

CANADIAN ALLIANCE  
ON MENTAL ILLNESS  
AND MENTAL HEALTH



ALLIANCE CANADIENNE  
POUR LA MALADIE MENTALE  
ET LA SANTÉ MENTALE

# FRAMEWORK FOR ACTION ON MENTAL ILLNESS AND MENTAL HEALTH

**Recommendations to  
Health and Social Policy Leaders of Canada  
for a National Action Plan  
on Mental Illness and Mental Health**

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FEBRUARY 2006

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CAMIMH's membership is made up of national NGOs whose mandates encompass mental illness and mental health issues. Members currently include: Autism Society Canada - Canadian Association for Suicide Prevention - Canadian Association of Occupational Therapists - Canadian Association of Social Workers - Canadian Coalition for Seniors Mental Health - Canadian Healthcare Association - Canadian Medical Association - Canadian Mental Health Association - Canadian National Committee for Police/Mental Health Liaison - Canadian Psychiatric Association - Canadian Psychiatric Research Foundation - Canadian Psychological Association - Mood Disorders Society of Canada - National Network for Mental Health - Native Mental Health Association of Canada - Psychosocial Rehabilitation Canada - Registered Psychiatric Nurses of Canada - Schizophrenia Society of Canada.

# What is CAMIMH?

Founded in 1998, the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) is the largest coalition in Canada focused on mental illness, mental health, and addictions.

CAMIMH's membership comprises the major national organizations whose activities span the broad continuum of mental health. They represent consumers and their families, health care and social service providers, professional associations, and community and research organizations. Together, they constitute a vibrant network of national, provincial, and community-based organizations dedicated to serving the mental health needs of the people of Canada from coast to coast.

## CAMIMH's Mission

CAMIMH's mission is to promote and facilitate the development, adoption, and implementation of a national action plan on mental illness and mental health.<sup>a</sup>

To that end, CAMIMH advocates for increased access and improved quality of services and supports for persons facing mental illness or mental health obstacles, as well as for an increased focus on best practice mental health promotion strategies.

CAMIMH adopts a population health perspective, which includes the full continuum of health determinants that have a demonstrated positive impact on mental health and well being. Mental illness care and recovery, as well as efforts to prevent mental illness and promote mental health, are all part of the continuum of mental health and mental illness. It is CAMIMH's view that these activities should be delivered in the community and that consumers must be educated about their importance to daily life.

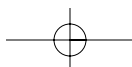
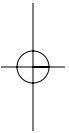
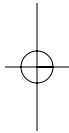
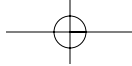
CAMIMH maintains:

- That the health system must be able to provide access to all people in Canada for their physical and mental health needs.
- That mental health promotion, along with treatment of mental illnesses, disorders, and addictions, as well as their follow up and prevention, are the responsibility of *all* governments.
- That mental health programs and services must be based on best practices.
- That consumers of mental health services and their families must play an active role in the development and delivery of programs and services.
- That the social determinants of health are essential for mental health.
- That there is no health without mental health.
- That the cultural determinants of health are vital for First Nations, Inuit, and Métis peoples.
- That mental health affects individuals across the age span.

CAMIMH members are a source of expertise on policies, programs, and strategies for system reform. They take advantage of all opportunities to champion improved access and quality of services, foster awareness through education, and advance knowledge through research and knowledge translation.

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<sup>a</sup>NOTE: In general, CAMIMH uses the generic term *mental health* to encompass the continuum of positive mental health, mental illness, disorders, conditions, and addictions; and the term *“mental health conditions”* or *“mental illness”* to encompass the spectrum of diagnosable mental illnesses, disorders, conditions, and addictions.



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# Framework for Action on Mental Illness and Mental Health

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# SUMMARY

Canada is the only advanced industrial country that does not have a national strategy or plan on mental health. As a result, people in Canada suffer unnecessary disability and mortality from mental illness, addictions, and poor mental health, and system costs continue to rise. One in five people in Canada experience mental illness and are dependent on support from their families, communities, the economy, and a stretched social service system. This paper explains why a national mental health strategy is urgently needed.

Canadian jurisdictions have undertaken measures to improve mental health service quality and access, as well as mental health promotion. However, these measures have typically been piecemeal, underfunded or unaligned. Only a coordinated inter-jurisdictional approach among governments can overcome the obstacles that stand in the way of getting mental health reform right in Canada.

In September 2004, the federal, provincial, and territorial governments committed themselves to a 10-Year Action Plan on health care based on a national vision of improved access and quality of services. This action plan, unfortunately, overlooked commitments to comprehensively improve mental health treatment, follow-up services, prevention strategies, and to address mental health promotion. Without a concerted commitment in this area, the human and financial costs of mental illness and poor mental health will only increase, and our health care system will continue to falter.

Governments in Canada need to act quickly to respond to the mounting prevalence of mental health conditions, their rising costs to our economy, and the serious incapacities of our health and social service systems to respond to changing needs.

Governments must also begin to face the especially difficult and long-ignored mental health challenges experienced in Canada's First Nations, Métis and Inuit communities. Developing solutions must include the full involvement of First Nations, Métis and Inuit leaders, and the communities themselves.

Canada's situation regarding a national mental health strategy can be compared to that of the United Kingdom, Australia and New Zealand. Each country has adopted national mental health action plans in recent years, and in each country, the successful evolution of a national plan was predicated on the active involvement of a federal government. Each country's plan emphasizes mental health promotion, increased research, appropriate indicators or targets, and robust surveillance systems. Consumers of mental health services have played an instrumental role in the design and delivery of these countries' mental health strategies.

