

Mental Health Now!

Advancing the Mental Health of Canadians: The Federal Role

SEPTEMBER 2016

OUR MEMBERS

Canadian Association of Occupational Therapists
Canadian Association of Social Workers
Canadian Association for Suicide Prevention
Canadian Coalition for Seniors' Mental Health
Canadian Counselling and Psychotherapy Association
Canadian Federation of Mental Health Nurses
Canadian Medical Association
Canadian Mental Health Association

Canadian Psychiatric Association
Canadian Psychological Association
College of Family Physicians of Canada
HealthCareCAN
Mood Disorders Society of Canada
National Initiative for Eating Disorders
Psychosocial Rehabilitation Canada
Schizophrenia Society of Canada



CANADIAN ALLIANCE ON MENTAL ILLNESS AND MENTAL HEALTH
ALLIANCE CANADIENNE POUR LA MALADIE MENTALE ET LA SANTE MENTALE

WHO WE ARE

The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) is the national voice for mental health in Canada.¹ Established in 1998, CAMIMH is an alliance of 16 mental health groups comprised of health care providers and organizations that represent people with mental illness, their families and caregivers.

CAMIMH's fundamental objective is to engage Canadians in conversations about mental health and mental illness. CAMIMH and many of its partners have long talked to Canadians about reducing the stigma and discrimination associated with mental illness, now is time to advance the conversation. We need to talk about how to ensure that people get better access to the services and supports they need.

Vision

A Canada where everyone enjoys good mental health.

Mission

CAMIMH advocates for a Canada where all who live with mental illness and mental health issues, their families and caregivers, receive timely and respectful care and supports in parity with physical health conditions.

Guiding Principles

CAMIMH is committed to a National Mental Action Plan rooted in the following principles:

1. Mental illness and mental health issues **must** be considered within the framework of the determinants of health, recognizing the important links between psychological, social and biological health.
2. Given the impact of mental illness and mental health issues – the suffering of Canadians, early death, suicide and the increased use of health, justice and social services – governments, regional health authorities and health planners must increase access to mental health services to a level proportional to the burden on individuals, families and society.²
3. Mental health promotion and the treatment of mental illnesses must be timely, continuous, collaborative, culturally safe and appropriate and integrated across the life cycle (from children to seniors) as well as the continuum of care (from tertiary to home/ community care) and including social supports.

For more information on the activities of CAMIMH, please visit www.CAMIMH.ca

EXECUTIVE SUMMARY

The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) is the national voice for mental health in Canada. Established in 1998, CAMIMH is an alliance of 16 mental health groups comprised of health care providers and organizations that represent people with mental illness, their families and caregivers.

In its role as advocate, CAMIMH believes now is the time for the federal government, in strategic collaboration with the provinces and territories and as part of a negotiated First Ministers' health accord, to significantly accelerate investment in mental health programs and services.

To advance the policy discussion, CAMIMH has developed a five-point plan focused on funding, structure, innovation, system performance and health outcomes. While additional resources for mental health are desperately needed, they must be invested where they truly make a difference.

Ensure Sustainable Funding for Access to Mental Health Services

Government funding for mental health should increase from 7.2 percent of total public health spending to a minimum of nine percent. The federal government's share of this should be 25 percent. This means the federal government would contribute an additional \$777.5 million annually to the provinces and territories to improve access to a range of mental health programs and services, and to get better health outcomes. CAMIMH believes these dollars must be protected for mental health initiatives. Respecting the flexibility each province and territory requires to set its priorities, CAMIMH has identified areas where investment will improve timely access to care, by focusing on the objectives of *mobilizing* the capacity of the mental health system and improving the overall *integration* of services and programs. Federal infrastructure funds could be used to support this work.

CAMIMH also recommends that the federal government introduce a *Mental Health Parity Act* that affirms that mental health is valued equally to physical health.

In addition to playing a catalyst role with the provinces and territories, CAMIMH recognizes the primary responsibility of the federal government in funding and providing mental health care for indigenous peoples, veterans and Canadian Forces federal inmates, and public servants.

Accelerate the Adoption of Proven and Promising Mental Health Innovations

CAMIMH recommends that the federal government establish a five-year, \$100 million Mental Health Innovation Fund. This targeted and time-limited fund would jump-start the spread of innovation and lead to systemic and sustainable change to effectively address the mental health needs of Canadians.

In addition, and with the goal of sustainability, we believe that the federal government should engage the provinces and territories in thinking through the system change that will deliver effective mental health care to more Canadians. The United Kingdom and Australia have taken a more systemic approach to redressing needed mental health service gaps, with promising results. Options for Canada to implement system-wide change to the delivery of mental health care have been considered and costed out; either by enhancing the capacity of mental health resource on primary care teams, augmenting fee-for-service models through private, extended health care insurance, or adapting UK models for Canada.

Given the close relationship between health research and the adoption of innovation, CAMIMH calls on the federal government to review funding levels for mental health research.

Measure, Manage and Monitor Mental Health System Performance

CAMIMH understands that you cannot manage what you cannot measure. In mental health, there are data gaps for both the public and private sector. More collaboration with the Canadian Institute for Health Information (CIHI) and the Canadian Life and Health Insurance Association is required to get a comprehensive picture of how access to mental health care services are funded.

Currently, there are no comparable pan-Canadian mental health indicators to assess the performance of mental health programs and services at the federal, provincial and territorial level. While CAMIMH strongly endorses the Mental Health Commission of Canada's (MHCC) groundbreaking work on mental health indicators, it recommends the development of a set of mental health performance indicators which are comparable within and across the provinces and territories. CAMIMH supports

expanding the scope of the MHCC project to a larger number of indicators that cover the continuum of mental health care across all provinces and territories and focuses on the dimensions of quality, such as, safety, effectiveness, patient-centered care, timeliness, efficiency and equity. This standardized set of pan-Canadian measures would improve the overall accountability and transparency of the mental health system, and help identify areas of high performance, accelerate the adoption of leading practices and highlight where improved oversight is required.

CAMIMH believes that CIHI has a transformational role to play in collecting and reporting such data to the public. To make this a reality, the federal government *must* dedicate additional resources to CIHI to increase its capacity to collect data on mental health system performance indicators and mental health expenditures.

Establish an Expert Advisory Panel on Mental Health

An expert panel can provide exceptional value in terms of engagement. Representation should be national in scope and include the lived experience community and mental health service providers. Areas of focus could include: (1) Exchange perspectives on the challenges and opportunities to improve the mental health of Canadians, (2) Discuss strategies, policies and programs that improve mental health and access to mental health services, (3) Present innovative practices and system reforms from Canada and elsewhere that advance the mental health of Canadians and improve system performance, (4) Review the public-private interface to access mental health services, and (5) Identify gaps in mental health research priorities. It is essential that the Advisory Council and the Mental Health Commission of Canada complement each other's work.

Invest in Social Infrastructure

Programs that support economic and social well-being are compassionate, evidence-based preventative health strategies that can produce significant long-term cost savings. Improving the social determinants of health can transform the lives of those living with mental illness. It is recommended that the federal government consider social infrastructure in a more holistic way.

