How to fix Canada's mental health system

Dr. Christina Cookson speaks with a patient in her London drop-in clinic. (Glenn Lowson For The Globe and Mail)

How to fix it

Too many patients seeking mental health diagnosis and treatment are falling through the cracks – at tremendous economic and human cost. But, Erin Andersen reports, it doesn't have to be this way. Public coverage for psychotherapy, using technology to reach across vast distances and making sure we educate the young about mental health are just a few of the proven ways Canada can deliver the quality care patients need

This is part of a series on improving mental health research, diagnosis and treatment. Join the conversation on Twitter with the hashtag #OpenMinds

A weary-looking single mother brought her son into the London, Ont., walk-in clinic where Christina Cookson works on a weekday evening. Her son, who recently attempted suicide in another city, was sent home from hospital with no follow-up. Now, with a doctor they had never met before, they were trying to get help. Dr. Cookson asked a few questions about his current treatment, learned of a new antidepressant that the mother said seemed to be working.

With no history of care, Dr. Cookson had no way to know for sure. She advised him to make sure he told his mom if he had suicidal thoughts again and wrote a referral to see a psychiatrist, though even an urgent request would take weeks. Other than that, she had little to offer. They had no coverage for psychotherapy, which ideally, she would have prescribed. Since the young man was a walk-in patient, there is no guarantee she will see him again. "I want to be able to give them the care they deserve, and I know will benefit him, and I have no way of arranging that," she says. "It's a pretty helpless feeling." And one to which many family doctors, struggling to help mentally ill patients, can attest.

After months of research, and as detailed in our Open Minds series, The Globe and Mail identified some of the top evidence-based approaches to building a mental-health system that will work for Canadians. These are changes that would move the country beyond its patchwork, fragmented mental-health system in which the care patients receive is too often determined by what they can afford, or where they live, or what they are savvy enough to cobble together on their own. These initiatives abide by the principals of Medicare and good science, and treat the disorders of the mind as diligently as the diseases of the body.

Expanding access to publicly funded therapy

One in five Canadians will be affected by mental illness in their lifetimes. The cost to the country's economic is staggering: $50-billion a year in health care and social services, lost productivity and decreased quality of life, estimates the Mental Health Commission of Canada. The personal costs are more devastating – unemployment, family breakup, suicide.

Canadians who seek help for a mental illness will most often be prescribed medication, even though research shows that psychotherapy works just as well, if not better, for the most common illnesses (depression and anxiety) and does a better job at preventing relapse. According to a 2012 Statistics Canada study, while 91 per cent of Canadians were prescribed the medication they sought, only 65 per cent received the therapy they felt they needed. Access to evidence-based psychotherapy, which experts say should be the front-line medical treatment, is limited and wait lists are long.

The Series

OPEN MINDS

How to build a better mental health care system

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- Why medicating our kids isn't the only, or best, answer
- Is childhood self-harm contagious?
- Can kids refuse treatment? All you need to know about consent
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- Workplaces have responsibility to promote mental well-being of employees

No provinces cover therapy delivered in private practice by a psychologist, social worker or psychotherapist, creating a two-tier system which means families without coverage through work – those more likely to be low-income – often either pay out of pocket or go without, or, if they are lucky, rely on a non-profit group working to fill a gaping hole in a flawed health-care system. Even Canadians with coverage, rarely have enough for a proper dose that meets treatment guidelines. This kind of inconsistent, unequal and scientifically flawed approach to care would be untenable for diabetes, cancer or heart disease. Yet it persists for some of the most debilitating illnesses suffered by Canadians.

"Clearly this is the biggest gap we have, and the one that most needs to be fixed," says psychiatrist Elliot Goldner, director of the Centre for Applied Research in Mental Health and Addiction. Psychotherapy is a medically necessary treatment, he argues, that should be publicly funded. The question is not whether Canadians need it, but how to deliver it.

A system that responds nimbly to patients' needs would have clear treatment guidelines, appropriate screening and good data collection to ensure that therapies are working for patients. There should be a role, for instance, for non-profit groups on the ground to be woven into a comprehensive system to provide additional supports, particularly in areas such as housing, employment and mental-health promotion – without expecting them to patch up shortfalls in services the system should provide.

