Externally-Informed Annual Health Systems Trends Report – Third Edition
Trend Backgrounder

Trend 5 – MENTAL HEALTH AND ADDICTIONS

INTRODUCTION

One in five Canadians will experience mental illness in their lifetime.[1] Mental illness is accompanied by significant costs to the health care system, employers, as well as the individuals affected by mental illness. In Ontario, approximately one third of claims for short and long-term disability benefits (70% of total costs) are due to mental illness, which amounts to an estimated $15 billion to $33 billion annually. [2] The World Health Organization estimates that depression will be the second leading cause of disability by the year 2020.[3]

SUMMARY OF KEY FINDINGS

Growing Challenges:

- According to a 2009 survey by the Centre for Addiction and Mental Health there is a 31% prevalence rate of psychological distress, a 21% prevalence rate of hazardous drinking, and a 16% prevalence rate of drug use problems in Ontario students in grades seven to twelve.[5]
- In 2003, the economic burden of mental health illness of persons over 20 in Canada was estimated at $51 billion.
- In 2003/2004, total mental health care spending in Canada was $6.6 billion, five percent of total health care spending, a rate below most comparable countries.
- A study using data from the population health supplement to the Ontario Health Survey found that anxiety disorders and affective disorders were more prevalent among caregivers than non-caregivers.

Emerging Responses:

- The harm reduction philosophy of treatment has emerged and evolved over the past two decades as a response to growing concerns about the adverse consequences of substance abuse for both the individual and society – namely the spread of HIV and other blood-borne infections.
- "Supported employment" – a model that places clients in competitive jobs without extended preparation and provides on the job support from trained "job coaches" or employment specialists – has been found to be a best practice for employing people with a mental illness.
- Scotland's National Programme for Improving Mental Health is highlighted in the literature as a successful public mental health policy that addresses the Social Determinants of Health.
- The mental health of caregivers is starting to be recognized as an issue of concern. Several jurisdictions are setting up paid informal caregiver policies to help caregivers alleviate the burden of juggling work and caring for an individual.

GROWING CHALLENGES

A WHO report states that mental health is determined by socioeconomic and environmental factors, as the risk of mental illness is associated with indicators of poverty, including low levels of education, and in some studies with poor housing and low income.[4]

Substance Abuse and Addictions

- Twin reports on a 2009 survey of Ontario students in grades seven to twelve found a 31% prevalence rate of elevated psychological distress, and 12% prevalence rate of self-reported poor mental health among students.[5] Furthermore, the survey found that 21% of students reported drinking at a hazardous level, and approximately 16% of students may have a drug use problem.[6]

- According to 2005 survey data, 2.6% of Ontarians had moderate gambling problems while 0.8% had severe gambling problems.[7]
- A national survey found that between 1994 and 2004, the proportion of Canadians who reported having used an illicit drug in their lifetime rose from 28% to 45%. Cannabis was found to be the most widely used type of drug, followed by hallucinogens, cocaine (or crack), speed and heroin.[8]
- Between 1977 and 2007, the number of police-reported drug offences had increased, with the largest category of drug crimes involving cannabis and the second largest category involving cocaine. Although police-reported cannabis offences have been decreasing over the past 30 years, cocaine offences have been increasing over the past 30 years.[9]
- According to a US survey, rates of current use of illicit drugs in 2008 were higher for young adults aged 18 to 25 (19.6%) than for youths aged 12 to 17 (9.3%) and adults aged 26 or older (5.9%). 4.6% of men and women ages 18 to 25 reported use of prescription pain drugs for non-medical reasons, a 12% rise from the previous year, continuing the rising trend of recent years while 1.5% in this age group used cocaine in 2008, a 23% drop from 2007.[10]
- A US study found that of 8,455 Midwestern youth, 40% had at least some problems with gambling and 10% of the sample fit the profile for probable pathological gamblers.[11]
- In 2007, 25% of youth aged 11 to 15 in England reported trying drugs at least once.[12]
- The proportion of youth in England who took illicit drugs in the last year was 17% in 2007.[13]

