# Canadian Psychological Association's Participation and Comments on the Mental Health Commission of Canada's "Toward Recovery and Well Being: A Framework for a Mental Health Strategy for Canada. January 2009 Draft for Public Discussion"

# **Key Recommendations**

The Canadian Psychological Association (CPA) fully supports and applauds the Mental Health Commission of Canada (MHCC) in taking on the development of a mental health strategy for Canada. This is an initiative that is long overdue and one that promises significant benefit to mental health policy, service and, most importantly, to Canada's mental health. The following summarizes our key recommendations. The sections that follow provide some elaboration of these key points.

- Consider the use of descriptive rather than causal labels. The draft acknowledges that mental health problems have no single aetiology which, by definition, makes them disorders not illnesses.
- 2. **The MHCC needs to help launch a mental health system not transform one**. At present, Canada has a collection of unintegrated, multi-sectorial services.
- 3. In CPA's view, Goal 5 needs the most attention. Mental health and mental health problems happen in many settings and involve the practice and, ideally the collaboration, of many health and specialized mental health care providers. Multiple doors, accessed through communities, hospitals, the public and private practice offices of licensed health care providers, schools, or correctional facilities, should lead a person with a mental health problem to the care he or she needs. The largest numbers of Canada's regulated and specialized mental health care resource (i.e. psychologists and social workers) increasingly provide care outside of the publicly funded health care system. This means that the Canada's publicly funded health insurance plans fall significantly short of offering the evidence-based mental health service that people with mental health problems need. The MHCC needs to call for a system that is client or service based, not provider-based. The MHCC needs to call for a system that ensures that a person with a mental health problem has timely and equal access to the service demonstrated to meet his or needs.
- 4. We need a system that supports and offers evidence-based or evidence-informed services be these prevention and promotion, assessment, diagnostic, treatment, or social services.

  Just as practice should be informed by science, the questions posed by science should be informed by the lived experiences of persons with mental disorders as well as by the practice experiences of the providers of mental health care

# **General Comments**

The draft embodies some very interesting and progressive visioning for Canada's mental health. The progressive components are well developed and significant. They include a call for

• a client-centered and integrated mental health care system that operates from a principle of recovery and within communities in which people are psychologically literate and in which there is no tolerance for discrimination against those with mental disorders.

• a system that is responsive to diversity and culture and which recognizes and engages the many partners in mental health, most notably consumers and their defined families.

The draft also embodies some components that advance a more traditional or even regressive vision and that CPA hopes the MHCC will revisit in its next iteration of the draft Strategy. They include

- "Mental Illness" is used throughout the Strategy when in fact by definition they are disorders.
   Illness connotes a single aetiology which the draft clearly acknowledges is not the case for
   mental disorders. This nomenclature is clearly supported by diagnostic manuals in common use
   within mental health care (i.e. DSM).
- The Strategy calls for a transformation of a mental health system when in reality we have no system at all. We have a collection of multi-sectoral services that are not, but need to be, integrated in a way that ensures that the right service from the right provider reaches the right person in the right place and at the right time. Mental health and mental health services and supports happen across sectors (i.e. communities, schools, private practice, hospitals, clinics, the workplace, correctional facilities). The Strategy needs to more explicitly articulate this reality and propose a mechanism for creating a 'system' out of these largely unintegrated services and programs in a way that facilitates access to the mental health services and supports that people need. The Strategy needs to help launch a system not transform one.
- Though the Strategy acknowledges the range of mental health service providers working across systems, sectors and models of care, it proposes to integrate them and their services within traditionally or ill-defined models of primary care. As mentioned at the Ottawa strategy consultation meeting, we need a system in which every door or multiple doors lead a person to the care or support he or she needs. The primary care door (i.e. family physicians' offices) is an important one but not the only one.
- The Strategy insufficiently discusses concerns related to health human resource. The challenges of mental health human resource are not just absolute numbers or demographics of cohorts of health professionals but the need to best mobilize the mental health human resource that exists within Canada. Rather than advocate for the creation of a new category of paraproviders (i.e. system navigators) to assume roles already fulfilled by existing providers, the Strategy needs to do a better job at calling for more efficient and effective deployment of existing mental health human resource.