It is recommended a targeted basic income to support all Canadians who are vulnerable because of age, labour-market status or ability be explored. This program could build on existing negative income tax mechanisms such as the Guaranteed Income Supplement for seniors, the Canada Child Tax Benefit for families with young children, and the Goods and Services Tax/ Harmonized Sales Tax Credit.

As a poverty reduction measure, a targeted basic income would reduce the long-term social and financial costs of poverty and directly affect the mental health of Canadians. A basic income, paired with other comprehensive strategies such as an affordable housing strategy, would be a key part of a national mental health strategy. It is recommended that the federal government work with the provinces and territories to build on the success of the At Home/Chez Soi program. In addition to reducing homelessness, such a program would alleviate poverty and address concurrent mental health and addiction issues.

The numbers around the burden of mental illness (pages 5-8), illustrate why now is the time to invest in the mental health of Canadians. There is a growing awareness among the public and politicians that the status quo for mental health is not acceptable. The ongoing negotiations around a First Ministers' health accord presents a unique opportunity for the federal government to lead efforts to improve timely access to care, accelerate the adoption of innovative models of care, and more comprehensively measure system performance. It is also an opportunity to create a mechanism for ongoing discussion, dialogue, learning and action.

BACKGROUND

CAMIMH has been a leading advocate for a national action plan on mental health and mental illness since 1998. CAMIMH was instrumental in campaigning for a Mental Health Commission of Canada (MHCC) with a mandate to develop a national mental health strategy. In 2007 the Commission was established and in 2012 it released, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*.

More recently, CAMIMH advocated for the 10-year renewal of the MHCC's mandate which was subsequently announced in the 2015 federal budget. CAMIMH applauds successive federal governments for their leadership in understanding the importance of mental health and the Commission's role. In the last year CAMIMH members contributed to the Commission's draft action plan to implement the national strategy's recommendations.

CAMIMH reaches out to Members of Parliament and Senators on a regular basis, the public and the media through its *Faces of Mental Illness* campaign which features the stories of Canadians living in recovery from mental illness. Initially launched as *Let's UnMask Mental Illness* during the inaugural Mental Illness Awareness Week in 1992, this was the first national grassroots campaign to open a public discussion about mental illness with Canadians and was critical in creating awareness and decreasing stigma and discrimination.

CAMIMH also recognizes the significant contributions of individuals and organizations that have advanced the mental health agenda in Canada at its annual *Champions of Mental Health Gala*. Champions include those with lived experiences, politicians, business leaders and members of the national media who have made a difference in the lives of Canadians with mental illness.

THE TIME IS NOW!

In its role as advocate for the mental health of Canadians, CAMIMH believes the time is now for the federal government, in strategic collaboration with the provinces and territories, to accelerate investment in mental health programs and services.

CAMIMH strongly supports Prime Minister Trudeau's commitment to develop a First Ministers' Health Accord with the provinces and territories and, as was articulated in the 2016 federal budget, his government's intent to improve access to high quality mental health services in Canada.³ CAMIMH also notes the importance the Prime Minister placed on mental health by identifying it as a priority in eight Ministerial Mandate letters. This is unprecedented and sends a strong message that the time is now for mental health! This attention is long overdue. CAMIMH applauds the federal government for its leadership and looks forward to working with them to advance the mental health of Canadians.

MENTAL HEALTH BY THE NUMBERS

Mental Health and Canadians

While Canadian society has grown in its recognition that mental health is important, CAMIMH believes it is crucial to understand the numbers that illustrate the burden of mental illness across the life span.



1 in 5 (6.7 million)

Canadians suffer from a mental illness each year.⁴

By comparison,



1 in 15 (2.2 million)

Canadians suffer from Type 2 diabetes.



The proportion of Canadians at *high risk for mental illness* has increased from **33% to 35%** year-over-year.⁶

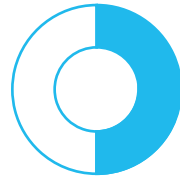
As part of the 6.7 million Canadians with mental illness, *Substance Use Disorder* (addiction), not always recognized as a mental disorder, is the *second most common*.⁵



70% of young adults living with mental health problems report their symptoms *started in childhood*.⁷



28% of people aged 20-29 experience a mental illness.



By age 40, **50%** will have or have had a mental illness.⁸



By 2020, *depression will become the second leading cause (next to heart disease) of disability* adjusted life years for all age groups and both sexes.⁹



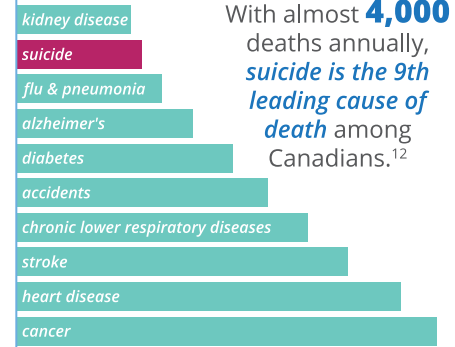
500,000

Canadians, in any given week, are *unable to work* due to mental illness.¹⁰



People with mental illness and addictions are *more likely to die prematurely* than the general population.

*Mental illness can cut 10 to 20 years from a person's life expectancy.*¹¹



First Nations youth die by suicide about **5 to 6 x more often** than non-Aboriginal youth.



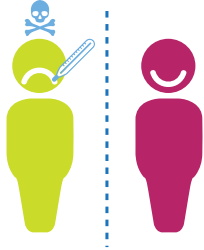
Suicide rates for Inuit youth are among the *highest in the world* at **11 x the national average**.¹³

more on next page

MENTAL HEALTH BY THE NUMBERS

Mental Health and Canadians

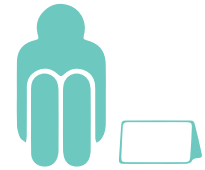
While Canadian society has grown in its recognition that mental health is important, CAMIMH believes it is crucial to understand the numbers that illustrate the burden of mental illness across the life span.



People with mental illness are **more likely to die from suicide** compared to those with no mental illness, and tend to have **higher rates of physical illness**.¹⁴



People living in **low-income neighborhoods are more at risk** of developing mental illness such as depression than people living in high-income neighborhoods.¹⁵



Studies in various Canadian cities indicate that **between 23% and 67%** of homeless people report having a mental illness.¹⁶



Almost **40%** of male offenders **require further assessment** at admission to determine if they have mental health needs.¹⁷



30% of women offenders had been **previously hospitalized** for psychiatric reasons.

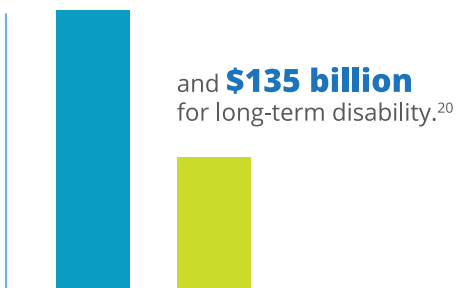
60% of incarcerated women are **prescribed psychotropic medication** to manage their mental health.¹⁸



The cost of mental illness and addictions in developed countries is estimated at **between 3%-4%** of gross domestic product.¹⁹

In 2015 this was **\$143.4 billion**.

