. This fact sheet is available at www.nimh.nih.gov.

²⁵⁵ *Ibid.*

²⁵⁶ WHO (2001), pp. 24-25.

TABLE 5.9

THE COST OF ALCOHOL AND ILLICIT DRUG ABUSE IN CANADA, 1992

	ALCOHOL	ILLICIT DRUGS	TOTAL
	Millions of Dollars		
Direct Costs:	3,385.6	547.9	3,933.5
Health Care	1,300.6	88.0	1,388.6
Workplace (e.g.: EAP)	14.2	5.5	19.7
Social Programs	52.3	1.5	53.8
Prevention and Research	141.4	41.9	183.3
Law Enforcement	1,359.1	400.3	1,759.4
Other Costs	518.0	10.7	528.7
Indirect Costs (Productivity Losses Due To)::	4,136.5	823.1	4,959.6
Morbidity	1,397.7	275.7	1,673.4
Mortality	2,738.8	547.4	3,286.2
TOTAL	7,522.1	1,371.0	8,893.1

Source: Eric Shingle, Linda Robson, Xiaodi Xie, Jurgen Rehm *et. al.*, *The Costs of Substance Abuse in Canada*, Canadian Centre on Substance Abuse, 1996 (<http://www.ccsa.ca/>).

5.4.3 The Cost of Suicide

To date, no national figures on the economic cost of suicide deaths are available, although a 1996 study in New Brunswick estimated the average cost per suicide death (direct and indirect) to be \$850,000.²⁵⁷

5.5 COMMITTEE COMMENTARY

Canada currently lacks a national information base to enable us to identify accurately the prevalence of either mental illness or addiction, to measure the mental health status of Canadians and to assist in the evaluation of policies, programs and services in the fields of mental health, mental illness and addiction. This is a major impediment to determining the need for and the level of provision of appropriate and adequate treatments and services. The recent release of Statistics Canada’s Canadian Community Health Survey (CCHS) has helped to alleviate this situation by providing, for the first time, a set of data on some mental illnesses, substance use disorders and gambling. However, the Committee feels that this survey should be repeated soon and that its base should be expanded to cover a wider range of disorders. We also believe that a national study, like the one being planned in Australia, should be undertaken to assess the prevalence rates of mental disorders among children and adolescents.

The economic burden of mental illness, addiction and suicidal behaviour is enormous. It is clear that governments must take the necessary steps to contain or reduce such a heavy burden. The Committee concurs with the Canadian Psychological Association that mental

²⁵⁷ Dale Clayton and Alberto Barceló, “The Cost of Suicide Mortality in New Brunswick, 1996”, *Chronic Diseases in Canada*, Vol. 20, No. 2, 1999, pp. 89-93.

health is as essential to a healthy society as physical health. We believe that now is the time to develop mental illness and addiction policies and programs that reflect their burden, social and financial, to Canadian society.

The indirect costs attributable to mental illness and addiction – the cost of absenteeism and lost productivity – are substantial and exert great pressures in the workplace. In contrast to other illnesses, the indirect costs of mental disorders appear to be higher than the associated direct health care costs. In the next chapter, we examine the prevalence and consequences of mental illness and addiction in the workplace.

Mental health is at the core of a healthy society. The prevention and treatment of mental illness and addiction require the same attention and resources as any other disease based on prevalence, burden and outcomes research.

[Canadian Psychological Association, Brief, 2003, p. 12]

CHAPTER 6: MENTAL ILLNESS, ADDICTION AND WORK

The effects of mental health are not just mental. (...) What is good for individual mental health is good for firm performance.
[Professor E. Kevin Kelloway, Saint Mary's University, Halifax]²⁵⁸

INTRODUCTION

The relationship between mental illness/addiction and work can be characterized as bi-directional. On the one hand, mental illness and addiction are a major cause of absenteeism from work, under-performance, employee turnover and reduced productivity. On the other hand, the workplace can be a major cause of stress affecting mental health and work performance. Some forms of workplace stress may even trigger the onset of mental illnesses and/or substance use disorders.

Whatever the direction of causality between mental illness and work, there is strong consensus among those who testified before the Committee that the workplace is a critical environment for the promotion of mental health, the early detection of mental illness and addiction, and the accommodation/integration of employees suffering from mental disorders. Such attributes of a healthy workplace will benefit not only the individual and the employer but society as a whole by enhancing Canada's productivity and reducing the overall economic burden of mental illness.

The employers have a vested interest to support a strong mental health system as a result of absenteeism, or loss of productivity, and financial losses.

[Rod Phillips, President and CEO, Warren Shepell Consultants, (18:9)]

This chapter is divided into nine sections. Section 6.1 briefly describes the benefits of employment and the consequences of unemployment for individuals with mental illness and addiction. Section 6.2 summarizes the existing information on the prevalence of mental illness and addiction in the workplace. Section 6.3 provides some data on the cost related to mental illness and addiction in the workplace. Section 6.4 examines the issue of disability attributable to mental illness and addiction. Section 6.5 highlights the role of employers with respect to Employee Assistance Programs and accommodation for workers with mental illness. Section 6.6 summarizes the testimony heard by the Committee with respect to the role of governments in helping to reduce the economic cost of mental illness and addiction in the workplace. Section 6.7 provides some information on businesses established and run by individuals with mental illness and addiction. Section 6.8 discusses the need for a research agenda on mental illness, addiction and work. Section 6.9 presents the Committee's commentary.

²⁵⁸ E. Kevin Kelloway, Ph.D., Professor of Management and Psychology, Saint Mary's University (Halifax, Nova Scotia), Brief to the Committee, 2004.

6.1 THE BENEFITS OF EMPLOYMENT

Recently, Professor Heather Stuart, Community Health and Epidemiology, Queen's University, eloquently pointed out that:

(...) no single activity conveys a sense of self more so than work. Work influences how and where one lives, it promotes social contact and social support, and it confers title and social identity.²⁵⁹

For those affected by mental illness and addiction, employment is an important contributor to recovery. It may aid recovery and reduce the frequency and severity of episodes of acute illness by providing structure, the opportunity for social connections and a fuller life. Through regular remuneration, employment can end or reduce dependence on social assistance and reduce individual need for mental health services and supports.

In contrast, loss or lack of employment due to mental illness may jeopardize a person's recovery. Income and standard of living are reduced, resulting in economic dependence and low self-esteem. Inadequate employment also leads to the loss of personal relationships with fellow workers, social marginalization and changed relationships with family and friends.

Many individuals with mental illness succeed in their employment without any assistance being provided to them; recent advances in treatment and drug therapy have increased their capacity to join the mainstream and live independently. Those who participate in the labour force contribute to Canada's productivity and competitiveness. Others, however, need assistance to get and keep a job. In this context, the issue of mental illness, addiction and work can be explored from three different perspectives. The first addresses the issue of making employment accessible to individuals who never had a job. The second emphasizes mental illness and addiction that may affect currently employed individuals. The third focuses on individuals who have lost their job due to mental illness or addiction and wish to reintegrate the labour market.

As discussed in Chapter 4, the onset of a mental disorder tends to occur in late adolescence or early adulthood, at a time when the affected person's education and training are not yet complete. The process of obtaining qualifications is interrupted, often never to be resumed. The young individuals affected are significantly disadvantaged, as their lack of skills and qualifications is a major lifelong barrier to their future employment.

For those who do find work, periods outside the labour force caused by their mental illness often impede re-entry into the labour force. Three key barriers apply. First, individuals may be subject to discrimination by their employer and/or work colleagues. Second, they may require flexible work arrangements that employers are unwilling, or do not know how to provide. And third, those who have been outside of the labour force for extended periods are unlikely to possess the type of credentials, skills and employment experiences that make them attractive to employers.

²⁵⁹ Heather Stuart, *Stigma and Work*, discussion paper commissioned by the workshop supported by the Institute of Population Health and the Institute of Neurosciences, Mental Health and Addiction of the Canadian Institutes of Health Research, April 2004, p. 80.

The Committee was told that unemployment rates among individuals with mental illness are unacceptably high. International evidence suggests that the unemployment rate of individuals affected by severe and persistent mental illness is around 90%. This contrasts with the approximately 50% unemployment rate of individuals with physical or sensory disabilities. In other words, only 10% of individuals with severe mental disorders who wish to work are judged capable of working and are in fact working.²⁶⁰

In Canada, information from the Canadian Psychiatric Association reveals that persons diagnosed with a mental illness are likely to experience long term unemployment, underemployment and dependency on social assistance. The Association believes that, of all individuals with disabilities, those with a mental illness face the highest degree of stigmatization in the workplace and the greatest barriers to employment opportunities.²⁶¹ A major problem with unemployment is that the longer a person is away from a job, the less likely it is that he or she will ever resume a productive work life. Statistics show that after six months on disability leave an individual has a 50% probability of returning to work; this is reduced to 20% after one year, and to 10% after two years.²⁶²

Two main factors make mental illness specifically a workplace issue. First, mental illness usually strikes younger workers. Second, many mental illnesses are both chronic and cyclical in nature, requiring treatment on and off for many years. There is a vital role for employers and government to play in addressing mental illness and addiction in the workplace, including through accommodation policies, return to work programs and disability management.

In saying this, the Committee is not suggesting that this is an easy or an inexpensive task for either employers or governments. Nevertheless, we feel strongly that increased attention to workplace mental health and addiction issues is essential.

6.2 PREVALENCE OF MENTAL ILLNESS AND ADDICTION IN THE WORKPLACE

There is currently no single source of information available in Canada that provides comprehensive and accurate information on the prevalence of mental illness and addiction in the workplace. However, a review of the relevant literature provides some indication of the scope of the problem:

- Addiction (alcohol and drug abuse) is a serious concern in the Canadian manufacturing sector. The rate of addiction among employees in this sector is estimated to be almost twice the national average; this may be a substantial underestimate given that addiction in the workplace is often not reported. Levels of

²⁶⁰ Gaston Harnois and Phyllis Gabriel (2000), *Mental Health and Work: Impact, Issues and Good Practices*, joint publication of the World Health Organization and the International Labour Organization, Geneva, 2000, p. 19.

²⁶¹ Canadian Psychiatric Association, *Mental Illness and Work*, pamphlet available on the Internet (accessed on 15 June 2004).

²⁶² Ontario Medical Association, *Mental Illness and Workplace Absenteeism: Exploring Risk Factors and Effective Return to Work Strategies*, April 2002.

- anxiety and anger have been rising significantly among employees in the manufacturing sector over the last three years. A survey has shown anxiety disorders in the manufacturing sector to be more prevalent in male-dominant populations in which addictions issues are also present.²⁶³
- Compared to national averages, the rates of depression and anxiety are high in the information technology sector. Depression rates vary widely from one year to another, reflecting the volatility of the technology sector.²⁶⁴
 - Some segments of the workforce appear to be more vulnerable to mental illness and addiction, in particular men and women in their prime working years who have had 10 to 14 years of service with the same employer, and new entrants to the labour market.²⁶⁵
 - A recent survey indicates that more and more hospital workers are accessing employee assistance programs. Hospital workers are experiencing progressively higher levels of stress than workers in other sectors. This may be explained in part by hospital restructuring, downsizing and human resource shortages. Addressing stress in the hospital sector may be even more important than in other sectors since stress-related errors in patient care can have a very negative impact on patients.²⁶⁶
 - Similarly, a survey by the Canadian Medical Association in 2003 reported that stress and dissatisfaction among physicians was rising. More particularly, the survey found that 45.7% of physicians were in an advanced state of burnout. In addition, women physicians appeared to be at a higher risk of suicide than others in the general population.²⁶⁷
 - Relative to other sectors, workers in the retail and hospitality sectors face a number of particular stress factors in their work environments, for example, the occurrence and threat of armed robbery. Individuals working in the retail sector also report a higher incidence of domestic violence. Employees of both the retail and hospitality sectors report greater stress and depression symptoms than employees in most other sectors. Workers in the hospitality sector experience a higher frequency of substance use, including alcohol and tobacco, and a higher incidence of distress and anxiety than other workers.²⁶⁸

²⁶³ Based on a sample size of 136 companies and 54,050 employees. Data from Warren Shepell Consultants Corporation, *Sector Review: Organizational Health & Wellness Trends in Manufacturing*, March 2003 (available at www.warrenshepell.com).

²⁶⁴ Based on a sample size of 153 organizations with 86,000 employees across Canada. Data from Warren Shepell Consultants Corporation, *Sector Review: Organizational Health & Wellness: Trends in Technology*, February 2003 (available at www.warrenshepell.com).

²⁶⁵ Global Business and Economic Roundtable on Addiction and Mental Health, *Roundtable Roadmap to Mental Disability Management in 2004-2005*, 25 June 2004, p. 4.

²⁶⁶ Warren Shepell Consultants Corporation, *Sector Review: Organizational Health & Wellness Trends in the Healthcare/Hospital Sector*, Winter 2004 (available at www.warrenshepell.com).

²⁶⁷ Dr. Sunil V. Patel, President, Canadian Medical Association, Brief to the Committee, 31 March 2004, p. 3.

²⁶⁸ Warren Shepell Consultants Corporation, *Sector Review: Organizational Health & Wellness Trends in Retail/Hospitality*, Winter 2004 (available at www.warrenshepell.com).

- The Canadian Bar Association reported alarming and increasing rates of depression and addiction among lawyers. The rate of alcoholism is three times that of the general population. It has been suggested that excessive working hours, relentless competition, and unyielding pressures by law firms for increased billable hours are important contributors to these problems.²⁶⁹
- In the Canadian workforce overall, some 3.5% of women and 3.0% of men report psychological distress (defined as depression and anxiety). Psychological distress tends to be high among workers in jobs with high demands but little latitude for decision-making. About 40% of workers in such jobs indicated high levels of psychological distress (see Table 6.1 below).²⁷⁰

TABLE 6.1

PERCENTAGE OF CANADIAN WORKERS REPORTING HIGH PSYCHOLOGICAL DISTRESS BY JOB DECISION LATITUDE AND JOB DEMANDS

JOB DEMANDS	JOB DECISION LATITUDE			
	High	Moderate	Low	Very Low
High	27	33	33	40
Moderate	24	26	30	35
Low	19	20	21	30
Very Low	16	18	22	20

Source: Kathryn Wilkins and Marie P. Beaudet, "Work Stress and Health", *Health Reports*, Statistics Canada, Catalogue 82-003, Winter 1998, Vol. 10, No. 3, p. 52.

- In Québec, a 2001 study by Bourbonnais and colleagues found that individuals who experienced work-related stress were twice as likely to have a mental illness than those who did not (23% versus 11% for men and 30% versus 15% for women).²⁷¹
- Workplace stress and work-related conflict and harassment are among the top eight reasons why Canadian employees request help from an Employee's Assistance Program (EAP). Stress associated with work-related issues accounts for about 40% of all work-related EAP cases. The number of employees seeking help for work-related conflict has increased from 23 percent of all work related cases in 1999 to

²⁶⁹ Bill Wilkerson, *Since September 11th – The Business State of Mind: Mental Health in the Knowledge Economy*, Speech before the "Beyond Awareness Conference (A Campaign to Reduce the Stigma of Mental Illness)", 6 February 2002, p. 7.

²⁷⁰ Kathryn Wilkins and Marie P. Beaudet, "Work Stress and Health", *Health Reports*, Statistics Canada, Catalogue 82-003, Winter 1998, Vol. 10, No. 3, pp. 52-53.

²⁷¹ Renée Bourbonnais, Brigitte Larocque, Chantal Brisson and Michel Vézina, «*Contraintes psychosociales du travail*», in *Portrait Social du Québec*, Institut de la Statistique du Québec, 2001, pp. 267-277.

close to nearly 30 percent in 2001. The number of employees seeking help for harassment almost tripled from 1999 to 2001.²⁷²

- In the United States, 40% of all EAP referrals in several leading companies relate to symptoms of depression.²⁷³

6.3 THE COST AND CONSEQUENCES OF MENTAL ILLNESS AND ADDICTION IN THE WORKPLACE

In the labour market, productivity can be linked to the concept of disability. More precisely, the less disabled a worker, the more productive she/he is and *vice versa*. Productivity is affected both by ‘presenteeism’ – days during which an individual is present at work but functions at less than full capacity – and by absenteeism – days during which an employee did not report to work.

Mental illness and addiction are among the most important causes of absenteeism and presenteeism worldwide: the 1998 report of the World Health Organization stated that “more working days are lost as a result of mental disorders than physical conditions.”²⁷⁴ In Canada, 20% of the normal work time of employees suffering from an undetected mental illness or addiction is not productive because it is “taken off”. This is four times the rate of their co-workers.²⁷⁵

When compared with all other diseases (such as cancer and heart disease), mental illness and addiction rank first and second in terms of causing disability in Canada, the United States and Western Europe (see Chart 6.1).²⁷⁶ Of the ten leading causes of disability worldwide, five are mental disorders: unipolar depression, alcohol use disorder, bipolar affective disorder, schizophrenia and obsessive-compulsive disorder.²⁷⁷

We would suggest that employers are already bearing a significant burden of the costs associated with mental health in Canada. In that sense, they are subsidizing what we have in the public health care system and, in some cases, compensating for deficiencies in that system.

[Rod Phillips, President and CEO, Warren Shepell Consultants (18:9)]

As reported in Chapter 5, the value of lost productivity in Canada that is attributable to mental illness alone has been estimated at some \$8.1 billion in 1998.²⁷⁸ More recently, it has been estimated that if substance abuse is taken into account as well, Canada’s economy loses

²⁷² Warren Shepell Consultants Corporation, [Workplace Trends Linked to Mental Health Crisis in Canada](#), Press Release, 15 November 2002.

²⁷³ Bill Wilkerson, [A Business Charter for Mental Health and Addiction in the Knowledge Economy](#), Speech to the Ontario Public Service Commission and Management Board, 25 September 2002, Toronto, p. 9.

²⁷⁴ World Health Organization, [Life in the 21st Century: A Vision for All](#), Geneva, 1998.

²⁷⁵ Bill Wilkerson, [Text of Speech](#), Warren Shepell Consultants Business Forum, 16 October 2002, p. 14.

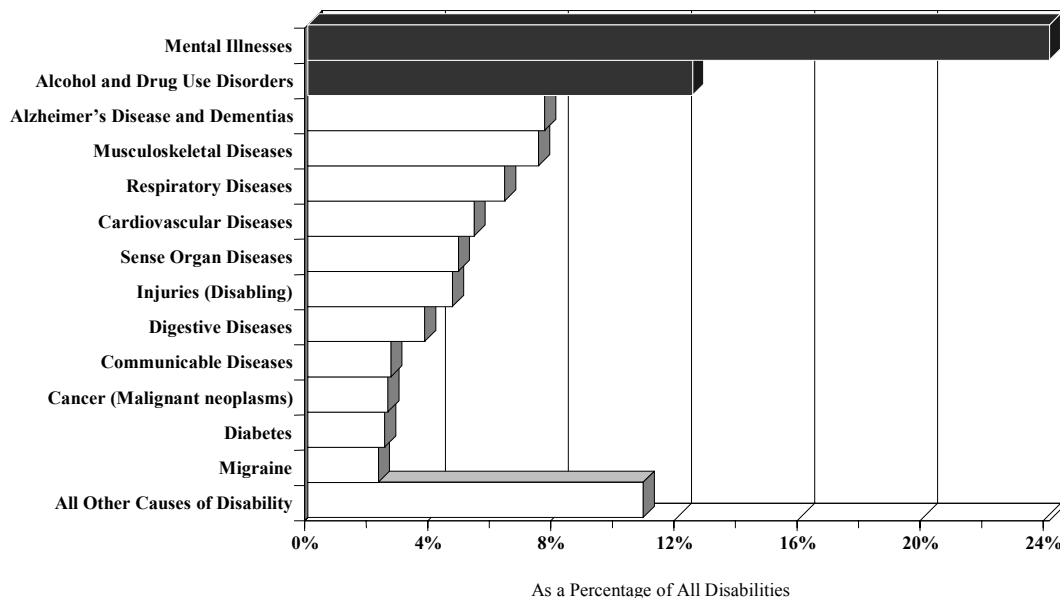
²⁷⁶ President’s New Freedom Commission on Mental Health, [Interim Report](#), United States, 29 October 2002.

²⁷⁷ *Ibid.*

²⁷⁸ According to calculation by Thomas Stephens and Natacha Joubert, “The Economic Burden of Mental Health Problems”, [Chronic Diseases in Canada](#), Vol. 22, No. 1, 2001.

some \$33 billion annually to lost productivity caused by mental illness and addiction.²⁷⁹ This corresponds to 19% of the combined corporate profits of all Canadian companies or to 4% of the national debt.²⁸⁰ In other words, the business sector pays two-thirds of all costs associated with mental illness and addiction in the form of lost productivity, absenteeism, disability, wage replacement costs, employee group health care premiums and prescription drugs.²⁸¹

CHART 6.1
CAUSES OF DISABILITY
CANADA, THE UNITED STATES AND WESTERN EUROPE, 2000



Note: Causes of disability for all ages combined. Measures of disability are based on the number of years of “healthy” life lost with less than full health (ie. YLD, years lost due to disability).
Source: President’s New Freedom Commission on Mental Health, [Interim Report](#), United States, 29 October 2002.

Overall, there are many consequences deriving from mental illness, addiction and work-related stress in the workplace (see Table 6.2). The Committee heard repeatedly that no one benefits from ignoring the existence of mental illness, addiction and occupational stress in the workplace and from the marginalization of potentially productive citizens— not the affected individuals, nor employer, nor society at large. Given both the economic and social costs associated with these disorders, it is essential that the public and private sectors urgently address the issue.

²⁷⁹ Martin Shain et. al., *Mental Health and Substance Use at Work: Perspective from Research and Implications for Leaders*, Backgrounder, prepared for the Global Business and Economic Roundtable on Addiction and Mental Health, 14 November 2002 (unpublished).

²⁸⁰ Estimated by the Economics Division, Parliamentary Information and Research Services, Library of Parliament.

²⁸¹ Bill Wilkerson (6 February 2002), p. 8.

Again, as the Committee noted at the end of Section 6.1, addressing this issue is not a simple task. Nonetheless, there are both economic reasons and compassionate ones that require that it be done.

TABLE 6.2

CONSEQUENCES OF MENTAL ILLNESS, ADDICTION AND WORK-RELATED STRESS IN THE WORKPLACE

Absenteeism	<ul style="list-style-type: none"> • increase in overall sickness absence, particularly frequent short periods of absence • poor health (depression, stress, burnout) • physical conditions (high blood pressure, heart disease, ulcers, sleeping disorders, skin rashes, headache, neck- and backache, low resistance to infections)
Presenteeism	<ul style="list-style-type: none"> • reduction in productivity and output • increase in error rates • increased number of accidents • poor decision-making • deterioration in planning and control of work
Staff Attitude And Behaviour	<ul style="list-style-type: none"> • loss of motivation and commitment • burnout • staff working increasingly long hours but with diminishing returns • poor timekeeping • labour turnover (particularly expensive for companies at top levels of management)
Relationships at Work	<ul style="list-style-type: none"> • tension and conflicts between colleagues • poor relationships with clients • increase in disciplinary problems

Source: Gaston Harnois and Phyllis Gabriel, [Mental Health and Work: Impact, Issues and Good Practices](#), joint publication of the World Health Organization and the International Labour Organization, Geneva, 2000, pp. 8-9.

6.4 MENTAL ILLNESS, ADDICTION AND DISABILITY

Coverage for disability resulting from psychiatric disorder should be available just as it is for disability resulting from either medical or surgical illness.
[Canadian Psychiatric Association]²⁸²

The unpredictable and episodic nature of disability resulting from mental illness is an important factor that distinguishes it from many other disabilities. Individuals with mental

²⁸² Canadian Psychiatric Association, [Insurability of the Psychiatrically Ill or Those With a Past History of Psychiatric Disorder](#), Position Paper, 1988.

illness tend to cycle between periods of illness and wellness. When they are symptom-free, they are usually able to work and carry out the normal tasks of life. During episodes of psychiatric illness, however, they may be incapable of functioning at a level that would permit them to work in regular employment.

The Committee was informed that disability claims attributable to mental illness have overtaken claims associated with cardiovascular disease as the fastest growing category of disability costs in Canada.²⁸³ Currently, mental illness and addiction account for 60-65% of all disability insurance claims among selected Canadian and American employers.²⁸⁴ It is expected that disability insurance claims for mental health problems and illnesses may climb to more than 50% of the total number of claims administered through employee group health plans over the next five years.²⁸⁵

Mental illness and addiction in Canada generates tremendous suffering and disability – a situation we do not believe would be tolerated for physical illnesses of similar prevalence and severity.

[Centre for Addiction and Mental Health, Brief to the Committee, 27 June 2003, p. 6.]

The following sections provide information on the disability insurance claims associated with mental illness and addiction available through employer sponsored disability benefit plans, workers' compensation boards (WCBs), the Canada Pension Plan Disability program (CPP(D)) and Employment Insurance (EI).

6.4.1 Employer-Sponsored Disability Insurance Plans²⁸⁶

There are two types of disability income insurance plans offered by employers: short term (STD) and long term disability (LTD). STD plans replace a percentage of pre-disability employment earnings (70% for example) for periods less than one year of duration (e.g., six months). They are generally harmonized with sick leave, other employee benefits and EI benefits, providing continuity of income for the plan member who has suffered a disabling illness or injury.

LTD plans focus on longer periods of disability. They typically commence payments after the disabled individual has been off work for a significant period, such as six months, and replace a specified percentage of the person's pre-disability employment income, for example 70%. LTD benefits typically run for up to two years for recipients who are unable to perform their own jobs, and can continue to a limit of age 65 or the onset of retirement benefits for recipients who cannot perform their own or any reasonably comparable job. LTD benefits provided by the employer's plan may be reduced by the amount obtained by the recipient under CPP(D).

²⁸³ Mental Health Works, *Mental Health in the Workplace: Facts and Figures*, Canadian Mental Health Association – Ontario Division, 2003.

²⁸⁴ Global Business and Economic Roundtable on Addiction and Mental Health (25 June 2004), p. 14.

²⁸⁵ Bill Wilkerson, *Mental Health – The Ultimate Productivity Weapon*, Summary of Remarks to the Industrial Accident Prevention Association Conference and Trade Show, Toronto, 22 April 2002, p. 5.

²⁸⁶ Unless otherwise indicated, the information contained in this section is based on the following document: Canadian Life and Health Insurance Association Inc., *The Role of Disability Income Insurance Plans in Canada's Disability Income System*, Submission to the House of Commons Sub-Committee on the Status of Persons with Disabilities, May 2003.

An important aspect of STD and LTD plans is the commitment to assist recipients to return to the workplace, preferably to their own jobs, or to another job if that proves not to be feasible. Consistent with this commitment, disability income insurance plans are designed to ensure that there is a financial incentive for recipients to return to work; thus disability income replacement benefits do not exceed and are usually less than pre-disability employment income.²⁸⁷

There is no comprehensive Canadian survey that provides information on the total cost borne by employers for STD and LTD benefits associated with mental illness and addiction. The information given to the Committee on this issue is summarized below:

- Since 1994, depressive disorders alone have doubled as a percentage of STD and LTD claims and have grown 55% across all categories of disability-related absences from work.²⁸⁸
- Similarly, a 2002-2003 survey by Watson Wyatt Worldwide estimated that mental illness and addiction were the leading cause of STD claims, and 73% of the respondents confirmed that these disorders were also the leading cause of LTD claims.²⁸⁹
- An analysis by the Global Business and Economic Roundtable on Addiction and Mental Health estimates that between 640,000 and 1,075,000 full-time employees in Canada are currently on disability leave with mental illness as their primary or secondary diagnosis. This translates into 35 million days of work lost for the Canadian economy. In other words, mental illness and addiction account for 46% of all long term and short term disability claims.²⁹⁰

Three specific issues were raised with respect to employer-sponsored disability insurance plans. First, Watson Wyatt Worldwide, a global consulting firm focussing on human resources and group benefits and health care plans, stressed that all corporations should conduct a review of their STD and LTD claims in order to properly assess the incidence of mental illness and addiction in their workplaces. The results of the review would help to identify the type of action that is required.²⁹¹

Second, it would be important to understand the influence that the type and extent of disability coverage have on the duration of claims in order to determine the conditions necessary to optimize individual situations. Disability insurance should not be a disincentive to work. In this context, the Canadian Psychiatric Association explained:

²⁸⁷ Disability income insurance plans are frequently part of a group benefits program that includes extended health care coverage (which may include prescription drugs, special nursing services, and special services that fall outside government plans such as registered psychologists, chiropractors, massage therapists, etc.).

²⁸⁸ Bill Wilkerson (6 February 2002), p. 7.

²⁸⁹ Watson Wyatt Worldwide, *Addressing Mental Health in the Workplace*, June 2003.

²⁹⁰ Global Business and Economic Roundtable on Addiction and Mental Health, "Full-Time Employees in Canada Losing 35 Million Days of Work a Year Due to Mental Disorders; Half of All Days Lost to Illness and Disability", Press Release, 14 July 2004.

²⁹¹ Watson Wyatt Worldwide, *Addressing Mental Health in the Workplace*, June 2003.

Disability insurance for any illness requires a precise definition of that illness. Whereas it is important that disabled psychiatric patients receive an adequate income to protect themselves from serious financial reverses over the time that they are not able to work, it is just as important to recognize that disability payments may constitute a major secondary gain actually impeding a patient's progress and delaying rehabilitation. There are two factors to be considered: a) the prevalent misconception that work is ipso facto stressful and likely to aggravate a diagnosed psychiatric disorder; and b) the recognition that some patients who have undergone a serious psychiatric disorder may want to avoid exposure to what they presume to be stressful factors at work because of lack of confidence even after they have improved clinically. It should be recognized that return to work as soon as possible is likely to improve the patient's self-esteem, re-establish him/her in a familiar social network and otherwise aid rehabilitation. There is some evidence that work deprivation may be one of the causes of psychiatric disorder.²⁹²

Third, and perhaps more importantly, employers, managers and insurers must become more knowledgeable about mental illness and addiction in order to better manage disability claims. During a recent speech, Bill Wilkerson, co-founder and CEO, Global Business and Economic Roundtable on Addiction and Mental Health, commented:

In a landmark Supreme Court of Canada case in Saskatchewan, a woman was disabled by a mental disorder, was off work and on long-term disability and was in hospital. While there, her disability insurance benefits continued. Once released, they were cut off – this, incredibly, because her institutionalization established the criteria of her continued eligibility. The Supreme Court ruled the practice discriminatory, because those with physical disabilities remained eligible for their benefits outside hospital while recuperating at home.

Meanwhile, were the insurer's practices simply obsolete or malevolent? Either way, the company suffered its own perceptual disorder of what the reality of mental illness is or isn't. The insurer, presumably, was confounded by the nature of mental disorders, by the treatment process and the critical even superior role of out-patient care and community family support in the patient's sustainable recovery.

I tell this story not to belittle or criticize the insurance industry at large. I am part of that community and, to be sure, there are examples where the life and health insurance industry has shown leadership in the promotion of mental health. Rather, I speak to a broader point. This industry must develop a perspective based on knowledge of mental health issues. Like

²⁹² Canadian Psychiatric Association (1988), *op. cit.*

business generally, the insurance sector needs a mental health education agenda.

An example of where this is especially true is in the comorbidity of mental illness and physical chronic diseases as this pertains to: origin and the duration of human disability; the complexity, lengths and risks of treatment and recovery; and, the pace and timing of the sufferer's return to work.

The insurance industry needs – at the levels of claims management – to know more about the medical science of mental health. (...). The industry needs to develop a knowledge base about the expanding universe of neuroscience and its illumination of the origins of behaviour.²⁹³

6.4.2 Workers' Compensation Boards

In all provinces and territories, Workers' Compensation Boards (WCBs) receive an increasing number of mental health related claims (referred to as “occupational stress”) and, in a growing number of cases, the Boards have provided compensation for claims related to mental illness. A review of occupational stress claims reported to WCBs was undertaken by the Association of Workers' Compensation Boards of Canada to find out how many types of claims were filed on an annual basis, whether they were of an episodic or chronic nature, and how much compensation was paid in each case. This review proved to be very difficult. In many cases, the Boards do not collect this type of data, or if they do, the data are not comparable because the definitions employed by each WCB may be different (see Table 6.3). The review could not, therefore, provide a national perspective on the number of claims resulting from occupational stress and the associated costs of compensation.²⁹⁴

²⁹³ Bill Wilkerson, [Notes for Remarks](#), 55th Annual Meeting of the Canadian Life Insurance and Medical Officers Association, 17 May 2004, p. 9.

²⁹⁴ Association of Workers' Compensation Boards of Canada, *Occupational Disease and Occupational Stress Legislation and Policies*, 1998.

TABLE 6.3

**WORKERS' COMPENSATION BOARDS IN CANADA:
INTERJURISDICTIONAL COMPARISON OF OCCUPATIONAL STRESS
COMPENSABILITY**

	Compensation for occupational stress provided if:
Alberta	<ul style="list-style-type: none"> • there is a confirmed diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; • the work-related events or stressors are the predominant cause of the injury; • the work-related events are excessive or unusual in comparison to the normal pressures experienced by the average worker in a similar occupation; and • there is objective confirmation of the events.
British Columbia	<p>Compensable forms of stress include:</p> <ul style="list-style-type: none"> • stress caused by a sudden and unexpected traumatic event; and • stress that results from a compensable injury such as severe anxiety following the amputation of a leg. <p>Stress that is caused by the pressures encountered in daily personal and work life is not compensable.</p>
Manitoba	Definition of accident/occupational disease excludes stress except as an acute reaction to a traumatic event.
New Brunswick	Definition of accident/occupational disease excludes stress except as an acute reaction to a traumatic event.
Newfoundland and Labrador	Legislative definition of injury covers stress only where it results from an acute reaction to a sudden and unexpected traumatic event and to exclude stress due to labour relations issues.
NWT & Nunavit	Claims for occupational stress are considered on a case-by-case basis.
Nova Scotia	Definition of accident/occupational disease excludes stress except as an acute reaction to a traumatic event.
Ontario	<p>Mental stress is compensable in respect of situations where there is an acute response to a sudden and unexpected traumatic event arising out of and in the course of employment.</p> <p>Mental stress due to the employer's employment decisions does not entitle a worker to benefits.</p>
Prince Edward Island	Definition of accident/occupational disease excludes stress except as an acute reaction to a traumatic event.
Quebec	Stress is compensable if the worker can show a relationship between the illness and the work or a risk in the work.
Saskatchewan	Compensation for occupational stress is specifically allowed for as a matter of policy where clear and convincing evidence is provided that the work stress was excessive and unusual; routine industrial relations actions taken by the employer are considered normal and not unusual.
Yukon	Post-traumatic stress considered compensable under legislation; current practice is to assess all other stress-related claims on a case-by-case basis.

Source: Paul Kishchuk, *Expansion of the Meaning of Disability*, paper commissioned by the Yukon Workers' Compensation Board, March 2003, p. 12.

A major issue raised with respect to compensation by WCBs concerns the fact that it is more difficult to prove the genesis of a mental disorder than it is of a physical illness. As a result,

there is some controversy about whether and how mental disorders should be covered under worker's compensation schemes. Under an occupational disease model, compensation for a disability is based on whether the disability arises from continuous exposure to hazardous conditions related to an individual's employment. Yet, most advanced etiological models of mental disorders include the variety of factors discussed in Chapter 4, such as genetic vulnerability, developmental circumstances and neurobiological factors, in addition to life events such as a stressful work environment. The relative weight of each of these dimensions is not yet understood, nor is it clear how they fit together. As a result, some WCBs are more reluctant than others to provide mental health related disability benefits. They are left wrestling with the question of the extent to which disability benefits related to mental disorders should be paid by worker's compensation rather than by health care insurance.²⁹⁵

6.4.3 Federal Income Security Programs

The Canada Pension Plan Disability program or CPP(D) is the largest single disability income program in Canada. It is generally the first payor of disability benefits preceding other entities such as provincial workers' compensation boards and private insurance companies.

CPP(D) benefits are paid to contributors under age 65 who have a physical or mental disability which is "severe and prolonged" (lasting at least one year and preventing work on a regular basis) and meets specific requirements relating to the level of earnings and years of contribution (contributions must have been paid in four out of the last six years).

In the past two decades, there has been a sharp increase in the number of CPP(D) beneficiaries due to mental illness. Between 1980 and 2000, the proportion of individuals receiving CPP(D) benefits attributable to mental disorders increased from 11% to 23%. Mental illness ranked second, behind disease of the musculoskeletal system, and affected a higher proportion of females than males. In 2000, mental disorders also represented the most prominent cause of CPP(D) disability among younger beneficiaries.²⁹⁶

For many years, individuals with mental illness and addiction and their representatives have raised concerns that CPP(D) does not address the question of mental illness and disability appropriately. More specifically:

- Many individuals with mental illness have limited work histories. Because mental illness often strikes in early adulthood at a time when education, job skills and careers are being developed, many of these individuals are not eligible for CPP(D) due to insufficient years of employment. Out of necessity, many turn to provincial social assistance programs for support.

²⁹⁵ Carolyn S. Dewa, Alain Lesage, Paula Goering and Michèle Caveen, *The Nature and Amplitude of Mental Illness in the Workplace*, discussion paper commissioned by the workshop supported by the Institute of Population Health and the Institute of Neurosciences, Mental Health and Addiction of the Canadian Institutes of Health Research, April 2004, pp. 2-19.

²⁹⁶ Office of the Chief Actuary, *Canada Pension Plan – Experience Study of Disability Beneficiaries*, Actuarial Study No. 1, November 2002.

- To qualify for CPP(D) disability benefits, the beneficiary must accept the designation of “permanently unemployable” by declaring him/herself as entirely incapable of pursuing any employment on a regular basis. Because of the cyclical and unpredictable nature of mental disorders, individuals with mental illness can work, but often only on a part-time basis; they are not necessarily capable of achieving full financial independence. Individuals with mental illness and addiction have recommended that CPP(D) pay partial or reduced benefits rather than full benefits to enable them to work part-time while still retaining a portion of their benefits.
- Since disability is currently equated with permanent unemployability, individuals on CPP(D) are reluctant to look for or take employment for fear of losing their benefits. Those affected are penalized for trying to improve their circumstances even if they are not capable of participating in regular full-time work again.
- Some 66% of all initial applications to CPP(D) are denied and almost two-thirds of those rejected do not apply for reconsideration. It has been suggested that the proportion of applications rejected from those with mental illness is much higher. Some experts claim that the system is designed in such a way as to discourage individuals from pursuing rightful claims. This is particularly true for individuals with mental disorders who, because of their illness, may lack the ability to “push the system”.²⁹⁷

In its 2003 report, the House of Commons Standing Committee on Human Resources Development and the Status of Persons with Disabilities recognized that CPP(D) does not address the question of mental illness and disability appropriately. The Committee made a number of recommendations to ensure that CPP(D) takes into account of the cyclical and unpredictable nature of mental illnesses. In addition, it recommended that the federal government develop, in consultation with stakeholders and health care professionals, specific evaluation tools for these particular disabilities to be used in assessing eligibility for CPP(D).²⁹⁸

In its response to the House of Commons Committee’s report, the federal government indicated that CPP(D) guidelines already recognize recurrent and episodic disabilities, including mental disorders, and that many individuals with mental disorders currently receive CPP(D) benefits. Furthermore, it stated:

The Government therefore does not believe regulations and guidelines need to be changed to accommodate the needs of individuals with episodic or recurring conditions. Because the determination of disability for CPP is based on the functional limitations that prevent a person from working, and not simply on a medical diagnosis or prognosis, the adjudication process is able to take into consideration the short- and

²⁹⁷ Wendy Steinberg, [Position Paper on Federal Income Security Programs](#), prepared for the Canadian Mental Health Association, December 2001.

²⁹⁸ Subcommittee on the Status of Persons with Disabilities (Dr. Carolyn Bennett, Chair), [Listening to Canadians: A First View of the Future of The Canada Pension Plan Disability Program](#), June 2003.

*long-term impacts of recurrent or episodic medical conditions on the client's ability to function in the workplace.*²⁹⁹

Individuals with mental illness may also be eligible to receive EI benefits as a source of temporary income replacement. They have raised some concerns, however, with respect to EI:

- In terms of EI eligibility, employees who are dismissed because of “misconduct” or quit “without just cause” are not eligible for EI benefits. Due to stigma, individuals with mental illness in the workplace often conceal their illness. When they experience difficulty on the job, they may be fired or may quit as a result of their illness, but would not be in a position to claim EI benefits because they have not previously disclosed their illness.
- When a person applies for EI sickness benefits, he/she is required to obtain a medical certificate indicating how long the illness is expected to last. The unpredictable nature of mental illness makes it difficult to provide this kind of medical information.
- Individuals with mental illness and addiction share the view that EI should exempt individuals with recurring illnesses or disabilities from fulfilling the additional number of insurable hours required of those who are considered new to the labour force. In their view, without this exemption, individuals with mental illness are unjustly disadvantaged. Few are able to meet the eligibility criteria in terms of the total number of insurable hours required of new workers.

In his brief to the Committee, Dr. Sunil V. Patel, President of the Canadian Medical Association, recommended that the federal government review CPP(D) and other federal income support policies to ensure that mental illness is on a par with other chronic diseases and disabilities in terms of the benefits available to affected persons.³⁰⁰

6.5 THE ROLE OF EMPLOYERS

There is a compelling case for employers to address mental illness and addiction in the workplace. In the global economy, information and innovation have become the keys to competitive success. And using these keys requires skilled, motivated, reliable workers. Human capital – motivation, knowledge, perspective, judgement, the ability to communicate, share ideas and have relationships – drives the global economy. In short, it is mental performance that drives competitive success in the worldwide economy.³⁰¹ According to Bill Wilkerson, co-founder and CEO of the Global Business and Economic Roundtable on Addiction and Mental Health:

²⁹⁹ Human Resources Development Canada, [*Government of Canada's Response to "Listening to Canadians: A First View of the Future of the Canada Pension Plan Disability Program"*](#), November 2003, p. 22.

³⁰⁰ Dr. Sunil V. Patel, President, CMA, Brief to the Committee, 31 March 2004, p. 5.