Employment and Mental Health

- It has been suggested that depressive disorders are highly prevalent in the workplace and have a negative impact on performance, productivity, absenteeism, and disability costs.[14, 15, 16]
- Mental illnesses have been identified as the leading cause of workplace disability in the US and Canada for persons aged 15 to 44.[17]
- In 2002, nearly half a million employed Canadians aged 25 to 64 reported the occurrence of a major depressive episode in the previous 12 months. An additional one million workers had experienced depression during some other period in their lives.[18]
- According to 2003 Statistics Canada data, 275,315 Ontarians living with a serious mental illness were unemployed.[19]
- In 2003, the economic burden of mental health illness of persons over 20 in Canada was estimated at $51 billion.[20]
- Some of the challenges of dealing with mental illnesses in the workplace include addressing misconceptions about mental illness and overcoming both the stigma and discrimination of living with mental health issues.[21, 22]

Access to Mental Health Services

Access to mental health services is a critical issue facing consumers nationwide. The need for timely access to integrated mental health services has been highlighted and identified by many including the Kirby and Keon *Out of the Shadows at Last* report[23], the Canadian Mental Health Association, [24] and Ontario's Select Committee on Mental Health and Addictions.[25]

- In 2003/2004, total mental health care spending in Canada was $6.6 billion, five percent of total health care spending, a rate below most comparable countries.[26]
- In a 2010 report, Ontario's Select Committee on Mental Health and Addictions found that one of the main problems in Ontario's mental health and addictions system is that there is no coherent system. Mental health and addictions services are funded or provided by hundreds of agencies, and no one person or organization is responsible for connecting these various parts. As a result, many people do not access care as a result of the complexity of the system.[27]
- A study assessing mental health practices in Ontario used a sample of physicians from a mixture of rural, urban and university settings to determine access issues. Identified barriers to delivery of optimal mental health care included difficulties in accessing psychiatric care, poor

communication with mental health care providers, and difficult intake procedures for many mental health services.[28]

- A recent study found more than 80% of a sample of Saskatchewan family physicians saw at least six patients per week with mental health problems. Many family physicians were generally dissatisfied with the quality of mental health care they were able to provide because of issues of access to mental health professionals – especially psychiatrists.[29]
- According to a qualitative study that interviewed senior managers of children's mental health centres across Ontario, the central challenges of access and delivering mental health care to children were: funding, case complexity, waitlists, staffing, and system integration. Senior managers noted that desires for system integration and collaboration were countered by competition for funding and the struggle to meet service demand.[30]
- A nationally representative survey of 6,600 primary care physicians (PCPs) in the US found that PCPs had far more difficulty obtaining mental health services for patients than they did obtaining other commonly used services. Two-thirds of PCPs reported that they were unable to get outpatient mental health services for patients; more than twice the rate reported for any of three other common referrals. Reasons cited for the difficulties included lack of insurance, lack of providers, and health plan barriers.[31]

Mental Health of Caregivers

- It has been suggested that caregiving can lead to increased rates of depression, stress, and anxiety.[32]
- A recent Ontario study found that anxiety disorders and affective disorders were more prevalent among caregivers than non-caregivers.[33]
- Despite the valuable contributions that are made by informal caregivers in Canada, there are too few services in place to help caregivers maintain their own health and balance. Although there are some supports and resources for caregivers across Canada, they tend to be limited and are often provided through voluntary organizations.[34, 35]
- A US study examining caregiver burden found that 13% of caregivers met the diagnostic criteria for one or more psychiatric disorders.[36] Additionally, 80.8% of participants had discussed a mental health concern with a health care provider before their loved one was diagnosed with cancer, but only 46.2% had sought professional help with their mental health after their loved one's diagnosis.[37]

EMERGING RESPONSES

Substance Abuse and Addictions

- The harm reduction philosophy of treatment has emerged and evolved over the past two decades as a response to growing concerns about the adverse consequences of substance abuse for both the individual and society – namely the spread of HIV and other blood borne infections.[38]
    - The harm reduction philosophy emphasizes the provision of specific interventions (e.g., needle exchange, drug substitution, safe injection sites) in which the expectation of reduced drug consumption is secondary to changing *patterns* of consumption and related behaviour (e.g., sexual or criminal behaviour) to reduce the risks to the individual and society.[39]
    - Several countries have explicitly adopted harm reduction as a national drug policy and many jurisdictions including Ontario have woven this philosophy into treatment policy.[40]
    - In September 2010, the UN committed to combat HIV/AIDS and other diseases in part through the use of harm-reduction techniques such as expanding access to sterile injecting equipment.[41]
    - In Toronto, Ontario, the Annex Harm Reduction Program at Seaton House is home to 140 homeless men who have lived on the street and require help because of alcohol addiction and other serious illnesses. The Annex

