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The Grim Challenge of Mental Health (Part II)

By Dr. John Conway

As I read last week's Statistics Canada report on community mental health, I was reminded of Bertrand Russell's definition of a civilized citizen: "One who can read down a column of statistics and weep."

The two headline numbers were that more than 10 per cent of Canadians (2.6 million) suffer from mental illness, but only 37 per cent see or talk with anyone in a position to provide help. As one who has looked at a great many such statistics, I know that the number of Canadians who each year suffer from mental illness is closer to 20 per cent. One in four families has at least one member suffering from a mental disorder right now.

The survey, an initial release of a multi-year study, did not include children under age 15, First Nations people living on reserves, or severely and persistently mentally-ill persons such as those suffering from schizophrenia. Including these and others not surveyed, the prevalence of mental illness is almost certainly about twice the rate reported by Statistics Canada, if we apply the best epidemiological community surveys from the U.S. to the Canadian population.

The burden of mental illness on health and productivity is immense. Permit me to cite another statistic, this one from research undertaken in recent years by the World Health Organization.

Mental illness, excluding substance-abuse disorders, ranks second in the "global burden of disease" in established market economies like Canada. "Global burden of disease" is a measure that accounts for lost years of healthy life due to disability or premature death.

Mental disorders collectively account for slightly more than the burden associated with *all* forms of cancer. When substance-abuse disorders are included with mental disorders, they are the leading causes of years lost to disability or premature death. Major depression ranks second only to HIV/AIDS in the world in the magnitude of disease burden for adults. The burden of depression is equivalent to that of blindness or paraplegia; schizophrenia is equal in disability burden to quadriplegia.

Productivity losses, like absenteeism and downtime costs, due to depression, anxiety, substance abuse and burnout run at about $33 billion a year in Canada, according to estimates released this summer by a high-powered panel of corporate leaders and health-care experts called the Global Business and Economic Roundtable on Addiction and Mental Health. The panel is led by former federal finance minister Michael Wilson, whose son committed suicide in 1995.

Suicide

(As an aside on suicide in this country, few will know that during the months that SARS took some 70 lives in the Toronto area, about twice as many people in Toronto would have taken their own lives.)

The Roundtable has declared the next 12 months as the Business Year for Addiction and Mental Health. During the year, the group plans to allocate resources to reduce workplace stress, depression and anxiety, and promote mental and cardiovascular health. They want to get as many as 1,000 companies involved in "an all-out frontal attack."

I applaud this important initiative in tackling mental illness in the workplace. It is about time.

Another piece of good news is that, contrary to what many still think, there are now effective professional treatments for many mental illnesses. The evidence base for the efficacy of these treatments is well-documented, notably by the the first-ever report on mental illness by the U.S. Surgeon General in 2000.

Psychiatrists today have drugs available that are significantly more effective than 10 years ago -- drugs for anxiety, depression, bipolar disorder, schizophrenia, attention deficit hyperactivity disorder. Most of the drugs for these disorders are prescribed by family physicians.

Between one-third and one-half of all patients who visit family doctors have a significant mental-health problem. The problem is that family physicians do not detect many such mental illnesses. And when they do, they often do not prescribe the best newer drugs at effective dosages, or take necessary follow-up measures to ensure that patients continue to take prescribed medications.

Psychologists and other counsellors today have newer therapies available that also are significantly more effective than a decade ago. The evidence is compelling for the effectiveness of such therapies as cognitive behavioural therapy for anxiety and depression; assertive community-treatment approaches and assisted-employment programs for the severely and persistently mentally ill; behavioural programs for parents and children with ADHD and disruptive disorders; and multisystemic community-based programs for youth with antisocial behaviour problems and substance abuse.

One problem with these new psychological therapies, however, is that most therapists and counsellors simply do not use them or do not use them appropriately, relying instead on old practices.

Still, the real "problem" with psychiatrists and psychologists is that, despite their pleas that more and more of their kind are desperately needed (and more would surely be better), there will never be enough mental-health specialists to provide anything close to

the volume of services needed to meet the needs of the six million Canadians who suffer from mental-health problems each year.

What saddens me most of all, as someone who has devoted time to policy and advocacy work in mental health, is that none of this is new to decision-makers in our governments. Earlier this year, a report I authored on mental health in Saskatchewan was released. A friend and fellow advocate said "There is nothing really new in these 160 pages." He was right. I could have subtitled my report with the same words used in the last Saskatchewan report done almost 20 years ago: The Forgotten Constituents.

Almost 40 years ago, Mr. Justice Emmett Hall's famous medicare commission identified mental illness as the problem of greatest public concern. This year, Roy Romanow called mental-health care the orphan in our health-care system.

Health dollars

How can mental-health needs compete for health dollars today when reducing waiting-lists for surgery, cancer treatment and other acute-care needs spawn headlines almost every day? Less than five per cent of the Saskatchewan health budget goes to mental-health care, and its share has decreased each year as dollars for acute care have risen. Mental-health care, however, extends well beyond our provincial health departments.

What is needed are community programs in our schools, churches, workplaces and the criminal justice system to identify mental-health problems early and provide some help. It is here, in our communities, where mental-health professionals are perhaps most needed -- to design and implement programs and support those others who will be on the front lines providing these early services.

On the federal front, national standards for best services in mental health are long overdue. Research funding for mental health here is a tiny fraction of what it is in the U.S. Ottawa should be taking the lead, in partnership with provinces, in public education to reduce the stigma that remains attached to mental illness -- the main reason why almost two-thirds of sufferers do not seek out help from either professionals or their families and friends.

Finally, there are the mental-health needs of our aboriginal peoples, who comprise about 13 per cent of the population in Manitoba and Saskatchewan. Their mental-health problems are, in important part, the result of a long history of oppression and abuse, a legacy of colonization and cultural dislocation.

The statistics here have brought tears to my eyes.

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