³⁰¹ Bill Wilkerson (6 February 2002), p. 6.

(...) it falls to business to protect its strategic investment in its people – its vital asset – and, therefore, by definition of the economy of mental performance in which we compete, in their emotional and mental health.³⁰²

The Committee heard over and over again that, given the burden of mental illness and addiction on society and on individual workers, and given the rising cost of occupational disabilities, employers must help to enhance the level of awareness about mental illness and addiction in their organizations; they also must devote more attention to improving access to treatment and rehabilitation services for workers through their EAPs. Employers must also place greater emphasis on work flexibility and accommodation for employees who suffer from mental illnesses.

Given recent estimates that about 75 per cent of the new jobs in the economy have to do with cognitive ability, not physical ability, and that the heavy lifting in the economy is now being done with people's minds, not with their backs, this aspect of mental disability is more significant than it might have been a number of years ago.
[Rod Phillips, President and CEO, Warren Shepell Consultants Corporation (18:8)]

Although the Committee was repeatedly told that employers had to do all the things listed in the previous paragraph, none of the testimony recognized explicitly how difficult this would be to do it in practice or how much it would cost. The Committee hopes therefore that during the nationwide public hearings which will follow the release of the Committee's Issues and Options paper in November 2004, we will receive advice on how employers can actually implement the changes suggested in the previous paragraphs and how much this would cost. Consistent with the Committee's earlier reports that contained recommendations for reform of the acute health care system, we are determined that the recommendations contained in our final report on mental health, mental illness and addiction, which will be released in November 2005, will be pragmatic and implementable, rather than merely pious statements of good intentions.

6.5.1 Employee Assistance Programs

EAPs are employer-sponsored variety of workplace problems. financial, marital or family-related or work-related (conflict on the job)

Typically EAPs provide counselling, diagnostic, referral and treatment services. The staff of EAP programs usually hold a degree in a mental health or social service

Employee assistance programs, EAPs, play a role in the current system of how mental health is delivered in Canada. Essentially, they provide professional assessment, short-term counselling, and referral services as a benefit to employees. In most cases, Canadian EAPs also cover employees and their dependents, similar to drug or other employee benefit plans.

[Rod Phillips, President and CEO, Warren Shepell Consultants (18:8)]

³⁰² Bill Wilkerson (6 February 2002), p. 8.

discipline (social work, psychology, psychiatry, counselling and/or marital and family therapy). Some services may also be contracted out to persons with other degrees, diplomas and qualifications.

EAP services are available both in private and public organizations and are usually administered completely independently of other programs within the organization. Confidentiality is the cornerstone of an effective EAP. The anonymity of clients, the confidentiality of interviews, the maintenance, transfer and destruction of files are subject to the applicable federal and provincial laws which define the conduct of counsellors. Generally, information may be released by an EAP counsellor only in situations where the client has provided informed and signed consent specifying what information is to be released and to whom.

The Committee was told that between 60 and 80 per cent of Canadians who are employed in a medium- or large-sized company (over 500 employees) currently have access to some form of EAP. According to Rod Phillips, President and CEO, Warren Shepell Consultants Corporation, EAPs are very effective; they have become the primary portal through which working Canadians often get their first access to mental health care and addiction treatment:

In many cases, in our experience, you would have about 85 per cent of the people who we see in a given year getting sufficient treatment through the EAP program that they would require no further treatment. About 15 per cent of the people would then be referred into community programs or into the public health care system.³⁰³

EAPs also have a strong prevention component. Much of the work being done with employers focuses on wellness and other programs that support a healthy mental health work environment,

Watson Wyatt Worldwide have recommended that employers who do not offer EAPs should consider implementing such programs in order to address mental illness and addiction, and a variety of other issues. They pointed out that some insurers provide disability rate discounts to smaller employers who implement an EAP, usually through a preferred provider.³⁰⁴

For those organizations that already have an EAP in place, Watson Wyatt Worldwide recommended that their programs be reviewed and revised as needed to better address better the needs of employees affected by a mental illness and/or an addiction. Specific elements to be examined should include the need for meaningful reports, performance standards and user feedback. Internal reviews that compare EAP utilization and absenteeism data should be undertaken by operating units in order to identify internal 'best practices' which can then be introduced across the organization. Finally, Watson Wyatt

³⁰³ Rod Phillips (18:9).

³⁰⁴ Watson Wyatt Worldwide, [*Addressing Mental Health in the Workplace*](#), June 2003.

Worldwide recommended that employees be told about the availability of the organization's EAP on an ongoing basis.³⁰⁵

Ash Bender and his colleagues (2002) warned that EAP programs are effective only when the working environments into which they are injected actively promote healthy workplaces. In other words, it is very important for employers to be well informed about mental illness and addiction, to address stigma and discrimination properly within their organization and to establish healthy workplaces.³⁰⁶

Another concern raised by Bender *et al.* related to the number of therapeutic sessions being offered to EAP clients; based on anecdotal evidence, these have decreased dramatically from 7 per individual to less than 3 over the last ten years. The authors concluded that the likelihood of effectively addressing any serious substance abuse or mental illness problem in this limited therapeutic timeframe would be low.³⁰⁷ This concern requires particular attention.

6.5.2 Accommodation

The solution will certainly require involvement on the part of the workplace. We cannot consider the workplace as if it were a school or a hospital. It is an entity in itself, a family with its own rules and its own way of behaving and we cannot do without its involvement.

[Jean-Yves Savoie, President, Advisory Board, Institute of Population and Public Health, CIHR (18:6)]

Accommodation refers to “any modification of the workplace, or in the workplace procedures, that makes it possible for a person with special needs to do a job.”³⁰⁸ Just as individuals with physical disabilities may require physical aids or structural changes to the workplace, individuals with mental disorders most often require social and organizational accommodations to be made. These generally involve changes to the way things have traditionally been done in a particular workplace. Permitting someone with a mental illness to work flexible hours, for example, provides him or her access to employment in the same way that a ramp does for an individual in a wheelchair. Such accommodation does not constitute preferential treatment. Accommodation means equitable treatment for individuals with disabilities.³⁰⁹

According to the Canadian Psychiatric Association, accommodation should be built on positive arrangements that promote equality in employment, including:

³⁰⁵ *Ibid.*

³⁰⁶ Ash Bender et al., [Mental Health and Substance Use at Work: Perspectives from Research and Implications for Leaders](#), background paper prepared for the Global Business and Economic Roundtable on Addiction and Mental Health, 14 November 2002.

³⁰⁷ *Ibid.*

³⁰⁸ Lana M. Frado, [Diversity at Work: Accommodations in the Workplace for People with Mental Illness](#), Canadian Mental Health Association, 1993, p. 8.

³⁰⁹ Lana M. Frado (1993), p. 10.

- Creating an environment in which arrangements are made in relation to the individual needs of each employee;
- Respecting the employee's desire for confidentiality as well as identifying specific the form and the degree of confidentiality required;
- Being willing to engage in joint problem solving;
- Making all arrangements voluntary for the employee, and being prepared to review plans periodically to meet changing needs;
- Being flexible in enforcing traditional policies;
- Being concrete and specific when identifying accommodations that are made. Putting them in writing is a good idea.³¹⁰

One study suggests that the cost of accommodating an employee with a mental illness is fairly low, usually well under \$500. Moreover, for those who get effective treatment, the employer will save between \$5000 to \$10,000 per employee per year in the cost of prescription drugs, sick leave, and average wage replacement alone. Employees who are diagnosed with depression and take appropriate medication will save their employer an average 11 days a year in prevented absenteeism.³¹¹

Another study found that over a 10 year period, 240 persons with serious mental illnesses were able to maintain gainful employment, largely because of formal work reintegration programs. These individuals earned \$5 million, paid \$1.3 million in income taxes, and saved the government an estimated \$700,000 in welfare costs. The result was a net \$2 million increase in collective wealth.³¹²

For its part, the Global Business and Economic Roundtable on Addiction and Mental Health believes that employers must provide an appropriate environment for the promotion of good mental health, awareness of mental illness and addiction, early detection of mental illness and addiction, and integration of and accommodation for employees suffering from a mental disorder. In this regard, the Roundtable published the 12-step business plan to mental illness and addiction, summarized in Table 6.3.

310 Canadian Psychiatric Association, op. cit.

311 Mental Health Works (2003), op. cit.

312 Gaston Harnois and Phyllis Gabriel (2000), op. cit., p. 47.

TABLE 6.3

**12 STEP BUSINESS PLAN TO DEFEAT MENTAL ILLNESS
AND ADDICTION AT WORK**

Step One:	CEO briefing on mental illness and addiction
Step Two:	Early detection of mental illness and addiction
Step Three:	Reforming EAP and group health plans
Step Four:	Establishing a healthy mental workplace
Step Five:	Reducing the overflow of e-mail and voice-mail messages
Step Six:	Developing flexible return to work policies
Step Seven:	Educating managers and supervisors on connections between mental illness and physical illness
Step Eight:	Reducing emotional work hazards
Step Nine:	Promoting work/life balance policies
Step Ten:	Encouraging people to seek the necessary professional assistance
Step Eleven:	Monitoring the health status of the organization through specific targets
Step Twelve:	Eliminating the 10 main sources of workplace stress.

Source: Adapted from Bill Wilkerson, *Mental Health – The Ultimate Productivity Weapon*, Summary of Remarks to the Industrial Accident Prevention Association Conference and Trade Show, Toronto, 22 April 2002, pp. 10-14.

More recently, the Roundtable drafted its “Roadmap to Mental Disability Management” which unifies physical and mental health within a single environmental, health and safety system. The Roadmap also provides standards for governing return-to-work policy. More precisely:

- Employers do not need to know the nature of the diagnosis of the disabling illness that is involved in any given case. This information is private and confidential.
- Employers do need to understand, support and participate in return-to-work plans which will inevitably involve customized adjustments in the content of the employee’s job or hours of work in order to make the transition go smoothly.
- Employers need to know that while the employee is coming back, he/she is not 100 per cent and gradual return-to-work is necessary to help the individual catch up with things, get up to speed and build tolerance and endurance.³¹³

The Roadmap stressed that unions also share the responsibility to accommodate an employee’s return-to-work. In particular, unions have a duty to represent their members at the higher end of the salary scale in matters concerning a disabled employee. This is particularly true when an employee is mentally disabled and the issue is termination.³¹⁴

Again, the Committee wants to emphasize the critical importance of turning the goals and objectives described throughout Section 6.5 into achievable recommendations. The Committee will only be able to do this if it receives concrete suggestions from both workers and employers, along with estimates of what it would cost to implement these proposals.

³¹³ Global Business and Economic Roundtable on Addiction and Mental Health (25 June 2004), p. 11.

³¹⁴ *Ibid.*, p. 23.

6.6 THE ROLE OF GOVERNMENTS

The Committee was told that governments must share responsibility with employers for shouldering the economic burden of mental illness and addiction in the workplace. According to Rod Phillips, such cost sharing could take the form of tax incentives:

Progressive employers are subsidizing Canada's inadequate public mental health care system. Their investment in mental health programs for their employees and family members should be encouraged through tax-based incentives and rebates, cost sharing, and joint service delivery. (...) The absence of accessible publicly-funded mental health services in Canada is a significant failing of our health care system. Given that a great percentage of the rising costs of mental illness are being borne by employers, there is a huge incentive for the costs associated with reducing these to be shared between employers and government. This avenue for cost sharing is, in our opinion, under explored and underused. I urge the Committee to consider innovative options.³¹⁵

For its part, the Canadian Mental Health Association (Ontario Division) strongly blamed governments from their lack of action with respect to mental illness and addiction:

For several years we have been talking about the projections by the World Health Organization that by 2020 mental illness will be the leading cause of days lost to disability. What we have not heard is the commitment that governments usually make when faced with a growing health problem, particularly one that impacts not only on the individual, but on society as a whole, including the economy. The WHO [projections] need to be treated as a challenge and wake up call, not an inevitable result.

(...)

Governments have an obligation to lead. The federal, provincial and territorial governments should commit to working together – and to support businesses – to achieve specific goals in terms of reducing the potential days lost to disability from mental illness. This requires a commitment on the part of all stakeholders to address the conditions that make people more vulnerable to mental illness and make the recovery or remission harder.³¹⁶

During the hearings that the Committee will hold on its Issues and Options paper, the Committee will be seeking advice on how governments should go about implementing the

³¹⁵ Warren Shepell, "[Warren Shepell Calls for Tax Incentives to Support Employer Mental Health Programs](#)", *Press Release*, 12 June 2003.

³¹⁶ Canadian Mental Health Association (Ontario Division), *Brief to the Committee*, 12 June 2003, pp. 6-7.

suggestion that “governments have an obligation to lead”. We need to hear the views of Canadians on what this actually means in practice.

6.7 BUSINESSES RUN BY INDIVIDUALS WITH MENTAL ILLNESS AND ADDICTION

During its hearings, the Committee learned about the Ontario Council of Alternative Business (OCAB). This is a provincial organization that assists in the development of economic opportunities for individuals with mental illness and addiction. It is an umbrella organization of 11 businesses operated by individuals with mental illness and addiction and which employ some 600 workers in various initiatives across the province.³¹⁷

Evaluation of businesses run by individuals with mental illness and addiction demonstrates that individuals with mental disorders, even severe and persistent illnesses, can succeed and be competitive in the business they undertake.³¹⁸ The Committee strongly encourages the development of these initiatives.

6.8 A RESEARCH AGENDA ON MENTAL ILLNESS, ADDICTION AND WORK

The issues related to mental illness, addiction and work are complex and multifaceted. Society is confronted with a rapidly growing problem which has huge financial implications and involves a multitude of stakeholders. However, there is currently no coordinated comprehensive strategy for pursuing research, disseminating information, implementing results, and evaluating them. Such a strategy should include not only research on disease, treatment and therapy; it should also examine the relationship of the workplace

From the currently existing body of literature, we know that mental health problems present a serious threat to the nation’s productivity. At the same time, we are only beginning to fully comprehend the prevalence and magnitude of the impact of mental health problems in the workplace. There is still much work to be done.

[Dewa, Lesage, Goering and Caveen, Nature and Amplitude of Mental Illness in the Workplace, April 2004.]

to mental health, how therapies and treatments can be carried into the workplace and the home, as well as looking at how employers, employees and families can take action.

The need for more research in the field of mental illness, addiction and work was highlighted in a recent workshop organized jointly by the Institute of Neurosciences, Mental Health and Addiction and the Institute of Population and Public Health of the Canadian Institutes of Health Research (CIHR). It enabled researchers to take stock of the nature and severity of mental illness and addiction in the workplace, to review the state of research in Canada in this field, and to develop a research agenda.

³¹⁷ Additional information can be found at <http://www.icomm.ca/ocab/>.

³¹⁸ Heather Stuart (April 2004), p. 84.

Participants at the workshop identified many areas that require more research, such as: understanding the patterns of mental disorders among the different occupational groups and industry sectors; understanding the relationship between employer– sponsored benefits and the prevalence and pattern of disability related to mental illness; examining the relationship between stress at work and the onset of disability; understanding how mental health is affected by prominent trends in workplace organizational practices; identifying effective methods to improve diagnoses and treatment interventions for mental illnesses amongst working individuals; analyzing policy and guidelines that relate to occupational disability; and determining the scope and nature of stigma in work settings.

The Committee welcomes this initiative by CIHR. We hope that the workshop will lead to the development of a research agenda which will help advance the understanding of mental disorders and the disabilities they cause, and identify innovative business practices that can help employees with a mental disorder.

The Committee also heard about a research plan called the “Research and Return on Investment Initiative”, a joint initiative undertaken by the Global Business and Economic Roundtable on Addiction and Mental Health, the Centre for Addiction and Mental Health and the Institute for Work and Health, that is funded by CIBC, TD Bank, Scotiabank, RBC, BMO and Great-West Life. The purpose of this research is to survey Canadian and American companies and gather and share information about successes in managing mental disability and facilitating the return-to-work of individuals with mental illness and addiction.³¹⁹ The Committee strongly encourages the Roundtable and business leaders to share best practices in the management of mental disability in the workplace and in the development of effective return-to-work strategies.

6.9 COMMITTEE COMMENTARY

The Committee agrees with numerous witnesses that securing and sustaining meaningful employment is beneficial to individuals with mental illness; it is also an essential part of the recovery process. In addition, we believe strongly that enabling these individuals to participate in the workforce can be beneficial to the companies employing them; recent advances in treatment now make it possible for people with mental illnesses to make valuable contributions in the workplace.

There is still a debate as to how much an employer wants to or should know concerning an employee’s mental illness. The Committee is of the view that legislation should not allow disability to be a sufficient ground to refuse employment unless it is clearly impossible for the person to do the job. The assurance that there will be quick and easy access to appropriate mental health services and supports has been found to influence very positively the willingness of employers to offer employment to persons with mental illness. In the Committee’s opinion, the disability associated with mental illness and addiction can no longer serve as an excuse to deny employment to those who want a job and are able to do it.

³¹⁹ Honorable Michael Wilson, [Text of Remarks](#), CIHR IRSC Workshop, 28 April 2004.

There is no doubt that employers bear a large burden in terms of lost productivity as a result of mental illness and addiction in the workplace. The presence of mental health and addiction problems in the workplace triggers the following question: “to what extent are these disorders imported into the workplace by individual employees and to what extent are they engendered by the workplace itself?” Obviously, the answer given to this question has profound implications for strategies aimed at preventing and managing mental illness and addiction in the workplace; it could also impact substantially on how disability claims attributable to mental disorders should be managed.

The Committee believes that more research must be undertaken in the field of mental illness, addiction and work. For example, we believe that it is important to understand the influence that the type and extent of disability coverage have on the duration of claims and to define the best model. It is important to understand the influence of healthy and non-healthy workplaces on the incidence of mental illness claims. It is also important to assess the impact of EAP programs.

The Committee strongly supports the view that it is imperative to provide education and awareness programs to inform everyone in the workplace, from the top down, about the causes, symptoms and treatment of mental illness and addiction. This would help overcome the stigma associated with mental disorders. While the implementation of such programs cannot eliminate stigma or guarantee that all employees will seek early treatment, they would certainly reduce the stress faced by those suffering from mental illness and addiction.

We also agree with experts that return-to-work policies must be reviewed and revised where necessary. Mental disorders do not fit the typical model of disability; many employers still view disability in terms of a physical impairment. Accordingly, the needs of employees returning to work following a mental health-related absence may be quite different from those of an employee returning after back surgery. Existing return-to-work arrangements should be reviewed and revised to address such different situations.

Furthermore, the Committee believes that an organization’s internal culture can make a huge difference to how mental illness and addiction is approached in the workplace. Employers should examine carefully all workplace issues (i.e., harassment, adversarial relationships between management and employees, etc.) that are creating unnecessary stress and hostility. Such situations have a detrimental impact on all employees, but especially on employees affected by mental illness and addiction. Employers should take steps to remedy problems that emerge as a result of such examinations.

Finally, the concern raised with respect to the need to review CPP(D) and EI in order to take into account the cyclical and unpredictable nature of mental disorders must be examined. The federal government should also consider how to share more equitably with employers the costs associated with mental illness and addiction.



PART 3

**Service Delivery and
Government Policy in
the Field of Mental
Illness and Addiction**

CHAPTER 7:

MENTAL HEALTH SERVICE DELIVERY AND ADDICTION TREATMENT IN CANADA: AN HISTORICAL PERSPECTIVE

INTRODUCTION

The history of mental health services and addiction treatment in Canada parallels the European and American experience. The delivery of mental health services has, for the most part, evolved differently from the provision of addiction treatment throughout the last century. This has led to the emergence of two distinct systems of care and support – one for individuals with mental illness and another for individuals suffering from addiction. It is only during the last decade that efforts have been encouraged to better integrate the two systems.

The mental health service system and the addiction treatment system have struggled to provide the most compassionate and responsive treatment possible, but both have been dogged by the problem of stigma which had a negative impact on their development. Arising out of widespread misunderstanding and broad misconceptions, individuals with mental illness were often labelled as “idiots”, “imbeciles” and “lunatics”, while addiction problems were perceived as a sign of personal weakness. In some cases, a punitive attitude, exemplified by a desire to remove individuals with mental illness and addiction from public sight, has hampered the delivery of appropriate services. Despite many advances in models of care, policies and legislation, negative perception and stigma still persist today (see Chapter 3, above).

Although dramatic improvements have been made in the past two decades in the delivery of mental health services and addiction treatment, the Committee concurs with numerous witnesses that neither area has gained sufficient public support or government funding to ensure that Canadians obtain the same quality of services as they do when they receive treatment for physical illnesses, such as cancer or heart disease.

This chapter provides a chronological overview of the development of mental health services and addiction treatment in Canada. Section 7.1 summarizes the evolving views of mental illness that, over the course of time, have influenced the approach taken in Canada. Section 7.2 provides an historical perspective of the development of the mental health service system in Canada. Section 7.3 briefly reviews the evolution of the addiction treatment system.

7.1 EVOLVING VIEWS OF MENTAL ILLNESS THROUGHOUT THE CENTURIES³²⁰

The care of people with mental and behavioural disorders has always reflected prevailing social values related to the social perception of mental illness.
[WHO, 2001, p. 49]

For many centuries, religious, spiritual or cultural beliefs dominated the way in which individuals with mental illness were treated and regarded by society. Psychiatry is a “young” science relative to other scientific disciplines.

Stein and Santos (1998) recount that 5,000 year old skulls have been found in Eastern Mediterranean and North African countries with openings in them of up to two centimetres in diameter. It is thought that these holes were made by sharp instruments and that the procedure, trephination, was performed for therapeutic reasons. Some individuals were believed to have a mental illness which, at the time, was assumed to be the result of having evil spirits in their heads. The purpose of trephination was to allow the evil spirits to be released.³²¹

In ancient Greece, individuals with severe mental illness were thought to be influenced by angry gods; they were undoubtedly abused. Those with relatively mild conditions remained free but were treated with contempt and humiliation.³²² According to Prince (2003), the cultural values of ancient Greece were precursors to the modern stigma that is associated with mental illness.³²³

In Europe, during the Middle Ages (5th to 16th century), people thought mental illness had supernatural causes and was associated with demonic or divine possession. The affected individual was either tortured, burned at the stake, hanged or decapitated to liberate the soul from demonic possession.³²⁴

In the 17th and early 18th centuries, the dominant view was that mental illness was an impaired physical state self-inflicted through an excess of passion. This view did not encourage compassion or tolerance; rather, it was used to justify poor living conditions and

³²⁰ The information contained in this section is based on the following five documents: 1) Leonard I. Stein and Alberto B. Santos, *Assertive Community Treatment of Persons with Severe Mental Illness*, New York, 1998; 2) World Health Organization, “Historical Perspective”, Section 3, in *The Mental Health Context, Mental Health Policy and Service Guidance Package*, Geneva, 2003; 3) World Health Organization, “Solving Mental Health Problems”, Chapter 3 in *Mental Health: New Understanding, New Hope*, Geneva, 2001; 4) Pamela N. Prince, “A Historical Context for Modern Psychiatric Stigma”, in *Mental Health and Patients’ Rights in Ontario: Yesterday, Today and Tomorrow*, published by the Psychiatric Patient Advocate Office, Ontario, 2003, pp. 58-60; 5) Canadian Mental Health Association, *More for the Mind – A Study of Psychiatric Services in Canada*, Toronto, 1963.

³²¹ Stein and Santos (1998), p. 6.

³²² Stein and Santos (1998), p. 6.

³²³ Prince (2003), p. 58.

³²⁴ WHO (2003), pp. 17-19, WHO (2001), p. 49, and Stein and Santos (1998), pp. 6-7.

the use of physical restraints in places of confinement. Some individuals were chained to walls or even kept in cages.³²⁵

In the late 18th century, Philippe Pinel, a French physician, and William Tuke, an English layman, pioneered the belief that those who behaved in strange and unexplainable ways did so because they were mentally ill. Pinel reformed the Bicêtre and Salpêtrière hospitals in France; he unchained the inmates and related to them as reasonable individuals, providing decent living conditions and treating them with respect. Similarly, Tuke, guided by humanistic ideals, founded the York Retreat in England where individuals with mental illness were provided with decent living conditions, related to in a respectful manner, and were expected to work to the extent they could.³²⁶

The approach developed by Pinel and Tuke became known as “moral treatment”. Its success, based on considering of individuals with mental illness to be medical patients, led to the building of many psychiatric institutions, once known as “lunatic asylums”, in European countries and the United States. In parallel, this period saw the field of psychiatry burgeon as a medical discipline.³²⁷

In the 19th and 20th centuries, a more “scientific approach” to the treatment of mental illness was introduced. Attempts were made to explain mental illness as a result of disease and/or damage to the brain, or as the sequella of congenital and hereditary defects. Because damaged, devitalized brain tissue cannot be renewed and little can be done to correct inherited constitutional defects, this new “scientific” approach led to an era of pessimism regarding the possibility of treatment.³²⁸

Asylum: A place of refuge and protection for people with long term mental illnesses who do not require acute hospital treatment, but do require ongoing supervision, care and treatment in a community facility or institution.

[\[The 1998 British Columbia Mental Health Plan, p. 85.\]](#)

It only dawned on people that a rational, even scientific, psychological treatment of mental illness was possible dawned only when thousands of World War I “shell shock” casualties demonstrated poignantly that everyone is vulnerable to psychological, social and physical stress and has a breaking point.³²⁹ This realization led to the development of modern psychiatry and clinical psychology.

³²⁵ Stein and Santos (1998), pp. 6-7.

³²⁶ Stein and Santos (1998), p. 8.

³²⁷ Stein and Santos, (1998), pp. 6-8, and WHO (2001), p. 49.

³²⁸ Canadian Mental Health Association (1963), p. 2.

³²⁹ *Ibid.*

7.2 DELIVERY OF MENTAL HEALTH SERVICES IN CANADA³³⁰

The evolution of mental health service delivery in Canada, as in other developed countries, has been marked by three distinct periods, beginning with a moral or humanitarian approach to treating mental illness, followed by institutionalization and, finally, deinstitutionalization.

7.2.1 Moral or Humanitarian Approach to Mental Illness (Before the 1900s)

Prior to Confederation, many individuals who suffered from mental illness were either jailed or cared for within the family home or by religious bodies.³³¹ At that time, few physicians practised psychiatry in either Upper or Lower Canada. There were even some who held that it was a waste of time to attempt any kind of treatment, either medical or psychological, for individuals with mental illness; they were considered incurable, non-functioning members of society.³³² The treatment of individuals with mental illness, then, was mostly custodial.

In the late 19th century, both Upper and Lower Canada borrowed from the European experience and developed a number of small institutions that patterned themselves after the Tuke and Pinel approaches to provide patients the benefit of moral or humanitarian treatment. Initially, however, there were insufficient moral hospitals to accommodate all who needed them. Many individuals with mental illness remained locked in a room in their homes, or were incarcerated with common criminals.

The success of moral treatment led eventually to the building of numerous large asylums across the country. Thus began the process of institutionalization for individuals with mental illness. Initially, the patient-to-staff ratio was sufficient to provide moral treatment and decent living conditions, but, for reasons explained below, most of these institutions were unable to sustain the success rate of the dedicated pioneers of moral treatment.

7.2.2 Institutionalization (1900 to 1960)

Following European and American experience, lunatic asylums proliferated across Canada.³³³ These large institutions were usually self-contained and located in very isolated areas. Many

³³⁰ The information contained in this section is based on the following nine documents: 1) Health and Welfare Canada, *Mental Health Services in Canada*, Ottawa, 1990; 2) .E. Appleton, "Psychiatry in Canada A Century Ago", *Canadian Psychiatric Association Journal*, Vol. 12, No. 4, August 1967, pp. 344-361; 3) Elliot M. Goldner, *Sharing the Learning – The Health Transition Fund: Mental Health*, Synthesis Series, Health Canada, 2002; 4) Cyril Greenland, Jack D. Griffin and Brian F. Hoffman, "Psychiatry in Canada from 1951 to 2001", in *Psychiatry in Canada: 50 Years*, Canadian Psychiatric Association, 2001, pp. 1-16; 5) Quentin Rae-Grant, "Introduction", in *Psychiatry in Canada: 50 Years*, Canadian Psychiatric Association, 2001, pp. ix-xiii; 6) Henri Dorvil et Herta Guttman, *35 Ans de Désinstitutionalisation au Québec, 1961-1996*, Annexe 1 du rapport du Comité de la santé mentale du Québec intitulé *Défis de la Reconfiguration des Services de Santé Mentale*, 1998; 7) Julio Arboleda-Florez, *Mental Health and Mental Illness in Canada: The Tragedy and the Promise*, Brief to the Committee, 19 March 2003; 8) Paula Goering, Don Wasylenki and Janet Durbin, « Canada's Mental Health System », in *International Journal of Law and Psychiatry*, Vol. 23, No. 3-4, May-August 2000, pp. 345-359; 9) Donald Wasylenki, "The Paradigm Shift From Institution to Community", Chapter 7, in *Psychiatry in Canada: 50 Years*, Canadian Psychiatric Association, 2001, pp. 95-110.

³³¹ Health and Welfare Canada (1990), p. 13.

³³² V.E. Appleton (1967), pp. 344-361.

³³³ Elliot Goldner (2002), p. 1.

individuals with mental illnesses, once admitted, would spend the rest of their lives there. Some patients were admitted involuntarily using legal processes and were retained in locked wards. Treatment attempted to incorporate work through occupational or industrial therapy (which gave patients small amounts of remuneration), together with recreational and social activities. Relationships between the staff and patients were marked by paternalism. Most patients remained isolated from their families and communities.³³⁴

Many psychiatric treatments common in use in this period – hydrotherapy, insulin coma, crude psychosurgery (namely lobotomy) – have since fallen into disfavour or been abandoned as unethical or scientifically invalid.³³⁵ Electroconvulsive therapy (or ECT), given initially without general anaesthetics or muscle relaxants, was a commonly used but controversial treatment.³³⁶ The convulsions accompanying ECT often caused serious complications – seizures that lasted longer than expected, increased blood pressure, changes in heart rhythm, and compression fractures of the spine. Since then, ECT, while still the subject of controversy in some circles, has been widely recognized and endorsed by psychiatry and medicine generally as a safe and effective treatment for schizophrenia, severe depression and extreme mania.³³⁷ The lack of effective treatments for patients with mental illness is generally acknowledged to have significantly contributed to the relatively low esteem in which psychiatry was held throughout this period.³³⁸

It should be noted that, during the process of institutionalization, efforts were made to promote mental health and de-stigmatize mental illness. For example, in 1948, the federal government established the Dominion Mental Health Grants to improve training and services. Funds from this source also led to the development of public awareness campaigns to promote the mental health of infants and children. “Mental Health Week” was designated in Canada for the first time in 1951. Similarly, during this period, the Canadian Mental Health Association fought to change the language used in legislation, and that also appeared in public discourse, that referred to individuals with mental illness as “idiots”, “imbeciles”, and “lunatics”.³³⁹

After World War II, psychiatric institutions in Canada became overcrowded. In 1950, there were some 66,000 patients in psychiatric hospitals in Canada; they outnumbered patients in non-psychiatric hospitals.³⁴⁰ Most psychiatric institutions operated at more than 100% capacity. Understaffing, overcrowding and the lack of effective treatments led to an emphasis on custody rather than therapy. Contrary to the initial intent of moral treatment,

³³⁴ Greenland, Griffin and Hoffman (2001), p. 2.

³³⁵ Hydrotherapy, which is also called the water cure, is a mode of treating diseases by the copious and frequent use of pure water, both internally and externally. Insulin coma treatment was a rarely used treatment of mental illness by means of hypoglycaemic coma induced by insulin.

³³⁶ ECT is a procedure that consists in passing a small electric current through a region of the brain for a period of 1-3 seconds for the purpose of inducing neurochemical changes associated with the relief of psychiatric symptoms; the electrical stimulation also induces a brief seizure, whose appearance is modified by muscle-relaxing drugs. It generally lasts 20-30 seconds and then ends spontaneously. The patient is anaesthetized and asleep during the treatment and the seizure.

³³⁷ Health and Welfare Canada (1990), p. 13.

³³⁸ Quentin Rae-Grant (2001), p. x.

³³⁹ Greenland, Griffin and Hoffman (2001), p. 3.

³⁴⁰ Greenland, Griffin and Hoffman (2001), p. 2.

institutional care became primitive and restrictive, relying on methods involving seclusion, as well as on chemical and physical restraints.³⁴¹ All these negative consequences contributed to the process of deinstitutionalization described in the following section.

7.2.3 Deinstitutionalization (1960 Up to Now)

(...) deinstitutionalization is not merely the administrative discharge of patients. It is a complex process in which de-hospitalization should lead to the implementation of a network of alternatives outside mental hospitals. In many developed countries, unfortunately, deinstitutionalization was not accompanied by the development of appropriate community services. (...) It has become increasingly clear that if adequate funding and human resources for the establishment of alternative community-based services do not accompany deinstitutionalization, people with mental disorders may have access to fewer mental health services and existing services may be stretched beyond capacity. (WHO, 2003, p. 18)

A number of factors encouraged the trend towards deinstitutionalization. First, as a result of overcrowding and understaffing, many psychiatric institutions were seen as non-therapeutic environments wherein individuals were thought to be housed and dealt with in an inhumane, custodial fashion. Second, numerous studies in Canada, Europe and the United States highlighted the negative impact of long term institutionalization on the well-being of individuals with mental illness. These included: indifference, apathy, passive obedience, self-neglect and, sometimes, aggressive behaviour, as well as substantial loss of social abilities, increased dependence and added chronic physical illness resulting from isolation, in addition to authoritarian relationships between staff and patients.³⁴²

Third, with the advent of chlorpromazine – an effective medication that controls psychosis and severe mood disorders – and other neuroleptic medications came the hope that “cures” for severe and persistent mental illnesses such as schizophrenia were on the horizon (it is interesting to note that these early research findings stimulated considerable research interests in psychopharmacology and neuroscience in Canada). At the very least, it was expected that with these new medications

[At] the time of the revolution in psychiatry (...) [w]e started by meeting with priests and community leaders to tell them that psychiatric patients are not dangerous, at least not any more dangerous than other people, and that they should be given a chance. We could not take patients out of psychiatric hospitals and integrate them into the community until they had acquired certain social skills. That is when social workers, psychological educators, started teaching psychiatric patients the skills they would require to function in society.

[Henri Dorvil, Professor, School of Social Work, UQAM (14:39)]

³⁴¹ Health and Welfare Canada (1990), p. 13.

³⁴² Dorvil and Guttman (1998), p. 116.

individuals with mental illness could live comfortable lives outside of hospitals, allowing them to resume the functions of everyday life without constant supervision and care. And fourth, financial incentives that were offered to provincial governments through federal-provincial cost-sharing arrangements to fund psychiatric units in general hospitals proved hard to resist.³⁴³

Two important national reports, along with the reports of several provincial commissions,³⁴⁴ highlighted these observations and encouraged the shift toward deinstitutionalization. In 1963, the National Scientific Planning Council of the Canadian Mental Health Association released *More for the Mind* which insisted that mental illness should be dealt within the same organizational, administrative and professional framework as physical illness. It recommended that psychiatric services be integrated with the physical and professional resources of the rest of the health care system.³⁴⁵

Similarly, in 1964, the Royal Commission on Health Services, chaired by Emmett Hall stated: “Any distinction in the care of physically and mentally ill individuals should be eschewed as unscientific for all time”. The Hall Commission recommended that patients capable of receiving care in general hospital psychiatric units should be moved from psychiatric hospitals with all due speed. It was expected that patients would occupy beds in psychiatric units of general hospitals for brief periods of time during episodes of illness, but otherwise would live successful and satisfying lives in their communities.³⁴⁶

Thus, in the 1960s the process of deinstitutionalization began. It was a long journey. Indeed, the deinstitutionalization process itself can be described in three distinctive phases covering the period beginning in the early 1960s and continuing to the present. The first phase (section 7.2.3.1) involved a shift from care in psychiatric institutions to care in the psychiatric units of general hospitals. The second phase (section 7.2.3.2) focussed on the need to expand mental health care into the community and to provide necessary community supports for individuals with mental illness and their families. In the third and current phase (section 7.2.3.3), the emphasis is on integrating the various mental health services and supports available within communities and enhancing their effectiveness.³⁴⁷

7.2.3.1 Psychiatric Units in General Hospitals (1960s)

Deinstitutionalization (...) evolved as a natural phenomenon following the advent of new pharmacological treatment, with the first era of anti-psychotic medication. Patients who spent years in institutions could now be treated with effective medications and their conditions often improved to the point that they could re-enter the

³⁴³ Donald Wasylenki (2001), pp. 95-110.

³⁴⁴ Such as the Bédard Commission in Québec (1961-1962) and the Blair Commission in Alberta (1967-1969).

³⁴⁵ Canadian Mental Health Association, *More for the Mind – A Study of Psychiatric Services in Canada*, Toronto, 1963.

³⁴⁶ As quoted and reported in Donald Wasylenki (2001), p. 96.

³⁴⁷ Donald Wasylenki (2001), pp. 95-110.

community. In following years, deinstitutionalization became a desirable goal. In the beginning of community psychiatry, it was thought that behavioural problems of many chronic patients were secondary to some form of "institutional neurosis". By taking steps to remove these patients from a pathological milieu and rehabilitating them in the society, it was hoped that social reinsertion would be successful for a large number of them.

[Dr. Dominique Bourget, Forensic Psychiatrist, Royal Ottawa Hospital, Brief to the Committee, June 2003, pp. 2-3.]

The first phase of the deinstitutionalization process involved discharging large numbers of long-term stay individuals from psychiatric hospitals both into the psychiatric units of general hospitals and directly into relatively unprepared communities. This resulted, during the 1960s, in the closing of several of Canada's larger, more isolated institutions. Long term hospitalization was slowly being replaced by shorter, intermittent stays. From 1960 to 1970, the number of patient days in psychiatric institutions was cut in half. The bed capacity of psychiatric hospitals decreased from approximately four beds per 1,000 population in 1964 to less than one bed per 1,000 in 1979.³⁴⁸

It was intended that this shift from psychiatric institutions to general hospitals' psychiatric units would have a significant impact, in particular by lessening the stigma associated with mental illness and psychiatry, as these illnesses and the practitioners who treated them became more closely integrated with the rest of medicine.³⁴⁹

Initially, both general hospitals and psychiatric institutions resisted the placement of psychiatric patients in general hospitals; some general hospitals did not want psychiatric patients, while some psychiatric institutions worried that their resources were being dramatically reduced.³⁵⁰ However, there were benefits to shifting care to general hospitals. The general hospital units had the potential to enable early identification, to facilitate preventive psychiatry, and to treat a wide range of less serious psychiatric disorders.³⁵¹

Unfortunately, the psychiatric units of general hospitals did not adequately serve the patient population discharged from the former psychiatric institutions. On the one hand, human and financial resources were not reallocated to general hospitals as individuals were discharged from psychiatric institutions. Indeed, studies in the late 1970s showed that individuals with severe and persistent mental illnesses who were treated in the psychiatric units of general hospitals benefited from far fewer resources than had been available in the psychiatric institutions in which they accommodated.³⁵²

³⁴⁸ Health and Welfare Canada (1990), p. 15.

³⁴⁹ Donald Wasylenki (2001), pp. 107-109.

³⁵⁰ Greenland, Griffin and Hoffman (2001), p. 4.

³⁵¹ Greenland, Griffin and Hoffman (2001), p. 7.

³⁵² Don Wasylenki (2001), p. 97.

On the other hand, general hospital psychiatric units tended to be used on a voluntary basis by middle and upper income individuals who were referred to them by private psychiatrists, while psychiatric institutions continued to provide services to poorer individuals and to those who had been admitted involuntarily. This, in effect, created a two-tiered system of mental health care: the general hospitals and psychiatric institutions served groups of patients that rarely overlapped.

Most importantly, the closing or downsizing of psychiatric institutions was achieved without providing adequate funding at the community level to provide for psychological support and rehabilitation outside the hospital. Thus, communities were left ill-prepared to provide discharged patients with appropriate support. Many individuals, disabled by persistent psychiatric illnesses, were left merely to subsist in the community. Although now living in a less restrictive environment, they received dramatically fewer services and less care if any care at all. According to numerous witnesses, this is a critical lesson that should never be forgotten in any movement to reform the mental health system.

The lack of proper services and supports in the community for those suffering from mental illnesses resulted in:

- a high frequency of relapse (back to the psychotic state) and, therefore, increased readmission rates to hospitals;
- the “revolving door syndrome”, where patients, after readmission to the hospital and treatment, were discharged back to inadequate care in the community, only to become ill again and start the process all over again;
- increased homelessness;
- increased criminal behaviour and incarceration (sometimes for minor crimes).

This situation was tragic for individuals with mental illnesses and their families. Some experts came to believe that the deinstitutionalization policy itself was a major mistake. They came to believe that patients would be better off if they lived their lives in institutions. By and large, however, most experts, including individuals afflicted with mental illness, did not agree. They resisted joining the chorus for massive re-institutionalization and advocated the provision of long term services and supports for everyday needs so that they could live stable lives in the communities.

7.2.3.2 Community Mental Health Services and Supports (1970s and 1980s)

In this second phase of deinstitutionalization, the shift from institutional to community care continued with an emphasis not only on community mental health care *per se*, but also on community mental health supports.

In this phase, provincial governments began to fund mental health services outside the hospital setting, mainly in response to deficiencies in the general hospitals’ psychiatric units. These services were provided by community mental health clinics. In addition, this phase also focussed on the need for an extensive array of community supports and services (such

as residential services, vocational rehabilitation programs, and income support) to maintain individuals with mental illness, particularly those with serious and persistent illnesses, in the community. People believed that a more balanced approach was needed in the allocation of funding for mental health services between expensive, facility-based, treatment-oriented care and community mental health care and support. Case management was needed to ensure the coordination of services in a community-based delivery system.

