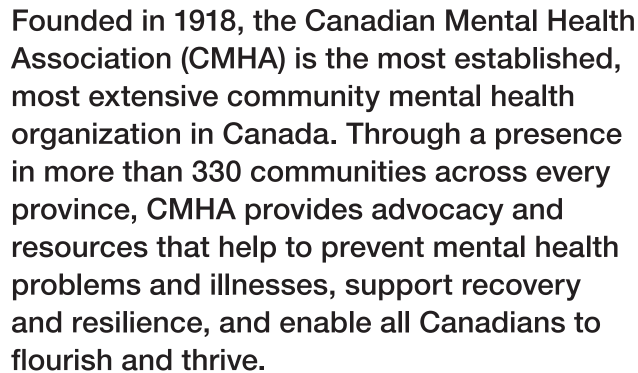
Mental Health in the Balance

ENDING THE HEALTH CARE DISPARITY IN CANADA

September 2018

Canadian Mental Health Association
Mental health for all
100 years of community



Founded in 1918, the Canadian Mental Health Association (CMHA) is the most established, most extensive community mental health organization in Canada. Through a presence in more than 330 communities across every province, CMHA provides advocacy and resources that help to prevent mental health problems and illnesses, support recovery and resilience, and enable all Canadians to flourish and thrive.

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Introduction

Mental health and physical health are both intrinsic to well-being.[1] And yet, global efforts to improve population health outcomes have been primarily focused on preventing and treating physical health conditions.[2] The focus on physical health has produced an imbalanced health-care system, with "lower treatment rates for mental health conditions, premature mortality of people with mental health problems and underfunding of mental health care relative to the scale and impact of mental health problems."[3]

The health-care system in Canada is no exception; in fact, as a nation, Canada lags behind when it comes to promoting mental health and treating mental illness and addictions.[i] In a given year, 6.7 million Canadians – or one in five people – experience mental illness, and by age 40, that number increases to one in two Canadians.[4] Despite the high prevalence of mental illness in Canada, a high number of Canadians report that they have unmet needs when it comes to mental health care. In 2012, it was estimated that 1.6 million people had an unmet mental health-care needs, with counselling reported as the highest unmet need.[5] Evidence-based psychological services, delivered by psychologists and other allied professionals, are not typically publicly funded. When funded, these services have long wait times, making them unavailable when they are most needed. In Ontario, for instance, in 2016, 12,000 youth were reported to be waiting up to 18 months for these services.[6] An added challenge for our mental health-care system is that Canada's population is increasing and has a growing aging population. With the higher number of newcomers welcomed to Canada and a larger population of Canadian seniors at risk of experiencing mental health problems as they get older, the incidence of mental illness and the demand for quality and accessible treatment will also be higher.

1.6 million

Canadians with unmet mental health care needs each year

In Canada, we are also in the midst of an opioid crisis. In 2017, an estimated 3,987 Canadians died of an overdose, although this number is likely an underestimation of the number of lives lost.[7] As we have shown in our report, *Care not Corrections: Relieving the Opioid Crisis in Canada*, the opioid crisis stems from pain and suffering – physical, spiritual and psychological – and is linked to many factors, including: social inequality, colonialism and intergenerational trauma, the stigmatization of people experiencing mental illness and who use drugs, inadequate access to appropriate and effective mental health-care and addictions services, and gaps in existing approaches to treating pain. Canadians looking to access addictions services or treatment for chronic pain may have to travel considerable distances, cope with long wait lists, and/or pay for services privately.

[i] Throughout this document, references to mental health and illness are inclusive of substance-related issues, including addictions. Similarly, mental health and illness services include the full continuum of substance and addiction-related services, even when the latter are not explicitly named.

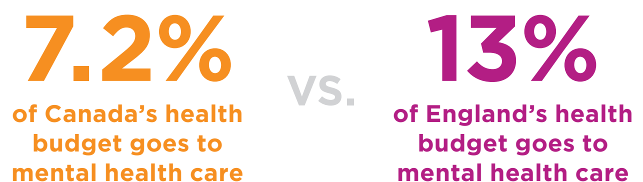
The historical underfunding of mental health has been most pronounced in community-based mental health services.

With the legalization of cannabis on the horizon, there may also be an increased demand for services to treat cannabis use disorders and other mental health problems linked to cannabis use. While there are proven benefits associated with cannabis use in the treatment of some illnesses, including depression and post-traumatic stress disorder, cannabis, like many other substances, can present mental health risks and potential harms, particularly for youth.[8] The impacts of the legalization of cannabis on public health in Canada are unknown at this time, given that they will depend on how new laws are implemented and specifically whether they will have an effect on the use of other substances such as alcohol, tobacco, and prescription opioids.[9]