That should include, says Dr. Goldner, non-physicians with training in psychotherapy who are integrated into the mental-health system, so that access to care is based on sound science and the best treatment plans for individual patients, rather than what happens to be available.

Canada doesn't have to start from scratch. As Dr. Goldner points out, Britain and Australia have both made huge investments to expand public access for all citizens to psychotherapy, recognizing both its clinical value and cost-effectiveness over the long run. Britain's system, especially, has been designed to be accountable, to track outcomes with extensive data, and to be flexible enough to incorporate changes to the system to improve results.

Not all of the patients Dr. Christina Cookson meets in her London drop-in clinic have insurance, which affects access to urgent psychiatric care. (Glenn Lowson For The Globe and Mail)

Using technology to deliver therapy into the homes of Canadians

It can be hard enough to get timely treatment if you only have to drive a few blocks to find it. But what if access to care for, say, an anxiety disorder requires traversing a sprawling wilderness, for hours by car, sometimes through a blizzard? These were the stories that Fern Stockdale Winder heard often from Saskatchewan patients, as the psychologist charged with developing the province's new mental-health strategy. Even when mental-health care was available, reaching treatment was often one more layer of stress.

It doesn't have to be this way. Chief among the strategy's recommendations: a province-wide online therapy system. The evidence for tech-delivered therapy, with support over the phone, is strong – for many patients with depression and anxiety, it can be just as effective as face-to-face sessions. It allows patients to manage care around their work and school schedules, to maintain privacy and to take control of their own recovery in a way less likely to happen with medication. And it's cost-effective, says Dr. Stockdale Winder, potentially reducing appointment no-shows, cutting down on travel time for patients and therapists to and from remote communities.

By the numbers

$50-Billion

The annual cost to the Canadian economy of mental-health problems and illnesses – though the Mental Health Commission of Canada says the costs "are likely significantly greater"

30 per cent

of all short- and long-term disability claims are due to mental-health problems and illnesses

70 per cent

The estimate of mental-health problems and illnesses that begin in childhood or adolescence

Canadians have ready access to medication for mental illness not because it's the best option, but because it's the easiest – even though psychotherapy works as an effective early intervention, a standalone treatment or in combination with drugs, and to prevent relapse. This front-line treatment can also be delivered in a modern and increasingly convenient way that gives patients more choice in how they receive their care.

"It's very much about how people like to learn. Whether for reasons of stigma or personal preference, many people like to work on life challenges by themselves," says Chris Williams, a psychiatrists the University of Glasgow, whose self-guided program is used as a first-stage treatment in Britain's publicly funded psychotherapy system. It has also been adapted in British Columbia and is being piloted in other provinces by the Canadian Mental Health Association. Self-guided therapies vary – some use DVDs, or booklets, others are delivered online – but the evidence is strongest for ones that also link patients to therapists, either by e-mail or with brief phone calls.

A separate online program at the University of Regina has already had promising results. (Even so, the government is taking a wait-and-see attitude: Health Minister Dustin Duncan said last week that the government is keeping an eye on the project and will consider whether to expand the service after the pilot concludes next year.)

What Dr. Stockdale Winder envisions is a system in which family doctors could use depression and anxiety screening to easily steer appropriate patients away from medication and toward accessible, online therapy. "She clicks a button, and the patient is in," she says. Such a system would also monitor the progress of participants and direct them into more intensive care if their conditions worsened.

The need for early intervention is pressing, and the evidence for online therapy is already convincing. In a country of wide open spaces, with remote communities difficult to reach even in the best weather, it's necessary. What are policy makers waiting for?