The private sector spends between **\$180-\$300 billion** on short-term disability for mental illness

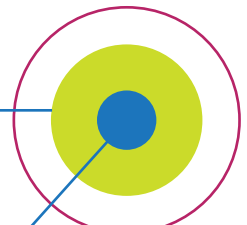


and **\$135 billion** for long-term disability.²⁰



Mental health issues account for more than **\$6 billion** in **lost productivity** due to absenteeism and presenteeism.²¹

The economic cost of mental health problems is **\$51 billion** (2.8% of GDP [2011])...



...of which **\$20 billion** stems from the workplace.

In 30 years, the total cost is projected at **\$2.5 trillion**.²²

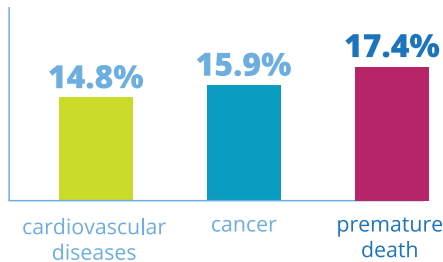
MENTAL HEALTH BY THE NUMBERS

Mental Health and the Health Care System

While Canadian society has grown in its recognition that mental health is important, CAMIMH believes it is crucial to understand the numbers that illustrate the burden of mental illness across the life span.



Mental disorders account for *more of the global burden of disease than all cancers combined*.²³



Mental health disorders in developed countries account for *more premature deaths than cancer and cardiovascular diseases*.²⁴



At 24%, depression (along with high blood pressure) was the *top ranked reason* Canadians see a physician.²⁵



33% of hospital stays in Canada are due to mental disorders.²⁶



10% of patients with mental illness experience a *repeat hospital stay*



and it is **20%** higher for patients living in *poorer neighborhoods*.²⁷

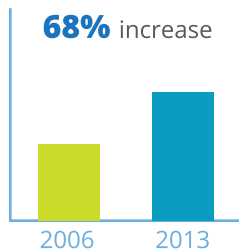


While *hospitalizations for children and youth* have increased by **42%**...

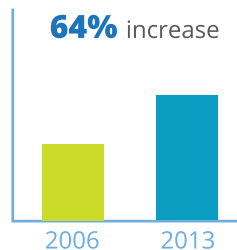
hospitalizations for other conditions have decreased by **16%**.²⁸



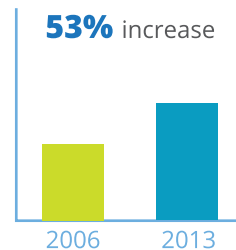
1 in 12 youth were dispensed a mood/anxiety or antipsychotic medication.²⁹



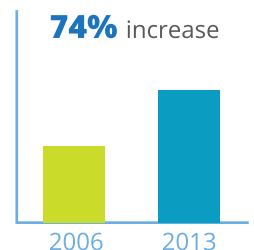
E.D. visits for *children and youth aged 10-14*



inpatient hospitalizations involving *one overnight stay*



E.D. visits, *youth aged 15-17*



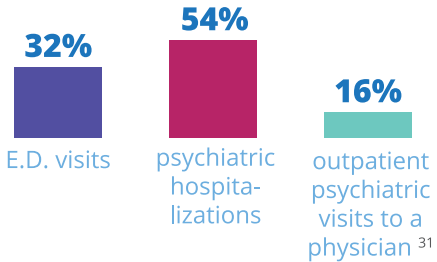
E.D. overnight stays, *youth aged 15-17*³⁰

MENTAL HEALTH BY THE NUMBERS

Mental Health and the Health Care System

While Canadian society has grown in its recognition that mental health is important, CAMIMH believes it is crucial to understand the numbers that illustrate the burden of mental illness across the life span.

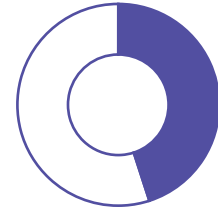
Between 2006-2011 among Ontario children and youth, there were significant increases in...



In 2015 **6,000 children** waited one-year for treatment.



In 2016, this number **doubled to 12,000**



44% of seniors living in residential care facilities has a diagnosis and/or symptoms of depression.³³



Hospital stays for mental illness



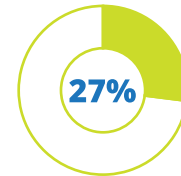
29 days for seniors



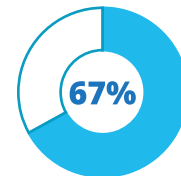
16 days for adults 45-64³⁴



At **33%**, **mental health** was ranked second behind cancer (36%) as a **top priority for new funding**.³⁵



Canadians think mental health conditions should be given a **higher rather than lower funding priority (4%) than physical health conditions**.



A significant majority would treat **mental and physical health equally**.³⁶

The numbers are compelling and tell us:

1. Mental illness affects all segments of Canadian society. **No one is immune.**
2. Only one-third of those with a mental health problem reported that they will seek and receive care;³⁷ this because of stigma and because **care is not sufficiently accessible.**
3. There is a growing demand for the treatment of mental illness and **Canada needs to expand its capacity to provide care.**
4. More resources are needed to increase the capacity to make the treatment of mental illness **accessible and timely.**
5. To provide quality care that is cost-effective and evidence-based, increased collaboration among governments, public and private sector providers, people with lived experience, and their families and caregivers is **urgently needed.**
6. We can't just talk about mental health and mental illness. **The time to act is now.**

OUR FIVE-POINT ACTION PLAN

As the federal, provincial and territorial governments negotiate an agreement on the future of health and health care in Canada, mental health must be addressed in a significant way. To assist them in improving access to mental health services across the country, CAMIMH has developed a five-point plan focused on funding, structure, innovation, system performance and health outcomes. While additional resources for mental health are desperately needed, they must be invested where they truly make a difference.

1 Ensure Sustainable Funding for Access to Mental Health Services

It is generally acknowledged that mental health is underfunded in Canada. Recent analysis from the Mental Health Commission of Canada suggests that mental health funding should be increased from 7 to 9 per cent of total public health spending.³⁸ The most recent estimates place provincial and territorial government spending on mental health and addictions at 7.2 per cent of total public health spending.³⁹ CAMIMH agrees that 9 per cent is the *minimum* level of public investment required to improve access to a range of mental health programs and services, and get better health outcomes.⁴⁰

While a two percentage point increase amounts to close to a 30 per cent increase in mental health funding, an essential question remains, *what should be the federal government's share?* CAMIMH is of the view that the federal government, in its national leadership role, should contribute a minimum of one out of every four health care dollars to the provinces and territories.⁴¹

With the federal share increased to 25 per cent, the annual federal investment to support increased access to mental health services would be an additional \$777.5 million.⁴² While such dollars could flow to the provinces and territories via the Canada Health Transfer, CAMIMH strongly recommends the funds be earmarked through a Mental Health Transfer, or a dedicated envelope to maximize accountability, transparency and impact. Further discussion is needed to determine over what time frame federal funding for mental health should increase.