With only 7.2% of its health budget dedicated to mental health care, Canada leaves the mental health of Canadians hanging in the balance. Canada spends the lowest proportion of funds on mental health among all G7 countries. For example, England's National Health Services spends 13% of its budget on mental health care. However, the OECD's recent analysis of spending on mental health worldwide concluded that even England's 13% spending might be too low, given that mental illness represents as much as 23% of the total disease burden.[10] The historical underfunding of mental health has been most pronounced in community-based mental health services. The *Canada Health Act* does not specify that Canada's "universal health-care" system must include basic mental health care provided by addiction counselors, psychologists, social workers, and specialized peer support workers. These services are the foundation of the mental health response in other G7 countries.[11]

To address this longstanding under-investment in mental health care, the Canadian government recently demonstrated unprecedented leadership in recognizing the dramatic gaps in mental health care and implementing measures to redress them by committing additional funds for mental health. In 2017, it announced that it would dedicate $5 billion to support mental health initiatives over 10 years, with funding earmarked for community-based mental health and addictions services.[12] We applaud and welcome this new investment, but recognize there is some distance to go before mental health care is funded on par with physical health care and in proportion to the burden of illness.

Currently, Canadians are suffering from health conditions that are preventable or manageable with the right supports. Canadians deserve access to a continuum of publicly funded mental health and addictions services that are integrated and coordinated at the community level to promote and enhance their quality of life. **We call on the Government of Canada to introduce a *Mental Health Parity Act* in order to bring mental health care into balance with physical health care.**



METHODOLOGY

This call for parity legislation is based on a collection of the strongest recommendations drawn from research and evidence-based policies by mental health organizations, governments, researchers and research institutes, including the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), the UK National Health Service, the Australian Department of Health, the Royal College of Psychiatrists, and the Mental Health Commission of Canada (MHCC). The recommendation to introduce a *Mental Health Parity Act* was first introduced by CAMIMH, of which CMHA is a member, in the policy document *Mental Health Now* – a document that formed an important foundation for the strategy presented here. In addition to reviewing clinical research, we conducted jurisdictional scans to examine parity policies and practices in other countries. This research was led by CMHA's Public Policy Working Group, which is comprised of policy experts representing CMHA local branches, regions and provincial divisions from across Canada, and in consultation with our National Council of Persons with Lived Experience, and National Board of Directors.

The state of mental health care in Canada

In Canada, health care is governed by the *Canada Health Act* (1984), which has a mandate to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[13] Currently, however, the Act only requires the public funding of treatments deemed to be "medically necessary" and that are most often delivered in a hospital or physician's office. Low-intensity and low-barrier services at the community level such as psychotherapy, counselling, and peer support are not included.

As a result, Canadian physicians are at the core of existing publicly funded mental health service delivery. Up to 80% of Canadians rely on their family physicians to meet their mental health-care needs, but these services are limited: physicians typically offer drug therapy, emotional support, health promotion and wellness counselling, advice and referrals.[14] Many physicians do not have the necessary supports or resources to treat people with mental illness or may not have the time or resources to meet the service demand.[15] Furthermore, 14.9% of Canadians, or roughly 4.5 million people, do not have a family physician, which means that they may not have access to even basic mental health care.[16]

80% of Canadians rely on their family doctor for mental health-care needs.

Most Canadians needing formal psychological treatment for mild-to-moderate mental illnesses must pay out of pocket or access services through private insurance plans. It is estimated that Canadians collectively spend $950 million annually on private-practice psychotherapists, with 30% paying out of pocket.[17] Private insurance programs often have annual limits, with coverage typically ranging from $400 to $1,500 annually – which may only cover two to eight therapy sessions. This insurance may also be lumped in with other services such as massage and physiotherapy, further reducing funds for mental health services.[18]

Recently, several companies based in Canada have increased their benefit plans for mental health services. In 2017, Manulife increased its mental health support benefit to $10,000 per person annually, and both Great West Life and Starbucks now also provide $5,000 to their employees. CMHA applauds these companies for their commitment to the mental health and psychological well-being of their employees. Collectively, Canada's private sector spends between $180 and $300 million on short-term disability benefits related to mental illness, and $135 million for long-term disability – costs which can be substantially reduced with the kinds of investments in mental health care made by Manulife, Great West Life and Starbucks.[19] However, we also recognize that the private sector alone cannot meet the mental health-care needs of all Canadians. As it stands, some of the best

private coverage for mental health treatment is available to those with good, stable employment and consequently, Canadians who are poor, unemployed, or underemployed are left out.

Individuals with more complex mental illnesses face even greater barriers to services. Psychiatric services are covered under provincial and territorial health insurance. However, in the National Physician Survey conducted in 2010, Canadian family physicians most often rated access to psychiatrists for their patients as "poor" and reported frustration with long wait times.[20] Low-income communities experience higher rates of mental illness and have a greater need for mental health services, yet research shows that there are inequities in the provision of psychiatric services and that our universal health-care coverage tends to support "regular psychiatric treatment for individuals with high socioeconomic status and comparatively milder psychiatric disorders than it supports care for disadvantaged groups or those with severe and persistent mental illness."[21] Many patients with complex mental illnesses who do not have access to a primary care physician and/or a psychiatrist rely on emergency departments as their primary source of care, from which they may be discharged without adequate supports and follow-up.[22] For people with persistent, complex and severe mental illnesses, the effective management of symptoms and recovery may require a team of service providers, peer support workers and families that is integrated into communities, schools, the workplace, and health-care facilities.[23]