It is proposed that a *Framework for Action on Mental Illness and Mental Health* should focus on four priorities:

- **Leadership:** Federal, provincial, and territorial governments must demonstrate co-operative leadership to improve access and quality of mental health services and programs.
- **Information:** Canada must build a national data collection and reporting system.
- **Research:** Governments must strategically invest in new research.
- **Promotion:** Effective mental health promotion initiatives must be undertaken.

The overriding goals of these actions should be to prevent disability, alleviate suffering from mental illness, and facilitate improved quality of life, thus improving the mental health status of people in Canada.

**CAMIMH's Framework for Action calls on Canada's health and social policy ministers to act by setting in motion a national action plan on mental health and mental illness.** It urges all jurisdictions to increase mental health resources and to work with stakeholders to change policies ensuring better access to quality services for those who need them and programs that result in improved mental health of the population. The Framework for Action urges the federal government to lead by example by demonstrating its resolve to bring all parties together in a national dialogue and by taking steps to improve policy capacity and service delivery in areas of its direct responsibility.

# WHY IS THERE CAUSE FOR CONCERN?

## 1. Prevalence of Mental Health Conditions and Their Impact on Society

Mental health touches all segments of the population in Canada. About 20 percent of Canadians will experience a mental illness at some point in their life.<sup>1</sup> Often called the invisible disease, many mental health conditions cause severe pain and suffering for individuals and their families. But beyond their private toll, the spectrum of mental health conditions has a profound impact on society.

- Some estimate that mental illnesses alone cost our health care system as much as \$7 billion a year, second only to cardiovascular disease.<sup>2</sup>
- Five out of 10 leading causes of disability are now related to mental disorders. Mental health conditions now contribute more to disability in Canada than any other single disease group, including cancer, diabetes, and cardiovascular disease, as is the case in other advanced market economies.<sup>3</sup>
- Aboriginal communities experience among the highest suicide rates in the world – related in great part to the despair experienced in Aboriginal communities resulting from historical social policies.
- Up to 10 percent of the cost of crime can be attributed to inadequate mental health care for children and youth.<sup>4</sup>
- Delirium occurs in up to 50 percent of older individuals admitted to acute care settings.<sup>5</sup>

Mental health conditions affect people of all ages, education and income levels, and cultures. Some groups may be more vulnerable such as the poor, women, the elderly, and indigenous populations.<sup>6</sup> Different segments of the population also experience the impact of mental illnesses and conditions differently. Rural and aboriginal populations and the poor have the most uneven access to services and supports. Children are less likely to receive the care they need.<sup>b</sup>

Mental health conditions cover a spectrum of onset, severity, and duration. They are influenced by a complex array of health determinants, including age, socio-economic status, genetics, community of origin, and cultural. Some illnesses, such as some forms of depression and anxiety, may be chronic and lifelong challenges for individuals. Many illnesses are effectively treated and do not significantly impair an individual's ability to work or live an equitable quality of life in the longer term. Some severely disabling disorders such as schizophrenia, which affects about 300,000 people in Canada, as well as personality disorder, bi-polar depression, the dementias, autism, and certain addictions, remain more challenging to treat biopsychosocially. Co-existing (co-morbid) disorders are common. Good early intervention in childhood or young adulthood onset disorders can make the difference between a mentally healthy adulthood or lifetime disability and dependence on others.

There is an increasing understanding about how physical illnesses intertwine with mental health. Mental illness and serious physical illness often co-occur and recovery from acute coronary syndromes, for example, can be lengthier if the co-existing mental health issues are not treated at the same time. It is estimated that 60 percent of depression goes undetected at the primary care level.<sup>7</sup> Not recognizing the significant link between physical and mental illness and disorders, increases health care costs for treating these conditions. In some cases, misdiagnosis also affects the outcome of the physical condition and misses opportunities for early and less costly intervention with mental health issues.

<sup>b</sup>Children's Mental Health Ontario says that the province has the capacity to serve 1 of every 3.8 children with a diagnosable disorder in 2004. That left an estimated 390,000 children without access to child mental health services in Ontario, while more than 1 out of 2 children in need likely had more than one disorder at the same time. They further estimated that the cost to serve one child through community mental health service is only \$2,250 per year in contrast to the \$120,000 per year it costs for each adolescent detained in youth detention.

Canada has no national system to identify population mental health needs and to measure how well needs are being met — even for populations under the sole jurisdiction of the federal government, such as First Nations and the military. Only one national survey has been undertaken to date<sup>8</sup> on a limited number of disorders and current provincial administrative data capture only mortality, hospital, and some physician services data.

Although we lack a clear picture of the mental health status of Canada's population, there are enough data to be alarmed about how many people are affected and how difficult it is for the majority of people in Canada to get the services and community supports they need to recover or live a decent quality of life.

### Consider these facts

- Untreated mental illness does kill: Each year, nearly 4,000 people in Canada will commit suicide – more than 40 times the number who died of AIDS in 2003.<sup>9</sup>
- Suicide is the second leading cause of death (after accidents) among 10- to 19-year-olds (24% of all deaths).<sup>10</sup>
- The average hospital stay per suicide attempt is 7.1 days.<sup>11</sup>
- Some 18 percent of children under 19 have a diagnosable disorder.<sup>12</sup>
- Each year, between 4 and 6 percent of people in Canada will experience at least one major depressive episode.<sup>13</sup>
- The incidence of depression in long-term care settings is 3-4 times higher than in the general population, and the estimated prevalence rate for all mental disorders among nursing home residents ranges between 65 and 91 percent.<sup>14</sup>
- The prevalence of schizophrenia in the general population is estimated to be one percent for all age groups.
- For countries such as Canada, the World Health Organization (WHO) estimates mental disorders comprise close to 25 percent of all diseases and injuries, with as much as 13 percent attributable to depression alone.<sup>15</sup>
- About 20.1 percent of Canada's population is now estimated to be in need of mental health services<sup>16</sup>, while the current prevalence rate of past year health service use for mental health was 9.5 percent across Canada.<sup>17</sup>
- Approximately 2 out of every 3 people with a diagnosable disorder in Canada do not seek or get care.<sup>18,19</sup>

We have learned from policies targeted at other diseases that significant investments in research, education, treatment advances, and health promotion inevitably lead to reduced incidence, earlier detection, and improved recovery and survival rates.