During this phase, proponents of community care were pitted against facility-based providers, and hospitals were seen to be part of the problem rather than part of the solution. Also, the interests of professionals were sometimes seen to be divergent both from those of individuals with mental illnesses and their families. Increasingly, provincial governments became less responsive to the advice of professionals and more responsive to the voice of individuals with mental illnesses and family members. Nongovernmental organizations, in particular, became especially strong and effective during this phase; pressure on governments to provide housing, income support, and opportunities for socialization matched the pressure that was exerted by professionals to secure treatment.³⁵³

History has taught us that mental health and mental illness transcend pure health boundaries, and intersect many social policy areas such as housing, income supports, social services, employment and justice.

[Canadian Mental Health Association, Brief to the Committee, June 2003, p. 1.]

The 1970s and 1980s were also marked by advances in biological psychiatry, which showed that abnormal neurotransmitter systems may underpin at least some mental illness. Research in this area of psychiatry was also key in explaining the effectiveness of psychotropic medications. During this period, research done in Canada contributed significantly, both nationally and internationally, not only to expanding knowledge about the brain functions, but also to developing new drugs and to the better therapeutic management of mental disorders. These years were also marked by major contributions from Canadian scientists in the field of genetics and mental disorders, such as schizophrenia and bipolar disorder.

By the end of the 1980s, mental health services and supports, although they existed in most provinces, were not well integrated. Indeed, it was often said that these were “three solitudes” – psychiatric hospitals, psychiatric units in general hospitals and community mental health clinics, supports and services.

7.2.3.3 Enhancing Effectiveness and Integrating Mental Health Services and Supports (1990s to Present)

As in the previous phase, it was recognized that there was a need for more community mental service interventions, including more home visits, outreach services, mobile crisis mental health teams, as well as better partnerships with self-help groups, and more assertive community treatment (ACT) teams, etc. But in this third phase of the deinstitutionalization process, individuals with mental illness and their families, through various nongovernmental organizations, continued to pressure governments to provide more and better community supports in various areas such as housing, income support, employment opportunities, etc.

³⁵³ Wasylenki (2001), pp. 107-109.

In contrast with the previous phase, however, this third phase has been marked by an emphasis on empirical research. In fact, there is an important trend toward the adoption of the “best practice” framework by policy makers, professionals, individuals with mental illness and family members. It is believed that the evidence-based approach will lead to a much greater degree of cooperation and collaboration in facilitating mental health reform. Hospitals (both general hospitals and psychiatric institutions) are no longer seen to be outside evolving systems of comprehensive care; rather, they are regarded as essential components even though they may require a rethinking of their key functions and mechanisms in order to better link facility and community-based care. This third and current phase is thus characterized by a greater degree of inclusiveness in planning and implementation activities as well as by a much clearer consensus on the reforms that are needed.³⁵⁴

In many provinces, the preferred model of mental health service delivery currently includes a broad range of coordinated community services operating in conjunction with the psychiatric units in general hospitals and an associated regional tertiary mental health care centre.

Major challenges remain, however. Simply put, mental illness has a social dimension that is not exhausted by the health care sphere. As those in larger cities are aware, the number of homeless people is increasing. As well, forensic psychiatry programs are under ever-increasing pressure for space. In addition, Canada is a multicultural society and mental health services and supports must accordingly be provided in a culturally appropriate manner.³⁵⁵ Perhaps most importantly, the many and changing needs of children, adolescents and transitional-aged youth suffering from mental illnesses – the “orphans’ orphan” – require major collaborative cross-sectoral action from the still poorly coordinated mental health, health care, social services, education, correctional, recreational, vocational and addiction systems.

In my view, deinstitutionalization makes sense for most – not all – but only if the community has the service capacity; if society has been informed in an appropriate public education policy; if safe and affordable housing exists; and if enhanced employment opportunities exist. Can you imagine a time-sensitive institutionalized consumer is suddenly discharged to find employment in a stigmatized society where a "not-in-my neighbourhood" housing policy exists?

[Michael J. Grass (17:44)]

7.3 PROVISION OF ADDICTION TREATMENT IN CANADA³⁵⁶

The development of addiction treatment in Canada has been characterized by five (5) distinct phases. The first phase, ending in the late 1940s, was dominated by moralistic attitudes and a general lack of attention to treatment. Some addiction treatment was

³⁵⁴ Don Wasylenki (2001), pp. 107-109.

³⁵⁵ Quentin Rae-Grant (2001), p. xi.

³⁵⁶ This section is based on information provided in the two following documents: 1) Health Canada, “The Development of Alcohol and Other Drug Treatment in Canada”, in *Profile of Substance Abuse Treatment and Rehabilitation in Canada*, Ottawa, 1999, pp. 3-5; 2) Colleen Hood, Colin McGuire and Gillian Leigh, *Exploring the Links Between Substance Use and Mental Health – A Discussion Paper*, prepared under contract to Health Canada, 1996.

available in private asylums and some counselling services were established in prisons. However, most individuals with addiction problems (either with alcohol or other drugs) had little access to treatment services. The dominant view was that these problems resulted from a “lack of will power” or from “personality defects”.

The second phase, ending in the mid-1960s, was marked by a change in attitudes towards alcoholism and, to a lesser extent, towards problems involving other drugs. A major influence during this period was the growth of Alcoholics Anonymous (AA). AA promoted the view that alcoholism, although incurable, could be arrested if treatment was provided for withdrawal and the alcoholic followed a 12-step recovery program. With the support of some community leaders, AA members lobbied successfully for government-sponsored treatment and education programs. Efforts to secure government support for alcoholism services were also spurred by the view of alcoholism as a preventable and treatable “disease” rather than an expression or sequella of moral weakness.

During this phase, most provinces established departments, commissions or foundations to provide or coordinate addiction treatment services; many new services established. Initially, these agencies were principally concerned with alcohol-related problems but later, as individuals with addiction to other drugs began to increase in number, their mandates were expanded to encompass problems involving other drugs. It is important to note, however, that treatment for individuals who used illegal drugs took place in the shadow of a strong punitive approach to dealing with drug addiction.

In contrast with the moral model that « blamed the victim » for the development of addiction, the new view was that addiction was a disease caused by genetic and biological factors. No longer was the addict held personally responsible for engaging in « bad habits » since the determinants of their habitual behaviour were biogenetic factors beyond their individual control. The disease model was first advanced by academic specialists in the alcoholism field. In more recent years, the concept of alcoholism as a disease has been generalized to other habitual drug use.

[Ministry of Health Services, British Columbia, Every Door is the Right Door, May 2004, Appendix III, p. 72.]

The third phase began in the mid-1960s. It accompanied a surge in drug use and was characterized by a rapid expansion of addiction services. The most rapid growth occurred between 1970 and 1976. Of approximately 340 specialized agencies operating in 1976, two-thirds were established after 1970; expenditures on treatment services increased from \$14 million to \$70 million during the same period. The range of services established during this period included detoxification centres, outpatient programs, short- and long-term residential facilities and aftercare services. Some services for individuals with problems involving drugs other than alcohol were provided by programs established primarily to serve those with alcohol problems, but some specialized “drug” treatment services were also established during this period, including a number of therapeutic communities. Throughout this period, individuals in treatment were increasingly found to have been abusing other drugs simultaneously with alcohol.

The fourth phase began during the 1980s. It featured the relative autonomy of the provincial foundations and commissions within their respective health and social service systems. In many cases, addiction research, education and treatment occurred in systems

that paralleled but were far from fully integrated with the general community health and social services systems. Despite this, there was a growing appreciation for the role of non-specialized health and social services in identifying and supporting specialized substance abuse treatment services.

This phase can also be characterized by the diversification and specialization of alcohol and drug treatment services, and with growth in special services particularly for women, adolescents and Aboriginal peoples. This trend was driven by research indicating that individuals respond differently to different types of treatment and by a growing belief that treatment should be adjusted for different populations and types of addiction problems. While various modifications of the medical model of treatment were prevalent across the country, a number of other treatments based on cognitive, behavioural and social theories and research also emerged during this period, an approach that has come to be known as the cognitive-behavioural (CB) model. Canada's Drug Strategy, conceived as a multi-sectoral partnership, was launched in 1987. It helped stimulate a range of activity, including support for innovative treatment and rehabilitation services across the country.

The fifth and current phase, which began in the early 1990s, has been fuelled by dramatic changes in the structure of health service delivery across the country. Within a general environment fostering health care reform, most government addiction services have been integrated into community health and social services delivery systems. During this phase, there has been increased awareness of the need to better integrate alcohol and drug services, not only into the mental health service system, but also into larger social welfare policy and social support systems. Such integration of services is the result of the adoption of a population health approach in all provinces and territories. The holistic population health model emphasizes a complex set of health determinants – social, economic, cultural and environmental conditions, including behavioural choices – that impact both psychological status and biological states.

During this phase, new breeds of more potent drugs have emerged, putting young children and adolescents at risk of addiction earlier than ever before. In addition, with the recent proliferation of gambling opportunities available to Canadians, problem gambling is an emerging concern in the field of addiction in many provinces and territories. Moreover, as corporate interest in addiction increases, the number of referrals from business and industry to Canadian addiction treatment services is growing.

7.4 COMMITTEE COMMENTARY

The stigma associated with mental illness and addiction in Canada has created serious obstacles to the provision of effective mental health services and addiction treatment. The Committee strongly believes that addressing stigma and discrimination is an important step towards the more efficient planning and provision of adequate mental health/addiction services and supports.

During the past 50 years, biomedical and clinical research, scientific advances in neuroscience, genetics and biology, and progress in cognitive and behavioural sciences have contributed to a better understanding of mental illnesses and substance use disorders. They

have led to the development of effective medications, treatments and therapies to which Canadian scientists have been major contributors. In fact, Canada was at the forefront of applying advances in neuroscience to mental disorders. In addition, the field of neuroscience has traditionally been a major international strength of Canadian research. Moreover recent breakthroughs may have a significant impact on the ability to treat many mental disorders including in preventing suicide. For example, advances in neurogenetics may help us better understand the nature of schizophrenia, while progress in neuropharmacology can yield gains in the treatment of depression. The Committee concurs with many witnesses that, thanks to health research, there are grounds for believing that the 21st century will see a significant improvement in the care and treatment of individuals with mental illness and addiction and perhaps in the prevention of diseases of this kind as well.

The deinstitutionalization process of the 1960s through the 1980s has yielded some important lessons with implications for how services and supports are delivered to individuals with mental disorders. In particular, significant reform at the system level must be undertaken to ensure the seamless provision of the full continuum of services and supports needed by individuals with mental illness and addiction. This can only be achieved through the integration of the ‘three solitudes’ – institutions, community services, and community supports – along with the integration of the currently separated systems – one for mental illness and the other for addiction. Individuals with mental illness and addiction must be regarded as people first, not as diagnoses or psychiatric labels. They must be engaged with their families in determining their path to recovery. This requires collaboration and the establishment of partnerships amongst players at all levels. Governments must play a leadership role in this very important undertaking.

The participation of individuals with mental illness and addiction and their families in community life must accompany every step along the road of reform and renewal. Individuals with mental illness/addiction and their families have important knowledge of how the system works (and doesn’t work). The Committee concurs with numerous witnesses that, by including the perspectives of individuals with mental illness and addiction and their families in planning, policy making, service design and delivery, many false steps can be avoided.

CHAPTER 8: MENTAL ILLNESS AND ADDICTION POLICY AND LEGISLATION IN CANADA: REVIEW OF SELECTED PROVINCIAL FRAMEWORKS

INTRODUCTION

Policies, programs and legislation in the fields of mental health, mental illness and addiction are the responsibility of both provincial/territorial jurisdictions and the federal government and involve numerous departments and agencies. The organization, governance, funding and delivery of mental health services and supports and addiction treatment in Canada are primarily the responsibility of provincial and territorial governments. Provinces and territories also govern mental health legislation in their respective jurisdictions.

The federal government has a direct responsibility for the delivery of mental health services and addiction treatment to: Status Indians and Inuit; the military; veterans; civil aviation personnel; the RCMP; inmates in federal penitentiaries; arriving immigrants; and federal public servants. The federal government also has various responsibilities, such as health promotion and disease prevention; disease surveillance; health research; human rights; drug approval; employment and disability benefits; etc. which have direct or indirect implications for the provision of mental health services and supports and addiction treatment in the provinces and territories.

The purpose of this chapter is to provide a general overview of the role and responsibilities of provincial and territorial governments with respect to mental health, mental illness and addiction. The role of the federal government in the field of mental health, mental illness and addiction is discussed in detail in a subsequent chapter.

Section 8.1 briefly describes and compares the organizational structure and level of integration of the mental health services and addiction treatment system in selected provinces – Alberta, British Columbia, Nova Scotia, Ontario and Québec; it also provides some information on recent reforms. Section 8.2 identifies a number of problems related to the provincial/territorial systems arising out of the testimony received by the Committee. Section 8.3 examines the mental health acts of all Canadian jurisdictions and highlights the major differences among them. Section 8.4 present the Committee's commentary.

8.1 PROVINCIAL SYSTEMS OF MENTAL HEALTH SERVICES AND ADDICTION TREATMENT

8.1.1 Alberta³⁵⁷

The Ministry of Health and Wellness has responsibility for overall policy development, implementation, funding, service planning and evaluation in the fields of mental illness and addiction. Responsibility for the provision of community-based and facility-based mental health services is split between nine regional health authorities (RHAs) and the Alberta Mental Health Board. Provision of addiction treatment is the responsibility of the Alberta Alcohol and Drug Abuse Commission (AADAC).

Since the beginning of April 2003, the delivery of mental health services and the management of Alberta's four mental health facilities are the responsibility of the nine RHAs. Service delivery in the province encompasses Aboriginal mental health and reflects a strong integrated care/case management orientation. In other words, the vast majority of provision of front-line clinical services is under the direction of the RHAs and is integrated with the provision of physical health services.

The Alberta Mental Health Board, a provincial health authority accountable to the Minister of Health and Wellness, governs and operates province-wide services and programs such as forensic psychiatry, suicide prevention, tele-mental health (video-conferencing) and promotion activities. The Board also advises the Minister of Health and Wellness on matters related to the integration and performance of the provincial mental health system.

AADAC is a Crown agency accountable to the Minister of Health and Wellness. It is mandated to operate and fund services addressing alcohol, other drug and gambling problems (such as detoxification, residential treatment services; prevention, education, counselling), and to conduct related research. The Commission offers hospital-based addiction services in all regions. AADAC is also responsible for coordinating the implementation of the Alberta Tobacco Reduction Strategy.

RHAs, the Alberta Mental Health Board and AADAC work in partnership with the Ministry of Health and Wellness and other ministries and agencies in the implementation of the province-wide Children's Mental Health Initiative (July 2001). This Initiative focuses on reducing the risk of mental health problems and substance abuse and on providing support and treatment for children, adolescents and their families.

³⁵⁷ Unless specified otherwise, the information contained in this section is based on the following documents: Provincial Mental Health Planning Project, *Advancing the Mental Health Agenda – A Provincial Mental Health Plan for Alberta*, April 2004; Alberta Children and Youth Initiative, *Children's Mental Health Initiative*, Fact Sheet, February 2004; Alberta Mental Health Board, *Brief to the Committee*, 2003; Alberta Alliance on Mental Illness and Mental Health, *Partnership, Participation, Innovation – A Blueprint for Reform*, March 2003; Alberta Health and Wellness, "Transition Underway to Fewer Health Regions, Integrated Mental Health", *News Release*, 23 January 2003; Alberta Mental Health Board, *Business Plan, 2002-2005*, 2002; Information on the website of the Alberta Alcohol and Drug Abuse Commission (www.aadac.com).

8.1.2 British Columbia³⁵⁸

In British Columbia, responsibility for policy development, implementation, funding, service planning, monitoring and evaluation in the fields of mental illness and addiction rests essentially with the Ministry of Health Services and the Ministry of State for Mental Health and Addiction Services. Responsibility for mental health policy for children and adolescents belongs to the Ministry for Children and Family Development which works in collaboration with the Ministry of Health Services and the Ministry of State for Mental Health and Addiction Services.

Governance, management and delivery of mental health services and addiction treatment, including community-based services, are the responsibility of RHAs which operate in 5 defined geographic areas. Core mental health and addiction services provided by the RHAs, with the assistance of the Ministry of Health Services, include: emergency response and short-term intervention services; intensive case management; outreach services; clinical services (assessment, diagnosis, treatment and consultation); addiction treatment (since 2002), preventive measures (research, education, early identification and intervention); psychosocial rehabilitation; case management and social supports, including respite care for family caregivers; residential services; and, when required, assistance in accessing housing, income assistance and rehabilitation services and benefits.

British Columbia has one large long-stay psychiatric hospital, Riverview Hospital, six community forensic psychiatric clinics and a Forensic Psychiatric Services Commission. RHAs are responsible for the community forensic psychiatric clinics. The Provincial Health Services Authority, the sixth health authority of the province, administers services provided province-wide by the Riverview Hospital and the Forensic Psychiatric Services Commission.

The Forensic Psychiatric Services Commission is a multi-site organization that provides specialized hospital and community-based assessment, treatment and clinical case management services for adults with mental illnesses and substance use disorders who are in conflict with the law. This unique, single-entry service ensures that forensic psychiatric clients have equitable access to mental health and addiction services throughout British Columbia.

The position of a provincial ministry of state responsible for mental health and addiction services in British Columbia is unique in Canada. It suggests strong recognition by the provincial government of mental illness and addiction as a serious public policy concern:

³⁵⁸ Unless specified otherwise, the information contained in this section is based on the following documents: Mental Health and Addictions, Ministry of Health Services, British Columbia, *Brief to the Committee*, 9 September 2003; Mental Health and Addictions, Ministry of Health Services, British Columbia, *Development of a Mental Health and Addictions Information Plan for Mental Health Literacy, 2003-2005*, 4 February 2003; Government of British Columbia, *Child and Youth Mental Health Plan for British Columbia*, February 2003; Addictions Task Group, Kaiser Youth Foundation, British Columbia, *Weaving Threads Together – A New Approach to Address Addictions in BC*, March 2001; Minister's Advisory Council on Mental Health, *Moving Forward*, Annual Report, 2001; Ministry of Health Services, British Columbia, *Revitalizing and Rebalancing British Columbia's Mental Health System – The 1998 Mental Health Plan*, 1998; Information on the Website of the Provincial Health Services Authority (www.phsa.ca) and the British Columbia Mental Health Society or Riverview Hospital (www.bcmhs.bc.ca).

A unique approach has recently been implemented in British Columbia with the establishment of a Minister of State for Mental Health. This appears to be a direct acknowledgment of the importance of mental health issues within society and provides prominent office, with a seat in cabinet, to oversee governance and administration of the provincial mental health system.³⁵⁹

British Columbia has tried to implement best practices in mental health care. This has translated into the development of regionally integrated mental health services, with tertiary care provided in smaller, community-based facilities.

In recent years, British Columbia has established an addiction planning framework (May 2004), a child and adolescent mental health plan (February 2003), a depression strategy (October 2002) and an anxiety disorders strategy (April 2002). These province-wide initiatives are aimed at improving the quality and effectiveness of prevention, early detection/intervention, treatment and supports to individuals with mental illness and addiction.

8.1.3 Nova Scotia³⁶⁰

The Department of Health is responsible for the planning, organization, funding, management, monitoring and evaluation of mental health services and addiction treatment. These functions are achieved mainly through the Mental Health Services Section and the Drug Dependency Services of the Department of Health. The nine RHAs (called “District Health Authorities”) are responsible for the provision of mental health services and addiction treatment (alcohol, tobacco, drugs, gambling) in their respective geographic areas.

The Provincial Forensic Psychiatric Service, also administered by the Department of Health, provides inpatient treatment and assessment, and a few community support programs. All inpatient forensic psychiatric services are located in a single institution - the Nova Scotia Hospital.

The IWK Grace Health Centre is an academic health sciences centre affiliated with Dalhousie University. The IWK operates the provincial child and adolescent psychiatry unit, some outpatient clinics and telemedicine consultation services.

Nova Scotia was the first province to introduce, in 2003, formal standards for mental health service delivery. These standards were developed through collaborative efforts involving individuals with mental illness and addiction, their families, community groups and the

³⁵⁹ Dr. Elliot M. Goldner, *The Health Transition Fund – Sharing the Learning: Mental Health, Synthesis Series*, Health Canada, 2002, p. 11.

³⁶⁰ Unless specified otherwise, the information contained in this section is based on the following documents : Canadian Mental Health Association (Nova Scotia Division), *2004 Report Card on Mental Health Services Core Standards*, 8 March 2003; Department of Health, Nova Scotia, *Strategic Directions for Nova Scotia’s Mental Health System*, 20 February 2003; Department of Health, Nova Scotia, *Standards for Mental Health Services in Nova Scotia*, 20 February 2003; Roger Bland and Brian Dufton, *Mental Health: A Time for Action*, submitted to the Deputy Minister of Health, Nova Scotia, 31 May 2000; IWK Health Centre’s Website (<http://www.iwk.nshealth.ca/>).

Mental Health Services Section of the Department of Health. It has been argued that more funding is needed to implement these standards province wide.³⁶¹

8.1.4 Ontario³⁶²

Responsibility for the planning, organization, funding, management, monitoring and delivery of mental health services and addiction treatment rests with the Ministry of Health and Long-Term Care (MOHLTC). In contrast to other provinces, there are no RHAs in Ontario. There are 16 District Health Councils, but their mandate is limited to advising the Minister of Health on the health matters and needs in their respective districts; they do not control funding of any service, including mental health and addiction services. As a consequence, the many mental health services, supports and addiction treatment providers function largely independently of one another.

The MOHLTC also coordinates the provincial forensic strategy in partnership with the Ministry of Community, Family and Children's Services, the Ministry of the Attorney General, and the Ministry of Public Safety and Security.

The mental health and addiction treatment system in Ontario is currently in transition. In December 2002, 9 regional mental health implementation task forces released their reports on how to reform and renew the organization and delivery of mental health services and addiction treatment throughout the province. The main recommendation of these reports relates to the establishment of regional mental health authorities with responsibility for funding allocation and the delivery of mental health services and addiction treatment in their respective geographical areas. These regional systems would deliver a core basket of services and supports that would allow individuals to access a continuum of community-based services and supports where and when they need it. The Ontario government has not yet acted on the recommendations of these task forces.

8.1.5 Québec³⁶³

The *Ministère de la Santé et des Services Sociaux (MSSS)* (Department of Health and Social Services) has responsibility for planning, organization, management, funding, monitoring

³⁶¹ Canadian Mental Health Association (Nova Scotia Division), www.cmhans.org.

³⁶² Unless specified otherwise, the information contained in this section is based on the following documents : Provincial Forum of Mental Health Implementation Task Forces, *The Time Is Now : Themes And Recommendations For Mental Health Reform In Ontario*, Final Report, December 2002; Forensic Mental Health Services Expert Advisory Panel, *Assessment, Treatment and Community Reintegration of the Mentally Disordered Offender*, Final Report, December 2002; Ministry of Health and Long-Term Care, *Make it Happen – Operational Framework for the Delivery of Mental Health Services and Supports*, Government of Ontario, 1999;

³⁶³ Unless specified otherwise, the information contained in this section is based on the following documents : Ministère de la Santé et des Services Sociaux, *Agir Ensemble – Plan d'action gouvernemental sur le jeu pathologique, 2002-2005*, Government of Québec, 2002; Ministère de la Santé et des Services Sociaux, *Plan d'action en toxicomanie, 1999-2001*, Government of Québec, 1998; Ministère de la Santé et des Services Sociaux, *Québec's Strategy for Preventing Suicide*, Government of Québec, 1998; Ministère de la Santé et des Services Sociaux, *Plan d'action pour la transformation des services de santé mentale*, Government of Québec, 1998, Comité de la santé mentale du Québec, *Défis de la reconfiguration des services de santé mentale*, Government of Québec, 1997.

and evaluation of mental health services and addiction treatment. The Minister for MSSS is guided in this responsibility by two distinct advisory bodies: the Comité de la santé mentale du Québec and the Comité permanent de lutte à la toxicomanie. The 18 RHAs are responsible for the provision of inpatient, outpatient and community mental health services and supports as well as addiction treatment in their respective regions.

The MSSS is responsible for implementing and coordinating the provincial action plan on addiction; the plan covers promotion, prevention, early detection and intervention, detoxification, social rehabilitation and reintegration. In addition, the MSSS coordinates Québec's Strategy for Preventing Suicide. The purpose of this strategy is to consolidate and coordinate the various suicide prevention efforts to ensure equitable access to essential services in all regions. Essential services include: telephone hotline on a 24/7 basis; suicide crisis intervention (assessment, referral services, support services, monitoring); post-intervention (individual or group debriefing services for friends, relatives and caseworkers within 48 hours of a completed suicide). The strategy involves not only governmental departments, but also RHAs, CLSCs, hospitals, suicide prevention centres, police, schools, youth centres, community organizations, etc.

8.1.6 Brief Comparative Analysis

In two important aspects, British Columbia is unique in its approach to mental health and addiction policy in Canada. It alone has a minister of state responsible for mental health and addiction who can bring mental health issues to the forefront in Cabinet discussions. And second, only in British Columbia have the policy framework, governance and service delivery for both mental health and addiction been integrated.

In Alberta, Nova Scotia, Ontario and Québec, responsibility for mental health and addiction policy development and service planning rests with the provincial department of health. A number of provincial reports have noted, however, that policy development which impacts on individuals with mental illness and addiction has not been well coordinated across various social policy ministries. This has diminished the impact which would be derived from more thorough, consultative and inclusive inter-ministerial planning among the several ministries that must inevitably be involved in the provision of services to individuals with mental illness and addiction.

In all provinces but Ontario (which does not have RHAs as yet), programs and services to support individuals with mental illness and addiction are organized and provided by RHAs. Devolution through regionalization has facilitated the tailoring of services and supports to meet regional needs more closely. It has also facilitated collaboration among the various stakeholders involved in service delivery.

Reform of the mental health and addiction treatment system is occurring in most jurisdictions. While there are variations across provinces, a number of best practices criteria have been identified and largely agreed upon:

1. a shift from hospital to community-based services to create a more balanced approach to the delivery of mental health/addiction services;

2. specified, protected funding for an integrated mental health and addiction treatment system, including community, hospital-based and community-based tertiary care;
3. a single point of accountability where responsibility for the operation of an integrated system at the local/regional level;
4. mechanisms for the meaningful involvement of individuals with mental illness and addiction and communities in decision-making.

During its hearings, the Committee did not hear from individuals with mental illness and addiction or others about whether a particular province, region or RHA can be considered as a model to emulate in terms of policy development, organizational structure, governance and service delivery. Significant questions remain. For example, should the central authority for mental illness and addiction be at the provincial rather than at the regional level? Has any province or region been particularly successful at integrating hospitals and community services and supports? How can mental health services and supports best be integrated with addiction treatment? Has a particular province or region been able to coordinate mental health and addiction services with the broader social system (education, housing, justice, income support, etc.)?

8.2 COMMON PROBLEMS IDENTIFIED WITH RESPECT TO PROVINCIAL/TERRITORIAL FRAMEWORKS FOR MENTAL ILLNESS AND ADDICTION

8.2.1 Fragmentation and Lack of Integration

The Committee heard repeatedly that the mental health and addiction system is not, in fact, a real system, but rather a complex array of services delivered through federal, provincial and municipal jurisdictions and private providers, including initiatives by individuals with mental illness/addiction themselves. This system is a mix of acute care services in general hospitals, specialized services for specific disorders or populations, outpatient community clinics, community-based services providing psychosocial supports (housing, employment, education, and crisis intervention) and private counselling, all of varying capacity and quality, often operating in silos, and all-too-frequently disconnected from the health care system. In most jurisdictions, there are limited if any ties between the “formal” mental health and addiction system and self-help initiatives that have taken root in communities nationwide. The result is, in most jurisdictions, a highly fragmented (non-) system that has become increasingly difficult to navigate by both individuals with mental illness and addiction and service providers.

Compounding this fragmentation is the fact that while mental health services/supports and addiction treatment are delivered by many different agencies, data information systems are not yet adequately linked across the sectors concerned (e.g. health, housing, education, family benefits, work environment, etc.). This makes it virtually impossible to monitor mental health services and addiction treatment other than those provided by hospitals or

primary health care providers where some records are kept and can be accessed under the right circumstances.

The Committee was told that ensuring coordinated access to a broad continuum of services and supports is critical to the development of an effective strategy to address mental illness and addiction. This means that governments must invest in the community-based sector, as well as in hospitals and other institutions. Many witnesses stressed that a broad continuum of services and supports, including supportive housing and income supports, is key to meeting effectively the different needs of individuals at different stages of their illness and recovery; it is also key to ensuring a responsive mental health and addiction system capable of preventing acute episodes of illness, or of reducing their intensity or duration. Moreover, it is imperative that addiction be included in mental health reform initiatives.

A review of selected documents from a number of jurisdictions suggests that most provinces face very similar problems and challenges with respect to the current delivery of mental health services and addiction treatment. These problems and challenges are summarized below:³⁶⁴

- First, as mentioned above, existing services and supports for individuals with mental illness and addiction are fragmented among many separate agencies and many access points. There is also the need to better integrate the mental health system with the health care system and the mental health system with the addiction treatment system.
- Second, the current mental health services system still reflects to a large extent an institutionally-driven philosophy of care; services and supports should be patient-centred and community-based.
- Third, the current mental health services system is not comprehensive; it does not provide the continuum of services and supports needed. As a result, individuals with mental illness and addiction often do not receive the services and supports they need when and where they need them.
- Fourth, historically, mental health services have been under-funded. This has been detrimental to those with severe and persistent mental disorders, particularly to those hardest to serve – individuals from different ethnocultural communities, people who are homeless, and those with concurrent disorders.

³⁶⁴ Information based on the following documents: Department of Health, *Strategic Directions for Nova Scotia's Mental Health System*, Government of Nova Scotia, February 2003; Elliot M. Goldner, *Synthesis Series – Mental Health*, Sharing the Learning: The Health Transition Fund, Government of Canada, 2002; Government of Newfoundland and Labrador, *Valuing Mental Health – A Framework to Support the Development of a Provincial Mental Health Policy for Newfoundland and Labrador*, September 2001; Minister's Advisory Council on Mental Health, *Moving Forward*, Annual Report, Government of British Columbia, 2001; Ministry of Health, *Making It Happen – Operational Framework for the Delivery of Mental Health Services and Supports*, Government of Ontario, 1999; Comité de la santé mentale du Québec, *Défis – De la Reconfiguration des Services de Santé Mentale*, Gouvernement du Québec, October 1997; Health Systems Research Unit, Clarke Institute of Psychiatry, *Best Practices in Mental Health Reform*, Discussion Paper Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, 1997; Alberta Mental Health Board, *Building A Better Future – A Community Approach to Mental Health*, Government of Alberta, March 1995.

- Fifth, there are major human resource shortages in the mental health sector.
- Sixth, there is a significant lack of measures of accountability in the mental health services system. The roles and responsibilities of service providers are not clearly set out and an information system is needed to support the planning and operation of a more effective, comprehensive system and to monitor the effectiveness of the services it provides.
- And seventh, widespread stigma persists throughout society despite many efforts to educate the general public and the health care system as a whole. It has been said that stigma is the largest barrier to change in every level of the system.

Several witnesses stressed that recovery from mental disorders requires much more than what are considered traditional mental health services. For certain individuals, recovery may require – in addition to medication, therapy and case management – access to housing, transportation, employment and peer support. Yet, the various mental health systems have been slow to acknowledge and respond to these needs. In many provincial reports, reference is made to mental health services “and supports” to highlight the critical importance of each in providing the tools that an individual with a mental illness may need to recover from his/her illness, to overcome isolation, and to gain or regain economic self-sufficiency.

The lack of coordination among the various sectors, the absence of clear authority at the regional level and limited community-based supports have had tragic consequences for individuals and society. As pointed out in Chapter 5, a significant number of individuals with severe mental illnesses are homeless, living on the streets or in public shelters. In addition, a high proportion of incarcerated individuals have a mental disorder. Many of these individuals are jailed for non-violent misdemeanours, others for “crimes of survival” such as stealing food, loitering, or trespassing; their incarceration is often the result of their unmet needs for mental health services or addiction treatment and for housing.

Many witnesses pointed to the particular needs of children and adolescents. In fact, the system of child and adolescent mental health services and supports has been called by witnesses the “orphan’s orphan” of the health care system. Mental health services for children and adolescents at the provincial and territorial levels often involve a variety of departments and agencies (e.g., mental health, child welfare, young offender, addiction services, and special education services). There is general dissatisfaction in most jurisdictions with the present delivery of children and adolescents services. Information suggests that:

- The current system is highly fragmented; services are delivered in an uncoordinated fashion through multiple providers. The problems of children and adolescents do not come as neatly divided in terms of responsibility as government departments are.
- The prevalence of mental illnesses among children and adolescents far exceeds the capacity of the current service delivery system; there is a lack of access to needed services and there are long waiting lists for the limited services that are available.
- Mental health policies and programs have focussed largely on the treatment of the adult population; consequently, services for children and adolescents have developed slowly and only as an adjunct to programs for adults.

- There is insufficient funding for mental health services directed at children and adolescents.
- There is an urgent need to enhance preventive and early intervention services.
- Currently, many effective interventions are not made widely available to children and adolescents, and many ineffective interventions continue to be used even when shown to be more expensive and restrictive than available alternatives. Thus, there is a need to better incorporate research evidence about effective practices into decision making at all levels, including clinically.
- No clear goals and objectives have been set and few indicators of outcomes relevant to children and adolescents are reported on a regular basis to assess the performance and effectiveness of the system of mental health services.
- Nobody seems to be in charge, that is, there is no executive component with authority to cause the whole system of care to decide upon and implement coherent action.
- There are no external incentives for efficiency – surplus dollars must often be returned to central coffers rather than being reinvested locally.³⁶⁵

Witnesses also raised a number of concerns with respect to the specific needs of individuals with concurrent disorders (mental illness and addiction). These individuals may access needed services and supports through various entry points, either within the mental health system or within the addiction treatment sector. However, numerous barriers affect the ability of these individuals to access and obtain appropriate treatment:

- The mental health and addiction systems often operate in parallel, a barrier to ensuring that a person receives treatment for both problems in an integrated fashion. Current services provided for this population are poorly linked, both within and between the addiction and mental health systems.
- There are no systematic approaches and effective assessment tools to better identify this population.
- Because of inappropriate identification, individuals fail to receive proper care or receive care for only one disorder (either substance use or mental illness) but not both.
- Many mental health programs exclude individuals with active substance abuse problems, and similarly, many addiction programs exclude individuals with mental health problems.

³⁶⁵ Federal/Provincial/Territorial Working Group on the Mental Health and Well-Being of Children and Youth, *Celebrating Success: A Self-Regulating Service Delivery System for Children and Youth*, Discussion Paper, Health Canada, 2000, pp. 8-10; External Advisory Committee for Child and Youth Mental Health, *Child and Youth Mental Health Plan for British Columbia*, February 2003 (Revised July 2004), pp. 4-9; Charlotte Waddell et. al. (April 2002).

- Staff in both the mental health and addiction fields need cross-training to improve the identification of this client population and provide better treatment planning based on client needs.
- The fear/stigma associated with both mental illness and addiction often prevents individuals with concurrent disorders from seeking treatment and may lead to self-medication.
- Individuals with concurrent disorders and their families lack information on existing services and how they may be accessed.

Very similar concerns – such as fragmentation, the existence of silos, stigma, lack of specialized human resources, the need for early intervention and preventative measures – were expressed with respect to the mental health needs of senior Canadians and individuals in forensic psychiatry services.

8.2.2 Community Services and Supports

While a higher proportion of individuals than ever will make a complete or significant recovery from their mental illness/addiction, the illness will continue to have a significant impact on aspects of the lives of many for long periods, even a life time. Once the initial symptoms have been diagnosed and controlled properly, individuals with mental illness and addiction need three broad types of services: relapse prevention, clinical services and rehabilitation/support services. All three elements require management; for an individual with mental illness and addiction, the process is called “case management”.

As explained in Chapter 4, case management refers to the continuing and ongoing support provided to individuals with mental illnesses/substance use disorders to assist them to obtain needed services. When the severity of an individual’s illness or the complexity of the system precludes the affected person from accessing the needed services him/herself, case management may be provided by clinical and support service staff. For individuals with multiple needs intensive case management is essential. While case management is highly regarded as a core function in the system, a number of different approaches to providing case management have been used.

Relapse prevention consists in helping individuals maintaining their recovery. The Committee was told that the most important component of relapse prevention is to ensure that the affected person continues to take his/her medication. Often, individuals stop taking their medication because they feel well and are no longer motivated to continue. They may also experience what they consider to be intolerable side effects and stop medication. In both cases, they then lose insight into the benefits of taking medication and suffer relapse of their illness. Once-a-day dosing and minimizing toxicity/side effects can help to reinforce patient compliance. However, education, counselling and regular monitoring are also vital to improve compliance. Witnesses told the Committee that developing standards and guidelines for relapse prevention measures, in consultation with health and educational authorities, is critical.

Clinical services are a core component of overall services and supports because many individuals do experience relapse. Even when they follow a treatment plan faithfully, many

individuals can become severely ill and require acute treatment. For some, where safety or complexity is an issue, hospital admission is also necessary. Clinical services include inpatient services, hospital-based clinics, support groups, information sessions, outpatient clinics, mental health centres, visiting clinical teams, emergency teams and a variety of other clinical services located in community settings; all are necessary to meet the varying needs of individuals with mental illness. Such clinical services, together with NGOs, are needed to provide a full spectrum of care for affected individuals and their families. Coordinating such a complex system is essential. Again, the Committee was told that clinical guidelines or standards are essential to promote their effectiveness and efficiency.

Rehabilitation and ongoing support services must be available to help optimize the quality of life of affected individuals and help them recover their abilities to the fullest extent possible. These services include: housing, ranging from professionally staffed group homes to independent apartments with regular consultation and the availability of 24-hour 7-day crisis response; vocational services including job finding and support and skill training; social and recreational services including assisting people to join in normal community activities and “drop in” places; and income support, as many individuals have difficulty in obtaining and maintaining employment. All these services and more should contribute to ensuring the continuum of care of a seamless system.

8.2.3 Uneven Regional Distribution and Quality of Services

The Committee was told that, as with other health services, mental health services and addiction treatment are especially lacking in rural and remote areas of the country, including most Aboriginal communities. In many such areas, there is no resident psychiatrist. The result is that individuals with mental disorders living in rural and remote regions and Aboriginal settings are forced to travel far from their homes to receive needed services. This hardship, ironically dubbed “Greyhound Therapy”, is doubly stressful for someone affected by mental illness and addiction.

When individuals must travel from their communities to access mental health and addiction services, they are separated from their natural support systems and informal care networks that provide the kind of financial, emotional and social supports for recovery that are not found in the formal system. Although for some the anonymity of the city is a welcome respite from the shame and stigma that usually affect individuals with mental illness and addiction in a small community, being removed from that community can also compromise treatment interventions and outcomes.

The Canadian Mental Health Association pointed out that rural and remote communities also experience particular mental health issues such as those triggered by drought, flood and other environmental disasters. Such communities may also be characterized by compounding factors, such as lower educational and income levels, higher adolescent birth rates, a higher proportion of unwed mothers, and higher unemployment rates, that can contribute to the development and exacerbation of mental health problems and illnesses. According to the Association, transplanting urban professional mental health workers into

rural settings, even if they are willing to relocate, would not necessarily qualify or equip them to deal with the distinctive rural and cultural issues affecting their clients.³⁶⁶

8.2.4 Primary Health Care Sector

The primary health care sector is usually the first point of contact of individuals with mental illness and addiction with the health care system. Yet, the Committee heard repeatedly that many family physicians lack sufficient knowledge, skills and motivation to manage patients with mental illness and addiction, to accurately screen for mental disorders, or to navigate the appropriate referral pathways to access the more specialized mental health and addiction system. Dr. Sunil V. Patel, President of the Canadian Medical Association (CMA), told the Committee:

*While family physicians can deal with a number of mental illnesses, most are not trained in the complicated medical management of severe mental illness. Many family physicians' offices are also not sufficiently resourced to deal with family counselling, or related issues such as housing, educational and occupational problems often associated with mental illness.*³⁶⁷

Witnesses also told the Committee that many provincial health care insurance plans limit the amount of mental health services that can be billed by family physicians. For example, Patrick Storey, Chair of the Minister's Advisory Board on Mental Health (British Columbia), stated:

*Medical billing schedules and procedures, extended health benefits, pension plans, et cetera, do not recognize the special features and challenges of mental illness and create unnecessary obstacles to recovery and health. For example, in British Columbia, a family doctor can bill for only four counselling sessions per patient per year; yet, most people with depression go to see their family doctor. Though antidepressant medication is a helpful adjunct, alone it is not sufficient to help people deal effectively with that sometimes debilitating condition. Doctors are not in a position to provide the help required for a person in a depression.*³⁶⁸

Dr. James Millar, Executive Director, Mental Health and Physician Services, Nova Scotia Department of Health, expressed similar view when he stated:

Even physician services are restricted. (...) Many provincial health plans restrict the number and types of mental health services that can be provided by general practitioners. In many cases, family practitioners are

³⁶⁶ Canadian Mental Health Association, Brief to the Committee, June 2003, pp. 8-9.

³⁶⁷ Dr. Sunil V. Patel, President of the Canadian Medical Association, Brief to the Committee, 31 March 2004, pp. 1-2.

³⁶⁸ Patrick Storey, Chair of the Minister's Advisory Board on Mental Health, British Columbia (15:8).

ill prepared to treat the serious mental disorders that appear [sic] in their offices. There is little support for education or on-site consultations.³⁶⁹

Another concern brought to the attention of the Committee is that, currently, primary health care reform is occurring in relative isolation from the reform of the mental health and addiction system in communities across the country. Yet, many witnesses felt that these two systemic reforms ought to share the same goal of improving the provision of quality, accessible, comprehensive, integrated, timely services to all those who need them regardless of the type of underlying disease.