75 per cent

As many as three in four children and youth don't access services and treatments – despite the fact that children who experience such mental-health illnesses and problems are at much higher risk of experiencing them as adults and are more likely to have other complicating health and social problems

$200-billion

Estimated long-term cost of childhood mental-health disorders in Canada

$280,000

Lifetime savings to be had through early intervention to prevent conduct disorders in one child

85,000

Number of children in Canada already experiencing conduct disorders

7 per cent

The amount of every public health-care dollar that goes to mental health (below the 10 to 11 per cent of public health spending on mental health in other countries, including New Zealand and the United Kingdom)

55

The percentage of homeless people who had visited an emergency room or been hospitalized in the past year

Teaching the next generation about mental health

Twenty years ago, a concerted education campaign taught students about the dangers of smoking. Today, mental health requires a similar concerted public-health strategy, considering that as many as 20 per cent of Canadian youth are affected by a mental illness or disorder. Education about mental illness needs to start early, reaching deliberately into classrooms to teach the next generation about positive mental health and how to recognize and seek help when problems first start, especially since symptoms often first appear in childhood.

That requires a mental-health curriculum in every school board, like the one developed by Stanley Kutcher, a professor of psychiatry at Dalhousie University; it is now being used in high schools in Alberta, Ontario and Nova Scotia, where education officials report it is already making a difference. "Kids are starting to see problems with mental health the way they see problems with physical health," says Lance Bullock, co-ordinator of programs and student services at the Halifax Regional School Board, suggesting it has not only encouraged students to seek help, but also helped to reduce bullying. "That's a huge, huge step forward."

But this also means that teachers need to know what they are talking about and be trained to spot early signs of troubled students. "Teachers want to help, but they don't know how," says Susan Rodger, an associate professor in Western University's education faculty.

In a 2012 national survey, about two-thirds of Canadian teachers said they had never received any education on children's mental health. According to Prof. Rodger, only Ontario to date has specifically added a mental-health requirement to its teacher accreditation guidelines – a step, she says, that all provinces need to take.

This would require universities to make mental health a mandatory component of teacher's education, as is now happening at Western. In many ways, this is the same conversation happening in the medical profession around training in areas such as psychotherapy. And just like for students learning lessons about positive mental health, that professional education needs to happen early. "The initial training you get in your profession will have an impact on the rest of your career," says Prof. Rodger.

$19,582

The annual cost of the Housing First initiative for the most severely mentally ill clients with the highest needs

$42,536

The annual costs saved in services that otherwise would have been used on these clients

>Source: Mental Health Commission of Canada ; At Home/Chez Soi Final Report, 2014; 2010 Health and Housing in Transition Study.

Teachers may not be able to solve every problem – that requires, as with the successful anti-smoking strategy, a public-health campaign that reaches into families, workplaces, doctor's offices and government policy. But standing in the front of the class, she says, "teachers are the ones in the best position to notice" when students need help, if and when they haven't raised their hands to ask for it.

Brochures line a shelf in Dr. Christina Cookson London clinic. Many of the patients she meets do not have a ongoing relationship with a doctor, making it nearly impossible to provide them with good followup. (Glenn Lowson For The Globe and Mail)

Giving youth early access to good clinical care

Arthritis, heart disease and dementia: These are diseases that plague us the creakier we get with age. Not so with mental health: It begins early, often taking root in adolescence. Yet we have designed a system that traditionally responds best to crisis, as if a wounded mind was a fractured hip. With mental health, however, it is essential to catch our youngest patients long before they fall.

This is starting to happen. Efforts are being made in provinces to direct children and youth more quickly to psychiatrists, to streamline routes that parents can take to get help more quickly. But diagnosis is one thing; consistently good treatment is another. Many young patients, if identified early, could avoid medication. Many families require a more collaborative approach that considers the fallout of having a child with a mental health needs.

That's what makes the new ACCESS project, a $25-million, five-year program being funded by the federal government's Canadian Institutes of Health Research and the private Graham Boeckh Foundation, so promising. The program combines social supports and clinical treatment in one location, and focuses in particularly on parts of Canada where care can be hardest to access: rural towns, immigrant communities and First Nations.

The research project, launching this year, will eventually place psychologists and consulting psychiatrists at 12 sites across the country, blending them with existing outreach workers and crisis teams. The goal is to have ACCESS clinicians assess young people within 72 hours of seeking help and to get them appropriate care within one month. (That compares with current waiting times of five or six months in some of the project's targeted sites and a year or more for some 6,000 children and adolescents in Ontario.) The project is adapted from a similar centre-based system now used widely in Australia.

