SENATE SÉNAT
CANADA

REPORT 3

Mental Health, Mental Illness and Addiction:

Issues and Options for 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 3

MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION: ISSUES AND OPTIONS FOR CANADA

Chair
The Honourable Michael J.L. Kirby

Deputy Chair
The Honourable Wilbert Joseph Keon

November 2004

TABLE OF CONTENTS

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: ISSUES AND OPTIONS FOR CANADA

INTRODUCTION

The purpose of this paper is to outline the major issues facing the provision of mental health services and addiction treatment in Canada, to present potential policy options to address some of these issues, and to launch a public debate to enable Canadians to provide input on how the issues should be addressed.

Two companion reports are being released, along with this Issues and Options paper, that summarize the background material used in the preparation of this paper. The first, entitled *Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada*, presents an overview of mental health, mental illness and addiction policies and services in Canada.[1] The second, *Mental Health Policies and Programs in Selected Countries*, draws some lessons for mental health reform in Canada from descriptions of the mental health policies and programs in four selected countries: Australia, New Zealand, the United Kingdom and the United States.[2] The Committee encourages strongly respondents to review carefully the two companion reports when preparing their submissions to the Committee.

The policy issues, questions and options contained in this paper have been developed, in part, on the basis of information the Committee received from its public hearings. From February 2003 to May 2004, the Committee heard 104 witnesses and held 24 public hearings over a total of 55 hours. In addition, the Committee received 114 submissions and 43 letters. The Committee also commissioned two papers, one on research and the other on ethics. Moreover, the Committee has made extensive use of the academic and professional literature on mental health, mental illness and addiction.

The Committee is eager to receive the views of Canadians on what the most appropriate public policy responses should be to the matters raised in this Issues and Options paper, whether by a provincial/territorial government or the federal government. The Committee will hold public hearings throughout the country, during the period from February to June, 2005. Then, in November 2005, the Committee will publish its recommendations on how best to address the issues and questions raised.

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This Issues and Options paper can be viewed as an executive summary of the findings and observations contained in the two companion reports. This paper cannot be read on its own without reference to the first and second reports. **Therefore, the Committee**

[1] thereafter referred to as the "First Report" in this document.

[2] thereafter referred to as the "Second Report".

strongly encourages readers to refer to the appropriate sections of the first and second reports as they review the list of issues, questions and options contained in this report.

This report has been structured to reflect the perspective of patients/clients as its primary focus. For example, the discussion of service delivery issues is from the point of view of the individual receiving the service/support rather than from that of the institution or organization providing it. Similarly, the issues raised focus on the particular needs of specific population subgroups – children and adolescents, seniors, Aboriginal Canadians, individuals with complex mental health needs – rather than on specific mental disorders.

The report also deals with the services and supports required to meet adequately patient/client needs. It raises issues related to the appropriate public policy response to mental health human resources, primary health care reform, mental health research, and the use of technology (such as electronic patient records and telehealth).

Finally, the Issues and Options paper concludes with a series of questions about what the role of the federal and provincial/territorial governments should be in improving Canada's system of mental health and addiction treatment services. For example, what should the key elements of federal and provincial mental health, mental illness and addiction action plans be? How should progress on implementing such plans be monitored, and how should governments be held accountable for implementing their plans effectively and by whom? How should improvements in mental health services and addiction treatment be financed? If more funding is needed, how should any new funds be obtained and from what sources?

The Committee realizes that making recommendations is not enough! Implementation is essential if its work on mental health, mental illness and addiction is to be truly useful.

The Committee urges everyone interested in mental health, mental illness and addiction issues to participate in our forthcoming consultation phase, either by testifying during the period from February to June 2005, or by sending us a letter or a brief setting out your views. The quality of our final report and its recommendations, indeed the well-being of all individuals living with mental illness and addiction throughout Canada, depends on an open debate of the issues, questions and options presented in this paper and on the Committee receiving generous "feedback".

The Committee realizes that making recommendations is not enough! Implementation is essential if its work on mental health, mental illness and addiction is to be truly useful. We also recognize that no matter how intellectually sound they may be, reports that meet excessive resistance from vested interests will simply gather dust. Therefore, the Committee is particularly anxious to receive guidance on the practical issues associated with maximizing the chances of its recommendations being acted upon. Given the level of resistance to

The Committee understands fully that progress will be made only when a very large proportion of those involved in mental health, mental illness and addiction issues is prepared to make a meaningful contribution to change – including the way they each contribute to and participate in the "system".

change which exists in any large system, especially one that involves as many players as does mental health and addiction, producing recommendations on which action can and will be taken is difficult, yet it is a prime goal of the Committee. Having said that, the Committee understands fully that progress will be made only when a very large proportion of those involved in mental health, mental illness and addiction issues is prepared to make a meaningful contribution to change – including the way they each contribute to and participate in the "system".

CHAPTER 1:
DELIVERY OF SERVICES AND SUPPORTS

The Committee has in mind a mental health and addiction treatment system with two key characteristics: it is patient-centered and is focused on recovery. It tailors services to meet the needs of individual patients/clients in a culturally appropriate manner. It provides early diagnosis and treatment to individuals soon after the onset of the mental illness and addiction.

It is also a seamless system in which services and supports are accessible, of high quality, and are well coordinated and integrated. In this system, the silo approach that currently dominates the provision of mental health services and addiction treatment (and too much of the health care "system" generally) is completely disbanded.

1.1 A PATIENT/CLIENT-CENTERED SYSTEM ORIENTED TOWARD RECOVERY AND WITH PERSONALIZED CARE PLANS

A major criticism of mental health services and supports and addiction treatment in Canada is that it is largely organized around (and often for the convenience of) providers, not patients/clients. Rather than the system adapting to meet their needs, it seems that individuals with mental illness and addiction are expected to adapt to fit into the system and access services and supports only when and where the system can provide them.[3]

A major criticism of mental health services and supports and addiction treatment in Canada is that it is largely organized around (and often for the convenience of) providers, not patients/clients.

This rather damning observation is confirmed in several provincial reports that have acknowledged that the delivery of mental health services and supports and addiction treatment needs to be more strongly person-oriented. To improve the quality of patients'/clients' lives, safe, timely and effective treatments, services and supports should be coordinated around the needs of individuals with mental illness and addiction.[4]

Our international comparative analysis showed that in other countries changes have been made to the mental health/addiction system to make them more patient/client centred.[5] For example, personalized care plans that focus strongly on recovery have been introduced in some countries for every individual with severe mental disorders.

Providing services and supports that are tailored to meet individual needs is fundamental to recovery.

[3] First Report, Chapter 8.
[4] First Report, Chapter 8, Section 8.2.1.
[5] Second Report, Chapter 5, Section 5.7.

Providing services and supports that are tailored to meet individual needs is fundamental to recovery. Personalized care plans provide a detailed description of the particular services and supports individuals with mental illness and addiction need to achieve and maintain recovery; they are responsive to the changing needs of patients/clients as they evolve during the course of an illness and throughout the individual's lifespan.[6] Funding for implementation of personalized care plans usually follows the patient/client. Individuals who need multiple services and supports and/or their families should not have to bear the burden of coordination and access to services (as they largely do now); that burden should be shared by the providers of the necessary services and supports.

The Committee has become convinced that the *status quo* is not an option. What, then, is necessary to make the mental health/addiction system more patient/client oriented?

The Committee has become convinced that the *status quo* is not an option. What, then, is necessary to make the mental health/addiction system more patient/client oriented? Should it go all the way to personalized care plans, and if so, for which types of patients/clients? What types of information should these plans contain, that is, what should be the content of such a plan? What changes are needed in the current service delivery structure to implement personalized care plans for individuals with mental illness and addiction? Who should coordinate the implementation of the personalized care plan for each patient/client?

What are the incentives and how should they be introduced into the system to stimulate the changes required to make the system truly patient/client oriented?

Would changing the method of remunerating individual and institutional providers to one in which the money follows the patient/client provide an incentive sufficiently strong to achieve a system of truly patient/client oriented mental health and addiction services and supports? If so, what changes are necessary to implement such a new funding/remuneration system? If not, what are the incentives and how should they be introduced into the system to stimulate the changes required to make the system truly patient/client oriented? More generally, what would be the implications of having "the money following the patient"?

Moreover, in its first report, the Committee noted that decision-making capacity of those suffering from mental illness and addiction may be impaired to varying degrees and at different times.[7] Accordingly, how can a patient/client oriented system ensure an appropriate balance between the rights of individuals with severe mental disorders and the role of society in caring compassionately for them while also protecting itself? Do the current disparities found in mental health legislation across the provinces and territories require formal review so as to achieve a more uniform, national, legislative framework?

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6 First Report, Chapter 4, Section 4.9.

7 First report, Chapter 8 (Section 8.3) and Chapter 11 (Section 11.2).

1.2 CULTURALLY APPROPRIATE DELIVERY OF SERVICES AND SUPPORTS

Some population groups in Canada encounter specific access problems and receive services of diminished quality due to cultural, linguistic and geographical barriers. They include Aboriginal peoples, individuals from culturally and linguistically diverse backgrounds, and people living in rural and remote areas. The absence of culturally appropriate services and supports has had a strong negative impact on many individuals.

Increasingly Canadians come from different cultural and linguistic backgrounds. What mechanisms must be put in place to deliver services and supports in a culturally appropriate manner?

Increasingly Canadians come from different cultural and linguistic backgrounds. What mechanisms must be put in place to deliver services and supports in a culturally appropriate manner? Is there a specific role for the federal government, given its responsibility for the promotion of multiculturalism? In addition, what are the views of Canadians from official language minorities with respect to their access to the mental health/addiction system? What can the federal government do to help ensure that language is not barrier to receiving needed care? [The federal government's role with respect to the provision of mental health services and addiction treatment to Aboriginal communities is addressed in more detail in Chapter 2 (Section 2.2) and Chapter 7 (Section 7.1) of this report.]

1.3 SYSTEM COORDINATION AND INTEGRATION WITH STRONG FOCUS ON COMMUNITY-BASED DELIVERY

How can the burden of coordinating and integrating services and supports be shifted to the system itself and away from affected individuals and their families?

Individuals with mental illness and addiction often feel bewildered and overwhelmed when they must not only access services and supports, but also integrate for themselves mental health care, addiction treatment, support services (housing, education, etc.), and disability benefits across multiple, disconnected programs that span federal, provincial and regional agencies, as well as several nongovernmental organizations.[8] How can the burden of coordinating and integrating services and supports be shared equitably between the system itself and affected individuals and their families?

Reforming the silo approach that currently dominates the provision of mental health services and addiction treatment so that seamless service delivery is provided would require many existing service delivery organizations to give up their autonomy. What tools could be used to put a seamless system of mental health services and supports and addiction treatment in place? What incentives are needed to overcome the difficulties associated with getting existing organizations to work together – to give up their autonomy in favour of interdependence? There appears to be significant duplication and overlap among the great

[8] First Report, Chapter 8, Section 8.2.1.

number of NGOs delivering services and supports to individuals with mental illness and addiction; how can this problem be eliminated?

What incentives are needed to overcome the difficulties associated with getting existing organizations to work together – to give up their autonomy in favour of interdependence?

What is the best way of integrating addiction services and programs into a genuine system of mental health services? How can mental health/addiction services be best coordinated with other more broadly defined social sector "silos" (housing, education, employment, income support, etc.)? Other than top down command-and-control, what incentives are there available to speed up the changes needed in the mental health/addiction system? Should increased connectiveness between different programs and administrative structures be achieved informally through positive relationships, or formally through Memorandums of Understanding or service agreements? When beginning systemic integration, which community services and supports should be given priority? Are localized pilot projects a good idea?

There are many such questions as yet unanswered. How can Canada develop and adopt clear descriptions of the roles and responsibilities of the various organizations involved in the delivery of mental health services and supports and addiction treatment? In particular, what should be the roles and responsibilities of the federal government, the provincial/territorial governments, regional health authorities, various provincial government ministries and agencies (health, education, social services, housing, justice, welfare, etc.), mental health providers, nongovernmental organizations, self-help groups, etc.?

How should public funding be allocated to encourage collaboration between and within the addiction and mental health fields? What form of funding would provide the most appropriate and effective incentives to achieve this objective?