While the federal dollars are to be transferred to the provinces and territories for mental health services and programs only, there should be sufficient flexibility for the provinces and territories to invest the resources based on their respective priorities.

CAMIMH recommends that new resources be invested to expand access to evidence-based mental health services and include:

Access to Care

The biggest challenge facing Canadians experiencing mental illness and mental health issues is *timely access to care*. Public information on access to publicly-funded mental health services is limited,⁴³ and there is no data on the considerable mental health services not covered by provincial and territorial health insurance plans, services typically delivered by psychologists, social workers and counsellors. Patients who receive these services pay for them through private insurance and/or out-of-pocket.

Canadians deserve timely access to the right combination of evidence-based services, treatments and supports, when and where they need them. When it comes to many mental disorders, especially ones that may be severe, persistent and recurrent, effective management and recovery depends on a team of people working together; teams which include a range of service providers, peer support, patients and families. Teams need to be supported across the venues in which care is delivered; venues that include communities, schools, the workplace and healthcare facilities. Canada needs to do a better job supporting the delivery of team-based care where it is most clinically and cost-effective. The key policy question is how best to do this when it comes to the overall architecture of the mental health system.

The capacity to deliver timely access is hampered by fragmented and poorly coordinated services and supports. The mental health system is in urgent need of improved integration, and people with lived experience and their families and caregivers must be involved in the design and evaluation of these systems.

To move the conversation forward, CAMIMH believes it is important to focus on the twin policy objectives of mobilizing the *capacity* of the mental health system and *improving* the overall integration of services and programs. CAMIMH believes that the federal government, through targeted funding for mental health as part of a First Ministers' Health Accord, can play a crucial role in addressing the following challenges:

Collaboration in Primary Care

An expanded use of collaborative care/team-based practice has the potential to substantially increase the capacity of the system to see more patients across the lifespan and deliver care where and when they need it. These models include not only the service

of physicians but also that of other mental health providers such as psychologists, social workers, psychiatric/mental health nurses, counsellors and psychotherapists. Together they offer complementary services and supports to ensure individuals receive evidence-based care they need with a minimum of obstacles.

Acute and Specialized Services

When the need for acute hospital care or highly specialized services, like early psychosis intervention or residential addiction treatment arises, this should not result in wait times. All too often, those who need a psychiatric hospital bed cannot access one or spend long hours in the emergency room. In some cases, there are an inadequate number of beds, in other cases, patients who no longer need acute care remain in beds because there is a lack of step down care, supported housing, long-term care and home care services. Conversely, the absence of community supports can result in people with complex needs released with inadequate discharge and follow-up.⁴⁴ The effective management of severe, persistent and recurrent mental illness depends on a team of providers, peer support, patients and families working together. These teams need to be supported across the venues in which care is delivered.

Access to medications is a significant barrier for people with mental illness. In most provinces medications are covered only in hospital. Otherwise people must pay out-of-pocket if they do not have private insurance or public funding through disability support. Psychiatric medications can be very expensive and poverty and unemployment are more likely to be an issue for those with severe mental illness. Front line treatments for mental illness are medication and psychotherapies. Outside of publicly funded institutions, neither of these treatments are funded by Canada's public health insurance plans.

Community-Based Programs and Supports

Effective community-based programs and supports are essential to treating and supporting people in recovery. Evidence-based early interventions across a range of mental disorders are critical to treatment success and improve outcomes and save resources. These programs and services are particularly important tools for recovery which should be available to people living with severe and persistent mental illnesses – such as schizophrenia, bi-polar, addiction, obsessive compulsive and eating disorders.

A large body of evidence documents that community programs and supports such as assertive community treatment (ACT) teams and supported employment services are effective, evidence-based approaches which, particularly when combined

with cognitive behavioral therapies (CBT), significantly increase the success of community living while substantially reducing psychiatric emergency hospitalization.⁴⁵

These evidence-based community approaches are not only essential to people in recovery but are also the key to reducing or avoiding the major service system costs associated with acute care admissions as well as the related police and social services costs. For example, the substantial evidence evaluating the effectiveness of ACT Teams consistently demonstrates reductions in acute care hospital admissions and days of hospitalization in the order of 56-78%.⁴⁶

Despite strong evidence, the uptake of evidence-based community programs and supports in most Canadian provinces and territories has been slow. The vast majority of mental health funding goes to acute care.⁴⁷ The resulting failure to invest in effective programs and supports has ironically resulted in steadily escalating pressures on acute care.

The consequences are emergency department overcrowding, revolving door psychiatric admissions and discharges and high and increasing demands on police and social services. The high economic costs associated with insufficient investment in effective, community-based services are in addition to the enormous personal and social costs associated with failure to provide effective, community-based and recovery-oriented treatment and support.

CAMIMH sees the federal government's commitment to invest in physical infrastructure such as affordable housing and seniors' facilities (including long-term care facilities), as playing a critical role in expanding community-based capacity to assist those experiencing mental illness and mental health issues.⁴⁸

CAMIMH's position is that the provinces, territories and health authorities must invest in community-based mental health organizations that provide access to evidence-based services and supports which make it possible for seriously mentally ill people to recover, live successfully in their communities as participating and productive members of society. The investment in effective, community-based services and supports provides the greatest opportunities to mitigate and avoid the enormous costs of mental illness and the pressures on hospital, police and social

services, and would fulfill an important component of the Mental Health Strategy of Canada to improve access to services and facilitate leadership and collaboration.⁴⁹

Managing Chronic Disease and Mental Illness

Poor health is often linked to poor mental health. One seminal longitudinal study found that a pessimistic world view among men at age 25 predicted physical illness decades later.⁵⁰ There is a strong association between mental illness among those living with chronic physical disease and psychological factors have been found to even predict or impact the development of physical disease. Many chronic diseases, such as heart disease, diabetes and stroke are themselves risk factors for depression.⁵¹ Depression is a risk factor for first myocardial infarction and an even stronger predictor of recurrent cardiac events and mortality in patients with known disease.⁵² More needs to be done to recognize and manage the relationship between chronic disease and mental illness.

Supply, Mix and Distribution of Providers

With the growing demand for mental health services and programs, more thought and planning needs to be given to the number of providers, how they are organized and where they should practice. This will require developing more sophisticated methods to assess need and examining how high quality, evidence-based care is delivered, including the funding and models to support their delivery.

Use of Technology

We live in an increasingly digital world. Technologies like the internet, apps, and telemedicine/telehealth are increasingly part of the solution to treat mental illness. Governments at all levels need to work with providers and those with lived experience to develop the most useful technology tools to improve mental health.