The largest groups of regulated providers of specialized mental health care (i.e. psychologists, social workers) provide services largely outside of the public health system. This is because we have provider-based, rather than service or client-based, delivery of publicly-funded mental health care. The MHCC needs to speak more clearly and louder about the urgent need to provide better access to mental health care in Canada delivered by the licensed providers trained to deliver them. It was mentioned by MHCC staff in the Ottawa strategy consultation that the narrative for Goal 5 on access was a 'place-holder' for the significant access issues in mental health. We call on the MHCC to take that place holder and turn it into a permanent place for timely and accessible mental health care in Canada.

• The document appears adult-centric at times throughout. It would be worthwhile reading it through with a lens to ensure that the conceptualizations and illustrations used speak to

- children and seniors living with mental health problems. For example, it would be helpful to better articulate what 'recovery' means for younger and older persons.
- Conceptually, we suggest that the prevention and promotion goal precede the recovery goal.
   Mental health literacy and education may mitigate or even prevent the onset of a mental health
   problem or disorder. Recovery is a concept relevant only when a mental health problem or
   disorder is established. We strongly encourage the MHCC to consider the prevention and
   promotion work undertaken by the Public Health Agency of Canada and/or the Chronic Disease
   Prevention Alliance of Canada in elaboration of the Strategy's goal on prevention and
   promotion.

# Section by Section Commentary on the Draft Strategy

### Introduction

- **Top of page 6**, "medical diagnosis" should read mental health diagnosis. Physicians are not the only regulated health service providers who diagnose mental disorders.
- **Top of page 6**. The language in this paragraph "untreated mental health problems...can lead to suicide" illustrates traditional views of mental disorders that they are caused by factors out of our control and can lead to consequences beyond our ability to control. People commit suicide and this sometimes related to a mental disorder and to the fact that the person with the disorder has not received, participated in or benefited from available care.
- Page 6, paragraph 5. The draft appears to distinguish mental disorders from chronic diseases when in fact some mental disorders can be chronic. Chronic disease can be psychological, physical or some combination thereof.
- Page 7, second paragraph. There is an implication that the mental health 'system' is the only factor determining recovery or lack of recovery from a mental disorder. Government sets policy and mental health 'systems' and providers operationalize it. If a person's health care needs are not met, it is not just the result of what consumers and providers do or don't do, nor the result of their best or worst efforts. It is also the result of mental health policy and legislation that determine what services are implemented and how.
- Page 10. The MHCC Strategy needs to be informed by the views and expertise of Canada's
  many stakeholders in mental health (e.g. consumers and families, providers, regional
  governments who deliver health care). Stakeholder engagement will potentiate uptake and
  create champions for the Strategy so that they won't need to "be persuaded to adopt the
  strategy..."

### Goals

# Goal 1: Recovery

**Recovery may be a national vision or value but it is a personal goal**. Further, this section needs to better articulate how the concept or personal goal of recovery applies to other than adult populations (e.g. children, seniors). As was discussed at the Ottawa consultation, there is a need to develop a clear and common understanding among provider communities and communities of persons living with

mental disorders about the meaning and significance of the recovery model. CPA is also a member of the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) which, as you know, is a table of representatives from national organizations of providers of mental health care and of those living with mental disorders. CAMIMH is the best, and arguably the only, venue where this common understanding can be developed and disseminated. We strongly urge the MHCC to partner with CAMIMH for this purpose.

**Page 25, second paragraph.** The second sentence references community supports, primary care and hospitals – again a traditional view of service and systems. This section should specifically mention specialized mental health care, services and programs. Community supports, primary care and hospitals do not make up the sum total of mental health care delivery venues. Specialized mental health services and programs are delivered in private practice, schools, and correctional centres by psychologists, social workers and others in addition to nurses and physicians working in hospitals or primary care settings.

# **Goal 2: Promotion and Prevention**

The attention that the draft pays to research and the importance of evidence-based service needs to find equal voice in this section. It is as important that promotion and prevention programs are evidence-based and/or evidence-supported as is treatment.

**Page 28, paragraph 6.** Childhood trauma doesn't only impact brain development; it affects emotional and behavioural development and functioning!

