Volume 6, Number 2

December 2006

CANADIAN CATHOLIC BIOETHICS INSTITUTE

Bioethics Update

Scratching the Surface: Senate Report on the State of Mental Health Care in Canada

Michelle Davis, BSc., MDiv., ThM., PhD (candidate), Researcher, Canadian Catholic Bioethics Institute

"*In no other field, except perhaps leprosy, has there been as much confusion, misdirection, and discrimination against the patient, as in mental illness…*"[1]

In October 2004, the Standing Senate Committee on Social Affairs, Science and Technology (The Committee) was authorized to examine and report on issues concerning mental health and mental illness. The Committee would also look at the issue of addiction. In May 2006, the final report entitled "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada" was submitted. The Committee heard from Canadians across the country about how mental illness affected them and their families. In all there were over 2,000 submissions. The report made 118 recommendations.

There is a general lack of knowledge about mental illness in Canada despite the fact that approximately one out of five Canadians will develop some form of mental illness in their lifetime.[2] There is a lack of services for those with mental illness and this is due in part to a shortage of professionals and under funding in mental health care. Because mental illness does not manifest itself physically like cancer or diabetes, some people disregard it as an illness.

The report looked at those who suffer from mental illness, their caregivers and what is needed to improve the delivery of mental health. The report addressed special groups such as children and youth, seniors and the Aboriginal Peoples of Canada. It stressed the need for self help groups, peer support, mental health promotion, mental illness prevention and national mental health initiatives. The Committee acknowledged discrimination and stigma associated with those who suffer from mental illness, and the need for people to have employment or income support and affordable housing. The report looked at how the Federal government exercises its responsibility for seven client groups (First Nations and Inuit, Federal Offenders, Canadian Forces, Veterans, RCMP, Immigrants and Refugees and Federal Public Service Employees).

The Effects on Individuals

When individuals with mental illness gave their submissions many spoke of the lack of dignity and respect they have experienced from doctors, nurses, employers, and the general public. People found it difficult to access the mental health care system and social services. Those living with a mental illness want to be treated with dignity and respect, have access to community based care and support, employment opportunities (or income support if they cannot work) and affordable housing.

Often it is the family of the person suffering from mental illness that is left to care for that person. When asked what they needed in order to care for their loved one, family caregivers responded that they needed peer support, income support and respite support. Peer support lets families know that they are not alone and that there are people who can help them navigate the health care system. Income support is crucial when families have to step in to care for a family member. The burden can be as minimal as providing financial assistance; to as severe as a family member needing to quit work to stay at home to care for a person. For those who do stay at home with a loved one suffering from mental illness respite care is a welcome benefit. The caregiver cannot be of assistance to anyone if he/she is burnt out.

Mental Illness and Employment

About 90% of those with a mental illness are unemployed[3] and need assistance to survive. Those who work face discrimination in the workplace and often find it difficult to retain their job. Some employers are understanding,

and try to accommodate the person as best they can by adjusting work hours, providing frequent breaks, allowing extra time to learn tasks, providing a quiet work environment, or providing training courses tailored to the individual's needs.[4] Should mental illness appear in early adulthood when a person is completing higher education and entering the workforce, this can have a devastating effect since many hopes and dreams are dashed and the prospects for work look grim.

Further, mental illness is taking a toll on the economy. "A 1998 report of the World Health Organization observed that more working days are lost as a result of mental disorders than physical conditions."[5] Another study dealing with the global burden of disease estimates that almost as many individuals battle depression (15.4%) as have a cardiovascular disease (18%).[6] One would think that funding for mental illness and addiction should be comparable to the toll on the economy. Unfortunately, this is not the case.

The implications from this are important especially as society becomes a "brain based"[8] economy. It has been estimated that the annual loss to the economy due to mental illness and addiction is $33 billion in Canada.[8] Some companies experiencing the negative impact are beginning to take action by setting up Employee Assistance Programs (EAP) to help workers deal with mental illness and addiction. These programs provide an outside source for employees to contact and get the appropriate help they need. One advantage of this program is that confidentiality is maintained, which is very appealing to many employees.

Addiction

The Committee realized that the problem of addiction could not be adequately addressed within the scope of the report and therefore only gave a general overview of the problem. Addiction included substance abuse and gambling, and addiction was considered in terms of its relation to mental illness. What the Committee found was that those who suffer from mental illness plus an addiction often do not get the care they need, or only one problem is dealt with at a time. Those who suffer from a mental illness and an addiction need concurrent care. By this is meant treating both conditions at the same time by the same group of professionals.