How should public funding be allocated to encourage collaboration between and within the addiction and mental health fields? What form of funding would provide the most appropriate and effective incentives to achieve this objective? Which type of funding or mechanism could help achieve better coordination between the mental health/addiction system and the broader social system? [The issue of funding is addressed in detail later in Chapter 8 (Sections 8.1 and 8.2) of this report.]

1.4 EARLY DETECTION AND INTERVENTION

Early intervention is fundamental to arrest progression towards full-blown disease; it is important also in controlling symptoms and improving outcomes. The earlier the initiation of a proper course of treatment, the better the patient's/client's prognosis.[9]

Important in all age groups, early intervention is particularly important in children and adolescents. The onset of most adult mental disorders occurs during adolescence and young

[9] First Report, Chapter 8, Section 8.2.7.

adulthood when early intervention can significantly reduce disruptions to an individual's educational, occupational, and social development. Gains made at this time often have lifelong impact.

To put more emphasis on early detection of and intervention in mental disorders among children and adolescents, what would be required in terms of: school mental health programs, mental health screening for high school aged children, and screening for dual diagnosis and concurrent disorders? What changes must be made to the health care system, the mental health/addiction system, the education system, and the broader social service system to facilitate early intervention? [Children's and adolescents' issues are addressed in greater detail in Chapter 2 (Section 2.1) of this report.]

To put more emphasis on early detection of and intervention in mental disorders among children and adolescents, what would be required in terms of: school mental health programs, mental health screening for high school aged children, and screening for dual diagnosis and concurrent disorders?

Early detection and intervention should also be viewed through the lenses of a population health perspective. Improving the social conditions that we know are necessary for overall good mental health (e.g. healthy physical and social environments, strong coping skills, etc.) is essential to support positive mental health and recovery from mental disorders. This includes addressing the root causes of mental illness and addiction through public policy with respect to poverty, homelessness, education, etc., and the need to develop community capacity to deal adequately with these issues.

What role should the federal government play in the development and implementation of a population health approach aimed at the mental health of Canadians? Which federal departments should be involved? How can the federal government encourage the provinces/territories and other stakeholders to collaborate closely in addressing the root causes of mental illness and addiction?

1.5 ENHANCING ACCESS

Despite the efforts by all provinces and territories to improve the delivery of mental health services/supports and addiction treatment, a majority of Canadians suffering from mental disorders still do not seek and receive professional help. The Canadian Community Health Survey (CCHS) recently done by Statistics Canada showed that only 32% of individuals with mental illness and addiction saw or talked to a health professional (either a psychiatrist, a family physician, a medical specialist, a psychologist, a social worker or a nurse) during the 12 months prior to the survey.[10]

What could be done to improve this situation? One possibility is to establish a patient charter that would set standards for access to mental health services in primary health care, specialized mental health services and acute care. The Champlain District Mental Health Implementation Task Force (2002) in Ontario recommended the creation of a "Provincial

[10] First Report, Chapter 8, Section 8.2.6.

Mental Health Patients' Charter of Rights". Others have suggested some form of "mental health equitable act", legislation intended to bridge the gap between physical illnesses and mental disorders in terms of the services provided and their public funding. Still, others have advocated appointing "mental health advocates", officials who individuals having difficulty accessing needed mental health services and supports could contact for assistance. 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.[11] The Committee invites the views of readers on this set of options or others that might be pursued.

In its report of October 2002, the Committee recommended the establishment of a Health Care Guarantee along with a maximum needs-based waiting time set for primary health care consultations, specialist referrals, diagnostic tests and surgery.[12] In the current context of defining acceptable waiting times for access to health services, is there a need to set national standards with regard to access to mental health services and addiction treatment?

In the current context of defining acceptable waiting times for access to health services, is there a need to set national standards with regard to access to mental health services and addiction treatment?

Clearly, input from patients/clients will be needed increasingly as changes to the mental health/addiction system are developed and implemented. In the meantime, should the federal government (and each provincial/territorial government) establish a mental health/addiction advisory committee that is representative of the wide range of individuals with mental illness and addiction to facilitate the development of a patient-oriented system? If some other mechanism is preferable, what should that mechanism be?

Should the federal government (and each provincial/territorial government) establish a mental health/addiction advisory committee that is representative of the wide range of individuals with mental illness and addiction to facilitate the development of a patient-oriented system?

[11] *Ibid.*

[12] *Recommendations for Reform*, October 2002, Chapter 6.

CHAPTER 2:
SPECIFIC POPULATION GROUPS

The Committee has been convinced of the applicability of the adage "one size does not fit all". Individuals with mental illness and addiction are not homogenous. They are individual persons, each unique as all persons are; they should be respected as such. But they can be categorized to fall roughly within a number of population sub-groups, each with its own particular challenges and service delivery needs: children and adolescents, Aboriginal peoples, seniors, and individuals with especially complex needs, just to name a few.

2.1 CHILDREN AND ADOLESCENTS

As indicated in our first report, 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 children and adolescents who experience at any point in time mental illness and/or addiction of sufficient severity to cause significant distress and impaired functioning. The most common mental illnesses among children and adolescents are anxiety (6.5%), conduct (3.3%), attention deficit (3.3%), depressive (2.1%), substance use (0.8%), and autism and other pervasive developmental disorders (0.3).[13]

There is considerable dissatisfaction in most jurisdictions with the existing delivery of children and adolescent services. Child and adolescent mental health services and supports have been called the "orphan's orphan" of the health care system, a term that has its origin in the frequent reference to mental health as the "orphan" of the Canadian health care system.

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At the provincial/territorial level, the delivery of mental health services to children and adolescents is highly fragmented and uncoordinated; usually a variety of departments and agencies (e.g., mental health, primary health care, hospitals, child welfare, schools, young offender, addiction services, and special education services) is involved. Compounding the problem, most mental health policies and programs have largely focussed primarily on the adult population; consequently, services for children and adolescents have developed slowly and only as an adjunct to adult programs.

How can we best achieve a seamless, well coordinated, network of services and supports to address the prevalence of mental disorders among children and adolescents building on the current layering of multiple, well intentioned but uncoordinated programs? What specific measures need to be adopted in order to foster the mental

How can we best achieve a seamless, well coordinated, network of services and supports to address the prevalence of mental disorders among children and adolescents?

[13] First Report, Chapter 5, Section 5.1.2.

health of children and adolescents? Should the first step be for the various governmental departments and agencies to develop, in collaboration with other stakeholders, an inter-ministerial strategy for children and adolescent mental health? Subsequently, should formal protocols be developed and implemented to ensure effective collaboration and communication among the various players? Should each provincial government establish an agency or department with prime responsibility for children and adolescent mental health?

A number of provinces – such as Alberta, British Columbia and Prince Edward Island – have implemented specific mental health strategies for children. What can be learned from provincial initiatives? Are there particular provincial/territorial or regional models that the Committee should examine?

The value of providing mental health services within the school setting is intuitively apparent. Schools offer familiar environments to intervene with children and adolescents with mental health problems and in many jurisdictions are recognized as key players in the provision of mental health services and supports. What services and supports could be provided in an efficient and cost-effective manner in the school system?

What services and supports could be provided in an efficient and cost-effective manner in the school system?

Mental health services and supports for children and adolescents are not easy to find in most communities. When services are available, usually there are long waiting lists for access to service. It is clear that in most communities service capacity must be increased to provide a basic level of accessible services. The Committee was advised that when appropriate, services should be delivered in places where children, adolescents and their families spend most of their time (e.g., schools and homes) and at appropriately flexible times of day. This raises a series of further questions. How much funding is needed to increase capacity? How serious are the shortages of professionals in the field of children and adolescent mental health? Should more training in the early detection of mental disorders in children and adolescents be provided to primary health care providers and educational personnel? Should researchers in mental health devote more attention and resources to issues affecting children and adolescents?

Should researchers in mental health devote more attention and resources to issues affecting children and adolescents?

The Committee heard about the specific mental health care needs of those making the transition from adolescence to adulthood. In particular, the question of the general interface between systems and services set up for children and adolescents and those established for adults was raised. On the one hand, the need for mental health services and supports will likely continue following an adolescent's 18th birthday; children and adolescent mental health services, however, are generally no longer accessible when he/she turns 18. On the other, the period of transition from childhood to adulthood can be difficult, and requirements for mental health services and supports may actually increase rather than decrease during this important developmental period. How can the various systems work in an integrated, collaborative and timely manner to prepare and plan for adolescents experiencing the

Should new programs and services be developed to facilitate the transition to adult mental health services delivery programs?

transition into adulthood? Should new programs and services be developed to facilitate the transition to adult mental health services delivery programs?

2.2 ABORIGINAL PEOPLES

As noted in our first companion report, 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 assumes responsibility only for Indian peoples residing on-reserve and specified Inuit populations. 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 and supports to First Nations on reserve and Inuit people.[14]

The provincial and territorial governments are responsible for Aboriginal peoples living off-reserve, including the Métis and non-status Indians who have access to programs and services on the same basis as other provincial residents. The multifaceted nature of the Aboriginal population in combination with these jurisdictional divisions in Canada, have created serious barriers to the establishment of a comprehensive plan for dealing with mental health, mental illness and addiction among Aboriginal Canadians.[15]

The multifaceted nature of the Aboriginal population in combination with these jurisdictional divisions in Canada, have created serious barriers to the establishment of a comprehensive plan for dealing with mental health, mental illness and addiction among Aboriginal Canadians.

Although data on the prevalence of psychiatric disorders among Aboriginal peoples are quite limited, there is consensus in the literature that Aboriginal communities suffer significantly higher rates of mental illness, addiction and suicidal behaviour than the general population. Moreover, the prevalence rates of foetal alcohol syndrome/foetal alcohol effects (FAS/FAE) in some Aboriginal communities are higher than the national average.[16]

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.

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.[17]

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[14] First Report, Chapter 9, Section 9.2.1.
[15] *Ibid.*
[16] First Report, Chapter 5, Section 5.3.1.
[17] *Ibid.*

Several issues bear directly on the provision of mental health services and addiction treatment to Aboriginal communities:

- First, the system is highly fragmented. Services and supports are provided by different levels of government, different departments, and/or various departmental directorates or divisions, all without much collaboration. This fragmentation is illustrated by the current practice of isolating symptomatic problems – addiction, suicide, FAS/FAE, poor housing, lack of employment, etc. – and designing stand-alone programs to try to manage each one separately.

- Second, the habits of dependency have been fostered for a long time. Government departments must delegate to Aboriginal communities the authority to customize services and react flexibly to local circumstances. In other words, Aboriginal peoples should be supported in the development of their own solutions, rather than having solutions imposed on or provided for them. Such a change would foster the development of more culturally appropriate, and therefore effective, services and supports.

Aboriginal peoples should be supported in the development of their own solutions, rather than having solutions imposed on or provided for them. Such a change would foster the development of more culturally appropriate, and therefore effective, services and supports.

- Third, there is a critical shortage of adequately trained Aboriginal mental health and addiction professionals. For example, there are only 4 Aboriginal psychiatrists in Canada.

- Finally, some provinces have integrated Aboriginal issues with their province-wide mental health strategies. In those circumstances, federal programs for Aboriginal mental health on or off reserve should be harmonized with the provincial mental health plans and implementation strategies.

What should be the top priorities for the federal government as it starts the process of changing the way it delivers mental health services and addiction treatment to Aboriginal Canadians?

What should be the top priorities for the federal government as it starts the process of changing the way it delivers mental health services and addiction treatment to Aboriginal Canadians? What would be the most appropriate structures to ensure that Aboriginal peoples have adequate input into the design of services they need? How can the federal government organize itself to deliver those services most efficiently and effectively? Should the federal government offer financial incentives to encourage Aboriginal Canadians to train to become mental health workers?

Perhaps more importantly, given unnecessary and expensive duplication of uncoordinated programs, who should take responsibility for carrying out an environmental scan to determine what programs exist and identify duplication among governments, departments and organizations, significant gaps in programming, and how best to maximize the effective use of available resources?