**Page 30.** Has the MHCC consulted the Public Health Agency of Canada and their considerable work on health promotion and prevention in sourcing this goal and developing its objectives? The literature on resiliency and emotional wellness in the context of health promotion and prevention would inform the elaboration and discussion of this goal.

# **Goal 3: Cultural Safety**

In the elaboration of this goal, the MHCC puts the onus on the providers to ensure cultural safety for consumers. While providers do indeed have this responsibility, it is a shared responsibility. There is a corresponding onus on government and institutions to support and facilitate the means, mechanisms, services and structures necessary to providing culturally safe care.

As was the case with recovery, the Ottawa consultation highlighted stakeholder feedback that there is a need to develop a common understanding of cultural safety among stakeholder groups in mental health. CAMIMH is the unique table where this common understanding can be developed and disseminated.

**Page 32**. Providers have an obligation to provide safe care not just 'culturally safe' care. Cultural safety and safety in general is critical to health care, not just mental health care. Everyone, including providers, operate within multiple 'cultures'. This fact is not sufficiently acknowledged on this page though it is elaborated on page 33.

**Page 33, second to last paragraph**. This paragraph makes an assumption that providers need to become more competent in delivering culturally competent care. Many groups of providers have been paying attention to the need to train their members in the delivery of culturally competent care. While we can always do more and better, it is not the case that we have been doing nothing. For example, the need for doctoral programs to train psychologists to work with persons from diverse groups has long

been among our Accreditation Standards for doctoral programs and internships in professional psychology.

# **Goal 4: Importance of Families**

We suggest that this goal be better articulated so that it sufficiently recognizes that

- the consumer need be the centre of care,
- the involvement of families in a person's care should, whenever possible, be at the will of the consumer of care, and that
- confidentiality is a critical and legally and professionally enforced feature of the relationship between a provider and a consumer of care.

We strongly agree that attention must be paid to supporting the needs of the families of those living with a mental disorder and the need to direct prevention and promotion activities and information towards families.

**Page 36.** This section might be informed by the wealth of literature on disability. There is a value within physical medicine and rehabilitation that families should not be caregivers. Families should have familial relationships. With cuts to public health care, however, families have increasingly taken on caregiver roles (physical and mental caregiving) and, as pointed out at the Ottawa consultation, sometimes the fact that persons are judged to have family supports limits their access to professional care.

# Goal 5: Access

From CPA's perspective, this goal and section needs the most attention. It assumes a mental health system which the draft later acknowledges does not exist. The draft takes primary care as its starting point which it does not define. Traditional definitions of primary care are the offices of family physicians and family physician's offices are not, and need not be, the only access point to mental health care.

Though Canada's mental health would be better served by better integration of and access to service, this is not necessarily accomplished by shoring up traditional models of primary care. Consumers may consult family physicians because they are trusted health care providers. However, they also consult them for their mental health needs because that is what is on public offer in terms of mental health service. As the draft points out, the services of non-physician providers are not accessible. What the draft does not mention is that the largest numbers of specialized and regulated providers of mental health care in Canada provide services that are generally not publicly provided or accessible to everyone. We have a provider based public health 'system' in Canada. We need a service-based system where the needed service is delivered by the trained and regulated provider and, as the draft points out, with the consumer at the centre. The people of Canada deserve the evidence-based mental health service indicated for the mental health problem they are experiencing. For mental disorders, psychological treatments are among the best indicated interventions — particularly for anxiety and depression; the most commonly experienced of mental health problems. We need a system that enables people to get the service they need not just the services traditionally on public offer.

Page 42, The way to redress stigma is not to enhance primary care venues so that consumers are spared the embarrassment of having their mental health needs apparent. **We need to create a 'social movement' where it should be okay to openly seek mental health services.** Not all mental health issues need be filtered through traditional primary care venues – they are not currently and needn't be.

Access is not about providers – it is about service and as long as we have a public system that is only provider based, it will never fully be about needed and evidence-based service.