Children and Youth

In Canada approximately 15% of children and youth are affected by mental illness.[9] They live with anxiety, depression, addiction and other disorders. An increasing number of children and youth are committing suicide, especially in Aboriginal communities. A paediatrician, Dr. Diane Sacks, told the Committee that "most of the mental health disorders affecting Canadians today begin in childhood and adolescence and if not addressed early in life, threaten to bankrupt our health care system."[10] Children and youth, like adults, face stigma and discrimination by being bullied, misunderstood and labelled a "problem child". There is a shortage of child and adolescent mental health care providers. Another key issue is that of receiving "seamless care". Youths at a certain age are sent to the adult system, where too often they are considered too young for those programs. This means there is a gap in treatment and this needs to be corrected.

The Committee looked at screening children in schools for mental illness in a similar way that screening tests are done for sight and hearing. However, this has legal ramifications that are not easily resolved. The Committee would like to see teachers receive training to help recognize the signs of mental illness and take action. In an attempt to help teachers in this regard, Judy Hills, the executive director of the Canadian Psychiatric Research Foundation, developed a handbook for schools entitled "When Something's Wrong". The handbook identifies various mental illnesses that affect youth and is designed to help teachers recognize and deal with mood, thinking, and behaviour problems in young people. There is also a handbook for parents.

Seniors

Seniors with mental illness face the additional challenges associated with aging. Many have limited mobility and need assistance in their day to day activities. Seniors suffer from various mental illnesses like the general population but also from Alzheimer's and dementia. Their access to mental health care is affected by their mobility and by stigma and discrimination. Recovery is not a focus and treatment is not deemed important. In the hospital they are considered "bed blockers" and people to be "warehoused". Too often this goes hand in hand with over medication.

Seniors need care where they are located. This means providing community based care and support. Some seniors live in nursing homes and long term care facilities while others live with their caregivers. For seniors who can live on their own or with some home care services, they need decent and affordable housing.

Aboriginal Peoples

The Committee acknowledged that Canada's record of treatment of its Aboriginal citizens is a "national disgrace."[11] The area of mental health is no exception.

In fact, the mental health of Aboriginals is located at the extreme negative end of the continuum.[12] The rates of suicide and addiction are astonishing. Factors that promote wellness such as family and community support, economic opportunities, social and physical security are lacking for Aboriginal People.

Aboriginals make a distinction between mental illness and mental problems. They do not have higher levels of mental illness such as schizophrenia as compared to the general population but do have a higher rate of mental problems such as addiction and substance abuse, suicide and depression. The suicide rate among Aboriginals is 4 to 11 times higher than the non-Aboriginal population.[13] For Aboriginal youth (aged 10 to 19) the suicide rate is 5 to 6 times higher.[14] Suicide is not always linked to mental illness. Situational, socio-economic factors, desperation and despair contribute to suicide as do the effects of colonization, residential schools and racism. Children are committing suicide because they have just given up hope.

Access to services is a key issue since many Aboriginals live in remote areas that are under serviced in so many aspects. Aboriginals experience poverty, unemployment, and deplorable housing situations. Housing is scarce and the overcrowding so severe that people must take shifts for sleeping.

The Canadian Mental Health Commission needs to identify ways to decrease suicide rates, alcohol and substance abuse and addiction. This needs to be made a priority. Addiction programs need to be tailored to meet the needs of Aboriginals that are culturally based and use harm reduction and abstinence models. Mental health programs need to be delivered efficiently and effectively in a community based setting. Services offered need to be in language of the people and tailored to the traditions and customs of the Aboriginal Peoples. A "one size fits all" approach will not be useful.

THE CANADIAN FORCES

Brigadier-General Hilary Jaeger, the Surgeon General for the Canadian Forces (CF) stated before the Committee that "about half of the people who do have [mental health] issues are not coming forward to seek help, so we are still working on that."[15] She then went on to say that "[i]t is perhaps acceptable to have an operational stress injury or PTSD (posttraumatic stress disorder); it is not acceptable to have ordinary depression in the military."[16] In order to address some of these problems the CF decided to restructure its health care system. This restructuring project called Rχ2000 included an initiative to increase the number of mental health providers to CF members across Canada, develop standardized approaches to the assessment and treatment of key conditions, refine deployment-related psychosocial screenings to allow for earlier intervention, improve educational outreach, and to conduct research to improve practices and measure outcomes.[17] This is an important step as CF members continue to serve in various theatres of operation where they experience the deaths of fellow soldiers, genocide, armed attacks, suicide bombers and deaths of the civilians they are there to help.

In 1999, five Operational Trauma and Stress Support Centres were opened across the country to help deal with the psychological, emotional, social and spiritual issues that result from military operations.[18] These centres use a holistic approach with a multidisciplinary team. In 2002, the Department of National Defence and Veterans Affairs Canada launched Operational Stress Injury Social Support (OSISS) to help current and former CF members manage operational stress injuries. OSISS provides peer support, organizes support groups and helps the individual make contact with community resources. The Committee was pleased to see the breadth of services offered to CF members and their families. The Committee could see how similar programs could be modelled on the CF's programs.