2.3 SENIORS

Experts in the field contend that, with the rapid growth of the aging population, there will be an unprecedented demand on the system's current capacity to address seniors' mental health needs. Depression, dementia, delusional disorders and delirium are the most common mental illnesses among senior Canadians. The incidence of mental disorders in seniors in long term care settings and nursing homes is much higher than in the general population. The incidence of suicide among men 80 years of age or older is the highest of all age groups.[18]

Seniors with mental illness and addiction are a particularly vulnerable segment of the population with unique health needs. Many seniors mistakenly believe that mental health problems, such as depression or cognitive impairment, are part of the normal aging process and that no effective treatments are available. Mental illnesses in seniors may be confused or masked by other co-morbidity and concurrent disorders that can make accurate diagnosis and treatment of mental illness particularly difficult.

Seniors with mental illness and addiction are a particularly vulnerable segment of the population with unique health needs.

All this highlights the need for health care providers who are specialized in the care of seniors with mental health disorders, including those who reside in institutional settings. This raises the question as to whether the curriculum in faculties of medicine and nursing schools should be revised so as to provide additional education and training in the mental health needs of seniors.

This raises the question as to whether the curriculum in faculties of medicine and nursing schools should be revised so as to provide additional education and training in the mental health needs of seniors.

The Committee was told that current service delivery models do not meet the complex and ever changing mental health needs of seniors. Again, the lack of coordination among service providers compounds effective approaches to more appropriate and effective assessment, treatment and prevention of mental illness. Are there particular issues that impede the coordination and integration of needed services and supports needed by seniors?

Are there particular issues that impede the coordination and integration of needed services and supports needed by seniors?

There is limited published research specifically addressing best practices in mental health for seniors and the pressing need for the development of sophisticated, feasible, validated best practice guidelines to guide professionals who must manage simultaneously multiple mental illnesses together with physical problems in aging Canadians. Who should take responsibility for developing these best practices guidelines?

[18] First Report, Chapter 5, Section 5.1.3.

There is also a need to provide a coordinated range of supports to the family caregivers of seniors with mental disorders; the economic value of those support services is enormous. Currently, the support provided to family caregivers is very limited, usually insufficient to be of much help and is geared primarily to the needs of the affected family member, not to the needs of the caregiver.

What could the federal government do to alleviate the burden that now falls on the shoulders of thousands of family caregivers? What support services do caregivers need? Should the federal government consider adjusting the Canada Pension Plan, the Employment Insurance program and the Canada Labour Code to accommodate the needs of individuals who leave the workforce to provide care to a parent suffering from severe mental illness? How much would such changes cost? Are the current federal tax provisions adequate to compensate informal caregivers for the time and resources they provide?

What could the federal government do to alleviate the burden that now falls on the shoulders of thousands of family caregivers?

Similarly, what are the needs of elderly parents who are the primary caregivers of adult children with mental illness and addiction? What type of support (financial, respite) do these senior caregivers need?

What are the needs of elderly parents who are the primary caregivers of adult children with mental illness and addiction?

2.4 INDIVIDUALS WITH COMPLEX NEEDS

Canadians with complex mental health needs include individuals suffering from concurrent disorders (mental illness and addiction) and dual diagnosis (mental illness and developmental disability), as well as some homeless people and some inmates. Systematic approaches and effective assessment tools to identify better this population are lacking and, because they are often inappropriately identified, many individuals fail to receive proper care.

Those with concurrent disorders and dual diagnosis need help and services from several sectors – mental health, addiction, health care, education, and social services. Again, it is essential to integrate mental health services with addiction treatment services as well as the developmental and mental health sectors. The Committee is anxious to obtain the opinion of Canadians on the set of issues and options related to concurrent disorders and dual diagnosis that need to be addressed.

The Committee is anxious to obtain the opinion of Canadians on the set of issues and options related to concurrent disorders and dual diagnosis that need to be addressed.

Mental illnesses and substance use disorders are more prevalent among homeless people and inmates than in the general population; their prevalence among these segments of the Canadian population is growing. Improving access to the

With respect to the specific mental health needs of homeless individuals, we would like to hear Canadians' views on the issues and options that need to be addressed.

services and supports these individuals need requires inter-jurisdictional collaboration.

The Committee addresses the issues and options related to the mental health needs of federal inmates in Chapter 7 of this report. With respect to the specific mental health needs of homeless individuals, we would like to hear Canadians' views on the issues and options that need to be addressed. For example, what role can the federal government play in the context of the National Homelessness Initiative?

CHAPTER 3:
THE WORKPLACE

Two main factors make mental illness and addiction a critical workplace issue. First, mental disorders usually strike younger workers and second, many mental illnesses are both chronic and cyclical in nature, requiring treatment on and off for many years. Given the economic costs associated with these disorders – primarily those of absenteeism and lost productivity – it is essential that employers and governments join forces to address this issue on an urgent basis.

3.1 EMPLOYERS

Employers can play a vital role in dealing with mental illness and addiction among workers, in terms of disability management, accommodation policy and return-to-work programs.

Employers can play a vital role in dealing with mental illness and addiction among workers, in terms of disability management, accommodation policy and return-to-work programs. The global economy, in which information and innovation have become the keys to competitive success, requires skilled, motivated, reliable workers. Human capital – the motivation, knowledge, perspective, judgement, the ability to communicate, share ideas and to make and maintain strong relationships – drives competitiveness in the global economy.[19]

With respect to employer-sponsored disability insurance plans, the Committee is concerned with three specific issues. First, all corporations should conduct a review of their short-term and long-term disability claims in order to assess the prevalence of mental illness and addiction in their organizations. Second, employers should review the type and extent of disability coverage offered and their effect on the duration of claims in order to design optimally effective employer-sponsored disability insurance plan. And third, employers, managers and insurers must become more knowledgeable about mental illness and addiction.[20]

Large employers usually sponsor employee assistance programs (EAPs) which pay for (usually a limited number of) counselling sessions for their workers. EAP programs are designed to assist the employee in dealing with a variety of workplace problems. The Committee was told that EAPs need revision to address better the needs of employees dealing with mental illness and addiction; most do not provide sufficient therapeutic sessions to address mental illness and addiction effectively.[21]

The Committee was also told that employers need to take steps to accommodate individuals with mental illness and addiction in their workplaces. Such accommodation refers to "any

[19] First Report, Chapter 6, Section 6.5.
[20] First Report, Chapter 6, Section 6.4.1.
[21] First Report, Chapter 6, Section 6.5.1.

modification of the workplace, or the workplace procedures, that make it possible for a person with special needs to do a job." Permitting someone with a mental disorder to work flexible hours, for example, provides access to employment as a ramp does for an individual in a wheelchair. The needs of an employee returning to work following a bout of mental illness 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 those different needs.[22]

An organization's internal culture can make a huge difference to how mental illness and addiction are approached in the workplace. How can employers help to enhance the level of awareness about mental illness and addiction throughout their organizations? Perhaps more importantly, what can be done to enhance the knowledge of employers and managers about mental illness and addiction and their ability to help employees living with these disorders?

What can be done to enhance the knowledge of employers and managers about mental illness and addiction and their ability to help employees living with these disorders?

The Committee was informed that employers in some companies and institutions – such as Alcan Inc., the Canadian Imperial Bank of Commerce and Dofasco Inc. to name a few – are devoting more attention to mental health and addiction problems in the workplace with great success. Are there other success stories the Committee should hear about? What should be done to increase awareness about these company leaders' knowledge and experience?

Many Canadians have supplementary employer-sponsored health care insurance that covers an element of mental health care. How adequate are the levels of coverage in private health care insurance plans? Do they need to be expanded and, if so, in what areas of mental health is the expansion most needed? What specific changes in policy are required to ensure that disability insurance is not a disincentive for someone affected by mental illness or addiction to return to work? What would motivate employers best to devote more attention to improving access to treatment and rehabilitation services for workers through their EAPs?

What would motivate employers best to devote more attention to improving access to treatment and rehabilitation services for workers through their EAPs?

How can employers most effectively provide work flexibility and otherwise accommodate employees who suffer from a mental disorder? What steps should they take to remedy workplace situations that impact detrimentally on all employees, and especially on those affected by mental illness and addiction?

Are there specific suggestions/ideas for policies that would encourage businesses to employ individuals with mental illness and addiction, even if only on a part-time basis? In particular, are there programs that could be targeted specifically to adolescents disadvantaged by having

[22] First Report, Chapter 6, Section 6.5.2.

little education and no specific skill sets in addition to their mental illness that would enable them to get a job?

The Global Business and Economic Roundtable on Addiction and Mental Health has proposed a twelve-step program to defeat mental illness and addiction at work.[23] What is the evidence that this program works? If it does work well, what can governments do to encourage companies to adopt it? Should the federal government, in conjunction with the Roundtable, establish a joint working group to encourage its adoption?

Are there programs that could be targeted specifically to adolescents disadvantaged by having little education and no specific skill sets in addition to their mental illness that would enable them to get a job?

3.2 WORKERS' COMPENSATION BOARDS

In all provinces and territories, Workers' Compensation Boards (WCBs) receive an increasing number of claims related to mental health related (referred to as "occupational stress"); in a growing number of cases, they have provided compensation for such claims. A major issue raised with respect to compensation under 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, some WCBs are reluctant to provide mental health related disability benefits. They and affected workers are left to wrestle with the question of the extent to which disability benefits related to mental disorders should be paid for by worker's compensation versus health care insurance.[24] How can uniformity be achieved among the various WCBs in relation to mental illness and addiction? Should WCBs' policies with respect to mental health related claims be reviewed and by whom? What role should the Association of Workers' Compensation Boards of Canada play in bringing a national perspective to needed research and harmonization of benefit provisions?

How can uniformity be achieved among the various WCBs in relation to mental illness and addiction? Should WCBs′ policies with respect to mental health related claims be reviewed and by whom?

3.3 FEDERAL INCOME SECURITY PROGRAMS

The Committee was told about the need to review the Canada Pension Plan Disability Program (CPP(D)) and the Employment Insurance (EI) program in order to take into account the unpredictable and frequently cyclical nature of mental disorders.[25]

With respect to CPP(D), some individuals with mental disorders may not be eligible because of an insufficiently long employment history (contributions must have been paid in four out of the last six years). The Committee was advised that applicants must accept the designation of "permanently unemployable" to qualify for CPP(D) disability benefits. Many

[23] First Report, Chapter 6, Table 6.3.
[24] First Report, Chapter 6, Section 6.4.2.
[25] First Report, Chapter 6, Section 6.4.3.

individuals with mental disorders can work, but often only on a part-time basis. In addition, over 66% of individuals with mental illness and addiction are denied their initial application for eligibility and two-thirds of them do not appeal or re-apply.

Should the federal government change the CPP(D) in order to provide partial or reduced rather than full benefits to enable individuals with mental disorders to retain a portion of their benefits while still working part-time? Should CPP(D) staff members receive training to increase their awareness of mental illness and addiction? What other changes are needed so that CPP(D) can deal more equitably with workers suffering from mental illness and addiction?

Should the federal government change the CPP(D) in order to provide partial or reduced rather than full benefits to enable individuals with mental disorders to retain a portion of their benefits while still working part-time?

With respect to EI, employees who are dismissed because of "misconduct" or quit "without just cause" are not eligible for EI benefits. Due to the associated 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 under the influence of their illness, but are not in a position to claim EI benefits because they have not disclosed their illness previously. Also, 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.

What changes should be made to EI with respect to the way the program serves individuals with mental illness and addiction? For example, should individuals subsequent to leaving employment be found to be affected by mental illness and addiction be exempted from the requirement to fulfill the total number of insurable hours now required for eligibility? What other possible changes should the federal government consider?

What changes should be made to EI with respect to the way the program serves individuals with mental illness and addiction?

Some have suggested to the Committee that the federal government should find ways to share more equitably with employers the costs associated with mental illness and addiction in the workplace.[26] What mechanisms could be used to develop the basis of such cost sharing and to implement it?

3.4 THE FEDERAL GOVERNMENT AS AN EMPLOYER

The federal government is a major employer. In its role as the employer of the federal public service, Treasury Board oversees the health care benefits available to public servants under the Public Service Health Care Plan and the Disability Insurance Plan. These assure a reasonable level of income during periods of long term physical or mental disability. In

[26] First Report, Chapter 6, Section 6.6.

addition, Health Canada is mandated to provide occupational health and safety services to federal employees, including Employee Assistance Programs.[27]

The Committee invites the views of federal employees and their representatives on the quality and effectiveness of federal efforts in promoting mental health and preventing mental disability among public servants.