Efforts to improve the Canadian health-care system have been focused on the acute-care system, while community-based mental health services receive a smaller share of the funding.[24] As a result, many people with complex chronic health problems do not receive the full scope of care they need and end up "cycling through the acute-care system."[25] A greater reliance on acute care results in "emergency department overcrowding, revolving door psychiatric admissions and discharges and high and increasing demands on police and social services."[26]

There are consequences for the inadequate and inequitable treatment of mental illness. Mental illness can impact quality of life for the individual by engendering feelings of distress, loss of control, anxiety and worry, and can negatively impact energy levels and sense of self-efficacy.[27] The family may also experience stresses associated with providing emotional and physical support, which can include isolation, a restriction of social activities, and financial hardship.[28] People who experience psychosis, bipolar disorder and moderate-severe depression have a reduced life expectancy of 10-25 years, given that many people experience co-occurring chronic medical conditions such as diabetes, hypertension, and cardiovascular, respiratory and infectious diseases, as well as higher rates of suicide.[29] There are also economic consequences. A study from 2011 estimates that the cost of mental illness for health care, social services and income support in Canada is over $42.3 billion annually.[30] Furthermore, an estimated $50 billion annually is also lost through unemployment, and absenteeism and loss of productivity in the workplace.[31] Given the great personal and economic costs that can accompany untreated mental illness, it is critical that Canadians have access to well-funded and coordinated community-based mental health supports when and where they need them.

Bringing mental health into balance

A Mental Health Parity Act

Parity is the notion that mental health should have equal status with physical health within health-care systems.[32] Parity is not a new idea; other countries have introduced mental health parity acts, also known as "parity of esteem" legislation, to ensure that citizens have access to critical mental health services. In 1996, the United States introduced the *Mental Health Parity Act*, later amended as the *Mental Health and Addiction Equity Act*, which stipulates that annual or lifetime dollar limits on mental health and addictions not be lower than medical and surgical benefits. In 2012, England also amended its *Health and Social Care Bill* to address the disparity between treatment services for mental and physical health. Parity is not only about better funding for services, but also equal access to the most effective and safest care and treatment, equal efforts to improve the quality of care, the allocation of time, effort and resources, equal status within health-care education and practice, equally high aspirations for service users, and equal status in the measurement of health outcomes.[33] To achieve these goals in Canada, CMHA has identified five strategies that should be included in a *Mental Health Parity Act* to ensure that mental health care is valued proportionately and equitably within our health-care system.

These five strategies are:

1. Publicly fund evidence-based therapies
2. Improve the quality of care through a continuum of integrated services
3. Invest in promotion, prevention, and early intervention
4. Address stigma and discrimination and ensure equitable access
5. Research mental illness and evaluate health outcomes

We will be more successful in achieving parity if governments, community organizations and all other stakeholders work in collaboration with Indigenous communities and people with lived experience (PWLE) of mental health problems and mental illnesses. Policy planning and program development should be carried out in allyship with Indigenous communities, and health and social services for Indigenous communities should be grounded in culture, be Indigenous-controlled and culturally safe, and include trauma-informed supports to ensure their sustainability and success. It is critical to recognize that evidence-based practice includes traditional Indigenous healing practices and medicine alongside western scientific evidence. Ensuring that Indigenous communities have access to culturally appropriate and safe services and that traditional Indigenous Knowledge is valued will help advance the goals outlined by the Truth and Reconciliation Commission. Furthermore, involving PWLE engenders better population health outcomes; initiatives led by PWLE have proven particularly successful in ensuring that new initiatives are accessible, accommodating, relevant, and acceptable.

1 PUBLICLY FUND EVIDENCE-BASED THERAPIES

A compelling argument for publicly funding psychological therapies on a wide scale is that these modalities have shown effectiveness in treating some forms of mental illness. One therapy that is "rigorously evidence based" is Cognitive Behavioural Therapy (CBT). According to Gratzer and Goldbloom, CBT has been shown to be as effective as antidepressant medications in the treatment of mild-to-moderate depression, and both modalities combined are even more effective than when used alone.[34] CBT has also been used to help cancer patients coping with chemotherapy, assist patients with weight management, support recovery from problematic substance use, and help people with depression return to full-time work.[35] CBT and other psychological therapies are also recommended in national guidelines, including the National Institute for Health and Clinical Excellence in the UK and the American Psychological Association, as evidence-based practices for treating mental health problems.