One of sites identified is on the Eskasoni First Nation in Cape Breton, N.S. – a Mi'kmaq community all too familiar with the tragic cost of mental illness. Between 2007 and 2009, nine young people died by suicide, another four deaths resulted from drug overdoses. "You can imagine how that affected a community with a total population of 4,100 people," says Daphne Hutt-MacLeod, a psychologist and the director of Eskasoni mental-health services. "People were slipping through the cracks, and those cracks were literally grave sites."

The mental-health team on the First Nation, she says, has been successful at reaching out to youth. They run family violence intervention programs, offer support for grief and bereavement, and suicide crisis programs. But they have struggled to get effective screening and treatment early with a lack of clinical support – a missing step that the ACCESS program will correct.

The program has certain requirements, but allows for communities to add elements that suit their needs, so Eskosoni is also creating a position for an elder-in-residence to give youth access to sweat lodges, pipe ceremonies and sacred teachings. "That is part of the healing process," says Ms. Hutt-MacLeod, pointing out that one of the key elements of the ACCESS design is that all practitioners are meant to work as equal partners.

For young people and their families seeking help, two common issues are how they can find a way into the system, and how long they have to wait for comprehensive care once they get there. ACCESS is an evidence-based approach that addresses both.

Dr. Christina Cookson says that without insurance coverage, a patient doesn't have access to urgent psychiatric care. The patients she meets at her drop-in clinic in London do not have a ongoing relationship with a doctor, making it nearly impossible to provide them good follow-up. (Glenn Lowson For The Globe and Mail)

Providing affordable housing to those who need it

Imagine a city the size of Hamilton, in which every resident was either homeless or living in dodgy circumstances, crowded into a ramshackle rooming house or threatened with eviction or couch-surfing in a different apartment each night. Add an often debilitating mental illness for each of the citizens of this fictional city. Now consider that, according to a 2013 study led by the Mental Health Commission of Canada, these 520,000 people are real, scattered across the country – the squeegee women offering to wash your windshield, the muttering, drunk stranger that you awkwardly ignore at the bus stop.

Those people need homes, and a Canadian-grown solution called Housing First has figured out a tried and tested way to find them housing, no strings attached, and then circle them with the level of support they require to stay off the street, and better manage their mental health and addiction.

“Not only is there a right to safe, affordable housing but it should be a centrepiece of mental-health care.” says Steve Lurie, executive director of the Toronto branch of the Canadian Mental Health Association, who also worked on the 2013 Turning the Key study on housing and mental illness.

Ottawa has kicked in nearly $600-million over the next five years for Housing First, but spread out across the country it’s not nearly enough, says Mr. Lurie. The cost of building affordable housing from the ground up is about $200,000 a unit, says Mr. Lurie, citing a City of Toronto study.

In some cities, such as Vancouver, soaring rents have made existing apartments difficult to find. Another proposal: a market-based approach that guarantees long-term rent supplements to landlords and developers. They could then apply for mortgages from banks, to build affordable housing, Mr. Lurie suggests, the same public-private partnerships the country uses to build hospitals. “The government doesn’t have to worry about capital costs if they have a flexible approach to rent supplements,” he argues.

But even then, he says, people need choices to maximize their chance at recovery. Some who require more intensive care might benefit from being housed with others in similar situations. Some might prefer an apartment in a building dedicated to Housing First clients. Others with addictions might want to be scattered through the city, far from the temptations of their former street lives.

But given the wait lists, Mr. Lurie argues, Canada needs to further increase its investments in Housing First operations. In Toronto alone more than 10,416 people are waiting for supportive housing, roughly half are homeless or housed precariously and some people, he says, have been on that list for as long as five years. As a landmark five-year study by the Mental Health Commission of Canada demonstrated, giving people with high needs and severe illnesses stable housing makes it easier for them to get the help they need – and saves money on hospital stays and emergency rooms.

“Giving people their own place to live not only makes good public policy, it makes good economic sense,” says Mr. Lurie.