How effective is the federal government as an employer in accommodating individuals with mental illness and addition? How good are its return-to-work policies? What needs to be improved so that the federal government can lead by example in its role of employer?

How effective is the federal government as an employer in accommodating individuals with mental illness and addition? What needs to be improved so that the federal government can lead by example in its role of employer?

[27] First Report, Chapter 9, Sections 9.2.9 and 9.2.10.

CHAPTER 4:
SPECIFIC ISSUES

4.1 COMBATING STIGMA AND DISCRIMINATION

The Committee considers the problem of the stigmatization of, and discrimination against, individuals with mental illness and addiction to be of enormous importance.

Stigmatization and discrimination affect individuals with mental illness and addiction in many ways. 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 housing, employment, income, insurance, higher education, criminal justice, and parenting.

Individuals with mental illness and addiction also face discrimination and rejection by service providers both in the mental health system and the broader health care system and discrimination by policy makers and the media. For many individuals with mental illness and addiction, the stigmatization and discrimination they confront can be as important a source of distress as the disorder itself.[28]

For many individuals with mental illness and addiction, the stigmatization and discrimination they confront can be as important a source of distress as the disorder itself.

Because the stigma of mental illness is the cause of much of the distress individuals with mental illness and addiction experience in their daily lives, should it be more bluntly described for what it really is – discrimination – rather than stigma? Surely it is discrimination when someone with a mental illness is systematically treated differently from someone who is not affected by a mental illness. Has the word stigma become a polite linguistic way of justifying discrimination?

Has the word stigma become a polite linguistic way of justifying discrimination?

The Committee has had considerable discussion of how best to reduce stigmatization and combat discrimination. Doing so requires a multi-pronged effort sustained over a long period of time and includes: ongoing community-based education and action, media campaigns, and forums of exchange between affected individuals and other Canadians to enhance public awareness, and professional awareness campaigns to reduce structural discrimination in the health care system and in the mental health system itself.[29]

Several witnesses stressed the importance of developing a national anti-stigma strategy. Its adoption would indicate to Canadians that the federal, provincial and territorial governments attach equal importance to fostering mental health as they do to promoting the physical health of the population.

[28] First Report, Chapter 3, Section 3.3.
[29] First Report, Chapter 3, Section 3.4.

Importantly, several witnesses stressed the importance of developing a national anti-stigma strategy. The Committee was told that such a strategy would focus powerfully public attention on mental health and addiction issues. Its adoption would indicate to Canadians that the federal, provincial and territorial governments attach equal importance to fostering mental health as they do to promoting the physical health of the population.[30] At the same time, many witnesses noted that it is important to carefully target anti-stigma efforts and that the evidence indicates that overly general campaigns do not yield the desired results.

The Committee's review of mental health promotion initiatives in other countries pointed out that successful public awareness campaigns to combat stigma and discrimination require sustained funding, long term planning and ongoing evaluations. In addition, such campaigns, notably in Australia and New Zealand, seem to benefit from being tailored to a variety of circumstances, population groups and communities. Our international review also underscores the need from the outset for widespread consultation among the various levels of government, providers, NGOs and, most importantly, affected individuals themselves and their families.[31]

In addition to a campaign by governments, is there also a role for the media in trying to change Canadians' attitudes towards individuals with mental illness and addiction? If so, what should that role be? Are there public awareness strategies that have been particularly successful in Canada to reduce stigma and discrimination (such as the Canadian Strategy on HIV/AIDS) from which lessons could be learned?

Is there also a role for the media in trying to change Canadians' attitudes towards individuals with mental illness and addiction?

The Committee was also told that the most effective strategy for combating stigma and discrimination was to increase the amount of contact with individuals living with mental illness and addiction. In this regard, we learned that the United Kingdom established an Ambassador Bureau composed of more than forty individuals with mental illness and addiction who were trained to speak to the media and employers about their experiences.[32] It was successful in giving the anti-stigma campaign a personal and very human face. Should Canada establish a similar group?

The United Kingdom established an Ambassador Bureau composed of more than forty individuals with mental illness and addiction who were trained to speak to the media and employers about their experiences.[1] Should Canada establish a similar group?

Similarly, in Australia, a national mental health strategy was undertaken in journalism schools to teach journalists how to report in ways that do not stigmatize individuals with mental disorders and encourage the media to promote positive messages about mental health.[33] Should the federal government, working jointly with the media, develop a similar strategy in Canada? How much would it cost and how should it be funded?

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[30] First Report, Chapter 3, Section 3.4.1.
[31] Second Report, Chapter 5, Section 5.5.
[32] Second Report, Chapter 3, Section 3.4.1.
[33] Second Report, Chapter 1, Section 1.5.

Finally, there is need to increase the awareness among health care professionals about mental illness and addiction. Mental health care providers and addiction workers themselves are not immune from the influence of stigmatization of their patients/clients. How prevalent is this form of stigmatization? Should the curriculum in faculties of medicine and nursing schools be revised so as to provide additional education and training on mental illness and addiction? Is this an area of provincial responsibility, or can the federal government play a role? What other measures can be targeted at health care workers in order to reduce discrimination?

More generally, what can governments do to increase everybody's awareness that mental health is as important as physical health to the well-being of Canadians and that, as a corollary, the delivery of services and supports for mental illness and addiction is as critical as is the provision of health services for physical conditions?

More generally, what can governments do to increase everybody's awareness that mental health is as important as physical health to the well-being of Canadians and that, as a corollary, the delivery of services and supports for mental illness and addiction is as critical as is the provision of health services for physical conditions?

4.2 SUICIDE PREVENTION

Every year, some 3,700 Canadians commit suicide. It is the leading cause of death for men aged 25 to 29 and for women aged 30 to 34. In addition, a large number of other Canadians attempt suicide each year. In 2002, about 4% of Canadians aged 15 years and over had suicidal thoughts.[34]

In its first report, the Committee noted that, while not itself defined as a mental disorder, suicidal behaviour is highly correlated to mental illness and addiction; more than 90% of suicide victims have a diagnosable mental illness or substance use disorder. Suicide is the most common cause of premature death of individuals with schizophrenia and accounts for 15% to 25% of all deaths among individuals with severe mood disorders. Addiction often predisposes an individual to suicidal behaviour by intensifying a depressive mood swing and by reducing self-control.[35]

Unlike Australia, Finland, France, the Netherlands, New Zealand, Norway, Sweden, the United Kingdom and the United States, Canada does not have a national suicide prevention strategy. According to the Centre for Suicide Prevention, only two provinces – New Brunswick and Québec – have implemented suicide-specific prevention strategies. Many would like the federal government to work with the provinces/territories and relevant stakeholders in the development of a national strategy.

Unlike Australia, Finland, France, the Netherlands, New Zealand, Norway, Sweden, the United Kingdom and the United States, Canada does not have a national suicide prevention strategy.

A number of programs and activities could be included in a national suicide prevention strategy, namely:

[34] First Report, Chapter 5, Section 5.2.
[35] First Report, Chapter 4, Section 4.5.

- Public awareness campaigns to address the stigma associated with suicidal behaviour.
- Population health strategies to address the determinants of health, including housing, income security, education, employment and community attitudes towards those affected by mental illness and addiction.
- Prevention programs for adolescents, for individuals at high risk of suicidal behaviour, and for families in which a member has attempted or committed suicide.
- Equitable access to co-ordinated, integrated services, including crisis counselling by telephone and the treatment of mental illness and addiction.
- Measures to reduce access to lethal means of suicide, particularly firearms, medication and dangerous bridges and other sites.
- Training of service providers and educators in the early identification of suicidal behaviour and crisis management.
- Research and evaluation to inform the development of effective suicide prevention programs and to evaluate the effectiveness of health and social services in preventing suicide.

Who among the federal, provincial, territorial governments, and nongovernmental organizations should be involved in the development of a national suicide prevention strategy? What should be its specific goals and objectives? What programs and activities should be part of a national suicide prevention strategy?

Who among the federal, provincial, territorial governments, and nongovernmental organizations should be involved in the development of a national suicide prevention strategy? What should be its specific goals and objectives? What programs and activities should be part of a national suicide prevention strategy? How much would it cost and how should it be funded? Should there be a single national strategy, or should each level of government establish its own?

CHAPTER 5:
HUMAN RESOURCES

Professionals of many kinds are involved in the provision of mental health services and supports and addiction treatment. They include primary health care physicians, psychiatrists, addiction specialists, psychologists, registered psychiatric nurses, social workers, nurse practitioners, occupational therapists, case managers, addiction counsellors, special care educators, etc. The Committee was told that, as in other areas in the health care system, there are critical shortages of providers. The geographic mal-distribution of mental health and addiction professionals is also of concern.[36] Other countries face similar human resource challenges in the field of mental illness and addiction.[37] The Committee was also informed about a critical need to reform the primary health care sector with the view to improving people's access to mental health services and to expanding shared mental health care initiatives across the country.

As in other areas in the health care system, there are critical shortages of providers in the field of mental illness and addiction.

5.1 SUPPLY OF MENTAL HEALTH AND ADDICTION HUMAN RESOURCES

Although the Committee heard repeatedly about shortages of providers,[38] there is currently no national database that provides even a rough, much less a detailed, breakdown of the supply of human resources in the field of mental illness and addiction. At present, it is unclear if there actually is a shortage of mental health/addiction service providers in Canada and, if so, how serious it is. This is another example of how poor the state of health information generally is in Canada.

Are there specific categories of providers which are in particularly short supply? Have some provinces been more successful than others in addressing the perceived shortages of professionals practising in the field of mental illness and addiction?

This lack of information creates very serious obstacles to the appropriate planning of mental health and addiction human resources, notably the implementation of a national human resource strategy in the field of mental health, mental illness and addiction.[39]

How can credible, realistic estimates be made of the human resources currently at work and required in a restructured mental health/addiction system? What role should the federal government play in helping the provinces and territories to ensure an appropriate supply of professionals in this field throughout the country? How can the federal government get

[36] First report, Chapter 8, Section 8.2.5.
[37] Second Report, Sections 1.3.2, 2.3.2, 3.3.1, 4.3,1, 4.3.2 and 4.3.3.
[38] First Report, Chapter 8, Section 8.2.5.
[39] *Ibid.*

involved in human resource planning in the mental health/addiction sector without encroaching on provincial/territorial jurisdiction?

What elements should such a national human resource strategy encompass (planning, training, review of scope of practices, etc.)? What programs and incentives should be put in place to encourage people to become engaged in mental health and addiction services? The Committee invites views on the challenges and opportunities to develop and implement a human resource strategy.

The objective of a human resource strategy should be to ensure that the right skills and services are delivered in a culturally appropriate manner by the right person at the right time. How could we expand and enhance the education and training for mental health and addiction professionals and workers to meet the objective of providing culturally appropriate services?

What role should the federal government play in helping the provinces and territories to ensure an appropriate supply of professionals in this field throughout the country?

It is obvious that the current geographic mal-distribution of mental health and addiction professionals leads to reduced access to necessary services and supports in Canada's rural and remote regions.[40] How could such under-service be alleviated? The Committee wants to hear Canadians' views on the types of incentives that could be put in place to address the shortages of mental health and addiction personnel in rural and remote areas.

It is obvious that the current geographic mal-distribution of mental health and addiction professionals leads to reduced access to necessary services and supports in Canada's rural and remote regions. How could such under-service be alleviated?

5.2 PRIMARY HEALTH CARE SECTOR

The primary health care sector is usually the first point of contact with the health care system for individuals affected by disease and injuries of all kinds, including mental illness and addiction. Yet, the Committee has been told that primary health care providers may lack sufficient knowledge, skills and financial incentives to meet the needs of patients with mental illness and addiction, to accurately screen for mental disorders, and/or to help patients navigate the appropriate referral pathways to access more specialized mental health and addiction services.[41] If primary health care providers are to be the primary gatekeepers for a patient's entry into treatment for mental illness and addiction, what needs to be done to improve mental health care at the primary care level? How can this be achieved, given the current major shortage of family physicians, nurses and other health care professionals in Canada?

If primary health care providers are to be the primary gatekeepers for a patient's entry into treatment for mental illness and addiction, what needs to be done to improve mental health care at the primary care level?

[40] First Report, Chapter 8, Section 8.2.3.
[41] First Report,Chapter 8, Sectio 8.2.4.