The prevalence and social burden of untreated mood and anxiety disorders in Canada demands a different kind of health-care system – one that integrates evidence-based mental health and addictions services into primary care. For treating prevalent (mild to moderate) forms of mental illness, we can look to England and Australia for guidance, given that these two jurisdictions have been successful in implementing scalable and cost-efficient publicly funded systems for prevalent mental illnesses. In 2008, the Department of Health introduced the Improving Access to Psychological Therapies (IAPT) program offered through the National Health Service in England. The IAPT program is designed for adults with mild-to-moderate depression and anxiety and is based on the stepped-care model, which matches the level of care to the severity of the condition. In health-care systems that practice stepped care, individuals are matched to the most appropriate services that are likely to improve their health outcomes, and there is a built-in review process that allows them to be "stepped up" to more intensive treatment or "stepped down" to less intensive treatment as needed. Most people who enter treatment in the IAPT program begin with "wellness practitioners" – trained professionals who provide information and low-intensity therapy – and are stepped up to another treatment level only if they do not respond to treatment. This system ensures that individuals are referred to the appropriate treatment tier so that services delivered by specialized clinicians in the higher tiers are reserved for individuals with greater and more complex needs.[36]

Australia also delivers primary-care psychological treatments. The Access to Allied Psychological Services Program (ATAPS) and Better Access to Psychiatrists, Psychologists and General Practitioners initiative, introduced in 2001 and 2006 respectively, provide Australians with up to 10 sessions of therapy in addition to group therapy, paid by Medicare.[37]

Canada needs to integrate evidence-based mental health and addictions services into primary care.

Both the English and Australian programs are popular and effective. Since IAPT was launched in England, the NHS has trained over 6,000 new psychological therapists, and in the last year alone, it was able to provide treatment services to 965,000 people with over 50% making a recovery.[38] By comparison, the economic cost of depression, anxiety, and other mental illnesses in the UK is estimated to be $147 billion[ii] every year, with a cost to businesses of about $36 billion.[39] The Australian model has been particularly successful in encouraging collaboration among different health-care professionals.[40]

[ii] For the purposes of this paper, we have converted British Pounds into Canadian Dollars.

For Indigenous communities in Canada, the embedding of cultural approaches in therapeutic programs is critical for supporting mental wellness and recovery.

In Canada, it's encouraging that some provincial governments are beginning to invest more in psychological services. Last year, Ontario announced that it would invest $7.2 million over three years to support psychotherapy programs that will serve 100,000 Ontarians with mild-to-moderate anxiety and depression.[41] That same year, Quebec also announced that it will invest $35 million annually to provide free access to psychotherapy for 260,000 people.[42] We applaud these initiatives, but we know that universal access for Canadians will require commitments from all provinces and territories to fund and improve services and establish a national standard. Recent estimates on the costs of implementing a program such as IAPT in Canada suggest that we would need an investment of $950 million annually – which is well above the 7.2% currently earmarked for mental health service provision.[43] The case for this investment is simple: psychological treatment like CBT works and it produces substantial savings.

For Indigenous communities in Canada, the embedding of cultural approaches in therapeutic programs is critical for supporting mental wellness and recovery. However, dedicated funding for clinical mental health services does not exist in First Nations communities in Canada.[44] Some First Nations communities have access to the consulting services of psychologists and counselors through the funding they receive through programs such as the National Native Alcohol (NNADAP) and Drug Abuse Program and the National Youth Solvent Abuse Program (NYSAP). However, there is a lack of financial support for cultural practitioners, cultural teachers, and Elders who provide cultural interventions and clinical supervision.[45] Accessible and culturally appropriate services for Indigenous peoples may include land-based treatment, sweat lodge, and traditional medicines. Collaboration among governments is needed to support the nomination of First Nations advocates who can act as systems navigators and cultural translators within the mainstream mental health-care and addictions system, as recommended by the Assembly of First Nations.[46]

For many people who access psychological therapy, medications may also be part of their treatment plan. However, psychiatric medications can pose a financial burden.[47] Given that medications are generally covered only in hospitals, through disability support programs, and some provincial pharmacare programs, individuals who do not have access to these programs or to private insurance must pay out of pocket. This is a problem, given that many Canadians with severe mental illnesses experience high rates of poverty and unemployment.[48] Approximately 5.5% of Canadians report that they skip, stretch, or do not take their medications because they cannot afford them, and they are also most likely to forgo psychiatric medications over other drugs.[49] Furthermore, Canadians who

Individuals without access to financial support through private insurance, hospitals, disability programs or provincial pharmacare must pay for psychiatric medications out of pocket.

rely on provincial and territorial drug plans may not have access to the latest medicines to treat their mental illness because they have restrictive formularies.[50] We welcome the development of a National Pharmacare Plan, one that ensures that Canadians have access to a wide range of innovative psychiatric medications.

Greater investment and system change in Canadian mental health care – from promotion to treatment – will not be accomplished over the course of one sitting government, but will require a long-term and sustained commitment from our governments.

Spending on mental health programs and services should be commensurate with local needs and the burden of mental illness in Canada. Further, when we factor in that our spending for mental health should also include health promotion, not just illness prevention and treatment, we know that the current 7.2% needs to be much higher. While one in five Canadians have a mental illness, five in five must be concerned about and nurture their mental health, and health promotion is a critical part of sustaining mental wellness. Greater investment and system change in Canadian mental health care – from promotion to treatment – will not be accomplished over the course of one sitting government, but will require a long-term and sustained commitment from our governments. A *Mental Health Parity Act* will ensure that our governments are committed over the long term to improving mental health services.