***Given the consensus on the high prevalence and widespread impact of mental disorders on Canadian society, it is time that policy-makers designate mental health as a priority disease target and allocate resources accordingly.***

## 2. Prevalence in the Workplace and Cost to Our Economy

The workplace serves as a bellwether for the prevalence of mental illness in society and is an important environment for promoting good mental health. Although the workplace itself may or may not directly cause mental illness, it is in the workplace environment that the symptoms of mental illness are often noticed and measured.

Employers can directly measure the impact of mental health problems through absenteeism, on-site productivity loss, and direct expense to benefit plans. Research in developed nations has shown that the prevalence

of mental illnesses in the workplace has increased steadily in recent years, with a significant impact on economic productivity and competitiveness. In Canada, mental illness is already a leading cause of workplace productivity loss and the largest contributor to the cost of employee benefits programs.<sup>20</sup>

### Consider these facts

- The WHO predicts that depression will be the leading cause of workplace disability by 2020.<sup>21,22</sup>
- Mental illness accounts for 46 percent of all long-term and short-term disability claims.<sup>23</sup>
- In 2001, workplace absenteeism due to mental health problems accounted for about 7.1 percent of the total payroll.<sup>24</sup>
- Seven percent of all Canadian workers report absentee days attributable to mental and emotional problems.<sup>25</sup>
- In Ontario, about 8 percent of the working population has a diagnosable mental disorder.<sup>26</sup>
- Canada's economy loses \$33 billion annually in direct and lost productivity costs caused by mental illness and addiction.<sup>27</sup>

While there are large barriers to the implementation of prevention strategies, Canadian employers are beginning to work together to find common solutions. Some of the most comprehensive data about mental illness in the workplace are held by employer benefits programs and their insurers. While competitive and privacy concerns sometimes restrict the sharing of this data among employers, some important initiatives have been undertaken recently. For example, CAMIMH, the Global Business and Economic Roundtable on Mental Health and Addictions, and other groups recently partnered with the Canadian Institutes of Health Research (CIHR) on a 10-year program of applied research on mental health in the workplace. The roundtable will work with employers to secure research funds and to offer their workplaces for on-site research.

Current research data may not tell the full story, but they do suggest serious cause for concern and underline why governments must recognize mental health as a greater health priority.

### 3. Systemic Problems

In his report, *Building on Values: The Future of Health Care in Canada*, Roy Romanow, former Chair of the Commission on the Future of Health care in Canada, called mental health “the orphan” of Canada’s health care system. The Senate Standing Committee on Social Affairs, Science and Technology has also thoroughly described how the health care system is doing a poor job of promoting positive mental health, as well as preventing, treating, and reducing the disability impact of mental illness. It has described the many ways in which the system fails to meet consumer, family, and community mental health needs.

Released in November 2004, the Committee’s three volume report, “*Mental Health, Mental Illness and Addiction Services in Canada*,” is the most comprehensive study of Canada’s mental health system since the Hall Commission.

The Committee’s work has been informed by extensive stakeholder consultations, including significant input from consumers of mental health services, who testified about their encounters with Canada’s mental health care delivery system – and its shortfalls. The Committee’s final report, to be released in early 2006, is expected to recommend systemic reforms – including the need for a national action plan involving all governments.

# THREE PRIORITIES FOR REFORM

CAMIMH has identified three broad conclusions that can be drawn from the Senate Standing Committee on Social Affairs, Science and Technology's findings to date.

## 1. Access

The current system of mental health services and community supports is fragmented, difficult to access by many, and very uneven. Quality and availability varies greatly between, and even within, jurisdictions. In many cases, the lack of services both inside and outside of hospitals may contravene the *Canada Health Act*.

Wait lists for mental health services are seldom maintained because the gap between need and supply is simply too large. The *2004 National Physician Survey*, conducted by the Canadian Medical Association, found that family physician access to psychiatrists for consumers was much more difficult than for any other category of specialized medicine. Sixty-five percent of family physicians reported serious difficulty in getting access to mental health specialists.<sup>28</sup> Access to non-physician mental health professionals within the public health care system is limited and often only available on a private fee-for-service basis.

In many cases, a significant absence of community supports such as low-cost supportive housing and reasonable income support are impediments to recovery from mental illness by consumers.

There are three critical priorities to address access issues. They include:

- improved access to specialized, primary care, and culturally appropriate services,
- improved availability of supportive social programs and policies, and
- improved integration and collaboration of service components.

These priorities must be undertaken within a population health framework and with consumer involvement.

## 2. Stigma and Discrimination

Stigma and discrimination remain major barriers to mental health.

People in Canada, including many health care practitioners, generally have a poor understanding of, and hold negative attitudes about, mental illness. As a result, stigma towards mental illness persists both at the societal and health practitioner level.

People without mental illness often discriminate against those who experience it. For many living with a mental illness, this discrimination constitutes a major impediment to their recovery.

People with mental illness also experience self-stigma and, as a result, often do not seek diagnosis or treatment. Delays in treatment unnecessarily prolong suffering.

The causes of negative attitudes towards mental illness are multiple and complex. Regardless of cause, stigma remains a barrier to achieving equity and maximizing the health of the population.