The Committee was told that progress could be made, however, with support for “shared mental health care” initiatives across the country. These initiatives, which stem from a partnership between the College of Family Physicians of Canada and the Canadian Psychiatric Association, appear to be a success story; they refer to collaborative activities between primary health care providers and psychiatrists. Some shared mental health care initiatives have a strong clinical focus and integrate mental health services within primary health care settings.³⁷⁰

Irene Clarkson, Executive Director, Mental Health and Addictions, British Columbia Ministry of Health Services, stated that shared mental health care initiatives within primary health care settings would help to enhance early detection and intervention:

Through primary health care 60% of persons with mental disorders and substance use disorders currently access their services in B.C., and therefore improved primary care is a priority for change. (...) Evidence in the medical literature supports the delivery of these interventions by multidisciplinary teams. (...) In many instances physicians are the only source of mental health and addictions services for people at risk or with mental disorders and substance use disorders, therefore, attention to primary care can promote early detection and intervention for mental health and addictions problems which in turn leads to better long-term prognosis; allows for teaching clients self-management of their health; and, ensures ongoing, periodic assessments and treatment to promote stability and community tenure.³⁷¹

Many witnesses felt that the federal government could play a major role in ensuring that successful shared care initiatives continue to be funded and that best practice models be implemented and converted into permanent programs and policies in all provinces and territories.

³⁶⁹ Dr. James Millar, Executive Director, Mental Health and Physician Services, Nova Scotia Department of Health, Brief to the Committee, 28 April 2004, pp. 5-6.

³⁷⁰ Canadian Psychiatric Association and The College of Family Physicians of Canada, [*Shared Mental Health Care in Canada – Current Status, Commentary and Recommendations*](#), A Report of The Collaborative Working Group on Shared Mental Health Care, December 2000.

³⁷¹ Irene Clarkson, Executive Director, Mental Health and Addictions, British Columbia Ministry of Health Services Brief to the Committee, 9 September 2003, pp. 5-6.

8.2.5 Human Resources

Like other areas in the health care system, mental health services and addiction treatment suffer from a lack of coordinated planning for its human resources. There is no central planning mechanism to coordinate hiring or to ensure the appropriate distribution of appropriately qualified and experienced service personnel across communities. The growing geographical concentration of mental health and addiction professionals in large urban centres is also a major concern.

Witnesses told the Committee that there are chronic shortages of providers, including of psychiatric nurses, psychiatrists, social workers, case managers and occupational therapists with knowledge of mental health and addiction issues.

The growing need for expert services is exacerbated by a shortage of psychiatrists and limited access to psychologists. According to the Canadian Psychiatric Association, the ideal psychiatrist to population ratio (1:8,400) is far from being achieved, especially outside urban centres. To compound the problem, an increasing number of the Canada's 3,600 currently counted licensed psychiatrists are not working full time, particularly women and young graduates just entering the field who have made lifestyle choices to work fewer hours. Certain specialties are especially under-resourced, such as child, geriatric and forensic psychiatry. Individuals with concurrent disorders (mental illness and addiction) and dual diagnosis (mental disorder and developmental disability) have particularly limited access to appropriate psychiatric care.³⁷² In addition, particular groups such as immigrants/refugees lack a level of services appropriate to meet their needs.

For psychological services, equality of access appears to be the major problem. Publicly funded psychology services through hospitals or mental health clinic programs are spotty and limited in their availability. As general hospitals face budgetary constraints, their departments of psychology are frequently reduced or eliminated. Moreover, many low- and middle-income individuals, together with people who are unemployed and/or those who do not have private health care insurance, cannot afford to pay for private psychological services which are not covered under publicly funded provincial health care insurance.

Long waiting lists and significant delays in diagnosis, treatment and support are direct by-products of a mental health system that lacks the human resources to deliver care effectively. While there are no standardized sources of data currently available for compiling national information on waiting lists, provincial estimates depict a pretty grim picture. The Canadian Mental Health Association stated in its brief that:

(...) about half of the adult population who need services must wait for eight weeks or more – an eternity in the lifetime of a person, a family or a community struggling with serious mental illness or addiction. For some individuals, having to wait for services is the difference between life and death. While the crisis in surgical waiting lists makes the headline news, society remains fairly oblivious to the suffering and isolation of

³⁷² Canadian Psychiatric Association, *Human Resource Planning for Psychiatry in Canada – A Background Paper*, unpublished document.

*those experiencing a mental health crisis who suffer and wait in silence for critical and medically necessary supports. It is most tragic that when a person finally finds the strength and courage to reach out for help, more often than not their first contact with the mental health system becomes a discussion of how long they must wait.*³⁷³

Dr. Cornelia Wieman, Psychiatrist from the Six Nations Mental Health Services (Ohsweken, Ontario) informed the Committee that currently there are only four Aboriginal psychiatrists in Canada. In her view, it is important, indeed critical, to train an increased number of Aboriginal health professionals. This would help ensure that services are provided in a more culturally appropriate manner and remove some of the barriers to those seeking mental health services in communities universally acknowledged to have particular need for them.

My last plea in this area is that there is a common saying that "no one is irreplaceable" - so I ask you today : after 7 years of working in the Six Nations community and providing psychiatric services to over 400 patients for well over 600 episodes of care, who will replace me? (...) We desperately need to train more Aboriginal health professionals (...).

[Dr. Cornelia Wieman, Brief to the Committee, 13 May 2004, pp. 5-6.]

Many recommendations were suggested to the Committee with respect to the planning of human resources in mental health, mental illness and addiction. For example, it was recommended that the provinces and territories, in partnership with the federal government, develop a long term plan that will ensure high quality appropriately trained service providers – both professionals and para-professionals – to address the mental health needs of Canadians. This plan would include:

- a detailed national human resource plan for mental health and addiction personnel based on forecasted needs and projected trends;
- a compilation of information on waiting lists; development of national standards and guidelines for maximum waiting times across the full continuum of mental health care and addiction treatment services;
- review of the effective use of alternatives to professionals outside the medical field, such as home support workers, social workers, peer support workers and informal social networks to decrease the demand for psychiatrists;
- creation of a task force to review and make recommendations on how to improve the knowledge of and training in mental health intervention and promotion strategies as part of the curricula of training of all health professionals and of undergraduate and graduate students within the health disciplines, education, social work and other related programs at the university and college levels.
- analysis of the extent to which interdisciplinary opportunities for joint education (undergraduate, graduate and continuing education) could be used between

³⁷³ Canadian Mental Health Association, Brief to the Committee, June 2003, p. 8.

- physicians and psychologists, nurses, social workers, occupational therapists and addiction counsellors;
- incentives for the recruitment and retention of mental health professionals and students in these disciplines;
 - a study of various models of mental health service delivery in rural areas, including the use of telehealth.

8.2.6 Unmet Needs

[The] problem of access occurs across the continuum of services from primary care for common disorders to urgent and crisis services for more severe and persistent disorders. [Dr. Donald Addington, Professor and Head, Department of Psychiatry, University of Calgary, Brief to the Committee, 29 May 2003, p. 3.]

Despite efforts by provinces and territories to improve the delivery of mental health services/supports and addiction treatment, a majority of Canadians suffering from mental illness and addiction still do not seek and receive professional help. Statistics Canada's Canadian Community Health Survey (CCHS), Cycle 1.2 on Mental Health and Well-Being, found that only 32% of those suffering from mental illnesses and substance use disorders saw or talked to a health professional during the 12 months prior to the survey.³⁷⁴ These professionals included either a psychiatrist, a family physician, a medical specialist, a psychologist or a nurse.

When individuals did see a health professional for mental illnesses or alcohol or drug use and abuse, family physicians were most often consulted. Nearly 26% of those individuals surveyed consulted a family physician; some 12% consulted a psychiatrist, and 8% a psychologist. About 10% saw or talked to a social worker.

The CCHS also showed that adolescents and young adults (15 to 24 years old) were the least likely of all age groups to use any resources for mental illness and addiction than other age groups, although they exhibited higher prevalence rates for mental disorders. Only 25% of affected adolescents and young adults reported having consulted a professional or using other assistance during the previous year.

In his submission to the Committee, Phil Upshall, President of the Canadian Alliance on Mental Illness and Mental Health, enumerated the various factors that lead to unmet needs in mental health services/supports and addiction treatment:

“Why do people not receive treatment and, most likely, the other services they require?”

³⁷⁴ Statistics Canada, “Canadian Community Health Survey: Mental Health and Well-Being”, [The Daily](#), 3 September 2003.

- *In part, it is due to a general lack of awareness in the Canadian population of mental illness, or a lack of understanding of the symptoms of mental illness.*
- *Stigma stands in the way – the fear of having a mental disorder continues to be strong.*
- *Services are scarce. Governments choose to make their health investments in narrowly defined biomedical services at the expense of services for the mentally ill and those with psychological complications in physical illness and disability.*
- *Not all services are available to all Canadians. Only those with average to above average incomes can afford private practice services, and the mentally ill are often at the other end of the spectrum. They make up a disproportionately large percentage of marginalized populations – those without adequate income, housing or support systems to meet their basic needs.*
- *On the part of the medical community, low awareness and understanding of the symptoms of mental illness, and time constraints come into play.”³⁷⁵*

Dr. Donald Addington, Professor and Head, Department of Psychiatry, University of Calgary, recommended the establishment of a patient charter that would establish standards for access to mental health services in primary health care, specialized mental health services and acute care.³⁷⁶ In Ontario, the Champlain District Mental Health Implementation Task Force (2002) also recommended the creation of a “Provincial Mental Health Patients’ Charter of Rights”. The preamble of the proposed provincial patients’ charter of rights stated:

People living with mental illness are entitled to the full range of rights and privileges as citizens of Canada, including the right to health care, income maintenance, education, employment, safe and affordable housing, transportation, legal services, and equitable health and other insurance, and are not limited to the rights listed in this Charter.³⁷⁷

This charter would not be limited to mental health services but would also encompass broader social supports. More precisely, the proposed charter included, for example:

³⁷⁵ Phil Upshall, President, CAMIMH, Brief to the Committee, 18 July 2003, p. 8.

³⁷⁶ Dr. Donald Addington, Professor and Head, Department of Psychiatry, University of Calgary, Brief to the Committee, 29 May 2003, p. 3.

³⁷⁷ Champlain District Mental Health Implementation Task Force, « Consumer Charter of Rights for Mental Health Services », in [Foundations for Reform](#), Section 3.1.4, Ontario, December 2002.

- Mental health services that are safe, secure, evidence-based, timely, culturally appropriate and relevant to the individual's needs;
- Services and supports that encourage the involvement of individuals with mental illness and addiction and are based on the principles of recovery, self-help and independent living and functioning;
- Treatment that is respectful of relevant legislation (Mental Health Act, Canadian Charter of Rights and Freedoms, etc.);
- Respect for privacy and informed choices.

Other witnesses suggested some form of “mental health equitable act”, a piece of legislation intended to bridge the gap between physical illnesses and mental disorders in terms of public coverage and the services provided. Still, others supported the need for a “mental health advocate”, a contact person for individuals experiencing difficulty in accessing needed mental health services and supports. A mental health advocate existed for some time in British Columbia, but the position was eliminated when the Ministry of State for mental illness and addiction was created.

8.2.7 Early Detection and Intervention

The high level of unmet needs in the field of mental illness and addiction underscores the importance of early detection and intervention. As a matter of fact, numerous witnesses stressed that early intervention – which encompasses detection, assessment, treatment and supports – can interrupt the negative course of many mental disorders and lessen long term disability. New understanding of the brain indicates that early detection and intervention can sharply improve outcomes and that long periods of abnormal thoughts and behaviour have cumulative effects that can limit a person's capacity for recovery. For example, the Schizophrenia Society of Canada stated:

For most diseases, the earlier they are detected and treated the better the expected outcome is for the person affected by the illness. (...) Unfortunately, because of a lack of public and professional knowledge about the symptoms, stigma and denial of the illness, many people delay seeking treatment. It is estimated that half of the people with schizophrenia go for an average of about 2 years before they receive a diagnosis and treatment after first manifesting symptoms.

(...)

Research has shown that the longer the psychotic symptoms are left untreated the worse the long term prognosis. There is greater evidence of brain damage in persons who experience long, untreated psychotic episodes compared to those who experience shorter, more efficiently treated episodes. In addition to longer periods of non-treatment causing more evidence of brain damage, the person is more likely to lose employment or

*educational standing, lose friends and interpersonal skills, and is more likely to run afoul of the law due to the symptoms of the illness.*³⁷⁸

The benefits of early intervention extend to numerous mental illnesses and to individuals of all age groups. Without early intervention and treatment, child and adolescent disorders frequently continue into adulthood. If the system does not appropriately screen and treat them early, these childhood disorders are likely to persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. No other set of illnesses damage so many children so seriously.

Currently, no agency or system is clearly responsible or accountable for children and adolescents suffering from mental disorders. They are invariably involved with more than one specialized service system, including mental health services, special education, child welfare, youth justice, addiction treatment, and health care.

Schools are where children spend most of each day. While schools are primarily concerned with education, good mental health is essential to learning as well as to social and emotional development. Because of this important interplay between mental health and academic success, schools should be partners in the mental health care of children.

Early intervention is also essential to reduce the pain and suffering of children, adolescents and adults who have concurrent disorders (mental illness and addiction). Too often, these individuals are treated for only one of the two – if they are treated at all. If one disorder remains untreated, both usually get worse and additional complications often arise, including the risk for other medical problems, unemployment, separation from families and friends, homelessness, incarceration, and suicide. The Committee was told that few providers or systems that treat mental illness or addiction adequately address the problem of concurrent disorders.

Early intervention should occur in readily accessible settings such as primary health care settings and schools and where a high level of risk for mental illness exists, such as youth justice and child welfare services. A coordinated approach is necessary together with training the school workforce to screen for and recognize early signs of mental illness; training primary health care providers; and eliminating barriers to publicly funded health care insurance, particularly for psychology services.

8.3 MENTAL HEALTH LEGISLATION

In addition to their primary responsibility for delivering mental health services and addiction treatment within their jurisdiction, provinces and territories are responsible for enacting mental health legislation. Such legislation governs the provision of psychiatric treatment to individuals who are severely afflicted by mental illness and who are unable to seek out and accept needed care. At the present time, each province and territory has its own mental health act, except Nunavut in which the Northwest Territories law applies.

³⁷⁸ Schizophrenia Society of Canada, Brief to the Committee, 2004, p. 5.

All provincial and territorial mental health legislation defines criteria for involuntary admission to hospital for psychiatric treatment, treatment authorization and refusal, conditional leave, and review and appeal procedures. Without compulsory hospital admission and psychiatric treatment, individuals who will not accept voluntary treatment are abandoned to the consequences of their untreated illness. Individuals affected by untreated mental disorders have a high mortality rate and higher lifetime disability rates than those affected by most physical illnesses.

Mental health legislation is also meant to reflect a balance between the rights and dignity of the individual, the protection of society, and society's concern to help those not able to help themselves. In fact, all provincial and territorial legislation must comply with the *Canadian Charter of Rights and Freedoms*.

The pertinent sections of the *Charter* are sections 7, 9, 12, 15, as well as section 1. Under section 7, an individual cannot be deprived of life, liberty or security of the person unless that deprivation is in accordance with the principles of fundamental justice; under section 9, a person is guaranteed the right not to be arbitrarily detained or imprisoned; under section 12, a person has the right not to be subjected to cruel and unusual treatment or punishment; and, under section 15, every person is equal under the law and has the right not to be discriminated against on the basis of mental disability. Although the *Charter* guarantees certain rights under the sections mentioned, a qualification under section 1 serves to limit the absolute scope of those guarantees. Under section 1, *Charter* rights are subject to reasonable, justifiable limits. Thus, a court may decide that the violation of a right that is guaranteed under the *Charter* is reasonable and therefore justified in today's society.³⁷⁹

While compulsory treatment will usually restore someone's freedom of thought from a mind-controlling illness and restore their liberty by releasing them from detention, their feelings of autonomy and legal and civil rights may be impacted. For this reason, it is necessary for legislation to balance all their needs and those of society as a whole.

[Gray, Shone and Liddle (2000), Canadian Mental Health Law and Policy, p. 5.]

In 1984, prompted by anticipation that much of existing mental health legislation was susceptible to possible challenge under the *Charter*, a "Uniform Mental Health Act" was developed by a working group established under the Uniform Law Conference as a model for provincial mental health legislation. The working group consisted of a lawyer and a senior mental health official from each participating province and territory. The Uniform Mental Health Act was adopted by Uniform Law Conference representatives in 1987. The ensuing principles form the essence of the proposed Uniform Mental Health Act:

- A system that promotes voluntary admission and treatment with informed consent is preferred to compulsory services;
- Where there is no alternative to involuntary detention and treatment which limit a person's liberty or right to make decisions, these limitations must conform with the Charter;

³⁷⁹ Maureen Anne Gaudet, Mental Health Division, Health Services Directorate, Health Programs and Services Branch, Health Canada, *Overview of Mental Health Legislation in Canada*, 1994, p. 4.

- A range of appropriate treatment options, including the least restrictive and intrusive alternatives, are offered and explained to the person;
- The duty of confidentiality of information in the medical file/record is heightened by the vulnerability of mentally-ill persons and the potentially severe consequences of improper release of such information;
- The patient has the right to view, for purposes of accuracy, documents gathered for the purpose of his/her medical treatment;
- If a person's rights and freedoms are affected by legislation, an independent body or a court can review the decision to determine whether or not the decision was reached fairly.³⁸⁰

Although the Uniform Mental Health Act was never implemented as such in each province and territory, many jurisdictions have enacted legislation which conforms with its fundamental principles. There remain, however, significant differences in the provisions of the relevant mental health statutes among the various jurisdictions. These differences can have profound effects on individuals with severe mental illness, many of whom may not receive timely needed treatment. They can also create significant ethical dilemmas for psychiatrists. Gray and O'Reilly (2001) pointed to the following major disparities:

Mental health legislation can be a critical factor in determining whether a person who is severely afflicted by mental illness does or does not receive psychiatric treatment and whether this treatment occurs in a timely fashion.

[Gray and O'Reilly, "Clinically Significant Differences Among Canadian Mental Health Acts", Canadian Journal of Psychiatry, Vol. 46, No. 4, May 2001, pp. 315-321.]

- In some jurisdictions, involuntary admission criteria stipulate that a person must be likely to cause serious physical harm to himself/herself or others (Alberta, Nova Scotia, Northwest Territories and Nunavut). In the other jurisdictions, the criteria for involuntary admission also include the potential of non-physical (mental) harm. The criterion which limits involuntary admission and treatment to physical harm raises ethical issues for psychiatrists, who may see a patient who is extremely distressed because of a psychotic illness but who is not likely to be dangerous (physically) to himself/herself or others. In such cases, while psychiatrists know that treatment would be quickly effective and would relieve suffering, they can neither hospitalize nor treat the affected person. As a result, some individuals with severe mental illness and in need of psychiatric treatment will not receive timely care. According to Gray, Shone and Liddle (2000): "The rise in the number of people with mental illness in prisons and homeless on the streets is blamed in part on laws restricting involuntary admission to the physically dangerous."³⁸¹

³⁸⁰ Maureen Anne Gaudet (1994), pp. 17-18.

³⁸¹ John E. Gray, Margaret A. Shone and Peter F. Liddle, *Canadian Mental Health Law and Policy*, 2000, p. 5.

- Following involuntary admission, some jurisdictions do not allow the individual to refuse treatment (British Columbia, New Brunswick, Newfoundland, Québec and Saskatchewan)³⁸²; these provinces use an appointed officer of the state to authorize treatment (either the attending physician, the director of a psychiatric unit, a tribunal or the court). The other jurisdictions do allow a refusal, that may be overruled in the individual's best interests by a substitute decision-maker (either a guardian, relative, public trustee, review board or court). Still, three other jurisdictions (Ontario, Northwest Territories and Nunavut) honour a previously expressed wish not to be treated, even if that prolongs detention and suffering. All jurisdictions provide for a board or panel to review the validity of involuntary hospitalization. When the process for obtaining treatment authorization involves a tribunal, the court or a substitute decision-maker, there may be delays lasting a few days, months or even years before treatment can be provided.

Court processes can delay treatment of involuntary patients inordinately. Unfortunately, treatment must be stopped according to the Ontario Health Care Consent Act, as soon as a person appeals to the court. One study showed that where people appealed to the court, treatment was stopped for an average of 253 days. This means that people were detained against their will for over 8 months, causing undue anguish for the individual, the family and wasting a significant amount of taxpayer's money. A simple change to the law could remedy this problem.

[Schizophrenia Society of Canada, Brief to the Committee, 2004, p. 9.]

- All jurisdictions recognize that compulsory treatment in the community is a less restrictive option compared to involuntary admission and treatment in hospital. Accordingly, provincial/territorial mental health acts contain provisions that authorize conditional leave from hospital or community treatment orders (CTOs). The conditional leave provisions authorize an involuntary patient to be discharged in the community; the patient remains under the authority of the hospital but is continuing his/her treatment there. Under the CTO (Saskatchewan and Ontario), the individual is not an involuntary patient but is put on the order for the purpose of compulsory treatment while living in the community. CTOs are intended to reduce the “revolving door syndrome”, make hospital beds available to others and assist with integration into the community. For CTOs to be effective, however, the services and supports required to support the conditions must be available. A major criticism of CTOs is that the necessary services are not available out of hospital and, thus, individuals will fail in the community and be hospitalized. A similar criticism is that hospitals will prematurely discharge someone on leave and “dump” him/her on the community. Only four provincial mental health acts (British Columbia, Manitoba, Ontario and Saskatchewan) do not allow a person to be on CTO unless appropriate supports exist in the community.

It is clear that psychiatric management of individuals with severe episodes of mental illness differs greatly depending on where affected persons live in Canada. In some jurisdictions,

³⁸² In some cases, however, the patient may choose to have the court order the hospital to suspend treatment.

where individuals with severe mental disorders are admitted to hospital and treatment starts promptly, there is a good chance for their returning to “normal” daily activities. In other jurisdictions, many months, if not years, may elapse before an individual’s mental health deteriorates to the point where he or she is deemed to be at risk of inflicting serious bodily harm on himself/herself or on others, sufficient to warrant involuntary hospitalization. Even when hospitalized, treatment may be delayed for months or years in jurisdictions in which its initiation is prevented while an appeal is outstanding or those concerned are bound by a previous, capable, applicable wish not to be treated.

In their review of provincial and territorial mental health legislation, Gray and O’Reilly (2001) commented:

It is of considerable concern that such disparities of practice exist among Canadian provinces and territories. There is an increasing body of evidence that the duration of untreated psychosis is correlated with a poor prognosis and that early intervention may prevent progression of the underlying disease process. Moreover, it is also clear that psychosis occurring at a young age can interfere with the completion of such important developmental tasks as schooling, vocational training, and psychosocial treatment. (...) [t]here is evidence (...) that higher rates of homelessness, violence, victimization, and criminalization occur when individuals with a mental illness are not treated than when they are treated. Conditional leave and community treatment order measures are now common in Canadian jurisdictions and are becoming widespread in other countries. They have been shown to effectively reduce hospitalization and to facilitate treatment adherence.³⁸³

Should more uniformity among the various provincial and territorial mental health legislation be encouraged? Do disparities in mental health law reflect diverging views on the balance between protection of vulnerable persons, individual rights and freedom, and public safety? Gray, Shone and Liddle (2000) eloquently pointed out that, ultimately, mental health legislation is a matter of societal values:

Society must ask itself whether, in the name of freedom, people with a treatable brain illness who are escaping delusional enemies should be left suffering and homeless because they are not physically dangerous. Does society value the “right to be psychotic” to the degree that it should allow people to refuse treatment and, therefore, stay detained and warehoused at great public expense for long periods of time, putting themselves and others at risk of serious harm? Or should society keep people in hospitals when, with appropriate legislation, they could be at home in the community? Does society prefer to have people functioning in the community because they are legally required to take treatment or does it

³⁸³ John E. Gray and Richard L. O’Reilly, “Clinically Significant Differences Among Canadian Mental Health Acts”, *Canadian Journal of Psychiatry*, Vol. 46, No. 4, May 2001, p. 320.

*want these people to have repeated psychotic episodes and involuntary hospitalizations? A compassionate and just society must weigh these options including concerns for minimizing state intrusion in people's lives.*³⁸⁴

8.4 COMMITTEE COMMENTARY

All provinces and territories have undertaken the reform and renewal of their mental health care and addiction treatment system. Some jurisdictions are more advanced than others, but all share similar goal and principles. Similarly, most provinces face similar challenges and barriers to improving the provision of mental health services and supports and addiction treatment.

The Committee concurs with witnesses that the “silo philosophy” of policy planning and delivery of mental health services/supports and addiction must be addressed, through better integration, partnerships and collaboration. This is a critical step towards the development of a truly effective and genuine mental health and addiction system.

We also agree with witnesses that individuals with mental illness and addiction and non-governmental organizations must participate in the reform of the system. The development of a seamless system will only occur with the benefit of their first-hand experience and knowledge.

Achieving a truly seamless system of mental health services/supports and addiction treatment that is oriented to individuals with mental illness and addiction also requires tackling numerous challenges related to human resource planning and primary health care reform. In addition, more emphasis must be placed on early detection and intervention. In particular, the unique needs of children and adolescents must be addressed in a timely fashion.

The Committee also agrees that individuals living with severe mental disorders are particularly vulnerable and that, accordingly, the provision of mental health services and addiction treatment must reflect an appropriate balance between the rights of these individuals and the role of society in caring compassionately for them. It is important to decide whether the current disparities found in mental health legislation across the provinces and territories require formal review.

³⁸⁴ John E. Gray, Margaret A. Shone and Peter F. Liddle, *Canadian Mental Health Law and Policy*, October 2000, p. 358.

CHAPTER 9: MENTAL ILLNESS AND ADDICTION POLICIES AND PROGRAMS: THE FEDERAL FRAMEWORK

Given the level of burden of mental health issues and mental illness on society, Canadian governments can no longer afford to ignore reality. The time has come to redress historical imbalances. Canada can only achieve the holistic vision of mental health (...) if it addresses complex interrelated issues in a coordinated fashion. What is needed now is collaborative national leadership in a national action strategy. We hope that the federal government will embrace this challenge. As citizens, we all serve to benefit.

[Canadian Mental Health Association, Brief to the Committee, June 2003, p. 29.]

INTRODUCTION

This chapter examines the role and responsibility of the federal government in developing policies and programs in the field of mental health, mental illness and addiction. It also outlines various federal initiatives relevant to the development of an overall framework for mental health, mental illness, and addiction. In doing so, it attempts to separate the initiatives of the federal government for populations directly under its jurisdiction from others with a broader national focus involving multi-jurisdictional issues, notably those of primary concern to Canada's provinces and territories.

Section 9.1 provides an overview of the direct and indirect roles of the federal government in mental health, mental illness and addiction. Section 9.2 describes and assesses the direct role of the federal government with respect to the specific population groups that fall under its responsibility, including First Nations and Inuit; federal offenders; veterans and the Canadian Forces; Royal Canadian Mounted Police; and federal public servants. Section 9.3 examines federal interdepartmental coordination relevant to its direct role in mental health, mental illness and addiction. Section 9.4 reviews the roles and responsibilities of the federal government from a national perspective (indirect role); it also examines the legal and financial levers available to influence policy in the field of mental health, mental illness and addiction. Section 9.5 provides a general assessment of some federal policies and programs affecting the delivery of mental health services, addiction treatment and social supports. Section 9.6 discusses the potential for a national action plan. Section 9.7 examines mental health, mental illness and addiction from a population health perspective. Section 9.8 contains the Committee's commentary.

9.1 DIRECT AND INDIRECT ROLES OF THE FEDERAL GOVERNMENT

To provide a “picture” of the extent of the federal government’s role in mental health, mental illness and addiction, the Committee’s researchers searched the federal consolidated statutes and regulations using the terms “addiction”, “disability”, “mental disorder”, “mental health”, “mental illness”, and “substance abuse”. Table 8.1 provides the list of federal legislation that makes reference to these terms.

It appears clearly that the federal government has a role on two fronts in mental health, mental illness and addiction. On one front, it is *directly* responsible for specific groups of Canadians. According to the 2003 Canada’s Performance Report to Parliament: “The federal government provides primary and supplementary health care services to approximately 1 million eligible people – making it the fifth largest provider of health services to Canadians. These groups include veterans, military personnel, inmates of federal penitentiaries, certain landed immigrants and refugee claimants, serving members of the Canadian Forces and the Royal Canadian Mounted Police, as well as First Nations populations living on reserves and the Inuit.”³⁸⁵ In addition, the federal government is a major employer with management of a large workforce with particular health-related concerns.

On the second front, the federal government is expected to bring a national perspective to the social policy field that includes mental health, mental illness and addiction. This is an *indirect* role incorporating broad responsibility to oversee the national interest of all Canadians. It discharges this responsibility in several ways, including funding transfers to the provinces, surveillance activities and data collection, funding and performance of research and development activities, drug approval process, the provision of income support and disability pension provisions for affected Canadians, social programming such as housing initiatives, funding the criminal justice system, and the operation of a number of programs to promote overall population health and well-being.

³⁸⁵ Treasury Board of Canada, Canada's Performance 2003 – Annual Report to Parliament, Ottawa, 2004, p. 30.

TABLE 9.1

**FEDERAL LEGISLATION WITH RELEVANCE TO
MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION**

<i>Canada Elections Act</i>
<i>Canada Pension Plan</i>
<i>Canada Student Financial Assistance Act</i>
<i>Canada Student Loans Act</i>
<i>Canadian Centre for Occupational Health and Safety Act</i>
<i>Canadian Centre on Substance Abuse Act</i>
<i>Canadian Forces Superannuation Act</i>
<i>Canada Health Act</i>
<i>Canadian Human Rights Act</i>
<i>Canadian Institutes of Health Research Act</i>
<i>Controlled Drugs and Substances Act</i>
<i>Corrections and Conditional Release Act</i>
<i>Criminal Code</i>
<i>Department of Health Act</i>
<i>Emergencies Act</i>
<i>Excise Tax Act</i>
<i>Extradition Act</i>
<i>Federal-Provincial Fiscal Arrangements Act</i>
<i>Food and Drugs Act</i>
<i>Income Tax Act</i>
<i>Members of Parliament Retiring Allowances Act</i>
<i>Parliament of Canada Act</i>
<i>Pension Act</i>
<i>Pension Benefits Standards Act</i>
<i>Personal Information Protection and Electronic Documents Act</i>
<i>Privacy Act</i>
<i>Public Service Employment Act</i>
<i>Public Service Superannuation Act</i>
<i>Royal Canadian Mounted Police Superannuation Act</i>
<i>Supplementary Retirement Benefits Act</i>
<i>Vocational Rehabilitation of Disabled Persons Act</i>
<i>War Veterans Allowance Act</i>
<i>Youth Criminal Justice Act</i>

Source: Law and Government Division, Library of Parliament.

In both roles, any consideration of a framework for mental health, mental illness and addiction cannot displace the primary responsibility of the provinces/territories for program design and delivery. There is, however, an overriding need to move toward a framework that works for all Canadians regardless of whether they fall under federal or provincial jurisdiction.

The distinction between the federal and the provincial/territorial responsibilities with respect to mental health addiction services has been clearly emphasized by Tom Lips, Senior

Advisor, Mental Health, Healthy Communities Division, Population and Public Branch, Health Canada, when he stated:

The federal and provincial-territorial roles and responsibilities differ where mental health and mental illness are concerned. (...) Provincial and territorial governments have primary responsibility for the planning and delivery of health services for the general population. As you know, federal transfer payments contribute to health services delivery. The federal government has a special mandate for health service delivery to certain populations, notably First Nations people on reserve and Inuit. It also undertakes national health promotion efforts. Both levels of government have been involved in health promotion, research and surveillance, and have collaborated to address some service delivery issues, for example, identifying best practices.³⁸⁶

In fact, the range of federal programs and services relevant to mental health, mental illness and addiction is very large. It includes multiple initiatives aimed at specific groups under its direct responsibility and many endeavours to address broader national population concerns. The following sections examine the more specific federal and the broader national perspectives and, where possible, provide some information to assess those program and service activities.

9.2 THE FEDERAL DIRECT ROLE³⁸⁷

The following sections identify and assess the programs and initiatives in place for particular groups under direct federal jurisdictional responsibility.

9.2.1 First Nations and Inuit

Aboriginal peoples are defined in the *Constitution Act*, 1982 (section 35) as the “Indian, Inuit and Métis peoples of Canada.” Despite this broad constitutional definition, the federal government currently takes responsibility only for Indian people residing on-reserve and specified Inuit. Health Canada estimates that it serves approximately 735,000 eligible First Nations and Inuit people.

The provincial and territorial governments have general responsibility for Aboriginal peoples living off-reserve, including Métis and non-status Indian populations. These groups have access to programs and services on the same basis as other provincial residents. These jurisdictional divisions, in combination with the multifaceted nature of the Aboriginal population in Canada, have created serious barriers to the establishment of a comprehensive plan for the development of a genuine system of mental health, mental illness and addiction.

³⁸⁶ Tom Lips, Senior Adviser, Mental Health, Healthy Communities Division, Population and Public Health, Health Canada (11:6).

³⁸⁷ The information contained in this section is based on a paper by Nancy Miller-Chenier, *Federal Responsibility for the Health Care of Specific Groups*, Parliamentary Information and Research Services, Library of Parliament, forthcoming.

Over the years, the federal government has made several attempts to address mental illness and addiction in Aboriginal communities. In the early 1990s, the federal department of health, with the assistance of a multi-stakeholder steering committee, produced an “Agenda for First Nations and Inuit Mental Health.” It also targeted Aboriginal peoples in broader strategies such as the Drug Strategy, Family Violence Prevention Initiative, and Building Health Communities Initiative. In 1996, the Royal Commission on Aboriginal Peoples drew particular attention to the mental health problems that were linked to poverty, ill health and social disorganization in many communities.

The federal government’s response to the Royal Commission, *Gathering Strength – Canada’s Aboriginal Action Plan*,³⁸⁸ was announced in January 1998; it provided a strategy to begin a process of reconciliation and renewal of its relationship with Aboriginal peoples. Two significant initiatives had as their goal to give Aboriginal peoples more autonomy when addressing some of the concerns related to health and mental health. First, in 1998, the federal government funded the Aboriginal Healing Foundation, an Aboriginal-run, non-profit corporation to support community-based healing initiatives of Métis, Inuit and First Nations people on and off reserve directed to those who were affected by physical and sexual abuse in residential schools and to those affected indirectly by intergenerational impacts. Second, in 1999, Health Canada collaborated with several Aboriginal organizations to establish the National Aboriginal Health Organization. Officially incorporated as the “Organization for the Advancement of Aboriginal Peoples’ Health”, this new organization focuses on priority areas of health information and research, traditional health and healing, health policy, capacity building and public education.

In 2003, \$1.3 billion over five years was committed to develop an effective and sustainable health care system for First Nations and the Inuit.³⁸⁹ In the Throne Speech of February 2004, the federal government made further commitments aimed at ensuring a more coherent approach to multiple issues affecting Aboriginal communities. It promised to set up an independent Centre for First Nations Government, renew the Aboriginal Human Resources Development Strategy, expand the Urban Aboriginal Strategy, and establish a Cabinet Committee on Aboriginal Affairs.³⁹⁰

9.2.2 Assessment Relevant to First Nations and Inuit

At present, Health Canada and Indian and Northern Affairs Canada are the two major federal departments that provide health care, mental health services, addiction treatment and social services to First Nations and the Inuit.

Health Canada, through its First Nations and Inuit Health Branch, is responsible for the following programs that address mental illness and addiction:

- National Native Alcohol and Drug Abuse Program (NNADAP): This program is largely controlled by First Nations communities and organizations; it incorporates a network of 48 treatment centres and community-based prevention programs.

³⁸⁸ Indian and Northern Affairs Canada, *Gathering Strength—Canada’s Aboriginal Action Plan*, Ottawa, 1997.

³⁸⁹ Department of Finance Canada, *The Budget Plan 2003*, p. 13.

³⁹⁰ Government of Canada, *Speech from the Throne, 2004*, pp. 9-11.

- National Youth Solvent Abuse Program: This program delivers, through 10 treatment centres, assessment, inpatient treatment and counseling intended for First Nations and Inuit adolescents with solvent abuse problems.
- Indian Residential Schools Mental Health Support Program: This program provides mental health and emotional support to eligible individuals who are resolving claims against the Government of Canada for abuse(s) suffered while attending Indian Residential Schools. It is provided by Health Canada in collaboration with Indian and Northern Affairs Canada.
- First Nations and Inuit Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE) Initiative: This purpose of this initiative, which is part of the Canada Prenatal Nutrition Program, is to raise awareness about FAS/FAE and to deliver programs that provide mental health services to persons at risk and detoxification services for pregnant women at risk, their partners, and their families.
- Non-Insured Health Benefits (NIHB) Program: NIHB provides eligible registered Indians and recognized Inuit and Innu with medically necessary health-related goods and services that are not covered by other federal, provincial, territorial or third-party health insurance plans. These benefits complement provincial/territorial insured health services and include drugs, medical transportation, dental care, vision care, medical supplies and equipment, crisis intervention and mental health counseling.
- Aboriginal Head Start on Reserve: This initiative is designed to prepare young First Nations children for their school years, by meeting their emotional, social, health, nutritional and psychological needs. This initiative collaborates with Health Canada's Brighter Futures and Building Healthy Communities programs. Additional collaboration involves Human Resources Development Canada's Child Care Initiative and the Department of Indian and Northern Affairs' Kindergarten program, both at national and local levels, to ensure that Aboriginal Head Start on Reserve fills gaps and complements existing programs.³⁹¹

At Indian and Northern Affairs Canada, social policy and programs include Child and Family Services, Social Assistance, Adult Care, the National Child Benefit program and other social services that address individual and family well-being. All have components relevant to mental health. Specific programs addressing mental illness and addiction include:

- Aboriginal Suicide Prevention Program: This program, which is provided in collaboration with the RCMP, teaches young adults and community caregivers how they can help prevent suicides. Participants are selected by elders and other Aboriginal community leaders.
- Aboriginal Shield Program: This program is provided in collaboration with the RCMP; it offers education on substance abuse to Aboriginal communities. The program assists Aboriginal and non-Aboriginal police officers as well as community leaders, health care workers, teachers and youth leaders.
- Family Violence Prevention Program: The program provides operational funding to shelters located in First Nations communities. It also funds community-based family

³⁹¹ Health Canada, [*Report on Plans and Priorities, 2003-2004, Estimates*](#).

violence prevention programs that aim to prevent incidents of family violence on reserves.³⁹²

Witnesses told the Committee that federal programs addressing mental illness and addiction in First Nations and Inuit communities do not adequately address the needs of Aboriginal peoples. For example, Dr. Cornelia Wieman, Psychiatrist from the Six Nations Mental Health Services (Ohsweken, Ontario), talked about the psychiatric counseling sessions available under Health Canada's Non-Insured Health Benefits Program:

[Under NIHB], the limit is 15 sessions with the possibility of renewing for a further 12. A total of 27 sessions for many people is not sufficient to help them adequately address their mental health concerns. The mandate of the NIHB program is to provide support for clients in crisis or who cannot access counseling by other means. That counseling could be from an outpatient psychiatric clinic or health service that is funded by the provincial health care system. They could also pay for private counselling.

The vast majority of my patients live on a limited income and would not be able to pay for private counseling. As a result of transportation and access issues, many are also not able to access counseling services in smaller communities nearby or in larger urban settings such as Brantford or Hamilton. You can tell that these people do fall through the cracks in the system.³⁹³

Perhaps more importantly, witnesses identified the existing First Nations and Inuit program “silos” as a significant barrier to accessing needed mental health services and addiction treatment. Services and supports are provided without much collaboration by different departments, or by various departmental directorates or divisions. Moreover, the Committee was told that the current practice is to isolate problems on the basis of their symptoms – addiction, suicide, FAS/FAE, poor housing, lack of employment, etc. – and to design stand-alone programs to manage each one. This fragmented approach has had little success. Witnesses told the Committee that, in order to restore the well-being in First Nations and Inuit communities across the country, a significant re-thinking of, and departure from, current practice is needed.

Some of the recommendations that the Native Mental Health Association of Canada would like to offer is the elimination of operations of programs for services in what we call silos. Instead of funding for mental health, funding for social services and funding for other issues in the community, we favour more team approaches based on partnerships, so that what is available to a community is integrated and made available and accessible to our clients in a holistic way from the top to bottom – from policy-makers and planners to local governance. [Brenda Restoule, Native Mental Health Association of Canada (9:51)]

³⁹² According to information provided on the Website of Indian and Northern Affairs Canada (http://www.ainc-inac.gc.ca/sg/sg4_e.html).

³⁹³ Dr. Cornelia Wieman (9:55).

The Committee was also informed that the fragmentation of services set up to solve interconnected issues is a real problem. In particular, we heard that First Nations and Inuit are poorly served by government program delivery models that stress services to individuals over holistic, more culturally-appropriate, services to communities. For example, Dr. Laurence Kirmayer, Director, Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University, stated:

Mental health perspectives tend to be focused on the individual and on individual vulnerability and affliction. This kind of data really points to the working of social forces – things that are affecting entire generations of people and we need to conceptualize it in that way. Within this pattern there is individual vulnerability; not everyone is affected the same way by the same adversity. However, the overall high rate suggests that many people are being affected and that there are things that lie outside of the individual that are at play. We have the challenge to characterize social forces and to think about ways of helping people to take that in hand.³⁹⁴

Witnesses also stressed that the “one size fits all” approach to program and service delivery has not met the needs of Aboriginal peoples effectively. By and large, Aboriginal peoples know what their problems are, and are in better position to identify appropriate solutions, and to know what resources should be applied in accordance with community priorities. What this means, in structural terms, is that it would be far preferable for government departments to delegate to Aboriginal communities the authority to customize services and react flexibly to local circumstances. Accordingly, Aboriginal peoples should be supported in their development of their own solutions, rather than having solutions imposed upon them from “outside”.