Some CF members may be hesitant to seek help for mental health issues because of a fear of medical release. Brigadier-General Jaeger told the Committee that approximately 42% of all medically related time off work was for mental health issues and about 23% of CF members who are medically released have mental illness as their primary diagnosis.[19] This accounts for about 300 people. It was noted that the majority of people who are diagnosed with a mental illness return to work after treatment. Efforts are made to keep CF personnel and adapt work situations so medical release will not be necessary. Members who have a grievance and/or are medically released can bring their concerns to either the Ombudsman or the Canadian Forces Grievance Board. The Ombudsman investigates complaints and can serve as a neutral third party on matters related to CF members and employees of National Defence and the Canadian Forces.[20] The Ombudsman for National Defence was impressed by the high quality of care provided by OSISS. The Committee liked the concept of an Ombudsman and believed other Federal clients could benefit from one of their own.

FUNDING

The Committee recognized that there is much work to be done to provide quality accessible mental health care to

all Canadians and would like to see a Canadian Mental Health Commission set up to oversee initiatives. Like any project funding becomes an issue. The Committee estimates that $536 million annually for a 10 year period is needed to revamp the mental health care system. The money would be used to provide affordable housing, community based care, Telemental health services, a knowledge exchange centre, peer support groups, concurrent disorders programs, research, an anti-stigma campaign, mental health promotion and mental illness prevention.

Telemental health can work well for psychiatric diagnosis since it is more about communication (or lack of it) than about a physical examination of the patient. This service enables professionals who are in remote areas to stay connected to colleagues and can increase access to mental health services in these areas. Though the start up costs are high and practical problems such as licensing of practitioners and fees still need to be worked out, the Committee believes the benefits are worth the effort. Affordable housing is another initiative that requires funding. There needs to be new affordable housing units and rent supplement programs that subsidize people living with a mental illness who could not rent available units at current market rates. In Canada about 15% of the general population needs adequate, affordable housing and the rate is 27% (140,000) for those with a mental illness.[21] Cooperation with the Canada Housing and Mortgage Corporation is needed to help solve this problem.

The Committee recognized the need for more research into mental health, mental illness and addiction. They also realized that information about research projects, research findings and general knowledge about mental health issues needed to be readily accessible. The Committee recommended a Knowledge Exchange Centre (KEC), that is internet based and accessible to all be established to address this concern.

The Committee came up with a creative idea about how to raise the money needed to implement its recommendations. The Committee recommended that the government of Canada raise the excise duty on alcoholic beverages by $0.05/drink on alcoholic beverages with more than 4% alcohol content.[22] This duty would raise $478 million/year, leaving a shortfall of $58 million/year (10.8%). The Committee suggested that if the housing initiative was spread over 15 years instead of 10 years this would decrease costs. Ideally after 10 years the new system would be sustained by the normal revenue put towards mental health care.

CONCLUSION

At present the mental health care system in Canada is not meeting the needs of its citizens. Mental illness and addiction are taking a toll on the economy and on the lives of millions of Canadians. The Committee dedicated much time and effort to identify problems and come up with workable solutions. If action is not taken, the problem will only get worse. Education is the first step in the process of reform. The Committee stressed the need for a national strategy on mental health. This strategy would include mental health promotion, mental illness prevention, suicide prevention and addiction awareness. Good mental health is vital to the well being of all Canadians. Can we really afford to let the Senate Report be shelved and collect dust?

Endnotes

[1] Canadian Mental Health Association, *More for the Mind: A Study of Psychiatric Services in Canada* (Toronto, 1963)1.

[2] www.cmha.ca/bins/content_page.asp?cid=6-20-23-43 Accessed on November 13, 2006.

[3] The Senate of Canada. The Standing Senate Committee on Social Affairs, Science and Technology, "Out of the Shadows at Last" May 2006, p.171.

[4] *Ibid.*, p. 185.

[5] *Ibid.*, p. 178.

[6] *Ibid.*, p. 258.

[7] *Ibid.*, p. 179.

[8] *Ibid.*, p.178.

[9] *Ibid.*, p.135.

[10] *Ibid.*, p.135.

[11] *Ibid.*, p.361

[12] *Ibid.*, p. 361.

[13] *Ibid.*, p. 395.

[14] *Ibid.*, p. 395.

[15] *Ibid.*, p. 314.

[16] *Ibid.*, p. 314.

[17] *Ibid.*, p. 316.

[18] *Ibid.*, p. 316.

[19] *Ibid.*, p. 318.

[20] *Ibid.*, p. 320.

[21] *Ibid.*, p. 462.

[22] *Ibid.*, p. 474.

Canadian Catholic Bioethics Institute
81 Saint Mary St., Toronto, Ontario, Canada M5S 1J4
Telephone: 416-926-2335 Fax: 416-926-2336
Email: bioethics.usmc@utoronto.ca
Website: www.utoronto.ca/stmikes/bioethics