2 IMPROVE THE QUALITY OF CARE THROUGH A CONTINUUM OF INTEGRATED SERVICES

Cost and long wait times are not the only factors that render mental health services inaccessible for many Canadians. Services across different sectors also lack coordination, which means that people with mental health-care needs must navigate a complex and fragmented system, often with poor or suboptimal results. Youth are an important group when it comes to service access, given that 70% of mental health problems have their onset during childhood or adolescence.[51] A study in Ontario found that the parents seeking help for a child reported contacting, on average, five different agencies and receiving two different treatments for their mental illness, which suggests that they must navigate "a complicated system of services."[52] There is also a lack of collaboration among the sectors that serve youth with mental illness, including schools, child welfare, criminal justice, and health care, which is part of the reason that more Canadian youth with mental illnesses are incarcerated.[53] To achieve parity, services need to be better coordinated and include access to the full continuum of care. Services, including addictions, health, social services, housing, education, and the justice system, should be linked to ensure that those navigating through these different systems have the supports that they need. Further, individuals need adequate follow-up and wrap-around services, including culturally relevant support services for Indigenous communities.[54]

Assertive community treatment (ACT) programs illustrate how effectively community-based service providers can collaborate to support treatment and recovery. ACT programs are evidence-based interventions that assist people with severe and

To achieve parity, services need to be better coordinated and include access to the full continuum of care.

persistent mental illness. ACT is delivered at the community level by a team that is available 24/7 and may include a family physician, psychiatrist, nurse, social worker, addictions specialist, employment counselor, and peer support worker, among others. The treatment plan is tailored to the mental health needs of the individual.[55] ACT teams are less expensive than hospital-based care and cost about the same as other forms of community-based care. Furthermore, they have been shown to reduce hospitalizations, promote housing stability, and are considered by individuals and families to be more satisfactory than traditional care.[56]

Another approach that is creating better linkages among care providers is the hub-and-spoke model of care provision. Although there is not a consensus on how to define it, this model often involves clusters, networks, or satellites of care providers that coordinate their mental health and addictions services. In some models, the emergency department is the hub linking to and from other mental health, medical, social services, and housing services as required. In this way, the patient has access to emergency services if acute stabilization is needed.[57] Other hub-and-spoke models connect primary-care providers to specialists who provide training and consultation.[58] An excellent example of the first model is the Regional Opioid Intervention Service (ROIS) offered through the Royal Ottawa Hospital, which delivers services for concurrent opioid addiction and mental health problems. Here, a multidisciplinary team of community agencies, hospital programs, and family physicians collaborates to offer a full spectrum of care, creating new linkages among care providers and bringing "care closer to where clients live, with a focus on areas where no such services previously existed."[59]

To get the most out of our health-care system, mental health service delivery should be based on the stepped-care model. The stepped-care/matching model for mental health-care provision is based on the principle of "least burden," whereby service providers triage patients into the least intensive service that is likely to meet their needs and be effective. The lower tiers, Tiers I and II (figure 01), include supports that are community-based, rely more on non-specialist and peer support, and less on health-care resources. These include recovery coaches, mental health and addictions counsellors, school-based mental health services, screening and early intervention, nurse practitioners and structured intervention programs like Bounce Back.

What is ACT?

Assertive community treatment (ACT) is delivered at the community level by a team that is available 24/7 and may include a family physician, psychiatrist, nurse, social worker, addictions specialist, employment counselor, and peer support worker, among others. The treatment plan is tailored to the mental health needs of the individual.