To address stigma and discrimination, long-term education and awareness programs targeted at vulnerable populations must be implemented. Mental health promotion initiatives aimed at the general public must also be developed. The more people know about the importance of positive mental health and the more they feel comfortable with mental illnesses as a disease category on par with physical health conditions, the more quickly stigma and discrimination will be reduced.

### **3. National Data Gathering**

The fragmentation of our delivery system has fostered a fragmented approach to the mental health data gathering. There is no coordinated system to identify population mental health, mental illness, mental disorders, behavioural health and addictions needs and to measure how well systems are meeting these needs.

As a result, we do not have a good picture of the prevalence and nature of mental illness in Canada nor the capacity to evaluate the effectiveness of policies, programs, and services. Without a clear picture, it is impossible to define targets and effectively address the issues contributing to morbidity, disability, and mortality of mental illness, mental disorders, addictions, and poor mental health. A comprehensive surveillance system must be a priority.

## STEPS TAKEN BY OTHER WESTERN NATIONS

Canada's experience with a mental health care service delivery system is not unique. But Canada is unique in its failure to develop a national action plan. Canada is the only Western industrialized country that does not have a national strategy on mental health.<sup>29</sup>

The Standing Senate Committee on Social Affairs, Science and Technology reviewed national strategies developed by several federations, including the United Kingdom, Australia, and New Zealand. The Committee found that an overarching common feature of each country's plan was the inclusion of clear policy benchmarks, strategies to achieve them, and measurement systems to monitor progress. The Committee observed that accountability features, an essential part of each country's plan, are fundamental to measuring progress and securing long-term funding commitments. For a plan to be acted upon, policy-makers must be able to articulate the estimated costs of both implementation and non-implementation.

In Canada, it has been commonplace for governments to avoid the funding debate altogether by ignoring stakeholders' demands for the development of targets. In some jurisdictions, a lack of unity within the sector has eroded the political impetus for government action.

By contrast, governments in other countries have recognized the social costs of ignoring the growing burden of mental illness and addictions. They have embraced their leadership responsibilities and have assumed a unifying role with stakeholders, working with them to develop agreements on targets and priority activities. For each of the three countries referenced below, the successful evolution of a national plan was predicated on the active involvement of the national government. Each plan emphasizes the need for mental health promotion programs, increased research and robust surveillance systems.

In all three countries, consumers of mental health services, their families, and a broad range of providers and community organizations were consulted widely in the development of reform initiatives.

### United Kingdom

In 1999, the United Kingdom launched the National Service Framework for Mental Health, a 10-year plan that sets standards in five key areas:

- Mental health promotion
- Mental health care within primary care
- The needs of the severely mentally ill
- Services and supports for caregivers to the mentally ill
- Suicide prevention

For each set of standards, related benchmarks complemented by strategies to achieve them have been set. To facilitate oversight and ensure effective implementation, the National Institute for Mental Health in England was established. A recently completed five-year review of the plan noted major improvements in the country's record of care and prevention, including a drop in the suicide rate to its lowest recorded levels.<sup>30</sup>

## Australia

Australia is recognized as a world leader for its innovations in mental health care reform. Australia's National Mental Health Strategy was initiated in 1992 and it commits all state, territorial, and Commonwealth governments to improve the lives of persons with mental illness.

The strategy has been implemented through a series of five-year plans. Each iteration is revised to ensure that implementation strategies are responsive to changes in Australia's socio-economic structure. The current plan for 2003-2008 has four priority themes:

- Promoting mental health and preventing mental problems and mental illness
- Increasing service responsiveness
- Strengthening quality
- Fostering research, innovation, and sustainability.

Central to Australia's success with mental health policy reform has been the development of longitudinal data for tracking expenditures and measuring progress. Regular National Mental Health Reports have been an integral part of the country's planning.

## New Zealand

New Zealand launched its mental health reform process in 1994. Since 1998, the *Blueprint for Mental Health Services* has provided the main framework for action. The primary objective of the Blueprint is to provide access to services for persons with severe mental illness – approximately three percent of the population.

To achieve the three percent objective, the Blueprint includes action plans developed around seven themes:

- Implementing community-based and comprehensive mental health services
- Encouraging Maori (Aboriginal) involvement in planning, developing, and delivering mental health services
- Improving the quality of care
- Balancing personal rights with protection of the public
- Developing a national alcohol and drug policy
- Developing the mental health services infrastructure
- Strengthening promotion and prevention.

An important feature of the Blueprint has been its base analysis of the number of hospital beds and practitioners required to properly service targeted populations. The recommended resources are regularly measured against the actual resources available in priority areas, and then strategies and funds are deployed to close specifically identified gaps.

***Canada has the opportunity to become a leader internationally in mental health reform***

Canada has the opportunity to learn from the experiences of other nations and to become a leader in mental health reform. The first step is for all governments to commit to work together to develop and implement a national action plan on mental illness and mental health for Canada. This must include respect for the unique circumstances of Canada's Aboriginal populations in much the same manner as the New Zealand plan respects the unique circumstances of its Maori population. To this end, governments should ensure that the Aboriginal political leadership is an equal partner in the development and implementation of the Aboriginal component of the plan.

All of the above countries have taken a focused national approach to the de-fragmentation of services and programs. They have recognized that collaboration and collective action are the only effective means of addressing the urgency of today's mental health issues.

# FRAMEWORK FOR ACTION ON MENTAL ILLNESS AND MENTAL HEALTH

CAMIMH believes that a made-in-Canada national action plan on mental illness and mental health should be implemented within a population health framework. This can be achieved through action in the following four areas:

- Cooperative government leadership to address systems issues, including access and quality;
- A national data collection and reporting system;
- Strategic new investments in research;
- Implementation of a coordinated mental health promotion strategy.