Individual Engagement and Empowerment, and Carer Support

Individuals living with mental illness want to be involved in their own care. Engaging with individuals and families may be an important step to improve outcomes for both.⁵³ Carers provide daily supports and often do not experience mental health breaks from the tasks associated with looking after loved ones. A recent report says the stress load on people helping to care for an

elderly or sick family member or friend has more than doubled in Ontario in the past four years. Health Quality Ontario says 33 per cent of people who care for loved ones at home reported feeling distress, anger or depression in 2013-14, up from 16 per cent in 2008-09. We need to recognize this health care contribution and provide necessary supports for carers.⁵⁴

There is no substitute for being among people who are going through the same things as you are. Peer support is a crucial component to recovery and wellness maintenance. Peers recognize warning signs in others before they lead to crisis situations. Peers have the trust of their colleagues and this leads to a greater willingness to share. Peer training support needs to be better funded nationally to develop consistent standards of training. Peer support teams need access to a national community resource and referral system. Because a peer support team member can receive a cry for help from someone anywhere, they need to have access to a national system that allows them to connect immediately with peers in all locations of the country. Through a national system, tools, resources and learned lessons can be better shared.

Early Intervention

Approximately 70 per cent of mental disorders begin before young adulthood and the strongest evidence for return on investment in mental health involve services and supports for children and youth.⁵⁵ Good health is linked with self-worth, peer connectedness, school engagement, parental nurturance and healthy behavior.⁵⁶

Effective services and supports for families, children and youth focus on reducing conduct disorders and depression, deliver parenting skills, provide anti-bullying and anti-stigma education, promote health in schools and provide screening in primary health care settings for depression and alcohol misuse. Supporting children and families with access to the information, skills and tools they need for their well-being will advance health and aid in the management of illness.

Early psychosis programs provide early intervention to mitigate the long term consequences of psychotic disorders in young people. These programs are based on the early detection and optimal treatment of psychotic disorders, particularly schizophrenia. There is substantial evidence that these programs reduce the devastating impact of psychosis on young people, their families and society in general.⁵⁷ Accordingly, early psychosis programs have been developed and implemented in most provinces and territories.

Early intervention also applies to seniors. By 2041 it is projected that mental illness for adults between the ages of 70 and 89, including but not limited to dementia, will be higher than for any other age group.⁵⁸ There is a need to increase the capacity of older adults, their families, and those who work with them to identify mental illnesses, dementia, elder abuse, and risk of suicide, and intervene early when problems first emerge.

Mental Illness Prevention and Mental Health Promotion

There are two types of mental illness prevention – primary, which prevents mental illness developing in the first place, and secondary which reduces or prevents the recurrence of mental illness. Additionally, secondary prevention may also reduce the severity or acuity of any recurring mental illness. There are a number of studies in the mental illness prevention literature which document the effectiveness and cost-effectiveness of primary prevention approaches.⁵⁹ Accordingly, primary prevention programs and interventions for children, youth and individuals who are at risk for developing mental illness should be a high priority for health and human services.

With the goal of improving access to promotion, prevention, early intervention, community support and treatment programs, CAMIMH is supportive of a five-year \$40 million National Suicide Prevention Project proposed jointly by the Mental Health Commission of Canada and the Mood and Disorders Society of Canada.⁶⁰

Secondary prevention programs and services should be available to all individuals in recovery from serious mental illness.

Research proves that when the social determinants of health are supported, individuals are much less likely to develop mental health challenges. Access to adequate income, housing, and health care services are important preventative strategies.

To alleviate the maximum amount of suffering by Canadians with mental illness and mental health issues while getting the maximum impact for each dollar spent, CAMIMH recommends that governments target the policies, programs and services in the areas previously outlined.

We can no longer delay. We must begin now to reduce the significant disparity between the resources allocated to mental health and physical health. To demonstrate that mental health is valued equally to physical health,⁶¹ CAMIMH strongly encourages the federal government to take a clear leadership role and introduce a *Mental Health Parity Act*.⁶²

The Federal Government: A Direct Role

In addition to playing a catalyst role with the provinces and territories in the area of mental health, the federal government is the primary health care provider for specific, and often vulnerable, populations including Indigenous Peoples, veterans, Canadian Forces members, RCMP, federal inmates and public servants.

CAMIMH believes the federal government has an essential role in continuing to invest the resources needed to improve mental health access, health outcomes and system performance. As a national coalition, CAMIMH looks forward to directly engaging with the federal government on these issues.

Indigenous Peoples

Budget 2016 takes important first steps to invest in indigenous peoples.⁶³ This budget begins to address the social determinants of health by pledging to spend a substantial portion of \$8.4 billion over five years to improve indigenous housing, education, employment and training, safe shelter for victims of violence, childcare and early learning, water and waste management. \$270 million of this fund for indigenous peoples is also to be allocated to the repair, building and renovation of First Nations health care centres.

Criminal Justice System

There has been a 60 to 70 per cent increase in federal offenders with mental health problems at admission since 1997.⁶⁴ The Correctional Investigator of Canada has reported annually on the problematic treatment of federal inmates with mental illness. The Minister of Justice has been mandated to review how inmates with mental illness are treated and how to restrict the use of solitary confinement. The minister has also been tasked to work with the Minister of Public Safety and Emergency Preparedness as well as the minister of Indigenous and Northern Affairs to address gaps in services to Aboriginal people and to those with mental illness throughout the justice system. In addition to improving the care inmates receive while in jail, it will be important to increase programs that divert people with mental illness away from the corrections system, ensure that all inmates have a comprehensive discharge plan upon release into the community and that police, court and corrections workers are adequately trained to respond to mental health problems and illnesses. The federal government has the opportunity to lead by example and influence parallel change in the provincial justice system.

Veterans and Military Members

While work remains to be done, mental health services for Canadian Armed Forces (CAF) members have greatly expanded over the last decade, CAF members would benefit from periodic screening for PTSD and common co-occurring conditions such as major depressive disorder, anxiety, addictions and suicide, enhancing early detection and treatment. These co-occurring conditions are common and need to be treated aggressively to improve outcomes. Operational stress injuries also affect the spouses and children of military members and veterans. The federal government has a role to play in coordinating better access to provincial community services for families. Compared to CAF members, veterans have been comparatively neglected. CAMIMH is pleased that Veterans Affairs has launched a new initiative to consult with veteran stakeholders, forming six advisory groups, one of which focuses specifically on mental health.

Federal Public Servants

CAMIMH applauds the federal government's decision to adopt the Mental Health Commission of Canada's National Standard for Psychological Health and Safety in the Workplace. This is an important step that focuses on the mental health of those who serve all Canadians. Further, in 2014 Treasury Board doubled the coverage for psychological services that it offers its employees and their families through their extended health insurance program.⁶⁵ This decision demonstrates an awareness and commitment to the mental health needs of working Canadians.

2 Accelerate the Adoption of Proven and Promising Mental Health Innovations

There are pockets of excellence that provide Canadians with access to leading-edge, innovative mental health services and programs but there is a lack of national coordination and resourcing to scale these up and spread them across the country. In the absence of additional resources, innovative programs will remain local and admired from afar.