Page 47, The use of 'talk therapies' is dismissive and disrespectful. Evidence-based psychological treatments are among the best indicated interventions for many mental health problems and disorders. Revisit the wording of the last paragraph. It is presumptuous and inaccurate to say that providers need to train their members to provide evidence-based service. Regulated providers are driving the evidence-based bus – the introduction of non-regulated or para-providers such as system navigators may well compromise it.

# **Goal 6: Evidence-based care**

In addition to the specific comments below, the CPA would like to encourage the MHCC to consider calling for a separate funding envelope for mental health research so that funding is commensurate with the burden of these kinds of health problems. According to the World Health Organization, by 2020 depression will become the second leading cause of disability adjusted life years for all age groups and both sexes; second only to heart disease

http://www.who.int/mental\_health/management/depression/definition/en/
The burden and significance of mental health problems to Canadians needs to be reflected in the funds we direct to treatment and research.

Though the CPA endorses and promotes evidence-based care in its accreditation standards that govern the training of psychologists, we also recognize the need to consider evidence-informed care. In emergent situations, where there might not yet exist a strong evidence base, there is none-the-less a clinical imperative to provide service. An example might be the need to attend to the psychological distress experienced by persons in environmental disasters or pandemics. In these situations, service might be evidence-informed.

The draft spends some time addressing the limitations of randomized control trials and other scientific sources of information and highlights the need to take account of other sources of knowledge such as lived experience. While we do not disagree that different kinds of inquiry and sources of information can add to knowledge, the draft disproportionately addresses the limitations of the randomized control trials. Not all kinds of evidence are of equal value. All kinds of inquiry may be subject to various kinds of bias, unreliability and threats to validity – this is as, if not more, true of other kinds of inquiry as it is of the scientific method. Science-based practice is the hallmark of psychological training. However, psychological science is advanced when its inquiry is client-based as well as practice-based (i.e. research questions that are informed by the lived experience of clients or the practice experiences of providers) – both of which can be accomplished within the scientific method.

Finally, mental disorders have biopsychosocial determinants and their course is impacted by biopsychosocial factors. Research informs us that medication and psychological treatments work better in combination for many mental disorders than either alone and for some problems, psychological treatments are the treatments of choice

http://www.cpa.ca/cpasite/userfiles/Documents/advocacy/Cost-Effectiveness.pdf

It is extremely important that Canada fund research on this full range of factors and treatments for mental disorders, not just biomedical ones.

**Page 18, second bullet** under "In a transformed mental health system:", psychological needs to be added to the first bullet "...and will be focused on social, **psychological** as well as biological factors".

**Page 18, fourth bullet**, The MHCC cannot mandate specific kinds of research. It can call for support for specific kinds of research.

# **Goal 7: Discrimination**

**Page 19, Key Principles**, the second bullet mentions only 'social' programs? Why not support access to any kind of program (i.e. social, tax, health)?

**Page 50**, Another evidence of stigma is the lack of access to evidence-based mental health service by regulated providers of health care who are not medical providers.

Page 52, second to last paragraph, reads like it belongs in the recovery section, not the stigma section.

# **Goal 8: Social movement**

In addition to the specific comments below, we echo the feedback expressed at the Ottawa stakeholder consultation. We query whether a federally funded agency should be leading a social movement. The MHCC should consider that a social movement is best led by the grassroots and consider whether this is a mantle best taken up by the grassroots organizations, like CAMIMH, whose work and advocacy preceded, and in fact contributed to, the launch of the MHCC.

Page 20, under "In a transformed mental health system", fourth bullet. Stigma impacts a fundraising infrastructure – not the stigma among providers and systems but the stigma within societies and communities.

**Page 54,** Mental disorders are not analogous to AIDS or diabetes. Mental disorders comprise a diversity of conditions. Expecting one charity to address the diversity of issues and needs related to the range of mental health problems and disorders would be like expecting one physical disease charity to address the issues and needs of cancer, diabetes, AIDS, heart disease etc.

# **Conclusion and Contacts**

In conclusion, the CPA applauds the MHCC for its work thus far in developing a mental health strategy for Canada. We appreciate the opportunity to provide our feedback in contribution to this important work and look forward reviewing its next iteration once the stakeholder consultations are complete. We will follow up our feedback with Dr. Chodos and note that we are glad to lend our assistance to the work of the MHCC at any time.

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