To be successful, community-based initiatives must be accompanied by the development, in parallel, of community capacity adequate to deliver such programs effectively. Witnesses identified a critical shortage – if not absence – of adequately trained mental health and addiction professionals. In this perspective, Dr. Wieman stated:

One of the important ways in which access to health services and health outcomes, including mental health, can be improved is by training an increased number of Aboriginal health professionals. Barriers to seeking various mental health services could be overcome and providing more culturally relevant care could be accomplished. The Royal Commission on Aboriginal Peoples in 1996 recommended that 10,000 Aboriginal peoples be trained as health professionals in the next 10 years. We are now only two years away from 2006, and I do not believe that we are anywhere near that goal. Estimates state that there are approximately 150 Aboriginal physicians in this country, most of whom have trained to be family physicians. Off the top of my head, I would estimate the

³⁹⁴ Dr. Laurence Kirmayer (9:42).

*number of Aboriginal specialists at probably less than 25. I am only aware of two other Aboriginal psychiatrists in this country, with a fourth individual graduating from the residency program in Manitoba this June.*³⁹⁵

The Committee was also informed that the needs of Aboriginal peoples are complex and that short term approaches often fail. More precisely, short term funding can materially restrict the ability of Aboriginal governments to develop the long term strategies needed to address the needs of their communities. It can take years to develop effective programs, and often, the shorter the time frame of a given project, the less potential there is for it to be effective.

There was also a general consensus among witnesses that the current funding levels for mental health services and addiction treatment in First nations and Inuit communities are inadequate. Brenda Restoule, Psychologist and Ontario Board Representative, Native Mental Health Association of Canada, explained:

Current funding is already inadequate, at best, and does not meet the needs of the community and its members. Since the funding formula is based on population size, many communities receive a small amount of funding, making it difficult or, in many cases, impossible, to deliver mental health counselling and intervention services. Most communities must use their funding to establish mental health promotion and mental illness prevention programs. Although these types of programs are needed, the funding does not allow for a continuum of care that is desperately needed for First Nation communities.

(...)

*The funding is so low for the salary of mental health workers that professionals such as social workers, psychologists and psychiatrists often do not find it desirable to work in First Nation communities.*³⁹⁶

The Committee was informed that some provinces have integrated Aboriginal issues within their mental health strategies. To be truly successful, then, federal initiatives for Aboriginal mental health either on reserve or off-reserve should harmonize with the relevant provincial mental health plans and implementation strategies.³⁹⁷

To sum up, federal and provincial programs directed to Aboriginal mental health, which focus on individuals or specific aspect of an issue, have been criticized for operating with a silo mentality that precludes their smooth coordination with other programs. The result is an hodge-podge of similar programs, different tiers of service delivery and a complex array

³⁹⁵ Dr. Cornelia Wieman (9:55-56).

³⁹⁶ Brenda Restoule (9:49).

³⁹⁷ According to Ray Block, CEO, Alberta Mental Health Board, Brief to the Committee, 28 April 2004, p. 9.

of funding mechanisms that is bewildering to the individuals they are intended to serve and their families and communities. Ideally, a holistic or global approach would entail government departments pooling their resources so that interconnecting factors such as health, education, housing, and employment needs of individuals, families and communities could all be met or at least alleviated in a planned, structured and integrated way. Horizontal government initiatives would assist Aboriginal communities to plan and coordinate services better.

The ways in which [mental health issues] have been addressed on behalf of Aboriginal people have not worked well. One of the results is that Aboriginal people are significantly over-represented in the criminal justice system and in the child welfare system. Aboriginal people have a significantly worse well-being and health status than other Canadians. We have heard from community members that that status will not change until we are able to focus on those communities rather than on individuals.

[Ms. Bronwyn Shoush, Board Member, Institute of Aboriginal Peoples' Health, CIHR (16 :10)]

From a financial perspective, the lack of coordination often results in expensive and unnecessary program duplication. An environmental scan is required to determine what programs exist, where there is duplication across departments and organizations, where there are significant gaps in programming, as well as how best to maximize resources.

9.2.3 Offenders under the Federal Correctional System

Inmates in federal correctional institutions and others under the federal correctional system, those offenders who are sentenced to two years or more of incarceration, constitute another significant group of Canadians under federal health-related responsibility. Currently, Correctional Service Canada (CSC) manages about 12,600 inmates and 8,500 offenders on conditional release under parole officer supervision.³⁹⁸ The quality of mental health services and addiction treatment for federal offenders is a consideration for CSC but it is secondary to the primary focus of corrections, which is described as the “criminogenic” needs.

Federal offenders come completely under federal responsibility and are not considered as beneficiaries of provincial health care insurance plans. Françoise Bouchard, Director General, Health Services at CSC, observed that the legislative health care mandate of federal corrections is through the *Corrections and Conditional Release Act*, which states:

*The service shall provide every inmate with essential health care and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.*³⁹⁹

³⁹⁸ Correctional Service Canada, [Report on Plans and Priorities, 2003-2004](#), p. 5.

³⁹⁹ Françoise Bouchard (7:50).

With respect to mental health care, the goal of CSC is to provide: “a continuum of essential care for those suffering from mental, emotional or behavioural disorders (...) consistent with professional and community standards.”⁴⁰⁰

When admitted to the correctional system, each individual is assessed and asked fundamental questions about his/her mental health, mental illness and addiction. Following assessment, a correctional plan is developed for each offender and the offender is directed to either a regular institution or one in which treatment is available.

Over the last decade, CSC has issued specific directives on mental health services and addiction treatment provided to federal offenders. In 1994, directives from the Commissioner were implemented for psychological services, including assessment; therapeutic intervention; crisis intervention; program development, delivery and evaluation.⁴⁰¹ In 2002, directives on mental health services provided standards on assessment, diagnosis and treatment that affect the access to mental health professionals, emergency and community care, as well as transfers to psychiatric care and addiction treatment centres.⁴⁰² The same year, the CSC Commissioner issued directives for methadone maintenance treatment (diagnosis and treatment).⁴⁰³ In 2003, directives for the purpose of offenders who are suicidal or self-injurious were released; they include prevention, assessment and treatment guidelines.⁴⁰⁴ Also in 2003, a directive on health services was issued that stipulates that the cost of providing mental health and addiction treatment will be the responsibility of CSC.⁴⁰⁵

In addition to these directives, CSC has worked to develop a comprehensive health care strategy to address both the physical and mental health needs of offenders, including the integration of issues related to drugs and alcohol. Specific work on mental health policy included a 1991 Task Force report on mental health oriented to all offenders, a 1997 National Strategy on Aboriginal Corrections, and a 2002 mental health strategy for women offenders.

At CSC, the Aboriginal Initiatives Branch is mandated to create partnerships and strategies that enhance the safe and timely reintegration of Aboriginal offenders into the community. Aboriginal peoples represent less than 3% of the Canadian population, but account for 18% of the federally incarcerated population. Aboriginal-specific and culturally appropriate programs and services to address the needs of Aboriginal offenders in corrections include initiatives such as Aboriginal Healing Lodges (9 across Canada); Aboriginal Community Residential Facilities (23 across Canada); Aboriginal Community Reintegration Program;

⁴⁰⁰ *Ibid.* (7:51).

⁴⁰¹ John Edwards, Commissioner, [Commissioner's Directive – Psychological Services](#), Correctional Service Canada, 30 December 1994.

⁴⁰² Lucie McClung, Commissioner, [Commissioner's Directive – Mental Health Services](#), Correctional Service Canada, 2 May 2002.

⁴⁰³ Irving Kulik, Assistant Commissioner, [Guidelines – Methadone Treatment Guidelines](#), Correctional Service Canada, 2 May 2002.

⁴⁰⁴ Lucie McClung, Commissioner, [Commissioner's Directive – Prevention, Management and Response to Suicide and Self-Injuries](#), Correctional Service Canada, 3 September 2003.

⁴⁰⁵ Lucie McClung, Commissioner, [Commissioner's Directive – Health Services](#), Correctional Service Canada, 17 March 2003.

Elders working in institutions and in the community; and Transfers of Correctional Services to Aboriginal Communities (5 agreements signed).⁴⁰⁶ CSC is also responsible for the “National Strategy on Aboriginal Corrections” (currently being revised) that focuses on Aboriginal programs, Aboriginal community developments, Aboriginal employment/recruitment and partnerships on Aboriginal issues.⁴⁰⁷

Women with particular mental health needs at all security levels may receive treatment in a specialized, separate 12-bed women's unit at the Regional Psychiatric Centre in the Prairies (RPC). This unit serves also as a national mental health resource for Anglophone women. Francophone women may receive treatment at Institut Philippe Pinel in Montréal (Québec) where CSC has contracted for inpatient treatment services. Furthermore, the “2002 Mental Health Strategy for Women Offenders” provides a framework for the development of mental health services covering a continuum of care. The goal is to apply the elements of the strategy to all offenders and to include crisis intervention, acute care programs, chronic care programs, special needs units, outpatient treatment, consultation services, discharge and transfer planning, follow-up as well as interconnection with other programs and services.⁴⁰⁸

CSC also delivers the “Substance Abuse Program” which consists of a range of institutional and community-based programs that are matched to the severity of the offender’s substance abuse problem. The program is cognitive-behavioural in orientation and includes a strong emphasis on structured relapse prevention techniques. The program is also responsible for the provision of methadone maintenance treatment.⁴⁰⁹

9.2.4 Assessment Relevant to Offenders under the Federal Correctional System

Officials from CSC told the Committee that mental health care and addiction treatment are required to: reduce the disabling effects of mental disorders in order to maximize each inmate’s ability to participate electively in correctional programs, including their preparation for community release; help keep the prison safe for staff, inmates, volunteers and visitors; and decrease the needless extremes of human suffering caused by mental disorders.⁴¹⁰

The Committee heard that access to mental health services and addiction treatment, however, requires an enhanced CSC response capacity. CSC has 5 specialized treatment centres⁴¹¹ spread across the country, but they are not resourced at levels comparable to that of provincial forensic facilities. Although CSC has many psychologists, these are primarily engaged in risk assessment for conditional release decision-making. In addition, there is no

⁴⁰⁶ Aboriginal Initiatives Branch, [Aboriginal Offenders Overview](#), Correctional Service Canada.

⁴⁰⁷ Correctional Service Canada, [National Strategy on Aboriginal Corrections](#).

⁴⁰⁸ Jane Laishes, Mental Health, Health Services, Correctional Service Canada, [The 2002 Mental Health Strategy for Women Offenders](#), 2002.

⁴⁰⁹ Correctional Service Canada, [Substance Abuse Program](#).

⁴¹⁰ Correctional Service Canada, Brief to the Committee, April 2004, pp. 13-15.

⁴¹¹ The Shepody Healing Centre (Atlantic region) with 40 beds; the Archambault unit (Quebec region) with 120 beds; the Regional Treatment Centre (Kingston, Ontario) with 149 beds; the Regional Psychiatric Centre (Prairie region) is a 194 bed facility linked to the University of Saskatchewan through a special agreement; the Regional Treatment Centre in Abbotsford (Pacific region) with 192 beds.

specific training for correctional staff on mental illness and addiction.⁴¹² With respect to the Mental Health Strategy for Women Offenders, the Committee was told that the challenge of this new approach is that women requiring mental health intervention must move to another part of the country to obtain needed services.

Witnesses also talked about the need for better links between the federal and provincial governments and between the justice system and the provincial mental health services system. For example, Ms. Bouchard from CSC stated:

There is a need for a comprehensive, inter-jurisdictional strategy for the identification and management of offenders with mental disorders. While we try to do a comprehensive assessment at reception, much still needs to be done in respect of those identifying offenders who have mental health problems early in their sentences. That should also occur within the provincial systems as early as possible.

There is a need to have better links between the justice system and the health care system within the provinces. The search for solutions should start before imprisonment for those afflicted with mental health disorders. Within the federal corrections system, work is under way to improve capacities to assess and treat. However, we have no guarantees we will ever have additional resources to do that. We are, right now, conducting a review of our utilization of beds in our treatment centres to maximize and direct them to those who have the most needs. Sometimes that calls for a change of culture between correctional culture and treatment culture, so there is lots of work still to be done.

Our last observation is the issue of continuity of care when people are released. This calls for better links between us, at the federal correctional level, and our provincial counterparts and the community mental health care out there. Partnerships are key to address those gaps, but what will be the incentive to create those partnerships?⁴¹³

The Committee also heard about some discriminatory aspects of the judicial system. For example, Patrick Storey, Chair of the Minister's Advisory Board on Mental Health (British Columbia), stated:

For federal offenders, it is difficult to access provincially funded mental health services in the community due to specific provisions of the Mental Health Act of British Columbia. This act is, in itself, discriminatory to this population. It directs that directors of provincial facilities not provide care to people from federal institutions. That is a federal government funding responsibility, and so people who are in federal prison with

⁴¹² Correctional Service Canada, Brief to the Committee, April 2004, p. 19.

⁴¹³ Françoise Bouchard (7:54-55).

*mental illness trying to get a release into the community will not get service from the local mental health centre or from other services, which is intolerable. (...) Federal and provincial correctional authorities and health authorities must work together to address these deficiencies and reduce the discrimination faced by people in conflict with the law.*⁴¹⁴

In addition, the Committee was told that there is a need to harmonize better the Criminal Code with provincial mental health legislation. The Schizophrenia Society of Canada explained that under the Criminal Code a judge may order a person who is found not fit to stand trial to undertake treatment to make them fit. However, neither the judge nor the Board of Review can order treatment of a person found not criminally responsible based on mental illness to make them well enough to be discharged. The theory is that the provincial mental health acts will do that. In some provinces, however, that does not happen. The Schizophrenia Society of Canada recommended that the federal government should amend the Criminal Code to allow the Review Board to order treatment necessary for the probable release of a person affected by treatable mental illness. In their view, this is preferable to requiring the same person to stay incarcerated for an unreasonable time because the untreated illness makes him/her a significant threat to the safety of the public.⁴¹⁵

Ms. Bouchard from CSC made some observations about the need for better community supports:

*Addressing the needs of offenders who require specialized mental health intervention can reduce the “revolving door” phenomenon. There is what we call a revolving door between corrections, both federal and provincial, but also the community, where often people who are afflicted with mental health disorders find themselves in the criminal justice system. While mentally disordered offenders are often less likely to reoffend – including violently – they are more likely to return to prison due to a breach of their release conditions – often as a result of inadequate support while they are in the community.*⁴¹⁶

9.2.5 Veterans and Active Members of the Canadian Forces

Veterans Affairs Canada is responsible for delivering health services and pensions and for providing social and economic support to more than 150,000 aging Canadian veterans and members of the Canadian Forces (CF). The main beneficiaries are those veterans and civilians granted a pension or allowance.⁴¹⁷

The *Canada Health Act* specifically excludes CF members from the definition of “insured persons”. Therefore, CF members are not eligible for hospital care and physician services insured under provincial health care insurance plans.⁴¹⁸ The Canadian Forces Health

⁴¹⁴ Patrick Storey (15:8-9).

⁴¹⁵ Schizophrenia Society of Canada, Brief to the Committee, 2004, p. 9.

⁴¹⁶ Françoise Bouchard (7:54).

⁴¹⁷ Veterans Affairs Canada, [Health Care Program](#).

⁴¹⁸ National Defence, [Canadian Forces Health Services](#), Fact Sheets.

Services (CFHS) is the designated health care provider for 83,000 Regular and Reserve Forces personnel at home and on deployment. The CFHS provides access to more than 85,000 providers across the country. Atlantic Blue Cross Care has responsibility for program administration and payment.

Veterans Affairs Canada administers Ste. Anne's Hospital, located in Ste-Anne-de-Bellevue, Québec. The hospital provides medical and paramedical services to its residing veterans, in addition to a wide range of recreational and social activities. Ste-Anne's Centre, part of the hospital, provides mental health services to CF members and veterans; it has developed specialized expertise in the fields of post traumatic stress syndrome and dementia.⁴¹⁹ Inpatient and outpatient care are also provided in contract hospital beds, in veterans' homes, and in hospitals of choice.

Veterans Affairs Canada also provides pensions for disability or death and economic support in the form of allowances to various groups. These include: members of the Canadian Forces and Merchant Navy veterans who served in the First World War, the Second World War or the Korean War; certain civilians who are entitled to benefits because of their wartime service; former members of the Canadian Forces (including those who served in Special Duty Areas) and the Royal Canadian Mounted Police; as well as survivors and dependents of military and civilian personnel.⁴²⁰

The Department of National Defence is responsible for "Strengthening the Forces", a health promotion initiative designed to assist CF and Regular and Primary Reserve members to take control of their health and well-being. Suicide prevention and substance abuse interventions for tobacco and alcohol are two important components of this initiative. Mental health is an issue of concern within Strengthening the Forces. Beside its focus on active living, injury prevention and nutritional wellness, the initiative includes: "Addiction Free" (alcohol and other drug abuse, tobacco use cessation, problem gambling) and "Social Wellness" (stress management, anger management, family violence prevention, healthy families, suicide prevention, and spirituality).⁴²¹

Health Canada is responsible for occupational health and safety of CF members. The "Canadian Forces Member Assistance Program" is organized by the Workplace Health and Public Safety Program (WHPS) at Health Canada; it is a 24/7 toll-free telephone service that provides confidential counseling services to help members and their families when they have personal concerns that affect their well-being or work performance.⁴²²

9.2.6 Assessment Relevant to Veterans and Canadian Forces

Several reports have identified gaps in the care and treatment of CF personnel by the Department of National Defence specifically and, by extension, Veterans Affairs Canada. These included: the McLellan and Stow reports in April 1998, the Goss Gilroy Report in

⁴¹⁹ Veterans Affairs Canada, [*Ste. Anne's Hospital*](#).

⁴²⁰ Veterans Affairs Canada, [*Disability Pensions*](#).

⁴²¹ National Defence, [*Strengthening the Forces*](#).

⁴²² *Ibid.*

June 1998 and the October 1998 report from the House of Commons Standing Committee on National Defence and Veterans Affairs.⁴²³

The departments responded with a series of initiatives relevant to mental health. In April 1999, the DND-VAC Centre for the Support of Injured and Retired Members and Their Families opened in Ottawa to provide information, referral and assistance support to former and current CF members and their families. Subsequently, legislative and regulatory reform made access to services and benefits more equitable to all CF members, regardless of whether the injury occurred in Canada or on foreign deployment. In April 2001, Veterans Affairs launched an Assistance Service for former members of the CF and their families who require professional counseling.⁴²⁴

Recently, the major mental health focus for Veterans Affairs Canada and the Department of National Defence has been on the needs of CF members and veterans suffering from post-traumatic stress disorder and other operational stress injuries. In February 2004, they jointly announced a Canada Mental Health Strategy for the Canadian military. This strategy creates a network of mental health assessment and treatment facilities, educational forums, continuing education program and research for post-traumatic stress disorder and operational stress injuries.⁴²⁵

9.2.7 Royal Canadian Mounted Police

The Royal Canadian Mounted Police (RCMP) is an agency of the Ministry of Public Safety and Emergency Preparedness Canada. In addition to federal policing services for all Canadians, it provides policing services under contract to the three territories, eight provinces (all except Ontario and Quebec), approximately 198 municipalities and, under 172 individual agreements, to 192 First Nations communities. The on-strength establishment of the Force as of January 1, 2004, was 22,239.⁴²⁶

The definition of “insured persons” under the *Canada Health Act* excludes members of the RCMP. The administration of health care insurance for the RCMP has been the responsibility of Veterans Affairs Canada since 2003. Veterans Affairs Canada also assumes responsibility for the direct payment of disability pensions for approximately 3,800 RCMP pensioners as well as the provision of health care benefits for approximately 800 retired and civilian pensioners.⁴²⁷

9.2.8 Assessment Relevant to Royal Canadian Mounted Police

Information about mental health, mental illness and addiction concerns within the RCMP was not readily available to the Committee.

⁴²³ Veterans Affairs Canada, [Government of Canada's Response to the Standing Committee on National Defence and Veterans Affairs on Quality of Life in the Canadian Forces](#), 2001.

⁴²⁴ *Ibid.*

⁴²⁵ Veterans Affairs Canada, [Canada Mental Health Strategy](#), Backgrounder, 27 February 2004.

⁴²⁶ Royal Canadian Mounted Police, [About the RCMP](#).

⁴²⁷ [“Veterans Affairs Canada and the Royal Canadian Mounted Police Partner to Improve Services”](#), RCMP News Release, 17 February 2003.

9.2.9 Federal Public Servants

The federal government is a major employer. Although the size of its workforce diminished between March 1995 to March 2001 from 225,619 to 155,360 employees, it is reported to have grown in the last few years.

In its role as the general manager and employer of the federal public service, Treasury Board oversees benefits available to public servants such as the Public Service Health Care Plan that covers medical benefits and the Disability Insurance Plan that assures a reasonable level of income during periods of long-term physical or mental disability. It has mandated Health Canada to provide occupational health and safety services such as Employee Assistance Programs for Part I, Schedule I, Public Service employers.⁴²⁸

The Public Service Health Care Plan (PSHCP) is a private health care insurance plan established for the benefit of federal public service employees, CF members, the RCMP, members of Parliament, federal judges, employees of a number of designated agencies and corporations, and persons receiving pension benefits based on service in one of these capacities. The PSHCP is funded through contributions from the Treasury Board of Canada, participating employers, and the Plan members. The administrator, Sun Life Assurance Company of Canada, is responsible for the consistent adjudication and payment of eligible claims.⁴²⁹

PSHCP reimburses participants for all or part of costs they have incurred for eligible services and products, only after they have taken advantage of benefits provided by their provincial/territorial health care insurance plan or other third party sources of health care expense assistance. Eligible services and products are prescribed by a physician or a dentist who is licensed to practice in the jurisdiction in which the prescription is made. PSHCP reimburses eligible expenses on a “reasonable and customary” basis to ensure that the level of charges are within reason in the geographic area where the expense is incurred.⁴³⁰

PSHCP covers the cost of visits to a psychologist up to a certain specified limit of maximum eligible expenses. A psychologist prescription covers up to one year of services. The current rate of payment from the plan is about 80 percent of \$1,000 per calendar year, covering between 5 and 6 sessions per client.

Under the Long Term Disability Insurance Plan, benefits are payable for up to 24 months in respect of any medically determinable physical or mental impairment which a) results in the withdrawal of any mandatory licence required by the employee to carry out his or her occupation or employment, or b) renders the employee completely incapable of performing substantially all of the essential duties of his or her occupation or employment.⁴³¹

Short term counseling is offered through Employee Assistance Programs (EAP) that can assist people seeking help in juggling personal and work-related demands. A nationwide 24 hour toll-free (1-800) telephone line is operated by qualified and experienced bilingual

⁴²⁸ Treasury Board of Canada, [Information for Federal Employees](#).

⁴²⁹ Treasury Board of Canada, [Public Service Health Care Plan – Benefits Coverage and Plan Provisions](#), July 2001.

⁴³⁰ *Ibid.*

⁴³¹ Treasury Board of Canada, [Disability Insurance Plan](#), November 1993.

counselors; access to counseling to over 600 qualified psychologists and social workers (or equivalent) is also provided. Referrals can also be made for employees with personal or work-related problems to resources within the Public Service or in the community, when appropriate, and follow-up is provided. Federal organizations that are clients of the Employee Assistance Society of North America include: Department of National Defence, Department of Veterans Affairs, Department of Justice, Office of the Auditor General of Canada, Health Canada, Parks Canada, Environment Canada, Citizenship and Immigration, Department of Indian Affairs and Northern Development, Fisheries and Oceans, and the Transport Safety Board.⁴³²

The services described above do not replace those provided by the Public Service Health Program. Within the Healthy Environments and Consumer Safety Branch at Health Canada, the Workplace Health and Public Safety Program (WHPSP, formerly called the Occupational Health and Safety Agency) is mandated by Treasury Board to provide occupational health and safety services (including psychological services) for Part I, Schedule I, Public Service employers.⁴³³

In addition, Critical Incident Stress Management Services (CISMS) are available for dealing with traumatic incidents such as the death or serious injury of a co-worker on the job, a mass casualty, a threat, personal assault or other forms of violence in the workplace. Employees in certain occupational groups known as “emergency service workers” (e.g., law enforcement officers, firefighters, nurses and other health care workers, search and rescue teams) are at greater risk of experiencing traumatic incidents. Services include education/prevention, intervention, and evaluation.⁴³⁴

9.2.10 Assessment Relevant to Federal Public Servants

Recent studies have explored the issue of stress and the need for the federal government as an employer to make a greater effort to ensure work/life balance and healthy living for its employees. In January 2003, the federally-sponsored National Study on Balancing Work, Family and Lifestyle conducted by Linda Duxbury and Christopher Higgins for Health Canada was released. It confirmed that employed Canadians wanted flexible work schedules, limits on overtime, opportunities for part-time work, telework and family care provisions to help them achieve a better sense of balance in their lives. The study included public (including 8 federal departments) as well as private sector employees and found that public servants take a significant number of “mental health” sick days and spend more on prescription drugs than private sector employees.⁴³⁵

Another study conducted in 2002 by the Association of Professional Executives of the Public Service of Canada (APEX) found a significant increase in rates for coronary and cardiovascular diseases (CVD), particularly hypertension, among public employees. It also pointed to other key indicators of health status that demonstrated gradual deterioration. Among respondents, 95% reported sleep disturbances and an average of only 6.6 hours sleep

⁴³² Treasury Board of Canada, [Employee Assistance Program](#).

⁴³³ Health Canada, [Workplace Health and Public Safety Program](#).

⁴³⁴ Health Canada, Ibid., [“Traumatic Stress Management”](#).

⁴³⁵ Linda Duxbury, Christopher Higgins and Donna Coghill, [Voices of Canadians: Seeking Work-Life Balance](#), Health Canada, January 2003.

per night; 15% reported depressed mood; 53% reported high levels of stress, almost twice the rate for the average Canadian of the same gender and age; and 19% reported musculo-skeletal problems related to tension. Overall, the data showed that as a group, public service executives experience stress in the high to extreme range.⁴³⁶

Bill Wilkerson, co-founder of the Global Business and Economic Roundtable on Addiction and Mental Health stated that: “As an employer, the public sector needs to look deep within itself,” arguing that “we need governments as employers who lead by example in the promotion of mental health and prevention of mental disability.” Referring to the APEX study, he noted that “more than fifteen per cent of executives in the public service suffer depression – 50 per cent higher than the national average. (...) For senior civil servants, psychotropic medication is the prescription drug of necessity in 17.5 per cent of all drug utilization.”⁴³⁷

9.2.11 Landed Immigrants and Refugees

Citizenship and Immigration Canada (CIC) has responsibility for the assessment of landed immigrants and refugees. In the past 10 years, Canada has welcomed yearly an average of some 220,000 immigrants and refugees. A landed immigrant is one who has been granted the right to live in Canada permanently by immigration authorities. Refugees who are accepted to Canada are also landed immigrants. Refugee claimants do not have landed immigrant status; they arrive in Canada requesting to be accepted as refugees.⁴³⁸

Those claiming refugee status who are needy or living in a province with a three month eligibility waiting period for coverage under the provincial health care insurance plan can get emergency or essential health services through the Interim Federal Health Program at Citizenship and Immigration Canada (CIC). Landed immigrants arrange their own health care, including private insurance to cover the three month waiting period imposed in four provinces (British Columbia, Ontario, Quebec and New Brunswick).⁴³⁹

All applicants for permanent residence in Canada have a medical examination of their physical and mental condition. Based on this examination, applicants may be refused entry into Canada if they have a health condition that is likely to be a danger to public health or safety, or that could be very demanding on health or social services. Departmental information is not specific about possible responses to applicants with mental disorders of any severity.⁴⁴⁰

With the knowledge that newcomers to Canada face tremendous challenges, Citizenship and Immigration Canada has several programs aimed at easing the stress of integrating into Canadian society. The department works with provincial/territorial governments and non-governmental organizations on several initiatives relevant to the positive mental health of immigrants. These include:

⁴³⁶ APEX, *Study on the Health of Executives in the Public Service of Canada*, 27 November 2002.

⁴³⁷ Bill Wilkerson, *Text of a Speech to the Royal Ottawa Hospital Business Luncheon*, 6 May 2004.

⁴³⁸ Citizenship and Immigration Canada, *Report on Plans and Priorities, 2003-2004*.

⁴³⁹ *Ibid.*

⁴⁴⁰ *Ibid.*

- Immigrant Settlement and Adaptation Program that funds organizations to provide services such as reception, orientation, interpretation, counselling and job search.⁴⁴¹
- Host Program that matches new arrivals with Canadian volunteers who offer friendship and introduce them to services in their community.⁴⁴²
- Language Instruction for Newcomers to Canada Program that provides basic language instruction to adult immigrants to help them to integrate successfully.⁴⁴³

For refugee claimants, the Interim Federal Health Program is available to cover some health care costs. Administered by Citizenship and Immigration Canada, it ensures emergency and essential health services for needy refugee protection claimants and those protected persons in Canada who are not yet covered by provincial health care insurance plans. The 2002-2003 Departmental Performance Report refers to additional funding of \$7.6 million for the Interim Federal Health program, but does not indicate the program's original cost.⁴⁴⁴ The Report for Plans and Priorities for 2003-2004 refers to the program as a "\$50 million federal health insurance program covering emergency and essential health care for refugee claimants."⁴⁴⁵ There is no breakdown of particular expenditures that might relate to mental illness or addiction. However, these could be significant, given that many refugee claimants have been victims of torture and other threats to their mental health.

9.2.12 Assessment Relevant to Landed Immigrants and Refugees

No information was readily available to assess federal mental health policies and programs designed for landed immigrants and refugees.

9.3 FEDERAL INTERDEPARTMENTAL COORDINATION RELEVANT TO ITS DIRECT ROLE

In looking at federal government activities with respect to the specific groups under its responsibility, there is little evidence to suggest that there are specific population-targeted strategies, let alone a broad all-encompassing federal strategy applicable to all groups. Efforts are not apparent currently to develop an overall coordinated federal framework with collaboration by all involved departments or agencies. In most cases, there is little indication of a thorough and inclusive population specific strategy for addressing the mental health needs of any of the groups under federal responsibility. The provision of mental health services and addiction treatment and efforts toward mental health promotion and mental illness prevention remain highly fragmented, divided among numerous departments and departmental directorates.

There are, however, two examples of federal interdepartmental efforts to coordinate activities with respect to health care and substance abuse that may provide some lessons for

⁴⁴¹ Citizenship and Immigration Canada, [Immigrant Settlement and Adaptation Program](#).

⁴⁴² Citizenship and Immigration Canada, [Host Program](#).

⁴⁴³ Citizenship and Immigration Canada, [Language Training](#).

⁴⁴⁴ Citizenship and Immigration Canada, [Performance Report for the Period Ending March 31, 2003](#).

⁴⁴⁵ Citizenship and Immigration Canada, [Report on Plans and Priorities, 2003-2004](#), p. 34.

future efforts to do the same in the specific field of mental illness and addiction. These are the Health Care Coordination Partnership and Canada's Drug Strategy.

9.3.1 Federal Health Care Partnership⁴⁴⁶

The Federal Health Care Partnership, formerly called the Health Care Coordination Initiative, was established in 1994 by a partnership of federal departments that were separately providing health care products and services to specific groups of Canadians. These departments believed that they could lower costs and improve delivery by working together. At present, Veterans Affairs has the lead role with other partners including the Department of National Defence, the RCMP, the Canadian International Development Agency, Correctional Services, Citizenship and Immigration, the Treasury Board Secretariat, Public Works and Government Services, and the Privy Council Office.

The key objectives of the initiative are to negotiate joint agreements with professional associations, suppliers and retailers; coordinate purchases of specific health care supplies and services; improve the competitive environment by identifying alternatives to traditional service delivery; improve information sharing and collective decision making; facilitate joint policy analysis and development; support cooperative development of health and information management across federal jurisdiction; and create joint health promotion activities.

In 2002-2003, the partners jointly negotiated fees, bulk purchases and collaborative policy development that collectively resulted in improved quality of service to clients and \$11.6 million in cost savings. Savings of \$17.6 million were forecast for 2003-2004. To date however, although there is great potential for joint action, no such activities have been in the field of mental health, mental illness and addiction.

9.3.2 Canada's Drug Strategy

The initial 1987 National Drug Strategy emerged from concern about the abuse of illegal drugs. In 1988, a national non-governmental organization, the Canadian Centre on Substance Abuse, was created by legislation to provide a focus for efforts to reduce the health, social and economic harm associated with substance abuse.

In 1992, Canada's Drug Strategy was renewed and combined with the Driving While Impaired (DWI) Strategy. The continued objective was to reduce the harmful effects of substance abuse on individuals, families and communities by addressing both the supply of and demand for drugs. Coordinated by Health Canada (formerly the Department of National Health and Welfare), and involving several other departments, the Strategy sought to enhance existing programs and to fund new ones. Of the \$210 million allocated to the initiative, 70% was directed to reducing the demand for drugs through prevention, treatment and rehabilitation and 30% to enforcement and control.

In 1998, the federal government reaffirmed its commitment to the principles of Canada's Drug Strategy. Health Canada continued in its lead role and provided the chair for the

⁴⁴⁶ Treasury Board of Canada, [*Federal Health Care Partnership*](#).

Assistant Deputy Ministers' Steering Committee on Substance Abuse and interdepartmental committees such as the Interdepartmental Working Group on Substance Abuse. The federal departments involved in the Strategy extended beyond those with direct responsibility for the health of Canadians; they included others with broader national and international relevance: Solicitor General, Foreign Affairs and International Trade, Finance, Canadian Heritage, Justice, Canada Customs and Revenue, Transport, Human Resources Development, Status of Women, Indian and Northern Affairs, Canada Mortgage and Housing Corporation, Treasury Board, and the Privy Council Office.

In its 2001 report, the Office of the Auditor General criticized Canada's Drug Strategy for its fragmented approach and called for changes to the organizational culture throughout the federal government to emphasize structures and processes to maximize the benefits of working horizontally. When the comprehensive Drug Strategy for Canada was renewed in May 2003, the federal government committed \$245 million and the support of fourteen collaborating federal departments. There will be a report to Parliament on the Strategy's direction and progress in two years.

9.4 FEDERAL INDIRECT ROLE

In addition to its direct federal responsibility, the federal government has a major indirect role in developing a national, long term, cross-jurisdictional, integrated, mental health plan. Although some witnesses claimed that mental health has never been a priority for any level of government, they also stressed their belief that mental health, mental illness and addiction are concerns affecting the entire population of Canada. Therefore, the federal government, the ten provincial governments and the three territories have interconnected roles to play in meeting the health and health care needs of Canadians affected by mental illness and addiction.

There is, however, no centralized departmental capacity, either within Health Canada or any other federal department, or through some form of national structure, to coordinate or respond from a national perspective to the full gamut of mental health, mental illness and addiction issues. Moreover, few resources are devoted to the intergovernmental aspects of a national framework in this area. Currently, work through various federal, provincial and territorial forums is limited to exploring options in shared care initiatives in primary health care reform, homecare proposals, and telehealth. The federal government is sensitive to the need to approach all such issues in a way that respects the federal/provincial/territorial division of responsibilities and the primary responsibility of the provincial and territorial governments for the provision of mental health services and addiction treatment.

A formal structure – the Federal/Provincial/Territorial Advisory Network on Mental Health – was established on 17 April 1986 to advise the Conference of Deputy Ministers of Health on ways and means of ensuring federal, provincial and territorial cooperation on mental health issues. It was mandated to:

- Consider issues delegated by the Conference of Deputy Ministers of Health, or accepted by a significant number of the provinces as matters where a general

- consensus of informed opinion would be helpful, and make recommendations, where appropriate;
- Advise on the development and implementation of policies and programs for mental health services, with the aim of developing a uniformly high level of quality and effectiveness across Canada;
 - Provide a forum to assist the provinces and territories in the development, organization and evaluation of mental health services within each jurisdiction;
 - Serve as a forum for the presentation and exchange of information, relevant data, current research findings and expert opinion between the federal and provincial governments, universities and treatment settings, on problems of jurisdiction, organization, legislation, service delivery, evaluation and other relevant issues;
 - Make proposals for federal, federal-provincial and provincial strategies for mental health promotion, to enhance the mental health status of the population at large and particularly that of children and adolescents;
 - Receive reports on current mental health activities and programs at the national level and give advice, direction and support to these, as may be appropriate.⁴⁴⁷

The work of the F/P/T Advisory Network on Mental Health was at the time supported by the Mental Health Division of Health and Welfare Canada. This division was then part of the department's Health Services and Promotion Branch.⁴⁴⁸ In the late 1990s, however, the Council of Deputy Ministers of Health withdrew its support for the F/P/T Advisory Network. As a result, it is now difficult to find funding even to bring together mental health policy makers from across the country so that they can share information and develop coherent policies and plans. A number of provinces still continue to participate in the F/P/T Advisory Network, but their work is limited by the funding they can provide themselves. According to Dr. James Millar, Executive Director, Mental Health and Physician Services, Nova Scotia Department of Health, the dismantling of the F/P/T Advisory Network on Mental Health:

(...) has cut off a major venue for sharing and joint planning. Some jurisdictions continue to get together but struggle with funding. The number of meetings and jurisdictions participating has dropped off over the years. Special projects are funded on a formula basis with Ontario covering the majority of the costs with Health Canada second. Quebec does not participate.⁴⁴⁹

What then could the federal government do to encourage national coordination, collaboration and partnerships in the field of mental health, mental illness and addiction? There are two different types of levers available – legal (or policy) and financial (or fiscal) – for potential use in the mental health, mental illness and addiction area. While the federal

⁴⁴⁷ Health and Welfare Canada, *Mental Health Services in Canada, 1990*, Government of Canada, 1990, pp. 22-23.

⁴⁴⁸ *Ibid.*

⁴⁴⁹ Dr. James Millar, Nova Scotia Department of Health Brief to the Committee, 28 April 2004, p. 4.

government has *legal* authority through the power of criminal law, it has used its *fiscal* capacity to influence social policy. Neither lever, however, is well suited to achieve greater uniformity, establish and maintain standards, bring harmonization or establish national initiatives; these require a high degree of intergovernmental contact and willing collaboration.

9.4.1 Legal Levers

The federal government has several legal avenues for application in mental health, mental illness, and/or addiction. Over the years, criminal law, the *Charter of Rights and Freedoms* and human rights have been applied.

The *Criminal Code* has particular sections that relate to mental disorders. For example, a person can be found not criminally responsible for an offence on account of mental disorder. The Court can order the initial part of a custodial sentence to be served in a treatment facility, when an offender is found to be “suffering from a mental disorder in an acute phase” and is in need of immediate treatment.

With respect to addiction, Parliament has used the power of criminal law in several instances. This authority was used to pass laws regulating the sale, distribution and possession of psychoactive substances through the *Controlled Drugs and Substances Act*. The *Tobacco Act* provides for a broad range of restrictions on the composition of tobacco products, the access of young persons to tobacco products, tobacco product labelling, and tobacco product advertisement endorsement and sponsorship. For alcohol, the *Criminal Code* covers driving while impaired and the *Broadcasting Act* and the Code for the Broadcast Advertising of Alcoholic Beverages regulates advertising.

As discussed in the previous chapter, the *Canadian Charter of Rights and Freedoms* guarantees certain legal rights that have application in mental health and addiction. Relevant sections deal with such matters as the right to life, liberty and security and the right not to be subject to cruel and unusual punishment. The Charter also has emerged as a mechanism for the creation of national standards which Canadians can demand that both federal and provincial governments meet.

The *Canadian Human Rights Act* of 1977 provides a process for resolving cases of discrimination in areas of federal jurisdiction. Discriminatory actions and attitudes are discouraged by means of persuasion and education and by ensuring that those who have discriminated will bear the costs of compensating their victims. The Act applies to all federal government departments, agencies and Crown corporations, as well as federally regulated businesses and industries (e.g., banking, transportation and communications).

9.4.2 Financial Levers

Generally speaking, however, the federal government’s involvement is essentially fiscal in nature. As long as it does not legislate directly in relation to matters within the provincial/territorial jurisdictions, the federal government has used its taxing and spending power to launch a number of social program initiatives that are national in scope. Restraints on transfer payments to the provinces in the 1990s, however, prompted many provinces to

demand that federal actions taken unilaterally with respect to transfers be replaced with processes involving greater provincial and territorial participation.

The federal spending power forms the basis for the *Canada Health Act* as well as for the current Canada Health Transfer and the Canada Social Transfer. It is the impetus for federal participation/incursion in other social policy areas such as housing and income security. The Canada Pension Plan (CPP), established by legislation in 1965, is another area where federal/provincial involvement. There are other such examples of social policy initiatives, income security for the disabled being one, that can enhance the mental health of all Canadians and, in particular, the quality of life of individuals with mental illness and addiction.

The area of mental illness, however, provides one example where the federal government's constitutional spending power was applied and then withdrawn over the last 55 years. From the National Health Grants of 1948 to the First Ministers' Accord on Health Care Renewal of 2003, federal funding arrangements have significantly affected mental illness and addiction either implicitly or explicitly.

Ambivalence over the place of mental health services in a national health care system was evident for many years the years. The 1948 National Health Grants Program, described as "the first stage in the development of a comprehensive health care insurance plan for all Canada," encouraged "expansion of health services" including those for mental illness.⁴⁵⁰ One component of the program – the Mental Health Grant – was used to implement or expand mental health services, to strengthen professional and technical training facilities and to improve the quality and quantity of staff. In 1960-1961, the last year of the grant, some 53% of the funds were allocated to institutions, while 23% went to clinics and psychiatric units, 13% to training and 8% to research.⁴⁵¹

In 1957, however, the federal government's *Hospital Insurance and Diagnostic Services Act* explicitly excluded psychiatric hospitals, although it did cover psychiatric services in general hospitals. This exclusion was based, at the time, by the view that mental hospitals provided custodial care and, as such, together with tuberculosis hospitals, nursing homes and other long term care institutions, they were not eligible for federal cost-sharing. In 1966, however, with the enactment of the *Medical Care Act*, public coverage was provided for physician services, including those provided by psychiatrists, regardless of setting.⁴⁵²

The *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977* gave each province "block-funding", a federal transfer payment based on its population and paid partly in cash and partly in tax points. This Act, under its definition of "extended health care

⁴⁵⁰ Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 31, 1948*, Ottawa: King's Printer, 1948, p.77.

⁴⁵¹ Health and Welfare Canada, *Mental Health Services in Canada, 1990*, Government of Canada, 1990, pp. 13-15.