While the delivery of health care services is largely, but not exclusively, a provincial and territorial responsibility, CAMIMH believes the federal government can act as a catalyst to accelerate the adoption of proven and promising innovations in mental health.⁶⁶

CAMIMH recommends that the federal government create a strategically-targeted, time-limited fund, a Mental Health Innovation Fund, to deliver evidence-based mental health care to Canadians.⁶⁷ To start this should be a five-year fund valued at \$20 million per year for a total of \$100 million.⁶⁸

While a targeted and time-limited fund would jump-start the spread of innovation, Canada needs systemic and sustainable change to its health delivery systems in order to effectively address mental health needs. This means building a cost-effective system that allows people to access evidence-based services, treatments and supports.

In addition to a time-limited and strategically targeted fund, CAMIMH believes that the federal government has an even more important role to play in Canada's mental health. While the term "innovation" is an often-cited solution to many of the challenges facing the health system, pockets of innovation without sustainable system change will fall short of meeting Canada's mental health needs. We need a health system that will support and implement cost-effective and clinically-effective care where and when Canadians need it.⁶⁹

Accordingly, we believe that the federal government should engage the provinces and territories in thinking through the system change that will deliver effective mental health care to more Canadians. Work has been done to consider how the successful innovations from countries like the United Kingdom and Australia could be adapted to Canada. These models have taken a more systemic approach to redressing needed mental health service gaps, with promising results.

The United Kingdom's Improved Access to Psychological Therapies (IAPT) program has recovery rates in excess of 45 per cent and has seen more than 45,000 people move off sick pay and benefits following successful treatment. IAPT treatments are delivered by a range of service providers with different stepped care roles (e.g. psychologists, counsellors and/or therapists, and social workers). Options for Canada to implement system-wide change to the delivery of mental health care have been considered and costed out;⁷⁰ either by enhancing the capacity of mental health resource on primary care teams, augmenting fee-for-service models through private, extended health care insurance, or adapting an IAPT program for Canada. This work can be a starting point for inter-government discussion.

CAMIMH also understands the close links between research and applied health system innovation and strongly encourages the federal government to review its current funding levels

for mental health research which currently stands at less than five per cent of funding from the Canadian Institutes of Health Research. Given the burden of mental health on society at large, funding for mental health research must be more proportionate.

3 Measure, Manage and Monitor Mental Health System Performance

When it comes to improving the performance of the mental health system, CAMIMH understands that you cannot manage what you cannot measure. In mental health, there are data gaps for both the public and private sector. For instance, many CAMIMH members, with the exception of physicians, provide care through both the public and private sector (private insurance and/or out-of-pocket payments). Much more needs to be done in collaboration with the Canadian Institute for Health Information (CIHI) and the Canadian Life and Health Insurance Association to get a comprehensive picture of how access to mental health care services are funded.⁷¹

Furthermore, there are no comparable pan-Canadian mental health indicators to assess the performance of mental health programs and services at the federal, provincial and territorial level.

CAMIMH strongly endorses the Mental Health Commission of Canada's groundbreaking work on mental health indicators.⁷² This identifies 63 national level indicators across thirteen areas of focus, highlighting whether performance is moving in the right direction; is unchanged; or it is moving in an undesirable direction. It is essential that this work be undertaken at the national level to help us understand the bigger and connected picture of mental illness and mental health in Canada.

In addition to this work, CAMIMH is supportive of recent research that develops and reports on a relevant set of mental health performance indicators within and across the provinces and territories.⁷³ This initial project has six indicators collected across five provinces. CAMIMH supports expanding the scope of the project to a larger number of indicators that cover the continuum of mental health care across all provinces and territories and focuses on the dimensions of quality, such as, safety, effectiveness, patient-centered, timeliness, efficiency and equity.⁷⁴ This standardized set of pan-Canadian measures would improve the overall accountability and transparency of the mental health system, and help identify areas of high performance, accelerate the adoption of leading practices and highlight where improved oversight is required.

CAMIMH believes that CIHI has a transformational role to play in collecting and reporting such data to the public. To make this a reality, the federal government must dedicate additional resources to CIHI to increase its capacity to collect data on mental health system performance indicators and mental health expenditures.

CAMIMH is pleased that mental health and addictions is one of four priority populations identified in CIHI's strategic plan,⁷⁵ and is eager to contribute its perspective and expertise to the range of mental health indicators that should be developed.

4 Establish an Expert Advisory Panel on Mental Health

During the 2015 federal election campaign the Liberal Party of Canada committed to establishing a pan-Canadian Expert Advisory Council on Mental Health. While no details have been made available about its mandate or structure, CAMIMH agrees such a mechanism can provide exceptional value to the government and is a unique way to engage the mental health community. Representation should be national in scope and include the lived experience community and mental health service providers. The panel should allow for non-binding discussion on a range of issues including, but not be limited to:

1. Exchange perspectives on the challenges and opportunities to improve the mental health of Canadians.
2. Discuss strategies, policies and programs that improve mental health and access to mental health services.
3. Present innovative practices and system reforms from Canada and elsewhere that advance the mental health of Canadians and improve system performance.
4. Review the public-private interface to access mental health services.
5. Identify gaps in mental health research priorities.

It is essential that with the Advisory Council benefit from the in-depth knowledge, experience and skills from the lived experience community, health care providers, indigenous community, and national mental health organizations that comprise CAMIMH, in addition to the Mental Health Commission of Canada to ensure the best advice and guidance are present. CAMIMH would note

that they have been a strong proponent of the Commission, not only calling on the federal government for its creation in 2007, but contributing to its national mental health strategy and strategic action plan, and strongly supporting its renewal in 2017.

5 Invest in Social Infrastructure

As part of the federal government's phase 1 commitments, Budget 2016 invests \$3.4 billion over five years for social infrastructure including addressing homelessness through affordable housing (including shelters for victims of violence) and support early learning and child care. CAMIMH applauds the federal government for recognizing the importance of the broader social determinants of health and their relationship to mental health.

While new investments are required to improve access to mental health services and programs, the federal government has acknowledged that programs supporting economic and social well-being are compassionate, evidence-based preventative health strategies that can produce significant long-term cost savings. CAMIMH believes the social determinants of health can transform the lives of those living with mental illness and urges the federal government to consider social infrastructure in a more holistic way.

To this end, CAMIMH supports a targeted basic income to support all Canadians who are vulnerable because of age, labour-market status or ability be explored. This program could build on existing negative income tax mechanisms such as the Guaranteed Income Supplement for seniors, the Canada Child Tax Benefit for families with young children, and the Goods and Services Tax/ Harmonized Sales Tax Credit.

As a poverty reduction measure, a targeted basic income would reduce the long-term social and financial costs of poverty and directly affect the mental health of Canadians. A basic income, paired with comprehensive strategies such as an affordable housing strategy, would be a key part of a national mental health strategy. To this end, CAMIMH recommends that the federal government work with the provinces and territories to build on the success of the At Home/Chez Soi program. In addition to reducing homelessness, such a program would alleviate poverty and address concurrent mental health and addiction issues.