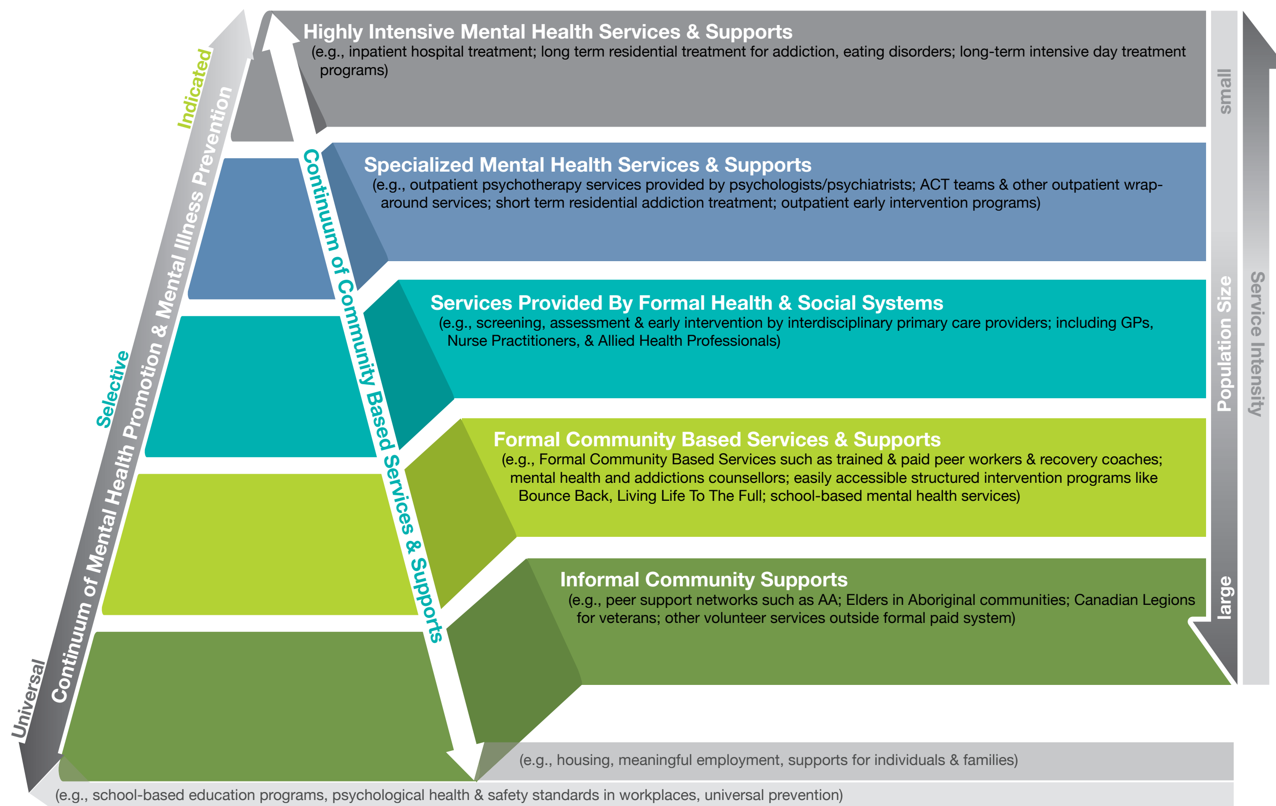


Figure 01 CMHA National Stepped Care/Matching model

The stepped-care/ matching model for mental health-care provision is based on the principle of "least burden," whereby service providers triage patients into the least intensive service that is likely to meet their needs and be effective.

However, these services are currently underfunded and underutilized. Investment in these lower tiers would enhance mental health promotion and reduce the strain on acute-care services. Mild-to-moderate depression and anxiety can be treated at the primary-care level in the lower tiers, rather than in intensive services such as those delivered by psychiatrists. 1.5% of Canadians experience severe and persistent mental illness, and require ongoing specialized and intensive services.[60] By adopting and promoting a stepped-care approach to mental health service delivery, Canadians will have access to the right care at the right time.

3 INVEST IN PROMOTION, PREVENTION, AND EARLY INTERVENTION

Mental health promotion aims to achieve the psychological well-being of a population by taking action on the determinants of mental health. It includes interventions that foster a healthy and resilient mood, create supportive environments and allow individuals to develop their personal skills – interventions such as parenting programs, anti-bullying programs and workplace mental health initiatives. Mental illness prevention overlaps with mental health promotion and addresses mental health problems before their onset, with interventions such as postpartum screening for women and depression screening for children.[61]

In the same way that health promotion and illness prevention aim to keep physical health conditions at bay, improve quality of life, and reduce health-care costs, mental health promotion can reduce the burden placed on our health-care system. A recent study on the treatment of depression estimated that for every $1 spent in publicly funded psychological services, a savings of $2 would result for the health system.[62] The return on investment is particularly promising for youth mental health promotion and illness prevention. One UK study, for instance, found that the preventative programming for moderate behavioural problems in children can result in a return of approximately $150,000 per child[iii] in lifetime costs.[63] There is also strong evidence of cost savings over the long term with investments in parenting and anti-bullying/stigma programs, suicide awareness and prevention, and primary health screening for depression and substance use problems.[64] Given that mental health promotion can reduce the burden of illness and improve the quality of life for youth and adults alike, we strongly suggest that our governments invest in programs that promote good mental health and intervene early when and where mental health problems arise.

For every
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Promote good mental health and intervene early.

Without the necessary supports, children are more likely to develop behavioural problems and are less likely to succeed in school, which can negatively impact their transition to adulthood. Programs for youth such as CMHA Nova Scotia's Socially and Emotionally Aware Kids project (SEAK) teaches social emotional learning (SEL) to improve young people's mental health, create positive and safe learning environments, and foster resiliency. SEL improves children's well-being by helping them to better identify emotions, develop healthy relationships, make good decisions, behave responsibly, and decrease aggressive behaviour.[65] This work aims to intervene early in young people's lives to foster individual protective factors and, in the long term, promote population health.