**The mental health of Canada's population is the responsibility of all levels of government and multiple ministries. Multi-jurisdictional and cross-departmental collaboration will be critical elements of success.**

The federal government must play a leadership role in this much-needed collaborative effort.

Canada's health ministers must work together through the Council of Health Ministers and in collaboration with Canada's social policy ministers to initiate and support widespread reforms.

**All jurisdictions must commit to a comprehensive mental health plan to appropriately address mental health issues within their responsibility.**

## 1. Government Leadership: Federal

**The federal government must support a national strategy by first demonstrating leadership within its own jurisdictional areas.**

The federal government must lead by example. It must improve its own capacity to develop mental health policy and deliver services in areas for which it has direct responsibility, such as First Nations and Inuit Branch of Health Canada, the Department of National Defense, and Corrections Canada. Also, as a major employer, it must demonstrate leadership through workplace mental health promotion programs, on-site research initiatives, and progressive return-to-work strategies.

The federal government must demonstrate its commitment by facilitating the union of all parties in dialogue — *and action*. It must act as a champion for consumers to ensure that their realities are the basis for policy and program reform, and that consumers have the ongoing capacity to inform reform.

The federal government must further commit the resources necessary for success.

At present, the federal government is limited in its capacity to contribute to a national collaborative reform initiative. Specific capacity shortfalls at the federal level include:

- Sparse human resources in the federal government dedicated to mental health policy development and program delivery.
- Inadequate coordination across federal departments of national programs and policies that do or could make a positive impact on population mental health (Disability, Health, Public Health, Income Security, Citizenship, Justice, etc).
- Lack of a mechanism to support inter-jurisdictional discussions and collaboration on change
- Inadequate coordination and resourcing of mental health and addiction services and programs delivered directly by the federal government (including First Nations and Inuit Health, National Defense, Veterans Affairs, Corrections Canada, Immigration).
- No separate agency or commission responsible for mental illness, mental health, and addictions; hence, accountability in this area is far too diffused.

### ***Recommended actions***

The federal government must learn from the best practices of its international peers and create a Mental Health Commission with appropriate leadership, staffing and funding. Its mandate must be consistent with the recommendations for such a Commission made by the Senate Standing Committee on Social Affairs Science and Technology in its 4th Mental Health Study Report.

The federal government must ensure it has an effective capacity to:

- Work with the Council of Ministers of Health on mental health initiatives.
- Support an interdepartmental mental health committee that comprises representatives from the federal programs with mental health responsibilities to coordinate their efforts, resources, and to share identified best practices with provinces and territories.
- Support the special ministerial advisor on workplace and mental health. Establish and monitor the impact of a permanent program to support workplace mental health research and workplace mental health education and awareness programs.
- Enhance support for the federal interdepartmental work just begun on workplace mental health in the public service.
- Fund, design, administer, and evaluate targeted education and awareness programs to reduce stigma with full involvement of consumers (see below).

- Facilitate the setting and monitoring of national mental health research goals and invest strategically in priority research and knowledge mobilization areas.
- Coordinate the development and implementation of a national data collection and reporting system. Work with provincial and territorial partners to secure agreement on key indicators and initiatives for collaborative data collection and reporting from public and private data sources.
- Ensure that mental health is a key component of Canada's public health goals.
- Ensure that mental health is a key component of Canada's disability support strategies.
- Ensure that mental health is considered in every relevant government policy initiative.
- Coordinate the design and implementation of a national mental health human resources strategy to support provincial and territorial delivery systems in collaboration with stakeholders, including the mental health professions and consumers.

In order to strengthen national capacity and to support a collaborative dialogue on a national mental health strategy, CAMMIMH recommends:

- That the Minister of Health enhance current initiatives.
- That the Minister of Health significantly increase the number of departmental staff dedicated specifically to the development of mental health policy and programs.
- That the Minister of Health seek support from the provinces and territories to upgrade the current Federal-Provincial-Territorial Advisory Network on Mental Health to become a full self-standing advisory committee to the Ministers of Health with a permanent funding mechanism and a secretariat.
- That the Minister of Health establish a Mental Health Transition Fund modeled after the Primary Health Care Transition Fund as the next phase for supporting health system reform.
- That the federal government increase the level of funding and departmental capacities in areas related to mental illness and mental health for the First Nations and Inuit Branch of Health Canada, the Department of National Defense, and Corrections Canada, as well as other federal departments whose mandates include the delivery of mental health services to populations directly under the jurisdiction of the federal government.

## 2. Government Leadership: Provinces and Territories

**A national action plan on mental illness and mental health must involve the Council of Health Ministers in collaboration with non governmental stakeholders.**

CAMIMH believes that the Council of Health Ministers must be directly involved in the development of a national strategy. Collaboration with stakeholders and the financial and administrative support of the federal government through the Health Minister are necessary prerequisites to achieving the objectives in each of CAMIMH's four areas for action (systems, data, research, and mental health promotion).

### ***Recommended actions***

- FPT Ministers of Health must make it a priority to improve mental health promotion, develop strategies that improve the capacity for preventive approaches, and ensure better access to treatment of mental illness along with follow-up support.
- FPT Ministers of Health, through the Council of Health Ministers but also in collaboration with their social policy counterparts, must initiate an inter-governmental dialogue about a national action plan and put in place a process to set national benchmarks and strategies to achieve them.
- The Council of Health Ministers must make Canada's shortfalls in mental health services and programs a permanent priority agenda item.

Some areas of specific action should include:

- strategies to address unacceptable wait times for mental health treatment services;
- strategies to improve availability of follow-up and supports necessary for recovery from mental illness;
- targets for the availability of early intervention, prevention programs, and health promotion initiatives across jurisdictions.