There is a need to increase awareness about mental illness and addiction among health care professionals. How much training in the field of mental illness and addiction should family physicians, nurse practitioners and other health care professionals receive while in medical and nursing schools? Should the curricula in nursing schools and faculties of medicine be revised so as to provide additional education and training on mental illness and addiction?

Some recommended to the Committee that medical billing schedules be modified so as to provide an incentive to family physicians to devote more time to individuals with mental illness and addiction when they need it.[42] This has been done in Alberta and Québec, following the initiation of such a program in Australia three years ago with great success. Family physicians who must take extra time to address the specific needs of individuals affected by mental disorders should have their fee-for-service rates adjusted to provide appropriate compensation.[43] Should such a program be started in provinces where there has not yet been such an adjustment to the fee schedule?

Another recommendation to the Committee called for the development of more shared mental health care initiatives across the country. This refers to collaborative work between primary health care providers and psychiatrists. Some such shared mental health care initiatives have a strong clinical focus and integrate mental health services within primary health care settings. The Committee was told that the federal government could play a major role in ensuring that successful shared mental health care initiatives continue to receive funding and that best practice models be implemented and incorporated in permanent programs and policies in all provinces and territories.[44]

Many provinces are in the process of reforming their primary health care sector. How can collaborative working relationships between primary health care providers and mental health professionals be encouraged? For example, should psychiatrists function as consultants to, or as members of, multidisciplinary primary health care teams? What specialized and/or institutionally-based mental health and addiction services could be relocated effectively to primary health care settings? What are the major barriers to implementing shared mental health care? What are the financial barriers? Do current scope of practice rules need to be changed to accommodate shared mental health care? In its current support to primary health care reform, should the federal government explicitly encourage shared mental health care? How much funding would be necessary to implement more broadly this approach?

How can collaborative working relationships between primary health care providers and mental health professionals be encouraged?

How can psychologists and social workers be made a part of a team of mental health service providers? Where would the money come from to pay for their services,

How can psychologists and social workers be made a part of a team of mental health service providers?

[42] *Ibid.*

[43] Second Report, Section 10.3.2.

[44] First Report, Chapter 8, Section 8.2.4.

given that they are not members of the medical profession with billing privileges under the *Canada Health Act* and therefore their services are not covered under Canada's publicly funded health care insurance system?

5.3 COMMUNITY SUPPORT WORKERS AND POLICE OFFICERS

A wide range of workers provide community supports to individuals with mental illness and addiction. These workers are members and/or employees of various nongovernmental organizations as well as of numerous social agencies (welfare, income support, employment, etc.).

Five years ago, New Zealand implemented a training program to provide formal certification to community mental health support workers.[45] What types of training are currently available to, and required of, a community mental health support worker in Canada? Should there be more uniformity in the training and education of community mental health support workers? Should training programs similar to that provided in New Zealand be developed? If so, what institutions should provide that training? Should provincial/national licensing bodies comparable to those of the self-regulating health professions be charged with regulating such workers? Should the federal government provide specific financial support to help launch a training program?

Five years ago, New Zealand implemented a training program to provide formal certification to community mental health support workers.[1] What types of training are currently available to, and required of, a community mental health support worker in Canada?

The Committee is also aware that, increasingly, it is often the police officer who first comes into contact with persons in the midst of a mental health crisis rather than health care agencies or providers. Oftentimes, individuals with severe mental disorders have nowhere to go when experiencing a crisis. When there is a crisis, police officers are the ones who are called to intervene. We were told, however, that law enforcement officers often lack the training and policy guidance on how to intervene when someone is in the midst of a mental health crisis. What should be done to improve the training of police officers to enable them to deal more effectively with individuals with mental illness and addiction? How can we increase the safety of those involved in the intervention and help to ensure that law enforcement officers use the least amount of force when apprehending someone who is experiencing a mental health crisis?

What should be done to improve the training of police officers to enable them to deal more effectively with individuals with mental illness and addiction? How can we increase the safety of those involved in the intervention and help to ensure that law enforcement officers use the least amount of force when apprehending someone who is experiencing a mental health crisis?

[45] Second Report, Chapter 2, Section 2.3.2.

5.4 SUPPORTING CAREGIVERS

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 health care system and the community, it is parents who house, care, supervise and provide financial assistance to their affected children.

Do families living with someone affected by mental illness or addiction have adequate access to the resources they need to help their loved ones?

Several studies have shown that this situation can be a source of enormous tension and emotional stress as well as financial strain for those close to individuals affected by mental illness and addiction. Do families living with someone affected by mental illness or addiction have adequate access to the resources they need to help their loved ones? Are families adequately equipped to deal with their relatives affected by mental illness and addiction?

Families are an integral part of the care provided to individuals with mental illness and addiction. They are benevolent and effective allies in limiting the pain and suffering their relatives are living with. Should family caregivers be more involved in the care and treatment of the affected members? How and in what form should we encourage their participation in the formal mental health/addiction system?

CHAPTER 6:
NATIONAL INFORMATION DATABASE, RESEARCH AND TECHNOLOGY

The Committee believes strongly that excellence in mental health services and addiction treatment depends on a strong commitment to developing a national information database, fostering research on how to manage health information generally and that related to mental health and addiction in particular, and to using information and communications technology appropriately. This would greatly help to inform and guide decisions, the setting of policies and priorities, and improve outcomes for individuals with mental illness and addiction.

6.1 CANADIAN COMMUNITY HEALTH SURVEY

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, suicidal ideation, and pathological gambling. It did not, however, cover the wide range of anxiety and affective mood disorders as did the National Survey of Mental Health and Well-Being undertaken in Australia in 1997. The Australian survey also distinguished between the harmful use of, and dependence on, alcohol and drugs, and permitted an assessment of both concurrent disorders and co-morbidity. The Australian government also plans a survey to assess the prevalence rates of mental disorders among children and adolescents as well as a survey of psychotic disorders of lower prevalence, such as schizophrenia.[46]

The CCHS survey should be repeated on a regular basis and its base should be expanded to cover a wider range of mental disorders, age groups and population sub-groups. Canada does not currently collect data on an ongoing basis on the prevalence of mental illness and addiction among Aboriginal peoples, homeless peoples and the prison population – groups that appear to be at higher risk for mental disorders than the general population.[47]

The CCHS survey should be repeated on a regular basis and its base should be expanded to cover a wider range of mental disorders, age groups and population sub-groups.

Should Statistics Canada undertake a survey of children and adolescents as will be done in Australia? Should Statistics Canada be asked to expand its next Canadian Community Health Survey to include, as the Australia survey does, questions which enable an assessment of both concurrent disorders and co-morbidity? What can be done to improve the information available on the prevalence of mental disorders among Aboriginal peoples, homeless people and the prison population? With what frequency should the CCHS be undertaken? Should we share our survey methodology with other countries to allow meaningful international comparisons?

What can be done to improve the information available on the prevalence of mental disorders among Aboriginal peoples, homeless people and the prison population?

[46] First Report, Chapter 5, Section 5.1 and 5.2.
[47] First Report, Chapter 5, Section 5.3.

6.2 NATIONAL INFORMATION DATABASE

Canada currently lacks a national information base on the prevalence of mental illness and addiction. We also lack the information system required to measure the mental health status of Canadians and to evaluate policies, programs and services in the fields to mental health, mental illness and addiction.

Canada currently lacks a national information base on the prevalence of mental illness and addiction. We also lack the information system required to measure the mental health status of Canadians and to evaluate policies, programs and services in the fields to mental health, mental illness and addiction. This is a major impediment to determining the level of mental health services and addiction treatments that the provinces/territories and the country need, and the quality of services currently provided.

The Canadian Alliance on Mental Illness and Mental Health is advocating the development of a national information system for mental health, mental illness and addiction characterized by a dynamic collaboration among all levels of government and all stakeholders ranging from individuals with mental illness and addiction to data collectors. Several databases, including those provided by an expanded CCHS survey, could be used to lay the base of such an information system. This basic system could be expanded over time into a well-organized database which could be used by policy makers and researchers both inside and outside of government with the addition of new indicators and new sources of data.

Who should take the lead in facilitating the development of such a national information database system?

Who should take the lead in facilitating the development of such a national information database system? What role should Statistics Canada, Health Canada, the Canadian Institute for Health Information and the Canadian Institutes of Health Research and provincial/territorial governments play in the establishment and maintenance of the system? Are there countries or provinces/territories that could be considered as a potential model for the development of a nationwide database? How much funding would be necessary to establish a comprehensive, well-managed national information database system for mental health, mental illness and addiction?

6.3 RESEARCH

6.3.1 Level of Funding

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. For the 2003-2004 fiscal year, CIHR has allocated $93 million to INMHA from its total base budget of $623 million. Some $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.[48]

Several witnesses presented the view that the proportion of health research dollars allocated to mental health, mental illness and addiction is too small. They claimed that the funding dedicated to research into mental health, mental illness and addiction does not reflect the burden of mental illness and substance use disorders on the Canadian economy. Estimates suggest that if funding were to be provided in relation to the economic burden of disease, then CIHR's support for mental illness and addiction would have to increase from its current base of $33 million to at least $80 million per year. The Committee was also told that CIHR's proportional investment in mental health, mental illness and addiction (5.3%) is relatively low in comparison to other countries (6.5% in the United Kingdom and 10% in the United States).[49]

The funding dedicated to research into mental health, mental illness and addiction does not reflect the burden of mental illness and substance use disorders on the Canadian economy. Estimates suggest that if funding were to be provided in relation to the economic burden of disease, then CIHR's support for mental illness and addiction would have to increase from its current base of $33 million to at least $80 million per year.

What measure should be used to determine the appropriateness of the proportion of research funds spent on research into any given disease? Should it be prevalence rates, morbidity and mortality, disability, or the economic burden associated with the disease? Is such an approach to measurement appropriate at all? What should be the role, if any, of international comparisons? Should research funding be decided solely or predominantly on the basis of merit and promise among all applications submitted to the granting agency concerned? Or, should it be determined after consideration of a combination of all of the measures and factors referred to above?

If more funding is required for INMHA, where should it come from – a reallocation within CIHR's budget or an increase in INMHA's total budget? Should a dedicated fund be established to support research into mental health, mental illness and addiction? Should a new institute dedicated to mental health, mental illness and addiction be created by CIHR and, if so, how should it relate to INMHA? The Committee welcomes opinions and suggestions on the options to increase federal funding for research into mental health, mental illness and addiction.

If more funding is required for INMHA, where should it come from – a reallocation within CIHR's budget or an increase in INMHA's total budget?

Other research funding questions include: is the research funding from provincial governments sufficient? What about the level of research funding from mental health organizations? Are pharmaceutical companies investing sufficient funds in this area?

[48] First Report, Chapter 10, Section 10.1.
[49] First Report, Chapter 10, Section 10.2.

6.3.2 Knowledge Translation

The Committee has also considered the issue of knowledge translation – bringing the outcomes of research to the provider/institution/community where services and supports are delivered. All too frequently, published research discoveries in mental health, mental illness and addiction (medications, psychotherapies, etc.) remain with researchers in their laboratories and have too limited an impact on service delivery and patients' outcomes.

This situation is not unique to Canada. In the United States, a report estimated that there is a 15 to 20 year lag between discovering effective forms of treatment (medications, therapies, new ways of delivering care, etc.) and incorporating them routinely into patient care. The same report also showed that when discoveries become routinely applied at the community level, actual clinical practices remain highly variable and are often inconsistent with the treatment model shown to be most efficacious.[50] At the same time, the Committee was told that, in the United Kingdom, the National Institute for Mental Health in England (NIMHE) has played an important role in making the most advanced research available to mental health providers on the ground.[51]

All too frequently, published research discoveries in mental health, mental illness and addiction (medications, psychotherapies, etc.) remain with researchers in their laboratories and have too limited an impact on service delivery and patients' outcomes.

What are the reasons behind the resistance to adopting evidence-based state-of-the-art medications and therapies? How can this resistance be overcome?

What are the reasons behind the resistance to adopting evidence-based state-of-the-art medications and therapies? How can this resistance be overcome?

What incentives will work to encourage the early and universal adoption of new beneficial evidence-based research results by mental health and addiction service providers? Should the federal government put in place an innovation fund to encourage innovation in service delivery and accelerate the adoption of research results in the mental health/addiction system? How big should this fund be? What conditions should be attached to projects supported by the fund?