Effective mental health promotion, which includes creating the conditions for inclusion and promoting wellness, also requires that we address the root causes of poverty, trauma, and marginalization. As one of the most important determinants of health, access to financial resources impacts

[iii] British pounds converted into Canadian dollars according to 2007 exchange rates.

educational success, access to health care, nutrition, employment, and housing security. Poverty impacts mental well-being and can threaten physical and mental health; studies of low-income communities in different parts of Canada, for instance, have linked poverty to experiences of material and social deprivation, stress and stigma, and self-harm.[66]

In order to act on the social determinants of health for all citizens, governments must intervene to provide strong income security programs, housing, disability supports, mental health care, unemployment benefits and family supports, including childcare.[67] Canada, however, has a low ranking with respect to investment in social supports compared to other industrialized nations, placing 28th out of 35 countries and spending only 17.2% of its GDP on social supports.[68] As a nation, we are among the lowest spenders when it comes to disability and income supports.[69] Last year, the federal government announced its plans to introduce a National Housing Strategy that will invest $41 billion over 10 years in order to address the chronic shortage of safe, affordable housing and reduce homelessness. However, as scholar Stephen Gaetz points out, although welcome, the housing strategy falls short because it does not include a plan to prevent homelessness.[70] The Mental Health Commission of Canada estimates that there are 520,000 Canadians living with mental illness who are inadequately housed or homeless.[71] Yet, the housing strategy will only fund 60,000 affordable and supportive new housing units across the country, which is a small number in proportion to the growing number of Canadians with low incomes.[72]

We urge our governments to increase social spending to ensure that our most vulnerable citizens have access to supports that will improve their well-being, will allow them to contribute to their communities and, in turn, will lessen the burden of illness nationally.

A recent Canadian study found that a one-cent increase in social spending for each dollar of health spending could reduce avoidable deaths by 3% and increase life expectancy by 5%.[73] Recognizing that social spending addresses the social determinants of health, we urge our governments to increase social spending to ensure that our most vulnerable citizens have access to supports that will improve their well-being, will allow them to contribute to their communities and, in turn, will lessen the burden of illness nationally. *A Mental Health Parity Act* for Canada should therefore include a commitment to mental health promotion and illness prevention, and should increase social spending by 2% to improve population health outcomes.

4 ADDRESS STIGMA AND DISCRIMINATION AND ENSURE EQUITABLE ACCESS

The underfunding of the addictions and mental health-care system itself is linked and contributes to the stigmatization of mental illness. As Dr. Nachiketa Sinha, president of the Canadian Psychiatric Association has asked, "how do we fix a stigma problem for illnesses that our very system defines as less important by both its actions and its measures?"[74]

The stigmatization of mental illness is multilayered. Stigma is "a problem of behaviours resulting in the unfair and inequitable treatment of people with a mental illness and their family members."[75] It can also create barriers to mental health services and better care.[76] Self-stigmatization can result in individuals choosing not to obtain the services they really need, and not fully adhering to treatment regimens because of a diminished self-esteem or the fear of being labelled "mentally ill."[77] In our greatly underfunded and under-resourced mental health system, stigma can also manifest, often unintentionally, among the professionals who support and treat people with mental illness. As one member of CMHA's National Council for Persons with Lived Experience (NCPLE) observed, too often, "private psychiatrists may be unwilling or reluctant to treat people with some serious diagnoses, not to mention all the other discriminatory practices by not just health-care practitioners but those who are specifically dealing with people like us." A study conducted with adults experiencing mental illness and substance use problems and health-care professionals in Toronto found that family physicians are sometimes reluctant to take on patients who have more complex mental health needs.[78] Furthermore, a 2018 survey conducted by the Canadian Psychiatric Association revealed that 79% of its members reported first-hand experiences of discrimination towards a patient and 53% observed other medical professionals discriminate against a patient from psychiatry.[79] An important part of the task of addressing the stigma of mental illness therefore lies in tackling discrimination in mental health service delivery and ensuring that people who experience mental illnesses are treated with care and compassion.

In addition to dealing with the stigma of mental illness, many Canadians who are marginalized also experience systemic discrimination that impedes their access to services or impacts their service use and health outcomes. Inattention to the specific mental health needs of ethno-cultural populations, for instance, can lead to increased use of crisis and emergency care, increased contact with the criminal justice system and involuntary hospitalization.[80] Systemic racism may also impede the availability of appropriate mental health services for certain populations, resulting in a lack of access or in longer wait times.[81] In 2015, for instance, it was reported that the median wait times for access to health care for Black Caribbean-Canadians with psychosis in Toronto and Hamilton was 16 months, compared to seven months for White Canadians.[82] Afrocentric mental health services are also chronically underfunded, and Black Canadian youth with mental health service needs, particularly young men, report a higher number of incidences of discrimination in their encounters with police.[83]

The underfunding of the addictions and mental health-care system contributes to the stigmatization of mental illness.

By 2020, Canada will have welcomed 450,000 refugees. Over the next 10 years we can expect 3,000,000 immigrants and refugees. In addition to the economic and social barriers that many immigrants and refugees face upon arriving to Canada, newcomers may also have trouble accessing mental health and addictions services that are culturally sensitive, trauma informed and offered in their language.[84] Access to mental health care in Canada – from promotion to treatment – must address these gaps to ensure that service delivery is equitable and that the system that is designed to help Canadians, Indigenous Peoples and newcomers does not further their marginalization.