### 3. National Data Collection and Reporting System

**Governments must implement a surveillance system to identify population mental health and mental illness needs and to measure how well they are meeting these needs.**

Surveillance systems provide ongoing information to decision-makers on the prevalence of mental illness and addictions, the mental health status of people in Canada, and the effectiveness of related policies, programs, and services. Surveillance systems are needed to measure how well Canada is meeting the needs of persons with mental illness and to provide guidance on how to improve access and awareness programs.

Under the auspices of the Public Health Agency of Canada, the federal government has direct responsibility for disease surveillance, yet its efforts to record the impact of mental illness on Canadian society have been limited.

Canada's national surveillance capacity relies on hospitalization and mortality databases. A survey by Statistics Canada, *Canadian Community Health Survey: Mental health and well being (2002)*, provided valuable data but has never been reported. This survey also focused only on a narrow range of mental health conditions. The Canadian Institute for Health Information has also identified the need for a comprehensive national surveillance system on mental health but does not currently have any initiatives to satisfy this need.

Surveillance needs ongoing data sources. Hospitalization and mortality data paint only a small part of the picture of mental illness in Canada. Most people with mental illness are not treated in hospitals. There are no permanent funding mechanisms to support longitudinal studies, which are necessary to identify and respond to trends.

The Canadian Public Health Agency intends to initiate mental health surveillance demonstration projects in the near future. CAMIMH supports this initiative but does not believe that it goes far enough. The anticipated scope of the project and pace of implementation would fall far short of what is urgently needed.

Appropriate and timely data can help guide, support, and evaluate programs and services. An effective surveillance system is the foundation of all health strategies. Canada's strategy on mental illness and mental health must be similarly rooted. The Public Health Agency must place a higher priority on the development of its surveillance capacity in respect of mental illness and mental health.

#### ***Recommended actions***

Federal, provincial, and territorial governments working collaboratively with Statistics Canada and the Canadian Institute for Health Information must commit to establishing a national system for mental health surveillance. The partners must agree to:

- Establish a framework for data collection and reporting based on common indicators and data standards.
- Identify priority areas for surveillance tools and methods.
- Commit to long-term stable funding for an ongoing surveillance system.
- Report surveillance information to the public on a regular basis.

## 4. Investments in Research

**Research funding must be increased to more closely correspond to the impact of health conditions on society.**

Mental health research currently commands less than five percent of Canadian health research funding, yet mental illness directly affects 20 percent of our population.

Few private institutions or community foundations fund mental illness and mental health research, and universities tend to direct their investments toward physical health.

Although in recent years, some governments in Canada have contributed to mental health research, funding for mental illness and mental health research continues to fall well short of the need to fill the current gaps in knowledge.

CAMIMH recognizes the research leadership of the Institute of Neurosciences, Mental Health and Addiction, one of the Institutes of the Canadian Institutes of Health Research. This Institute has developed research agendas on suicide and on mental illness in the workplace, as well as other priority issues to mental illness and mental health in Canada. Sadly, however, these agendas cannot be adequately pursued with existing levels of funding.

Mental health research is also a victim of the stigma surrounding mental illness, as well as of the under-resourcing of the mental health system. A professional career in mental health research is still not held in high esteem. The practice demands on mental health professionals often do not leave room for or create a culture conducive to practice-based research. Therefore, while increased research funding will help encourage existing researchers to pursue mental health research, Canada must also do more to foster the interest of young researchers in the fields of mental illness and mental health, and to foster research by practicing clinicians.

### ***Recommended actions***

Working collaboratively, governments, together with CAMIMH and other stakeholders, must foster the establishment and implementation of a national research agenda, which includes basic, clinical, community, and population-based research. This agenda should include setting targets, benchmarks, and measurement systems:

- to help direct research dollars to priority areas;
- to foster a climate of interest in mental health research;
- to increase the volume and quality of research output;
- to improve knowledge transfer so that research gets “off the shelf” and into practice;
- to develop long-term funding.

## 5. Mental Health Promotion

**A long-term national strategy is needed.**

Some Western nations have demonstrated that mental health promotion strategies can significantly improve the mental health status of their population. A comprehensive mental health promotion strategy involves promoting mental health through healthy child development, healthy schools, healthy workplaces, healthy communities, and personal skill development to cope with life events and relationships. It also engenders a positive attitude toward mental health.

**Start with a public education strategy to reduce the stigma and discrimination associated with mental illness.**

Stigma and discrimination are major barriers to advancements in mental health policy and positive mental health. People in Canada, generally, have a low awareness of mental illness and its symptoms. This lack of awareness extends to health care practitioners.

The result is misunderstanding, leading to considerable stigma of mental illness both at the societal and health practitioner level. The causes of stigma are multiple and complex and are influenced by a range of socio-economic and cultural factors. Regardless of cause, stigma is a serious barrier to wellness.

Governments in Canada do provide support for public education and mental health promotion initiatives; however, funding tends to be intermittent and allocated strategically. It is known, in the short term, uncoordinated campaigns do not have a discernable impact on attitudes and changing social norms.

***Recommended actions***

To achieve the necessary turnaround in public and practitioner attitudes, CAMIMH recommends that governments work toward a coordinated and collaborative education and awareness strategy supported by sustained long-term funding, which includes:

- Population-specific research, including consumer populations, into the causes of stigma and methods for changing public and practitioner attitudes.
- Health promotion strategies to increase provider capacity to detect and properly diagnose mental illness and to determine appropriate interventions.
- Long-term stigma reduction campaigns, based on best evidence, to change public perceptions and behaviours.
- Specific workplace targeted health promotion strategies to increase employer and employee awareness of mental health issues and increase the number of employees who seek support and treatment.
- Benchmarks and surveillance systems to measure the effectiveness of research, awareness campaigns and related expenditures.
- Adequate funding for the national voluntary sector to strengthen consumer-oriented initiatives and the capacity of consumer and community organizations to be meaningfully engaged in mental health reform, policy development, and program planning.