What incentives will work to encourage the early and universal adoption of new beneficial evidence-based research results by mental health and addiction service providers?

Should the federal government consider the possibility of establishing a body similar to NIMHE in the United Kingdom in order to facilitate knowledge translation? Or, should this task be the responsibility of CIHR's Institute of Neurosciences, Mental Health and Addiction (INMHA)? If so, what can be done to enhance INMHA's capacity to bring the outcomes of research into practice settings?

The Committee welcomes the views of readers on ways that could accelerate the application of research results with beneficial impacts on treating patients in mental health, mental illness and addiction.

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[50] First Report, Chapter 10, Section 10.4.
[51] Second Report, Chapter 3, Section 3.6.

6.3.3 Research Involving Human Subjects

As mentioned in the first report, 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 requires the participation of research subjects who suffer from mental disorders themselves.[52]

Special precautions are needed 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 is of particular concern because such disorders, particularly if they affect cognition or are severe, often impair their decision-making capacity. The capacity to give a valid consent is, of course, an essential condition for research involving human subjects. Therefore, keen vigilance must be applied when assessing the decision-making capacity of potential subjects and when determining and informing alternative decision-makers for the patient, especially when participation in a study may not directly benefit the patient/subject concerned.[53]

While all subjects of clinical research are vulnerable to some degree, the vulnerability of individuals participating in clinical mental illness/addiction research is of particular concern because such disorders, particularly if they affect cognition or are severe, often impair their decision-making capacity.

Recognizing the particular vulnerability of individuals participating in clinical mental illness/addiction, the Committee attaches paramount importance to the protection of the rights and well-being of those who participate as research subjects. Research advances should only be pursued in the most ethically responsible way and never at the expense of human rights and dignity. But neither should the protections be so stringent as to exacerbate existing social stigma associated with mental illness and addiction and exclude this vulnerable population from participating in vitally important research with the potential to improve scientific knowledge about their conditions, and sometimes, benefit them as individuals. Are the guidelines currently governing the conduct of research involving human subjects adequate to protect the special vulnerabilities of individuals with mental illness and addiction? Are the safeguards applied with sufficient stringency in clinical trials conducted outside teaching centres?

Are the guidelines currently governing the conduct of research involving human subjects adequate to protect the special vulnerabilities of individuals with mental illness and addiction? Are the safeguards applied with sufficient stringency in clinical trials conducted outside teaching centres?

6.3.4 A National Research Agenda

Those who addressed issues related to mental health and addiction research agreed unanimously on the need for a national research agenda. In their view, such an agenda should build on current Canadian expertise, coordinate the currently fragmented research

[52] First Report, Chapter 11, Section 11.6.
[53] First Report, Chapter 11, Section 11.6.

activities performed by a variety of actors (governments, non-governmental organizations, pharmaceutical companies, universities, etc.) and ensure a balance between biomedical, clinical, health services and population health research related to mental health, mental illness and addiction.[54] Who should have the responsibility of developing, implementing and coordinating such a national research agenda – INMHA, CIHR or another entity entirely? What research topics should claim initial priority?

6.4 INFORMATION AND COMMUNICATIONS TECHNOLOGY

6.4.1 Electronic Health Records

As explained in the Committee's October 2002 health care report, a system of electronic health records (EHRs) provides each individual with a secure, private and comprehensive lifetime record of his/her health history and care within and by the health care system, including visits to family physicians and specialists, hospital stays, prescription drugs, laboratory tests, etc. That record is available electronically anywhere, anytime, to its individual owner and those health care providers authorized by him or her to access it in support of high quality care.

Not only would such an EHR system greatly improve the quality and timeliness of health care delivery, it would also enhance health care system management, efficiency and accountability. The data collected from an EHR system would also be invaluable for the purposes of health research.[55]

All levels of government in Canada have recognized the importance of developing and deploying a system of EHR. In fact, on September 11, 2000, the First Ministers agreed to work together to develop an EHR system over the next three years and to work collaboratively to develop common data standards to ensure the compatibility and interoperability of provincial health information networks and the stringent protection of personal health information. In support of that agreement, the federal government established Canada Health Infoway Inc. (or *Infoway*) in 2001 with a budget of $500 million to support and accelerate the development and adoption of interoperable electronic health records solutions throughout the country.

The Committee believes that the effective health information management made possible in substantial part by an EHR system can improve effectiveness and efficiency of the provision of mental health services and the treatment of addiction.

In its report of October 2002, the Committee expressed strong support for the deployment of a national EHR system. In particular, we stressed that the work undertaken by *Infoway* represented a major step towards the full integration of the several provincial and territorial health infostructures. We recommended that the federal government provide *Infoway* with $2 billion over a five-year period for the development of a national system of electronic health records (EHRs) to support the Canadian hospital and doctor

[54] First Report, Chapter 10, Section 10.5.
[55] *Recommendations for Reform*, October 2002, Chapter 10, Section 10.2.

system insured under Medicare.[56] In 2003, the federal government increased *Infoway*'s capitalization to $1.1 billion.

The Committee believes that the effective health information management made possible in substantial part by an EHR system can improve effectiveness and efficiency of the provision of mental health services and the treatment of addiction. First, as in physical health care, an EHR is a necessary prerequisite to a truly patient-oriented mental health and addiction system. Second, it offers tremendous opportunities to support integration of the different components of the mental health service system and the addiction treatment system that currently work in silos. Third, exchanging health information through secure means makes important data available at the right times and places to support optimal mental health care and recovery for all patients/clients. And finally, EHR can dramatically reduce the need to repeatedly provide personal and family health history every time an individual with mental illness and addiction encounters a different mental health/addiction professional.

The Committee wants to know if the EHR system now being developed by Canada Health Infoway Inc. raises particular concerns among and with respect to patients/clients with mental illness and addiction. For example, do psychiatric records differ materially from other types of medical records and, if so, how? Should information about mental illness and addiction be dealt with differently than other personal health information under the EHR? We invite the views of mental health providers, addiction specialists, patients/clients and their families.

The Committee wants to know if the EHR system now being developed by Canada Health Infoway Inc. raises particular concerns among and with respect to patients/clients with mental illness and addiction. Should information about mental illness and addiction be dealt with differently than other personal health information under the EHR?

Issues related to the privacy, confidentiality and protection of personal health information are perhaps the most sensitive ones raised in relation to an EHR system. We address this question in detail in section 6.5 below.

6.4.2 Tele-Mental Health Services

As explained in the Committee's April 2002 report, telemedicine makes use of videoconferencing and related equipment to provide health care at a distance. As such, it can greatly improve the quality and timely access to care, particularly in rural and remote areas. Videoconferencing equipment can also be used for other purposes such as providing the continuing education and training of health care providers located in remote communities.[57]

Mental health services and supports are unevenly distributed geographically in Canada. They are specially lacking in rural and remote areas of the country, including in most Aboriginal communities/reservations. The result is that individuals with mental disorders living in rural

[56] *Recommendations for Reform*, October 2002, Chapter 10, Section 10.2.
[57] *Principles and Recommendations for Reform*, April 2002, Chapter 4.

and remote regions and in Aboriginal settings are forced to travel far from their homes for needed services. This hardship, ironically dubbed "Greyhound Therapy", is doubly stressful for someone affected by mental illness and addiction.[58]

When removed from their communities, individuals are separated from their natural support systems and informal care networks, those things that provide the kind of financial, emotional and social supports essential for recovery but not found in the formal treatment system. Although for some the anonymity of the city may be a welcome respite from stigma and shame, removal from the home community can have a significant negative impact on treatment interventions and outcomes.

The Committee was told that transplanting urban mental health workers into rural settings, even if they would be willing to relocate, would not necessarily do much good. The transplanted professionals would still not be qualified to deal with distinctive rural culture and the myriad of related issues.

What is the potential for telemedicine in the field of mental illness and addiction? What are the challenges? Is the current investment by the federal government in telemedicine adequate in the field of mental illness and addiction?

What is the potential for telemedicine in the field of mental illness and addiction? What are the challenges? Is the current investment by the federal government in telemedicine adequate in the field of mental illness and addiction?

The Committee wants to hear the view of Canadians on the need for expanded telemedicine applications in mental health service delivery and in mental health/addiction education and training.

6.4.3 Internet-Based Health Information Network

Individuals with mental illness and addiction and their families want up-to-date information about the mental disorders with which they are dealing, together with information on effective treatments, services and supports. But despite the quickly growing availability of communications via the Internet, reliable information is not always available when and how people need it most; certainly it is not readily or universally accessible to all Canadians. Moreover, most times it is difficult for individuals to assess the accuracy and objectivity of information available and whether or not it can be trusted.

The Canadian Health Network, a collaborative effort by the federal government and some health organizations across Canada, is considered by many to be among the best in the world. It provides in-depth health promotion and disease prevention information to Canadians on 26 key health topics, including mental health and substance use/addiction.

There are also provincial websites devoted to mental illness and addiction; an example is www.heretohelp.bc.ca, a website developed by a group of seven provincial non-profit agencies dealing with mental health and addiction in British Columbia and funded by the provincial government.

[58] First Report, Chapter 8, Section 8.2.3.

In its April 2002 report, the Committee recommended the creation of a national portal for the Canadian public that would provide comprehensive, trusted health-related information to support self-care decision-making. We stressed that the portal should build on the success of the Canadian Health Network and be linked strategically to provincial and territorial website services to ensure the consistency of health-related information. We also indicated that the national portal should allow better access by specific populations that currently have only restricted access to health-related information of assured high quality (e.g. Aboriginal Canadians, rural and remote communities, etc.).[59]

In its April 2002 report, the Committee recommended the creation of a national portal for the Canadian public that would provide comprehensive, trusted health-related information to support self-care decision-making. We stressed that the portal should build on the success of the Canadian Health Network and be linked strategically to provincial and territorial website services to ensure the consistency of health-related information.

Is the Canadian Health Network well positioned to become a universally trusted website in the field of mental health, mental illness and addiction? How could the Network build on successful provincial information websites and, at the same time, avoid resource-wasting duplication?

Is the Canadian Health Network well positioned to become a universally trusted website in the field of mental health, mental illness and addiction? How could the Network build on successful provincial information websites and, at the same time, avoid resource-wasting duplication?

6.5 PRIVACY

In its final report on health care (October 2002), the Committee discussed the need to protect the privacy of electronic health records and their use in research.

With respect to EHRs, we noted the significant variation in privacy laws and data access policies across the country. To address this concern, the Committee recommended ongoing federal/provincial/territorial efforts to develop a harmonized approach to protecting personal health information.

We also raised the issue of the large number of players involved in the collection of personal health information which would be included in a common EHR. We recommended that state-of-the-art security safeguards be implemented to protect personal health information and that the various custodians accessing EHRs be accountable for the use of those records.[60]

With respect to research, the Committee acknowledged the need to permit restricted access to personal health information for health research purposes while preserving the confidentiality of such information. We recommended that the federal government initiate a public awareness program to foster a better understanding of the benefit of using personal

[59] Principles and Recommendations for Reform, April 2002, Chapter 4, Section 4.7.
[60] Recommendations for Reform, October 2002, Chapter 10.

health information for health research purposes. We also recommended that the federal government, together with CIHR and other relevant stakeholders, examine the control and review mechanisms needed to ensure the adequate protection of personal health information.[61]

In the first report, the Committee noted that some people argue that considerations of privacy are perhaps of greater concern in mental health, mental illness and addiction than they are in the physical health care system. The testimony we heard compels us to ask if Canada's current legal and policy frameworks on privacy and confidentiality, which are acknowledged to serve the mentally competent well on the whole, nevertheless 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 a series of providers along the whole continuum of care.[62]

The testimony we heard compels us to ask if Canada's current legal and policy frameworks on privacy and confidentiality, which are acknowledged to serve the mentally competent well on the whole, nevertheless 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 a series of providers along the whole continuum of care.