5 RESEARCH MENTAL ILLNESS AND EVALUATE HEALTH OUTCOMES

In Canada, research on mental health and addictions is scant. The Canadian Institute for Health Research (CIHR) receives the financial support of more than 40 organizations that sponsor cancer research – approximately $230 million a year – while mental health typically receives infrequent and smaller donations. It is estimated that CIHR, as the largest contributor to mental health research in Canada, only spends approximately 4.3% of its annual research budget on mental health, even though mental illnesses account for more premature deaths than cancer and cardiovascular diseases.[85] These numbers do not suggest that funding be reduced for cancer research; rather, they build a case for increasing mental health research funding to the level of cancer research so that it is also proportionate to the burden of illness.

There are important gaps in mental health research, particularly with respect to treatment for some psychiatric illnesses. Despite significant advancements in biomedical genetic research that have resulted in improved health outcomes for people with physical diseases, those with mental illnesses have not benefitted to the same degree, given that the genetics research on mental illness has been more difficult to translate into practice.[86] Furthermore, while there is good evidence supporting the effectiveness of some psychological interventions, such as ACT for people with schizophrenia and CBT for those with mild-to-moderate depression, not all mental illnesses have established clinical treatment standards, as is the case for eating disorders.[87] These gaps point to the need for sustained research to continue innovating to better translate scientific knowledge into practice and to develop psychological therapies that are appropriate, effective and that promote treatment acceptance for people with mental illness. We also need research that accounts for and attempts to address disparities and barriers in access to effective psychological treatments and that explores the scalability and affordability of different treatment approaches so that they are sustainable over time.[88]

4.3%

The amount CIHR, the largest contributor to mental health research in Canada, spends of its annual research budget on mental health.

Research for new medicines is also important for innovation and the evaluation of safe medicines. Innovative research is currently well funded within the pharmaceutical industry, but there is a lack of after-market research on their real-life and long-term impact for people who experience more complex mental illnesses and comorbidities.[89] Furthermore, the Patented Medicine Prices Review Board (PMPRB), a body that regulates

and monitors the pricing of brand name medicines in Canada, is under review, and while the proposed changes aim to lower the prices of medications, unintended consequences may result in a limit to the number of medications that are available and diminished research and innovation in Canada. Changes to the PMPRB should not result in reduced access to safe and effective medications.

Information on access to publicly funded mental health services is also currently limited. Reporting on wait times and other performance indicators, including the range and quantity of services not covered by provincial and territorial health insurance plans in Canada, is not always consistent or available. Furthermore, there are few data recording Canadians' satisfaction with mental health services or which treatment pathways best support recovery.[90] Because of these limitations in data, few studies compare the quality and extent of mental health care in Canada with other countries.[91] Given these gaps, mental health advocates are calling for a system of data collection that can accurately capture the state of our mental health services.

CMHA is pleased that a portion of the $5 billion in mental health funding announced last year by the Government of Canada has been earmarked for the Canadian Institute for Health Information (CIHI) to work with federal, provincial and territorial governments to develop pan-Canadian indicators to measure access to mental health and addictions services.[92] CIHI's indicators, which include wait times, early intervention for youth, understanding of services available, access to effective community care, and addictions and self-injury, including suicide, promise to systematize data collection on mental health and addictions services so that services can be more effectively delivered to Canadians.[93] We hope that equity, prevention, and promotion will also be considered within each indicator. Another promising initiative known as ACCESS Open Minds, led by CIHR, has received $25 million to assess the quality of mental health care delivered to youth, primarily by measuring indicators such as rates of satisfaction with care, cost-effectiveness, and rates of early identification.[94] These initiatives are essential for achieving mental health parity in Canada and deserve continued funding.[95]

Every Canadian's right to mental health

Access to mental health care is not a privilege; it is a right. The Convention on the Rights of Persons with Disabilities, introduced in 2006, articulates a human-rights approach to disability that asserts the "right to the highest attainable standard of mental and physical health," which includes the "entitlement of underlying determinants, and the freedom to control one's own health and body."[96] These rights are enshrined in several international human rights treaties which Canada has signed or ratified, including the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the United Nations Declaration on the Rights of Indigenous Peoples, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women.[97] Recently, the Government of Canada declared access to adequate and affordable housing a human right, demonstrating its commitment to upholding this internationally recognized standard. This same declaration – and commitment – is possible for mental health.

Access to mental health-care is not a privilege; it is a right.

A Mental Health Parity Act in Canada will ensure better population health outcomes for Canadians. This Act should include a commitment to address the five strategies discussed in this paper: publicly fund evidence-based therapies; improve the quality of care through a continuum of integrated services; invest in promotion, prevention and early intervention; address stigma and discrimination and ensure equitable access; and research mental illness and evaluate health outcomes. Establishing a *Mental Health Parity Act* for mental health and addictions will take commitment and a will to work together. In developing a draft *Mental Health Parity Act*, federal, provincial/territorial and municipal governments should collaborate with Indigenous communities, people with lived experience of mental illness, the mental health sector and the public to ensure that proposed parity legislation responds to local needs.

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