# APPENDIX I

## The Determinants of Health

Excerpt from the World Health Organization:<sup>c</sup>

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.

### The determinants of health include:

- the social and economic environment,
- the physical environment, and
- the person's individual characteristics and behaviours.

The context of people's lives determines their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants – or things that make people healthy or not—include the above factors, and many others:

- Income and social status – higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.
- Education – low education levels are linked with poor health, more stress and lower self-confidence.
- Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions
- Social support networks – greater support from families, friends and communities is linked to better health. Culture – customs and traditions, and the beliefs of the family and community all affect health.
- Genetics – inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.
- Health services – access and use of services that prevent and treat disease influences health.
- Gender – men and women suffer from different types of diseases at different ages.

<sup>c</sup> <http://www.who.int/hia/evidence/doh/en/>

## APPENDIX II

### About the Canadian Alliance on Mental Illness and Mental Health:

#### A partner for change

CAMIMH is a source of expert knowledge on policies and programs and strategies for reform. We champion initiatives to improve access, foster awareness and advance knowledge through relevant research. We are an established partner in policy development initiatives. We are committed to bringing prospective partners together and in playing an active role in the development and implementation of solutions. To that end, we regularly contribute to the ongoing national dialogue on health and social policy issues. We appear before Committees of the Senate and House of Commons. We brief cabinet members, politicians, government officials and media on issues relating to mental illness and mental health. We support the Public Health Agency's development of Public Health Goals for Canada, which are informed by mental health considerations and inclusive of the social determinants of health.

#### Some of the activities in which we have recently been involved include the following.

**Canadian Consortium on Collaborative Mental Health Care:** The Consortium received \$3.8 million through the federal Primary Health Care Transition Fund to develop a national strategy to improve access to, and the quality of, mental health services at the primary care level. Several of the Consortium's 12 national organizations are CAMIMH members.

**Canadian Community Health Survey: Mental Health and Well Being:** CAMIMH was a partner in the development of Statistics Canada's first-ever Community Mental Health Survey, released in September 2003. The study surveyed the prevalence in Canada of five mental illnesses: mood disorders, schizophrenia, anxiety disorders, personality disorders, and eating disorders. It found that 20 percent of people in Canada experience mental illness, more than half of whom do not seek treatment. The survey provides the foundation for a much needed longitudinal study on prevalence rates.

**Mental Illness in Canada 2002:** CAMIMH supported the production of the first-ever report on mental illness in Canada, released in October 2002. This study relied primarily on hospitalization data to assess the prevalence of various mental disorders and to analyze hospital utilization patterns. The study concluded that 3.8 percent of hospital admissions are for mental disorders. *Mental Illness in Canada 2002* provides an important performance benchmark for the effectiveness of mental health awareness programs and strategies to reduce prevalence.

**Mental Illness Surveillance:** CAMIMH has partnered with the Public Health Agency of Canada in the workshop and subsequent development of mental illness surveillance projects that will lead to the development and funding of a national mental illness surveillance system.

**The Senate Standing Committee on Social Development, Science and Technology:** Since 2002, CAMIMH and its members have worked with this Committee, co-chaired by Senators Michael Kirby and Wilbur Keon, to assist in its research and public hearings, as well as in its interim and final reports on the mental illness, mental health and addictions issues in Canada.

**Mental Illness Awareness Week.** Hosted annually in October, this is a national public education initiative coordinated by CAMIMH. Bookmarks and posters are distributed to hundreds of community organizations across the country. The campaign theme, “Face Mental Illness,” is designed to reduce stigma attached to mental illness.

**National Champions of Mental Health Luncheon.** Hosted by CAMIMH annually in Ottawa, this luncheon brings together mental health stakeholders to recognize “champions” of mental health within government, the private sector, and the media.

**Canadian Mental Health Association: Citizens for Mental Health.** The Citizens for Mental Health project was funded by Health Canada as part of the Sectoral Involvement in Departmental Policy Development (SIDPID), Voluntary Sector Initiative to undertake part of the consultations CAMIMH had envisioned after releasing its first Call to Action paper. It was anticipated that the project would build on CAMIMH’s paper concerning possible federal government action, which in turn could inform CAMIMH’s evolving consensus agenda.

## APPENDIX III

### Membership of the Canadian Alliance on Mental Illness and Mental Health

#### **Autism Society Canada (ASC)**

ASC is the only national autism charitable organization committed to advocacy, public education, information and referral, and provincial development support. ASC works nationally to address issues and concerns common to its constituent members, the provincial and territorial autism societies, which provide support to individuals and families affected by Autism Spectrum Disorder. ASC is governed by a voluntary Board of Directors, which comprises a representative of each provincial society.

#### **Canadian Association for Suicide Prevention (CASP)**

CASP works to reduce the suicide rate and to minimize the harmful consequences of suicidal behaviour for individuals, families, and society. CASP works toward this goal by facilitating, advocating, supporting, and advising, rather than by providing of direct services. CASP facilitates broad-based information sharing on intervention and research, and advocates for policy development at the federal, provincial and territorial level.

#### **Canadian Association of Occupational Therapists (CAOT)**

Through advocacy and policy development activities, CAOT promotes excellence in occupational therapy. CAOT advocates for a client-centred approach to occupational therapy in Canada and internationally. CAOT provides services, products, events, and networking opportunities that assist occupational therapists in achieving excellence in their professional practice.