In the context of an EHR system, the Committee is well aware that any erosion of privacy and confidentiality protections can have serious negative consequences on an affected individual's trust in his or her mental health providers. Witnesses have told us, however, that rigid adherence to privacy and confidentiality rules in certain circumstances works against the interests of individuals whose mental health is compromised. This particular challenge must be recognized when developing, interpreting and applying rules of privacy and confidentiality so as not to prevent health care providers from providing patients/clients with the much needed support they require.[63]

The Committee wants to obtain the views of Canadians on whether more safeguards are required under a system of EHRs for protecting mental illness and addiction information or whether more flexibility is needed to allow for the flow of information to provide better mental health care and greater continuity of care. In addition, we need to know whether amendments to existing provincial legislation are required to permit the sharing of patient information among providers.

Concerns relating to the strict observation of current privacy and confidentiality rules extend also 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 at times, a physician cannot currently share personal information with the involved caregivers, parents, siblings or children.[64]

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[61] *Recommendations for Reform*, October 2002, Chapter 12.
[62] First Report, Chapter 11, Section 11.3.
[63] First Report, Chapter 11, Section 11.7.
[64] First Report, Chapter 11, Section 11.3.

Are there mental health systems that have better, clearer procedures and consent forms for releasing information to families? What changes are required in Canada to facilitate the sharing of information about a patient's/client's condition with his or her family? Should there be greater consistency and standardization of information sharing practices in Canada with respect to patients with mental illness and addiction?

What changes are required in Canada to facilitate the sharing of information about a patient's/client's condition with his or her family? Should there be greater consistency and standardization of information sharing practices in Canada with respect to patients with mental illness and addiction?

CHAPTER 7:
THE ROLE OF THE FEDERAL GOVERNMENT

The federal government has both a direct and an indirect role in the field of mental health, mental illness and addiction. Its direct role stems from its constitutional responsibility for First Nations living on reserves and the Inuit populations, inmates of federal penitentiaries, veterans and serving members of the Canadian forces, the RCMP, and certain landed immigrants and refugee claimants. Through its direct role, the federal government is also a major employer with management of a large workforce with particular health-related concerns. Its indirect role derives from its broad responsibility to oversee the national interest of all Canadians and encompasses: funding transfers to provinces/territories, data collection, funding research, drug approval process, income support and disability pension benefits, social programming such as housing initiatives, criminal justice, and ongoing work to promote overall population health and well-being. Therefore, the range of federal programs and services relevant to mental health, mental illness and addiction is large.[65]

7.1 DIRECT ROLE

In its first report, the Committee noted that the federal approach to mental health, mental illness and addiction for the specific population groups who fall under its responsibility is highly fragmented: services and supports are provided by different departments, or various departmental directorates or divisions, all without much collaboration. We also commented on the lack of collaboration between federal and provincial governments with respect to programs targeted at First Nations, Inuit people and federal inmates. In addition, we noted gaps in services in many of the programs reviewed.[66]

The federal approach to mental health, mental illness and addiction for the specific population groups who fall under its responsibility is highly fragmented.

Overall, we concluded that there is little evidence to suggest that the federal government is following specific population-targeted strategies for the groups for which it has direct responsibility, let alone a broad all-encompassing strategy for all Canadians. There is no evidence of any effort to develop an overall coordinated federal framework or to elicit the collaboration of all involved departments or agencies. Neither is there apparent any initiative to develop a comprehensive population specific strategy to address the mental health needs of any of the groups under federal responsibility.[67]

There is no evidence of any effort to develop an overall coordinated federal framework or to elicit the collaboration of all involved departments or agencies.

What can be done to coordinate and better integrate the federal approach to mental illness and addiction for Canadians falling under its responsibility? For example, should Health

[65] First Report, Chapter 9, Section 9.1.
[66] First Report, Chapter 9, Section 9.2.
[67] First Report, Chapter 9, Section 9.3.

Canada work in partnership with the Department of Indian and Northern Affairs, Human Resources Development and other relevant departments to improve the effectiveness and efficiency of the delivery of mental health services and addiction treatment to First Nations and Inuit communities? How can such inter-ministerial collaboration be fostered? Or should a single department be responsible for the delivery of mental health/addiction services? Or should responsibility be transferred to the provinces with the federal government paying the cost of the services provided?

What can be done to coordinate and better integrate the federal approach to mental illness and addiction for Canadians falling under its responsibility?

Similarly, how can the access to, and quality of, needed services and supports be improved for inmates of federal penitentiaries? What can the federal government do to enhance Correctional Service Canada's response capacity for those in need of mental health services and addiction treatment?

How can inter-jurisdictional collaboration be enhanced in the delivery of mental health services and addiction treatment for First Nations and Inuit people and federal inmates? For example, with respect to the inmates of federal penitentiaries, what relevant federal and provincial policies and programs should be harmonized (e.g.: Criminal Code and provincial mental health legislation)?

Veterans, members of the Canadian Forces and RCMP are excluded from the definition of "insured persons" under the *Canada Health Act*. Health care, mental health services, suicide prevention and addiction treatment are the responsibility of Veterans Affairs Canada, the Department of National Defence and Health Canada. How should the programs and activities of these departments be better coordinated?

7.2 INDIRECT ROLE

In addition to its direct role, the federal government has an indirect role in the field of mental health, mental illness and addiction with broad responsibility to oversee the national interest of Canadians. The Committee was told that traditionally the federal government has made use of its constitutional spending power to influence broad national initiatives in the area of health and social policy. As a matter of fact, that spending power forms the basis for the *Canada Health Act*, the Canada Health Transfer and the Canada Social Transfer.[68]

A major issue raised during the Committee's hearings with respect to the indirect federal role relates to the apparent ambivalence over the last 55 years about the place of mental health services in the publicly funded health care system.[69] Today, the *Canada Health Act* expressly excludes from its definition of comprehensiveness services provided by psychiatric institutions. Many mental health services provided in the community by non-

A major issue raised during the Committee's hearings with respect to the indirect federal role relates to the apparent ambivalence over the last 55 years about the place of mental health services in the publicly funded health care system.

[68] First Report, Chapter 9, Section 9.4.
[69] First Report, Chapter 9, Section 9.4.2.

physician providers are not covered under the *Act*; this is true for the counselling services provided by psychologists, for example.[70]

Currently, no specific amount of federal transfers is dedicated to mental health care and addiction treatment. While the Canada Health Transfer includes funding for acute community mental health care, no portion of the transfer is expressly designed for this purpose.[71]

How can the federal government correct what is described as its "ambivalent approach" taken over the years about the place of mental health in its broad national policies and programs? Is it appropriate at this point in time to re-open the *Canada Health Act* to include under its publicly insured services those provided by psychiatric institutions and by psychologists? Should the federal government devote a specific portion of its transfer payments to mental illness and addiction? Would this require passage of a "Canada Mental Health Act"? Should the Prime Minister appoint a Minister of State for mental health, mental illness and addiction?

How can the federal government correct what is described as its "ambivalent approach" taken over the years about the place of mental health in its broad national policies and programs?

Or, should the federal government provide funding for the support of mental health, mental illness and addiction under a new funding mechanism? Should conditions be attached to any federal transfers to the provinces/territories for the purpose of mental illness and addiction and, if so, what should they be? If the federal government is to develop a set of incentives to ensure that individuals with mental illness and addiction get universal and equitable access to needed services and supports, what should they be and how best could this objective be achieved?

If the federal government is to develop a set of incentives to ensure that individuals with mental illness and addiction get universal and equitable access to needed services and supports, what should they be and how best could this objective be achieved?

Access to prescription drugs and home care is also an issue identified during the Committee's hearings. What role can the federal government play to ensure that individuals with mental illness and addiction have access to the drug therapy they need? Will the catastrophic prescription drug plan envisioned by the Committee[72], and included in the First Ministers' *10-Year Plan to Strengthen Health Care* (September 2004), ensure that individuals with mental illness and addiction get the prescription drugs

Access to prescription drugs and home care is also an issue identified during the Committee's hearings. Will the catastrophic prescription drug plan envisioned by the Committee[1], and included in the First Ministers' *10-Year Plan to Strengthen Health Care* (September 2004), ensure that individuals with mental illness and addiction get the prescription drugs they need?

[70] First Report, Chapter 9, Section 9.5.1.
[71] First Report, Chapter 9, Section 9.5.2.
[72] *Recommendations for Reform*, October 2002, Chapter 7.

they need? Do affected individuals have specific concerns with respect to such a plan?

Similarly, what form of home care program (short-term acute care, needs assessment, or long-term care in the home) is needed in the field of mental illness and addiction? Is the September 2004 First Ministers' agreement, which provides first dollar coverage for some home care services, particularly short-term acute community mental health home care for two-weeks and for the provision of case management and crisis response services, sufficient or is a more comprehensive program needed?

What form of home care program (short-term acute care, needs assessment, or long-term care in the home) is needed in the field of mental illness and addiction?

7.3 INTERGOVERNMENTAL COLLABORATION

While traditionally the federal government has used its fiscal capacity to influence health and social policies at the national level, some have claimed that this is not sufficient. Witnesses told the Committee that a high degree of intergovernmental consultation and collaboration is essential to achieve uniformity, to develop and maintain standards, bring harmonization and establish a national mental health initiative across the country. The provinces and territories have major responsibility for the delivery of services for mental illness and addiction in their particular jurisdictions. Any consideration of a federal role in mental health, mental illness and addiction, however, cannot displace or reduce the primary provincial/territorial responsibility for the design and delivery of programs for individuals with mental illness and addiction. Therefore, to restructure and reform the mental health/addiction system, a great deal of effort must be devoted to intergovernmental consultation, partnerships and collaboration.

A high degree of intergovernmental consultation and collaboration is essential to achieve uniformity, to develop and maintain standards, bring harmonization and establish a national mental health initiative across the country.

To restructure and reform the mental health/addiction system, a great deal of effort must be devoted to intergovernmental consultation, partnerships and collaboration.

Currently, however, few resources are devoted to the intergovernmental work in this area. 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 cooperation among federal, provincial and territorial governments on mental health issues. In the late 1990s, however, the Council of Deputy Ministers of Health withdrew its support for the F/P/T Advisory Network on Mental Health. As a result, there is now insufficient funding available even to bring together mental health policy makers from across the country to share information and develop coherent policies and plans. A

Currently, there is not enough funding available to bring together mental health policy makers from across the country to share information and develop coherent policies and plans.

number of provinces still continue to participate in the F/P/T Advisory Network, but their work is limited by the small amount of funding they provide.[73]

What could the federal government do to encourage intergovernmental coordination, collaboration and partnerships in the field of mental health, mental illness and addiction?

What could the federal government do to encourage intergovernmental coordination, collaboration and partnerships in the field of mental health, mental illness and addiction? Should the F/P/T Advisory Network be re-established with a broader mandate to encompass both mental health and addiction? Or should another entity, either a new body (such as the Mental Health Commission in New Zealand[74], the National Institute of Mental Health in England[75] or the former Mental Health Commission in New Brunswick) or an existing one (like the Canadian Public Health Agency) take over such a mandate?

What could the federal government do to assist the provinces and territories in their efforts to reform and renew their mental health and addiction systems?

What could the federal government do to assist the provinces and territories in their efforts to reform and renew their mental health and addiction systems? Is there a province, region or country whose mental health delivery system and addiction treatment system can be used as a model? Would the position of a Minister of State responsible for mental health and addiction, as in British Columbia, be helpful in other jurisdictions, including the federal government?

7.4 NATIONAL ACTION PLAN

Canada needs to develop a comprehensive national action plan on mental health, mental illness and addiction to ensure successful reform and restructuring. Canada lacks national leadership in mental health, mental illness and addiction, a serious deficiency that, in the view of many, has left a very large void.

The Committee was told that, in addition to intergovernmental collaboration, Canada needs to develop a comprehensive national action plan on mental health, mental illness and addiction to ensure successful reform and restructuring. Australia, New Zealand and the United Kingdom have already adopted such a national mental health strategy or action plan. Canada lacks national leadership in mental health, mental illness and addiction, a serious deficiency that, in the view of many, has left a very large void: there is no focus on mental illness and addiction within national and provincial/territorial health care reform initiatives; there is no clear delineation of the roles and responsibilities of the various stakeholders; troublesome inequities are the result of different provinces and territories being at various stages in the reform of their mental health care and addiction treatment systems.