helps the men get better through a harm reduction approach that helps them with alcohol addictions and health problems. At the Annex alcohol intake is closely supervised to make sure future harm is reduced.[42]
    - A recent study found that Vancouver's supervised injection site is associated with improved health and cost savings, even with conservative estimates of efficacy.[43]
- The development of treatments for gambling problems has been based largely on treatments for substance use problems. The decision to integrate substance use and gambling treatment services in Ontario is consistent with similarities in the neurobiology and treatments for these two problems, as well as their high rates of co-morbidity.[44]
- Recent evidence supports the effectiveness of Methadone Maintenance Treatment (MMT) for opioid dependence.[45, 46, 47] A recent systematic review of 11 trials found that MMT retains patients in treatment and decreases heroin use better than treatments that do not use opioid replacement.[48] A number of factors have been found to be associated with better MMT outcomes, including rapid access to treatment, higher methadone doses, flexibility regarding doses, a non-punitive attitude toward illicit drug use, an explicit orientation toward maintenance (as opposed to reduction), and the provision of ancillary psychosocial services.[49]
    - In April 2006, the Ministry of Health and Long-Term Care commissioned a task force to advise the ministry on how to improve MMT in Ontario. In 2007, the Task Force made 26 recommendations based on improving access to a range of integrated services at the community level, education for health professionals, and appropriate payment and support of MMT.[50]
    - In Australia, MMT programs have been available since 1985. A report on their national drug strategy notes that methadone is the most common pharmacotherapy used in Australia for opioid-dependence, and it is recognised nationally and internationally as an effective method for treatment of opioid dependence.[51]
    - A recent systematic review suggested that heroin should be provided to patients with histories of past treatment failures as a last resort. Patients who were prescribed heroin with flexible doses of methadone had reduced use of street heroin and reduced criminal activity, and were more likely to remain in treatment.[52]

Employment and Mental Health

- The Canadian Institute of Health Research offers funding to support research teams in creating innovative research programs designed to reduce the burden of mental illness in the workplace and foster the development of policy and program interventions.[53]
- A recent pilot study found that a collaborative mental health care team model (primary care physician and psychiatrist) may be more cost-effective than independent medical examinations for addressing workplace short-term disability leave related to psychiatric illness. The study found that with this model of care, for every 100 people on short-term disability leave, there could be $50,000 in savings related to disability benefits along with more people returning to work, and 1600 more workdays.[54]
- "Supported employment" – a model that places clients in competitive jobs without extended preparation and provides on-the-job support from trained "job coaches" or employment specialists – has been found to be a best practice for employing people with a mental illness.[55]
    - A recent systematic literature review found that supported employment is more effective than pre-vocational training in helping severely mentally ill people obtain competitive employment. Thirty-four percent of people who received supported employment were still employed after

one year, whereas only 12% of people who had received pre-vocational training were still employed.[56]

- Individual placement and support, a model that emphasizes rapid job search and continued support to patient and employer from an employment specialist who is an integral member of the mental-health service team, has been extensively applied in the US and has been recommended to the Governments of England and Scotland as an approach to consider when developing employment programs for people with mental health problems.[57]