#### **Canadian Association of Social Workers (CASW)**

As a federation of the nine provincial and one territorial social work organizations, CASW provides a national leadership role in strengthening and advancing the social work profession in Canada. CASW promotes social justice and well-being for all people in Canada and advocates for changes to national social policy and legislation that will advance these principles.

#### **Canadian Coalition for Seniors Mental Health (CCSMH)**

CCSMH promotes the mental health of older persons by connecting people, ideas, and resources. CCSMH supports collaborative initiatives that facilitate positive mental health for seniors through innovation and dissemination of best practices. CCSMH believes that the more we recognize and respond to seniors' mental health needs, the more we will all benefit. This includes seniors, family members and caregivers, health professionals, front-line workers, researchers, government, industry, and advocacy groups.

#### **Canadian Healthcare Association (CHA)**

CHA is a federation of provincial and territorial hospital and health organizations across Canada. Through its members, CHA represents a broad continuum of care, including acute care, long-term care, and mental health. These services are provided through regional health authorities, hospitals and other facilities and agencies that serve all people in Canada, and are governed by trustees who act in the public interest. CHA's mission is to improve the delivery of health services in Canada through policy development, advocacy, and leadership.

**Canadian Medical Association (CMA)**

CMA is a national voluntary organization of individual member physicians that works in partnership with the people of Canada to advocate for the highest standards of health and health care. CMA performs a wide variety of functions, such as advocating for health promotion and disease/accident prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage, and adapt to changes in health care delivery.

**Canadian Mental Health Association (CMHA)**

As a nation-wide, voluntary organization, the CMHA promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. The CMHA accomplishes this mission through advocacy, education, research, and service. Each year, it provides direct service to more than 100,000 people in Canada through the combined efforts of more than 10,000 volunteers and staff in over 135 communities.

**Canadian Psychiatric Association (CPA)**

CPA is the voice of Canadian psychiatrists. Its mission is to achieve the highest possible standard of psychiatric services for people in Canada. Its services include continuing professional development, development of practice and professional guidelines, and public education. The Association places a priority on collaborative efforts within psychiatry and with other professions, consumer groups, government, and the private sector in advocating for improved mental health services and strategies.

**Canadian Psychiatric Research Foundation (CPRF)**

The CPRF is a national charitable organization established in 1980 to raise and distribute funds for psychiatric research in Canadian universities and teaching hospitals. With a staff of three, overseen by a volunteer Board of Directors and a Professional Advisory Board, the CPRF has to date provided over \$9 million in support of 312 fellowship and research grants.

**The Canadian Psychological Association (CPA)**

The CPA leads, advances, and promotes psychology as a science and as a profession for the benefit of people in Canada and for all of humanity. The CPA promotes the advancement, dissemination, and practical application of psychological knowledge and develops standards and ethical principles for education, training, science, and practice in psychology.

**Mood Disorders Society of Canada (MDSC)**

MDSC is a national, registered, not-for-profit charitable organization committed to improving the quality of life for people affected by depression, bipolar disorder, and other related disorders. MDSC provides a national voice for consumers and families to ensure that their issues and concerns are understood and considered in the setting of research priorities, the development of treatment strategies, and the creation of government programs and policies related to mental illness.

**National Network for Mental Health (NNMH)**

NNMH exists to advocate, educate, and provide expertise and resources for the increased health and well-being of the Canadian mental health consumer/survivor community. The principals of inclusion, informed choice, and individuality are the focal point of NNMH. The individuality of each consumer/survivor is valued and appreciated. Working toward the common goal of advocating on behalf of the national mental health consumer/survivor community is accomplished by empowering individuals who together create a powerful united voice.

**Native Mental Health Association of Canada (NMHAC)**

The NMHA of Canada is a not-for-profit association that is managed by Aboriginal leaders and exists to improve Canada's First Nations, Métis, and Inuit populations by addressing healing, wellness, and other mental health challenges including addictions. This association grew out of the Canadian Psychiatric Association Section on Native Mental Health, which was formed in 1975. The NMHAC was incorporated in 1990. It provides a year-round information service, handles an inventory of conference transcripts, and serves as a bank of resources.

**Registered Psychiatric Nurses of Canada (RPNC)**

RPNC represents the licensing and regulating bodies for professional psychiatric nurses in the provinces of British Columbia, Alberta, Saskatchewan, and Manitoba. The RPNC is an innovative, proactive, recognized leader in mental health reform, committed to ensuring that people in Canada have accessible, effective, efficient mental health delivery systems that fully utilize the skills and expertise of registered psychiatric nurses. RPNC strives for excellence in the delivery of mental health care.

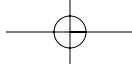
**Schizophrenia Society of Canada (SSC)**

SSC supports families and individuals affected by schizophrenia. It advocates for improvements to treatment and services, and for necessary changes to provincial and federal legislation. SSC strives to reduce discrimination and stigma suffered by people who live with schizophrenia by raising public awareness and supporting research into schizophrenia through the SSC Foundation.

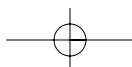
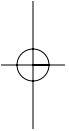
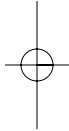
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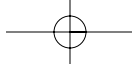
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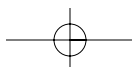
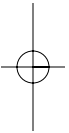
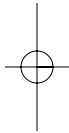


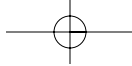
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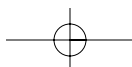
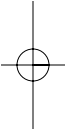
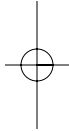


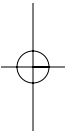
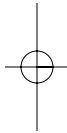
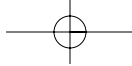
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