⁴⁵² *Ibid.*

services”, listed mental hospitals together with nursing home intermediate care service; adult residential care service; home care service; and ambulatory health care service.⁴⁵³

In 1984, the *Canada Health Act* was enacted “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.”⁴⁵⁴ Most provisions of the two previous insurance Acts were consolidated in the new law; but one major change related to the new definition of extended care services: all references to mental hospitals was deleted.

In the 1990s, the role of the federal government in health care nationally and by extension its role in mental health was further curtailed as its transfer payments to the provinces and territories were reduced. In 1996, the Canada Health and Social Transfer (CHST) was established, merging the Established Programs Financing (EPF) and the Canada Assistance Plan (CAP); this left the provinces to decide themselves how to allocate their block funding among health care, post-secondary education and social programs.⁴⁵⁵

When departmental legislation established Health Canada in 1996, it provided general guidance for the health minister concerning national health issues. More precisely, the *Department of Health Act* assigned responsibility to the Minister of Health to oversee “the promotion and preservation of the physical, mental and social well-being of the people of Canada.”⁴⁵⁶ This was interpreted as limiting the Minister to broad programs that promote and preserve mental and social well-being; monitoring mental health conditions or programs; conducting research and/or investigating mental health among other public health issues; and collecting and publishing statistics on mental health.

A turning point occurred in 1999 with the Social Union Framework and the related Health Accord that committed the federal government to increase funding for health care through the CHST, to ensure predictability of funding and to work collaboratively with all provincial and territorial governments to identify Canada-wide priorities and objectives.⁴⁵⁷ By 2000, the First Minister’s Communiqué on Health contained a pledge to “promote those public services, programs and policies which extend beyond care and treatment and which make a critical contribution to the health and wellness of Canadians.”⁴⁵⁸ In the 2003 Health Accord, the First Ministers agreed to provide first dollar coverage for a core set of fully portable home care services for community mental health services with access to them based on

⁴⁵³ *Federal-provincial Fiscal Arrangements and Established Programs Financing Act 1977*, Chapter 10, 1977, Clause 27 subsection 8.

⁴⁵⁴ *Canada Health Act, 1984* (An Act relating to cash contributions by Canada in respect of insured health services provided under provincial health care insurance plans and amounts payable by Canada in respect of extended health care services) Chapter C-6, 1984, Clause 3.

⁴⁵⁵ The CHST was established through separate budget bills tabled in February 1995 and March 1996. Its operation is governed by the *Federal-Provincial Fiscal Arrangements Act*.

⁴⁵⁶ *Department of Health Act*, 1996, chapter 8.

⁴⁵⁷ [A Framework to Improve the Social Union for Canadians](#), An agreement between the Government of Canada and the Governments of the Provinces and Territories, 4 February 1999; and *The Federal, Provincial, Territorial Health Care Agreement*, 4 February 1999.

⁴⁵⁸ News Release, [First Ministers’ Meeting Communiqué on Health](#), September 2000.

need. The plan is to have a range of services available including case management, professional services and prescribed drugs by 2006.⁴⁵⁹

In addition to assistance with health-related services, the federal government has provided access to other programs to assist individuals with mental disability. For example, in 1961, the federal government agreed to share the cost of the Vocational Rehabilitation of Disabled Persons Program for mentally disabled persons of working age. In 1965, the Canada Pension Plan (CPP) offered disability benefits for a person with severe or prolonged mental disability. In 1966, the Canada Assistance Plan (CAP) offered the provinces 50% of the cost of shareable assistance and welfare services to people with disabilities, including mental disability.⁴⁶⁰ Cost sharing under CAP was considered instrumental in establishing community based social services integral to the provision of effective mental health supports in the community.

At present, through its Office for Disability Issues, Social Development Canada is the focal point within the federal government for work on the participation of Canadians with disabilities in learning, work and community life. Its key objectives include fostering policy and program coherence; building the capacity of the voluntary sector; creating cohesive, action-oriented networks and providing knowledge and building awareness. Other players include Canada Revenue Agency. Under the *Income Tax Act*, an individual with a severe and prolonged mental or physical impairment, or a person caring for a person with such impairment, can claim a disability tax credit.

Homelessness is another area in which the federal government used its spending power to facilitate development of a national framework. More precisely, the federal government launched in 1999 the National Homelessness Initiative (NHI), a community-based approach designed to alleviate and prevent homelessness. The initiative involves partnerships with all levels of government, the private sector and the voluntary sector. Its multidisciplinary approach reflects the belief that homelessness has no single cause and that the problem requires interventions in a number of areas, including the provision of shelter, opportunities for employment, mental health care, programs to combat drug abuse and welfare services. It recognizes the diversity of the needs of the homeless and the requirement for “tailored” responses and solutions relevant to specific communities.⁴⁶¹

While the federal government provides provinces and territories with funding in support of mental health services, social programs, income support and housing, the levels of funding for mental health services, per diem payments for transitional and supportive housing providers, and income assistance for individuals are all within provincial, territorial and municipal jurisdictions.

⁴⁵⁹ News Release, [First Ministers' Accord on Sustaining and Renewing Health Care for Canadians](#), 23 January 2003.

⁴⁶⁰ For more details on these federal programs, see William Young, *Disability: Socio-Economic Aspects and Proposals for Reform*, Current Issue Review 95-4E, Ottawa: Parliamentary Research Branch, 1997.

⁴⁶¹ Government of Canada, [National Homelessness Initiative](#).

9.5 ASSESSMENT OF THE FEDERAL ROLE WITHIN THE CURRENT NATIONAL FRAMEWORK

9.5.1 The *Canada Health Act*

(...) when the Canada Health Act was developed, mental health services provided in psychiatric hospitals were excluded. The Act provides that only medically mental health services provided in general hospitals and physician services will be covered by the Act. This significant omission has left those trying to provide mental health services at a serious disadvantage when providing community based services.

[Dr. James Millar, Executive Director, Mental Health and Physician Services, Nova Scotia Department of Health (Brief to the Committee, 28 April 2004, p. 5.)]

As mentioned above and previously, the *Canada Health Act* expressly excludes from its definition of comprehensiveness services provided in psychiatric institutions. Numerous witnesses stated that this omission reinforces an artificial distinction between physical and mental illness and contributes to the stigma and discrimination associated with mental disorders. For example, Dr. Sunil V. Patel, CMA President stated:

(...) it is (...) important to recognize the deleterious effect of the exclusion of a “hospital or institution primarily for the mentally disordered” from the application of the Canada Health Act. Simply put, how are we to overcome stigma and discrimination if we validate these sentiments in our federal legislation?⁴⁶²

Dr. Patel recommended that the *Canada Health Act* be amended to include psychiatric hospitals and that federal funding under the Canada Health Transfer be adjusted to provide for these additional insured services.

The Committee also heard that the exclusion of psychiatric hospitals from the *Canada Health Act* generates problems with respect to the principle of portability. More precisely, because psychiatric hospitals are explicitly excluded from the Act, they are not subject to reciprocal billing arrangements between provinces. Ray Block, CEO, Alberta Mental Health Board, stated that:

Case management also needs to be considered at a cross-jurisdictional level for those occasions when mental health patients from one jurisdiction need services while in another jurisdiction. Reciprocal arrangements relating to access and payment should facilitate their access to care as well as to the consistency and continuity of that care across jurisdictions. This

⁴⁶² Dr. Sunil V. Patel, President, Canadian Medical Association, Brief to the Committee, 31 March 2004, p. 3.

*would be a matter for discussion at a future federal/provincial/territorial Conference of Ministers of Health.*⁴⁶³

Moreover, numerous witnesses pointed out that many mental health services are provided in the community by providers other than physicians and are thus not covered under the *Canada Health Act*. This is particularly true for services provided by psychologists. In this context, Dr. Diane Sacks, President, Canadian Paediatric Society, told the Committee:

*(...) currently, the majority of professionals who offer [cognitive behavioural] therapy are uninsured by most provincial health plans. There are trained, regulated professionals that, if society's will was there, could treat many of our children and youth. (...) Having said that, there are professionals who can help make the diagnosis and treat these illnesses, but only if you have money, and lots of it. The waiting list to get the public school system or a community mental health centre to diagnose ADHD in Toronto today is 18 months – that is two full school years. That is if you do not have money. If you happen to have \$2,000, I can get you a psychologist within a week or two who will make a diagnosis and, if necessary, lay out for the school an extensive program to help your child succeed. Most employer-run insurance programs cover an average of only \$300 for psychology. Most public programs cover zero.*⁴⁶⁴

In its brief, the Centre for Addiction and Mental Health (Toronto) stated that the *Canada Health Act* should apply to more than general hospitals and physicians and should include home care and prescription drugs prescribed outside of hospitals. In the view of the Centre, public funding for the cost of medications would make a tremendous improvement in the lives of many individuals with mental illness who require long term pharmacotherapy. For these individuals, access to medication is key to their ability to maintain employment, housing and the other community connections that support treatment and recovery.⁴⁶⁵

Many witnesses supported the work already underway by First Ministers to expand home care to individuals with mental illness. They contended that any national home care program should encompass both mental illness and addiction.

9.5.2 Federal Funding

Federal transfers to the provinces and territories for the purpose of health care are provided under the Canada Health Transfer (CHT). There has never been any, nor is there now, an identified, specific transfer to any province or territory dedicated to mental health care and addiction treatment. Currently, as a result of the [2003 First Ministers' Accord on Health Care](#)

⁴⁶³ Ray Block, CEO, Alberta Mental Health Board Brief to the Committee, 28 April 2004, p. 7.

⁴⁶⁴ Dr. Diane Sacks, President, Canadian Paediatric Society (13:53-54).

⁴⁶⁵ Centre for Addiction and Mental Health (Toronto), Brief to the Committee, 27 June 2003, p. 3.

Renewal, the CHT provides funding for acute community mental health care,⁴⁶⁶ but no specific proportion of the transfer is expressly designed for this purpose.

The Mood Disorders Society of Canada recommended that federal transfer payments for the purpose of health care should have a portion dedicated specifically to the delivery of mental health care. The Society argued that two conditions should be attached to this funding: 1) provinces and territories should be prevented from reducing their spending on mental health care; 2) ongoing evaluations of provincial mental health care programs should be undertaken to ensure value for money.⁴⁶⁷

Another proposal to raise revenue to support the treatment and prevention of addiction was made to the Committee. Called the “Behavioural Insurance Model”, this proposal is based on raising money for the purpose of addiction prevention and treatment through a certain dedicated percentage of revenues generated from behaviour associated with addiction (tobacco, alcohol, gambling).

The Ontario Federation of Community Mental Health and Addiction Programs informed the Committee that a Behavioural Insurance Model was introduced in 1999 by the Government of Ontario to fund an integrated array of services to address pathological gambling. Under this model, 2% of gross revenues from slot machines in provincial charity casinos and race tracks are dedicated to treatment, prevention and research. In 2002-2003, this formula generated approximately \$36 million, an amount sufficient to support a comprehensive response to this serious problem.

In his brief, Dr. Wayne Skinner, Clinical Director, Concurrent Disorders Program, Centre for Addiction and Mental Health (Toronto), stated

(...) it is important to recognize that a number of behaviours that have addictive liability are regulated by the state, which also derives considerable tax revenue from them. This includes tobacco and alcohol, and more recently gambling. It has been estimated that more than half the revenues from alcohol and gambling come from 10 per cent of people who spend the most money on these activities. This 10 per cent population is the one at highest risk to being addicted to these behaviours. Given that over half of tax revenues from these behaviours are coming from that part of the population that is most vulnerable, government, if only from a crisis of conscience, should challenge itself to develop a proactive strategy toward the prevention, treatment and research of addictive behaviours and their mental health comorbidities. But beyond that, there is strong evidence that social spending to prevent and treat addiction and mental health problems provides an enviable return on investment. It is not unreasonable to expect that more of the revenues

⁴⁶⁶ Acute community mental health care refers to acute care provided in the community to individuals with mental illness who have an occasional acute period of disruptive behaviour; the aim is to prevent or minimize recurrent institutionalization.

⁴⁶⁷ Mood Disorders Society of Canada, Brief to the Committee, 12 May 2004, p. 7.

*that behaviours with addictive potential provide be invested in helping people who are harmed by these behaviours.*⁴⁶⁸

9.5.3 The National Homelessness Initiative (NHI)

In his submission to the Committee, Bill Cameron, Director General of the National Secretariat on Homelessness, stated that the NHI addresses mental health issues in two ways through 1) financial support for community initiatives and 2) partnership agenda on research.⁴⁶⁹

The “Horizon Housing Society” is an example of community-based initiatives funded through the NHI; the Society acquired an apartment building in Calgary to be used as transitional housing for individuals with mental illness and addiction who are homeless or at risk of becoming homeless. The research agenda includes issues surrounding the availability and accessibility of mental health services for homeless people, the incidence of mental illness among homeless people and the causal relationship between deinstitutionalization and homelessness. Research under the NHI is also undertaken in partnership with CIHR.⁴⁷⁰

According to Bill Cameron, many mental health services to homeless people end up being delivered in emergency departments. Moreover, the homeless population faces many barriers that impact their access to the mental health services they need. For example, many are unable to make health appointments, and their ability to access coordinated care is impaired by their lack of an address and/or place of contact. In particular, many women with serious mental disorders do not receive needed care, apparently because, in part, they are not perceived to have mental health problems and also because of a lack of services designed to meet the special needs of homeless women.⁴⁷¹

Mr. Cameron also identified other major gaps in community services and supports directed to the homeless population, including emergency housing, supportive housing, and community-based mental health services.⁴⁷² According to Mr. Cameron, safe and affordable housing with individualized supports is a key factor in the in helping the homeless generally, but he stressed that this may not be enough for those with severe mental illness and addiction. Long term supporting facilities such as emergency shelters and supports and transitional housing are necessary to help the chronically homeless. There is also a need for preventative measures such as dedicated affordable housing for individuals discharged from psychiatric institutions and the provision of short term intensive support services to be available immediately to those discharged from acute care hospitals, shelters and jails.⁴⁷³

⁴⁶⁸ Dr. Wayne Skinner, Clinical Director, Concurrent Disorders Program, Centre for Addiction and Mental Health (Toronto), Brief to the Committee, 2004, p. 6.

⁴⁶⁹ Bill Cameron, Director General of the National Secretariat on Homelessness, Brief to the Committee, 29 April 2004, p. 1.

⁴⁷⁰ *Ibid.*, pp. 1-2.

⁴⁷¹ Bill Cameron (2004), p. 2.

⁴⁷² Bill Cameron (2004), p. 3.

⁴⁷³ Bill Cameron (2004), p. 4.

9.6 THE NEED FOR A NATIONAL ACTION PLAN ON MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION

Witnesses told the Committee repeatedly that Canada needs a national action plan on mental health, mental illness and addiction. Many countries have already adopted such a national mental health policy or action plan. For example, in 1992, Australia developed a national mental health strategy to improve the lives of individuals with mental illness; also in 1992, the United Kingdom developed an action plan in five key health areas, one of which was mental health, which established targets for improvement of the health of individuals with mental illness and to reduce the suicide rate; in 1999, the report of the US Surgeon General made a commitment to improve mental health within the United States.⁴⁷⁴

Canada has no national framework for mental health. There is no national commitment to mental health services.

[Dr. James Millar, Nova Scotia Department of Health, Brief to the Committee, 28 April 2004, p. 4.]

Canada is currently characterized by a serious lack of leadership on mental health, mental illness and addiction which, in the view of many witnesses and the Committee, has created a large void: there is no focus on mental illness and addiction within health care reform initiatives; there is no clear delineation of roles and responsibilities of the various stakeholders. Phil Upshall, President, Canadian Alliance on Mental Illness and Mental Health (CAMIMH), stated:

The current status of mental illness and mental health in Canada paints a very bleak picture, beginning with a large void in leadership. (...) no policies and very few processes exist to address mental illness and mental health at a national level in Canada. There is no clear identification of the roles and responsibilities of the government players involved. One of the most significant barriers to securing a national action plan appears to be the division of powers between provinces/territories and the federal government for health and social services. This need not be a hindrance to developing a coherent approach that will meet the needs of Canadians equitably.⁴⁷⁵

Many witnesses recommended a strong leadership and development of a national action plan. This has contributed significantly to the piecemeal approach to mental illness and addiction, to the development of various programs and duplication and waste of resources. For example, Dr. James Millar, Executive Director, Mental Health and Physician Services, Nova Scotia, stated:

(...) the piecemeal work being done in isolation by the provinces, territories and advocacy groups is leading to duplication of effort and wasted resources.

[Dr. James Millar, Executive Director, Mental Health and Physician Services, Nova Scotia Department of Health (7:19).]

Nationally, we are not doing (...) well. Provinces, individually, have been struggling with providing

⁴⁷⁴ See the Committee's second report, *Mental Health Policies and Programs in Selected Countries*, for a full description of national mental health strategies in Australia, New Zealand, England and the United States.

⁴⁷⁵ Phil Upshall, President, CAMIMH, Brief to the Committee, 18 July 2003, p. 7.

*appropriate services and developed various models from the Mental Health Commission of New Brunswick to the Alberta Mental Health Board. The federal government has not provided leadership in developing a national strategy.*⁴⁷⁶

Similarly, Dr. Sunil V. Patel, President, Canadian Medical Association, told the Committee:

*Canada is the only G8 country without such a national strategy. This oversight has contributed significantly to fragmented mental health services, chronic problems such as lengthy waiting lists for children's mental health services and mental health.*⁴⁷⁷

National leadership on mental illness and addiction is long overdue. The federal government can play a major role in collecting national data, supporting research and knowledge dissemination, and educating Canadians about mental health, mental illness and addiction. Many witnesses stated that the federal government has a key role in addressing the housing, income and employment needs of individuals with mental illness and addiction. Moreover, there is the direct role of the federal government in the provision of mental health services and addiction treatment to Aboriginal peoples, federal inmates, the veterans and members of the Canadian Forces, RCMP and federal employees.

While numerous witnesses favoured national leadership, it was stressed that progress can only be achieved by the federal government in close partnership with the provinces and territories. For example, Dr. Pierre Beauséjour, Senior Medical Advisor, Alberta Mental Health Board, stated:

While we agree that national leadership by the federal government for the development of a national action plan on mental illness and mental health is crucial, we will propose that building consensus on national mental health goals, standards and accountability is imperative and that provincial/territorial leaderships in mental health are as necessary as federal leadership in that regard.

*We firmly believe that a result-oriented partnership approach, a clear redefinition of roles and responsibilities and a synergy of efforts between the federal government and the provinces/territories will be needed for the development and implementation of a national cross-jurisdictional policy framework on mental health.*⁴⁷⁸

⁴⁷⁶ Dr. James Millar, Executive Director, Mental Health and Physician Services, Nova Scotia Department of Health, Brief to the Committee, 28 April 2004, p. 3.

⁴⁷⁷ Dr. Sunil V. Patel, President, Canadian Medical Association Brief to the Committee, 31 March 2004, p. 2.

⁴⁷⁸ Dr. Pierre Beauséjour, Senior Medical Advisor, Alberta Mental Health Board, Brief to the Committee, 2003, p. 1.

Witnesses argued that the national framework must set standards for service delivery covering all aspects of mental health from prevention, promotion and advocacy through community-based services to inpatient and specialty services. It must also provide services throughout the lifespan and ensure clarity of roles and responsibilities along the continuum of care. In addition, because most mental illnesses have their roots in childhood and adolescence, there must be a new focus on child and adolescent mental health. Child and adolescent mental health has been ignored for too long. We must deal with problems early at their root before serious damage is done. In addition to children and adolescents, population groups also identified as in need of urgent action include Aboriginal peoples, senior Canadians, federal inmates, women and landed immigrants.

Mental illness and poor mental health are significant contributing factors in suicide with more people dying worldwide from suicide than war and homicide combined. Increasing the quality of mental health, and responding to mental illness on a timely basis will save lives.

[Phil Upshall, President, CAMIMH, Brief to the Committee, 18 July 2003, p. 3.]

Another priority area within a national action plan is suicide prevention. The fact is that Canada, unlike Australia, Finland, France, the Netherlands, New Zealand, Norway, Sweden, the United Kingdom and the United States, does not have a national suicide prevention strategy. Many witnesses who appeared before the Committee urged the federal government to work with the provinces/territories and relevant stakeholders in the development of such a strategy. According to Dr. Paul Links, Arthur Sommer Rotenberg Chair in Suicide Studies, countries that have implemented national strategies on suicide prevention have experienced reductions of between 10% to 20% in suicide rate.⁴⁷⁹ Moreover, the Centre for Suicide Prevention told the Committee that only two provinces – New Brunswick and Quebec – have implemented a suicide-specific prevention strategy. Witnesses urged the federal government to work with the provinces/territories and relevant stakeholders in the development of a national suicide prevention strategy.

A number of witnesses mentioned that there is an opportunity to coordinate a national mental health strategy with the National Drug Strategy. Given the high rate of concurrent disorders (mental illness and addiction), it is critical that links be forged between them. For example, national monitoring of the prevalence of substance use disorders through the National Drug Strategy would be of tremendous benefit to efforts to plan services for individuals with concurrent disorders.

Through the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), some 20 NGOs representing individuals with mental illness/addiction, their families and service provider organizations have reached a consensus on the need for a national action plan on mental health, mental illness and addiction.⁴⁸⁰ This national action plan addresses four main areas: education and awareness; national policy framework; research; and surveillance:

⁴⁷⁹ Dr. Paul Links (11:20).

⁴⁸⁰ The following organizations have joined together to form the Canadian Alliance on Mental Illness and Mental Health: Autism Society of Canada, Mood Disorders Society of Canada, Canadian Medical Association, Canadian Health Care Association, National Network for Mental Health, Canadian Council of Professional Psychology Programs, Canadian Federation of Mental Health Nurses,

- Public awareness campaigns and professional education in a wide range of social and medical courses can help reduce the stigma and discrimination that is associated with mental illness, addiction and suicidal behaviour.
- A national policy framework is required in terms of identifying and implementing best practices (for treatment, prevention and promotion) and planning human resources (psychiatrists, psychologists, psychiatric nurses, addiction specialists, social workers, etc.). National leadership is also necessary to develop a comprehensive cross-jurisdictional policy framework that can ensure equitable access to professional and community supports across the country.
- The federal government is best positioned to establish and support a national research agenda for mental health, mental illness and addiction. Priorities for research need to be identified, research funding needs to be increased, and the voluntary fundraising sector needs to be strengthened.
- A national surveillance system must be implemented to monitor accurately and evaluate the incidence and prevalence of mental illness and addiction (including suicidal behaviour). The information collected nationally could also be used to report on how well the system is meeting the needs of individuals with mental illness and addiction.⁴⁸¹

Many witnesses stressed that a national action plan for mental health, mental illness and addiction can only be developed through collaboration among the federal government, provincial and territorial jurisdictions, NGOs and other stakeholders including individuals with mental illness/addiction. In this context, the Schizophrenia Society of Canada stated:

It will take the work of all levels of government, working in concert with non-governmental organizations, to create and facilitate a national action plan. (...) Existing, capable agencies such as hospitals, professional associations and volunteer organizations that have been acting as band-aids in the current system are poised to be part of the mental health care solution in Canada. The biggest challenge governments will face is coordinating a multi-tiered government system that was not designed to work together and integrating non-governmental organization into the system as a contributing partner. It is only through a concerted effort in these areas that Canada will witness a shift in mental health care that will effectively and efficiently treat and support individuals with mental

Canadian Coalition for Seniors' Mental Health, College of Family Physicians of Canada, Canadian Psychiatric Research Foundation, Canadian Association for Suicide Prevention, Canadian Association of Occupational Therapists, Schizophrenia Society of Canada, Canadian Mental Health Association, Canadian Academy of Child Psychiatry, Canadian Association of Social Workers, Canadian Psychiatric Association, Canadian Psychological Association, Native Mental Health Association of Canada.

⁴⁸¹ Canadian Alliance on Mental Illness and Mental Health, [*A Call for Action: Building Consensus for a National Action Plan on Mental Illness and Mental Health*](#), Discussion Paper, September 2000.

illness and their families and reduce the burden to individuals, families and society caused by [mental disorders].⁴⁸²

As stated by Phil Upshall, CAMIMH President, action must be taken now:

The time is now. (...) It has been fifteen years since the federal government released Mental Health for Canadians: Striking a Balance. Its policy document linked the national health promotion vision of “Achieving Health for All” to mental health. Other major reports, together with numerous provincial and regional policy and discussion documents have recommended significant changes to improve services and programs for: individuals with serious mental illnesses, children’s mental health services, suicide prevention, aboriginal peoples, and offender and prison populations. These reports continue to gather dust and Canadians continue to wait, as few of the recommendations and ideas have been implemented.⁴⁸³

Overall, witnesses called for a commitment by all levels of government to act, to work together on developing common goals and on creating a cohesive, integrated national framework on mental health, mental illness and addiction. One overlooked element of federal government activity in this field appears to be its direct responsibility for over a million Canadians, some of whom are facing serious mental health issues.

9.7 AN APPROACH BASED ON POPULATION HEALTH

Not only must the health care system treat mental illness (...) but Canada needs to take proactive steps based on the broader health determinants to protect and preserve the mental health of its entire population, including those living with mental illness. Improving the social conditions that we know are necessary for overall good mental health (e.g. healthy physical and social environments, strong coping skills, along with health services) is essential to support positive mental health and recovery from mental illness. [Canadian Mental Health Association, Brief to the Committee, June 2003, p. 3.]

Mental health, mental illness and addiction are strongly influenced by a wide variety of factors including biology and genetics, income and educational achievement, employment, social environment, and more. This fact points clearly to the need to address mental health,

⁴⁸² Schizophrenia Society of Canada Brief to the Committee, 2004, p. 3.

⁴⁸³ Phil Upshall, President, Canadian Alliance on Mental Illness and Mental Health, Brief to the Committee, 18 July 2003, p. 7.

mental illness and addiction from a population health approach, a broad perspective extending well beyond health care *per se*.

The Committee heard repeatedly that treatment and recovery are difficult to achieve when basic needs for shelter, income and employment are not met. Many witnesses pointed out that it would be good public policy to take action to address these needs since access to housing, income and employment has been demonstrated to improve clinical status, reduce hospitalization, and enable individuals with mental illness to stay in their homes and communities. Access to housing, income and employment are also key to someone's ability to participate in society and to enjoy the rights of citizenship free from stigma and discrimination.

Housing has been widely acknowledged as a priority in mental health policy at both the federal and provincial levels. What is needed now is action from both levels of government to implement new housing and supported housing programs based upon the foundation of existing policy and research that has shown convincingly that a diverse population of individuals with mental disorders can succeed in housing if appropriate supports are available. Appropriate housing and supports can substitute for long term inpatient care thereby decreasing society's and affected individuals' reliance on high cost hospital and institutional beds.

Access to adequate income and employment is another key determinant of health that must be a priority in any mental health strategy. Many individuals with mental illness must rely on government income programs, at some time during their illness, as their only source of income and access to prescription drug coverage. Unfortunately, many government income programs provide benefits that are too low, don't cover realistic living costs, create barriers to employment, and are not flexible enough to respond to the episodic nature of mental illness. In addition, disability is often defined too narrowly for many individuals with mental illness or addiction to qualify. In Ontario, for example, provincial income support programs exclude individuals affected by addiction from the definition of disability altogether. These systemic barriers within government income support programs must be addressed to ensure that individuals with mental illness and addiction are able to access the basic supports that will help restore them to health and keep them well.

Support for employment is also a key area in which governments can do more. Individuals with a range of mental health problems can succeed in employment if flexible supports, responsive to their changing needs throughout treatment and recovery are available. Greater emphasis must also be placed on ensuring that individuals with mental illness are meaningfully accommodated in the workplace. Access to skills development, training and education must also be improved by encouraging academic institutions and other learning environments to accommodate more appropriately individuals with mental illness.

9.8 COMMITTEE COMMENTARY

At present, the federal government has no comprehensive framework for mental health, mental illness and addiction federally or nationally. While several witnesses pointed to the fact that Canada stands alone among similar G8 countries in not having a national mental

health policy reaching across the applicable jurisdictional boundaries, others noted the absence of an integrated framework even at the federal level with its responsibility for the provision of mental health services and addiction treatment to specific groups.

The lack of a *federal* framework may be primarily a function of inadequate collaboration, cooperation and communication among the various federal departments that have involvement in related or overlapping areas. However, it may also be a consequence of the difficulties of trying to address the multiple needs of very diverse populations. Whatever the reason, the Committee believes that despite its direct responsibility for the mental health needs of specific groups in the Canadian population, the federal government has made too little effort to coordinate its initiatives internally. In these areas, the federal government has both the right and the obligation to act and can do so without intensive (or even any) negotiations with other jurisdictions.

Similarly, the absence of an overall *national* framework may be attributed to some extent to the lack of clear role differentiation in these areas where provincial/territorial responsibility takes precedence. In general, the *Constitution Act, 1867* gives the provinces power to legislate in the fields of health care, education, provincial jails, and the administration of the courts; while giving Canadian Parliament power over criminal law and procedure, as well as the management of penitentiaries. In addition to the power of criminal law, this leaves the federal government with two other potential constitutional powers when acting in a national capacity: its spending power; and the ability to pass laws for the peace, order and good government of Canada.

From both the federal and the national perspectives, it is obvious that the federal government's role with respect to mental health, mental illness and addiction is not limited to the activities of the Health Canada. Related policies, programs and services fall in the broader social sphere as well as in the justice arena, outside the traditional health care sector. Other federal departments such as Human Resources Development Canada, Indian and Northern Affairs Canada, Veterans Affairs Canada, Correctional Services Canada, Justice Canada are among those that currently play a role in federal and national initiatives. And at the workplace level, Treasury Board as the employer of public servants has a major role to play in assisting its employees with issues related to mental health and addiction.

In looking at federal government activities with respect to the specific groups under its responsibility, there is little evidence to suggest the existence of strategies targeted at specific populations, let alone a broad all-encompassing federal strategy. No current efforts to develop an overall coordinated federal framework with collaboration by all involved departments or agencies are apparent. In most cases, there is little indication of thought being given to the development of a thorough and inclusive population specific strategy for addressing the mental health needs of any of the groups under federal responsibility. The provision of mental health services and addiction treatment and efforts toward mental health promotion and mental illness prevention remain highly fragmented, provided by numerous departments and departmental directorates. More collaboration would lead to a more integrated approach towards mental health. This would be an important step toward a policy based on population health.

The Committee also concurs with witnesses that better links are needed between the federal and provincial governments and among the various overlapping systems – health care, mental health, addiction, justice, social supports, etc.

Finally, it would also be important for the federal government to lead by example. If it is to play a leadership role in the development of a truly national action plan on mental health, mental illness and addiction, it must also show that it is willing and capable of providing mental health services to the populations for which it has direct responsibility. Clearly, there is a need to correct the ambivalent approach taken over the years by the federal government about the place of mental health in its policies and programs.



PART 4

Research and Ethics

CHAPTER 10: RESEARCH INTO MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION IN CANADA

We believe that research is our most important weapon in our search for a better understanding, improved treatments and eventually a cure for devastating mental illnesses.
[Canadian Psychiatric Research Foundation, [Today](#),
Newsletter, Vol. 3, No. 1, Spring 2003.]

INTRODUCTION

In Canada, the federal government is the major sponsor of research into mental health, mental illness and addiction, while university-based scientists in research institutes and university-affiliated hospitals are the major performers. The Canadian Institutes of Health Research (CIHR), through its Institute of Neurosciences, Mental Health and Addiction (INMHA), is the primary federal funding agency for research into mental health, mental illness and addiction.

As with all CIHR-funded health research, research in mental health, mental illness and addiction encompasses the full spectrum of activities ranging from biomedical, to clinical, to health services, and to population health research:

- Biomedical research pertains to biological organisms, organs and organ systems. For example, this type of research would study the level of serotonin (a brain chemical) in patients suffering from eating disorders such as Bulimia Nervosa.
- Clinical research relates to studies involving human participants, healthy and ill. An example would include clinical trials on humans to test the toxicity and effectiveness of a possible new treatment for schizophrenia that, in basic biomedical research, has shown promising results and can then be safely studied in terms of its net and comparative (relative to other drugs) benefit to patients.
- Health services research embraces the administration, organization and financing mental health services delivery and addiction treatment. An example might be research into the mechanisms for caring for patients with bipolar disorder, from the manner of their diagnosis, through their treatment in hospital, then on an out-patient basis, or at home, to their long-term follow-up through hospital and community care.
- Population health research focuses on the broad factors that influence mental health status (socio-economic conditions, gender, culture, literacy, genetics, etc.). An example might be a study using large databases of health information to learn whether the incidence of attention deficit and hyperactivity disorder is associated with environmental or other factors.

This chapter provides an overview of the state of research into mental health, mental illness and addiction in Canada. Section 10.1 summarizes the role and mandate of CIHR and INMHA and highlights a number of issues raised by witnesses. Section 10.2 provides information on federal research funding for mental health, mental illness and addiction and examines the question of whether funding should reflect the burden of disease. Section 10.3 briefly reviews other sources of funding for mental health and addiction research. Section 10.4 discusses issues related to the translation of research knowledge into actual services and supports for individuals with mental illness and addiction. Section 10.5 discusses the need for a national research agenda for mental health, mental illness and addiction. Section 10.6 provides some Committee commentary.

10.1 CIHR AND INMHA

In Canada, there has been a net improvement in the past three years following the creation of the Canadian Institutes of Health Research, as well as an improvement in research funding, particularly for mental health. However, there is still great room for improvement.

[Michel Tousignant, Professor, Centre de recherche et d'intervention sur le suicide et l'euthanasie, Université du Québec à Montréal (14:41)]

As part of its commitment to becoming one of the top five research nations in the world, the federal government created in 2000 the Canadian Institutes of Health Research (CIHR). CIHR is an arms-length organization reporting to the federal Minister of Health.

CIHR takes an innovative, multi-faceted, problem-based and multidisciplinary approach to health research. This approach applies all types of research (biomedical, clinical, health services, population health) to disease mechanisms, treatment, prevention and health promotion. The majority of research funded by CIHR is investigator-driven (70%); 30% is reserved for strategic initiatives to respond to health challenges and scientific opportunities of high priority to Canadians.

CIHR's approach to research is facilitated by its structure, which brings together researchers across disciplinary and geographic boundaries in its 13 Institutes, each of which addresses a specific domain of health research. One of these 13 institutes is the Institute of Neurosciences, Mental Health and Addiction (INMHA).⁴⁸⁴

INMHA's creation marked the first focal point established in Canada for research into mental health, mental illness and addiction. INMHA supports research to enhance mental health, neurological health, vision, hearing, and cognitive functioning and to reduce the burden of related disorders through prevention strategies, screening, diagnosis, treatment, support systems, and palliation. As shown in Table 10.1, INMHA covers a wide range of research areas.

⁴⁸⁴ The first three paragraphs of this section are based on information contained on CIHR's website, under "About CIHR – Who We Are" (<http://www.cihr-irsc.gc.ca/e/about/7263.shtml#?>).

TABLE 10.1

AREAS OF RESEARCH SUPPORTED BY INMHA

- Mental health and neurological health promotion policies and strategies
- Addiction prevention policies and strategies
- Health determinants – to elucidate the multi-dimensional factors that affect the health of populations and lead to a differential prevalence of health concerns
- Identification of health advantage and health risk factors related to the interaction of environments (cultural, social, psychological, behavioural, physical, genetic)
- Disease, injury and disability prevention strategies at the individual and population levels
- Head injury prevention, treatment, and rehabilitation
- Addiction, mental health, and dysfunction of the nervous system affecting sensation, cognition, emotion, behaviour, movement, communication, and autonomic function
- Clinical research and health outcomes research into diagnostic technologies and methods; therapies; treatment, care, and rehabilitation models (long and short-term)
- Co-morbidity of conditions and impacts on prevention, diagnosis, treatment, care and rehabilitation
- Design and implementation of health services delivery – from prevention, to screening, to diagnosis, to intervention or treatment, to rehabilitation, to palliation
- Development and implementation of health technologies and tools (e.g. imaging, bio-engineering, drug delivery technologies)
- Development, regulation, function and dysfunction of the central, peripheral, and autonomic nervous systems
- Human psychology, cognition and behaviour; sleep and circadian biology; pain
- Ethics issues related to research, care strategies, and access to care (e.g. informed consent; hospitalization; addiction, mental health and the justice system)

Source: CIHR's Website (<http://www.cihr-irsc.gc.ca/e/institutes/inmha/9591.shtml#>).

INMHA's strategic plan for 2001-2005 lays out five strategic priorities:

1. To foster and develop a capacity for innovation in research in neurosciences, mental health and addiction that will strengthen Canada's health research

milieu in these fields and enhance its competitive position on the international scene. The focus areas include training, strategic initiatives, research in emerging areas and, research in bioethics;

2. To pursue and sustain collaborative partnerships with governmental, non-governmental and volunteer health organizations as well as pharmaceutical and biotechnology industries that will enable the INMHA to share, develop, obtain or leverage resources required to accomplish its mandate;
3. To promote linkage and exchange between the research community and municipal, provincial and national levels of decision-makers as well as the users of research results, including NGOs, through structured efforts aimed at knowledge translation (see section below);
4. To develop the INMHA's presence on the international stage through joint research, training and funding initiatives with scientific and research funding agencies in other countries; and,
5. To establish an organizational and an operational structure that will enable the INMHA to accomplish its goals.⁴⁸⁵

Witnesses and researchers largely supported CIHR's new approach to mental health, mental illness and addiction research. There also exhibited strong trust in the fairness and rigour of CIHR's peer-review mechanism. For example, in their paper to the Committee, Dr. Shitij Kapur and Dr. Franco Vaccarino, from the Centre for Addiction and Mental Health (Toronto), stated:

*(...) there is an important recognition and valuation of the role of CIHR in [mental health, mental illness and addiction] research. The rigour and transparency that CIHR brings to its evaluations and competitions is highly regarded and is seen as an indispensable mechanism to fill the "investor-driven" spectrum of research.*⁴⁸⁶

Witnesses acknowledged the multidisciplinary approach taken by CIHR as a positive step in research into mental health, mental illness and addiction. For example, Dr. Alan Bernstein, President of CIHR, observed:

*Canada has an exceptionally strong and internationally recognized neuroscience community. By creating a single Institute that embraces neuroscience, mental health and addiction, we have explicitly embraced an integrative vision that is helping to bring together laboratory-based neuroscientists, psychologists, psychiatrists, social scientists, and health services researchers to focus on mental health and addiction.*⁴⁸⁷

⁴⁸⁵ Institute of Neurosciences, Mental Health and Addiction, [Strategic Plan – 2001-2005](#), December 2001.

⁴⁸⁶ Shitij Kapur and Franco Vaccarino, *Translating Discoveries into Care – Enhancing Research in Mental Illness and Addictions*, paper commissioned by the Committee, 2004, p. 5.

⁴⁸⁷ Dr. Alan Bernstein, Letter to the Committee, dated 8 July 2003.

Dr. Rémi Quirion, Scientific Director of INMHA, also pointed to the excellence of research into mental health and mental illness in Canada, but stressed that research capacity was an issue in the field of addiction:

Canada is one of the world leaders in the area of neuroscience research. In terms of the impact of our discoveries in neuroscience, we rank second or third. We therefore have excellent capacity. We are quite strong in the area of mental health. We need to do some rebuilding on the addiction side: we lost many of our significant researchers in the 90s.⁴⁸⁸

Furthermore, most witnesses welcomed the inclusion of population health research and health services research as part of CIHR's mandate. They explained that this contrasted with the historical focus of CIHR's predecessor, the Medical Research Council, on biomedical research. The Committee was told, however, that population health research and health services research remain relatively weak in the fields of mental health, mental illness and addiction. In their paper, Kapur and Vaccarino contended that it is important to redress this situation, given the effects of the broader determinants of health on mental illness and addiction.⁴⁸⁹

With respect to health services research, a literature review suggested that there is still much to be learned in Canada about best practices to provide care and supports to individuals with mental illness and addiction whether in inpatient care, outpatient care, crisis response, housing, employment or self-help.⁴⁹⁰ The authors of the review indicated that, for those interventions where there is the strongest evidence relating to their effectiveness, there remains a pressing need for more detailed information about what works for whom. Where the evidence of effectiveness is unclear, more creative approaches are needed to assess effectiveness of specific interventions when traditional randomized controlled trials are not feasible or appropriate. Identifying best practices is essential to guide decisions about who should receive treatment resources and where, what treatment interventions should be provided, and how to provide the assurance that the care delivered is appropriate for the patient/client's needs.

Research must inform mental health service delivery. We need to know what works and what doesn't. We need to make informed decisions. We also must translate research knowledge into action.

[Dr. James Millar, Nova Scotia Department of Health, Brief, 28 April 2004, p. 11.]

Although many witnesses lauded the unique Canadian approach of fostering collaboration amongst researchers and between researchers and other organizations, some complained about heavy restrictions and major obstacles that prejudice the validity and quality of research and consume too much of the researchers' time. For example, Michel Tousignant, Professor, Centre de recherche et d'intervention sur le suicide et l'euthanasie, Université du

⁴⁸⁸ Dr. Rémi Quirion (14:9).

⁴⁸⁹ Kapur and Vaccarino (2004), p. 5.

⁴⁹⁰ Health Systems Research Unit, Clark Institute of Psychiatry, [Best Practices in Mental Health Reform – Discussion Paper](#), prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, Health Canada, 1997, pp. 27-28.

Québec à Montréal, told the Committee that researchers could spend many months, sometimes up to year, to fulfill all INMHA/CIHR's criteria before even starting a research project. He explained that as many as three ethics committees – university, research centres and hospital, –review a proposal. While ethics committees exist to protect everyone's interests, Professor Tousignant pointed out that very little time is allocated by them to consult with researchers who may also be required to submit protocols to the Access to Information Commission, which further delays the initiation of research projects and places another layer of bureaucratic burden on investigators.⁴⁹¹

10.2 FEDERAL FUNDING FOR RESEARCH INTO MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION

(...) the funding of mental health and addictions research in Canada is currently inadequate. Mental health and addictions are under funded in an absolute and a relative sense. When one combines this systemic under funding, with the impact of stigma, the limitations of the NGOs fund-raising in this area as well as the lack of commercial incentives for a lot of these activities, the under funding becomes even more acute. Given that the other constraints cannot be easily overturned (stigma, limits to fund-raising in this area, lack of commercial incentives) – it is critical that the federal government show leadership in securing fair funding for mental health and addictions research.