END NOTES

1. For more information on the Alliance, please visit our website at www.camimh.ca.
2. Mental health disorders account for 13 percent of the global burden of disease. The Canadian Institute for Health Information. While mental illness accounts for 10% of the burden of disease in Ontario, it receives just 7% of health care dollars (CAMH Facts and Statistics). Institute for Health Metrics and Evaluation (2015). *Global Burden of Disease, Injuries, and Risk Factors Study, 2013*. Roberts and Grimes (2011). *Return on Investment: Mental Health Promotion and Mental Illness Prevention*. A Canadian Policy Network/Canadian Institute for Health Information report.
3. Budget 2016 states "*The Minister of Health has begun discussions with her provincial to enhance the affordability and accessibility of prescription drugs, improve access to home care and mental health services (emphasis added), and support pan-Canadian innovation in the delivery of health services.*" Page 178.
4. Mental Health Commission of Canada. *The Facts*. Retrieved from: <http://strategy.mentalhealthcommission.ca/the-facts/>. 2012.
5. Mental Health Commission of Canada. *Making the Case for Investing in Mental Health in Canada*. 2013.
6. Ipsos. *Second Annual Ipsos Canadian Mental Health Check-up*. 2016. http://www.ipsos-na.com/dl/pdf/knowledge-ideas/public-affairs/IpsosPA_PublicPerspectives_CA_2016-05.pdf
7. Roberts, G. and Grimes, K. *Return on Investment. Mental Health Promotion and Mental Illness Prevention*. Canadian Policy Network (CPNET) and Canadian Institute of Health Information (CIHI). 2011.
8. Mental Health Commission of Canada. *Making the Case for Investing in Mental Health in Canada*. 2013.
9. World Health Organization. http://www.who.int/mental_health/management/depression/en/.
10. Mental Health Commission of Canada.
11. CAMH Facts and Statistics. Chesney, Goodwin and Fazel. Risks of All-Cause and Suicide Mortality in Mental Disorders: A Meta Review. *World Psychiatry*, 13: 153-160. 2014.
12. Statistics Canada. *Leading Causes of Death, by Sex*. 2012.
13. CAMH Facts and Statistics. Health Canada. *First Nations and Inuit Health – Mental Health and Wellness*. 2015.
14. Government of Canada. *The Human Face of Mental Illness in Canada*. Minister of Public Works and Government Services Canada, 2006. Bloom DE Cafiero ET Jané-Llopis E Abrahams-Gessel S Bloom LR Fathima S et al. *The Global Economic Burden of Noncommunicable Diseases*. Geneva: World Economic Forum, 2011.

15. Galea S Ahren J Nandi A Tracy M Béard J Vlahere D. *Urban neighborhood poverty and the incidence of depression in a population-based cohort study*. *Annals of Epidemiology* 2007; 17(3): 171-179.
16. CAMH Facts and Statistics. Canadian Institute for Health Information. *Improving the Health of Canadians: Mental Health and Homelessness*. 2007.
17. Office of the Correctional Investigator. Annual Report – 2014-2015.
18. Office of the Correctional Investigator. Annual Report – 2014-2015.
19. World Health Organization. *Investing in Mental Health*. Geneva: Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health, WHO, 2003. Source for 2015 GDP, Statistics Canada, Table 380-0063.
20. P. Jacobs et al. *The Cost of Mental Health and Substance Abuse Services in Canada: A Report to the Mental Health Commission of Canada*. Institute of Health Economics. 2010.
21. Mental Health Commission of Canada. *Making the Case for Investing in Mental Health in Canada*. 2013.
22. Mental Health Commission of Canada. *Making the Case for Investing in Mental Health in Canada*. 2013.
23. Mood Disorders Society of Canada. *Quick Facts – Mental Illness & Addictions in Canada*. September 2009.
24. The Economist. *Mental Health - Out of the Shadows*. Page 4. April 25, 2015. Mental health disorders account for 17.4 disability-adjusted life-years, cancer (15.9) and cardiovascular diseases (14.8).
25. Morneau Shepell. *Workplace Mental Health Priorities: 2016*. February 2016.
26. Government of Canada. *The Human Face of Mental Health and Mental Illness in Canada* (Ottawa, Ont: Minister of Public Works and Government Services Canada, 2006).
27. Canadian Institute for Health Information. *Our Health System*. 2013.
28. Discharge Abstract Database and Hospital Morbidity Database (CIHI), 2006-07 to 2014-15. Ontario Mental Health Reporting System, 2014-15; Hospital Mental Health Database (CIHI) 2006-07 to 2013-14.
29. Canadian Institute for Health Information. The most commonly prescribed antipsychotic medication was dispensed to youth almost exclusively at dosages below the recommended range for treating schizophrenia and bipolar disorders. 7.0% (65,008) of youth living in BC, Saskatchewan and Manitoba were dispensed at least 1 medication to treat a mood or anxiety disorder, and 1.6% (15,184) were dispensed at least 1 antipsychotic medication. This equates to 1 in 12 adolescents in 2014-15.
30. Canadian Institute for Health Information. *Care for Children with Youth and Mental Disorders*. June 2015.
31. Gandhi et al. *Mental Health Service Use Among Children and Youth in Ontario: Population-Based Trends Over Time*. *The Canadian Journal of Psychiatry*. February 2016; 61 (2).
32. Children's Mental Health Ontario. *2015 Report Card: Child & Youth Mental Health. Moving Towards a Fully Functioning System*.
33. Canadian Institute for Health Information. *Series on Seniors – Seniors and Mental Health*. 2010.
34. Canadian Institute for Health Information. *Series on Seniors – Seniors and Mental Health*. 2010.
35. Canadian Mental Health Association. Nanos Survey. March 2015.
36. Canadian Mental Health Association. Nanos Survey. March 2015.
37. Mental Health Commission of Canada. *Changing Directions Changing Lives – The Mental Health Strategy for Canada...*
38. Mental Health Commission of Canada. *Making the Case for Investing in Mental Health in Canada*. 2013. More recently, the following motion, moved by the MHCC was overwhelmingly passed at HealthCareCAN's 2015 Annual Meeting: "Resolved, that over the next ten years, all provincial and territorial governments, along with regional health authorities, increase the proportion of their respective health care budgets that is devoted to mental health by two percentage points from current levels".
39. Institute of Health Economics. *The Cost of Mental Health and Substance Abuse Services in Canada*. June 2010, page 15.
40. It is also important to recognize that a sizable share of mental health expenditures, at 35%, are covered through a combination of out-of-pocket and private insurance. Institute of Health Economics. *The Cost of Mental Health and Substance Abuse Services in Canada*. June 2010, page 14.
41. This view is consistent with the analysis and position of the Health Action Lobby (HEAL) as outlined in its consensus statement *The Canadian Way* (December 2014).
42. According to the Canadian Institute, in 2015 total public health spending amounted to \$155.5 Billion. An increase from 7% to 9% in public health spending for mental health would amount to \$3.11 Billion. 25% of the total is \$777.5 million.
43. The Wait Time Alliance report (2015) notes that no province reports wait times for psychiatric care. *Eliminating Code Gridlock in Canada's Health Care System*. 2015 Wait Time Alliance Report Card.