Access to Mental Health Services

- In its final report, Ontario's Select Committee on Mental Health and Addictions' first recommendation was the creation of a new umbrella organization (Mental Health and Addictions Ontario (MHAO) to ensure that a single body is responsible for designing, managing, and coordinating the mental health and addictions system, and that programs and services are delivered consistently and comprehensively across Ontario. The Select Committee made 23 additional recommendations including that a basket of core institutional, residential and community services is available in every region of the province, that MHAO should facilitate the creation of more 24/7 mobile crisis intervention teams, and that more be done to publicize Telehealth Ontario's ability to respond to callers with mental health and addictions issues.[58]
- In Ontario, service information on alcohol and drug, gambling, and mental health services are now located under one umbrella – *Connex*Ontario.[59]
- Telehealth is a promising approach for delivering children's mental health services especially in underserved areas. According to one study, participants in Nova Scotia's Family Help telehealth program felt comfortable and safe in their own home; they did not feel stigmatized or judged; they had little apprehension about self-disclosure and they felt that treatment was delivered at their convenience. As well, attrition rates were low and children felt actively engaged in the structured treatment.[60]
- According to a recent literature review, collaborative mental health care (health care professionals with different specialties or sectors working together to treat patients) is associated with positive patient outcomes including improvements in overall symptoms, depression and anxiety free days, and adherence to medication and treatment plans.[61] For example, one review found that collaborative care was associated with a two-fold increase in anti-depressant adherence.[62]
- The Ottawa Court Outreach Program is a community support program in which individuals with severe and persistent mental illness are referred for outreach services at a time in which they are legally involved. Outreach workers perform a variety of functions, including assertive outreach, client and systems advocacy, symptom management, life skills teaching, supportive counselling, and family support and crisis intervention.
  - A recent evaluation of the Ottawa Court Outreach Program found it resulted in diminished severity of mental health symptoms, reduced homelessness, and more desirable legal outcomes for clients as perceived by program staff. However, the program is limited in its ability to respond to the large population who needs its services.[63]
- Although acting early may prevent future episodes of mental illness and reduce the health, social and economic costs of mental illness and addictions,[64] a Cochrane review of early interventions for psychosis was unable to find sufficient evidence about the effectiveness of such programs to draw any definitive conclusions. [65]
- Assertive Community Treatment (ACT) is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and

persistent mental illness. It has been widely implemented in the United States, Canada, and England[66] and the Schizophrenia Patient Outcomes Research Team (PORT) has identified it as an effective and underutilized treatment modality.[67]

- The "Fusion of Care" model of shelter based collaborative mental health care for homeless men at Seaton House in Toronto is a service delivery model that offers physical and mental health care services at the shelter. Such collaborative care models may be a possible solution to the complex health needs of homeless individuals as primary care and mental health services are delivered in one place.[68]
- Scotland's National Programme for Improving Mental Health is a successful public mental health policy that addresses the social determinants of mental health. The National Programme aims to influence and join up with policy areas outside of health in order to develop a cross-sectorial approach to mental health promotion in all sectors of government. [69] Specifically, Scotland's mental health strategy includes an anti-stigma campaign and focuses on six priority areas including children's mental health and mental health in the workplace.[70]

Caregiver Supports

- Increasingly, more jurisdictions are setting up paid informal caregiver policies to help caregivers alleviate the burden of juggling work and caring for an individual.
    - The Netherlands provides a personal budget for caregivers, tax deductions, career interruption pay, and ten days of care leave at 70% of normal wage.[71]
    - In the UK, caregivers receive a caregiver's allowance and direct payments, as well as pension protection, tax discounts, and second pensions.[72]
- Strategies to alleviate depressive symptoms among caregivers include:
    - Multi-component caregiver support interventions
    - Respite care to reduce caregiver burden
    - Financial support to alleviate economic stress of caregiving
    - Primary care interventions that address caregiver needs.[73]
    - In September 2008, the Ministry of Health and Long-Term Care began the Caring-About-Caregivers Long-Range Scenario Planning (LRSP) project to explore ideas that would better support family caregivers and other informal caregivers. After consulting with project participants, partners and stakeholders, the project's final report recommends four strategic themes for further strategy and policy development:1) adapting the definition of caregivers to changing families and communities, 2) competing and caring in shifting economies and demographics, 3) system navigation and education, and 4) building on social networks.[74]
- In the US, the Middle Class Taskforce has made supporting family caregivers a priority.[75] The healthcare reform law contains the Community Living Assistance Services and Supports (CLASS) Act, which creates a voluntary insurance program for purchasing community living assistance services and supports;[76] these benefits can be used to compensate family caregivers.[77] Further, the US budget for 2011 provides tax relief of up to $2,100 for middle-class families to pay for the costs of caring for a relative, and $103 million for the Administration on Aging's Caregiver Initiative, an effort to expand help to families and seniors so that caregivers can better manage their multiple responsibilities. The initiative provides new resources to support agencies that already provide help to caregivers.[78]
- The Caregiver Support Program run through Vancouver Coastal Health provides information to connect people to health care, community, and support services in Vancouver, and helps caregivers assess their needs.[79]

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