[Dr. Shitij Kapur and Dr. Franco Vaccarino, Centre for Addiction and Mental Health (2004)]

10.2.1 Level of Federal Funding

CIHR, the primary funding agency for mental health and addiction research in Canada, has allocated \$93 million to INMHA from its total base budget of \$623 million for the 2003-2004 fiscal year. About \$33 million from the INMHA budget goes to mental health and addiction research, or 5.3% of the total envelope of CIHR health research funding. The remaining \$60 million is spent on fundamental neuroscience research, some of which, along with other health research, may well also contribute to a greater understanding of mental illness and addiction.

Dr. Bernstein stressed that INMHA currently receives the largest allocation of CIHR funds, followed by the Institute of Circulatory and Respiratory Health (\$64 million) and the Institute of Infection and Immunity (\$52 million).⁴⁹²

INMHA, together with the Institute of Aboriginal People's Health, created the National Network for Aboriginal Mental Health Research (NNAMHR) in the spring of 2003 with a

⁴⁹¹ Professor Michel Tousignant (14:43).

⁴⁹² Dr. Bernstein (8 July 2003).

budget of \$170,000 per year for four years. Its mandate is to conduct research in partnership with Aboriginal communities and academic researchers with the goal of training new researchers and developing the research capacity necessary to address the particular mental health needs of Aboriginal peoples.

In addition to CIHR, federal funding for research into mental health, mental illness and addiction is also available from the Social Sciences and Humanities Research Council (SSHRC). In particular, SSHRC supports research in the broad area of social psychology. Some 1.5% (approximately \$2.5 million) of its total base budget of \$167.5 million went to mental health research in 2002-2003.⁴⁹³

The Natural Sciences and Engineering Research Council (NSERC) is the third and final federal funding agency for health research. Clinical psychology is not eligible for NSERC support nor is brain research a key focus. But NSERC will consider projects relating to fundamental psychological processes, their underlying neural mechanisms, their development within individuals and their evolutionary and ecological context. Funding allocations specific to mental health, mental illness and addiction are included within the category “psychology” under “brain, behaviour and cognitive science”. In 2003, 113 projects were funded within this category at a cost of approximately \$3.25 million,⁴⁹⁴ which corresponds to 0.5% of the NSERC grants and scholarships budget of just over \$600 million.

Other sources of federal funding for research into mental health, mental illness and addiction may include Statistics Canada, Canada’s Drug Strategy (which funds the Canadian Centre on Substance Abuse), Health Canada, Correctional Service Canada (Addictions Research Centre), and the Canadian Health Services Research Foundation. The Committee did not receive information on the level of funding provided by these sources.

10.2.2 How Much Should the Federal Government Spend?

Several witnesses supported the view that the proportion of health research dollars allocated to mental health, mental illness and addiction was not adequate.

In their report, Dr. Kapur and Dr. Vaccarino noted that there are no guidelines in Canada (nor elsewhere, for that matter) for what the total funding envelope for health research should be and how funding for health research should be allocated among disciplines/research fields. In the absence of such guidelines, they suggested two approaches: first, to examine health research funding as a function of the relative burden of illness, and second, to compare research funding patterns in other jurisdictions.⁴⁹⁵

I want to make it very clear that the research in mental health and mental illnesses is underfunded in Canada compared with the costs to society.

[Dr. Rémi Quirion, INMHA (14:8)]

As discussed in Chapter 5 and Chapter 6, the prevalence of mental illness and addiction in Canada is high and the economic burden enormous. Nearly as many individuals battle with

⁴⁹³ Information obtained from personal communication.

⁴⁹⁴ Information obtained from the Website at: www.nserc.gc.ca.

⁴⁹⁵ Dr. Kapur and Dr. Vaccarino (2004), p. 3.

depression as have cardiovascular disease. Many witnesses have argued reasonably that mental illness and addiction impact on society as powerfully as any other class of disease or condition and that this burden should be reflected directly in the funding dedicated to research into mental health, mental illness and addiction.

A paper by the Autism Society Canada ranked 14 diseases according to prevalence rates and CIHR dollars for research per affected person. AIDS, which affects 1 Canadian in 500, is the most richly funded area of research, receiving from CIHR over \$1,500 per affected person. Attention deficit and hyperactivity disorder (ADHD), which affects as many as 1 Canadian in 17, is last on the list at \$0.09 (nine cents) per affected person. Schizophrenia, probably the most disabling of mental illnesses, ranked 7th; it affects 1 in 100 and receives from CIHR about \$84 per affected person. Autism, with a prevalence rate of 1 in 200, ranked 8th with CIHR funding amounting to \$67.10 per patient/client.⁴⁹⁶

In a letter to the Committee, Dr. Alan Bernstein, President of CIHR, estimated that, if funding were to be provided in relation to the burden of disease, CIHR's support for mental illness and addiction would be at least \$80 million per year. By this standard, CIHR's current expenditure of approximately \$33 million is very low. Nevertheless, Dr. Bernstein maintained that research into mental health, mental illness and addiction receives an appropriate a proportion of CIHR's budget,⁴⁹⁷ given that many factors have to be taken into account, including the capacity of researchers in the field to use research funding to best advantage.

The second approach suggested by Dr. Kapur and Dr. Vaccarino consists in comparing the federal government's performance in terms of funding research into mental health, mental illness and addiction to that of other industrialized countries. The National Institutes of Health (NIH) in the United States function similarly to CIHR through a number of "institutes", the relevant ones for comparison being the National Institute of Mental Health (NIMH), the National Institute of Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). In 2003, the total envelope of funding to the NIH amounted to US \$27 billion; NIMH received US \$1.4 billion, NIDA US \$1 billion and NIAA US \$0.4 billion. Thus, research into mental health, mental illness and addiction in the United States received US \$2.8 billion dollars, or just over 10% of the total funds allocated for health research, double the CIHR's 5.3%.⁴⁹⁸

In the United Kingdom, the main funding agency for biomedical research is the Medical Research Council (MRC) which funds six research areas: people and population studies, including health services and the health of the public; genetics, molecular structure and dynamics; cell biology, development and growth; medical physiology and disease processes; immunology and infection; and neuroscience and mental health. The most recent data available indicates that of the £292.6 million total base spending for the MRC in 2001-2002, some £74 million was allocated to neuroscience and mental health research and £18.9

⁴⁹⁶ Autism Society Canada, *Canadian Autism Research Agenda and Canadian Autism Strategy: A White Paper*, March 2004.

⁴⁹⁷ Dr. Bernstein (8 July 2003).

⁴⁹⁸ Information obtained from the NIH Website at: www.gov.nih.

million specifically to research into mental illness. This corresponds to 6.5% of the total allocated for biomedical research.⁴⁹⁹

On the basis of this information, a number of researchers in the field contended that Canada's investment is not sufficient.

What measure should be used to determine the proportion of research funds for any given disease? Should it be merely prevalence rates, morbidity and mortality, disability, or the economic burden associated with the disease? Should funding be determined on the basis of international comparative analysis? Should it be allocated competitively on the basis of merit and promise among all the applications submitted to the granting agency concerned? Should it be determined after consideration of a combination of all of these measures?

Dr. Bernstein testified that formally allocating research spending on the basis of burden of disease to Canadian society implicitly assumes that there is no spill over in concepts, techniques or results from one area of research to another. He explained that some of the most important advances in one disease area had their origins in a completely different area. Therefore, it would not be appropriate to allocate research funding solely on the basis of prevalence rates or burden of disease.⁵⁰⁰ Dr. Bernstein provided two examples:

CIHR is funding several teams, in Vancouver, Toronto and Québec city, to identify the genes involved in bipolar disease/schizophrenia. The science and technology to do this came out of a much broader goal to clone the genes involved in any human disease. It's reasonable to say that the identification of the gene(s) for human bipolar disease will be the single most important advance to date in bipolar disease research, and will transform approaches to diagnosis, treatment and perhaps prevention. And yet, the fundamental research that is making this possible had nothing originally to do with mental illness or indeed any particular human disease.

CIHR's Institute of Aging, Genetics and Population and Public Health are planning a major initiative – The Canadian Lifelong Health Initiative (CLHI) – that will follow cohorts of newborns and seniors, and measure the genetic, psychosocial, economic, environmental and cultural determinants of health and disease. This initiative, which will require in excess of \$100 million over 20-30 years, promises to tease out the multiple determinants of healthy aging and disease, particularly common and complex disorders like mental illness. How should we classify our investment in CLHI – mental illness, cardiovascular disease, arthritis, healthy aging, or all of the above?⁵⁰¹

⁴⁹⁹ Information obtained from the MRC Website at: www.mrc.ac.uk.

⁵⁰⁰ Alan Bernstein (8 July 2003).

⁵⁰¹ *Ibid.*

Determining the level of research funding on the basis of international comparisons also has drawbacks. First, a large number of countries should be examined before making such a comparison; second, the data should be truly comparable; and third, the research capacities of the countries concerned should also be truly comparable.

10.3 OTHER CANADIAN SOURCES OF FUNDING

10.3.1 Pharmaceutical Industry

The pharmaceutical industry is the largest single source of funding for health research in Canada. In 2002, the pharmaceutical industry invested \$1.4 billion in health research and development, or approximately 36% of the total health research in the country.⁵⁰²

It is not known just how much funding of research by the pharmaceutical industry in Canada goes into mental illness and addiction. However, there are at present more than 100 potential pharmaceutical agents for a variety of mental disorders that are either in human clinical testing or awaiting approval.

These investments by the pharmaceutical industry are made both in laboratory research (in-house, in universities and in research institutes) to discover new molecules, and in clinical trials to test the efficacy of new agents on individuals with mental illness and addiction and look for side effects. Clinical trials in this category of patients raise many ethical issues, and these are discussed in Chapter 16.

As well, pharmaceutical companies support training and research in mental illness and addiction through CIHR's Industry Partnered Strategic Initiatives. Examples of recent multi-partnered initiatives involving CIHR and the industry include the Biological Mechanisms and Treatment of Alzheimer Disease Grants Program, the Neurobiology of Psychiatric Disorders and Addictions Program (both with AstraZeneca) and the Vascular Health and Dementia Initiative (with Pfizer).

Pharmaceutical research has had, and continues to have, a major impact on the provision of health care to individuals with mental disorders. For example, it was noted in Chapter 7 that the discovery of neuroleptic agents in the 1970s made possible the safe deinstitutionalization of many individuals with mental illness. More recently, new drugs for schizophrenia and depression have contributed to the reduction of treatment costs for these disorders; it has been estimated that these costs fell by more than 15% between 1992 and 1999 largely because new therapeutic drugs reduced the need for hospitalization.⁵⁰³

Important research is being pursued by the pharmaceutical industry in Canada. Agents are presently being tested for a number of conditions such as addiction to illicit drugs (for example, a therapeutic vaccine to treat cocaine addiction), and dependence on alcohol and

⁵⁰² Statistics Canada, "Estimates of Total Spending on Research and Development in the Health Field in Canada, 1988 to 2002", *Science Statistics*, Service Bulletin, Catalogue 88-001-XIB, Vol. 27, No. 6, September 2003.

⁵⁰³ See Pharmaceutical Research and Manufacturers of America (PhRMA), "New Medicines for Mental Health Help Avert a Spending Crisis", *Value in Medicines*, 14 January 2004.

tobacco.⁵⁰⁴ Research on new agents for depression and for schizophrenia is also expected to improve greatly the prognosis for these conditions.⁵⁰⁵

Currently, the most prominent Canadian pharmaceutical companies in mental illness and addiction are Wyeth, Lilly, Glaxo-Smith-Kline (GSK) and Lundbeck. Lilly and GSK, with the addition of Pfizer, will continue to play a lead role in mental illness and addiction in Canada, given that these companies have a rich candidate drug pipeline in this area and are likely to invest heavily in future clinical trials.

10.3.2 Provincial Funding Agencies and NGOs

There are numerous other sources of funding for mental health, mental illness and addiction research. In most provinces, there are governmental bodies devoted to mental health and addiction research (e.g.: Réseau santé mentale du Québec; Ontario Mental Health Foundation, Alberta Mental Health Board; Manitoba Health Research Council, Centre for Addiction and Mental Health (Toronto), etc.).

There are two key ways for NGOs to support research. First, organizations can financially support research initiatives. Either through independent fundraising efforts, or by partnering with other organizations, NGOs have the ability to offer significant funds for research. (...)

[Dr. John Gray, President, Schizophrenia Society of Canada, Brief, 12 May 2004, p. 2.]

There are also many voluntary health charities and foundations (NGOs) that are effective at responding to the needs of different disease groups. As an example, the Committee heard about the excellent working relationship between the Schizophrenia Society of Canada (SSC) and CIHR. Last year, SSC was able to provide \$75,000 in matching funds for research.

The Committee also heard, however, that rarely are NGOs able to attract the funds required to sponsor research. Moreover, there are only two national non-profit organizations whose mandate specifically focuses on raising money and funding mental health and addiction research: the Canadian Psychiatric Research Foundation and NeuroScience Canada. The Canadian Psychiatric Research Foundation (CPRF) told the Committee that the stigma associated with mental illness and addiction creates significant barriers to its attracting appropriate publicity, getting corporate sponsorship, and raising research funding. This experience differs from other disease groups such as cancer and cardiovascular disease where the respective health charities are strong and successful fundraisers and supporters of research:

(...) there are not many [volunteer organizations] right now who raise a lot of money from the Canadian public, compared to the National Cancer Institute or the Heart and Stroke Foundation.

[Dr. Rémi Quirion (14:23)]

⁵⁰⁴ See the Website of Canada's Research Based Pharmaceutical Companies (Rx&D) at: http://www.canadapharma.org/Patient_Pathways/Health_Info/02mentalheal/index_e.html.

⁵⁰⁵ *Ibid.*

*CPRF faces a difficult challenge in raising awareness and research funds to determine the causes, treatments and ultimate cures for a variety of mental illnesses. Tragically, the stigma of mental illness persists and as a result, millions suffer unimaginable despair in silence, fearful of adverse personal consequences that public acknowledgement of their illnesses might bring. Under these conditions, awareness remains low, understanding minimal, support mechanisms few, misconceptions rife and critical funding for research is critically low.*⁵⁰⁶

Nevertheless, voluntary organizations still play an important role in research into mental health, mental illness and addiction in Canada, a role that must be recognized and expanded. Dr. Quirion told the Committee that when INMHA was created, it sought out and fostered collaboration with 60 volunteer and non-governmental organizations. These groups participated in drafting the Institute's strategic plan; they were also involved in developing a strategy for increased funding.⁵⁰⁷

Dr. Gray, from the SSC, also suggested that NGOs need to participate in the process of research. For example, where appropriate, NGOs can assist in the creation of research questions and their representatives can sit on review panels. He explained that, by doing so, scientists are better able to identify and conduct research that is most needed by the mental health and addiction sector. Importantly, their participation would reinforce the human aspects of science and be a continual reminder of the need for the practical application of research outcomes.⁵⁰⁸

A major concern raised with respect to research funding for mental health, mental illness and addiction is that there is currently no central database for all sources of funding. There is no information held by governments and non-governmental organizations on what is being investigated. The Canadian Psychiatric Research Foundation pointed out that there is no coordination among research funding bodies and no central responsibility for data collection. As a result, researchers find it difficult to negotiate their way through not only the government granting agencies, but also the private and the voluntary sector funding sources. Researchers are frequently not aware of similar research questions under investigation in different labs across the country. In many cases, the opportunity to collaborate would enhance productivity and work to eradicate the negative impact of competition among universities and hospitals. The Foundation recommended the establishment of a central database of research funding agencies that would encompass non-government sources of funding, a listing of what and where research is being conducted and a site for maintaining research findings.⁵⁰⁹

⁵⁰⁶ Canadian Psychiatric Research Foundation, Brief to the Committee, June 2003, p. 2.

⁵⁰⁷ Dr. Rémi Quirion (14:24).

⁵⁰⁸ Dr. John Gray, President, Schizophrenia Society of Canada, Brief to the Committee, 12 May 2004, p. 3.

⁵⁰⁹ Canadian Psychiatric Research Foundation (June 2003), p. 6.

10.4 KNOWLEDGE TRANSLATION

In terms of applying research findings to daily life (...) we have to dare to encroach a little on the autonomy of the medical and teaching professions in this field.

[Dr. Laurent Mottron, Professor, Department of Psychiatry, University of Montreal (14:21)]

In their paper, Dr. Kapur and Dr. Vaccarino stressed to the Committee that the major impetus for health research in our society is the promise to deliver better outcomes for patients, their families and their communities.⁵¹⁰ This involves taking discoveries from the bench to the community where care and support is delivered, a process often referred to as “knowledge translation”.

Although knowledge translation is within the CIHR’s mandate, many witnesses testified that it is not done well in mental health and addiction research. Biomedical research has established that mental illness and addiction are disorders of the brain, providing promising leads into the genetics of mental illness and addiction, and elucidating the role of a wide array of risk-factors. Many new system-level best practices and identified many new opportunities for pharmacological interventions in these disorders have also been identified. But many believe that all too frequently these discoveries have remained with researchers in their laboratories and have had limited impact on patients and their families.⁵¹¹

This state of affairs was highlighted in the 1999 U.S. Surgeon General’s Report entitled *Mental Health: A Report of the Surgeon General*. This 500-page publication, the first of its kind on mental health, confirmed that research has provided the knowledge needed to deliver effective treatment and better services for most mental disorders. The report also stated, however, that gaps exist between what have been shown to be optimally effective treatments and what many individuals receive in actual practice settings.⁵¹²

Similarly, the United States President’s New Commission on Mental Health, chaired by Michael F. Hogan, reported in 2003 on long delay that exist before research reaches practice. More precisely, the Commission stressed that the 15 to 20 year lag between discovering effective forms of treatment and incorporating them into routine patient care is far too long. The Commission also reported that, even when these discoveries become routinely applied at the community level, too often actual clinical practices are highly variable and often inconsistent with the original treatment model that was shown to be effective.⁵¹³

The translation of a new idea or discovery into an accepted practice has three distinct phases. The first is the basic discovery that identifies a new genetic association, a new method of delivering care, a new way of engaging patients in therapy or a new idea for using an established treatment. The second phase is proof-of-principle, which involves translating

⁵¹⁰ Dr. Kapur and Dr. Vaccarino (2004), p. 6.

⁵¹¹ *Ibid.*

⁵¹² United States Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999.

⁵¹³ The President’s New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, Final Report, 22 July 2003, p. 67.

that discovery into care and demonstrating that it works in a controlled setting, the clinical trial phase. The third phase, dissemination and application, involves incorporating the new practice into the community and into the pre-existing continuum of care.⁵¹⁴ Eric Latimer, a health economist at the Douglas Hospital (Montreal), told the Committee that mental illness and addiction research has had many successes at the level of discovery, especially given the level of funding and number of researchers involved, but that the other two phases remain major challenges and will require greater investment.⁵¹⁵

Clinical trials are necessary to test the efficacy of basic discoveries; their completion requires appropriately trained and experienced clinician scientists. Some witnesses emphasized that insufficient numbers of physicians are participating in research and that a major deficiency remains the fact that not enough clinician scientists are being trained to carry out crucial clinical trials. Among the top priorities in INMHA's strategic plan for 2001-2005 is the creation of more training opportunities for clinician scientists.

The dissemination and application phase of knowledge translation involves bringing validated new ideas or practices into the community. As stated earlier, one of the strategic priorities for INMHA is to promote linkage and exchange through structured knowledge translation programs between the research community and the municipal, provincial and national levels of decision-makers as well as users of research results, including NGOs. While witnesses agreed that this is not only a laudable but also a necessary goal, they felt that it could not be achieved at the current funding level. During his testimony, Professor Tousignant suggested that research budgets should contain funds dedicated to "scientific popularization".⁵¹⁶

The Committee was informed that knowledge translation and clinical research will be two of the top priorities of CIHR over the coming years. The Committee strongly supports this policy.

10.5 TOWARD A NATIONAL RESEARCH AGENDA FOR MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION

Mental health and mental illness are critical and we should have a national type of agenda.
[Dr. Rémi Quirion (14:34)]

The Committee heard that in the field of mental health, mental illness and addiction there is no coherent policy or strategy in place to deal with the complex issues involved and produce a coherent and coordinated response to them. Mental disorders are generally complex and chronic medical illnesses. Their determinants cut across many sectors, their management involves many different health professionals, and their impact on how society functions is broad. Witnesses stressed the need for better coordination of the efforts to deal with the many challenges posed by mental illness and addiction currently being undertaken by the

⁵¹⁴ Dr. Kapur and Dr. Vaccarino (2004), p. 6.

⁵¹⁵ Eric Latimer (14:44 to 14:48).

⁵¹⁶ Professor Tousignant (14:43).

federal and provincial governments along with non-governmental organizations and the pharmaceutical industry. Dr. Kapur and Dr. Vaccarino stated:

*(...) the issues of mental illness and addictions defy simple solutions. These illnesses have multiple determinants – biological, psychological and social, and adequate responses to them require coordination of multiple sectors. At present, research in these areas is a well-intentioned but uncoordinated effort. We strongly call for the development of a national policy or guiding framework to form the bases for a coordinated effort in the areas of Mental Health and Addictions Research.*⁵¹⁷

Witnesses who addressed issues related to research in the mental health and addiction field unanimously agreed on the need for a national research agenda. In their view, such an agenda would build on current Canadian expertise, coordinate the research activities performed by a variety of actors (governments, non-governmental organizations, pharmaceutical corporations) that are now fragmented and ensure a balance between biomedical, clinical, health services and population health research applied to mental health, mental illness and addiction. Perhaps more importantly, many witnesses stressed that now is the time to address the critical issues in mental health and addiction research. In particular, Dr. Quirion stated eloquently:

The time is now. There is a great deal of expertise in Canada because of the national health care system. That allows us to collect data and to have data banks that are much more impressive than in the United States. Take the new genome research, for example.

*I think we could have a major impact and we should not be afraid to forge ahead. If we forge ahead with the expertise we currently have, we will succeed in finding the causes of brain diseases and of mental illnesses.*⁵¹⁸

10.6 COMMITTEE COMMENTARY

The Committee notes that, during the past several decades, research in the fields of mental health, mental illness and addiction has advanced our understanding of how to improve the conditions of individuals with mental disorders and addiction. New treatments have made it possible to care for individuals in the community, without the need for long periods of confinement in public institutions. We are also closer to understanding the pathophysiology of mental disorders, and this knowledge has important implications for both treatment and prevention. The Committee also believes that research in the fields of mental health, mental illness and addiction can play an important role in informing policy decisions relating to the allocation of resources for treatments, services and supports that are needed by individuals with mental illness and addiction.

⁵¹⁷ Kapur and Vaccarino (2004), pp. 11-12.

⁵¹⁸ Dr. Rémi Quirion (14:15).

The Committee also acknowledges the major contribution made by Canadian researchers in the area of mental illness and addiction. Canada leads both nationally and internationally in many research fields including neuroscience, psychopharmacology and genetics. It is critical that this historical strength be preserved and enhanced.

The Committee recognizes the federal government's role in creating CIHR and the decision to create INMHA. We also applaud the increase in federal funding allocated to CIHR in recent years. In particular, we wish to highlight the major contribution of Dr. Rémi Quirion, INMHA's Scientific Director, in the promotion and conduct of research into mental health, mental illness and addiction.

The Committee is of the opinion that research is of enormous importance, and that it points the way towards a path that can lead to fundamental solutions to the problem of mental illness and addiction in Canada. However, an adequate level of resources must be allocated to make progress down that path. We believe the federal government should devote additional funding to mental health and addiction research, including for the education and training of more researchers and clinician scientists in order to expand Canada's capacity to do first class research in this area. Similarly, voluntary organizations should be strongly encouraged to develop or strengthen their fundraising activities in order to raise research funds.

INTRODUCTION

“Ethics” is usually defined as the systematic, reasoned attempt to understand values and principles underlying decisions about matters of fundamental human importance. Put simply, it is about the right and the good.

In many fields, difficult decisions usually involve consideration of numerous factors, each implicating different – and often conflicting – values, principles, viewpoints, beliefs, expectations, fears, hopes, etc. When facing such decisions, people may reach different conclusions not only because they consider different factors, but also because they weigh them against each other in different ways. The practical effect of the discipline of ethics is to help those who face difficult decisions to identify the inherent values and principles that apply, to weigh them against each other, and to come to the best possible decision.⁵¹⁹

A general research question (...) regards diverse and sometimes opposed understandings of “ethics” or “the good” as it relates concretely to the care of persons trying to cope with a mental illness. Any response to particular ethical challenges entails some commitment to a more general notion of the good.

[Canadian Catholic Bioethics Institute, Brief to the Committee, 20 February 2004, p. 6]

In the context of health and health care – either in practice, delivery or research – the ultimate goal of ethics is to improve the health and quality of life of individuals. In a paper commissioned by the Committee, Gordon DuVal and Francis Rolleston refer to long-standing and well-established ethical values and principles underlying this goal:

- beneficence and non-maleficence – to practice in accordance with established standards of quality care and the best interests of the patient, and not to harm him or her;
- autonomy – to show respect for the patient as an individual and to encourage the patient’s right to self determination, choice, and the protection of sensitive information; and,
- justice – to ensure that patients and research subjects are treated fairly and resources are allocated based on considerations of equity and fairness.⁵²⁰

Other important values mentioned by DuVal and Rolleston include the familiar elements of virtuous behaviour such as compassion, honesty, promise-keeping, moral courage, patience, tolerance, preserving dignity and accountability, as well as community and relational values.⁵²¹ These key ethical dimensions are largely reflected in professional and institutional

⁵¹⁹ Senate Standing Committee on Social Affairs, Science and Technology, *Recommendations for Reform*, Volume Six, October 2002, p. 222.

⁵²⁰ Gordon DuVal and Francis Rolleston, *Ethics Issues in Mental Health*, document commissioned by the Committee, 20 April 2004.

⁵²¹ *Ibid.*

codes of ethics and the law. Altogether, these principles and values guide decision-making in the programming and delivery of health services and supports, clinical care and related research.

This chapter examines various ethical issues related more specifically to mental illness and addiction. Section 11.1 analyzes ethical issues associated with the delivery of services and supports to individuals with mental illness. Section 11.2 discusses capacity to consent to treatment. Section 11.3 deals with privacy and confidentiality issues. Section 11.4 examines ethical issues with respect to specific population groups – children/youth, seniors and forensic patients. Section 11.5 discusses the ethical implications of advances in genetics and neuroscience. Section 11.6 reviews ethical concerns raised with respect to mental health and addiction research. Section 11.7 provides some Committee commentary.

At the root of many of the ethical issues and concerns canvassed throughout this chapter lies the social stigma associated with individuals affected by mental illness and addiction and their families. In itself, stigmatization contributes to a relative lack of compassion and withdrawal of the dignity and respect with which all individuals should be treated. In the end, stigmatization is at the base of injustice, the absence of beneficence and the inequality of access to needed services and supports.

I see three major ethical issues around mental health in Canada (...). The first problem in our society remains that of stigma of a mental health problem. (...)
[Mark Miller, Ethicist, St. Paul's Hospital, Saskatchewan, Letter to the Committee, 27 September 2003.]

11.1 ACCESS TO SERVICES AND SUPPORTS

According to DuVal and Rolleston, the ethical issues that relate to the provision of services and supports arise from the fact that “society has not taken practical steps necessary to ensure justice and beneficence for individuals with mental illness and addiction, both within Canada’s publicly funded health care system and beyond it.”⁵²² First, the complexity of mental disorders significantly increases the challenges faced by society in addressing the need for effective services and supports for individuals with mental illness relative to other categories of illness. Second, proper diagnosis, treatment and the continuing care of mental disorders involve not only many different health care providers, but also, to an extent not found in other illnesses, other professions, such as school teachers, law enforcement officers, clergy, social workers. Absent a well coordinated health care system, individuals suffering from mental illness and addiction and their families have greater difficulty than most in accessing adequate health care, resulting in a form of systemic discrimination.

In their paper, DuVal and Rolleston argue that the relatively poor treatment of individuals with mental illness and addiction arises not simply because people or systems want to discriminate against them, but because of the factors that derive directly from the nature of mental disorders. Mental illness and addiction often show themselves through behavioural signs whereas almost all other illnesses present with physical signs. Behavioural aberrations caused by mental disorders are the basis for the fear and incomprehension that they

⁵²² *Ibid.*, p. 3.

engender in many individuals. Such behaviours often result in problems with, for example, law enforcement authorities, or in school, which then, in effect, become the first line of treatment.⁵²³

Although there is no justification for adopting different standards of access, quality of care or priority setting when treating individuals with mental illness and addiction as compared to individuals with physical illness, this does seem to happen. This is particularly problematic in crisis situations, when timely and effective care is required. Dr. James Millar, Executive Director, Mental Health and Physician Services, Nova Scotia Department of Health, told the Committee:

People with schizophrenia are still treated like people with cancer were treated long ago, as if it were a moral disease instead of a physical one.

[Murray (9:18)]

*[We] must also put the same time emphasis on mental health as society does for physical health. It is unacceptable for people with chest pain to wait to determine the cause. If the cause is cardiac, people want immediate attention. Unfortunately, those with emotional pain do not get the same consideration. They will probably wait to seek help, wait further to see a professional caregiver, be treated with outdated and inappropriate methods, and continue to suffer much longer than is necessary.*⁵²⁴

Carlyn Mackey, Aurise Kondziela and Dorothy Weldon, from the Christ the King Family Support Group, wrote to the Committee that ethical standards that apply to mainstream medicine are not applied consistently to the provision of mental health care:

*Ethical standards for the care and treatment of the mentally ill do not appear to be consistent with normal ethical standards of mainstream medicine. One must question the ethics of tolerating dysfunctional mental health systems, or systems which can even be described as non-systems. It follows that the ethical issues of continuing and knowingly discriminating against the mentally ill in the area of safe and adequate health care provision must be addressed at all levels of government.*⁵²⁵

An additional challenge in providing services and supports to individuals with mental illness arises because many different professions and areas of expertise are involved. DuVal and Rolleston offered the example of a school teacher who first brings to a family's attention the possibility that their child's difficulties in school may be due to Attention Deficit Hyperactivity Disorder (ADHD). In cases of disruptive behaviour, the school system will give the priority to the protection of other students. Actions such as disciplining, suspension

⁵²³ *Ibid.*

⁵²⁴ Dr. James Millar, Executive Director, Mental Health and Physician Services, Nova Scotia Department of Health, (7:).

⁵²⁵ Carlyn Mackey, Aurise Kondziela and Dorothy Weldon (Christ the King Family Support Group - Winnipeg), Brief to the Committee, 24 October 2003, p. 2.

or expulsion reinforce stigmatization of the affected child. Retention in the school system requires special classes or special teaching support to minimize the impact on other students. If the mental illness leads to violence, law enforcement officers may become involved. Clergy may be an early recourse for affected individuals who feel themselves possessed by forces outside their control. Since recognition of mental illness by the sufferer himself or herself is so important to their management of their condition, school teachers, law enforcement officers, clergy and others in parallel professions often find themselves, sometimes inadvertently, thrust into the first line of diagnosis and treatment for individuals with mental illness.⁵²⁶

There are, however, multiple barriers based on split jurisdictions between the mental health system and the social services system which inhibit proper treatment of affected individuals. For example, Dr. Robert Quilty, a registered psychologist working with the Durham County School Board, informed the Committee about the “diagnostic halo” that inhibits the diagnosis and treatment of mental illnesses in children with developmental disorders. With autism, for example, this “halo” phenomenon often results in failure to recognize a disorder that could have been treated successfully if caught early enough. This problem is compounded by difficulties in entering children with developmental disability into behavioural service agencies within mental health agencies thus further clouding an already uncertain future. Children with high functioning autism (Asperger’s Syndrome) may fare somewhat better. However, even with partially successful treatment, on reaching adulthood, developmentally disabled individuals who need further mental health care often do not receive it because they are labelled as being in need of community support; this is the result of the lack of coordination in service provision between various provincial ministries.⁵²⁷

As a consequence, the delivery of mental health services and addiction treatment is highly fragmented, disconnected and uncoordinated. For individuals with mental illness, the problem of navigating this complex system of services and supports is compounded by the nature of their illness. Numerous individuals with mental illness and addiction and other experts told the Committee that this lack of cohesion and coordination has led to an increase in addiction, homelessness and incarceration.

DuVal and Rolleston pointed out that the fragmentation of the system is evident even when it is clear that institutional care is required. A telling recent case in Ottawa, that has received extensive media attention, concerns a young woman with violent and self-destructive behaviour. The Children’s Hospital of Eastern Ontario could not admit her because they do not have facilities for such patients; the Royal Ottawa Hospital, an adult institution which has the necessary secure facilities, could not take her because she is too young. This illustrates the serious ethical issues that flow from fragmentation of the “system” that is supposed to provide acute and long term care for patients of different ages and with differing mental conditions.⁵²⁸

The Committee was told that it is, above all, the family that usually bears the brunt of caring for an individual with mental illness who has been entrusted to home or community care

⁵²⁶ Gordon DuVal and Francis Rolleston (2004), p. 6.

⁵²⁷ *Ibid.*, p. 10.

⁵²⁸ *Ibid.*, p. 5.

where resources are, more often than not, inadequate or insufficient to meet their needs. Mark Miller, Ethicist, St-Paul's Hospital (Saskatoon), wrote:

And, I would say, the biggest ethical issue beyond the health care system itself is how often resources are lacking for family members caring for loved ones at home or in the community. Many parents, siblings and other caregivers are mostly abandoned to their own resources, which is grossly unfair and arguably creating more health problems among caregivers than necessary. Despair is not an uncommon feeling among families with a challenging member.⁵²⁹

11.2 CONSENT AND CAPACITY ISSUES

Society preserves individual choice – the right to consent to, or to refuse treatment – based on the individual's fundamental right of autonomy. But for consent to mental health services or addiction treatment to be genuine, the individual must be mentally and legally capable of making that choice.

While decision-making capacity is essential for valid consent, applicable clinical tests to assess competence are controversial, especially for those with mental illness and addiction. Decision-making capacity includes in the ability to understand the relevant information concerning treatment, to appreciate the significance of that information, and to reason so as to weigh the available options logically.

Determinations of decision-making capacity raise special issues regarding the vulnerability of those suffering from mental disorders. Clinical assessments of decision-making capacity focus primarily on cognitive functioning. Because mental illness and addiction can affect cognition, individuals with such disorders, particularly in severe cases, will often lack decision-making capacity. They may do so intermittently, however, as in the case of a person suffering from addiction, or gradually, as in the case of a person who is aging, slowly succumbing to dementia or some other degenerative process affecting cognitive function. Adapting the delivery of services, as the patient fluctuates in, or gradually loses, his/her capacity, is a challenge for the mental health and addiction treatment system. Respect for the person requires that the changing or diminishing capacity is identified and diagnosed, and that the system adapt accordingly, in order not to infringe unduly on the autonomy of the person affected.

In the context of mental illness, decision-making capacity can vary, and be highly dependent on the nature of the decision to be made. Difficulties relating to decision-making capacity include worries about capacity to manage financial affairs and to make personal care decisions, including decisions about housing.

[DuVal and Rolleston (2004), p. 11.]

Non-cognitive as well as cognitive functioning can also be influenced by mental disorders in ways that affect decision-making. For example, clinical depression and other pathological affective states may diminish an individual's capacity to choose or reject treatment even

⁵²⁹ Mark Miller, Brief to the Committee, 27 September 2003, p. 2.

though an understanding of the relevant information is largely unimpaired. Accepted conceptions of capacity do not account well for non-cognitive deficits such as the pessimism about the future that may characterize depression. The test for mental capacity is unclear in the presence of, for example, dominant but potentially transient feelings of hopelessness, worthlessness, or impulsivity.

Similarly, in patients with schizophrenia, the delusional and paranoid nature of the disease may undermine decision-making capacity in ways not clearly related to an absence or loss of cognition. Individuals suffering from addiction may have compromised decision-making by reason of difficulties in controlling the urge to engage in addictive behaviour. In some eating disorders, where a pathological body image distortion is experienced, the incapacity may be narrowly focused; the role of such distorted thinking in determining capacity is unclear.

Therefore, the clinical assessment of mental capacity in the presence of mental illness and addiction is a complex matter. Mental capacity to make decisions can exist at different levels and to varying degrees and can fluctuate over time. Yet, in law, upon expert testimony and at a given point in time the legal capacity to make decisions is decided by a judge. It is judged either to be present or absent in respect of distinct purposes (the capacity to care for one's property or to care for one's person, for example). There are no degrees of capacity or incapacity. The process for reviewing a judicial decision to establish protective supervision and to appoint a legal representative with each fluctuation in mental state can be time-consuming and cumbersome. In its brief to the Committee, the Canadian Catholic Bioethics Institute explained:

Mental health care is compromised when capacity is mistakenly denied or presumed.

[Canadian Catholic Bioethics Institute, Brief to the Committee, 20 February 2004, p. 3.]

The legal system tends to distinguish sharply between those who are deemed "capable" of decision-making regarding their health care and those who are incapable. Many persons with an active mental illness, such as severe depression or schizophrenia, may not meet the legal criteria for being declared "incapable", and yet they do have significant impairment of their ability to understand their condition, appreciate their options, make prudent decisions about their mental health care and follow through on these decisions. Since patient autonomy plays such a central role in contemporary medical ethics, it is helpful to consider the ethical challenges that arise when capacity is denied when in fact some level of capacity is retained, on the one hand, and when capacity is presumed when in fact it is significantly impaired, on the other.⁵³⁰

The Committee was told that Ontario and some other provinces have legislated community treatment orders (CTOs). A CTO is a doctor's order, obtained with the affected person's consent, for an individual to receive treatment or care and supervision in the community. To give consent, the individual must be capable of consenting to treatment under the law. If

⁵³⁰ Canadian Catholic Bioethics Institute, Brief to the Committee, 20 February 2004, p. 5.

found incapable of consenting under the law, and a substitute decision-maker has been authorized, the substitute decision-maker must consent to the CTO, even if the incapable person disagrees. There is concern among individuals with mental illness and addiction, however, that CTO legislation is too intrusive. Alternatively, families who in the absence of access to formal caregivers are sometimes the primary caregivers, believe that without such legislation they would at times lack the ability to help a loved one.

Witnesses explained that while family members and health care providers may wish to protect the health and well being of an individual who is vulnerable by reason of diminished capacity, it is still important to respect the individual's autonomy. It was suggested that families and health care givers must therefore tread a delicate balance between seeking to help an individual with mental illness/addiction and respect his/her autonomy – even partial autonomy. The answer is never black and white, but requires a response that seeks to understand the individual and the particularities of his/her condition.

More than with other types of disease, individuals with mental illness and addiction may lack insight into the existence and nature of the illness caused by their disorder. The result may be a high degree of mistrust of health care providers and high rates of refusal of treatment or of non-compliance. At what point does respecting a patient's refusal of treatment become tantamount to abandoning a vulnerable person in clear need of help or care when intervention or treatment is indicated?

There is little doubt that a person with unimpaired decision-making capacity may refuse treatment and that such refusal must be respected. However, when a person meets the legal standard of capacity – but nevertheless has compromised decision-making abilities – and is in need of care but refuses treatment, the situation for family members may be very difficult.

A related dilemma arises when a patient who is judged to be mentally and legally incapable of decision-making in respect of his or her own person resists the intervention needed to treat a mental disorder. Although a substitute decision-maker may legally authorize the treatment on behalf of the patient, the practical problem remains how to administer such treatment in the face of what may be stubborn resistance. The only available options may be to administer the treatment surreptitiously (such as by mixing medicine in food or drink), or employing force, or not at all.

Administering treatment using force or deception, particularly with vulnerable individuals such as those suffering from a mental disorder, raises serious ethical issues for family members and health care professionals. Force or deception may undermine trust, a vital ingredient in the relationship with the patient/client, making continued communication, cooperation and care even more difficult. Yet, it may be equally inappropriate *not* to provide treatment to a patient, who by virtue of incapacity, is vulnerable and in critical need of protection by some trusted person. Patients may later be grateful for treatment given against their will at a time when they were incapable of making treatment decisions or they may continue to harbour resentment and not seek treatment subsequently if their symptoms recur.

11.3 PRIVACY AND CONFIDENTIALITY

In its October 2002 report entitled *Recommendations for Reform*, the Committee explored the need to protect the privacy of electronic health records and their use in research. Considerations of privacy are equally and perhaps of greater concern in mental health, mental illness and addiction.

In their paper, DuVal and Rolleston suggest that a central presumption in society's preservation of privacy is that society as a whole, and each individual within it, benefits from strict preservation of the right of an individual to control the use of his or her personal information.⁵³¹

It is always used in a crisis situation. (...) The person is considered a danger to self or others. (...) It is not a matter of casually sharing information. There is a purpose to the action, which is to give the person the best possible and the most knowledgeable assistance. That is not sharing information widely.

[Nancy Hall, Mental Health Consultant (16:27-28)]

Moreover, the fiduciary relationship between health care provider and patient is built on trust and premised on the fundamental principle of confidentiality, as reflected in most professional codes of ethics. The testimony that we have heard, however, forces the Committee to ask whether our present legal and policy frameworks on privacy and confidentiality, which generally serve the mentally competent well, can act against the best interests of those who, because of the nature and pervasiveness of mental illness and addiction, become partially or completely dependent on the multiple care providers they encounter along the continuum of care. Mr. John Arnett, Head of the Department of Clinical Health Psychology, Faculty of Medicine, University of Manitoba, stated:

As a clinician, I cannot go down the hall to ask a colleague of mine, who has seen a patient that I am about to see, what they know that might help me to better evaluate that patient. The intent of the law is noble, there is no question about that, but it does impose limitations that impact negatively on patient care. A large part of patient care is having access to knowledge of history and information. The law creates a significant limitation.⁵³²

Concern arising from strict observation of privacy and confidentiality rules also extends to the family of individuals with mental illness and addiction. Without the patient's permission, which those with mental illness/addiction may not be competent to give, a physician cannot share personal information with his or her caregivers, parents, siblings or children. Murray, whose paranoid schizophrenic son was killed by a bus after escaping from hospital, asked:

Why is it that the medical profession is not allowed to share information with family members when it has been shown that family support is beneficial to the patient? The patient is on meds because his thinking is

⁵³¹ Gordon DuVal and Francis Rolleston (2004), p. 15.