44. In Ontario study, only 63% of people who had been hospitalized for depression had a follow-up visit with a physician within 30 days of discharge, compared to 99% of people with heart failure. In the same 30 days, 25% of people who had been hospitalized for depression either visited an emergency room or were readmitted to hospital.
45. Kreyenbuhl J Buchanan RW Dickerson FB Dixon LB. The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2009. *Schizophrenia Bulletin*. 2010 Jan; 36(1):94-103.
46. Latimer E. *Economic Considerations Associated with Assertive Community Treatment and Supported Employment for People with Severe Mental Illness*. *J Psychiatry and Neuroscience*. 2005 Sep; 30(5): 355-359.
47. Canadian Mental Health Association (British Columbia). *Community-Base Supports for Mental Health and Substance Use Care: 2015 Budget Consultation*, 2014.
48. The Liberal Party of Canada. *Real Change – Investing in Health and Home Care*. It states “As already announced, as part of a Liberal government’s commitment to a new ten-year investment of \$20 billion in social infrastructure, we will prioritize significant, new investment in affordable housing and seniors’ facilities – including long-term care facilities.” 2015.
49. Mental Health Commission of Canada. *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. Recommendation 6.1.3 states “Encourage broadly based coalitions in the non-government sector to help mobilize leadership and build shared approaches to complex issues.”
50. Peterson, C., Seligman, M. E. P., George, E. (1988). *Pessimistic Explanatory Style is a Risk Factor for Physical Illness: A Thirty-Five Year Longitudinal Study*. *Journal of Personality and Social Psychology*, 55 (1), 23-27.
51. Canadian Mental Health Association, BC Division. *Depression and Co-Existing Conditions*, British Columbia: Author
52. Kop, W.J. (2005). *Psychological Interventions in Patients with Heart Disease*. In Larry C. James (Ed.), *The Primary Care Consultant: The Next Frontier for Psychologists in Hospitals and Clinics*. (pp. 61-81). Washington: Health Psychology Series, American Psychological Association.
53. Baker GR. *Evidence Boost: A Review of Research Highlighting How Patient Engagement Contributes to Improved Care*. <http://goo.gl/28oeUt>. 2014.
54. Health Quality Ontario. *Taking Stock. A Report on the Quality of Mental Health and Addictions Services in Ontario*. 2015.
55. Roberts, G. and Grimes, K. *Return on Investment. Mental Health Promotion and Mental Illness Prevention*. Canadian Policy Network (CPNET) and Canadian Institute of Health Information (CIHI). 2011.
56. Canadian Institute for Health Information. *Improving the Health of Canadians: Healthy Weights* (Ottawa: CIHI). 2005.
57. Ehman, T, Yager, J and Hanson, L. *Early Psychosis: A Review of the Treatment Literature*. BC Ministry of Child and Family Development, 2004.
58. Smetatin P, Stiff D, Briante C, Adair C, Ahmad & Khan M. *The Life and Economic Impact of Major Mental Illness in Canada: 2011 to 2041*. Risk Analytica. On behalf of the Mental Health Commission of Canada. 2011.
59. Canadian Institute for Health Information. *Return-on-Investment: Mental Health Promotion and Illness Prevention*. 2007.
60. Mental Health Commission of Canada, Mood Disorders Society of Canada. *Far-Reaching and Effective Training for Canada’s Healthcare Providers in the Early Diagnosis and Treatment of PTSD in First Responders, and Veterans, and National Suicide Prevention Project*. Pre-Budget Proposals, February 2016.
61. In 1996, the United States introduced the *Mental Health Parity Act*, which requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. Source: Mental Health Parity Act.
62. This could mean that when compared with physical health care, mental health care is characterized by: (1) equal access to the most effective and safest care treatments; (2) equal efforts to improve the quality of care; (3) the allocation of time, effort and resources on a basis commensurate with need; (4) equal status with health care practice and education; (5) equal high aspirations for services users; and (6) equal status in the measurement of health outcomes. Source. UK Royal College of Psychiatrists. *Whole-Person Care: from Rhetoric to Reality...Achieving Parity Between Mental and Physical Health*. March 2013.
63. Budget 2016 provided: \$1.2 Billion over 5 years for social infrastructure for First Nations, Inuit and Northern communities; \$554.3 million over 2 years for urgent housing needs on reserve; \$177.7 million over 2 years to the North and Inuit communities

- for urgent housing needs; \$33.6 million over 5 years to support shelters serving victims of family violence in First Nations, and \$10.4 million to renovate or construct new shelters; and \$270 million over 5 years for the construction, renovation and repair of nursing stations, residences for health care workers and offices on reserve.
64. Service J. *Under Warrant: A Review of the Implementation of the Correctional Service of Canada's Mental Health Strategy*, prepared for the Office of the Correctional Investigator of Canada. September 2010.
 65. <http://o.canada.com/news/national/alert-unions-federal-government-reach-deal-on-health-care-benefits-for-retirees>.
 66. A recent report chaired by Dr. David Naylor called on the federal government to create a ten-year Healthcare Innovation Fund that would increase to \$1.0 Billion. Report of the Advisory Panel on Healthcare Innovation. *Unleashing Innovation: Excellent Healthcare for Canada*. July 2015.
 67. In 2008, the United Kingdom launched its Improving Access to Psychological Therapies program (IAPT) which organizes the delivery of evidence-based psychological therapy within the public health service. It develops programs, trains service providers and measures patient outcomes. By 2013, the program treated 400,000 people annually, nearly half of whom recovered by end of treatment.
 68. According to a 2015 Nanos survey sponsored by the Canadian Mental Health Association (CMHA), almost two-thirds (64%) and 30% somewhat support the federal government putting new money into a dedicated mental health transition fund that would help provinces and territories improve access to community-based mental health care including addiction services. CMHA. March 2015.
 69. An important recent development has been the Asia-Pacific Economic Cooperation (APEC) Forum has chosen Canada through the Mood Disorders Society of Canada and the University of British Columbia and the University of Alberta to become a global centre of excellence in mental healthcare by hosting a new international digital hub to coordinate and promote advanced research from some of the world's leading universities and their health institutes involved in the diagnosis, treatment and awareness of mental disorders.
 70. Canadian Psychological Association. *An Imperative for Change... Access to Psychological Services for Canada*. March, 2013.
 71. When it comes to tracking publicly-funded mental health expenditures, data is largely focused on acute care hospitals. While this is useful, this provides a limited picture as to how the mental health system is performing. As we know, a significant proportion of mental health programs and services are provided within communities.
 72. Mental Health Commission of Canada. *Informing the Future: Mental Health Indicators for Canada*. January 2015.
 73. Dr. Elliot Goldner et al. *Reporting Mental Health Performance Across Canadian Provinces*. March 2016.
 74. Institute of Medicine. *Crossing the Quality Chasm – A New Health System for the 21st Century*. 2001.
 75. Canadian Institute for Health Information. *CIHI's Strategic Plan, 2016 to 2021*. 2016.

Mental Health Now!

Advancing the Mental Health of Canadians: The Federal Role

OUR MEMBERS



CANADIAN ALLIANCE ON MENTAL ILLNESS AND MENTAL HEALTH
ALLIANCE CANADIENNE POUR LA MALADIE MENTALE ET LA SANTÉ MENTALE

www.camimh.ca