Many recommended to the Committee a strong leadership role for the federal government in the development of a national action plan. They believe that the lack of such leadership

[73] First Report, Chapter 9, Section 9.4.
[74] Second Report, Chapter 2, Section 2.1.1.
[75] Second Report, Chapter 3, Section 3.1.1.

has contributed to the piecemeal approach to addressing mental illness and addiction, has led to the development of potentially conflicting models in different provinces, and resulted in unnecessary duplication and a waste of resources.

Many recommended a strong leadership role for the federal government in the development of a national action plan.

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 apply to services provided throughout every affected individual's lifespan. It must provide a stronger focus on children and adolescents, Aboriginal peoples, senior Canadians, federal inmates, women and landed immigrants.

Many stressed that a national action plan for mental health, mental illness and addiction can only be developed out of the collaboration among the federal government, provincial and territorial jurisdictions, NGOs and other stakeholders, together with individuals with mental illness/addiction.

Many stressed that a national action plan for mental health, mental illness and addiction can only be developed out of the collaboration among the federal government, provincial and territorial jurisdictions, NGOs and other stakeholders, together with individuals with mental illness/addiction.

In September 2000, the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), an organization representing some 20 NGOs, released a discussion paper calling for the development of a national action plan that would lead to a fundamental shift in how Canada deals with mental health, mental illness and addiction. This discussion paper was intended to be the first step toward the development of consensus for a national action plan on mental health, mental illness and addiction. It was seen as a tool to facilitate discussion, stimulate ideas and build a strong national coalition to promote its implementation by all levels of government. It was not intended to be a policy discussion document nor a guide to systemic reform. What has been achieved at the federal, provincial and local levels since the release of CAMIMH's call for action? Have any of the goals or the vision put forward by CAMIMH been adopted in any regions of the country? Should the NGOs represented by CAMIMH go a step further and develop a more concrete proposal for restructuring the mental health/addiction system?

More generally, what are the current obstacles to the development of a national action plan on mental health, mental illness and addiction? How should such a plan be developed and implemented? Should it be by an incremental approach or through the simultaneous reform of several large scale systems? Should Canada have a single, national, action plan? Or, should each province/territory have its own action plan but with a common vision?

Should the national action plan be developed by an incremental approach or through the simultaneous reform of several large scale systems? Should Canada have a single, national, action plan? Or, should each province/ territory have its own action plan but with a common vision?

In addition to articulating a common, clear vision, should governments develop detailed goals, objectives and standards for mental health, mental illness and addiction? Would this

help to properly assess patient/client outcomes and in reporting on the system's performance?

What elements should be included in a national action plan?

What elements should be included in a national action plan: public and professional awareness and education; mental illness and suicide prevention, dissemination of information and/or guidelines on best practices, human resource planning (including training and education), research funding, incentives to encourage systemic integration and collaboration? What should the priorities be?

How can we ensure that individuals affected by mental illness and addiction and their families participate fully in the development of a national action plan?

How can we ensure that individuals affected by mental illness and addiction and their families participate fully in the development of a national action plan?

CHAPTER 8:
FINANCING REFORM AND FOSTERING PERFORMANCE AND ACCOUNTABILITY

Concerns have been expressed about the total amount of funding available for mental health services supports and addiction treatment. Another issue relates to the need for a financing approach that distributes funding for mental health services and addiction treatment equitably across Canada.

The Committee heard that successful restructuring of the mental health/addiction system depends not only on ensuring that there are sufficient resources to provide the necessary services and supports. It also depends on the establishment of effective performance monitoring and evaluation tools and structures an information management infrastructure, and a funding framework which would allocate funds equitably.

8.1 LEVEL OF FUNDING

Funding for mental health services and addiction treatment is the subject of intense debate in Canada, as it is in many other countries. Provincial reports document the historical under-funding of mental health services and addiction treatment. Many believe that those with severe and persistent mental disorders have been badly served by insufficient funding. Those who have suffered particularly negative impacts have been individuals from different ethnocultural communities, individuals who are homeless, and those with concurrent disorders.[76]

Many witnesses told the Committee that the proportion of overall government health care spending devoted to mental health services and addiction treatment in Canada is very low in relation to the prevalence and economic burden of mental illnesses and substance use disorders and in comparison with physical illnesses. Others claimed that not enough public funding has been allocated to ensure a successful shift from institutional care to more community-based services and supports.[77]

Many witnesses told the Committee that the proportion of overall government health care spending devoted to mental health services and addiction treatment in Canada is very low in relation to the prevalence and economic burden of mental illnesses and substance use disorders and in comparison with physical illnesses.

Unfortunately, there is no simple answer to the question: "What is the right amount to spend on mental health, mental illness and addiction?" There is currently no comprehensive information on current levels of spending on mental health services and addiction. But the

There is no simple answer to the question: "What is the right amount to spend on mental health, mental illness and addiction?

[76] First Report, Section 8.2.1.
[77] First Report, Chapter 7.

Committee heard repeatedly that there are serious gaps in services and in meeting the needs and improving outcomes for individuals with mental illness and addiction. Additional resources are likely to be required over time. To answer the question "what is the right amount to spend", there must first be a thorough review of how current resources are used to meet the mental health needs of Canadians and the development of a plan on the most effective ways to best use existing resources.

The question of best use raises many issues. For example, can sufficient changes to the mental health/addiction system be made so that the resulting efficiencies will generate enough money to pay for needed mental health services and addiction treatment? Is more public funding needed? If so, how much? If more funding for mental health services and addiction treatment is needed, how should it be obtained – from a reallocation of existing resources or from increased taxation?

What, if any, should be the relationship between the funding for mental illness and addiction and the prevalence and economic burden of these illnesses? What should be the level and form of the federal government's contribution to mental health services and addiction treatment? Should it be within current transfer payment mechanisms (under the CHT and CST) or should it be provided as part of a new, different funding envelope?

What, if any, should be the relationship between the funding for mental illness and addiction and the prevalence and economic burden of these illnesses?

The Committee noted with interest that the government of New Zealand has developed very detailed national targets to build capacity in the field of mental illness and addiction (such as the number of inpatient beds, community mental health workers, detoxification beds, methadone treatment places, etc.) and to calculate national funding levels and service development requirements.[78] Should Canada develop resource targets as New Zealand has done? If so, should these targets then form the basis for federal and provincial/territorial mental illness/addiction budgets? If not, how should budgets be set in this sector and by whom?

Currently, the mental health and addiction system relies on multiple sources of funding. Like its several services and supports, funding is fragmented across many different programs. Should public funding continue to reflect the fact that numerous departments are involved in mental health, mental illness and addiction? Or, should governments establish an inter-ministerial funding pool, or initiate inter-ministerial projects and initiatives with shared program costs and benefits?

Should governments establish an inter-ministerial funding pool, or initiate inter-ministerial projects and initiatives with shared program costs and benefits?

The Committee also feels that questions need to be raised about whether funding needs to emphasize the treatment of signs and symptoms of mental disorders, or the remediation of root causes. Similarly, it is crucial to determine what to fund and, perhaps even more importantly, what to stop funding.

[78] Second Report, Chapter 2, Section 2.1.1.

8.2 DEDICATED FUNDING

Many witnesses have advocated the need for a separate, protected funding envelope for mental health, mental illness and addiction. They cited Australia's experience with increased transfer payments to the states/territories earmarked for the purpose of mental health reform; In Australia, intergovernmental agreements were signed committing the states/territories to protect or maintain their level of funding. In other words, transfer payments were clearly additional or incremental to existing funding.[79] Should a comparable "ring fencing" approach to mental health funding be established in Canada? Or, should funding for mental health, mental illness and addiction be provided in a separate funding envelope? Would dedicated funds better ensure that funding for mental health, mental illness and addiction is predictable, sustainable and equitably allocated?

Should a "ring fencing" approach to mental health/addiction funding be established in Canada?

What would be the drawbacks of dedicated funding for mental health, mental illness and addiction? For example, is there a risk that funding would be directed primarily to treatment and care and away from broader social supports?

8.3 PERFORMANCE AND ACCOUNTABILITY

Numerous provincial reports and witnesses have pointed out to the Committee that there is a significant lack of accountability mechanisms in the current mental health/addiction system. The respective roles and responsibilities of the various levels of government and the multiple service providers are not clearly set out. A performance evaluation system is needed to monitor the quality and effectiveness of the services provided and the productivity of the overall system.[80]

There is a significant lack of accountability mechanisms in the current mental health/addiction system. The respective roles and responsibilities of the various levels of government and the multiple service providers are not clearly set out.

In its October 2002 report on health care, the Committee recommended the establishment of a National Health Care Council to improve accountability in the health care system and to measure and report on system performance (cost-effectiveness, efficiency, quality and patient outcomes).[81] We also recommended that both levels of government share accountability for the use of public health care funds.[82]

How can Canadians become well informed on the progress being made by governments in reforming the mental health/addiction system? In implemen-

How can Canadians become well informed on the progress being made by governments in reforming the mental health/addiction system?

[79] Second Report, Chapter 1, Section 1.2.
[80] First Report, Chapter 8, Section 8.2.1.
[81] *Recommendations for Reform*, October 2002, Chapter 1, pp. 5-21.
[82] *Recommendations for Reform*, October 2002, Chapter 14, pp. 255-264.

ting provincial and national plans? In reducing stigma and discrimination? In meeting human resource needs?

Should quality assurance programs be put in place? How should quality be defined and, equally importantly, how should it be measured? What is the process by which a quality assurance program should be developed?

Should quality assurance programs be put in place? How should quality be defined and, equally importantly, how should it be measured?

Accountability and performance indicators are as important in the field of mental illness and addiction as they are in health care everywhere. In 2000, the F/P/T Advisory Network on Mental Health released a document containing a resource kit of performance indicators to facilitate ongoing accountability and evaluation of mental health services and supports. This very detailed resource kit, which was prepared for the provinces and territories, provides indicators for tracking performance at the system, program and client level. Have these indicators of accountability and performance been utilized by any jurisdictions? Should the federal government encourage the use of these indicators? If so, how?

Have the indicators of accountability and performance developed in 2000 by the F/P/T Advisory Network on Mental Health been utilized by any jurisdictions? Should the federal government encourage the use of these indicators?

Is the National Health Care Council envisioned by the Committee, and subsequently established as the National Health Council, the appropriate structure to assess, and report on, the performance of the mental health/addiction system and to improve accountability? Or, given that the mental health/addiction system requires services from a much broader range of programs and sectors than the health care system, should another entity – such as the Canadian Public Health Agency or a new federal-provincial-territorial organization – take on this responsibility?

Is the National Health Council, the appropriate structure to assess, and report on, the performance of the mental health/addiction system and to improve accountability?

CONCLUSION

The Committee recognizes that the set of issues, questions and options presented in this report, while extensive, is far from being exhaustive. Some readers of this paper may want to add to the issues list and others will feel that our set of options in not complete and will want to add new options of their own. We will welcome these additions to our work. We believe strongly that the input of Canadians will help to inform the public policy debate on the broad range of issues related to mental health, mental illness and addiction.

We acknowledge that the real experts in the field of mental illness and addiction are those individuals confronted with these disorders and their families/caregivers. We understand that, because stigma is so strong, you may hesitate to speak openly about your concerns and suggestions for reform. But we need your input! We have developed a short set of questions which are available on the Committee's website. We would like you to respond to them either directly through the internet or by regular post as the questionnaire is available in printed format.

The Committee needs the input of individuals confronted with mental illness and addiction and their families.

In addition to individuals with mental illness and addiction, their families and caregivers, we strongly invite mental health and addiction professionals, other providers of health services, representatives from nongovernmental organizations, and officials from federal and provincial/territorial governments and departments, and members of the general public to take the time to review the Issues and Options paper and its two companion reports and write to the Committee with their views on which options for reform they prefer, and why. We very much look forward to receiving the guidance of all Canadians as we prepare our final report and our set of recommendations. Please write to:

The Standing Senate Committee on Social Affairs, Science and Technology

The Senate

Ottawa, Ontario

K1A 0A4

soc-aff-soc@sen.parl.gc.ca

fax: (613) 990-6666

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 Medecine	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
THE 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, Panning, 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 (*by videoconference)*	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

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 (*by videoconference)*	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 (*by videoconference)*	Michael Hogan, Chair	April 1, 2004	5
United Kingdom, Government of (*by videoconference)*	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 Reseach 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 Medecine	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 Eduction
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, Psychiatris-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
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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)