⁵³² John Arnett (16:26).

*affected; yet the medical profession believes that sharing information with a family member must be a decision of the patient, who cannot make a reasonable or thoughtful decision.*⁵³³

Bronwyn Shoush, Board Member, Institute of Aboriginal Peoples' Health, Canadian Institutes of Health Research, added to this by saying:

*I wish to identify one area of law that I think has had a significant, negative impact in the mental health area and stigma in particular. Privacy legislation is seen, at least in Aboriginal communities and I believe it is true elsewhere, to be a detriment to promoting secrecy concerning health matters. It is seen as not allowing people to discuss matters and feel that they are a normal part of the human condition. They do not allow people who might be able to offer supports to have a way to do that in a timely way.*⁵³⁴

These thoughts were echoed by the brief from the Christ the King Family Support Group in Winnipeg which stated that: "confidentiality requirements are cited to justify lack of adequate information to family care-givers regarding the nature and severity of the illness". They further wrote that family members are excluded from information about medication, safety issues and the care and treatment plans at the time of discharge; that family concerns are arbitrarily dismissed and not documented in the patient's files; and that families are not adequately supported in attempting to cope with the devastating consequences of severe and persistent mental illnesses.⁵³⁵ It should be noted, however, that in circumstances of clear, serious and imminent danger, a physician may have an overriding duty in law to break his/her patient's confidence in order to warn third parties and protect public safety.

11.4 SPECIAL POPULATIONS

11.4.1 Children/Adolescents

In previous chapters, the Committee described a number of issues concerning access to mental health services and supports for children and adolescents. In addition to these, mental health treatment for children and adolescents raises unique ethical challenges relating to vulnerability, decision-making capacity, and the use and disclosure of confidential information.

Mental health professionals must be aware of heightened vulnerability due to age when treating children and adolescents as well as the potential presence of co-occurring mental disorders and any history of social disruption. The capacity to consent to treatment interventions, and to do so voluntarily, is already compromised by mental illness but is even more difficult for young people. While parental and other family involvement in treatment

⁵³³ Murray (9:18).

⁵³⁴ Bronwyn Shoush (16:12).

⁵³⁵ Carlyn Mackey, Aurise Kondziela and Dorothy Weldon (Christ the King Family Support Group - Winnipeg), Brief to the Committee, 24 October 2003.

can be extremely helpful, those providing care must be aware of the potential for mistrust, dysfunctional relationships, or undue pressure resulting from parental guilt or overprotective attitudes toward the child. Complex issues of confidentiality may arise when having to determine whether particular circumstances warrant disclosure of patient information to parents and/or relevant governmental or social service agencies.

11.4.2 Seniors

A variety of specific ethical issues are raised in the provision of mental health services to seniors. For example, many patients in geriatric in-patient units lack decision-making capacity and either have no close family or may be in conflict with family members. Geriatric patients are sometimes homeless; family members may be difficult to locate, uncooperative, uninvolved or reluctant to play a significant role. It is estimated that only 10 to 20% of such geriatric patients benefit from any active family participation, and the balance have no involved family members. Many senior patients “fall through the cracks”, in that general hospitals may be ill equipped to manage individuals with mental illness and psychiatric hospitals may lack the resources to manage the patient’s general medical condition. Thus, geriatric patients with mental disorders often receive inadequate care.

In psychiatric hospitals, staff may misread pain symptoms, while expressions of pain by elderly patients with mental illness are often not taken seriously in general hospitals. Inexperience with opiate pain medication and worries about drug interactions with antipsychotic and other psychiatric medications can lead to inadequate management of pain in this population. Anecdotal evidence indicates that care and pain control may well be inadequate; long waits for attention may be followed by discharge back to the psychiatric hospital where the care may also be inadequate.

Stigma often makes palliative care difficult for patients and their families to access. Staff may lack clear direction in caring for psychiatric patients who are at the end of life. They are often uncertain when to initiate aggressive treatment as opposed to treatment oriented primarily for pain management. Psychiatric nurses may have minimal experience using morphine and other narcotics and feel uncomfortable using them assertively.

11.4.3 Forensic Patients

In its written submission, the York University Centre for Practical Ethics stated:

Many inmates are in our prisons because of the emotional instability or mental disorder, and once there, are not given appropriate treatment unless they are threatening others or themselves. Moreover, their condition is likely to deteriorate in such an inappropriate environment.⁵³⁶

DuVal and Rolleston identified two types of ethical dilemmas in relation to forensic psychiatry.⁵³⁷ First, mental disorders, particularly when untreated, sometimes manifest in behaviour that would otherwise be seen as criminal. While individuals with mental disorders

⁵³⁶ Centre for Practical Ethics, York University, Brief to the Committee, 2004.

⁵³⁷ Gordon DuVal and Francis Rolleston (2004), pp. 17-18.

who are accused of offences may sometime be found unfit to stand trial or not criminally responsible, police and courts often face a choice between referring mentally disturbed individuals for treatment or to the criminal justice system. Lack of effective training of police and other criminal justice officials may contribute to inappropriate referral of such persons away from mental health resources. Many believe that our jail and prison system house too many individuals with mental illness and addiction and insist that they, and society at large, would benefit from treatment rather than incarceration.

The second issue is that mental health professionals practicing in forensic institutions have a “double agency” problem. In assessing a person charged with an offence, or in giving ongoing treatment to a person under the Provincial Review Board system, or otherwise giving evidence before administrative bodies or courts, these health care professionals have two distinct and often conflicting sets of obligations. Their obligations as medical caregivers to their patient are unquestioned duties that include acting in their patient’s best interests, and to do no harm. But at the same time, they also have the perfectly legitimate obligation to society to offer their candid and objective judgement and advice to courts, Review Boards, and other administrative bodies with respect to the mental status, diagnosis, and prognosis of the persons under their care. Clearly, any such testimony and advice that places the priority on the benefits to society will not always be in the best interests of their patients/clients.

Are we incarcerating people because they are mentally ill rather than people who are fully capable who commit crimes? There are many mentally ill who are incarcerated. When in court, many of these people do not comprehend what is happening to them.

[The Salvation Army, Brief, October 2003, p. 3]

These conflicting obligations can be difficult to manage and can threaten the clinical relationship in a number of ways. Most importantly, while giving expert opinion serves a socially valuable role, the quality of care may be compromised because the forensic mental health practitioner is unable to promise the patient confidentiality. This has clear implications for the trust between the two. The practitioner may also be obliged to use information gathered in the clinical relationship that can be of detriment to the patient in court or administrative proceedings.

11.5 ETHICAL IMPLICATIONS OF ADVANCES IN GENETICS AND NEUROSCIENCE

11.5.1 Genetics and Mental Health

According to DuVal and Rolleston, the stigma associated with mental illness and addiction gives rise to particular worries about the privacy of genetic information and the traumatizing effects that disclosure may have on already vulnerable individuals. Genetic research and diagnosis relating to behaviours may be particularly threatening. Research thus far suggests that straightforward linkages between a given gene and specific psychiatric conditions are unlikely to be established. It seems more likely that genetic components of particular

phenotypes will involve complex interactions of genetic and environmental factors.⁵³⁸ Still, safeguards must be in place to protect sensitive personal information, particularly that which alone, or when linked with other information, reveals, or may reveal some potential mental disorder or behavioural condition.

DuVal and Rolleston explained that attempting to adequately inform patients, or their surrogates, of genetic test results using the language of susceptibility and risk will raise difficult problems for individuals with mental illness and addiction. Affected and healthy individuals alike will have to cope with their own vulnerabilities. Social stigma and privacy risks complicate this burden, particularly since therapeutic benefit may lag behind diagnostic reliability. The genetic component of mental illness and addiction also raises challenging questions for families and relatives of the patient or research subject, where heritability patterns are often difficult to predict. The individual's right not to know must be balanced against the responsibility to inform people of a genetic predisposition. How this balance is reached will depend in part on the likelihood of the person's developing the condition concerned, when it might manifest itself, and the chances of their being able to take steps to prevent or reduce the effects of developing a mental illness in the future.⁵³⁹

The Committee was also informed of “genetic essentialism”, the view that persons can be defined or characterized solely in terms of their genetic makeup. This raises special concerns for those with mental illness and addiction. People with genetic defects may come to feel they are flawed. Decisions about reproduction may also be affected; for some the availability of pre-natal screening may raise eugenic concerns. Since the social stigma of mental illness remains strong, worries about discrimination in insurance, employment, education, housing and others may be particularly acute.⁵⁴⁰ Proper management of predictive genetic information is a challenge generally, and it is even more acute when dealing with those with mental illnesses that are already marked by social stigma.

11.5.2 Neuroscience and Mental Health

Recent advances in both the technological and theoretical understanding of neuroscience raise difficult ethical problems and challenge traditional notions of free will, responsibility and the self. Society's response to these issues will have far-reaching consequences, perhaps as much or more than those related to emerging genetic technologies.

Here we provide just a few of these issues raised by DuVal and Rolleston. Our evolving understanding of brain function and processes, together with developing imaging technology, will increasingly permit behaviours, personality traits and other mental events to be identified, monitored and correlated with observable changes in the brain. Employment, education, insurance, legal processes, immigration, counter-terrorism and other social activities and relationships may all be affected by the ability to identify and possibly predict both positive and negative behavioural dispositions to, for example, violence, addiction, dishonesty, stress, sympathy, cooperativeness and other behaviours.⁵⁴¹

⁵³⁸ *Ibid.*, p. 18.

⁵³⁹ *Ibid.*

⁵⁴⁰ *Ibid.*

⁵⁴¹ *Ibid.*, p. 19.

Advances in neuroscience will also make cognitive and behavioural enhancements possible. DuVal and Rolleston contended that, aside from important questions about the ethics of enhancements involving behaviour, personality and cognitive abilities, there are real concerns for social justice if such enhancement technologies are initially expensive and available only to the wealthy and privileged. Further, as mental events become increasingly described in terms of brain structures and mechanisms, society may be obliged to re-examine accepted notions of free will, responsibility, and accountability – the so-called neuroscience of ethics. In the forensic context, for example, if criminal or other aberrant behaviour is found to be causally related to differences in brain structure or function, what would be the basis for appropriate criminal responsibility and punishment?⁵⁴²

11.6 ETHICS AND MENTAL HEALTH AND ADDICTION RESEARCH

As mentioned in the previous chapter, there has been an acceleration of clinical research into mental illness and addiction in the last two decades that has produced significant advances in treatment. Much of this important research, however, requires the participation of research subjects who suffer from mental disorders themselves.

In their paper, DuVal and Rolleston stressed that the history of psychiatric research is littered with public and private sector studies that have exploited the vulnerability of individuals with mental disorders, the neurologically impaired and developmentally disabled research subjects. In one particularly infamous example, the American CIA sponsored clinical trials conducted at the Allan Memorial Institute at McGill University during the 1950s and early 1960s in which psychiatric patients were given hallucinogenic drugs without their knowledge. The history of the unacceptable treatment of these vulnerable participants has played a pivotal role in the movement toward increased scrutiny and regulation of research involving human subjects; this provides an important context for the consideration of the ethics of research into mental illness and addiction.⁵⁴³

Advances in mental health science promise great benefits for those who suffer, or will come to suffer, from mental disorders and, in some cases, for research subjects themselves. While individuals with mental illness may be particularly vulnerable in a number of ways, research policies and regulations that focus primarily on their vulnerabilities and deficits could encourage and possibly exacerbate the stigmatization already suffered by this population. But on the other hand, it may be unjust to exclude, by overly restrictive regulation, those individuals with mental disorders who could benefit from their participation in research.⁵⁴⁴

There is a particular need for special precautions in research involving individuals with mental illness and addiction. While all subjects of clinical research are vulnerable to some degree, the vulnerability of individuals participating in clinical mental illness/addiction research warrants particular attention. On the other hand, most individuals with mental illness function reasonably well and it may be unnecessary to put too much focus on special regulations for research involving individuals with mental illness. Nevertheless, it is clear

⁵⁴² *Ibid.*

⁵⁴³ Gordon DuVal and Francis Rolleston (2004), pp. 19-20.

⁵⁴⁴ *Ibid.*, p. 20.

that ethical principles must be applied with care to the particular vulnerabilities of individuals with mental illness.⁵⁴⁵

An ethically appropriate framework for psychiatric research ethics balances rigorous protections for human subjects with recognition of the enormous social and individual benefits that flow from well-designed and ethically conducted scientific research. Ethical concerns that are particularly germane to mental health research and give rise to the need for special sensitivity and insight, include decision-making capacity and research design issues.

11.6.1 Decision-Making Capacity

This subject has been discussed in considerable detail earlier in this chapter. Decision-making capacity to give valid consent is an essential condition for research involving human subjects. The vigilance that must be applied when assessing decision-making capacity and determining the appropriate decision-maker in the context of clinical care, must be applied even more vigorously in the context of research where participation in a study may not be for the direct benefit of the patient concerned. For instance, article 21 of the *Civil Code of Quebec* requires that, in order for an adult who is incapable of giving consent to participate in research, substitute consent must be obtained not just by a family member (as in the context of necessary care), but by a formally appointed mandatory, tutor or curator. As a result of this heightened protection, however, incapable adults who do not have legally appointed representatives, cannot participate in research in Québec, apart from rare emergency situations.

11.6.2 Research Design Issues

Some study methodologies have drawn particular ethical scrutiny when used in mental health and addiction research, both because of their inherent risks and because the subject population are individuals with mental disorders. Three types of study design have raised particular ethical concerns.

- **Placebo-Controlled Studies:** The randomized, controlled trial is generally accepted as the “gold standard” experimental design for comparing the efficacy and safety of medications. Comparison with placebo is regarded by regulators as providing the best evidence for the efficacy and safety of a new medication. However, the use of a placebo control design has been strongly criticized where there is an existing established effective treatment for the disease being studied; such criticisms have been aimed prominently at research in psychiatry, where research subjects enrolled in the placebo arm of the trial might have to be deprived of their much needed existing treatment, suffer potential negative effects of withdrawal and potentially relapse into a state of mental illness for the duration of the study.
- **Washout Studies:** A washout study is one in which researchers discontinue the medication of a subject patient in order to study the patient in an unmedicated state or to initiate another therapy, often an experimental one. Accordingly, the existing medication is discontinued, usually following a gradual reduction in dosage. The withdrawal period typically must last long enough that the drug has completely

⁵⁴⁵ *Ibid.*

cleared from the patient's system, so that the residual effects from the withdrawn medication do not confound the study results, or result in unwanted drug interactions. Depending on the particular study design and the medication involved, the washout can last indefinitely, or until acute symptoms return.

- Challenge Studies: A “challenge” study is one in which a psychopharmaceutical agent or psychological challenge is administered to research subjects under controlled conditions to measure or observe behavioural response, a neurobiological response (using brain imaging), or both. In psychiatry, these designs have proven to be extremely valuable in testing hypotheses and characterizing a variety of neurochemical and pathophysiological processes. Research of this kind may lead to improved predictions of treatment response and effective new therapies.⁵⁴⁶

In order for placebo-controlled clinical trials to be considered ethically permissible, certain conditions must prevail. Currently, in Canada, existing regulatory frameworks and national research ethics guidelines differ on what those conditions must be. One major difference between the existing *International Conference on Harmonization's (ICH) Harmonized Tripartite Guideline for Good Clinical Practice (E-10)* and the existing *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS)* is that TCPS currently allows placebo-controlled trials only if no standard treatment is available to, appropriate for, or wanted by the individual, whereas ICH E-10 allows placebo-controlled trials to take place even if there is established effective treatment, as long as there is no risk of death or permanent ill effect to the individual. CIHR and Health Canada have undertaken a major initiative in an attempt to review the scientific, ethical and legal principles underlying these documents with a view towards harmonizing both national policies on the appropriate use of placebos in randomized controlled trials. The Committee highly encourages CIHR and Health Canada to pursue these collaborative efforts and to adopt and implement a harmonized national policy.

In the case of challenge studies, for practical reasons subjects must usually be deceived, or at best only partially informed about the details of the study. Even without impaired decision-making capacity, this has clear ethical implications for informed consent.

Despite a history that has included serious abuses, mental health and addiction research is vitally important, not least to those who suffer, and those who will come to suffer, from mental disorders. Clinical psychiatric research gives rise to challenging ethical dilemmas. The particular vulnerabilities attending mental illness/addiction merit particularly close attention to the design, review and conduct of research.

11.7 COMMITTEE COMMENTARY

As mentioned above, the Committee believes strongly that many of the ethical issues raised with respect to mental illness and addiction originate from the stigma associated with these disorders. Addressing stigma and discrimination through awareness campaigns designed for both mental health professionals, researchers and the general public would be an important step in responding to these ethical concerns.

⁵⁴⁶ *Ibid.*, pp. 20-21.

The ethical principles underlying the delivery of mental health services and addiction treatment – particularly those of beneficence and justice – must be addressed carefully and in a timely manner. It is clear that mental health and addiction lag behind other diseases and conditions covered under Canada’s health care system. They are technologically less advanced and critically more fragmented, and the development of evidence-based guidelines to inform best practices has not reached the level of other specialties. For these reasons, the Committee believes very strongly that the prevention and treatment of mental illness and addiction should be coordinated across the wide spectrum of potential services both within and outside health care, and should be given priority in decisions about the allocation of scarce resources.

The Committee acknowledges that decision-making capacity may be impaired by mental illness and addiction, and also that not all mental disorders impair decision-making capacity. Furthermore, decision-making capacity of those suffering from mental illness and addiction may be impaired to varying degrees and at different times. Given the structure of existing laws that draw rather rigid conclusions about the presence or absence of decision-making capacity, and the relative inflexibility of changing or adapting protective supervision regimes, there should be a more fulsome debate about how to give meaningful effect to a person’s partial and/or fluctuating capacity to make decisions for himself or herself. An appropriate balance must be struck between the respect owed to the right to individual autonomy and the need to protect vulnerable persons when their decision-making capacity is impaired by reason of mental illness or addiction.

With respect to privacy and confidentiality issues, the Committee is well aware that any erosion of privacy and confidentiality protections can have serious negative consequences on an individual’s trust in his or her caregivers. However, as noted above, witnesses have told us that rigid adherence to privacy and confidentiality rules in certain circumstances can work against the interests of individuals whose mental health is compromised. The unique challenges they describe must be recognized when developing, interpreting and applying privacy and confidentiality rules, so as to allow health care providers and family caregivers to provide patients with the much needed support they sometimes require.

As stated in Chapter 10, the Committee strongly supports research into mental illness and addiction; it is the foundation for future advances in treatment and prevention. Research involving human participants must be designed and performed in accordance with the highest scientific and ethical standards and must protect the dignity of individuals and their families who make this valuable contribution to scientific progress.

The Committee acknowledges that individuals suffering from mental illness and addiction are particularly vulnerable as research subjects. It is therefore of paramount importance to protect the rights and well-being of those research participants, while promoting ethically responsible research. Research advances should not be pursued, however, at the expense of human rights and human dignity. But nor should protections be so stringent so as to exacerbate existing social stigma associated with mental illness and addiction and potentially exclude this vulnerable population from vitally important research that can improve scientific knowledge about their condition and even benefit them as individuals.

It is clear that interdisciplinary research is needed to address adequately many of the challenging ethical, legal and socio-cultural issues arising from mental illness and addiction. The Committee was told of the need to conduct this kind of research in a comprehensive and fundamental manner. In a letter to the Committee, Dr. Julio Arboleda-Florez, Professor and Head, Department of Psychiatry, Queen's University, suggested that there is a pressing need for further research into mental health ethics and research ethics to address effectively issues such as those discussed above:

There is not much applied ethical research in Canada or elsewhere and no organizational or financial capacity. (...) Applied research in the sense of testing the social take and realities of ethical concepts, their transcultural reach and implications in terms of transcultural dissonances, their population acceptability, their social meaning, their ease of implementation, or even their usefulness, is sorely missing so the field is becoming a theoretical morass.⁵⁴⁷

We believe that Canada could play an important leadership role in this regard, both nationally and internationally.

Finally, the Committee agrees with experts that the acute and complex ethical concerns that arise in the context of neuroscience and genetic research must be addressed carefully so as to understand better the underlying values and principles associated with these and other evolving and rapidly advancing technologies in modern medicine.

⁵⁴⁷ Dr. Julio Arboleda-Florez, Brief to the Committee, 5 November 2003.

CONCLUSION

This report is the first comprehensive document on mental health, mental illness and addiction in Canada. It brings together, for the first time, historical analysis of the development of mental health and addiction services, a description of their current state and an assessment of how they are being delivered. It also provides the basis for a greater understanding of the mental health needs of Canadians, by describing the problems and challenges faced by individuals with mental illness and addiction.

This report was based on the testimony of many experts as well as on a review of relevant literature. This report is intended to serve as a useful reference document to anyone who wishes to participate in the Spring, 2005 phase of the Committee's study on mental health, mental illness and addiction.

During this next phase, the Committee will hold extensive public hearings across the country to hear the views of Canadians on how to reform and restructure the delivery of mental health services and addiction treatment. We hope that the Committee's report which will result from these hearings, and which will be released in November 2005, will serve as a catalyst for an informed debate on mental health, mental illness and addiction.

**APPENDIX A:
LIST OF WITNESSES
THIRD SESSION OF THE 37TH PARLIAMENT
(FEBRUARY 2, 2004 – MAY 23, 2004)**

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Alzheimer Society of Canada	Steve Rudin, Executive Director	June 4, 2003	17
As individuals	Thomas Stephens, Consultant	March 20, 2003	11
	Nancy Hall, Mental Health Consultant	May 28, 2003	16
	J. Michael Grass, Past Chair, Champlain District Mental Health Implementation Task Force	June 5, 2003	17
	Loïse David Murray Ronald	February 26, 2003	9
Canadian Academy of Psychiatric Epidemiology	Dr. Alain Lesage, Past President	March 19, 2003	11
Canadian Academy of Psychiatry and the Law	Dr. Dominique Bourget, President	June 5, 2003	17
Canadian Coalition for Senior Mental Health	Dr. David K. Conn, Co-Chair; President, Canadian Academy of Geriatric Psychiatry	June 4, 2003	17
Canadian Institute for Health Information	Dr. John S. Millar, Vice-President, Research and Analysis	March 20, 2003	11
	Carolyn Pullen, Consultant	March 20, 2003	11
	John Roch, Chief Privacy Officer and Manager, Privacy Secretariat	March 20, 2003	11
Canadian Institutes of Health Research	Bronwyn Shoush, Board Member, Institute of Aboriginal Peoples' Health	May 28, 2003	16

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Canadian Institutes of Health Research	Jean-Yves Savoie, President, Advisory Board, Institute of Population and Public Health	June 12, 2003	18
	Dr. Rémi Quirion, Scientific Director, Institute of Neurosciences, Mental Health and Addiction	May 6, 2003	14
Canadian Mental Health Association – Ontario Division	Patti Bregman, Director of Programs	June 12, 2003	18
Canadian Paediatric Society	Dr. Diane Sacks, President-Elect	May 1, 2003	13
	Marie-Adèle Davis, Executive Director	May 1, 2003	13
Centre for Addiction and Mental Health	Jennifer Chambers, Empowerment Council Coordinator	May 14, 2003	15
	Rena Scheffer, Director, Public Education and Information Services	May 28, 2003	16
Centre hospitalier Mère-enfant Sainte-Justine	Dr. Joanne Renaud, Child and Adolescent Psychiatrist; Young Investigator, Canadian Institutes of Health Research	April 30, 2003	13
Children's Hospital of Eastern Ontario	Dr. Simon Davidson, Chairman, Division of Child and Adolescent Psychiatry	May 1, 2003	13
CN Centre for Occupational Health and Safety	Kevin Kelloway, Director	June 12, 2003	18
Douglas Hospital	Eric Latimer, Health Economist	May 6, 2003	14
	Dr. James Farquhar, Psychiatrist	May 6, 2003	14
	Dr. Mimi Israël, Head, Department of Psychiatry ; Associate Professor, McGill University	May 6, 2003	14

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Douglas Hospital	Myra Piat, Researcher	May 6, 2003	14
	Ampara Garcia, Clinical Administrative Chief, Adult Ultraspecialized Services Division	May 6, 2003	14
	Manon Desjardins, Clinical Administration Chief, Adult Sectorized Services Division	May 6, 2003	14
	Jacques Hendlisz, Director General	May 6, 2003	14
	Robyne Kershaw-Bellmare, Director of Nursing Services	May 6, 2003	14
Global Business and Economic, Roundtable and Addiction and Mental Health	Rod Phillips, President and Chief Executive Officer, Warren Sheppell Consultants	June 12, 2003	18
Hamilton Health Sciences Centre	Venera Bruto, Psychologist	June 4, 2003	17
Health Canada	Tom Lips, Senior Advisor, mental Health, Healthy Communities Division, Population and Public Health Branch	March 19, 2003	11
	Pam Assad, Associate Director, Division of Childhood and Adolescence, Centre for Healthy Human Development, Population and Public Health Branch	April 30, 2003	13
Laval University	Dr. Michel Maziade, Head, Department of Psychiatry, Faculty of Medecine	May 6, 2003	14
Louis-H. Lafontaine Hospital	Jean-Jacques Leclerc, Director, Rehabilitation Services and Community Living	May 6, 2003	14
	Dr. Pierre Lalonde, Director, Clinique jeunes adultes	May 6, 2003	14

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
McGill University	Dr. Howard Steiger, Professor, Psychiatry Department; Director, Eating Disorders Program, Douglas Hospital	May 1, 2003	13
Province of British Columbia	Patrick Storey, Chair, Minister's Advisory Council on Mental Health	May 14, 2003	15
	Heather Stuart, Associate Professor, Community Health and Epidemiology	May 14, 2003	15
Queen's University	Dr. Julio Arboleda-Florèz, Professor and head, Department of Psychiatry	March 20, 2003	11
Registered Nurses of Canada	Margaret Synyshyn, President	May 29, 2003	16
Statistics Canada	Lorna Bailie, Assistant Director, Health Statistics Division	March 20, 2003	11
St. Joseph's Health Care London	Maggie Gibson, Psychologist	June 4, 2003	17
St. Michaels Hospital	Dr. Paul Links, Arthur Sommer Rothenberg Chair in Suicide Studies	March 19, 2003	11
Université du Québec à Montréal	Henri Dorvil, Professor, School of Social Work	May 6, 2003	14
	Dr. Michel Tousignant, Professor, Centre de recherche et intervention sur le suicide et l'euthanasie	May 6, 2003	14
University of British Columbia	Dr. Charlotte Waddell, Assistant Professor, Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, Faculty of Medicine	May 1, 2003	13

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
University of Calgary	Dr. Donald Addington, Professor and Head, Department of Psychiatry	May 29, 2003	16
University of Manitoba	John Arnett, Head, Department of Clinical Health Psychology, Faculty of Medicine	May 28, 2003	16
	Robert McIlwraith, Professor and Director, Rural and Northern Psychology Program	May 29, 2003	16
University of Montreal	Laurent Mottron, Researcher, Department of Psychiatry, Faculty of Medicine	May 6, 2003	14
	Dr. Richard Tremblay, Canada Research Chair in Child Development, Professor of Pediatrics, Psychiatry and Psychology, Director, Centre of Excellence for Early Childhood Development	May 6, 2003	14
	Dr. Jean Wilkins, Professor and Paediatrics, Faculty of Medecine	May 6, 2003	14
	Dr. Renée Roy, Assistant Clinical Professor, Department of Psychiatry, Faculty of Medecine	May 6, 2003	14
University of Ottawa	Tim D. Aubry, Associate Professor; Co-Director, Centre for Research and Community Services	June 5, 2003	17
	Dr. Jeffrey Turnbull, Chairman, Department of Medicine, Faculty of Medicine	June 5, 2003	17

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
University of Toronto	Dr. Joe Beitchman, Professor and Head, Division of Child Psychiatry, Department of Psychiatry; Psychiatrist-in-Chief, Hospital for Sick Children	April 30, 2003	13
	Dr. David Marsh, Clinical Director, Addiction Medicine, Centre for Addiction and Mental Health	May 29, 2003	16

**APPENDIX B:
LIST OF WITNESSES
SECOND SESSION OF THE 37TH PARLIAMENT
(SEPTEMBER 30, 2002 – NOVEMBER 12, 2003)**

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Alberta Mental Health Board	Ray Block, Chief Executive Officer	April 28, 2004	7
Alberta Mental Health Board	Sandra Harrison, Executive Director, Planning, Advocacy & Liaison	April 28, 2004	7
Anxiety Disorders Association of Canada	Peter McLean, Vice-President	May 12, 2004	9
As individuals	Charles Bosdet	April 29, 2004	7
	Pat Caponi		
	Don Chapman		
Australia, Government of <i>(by videoconference)</i>	Dermot Casey, Assistant Secretary, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing	April 20, 2004	6
	Jenny Hefford, Assistant Secretary, Drug Strategy Branch, Department of Health and Ageing		
British Columbia Ministry of Health Services	Irene Clarkson, Executive Director, Mental Health and Addictions	April 28, 2004	7
Canadian Association of Social Workers	Stephen Arbuckle, Member, Health Interest Group	March 31, 2004	5
Canadian Medical Association	Dr. Sunil Patel, President	March 31, 2004	5
	Dr. Gail Beck, Acting Associate Secretary General		
Canadian Mental Health Association	Penny Marrett, Chief Executive Officer	May 12, 2004	9

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Canadian Nurses Association, the Canadian Federation of Mental Health Nurses and the Registered Psychiatric Nurses of Canada	Nancy Panagabko, President, Canadian Federation of Mental Health Nurses	March 31, 2004	5
	Annette Osten, Board Member, Canadian Nurses Association	March 31, 2004	5
Canadian Psychiatric Association	Dr. Blake Woodside, Chairman of the Board	March 31, 2004	5
Canadian Psychological Association	John Service, Executive Director	March 31, 2004	5
Centre for Addiction and Mental Health	Christine Bois, Provincial Priority Manager for Concurrent Disorders	May 5, 2004	8
	Wayne Skinner, Clinical Director, Concurrent Disorder Program		
	Brian Rush, Research Scientist, Social Prevention and Health Policy		
Centre for Suicide Prevention	Diane Yackel, Executive Director	April 21, 2004	6
Cognos	Marilyn Smith-Grant, Senior Human Resources Specialist	April 1, 2004	5
Correctional Service of Canada	Larry Motiuk, Director General, Research	April 29, 2004	7
	Françoise Bouchard, Director General, Health Services	April 29, 2004	7
Douglas Hospital	Dr. Gustavo Turecki, Director, McGill Group for Suicide Studies, McGill University	April 21, 2004	6
House of Commons	The Honourable Jacques Saada, P.C., M.P., Leader of the Government in the House of Commons and Minister responsible for Democratic Reforms	April 1, 2004	5

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Human Resources and Skills Development Canada	Bill Cameron, Director General, National Secretariat on Homelessness	April 29, 2004	7
Human Resources and Skills Development Canada	Marie-Chantal Girard, Strategic Research Manager, National	April 29, 2004	7
Institute of Neurosciences, Mental Health and Addiction	Richard Brière, Assistant Director	April 21, 2004	6
McGill University (by videoconference)	Dr. Laurence Kirmayer, Director, Division of Social and Transcultural Psychiatry, Department of Psychiatry	May 13, 2004	9
Mood Disorder Society of Canada	Phil Upshall, President	May 12, 2004	9
Native Mental Health Association of Canada	Brenda M. Restoule, Psychologist and Ontario Board Representative	May 13, 2004	9
New Zealand, Government of (by videoconference)	Janice Wilson, Deputy Director General, Mental Health Directorate, Ministry of Health	May 5, 2004	8
	David Chaplow, Director and Chief Advisor of Mental Health		
	Arawhetu Peretini, Manager of Maori Mental Health		
	Phillipa Gaines, Manager of Systems Development of Mental Health		
Nova Scotia Department of Health	Dr. James Millar, Executive Director, Mental Health and Physician Services	April 28, 2004	7
Ontario Federation of Community Mental Health and Addiction	David Kelly, Executive Director	May 5, 2004	8
Ontario Hospital Association	Dr. Paul Garfinkel, Chair, Mental Health Working Group	March 31, 2004	5

ORGANIZATION	NAME	DATE OF APPEARANCE	ISSUE NO.
Privy Council Office	Ron Wall, Director, Parliamentary Operations, Legislation and House Planning	April 1, 2004	5
Privy Council Office	Ginette Bougie, Director, Compensation and Classification	April 1, 2004	5
Public Service Alliance of Canada	John Gordon, National Executive Vice-President	April 1, 2004	5
	James Infantino, Pensions and Disability Insurance Officer		
Schizophrenia Society of Canada	John Gray, President-Elect	May 12, 2004	9
Simon Fraser University <i>(by videoconference)</i>	Margaret Jackson, Director, Institute for Studies in Criminal Justice Policy	April 29, 2004	7
Six Nations Mental Health Services	Dr. Cornelia Wieman, Psychiatrist	May 13, 2004	9
Treasury Board Secretariat	Joan Arnold, Director, Pensions Legislation Development, Pensions Division	April 1, 2004	5
U.S. Campaign for Mental Health Reform	William Emmet, Coordinator	April 1, 2004	5
U.S. President's New Freedom Commission on Mental Health <i>(by videoconference)</i>	Michael Hogan, Chair	April 1, 2004	5
United Kingdom, Government of <i>(by videoconference)</i>	Anne Richardson, Head of the Mental Health Policy Branch, Department of Health	May 6, 2004	8
	Adrian Sieff, Head of the Mental Health Legislation Branch		

APPENDIX C:

**LIST OF INDIVIDUALS WHO RESPONDED TO A LETTER FROM
THE COMMITTEE ON PRIORITIES FOR ACTION**

CANADIAN RESEARCH GROUP

CancerCare Manitoba	Harvey Max Chochinov, MD, PhD, FRCPC, Canada Research Chair in Palliative Care, Director, Manitoba Palliative Care Research Unit, CancerCare Manitoba, Professor, Department of Psychiatry, Community Health Sciences and Family Medicine(Division of Palliative Care) University of Manitoba
Carleton University	Dr. Hymie Anisman, Canadian Research Chair in Neuroscience, Ontario Mental Health Foundation Senior Research Fellow
Douglas Hospital Research Centre	Ashok Malla, MD, FRCP Canada Research Chair in Early Psychosis, Professor of Psychiatry, McGill University, Director, Clinical Research Division
McGill University Health Centre	Eric Fombonne, MD, FRCPsych, Canada Research Chair in Child Psychiatry, Professor of Psychiatry, University McGill, Director, Montreal Children's Hospital
University of Alberta	Glen B. Baker, PhD, DSc, Professor and Chair, Canada Research Chair in Neurochemistry and Drug Development
University of Manitoba – Faculty of Medicine	Brian J. Cox, Ph.D., C. Psych., Canada Research Chair in Mood and Anxiety Disorders, Associate Professor of Psychiatry, Adjunct Professor, Departments of Community Health Sciences and Psychology

DEANS OF MEDICAL SCHOOLS

Kingston General Hospital	Samuel K. Ludwin, M.B.B., Ch., F.R.C.P.C., Vice-President, (Research Development)
McGill University Health Centre	Joel Paris, M.D., Professor and Chair, Department of Psychiatry
University of Alberta	Dr. L. Beauchamp, Dean, Faculty of Education
University of Sherbrooke	Pierre Labossière, P. Eng., Ph.D., Associate Vice-Rector, Research
University of Western Ontario	Dr. Carol P. Herbert, Dean of Medicine and Dentistry

ILLNESS RELATED GROUP

Canada's Research-Based Pharmaceutical Companies	Murray J. Elston, President
Eli Lilly Canada Inc.	Terry McCool, Vice-President, Corporate Affairs
GlaxoSmith Kline	Geoffrey Mitchinson, Vice-President of Public Affairs
Merck Frosst Canada	André Marcheterre, President
NSERC	Thomas A. Brzustowski, President
Ontario Mental Health Foundation	Howard Cappell, Ph.,D. (C.Psych) Executive Director
Roche Pharmaceuticals	Ronnie Miller, President & C.E.O.
Schizophrenia Society of Canada	Fred Dawe, President

MENTAL HEALTH ETHICS GROUP

Centre for Addiction and Mental Health	Paul E. Garfinkel, MD, FRCPC, President and CEO
McGill University – Douglas Hospital Research Centre	Maurice Dongier, Professor of Psychiatry

Parkwood Hospital, St. Joseph's Health Care London	Maggie Gibson, Ph. D., Psychologist, Veterans Care Program
Queen's University	J. Arboleda-Florèz, Professor and Head, Department of Psychiatry
Salvation Army – Territorial Headquarters Canada and Bermuda	Glen Shepherd, Colonel, Chief Secretary
St-Paul's Hospital	Mark Miller, C.S.s.R., Ph.D. Ethicist
University of Alberta	Wendy Austin, RN, Ph. D., Canada Research Chair, Relational Ethics in Health Care, Faculty of Nursing and John Dosseter Health Ethics Centre
University of Alberta, Faculty of Nursing	Genevieve Gray, Dean and Professor, Faculty of Nursing
University of British Columbia	Peter D. McLean, Ph.D. Professor and Director, Anxiety Disorders Unit
University of Western Ontario	Nancy Fedyk, Executive Assistant to the Dean
Winnipeg Regional Health Authority	Linda Hughes, Chair, WRHA Mental Health Ethics Committee
York University	David Shugarman, Director

PRESIDENT OF UNIVERSITY

Institute of Mental Health Research – University of Ottawa	Zul Merali, Ph. D., President and CEO
McGill University	Heather Munroe-Blum, Professor of Epidemiology and Biostatistics
University of Lethbridge	Lynn Basford, Dean, Health Sciences

GOVERNMENT RESPONSIBILITY

Canadian Coalition for Seniors	J. Kenneth Le Clair, MD, FRCPC, Co-Chair, Canadian Coalition for Seniors Mental Health, Professor and Chair, Geriatric Division, Department of Psychiatry, Queen's University, Clinical Director, Specialty Geriatric Psychiatry Program
Canadian Coalition for Seniors Mental Health	David K. Conn, MB., FRCPC, Co-Chair Canadian Coalition for Seniors Mental Health, Psychiatrist-in-Chief, Department of Psychiatry, Baycrest Centre for Geriatric Care, Associate Professor, Department of Psychiatry, University of Toronto, President, Canadian Academy of Geriatric Psychiatry
Canadian Institute of Health Research	Dr. Jeff Reading, PhD, Scientific Director – Institute of Aboriginal Peoples's Health
Canadian Mental Health Association	Bonnie Pape, Director of Programs & Research, Canadian Mental Health Association – National Office
Dalhousie University – Department of Psychology	Patrick J. McGrath, OC, PhD, FRSC, Co-ordinator of Clinical Psychology, Killam Professor of Psychology, Professor of Pediatrics and Psychiatry, Canada Research Chair, Psychologist IWK Health Centre
Dalhousie University, Faculty of Medicine	David Zitner, D. Ph., Director, Medical Informatics
Department of Health and Wellness New-Brunswick	Ken Ross, Assistant deputy Minister
Douglas Hospital Research Centre	Michel Perreault, Ph. D., Researcher, Douglas Hospital, Professor, Department of Psychiatry McGill University
Douglas Hospital Research Centre - Institute of Neurosciences, Mental Health and Addiction	Rémi Quirion, Scientific Director, (INMHA)

Faculty of Medicine – University of Ottawa	Jacques Bradwejn, MD FRCPC, DABPN, Chair of the Department of Psychiatry, Psychiatrist-in-Chief, Royal Ottawa Hospital, Head of Psychiatrist, The Ottawa Hospital
Family Council: Empowering Families in Addictions and Mental Health	Betty Miller, Coordinator, The Family Council
Global Business and Economic Roundtable on Addiction and Mental Health – Affiliated with the Centre for Addiction and Mental Health	Bill Wilkerson, Co-Founder and Chief Executive Officer
Human Resources Development Canada	Deborah Tunis, Director General, Office for Disability Issues
McGill University Health Centre	Juan C. Negrete, MD, FRCP(C) Professor of Psychiatry, McGill University, Chair, Addictions Section, Canadian Psychiatric Association
McMaster University	Dr. Richard P. Swinson, MD, FRCPC, Morgan Firestone Chair in Psychiatry, Psychiatry & Behavioural Neurosciences, McMaster University, Chief, Department of Psychiatry, St. Joseph's Healthcare
NAHO National Aboriginal Health Organization	Judith G. Bartlett, M.D. CCFP, Chairperson
Ottawa Hospital	Paul Roy, MD, FRCPC, Assistant Professor of Psychiatry, University of Ottawa, Director, Ottawa First Episode Psychosis Program
Royal Ottawa Hospital	J. Paul Fedoroff, M.D., Associate Professor of Psychiatry, University of Ottawa, Research Director, Forensic Unit, Institute of Mental Health Research
Six Nations Mental Health Services	Cornelia Wieman, M.D., FRCPC, Psychiatrist
Syncrude	Eric P. Newell, Chairman & Chief Executive Officer

University of British Columbia – Mental Health Evaluation & Community Consultation Unit, Department of Psychiatry	Elliot Goldner, MD, MHSc, FRCPC, Head, Division of Mental Health Policy & Services
University of Ottawa – Office of the Vice-President, Research	Yvonne Lefebvre, Ph.D., Associate Vice-President, Research
University of Ottawa- School of Psychology	John Hunsley, Ph.D., C. Psych., Professor of Psychology
University of Toronto – Sunnybrook & Women’s College Health Sciences Centre	Nathan Herrmann, M.D., F.R.C.P. (C)