ONTARIO MEDICAL ASSOCIATION

OMA SUBMISSION REGARDING MINISTRY OF HEALTH AND LONG-TERM CARE DISCUSSION PAPER: "Every Door is the Right Door"

September, 2009

Introduction

The OMA would like to take this opportunity to respond to the recommendations made by the Ministry of Health and Long-Term Care (MOHLTC) and the Advisory Group on Mental Health and Addictions in the Discussion Paper entitled "Every Door is the Right Door" (the "Paper"). The OMA commends the government on its commitment to improving the delivery of mental health care in this province. We also share many of your concerns; the current lack of service integration and access to appropriate treatment and counseling services is alarming. However, we have some reservations about the approach taken in the Paper and the effect this may have on the resulting 10 year provincial mental health strategy. Although the seven key directions have some merit, there is a glaring lack of recognition for the essential part clinical treatment plays in the healing process for those suffering with mental illness. This in turn undermines the fact that mental illness is a diagnosed, medical condition. Finally, greater consideration must be given to supporting physicians (both specialists and general practitioners) who are often the first or only point of contact for individuals dealing with mental illness. The Paper focuses its attention on the value of peer and community support without affording appropriate weight to the much needed work of physicians.

In 1993, the MOHLTC released its previous 10 year policy framework, "Putting People First." This document similarly de-emphasized the need for clinical treatment in mental health care delivery. We hope that any new plan will correct some of the challenges that have developed as a result of "Putting People First," particularly the diminishment of treatment services for persons with non-psychotic emotional illnesses as well as the marginalization of treatment professionals. We urge the government to consider the issues raised below and avoid committing the same oversights again.

Available Resources

In his introductory comments, Minister Caplan indicates that any changes to the mental health care system will be financed using existing resources. The OMA finds this proposition to be unrealistic given the significant transformation proposed in the Paper. On page 26, the Paper sets out how individuals will be expected to move through the mental health care framework. People should be able to access care from different points and move easily between services and settings. Although this objective is desirable, we question its feasibility given that most mental health programs are already operating at capacity. For example, there are an increased number of elderly patients afflicted with dementia in Ontario and not enough appropriate staffing units to address this. Access to expensive psychotropic drugs and other medications is an ongoing problem that also needs to be examined. The mental health system has been significantly under-funded for many years. A recent research study shows that Ontario lags behind many other provinces in terms of total percentage health care funding directed to mental health services.[1]

[1] Jacobs P, Yim R, Ohinmaa A, Eng K, Dewa CS, Bland R, et al. Expenditures on Mental Health and Addictions for Canadian Provinces in 2003 and 2004. Can J Psychiatry 2008; 53(5):306–313.

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While we appreciate that current resources may need to be redistributed to ensure a patient-centered and collaborative approach to care, the government should acknowledge that new monies must be injected into the system to accomplish the many goals set out in this Paper.

MEETING PEOPLE ON THEIR TERMS

Person-Directed Services/Recovery Model

The Paper advocates for person-directed services that allow patients to become "active partners in their care" and make informed decisions about support and treatment. The recovery approach is one of the corner-stones of the person-directed model. As described in the Paper, recovery "defines the person positively" and focuses on the individual's strengths rather than the illness. Many physicians embrace this approach as it gives practitioners the opportunity to engage with patients and their families to set reasonable expectations about what can and cannot be done. Nonetheless, we find the description and emphasis on recovery in the Paper to be misleading. The Paper discusses recovery and clinical treatment as two separate and disjointed concepts. Furthermore, the recovery model has yet to be clearly defined. We will explore each of these issues in turn.

The chart on page 10 suggests shifting focus away from treatment services to activities based on "healthy development and harm reduction." A movement is required from provider-centered care to person-driven or family-centered care. On page 29, recovery is thought of as a personal journey, a social process that does not simply "reduce symptoms." We question why such a shift is necessary. It is entirely possible for a patient to assume more control over his or her health while receiving appropriate medical guidance from a health professional. In fact, clinical treatment is an important part of the recovery process. Physicians who ascribe to the biopsychosocial model of Western medicine recognize that many interacting factors, from the cellular to the social, can either promote or harm health.[2] Thus, physicians can intervene not only at the biological level, but also with cognitive, behavioural and emotional strategies.[3] The Mental Health Commission of Canada (MHCC) notes that a recovery focus can be supported by "many different kinds of practices from psychotropic medications and psychotherapies to peer-run services, housing or employment support, and so forth."[4] Furthermore, the treatment provided by physicians is often a necessary part of a patient's recovery. Mental illness can impair thinking and judgment for many individuals, which can compromise one's ability to consider various care options and participate in decision-making. Different people will be prepared to take greater responsibility over their recovery at different times.[5] Although the goal should be for patients to be

[2] Novack DH, Cameron O, Epel E, Ader R, Waldstein S, Levenstein S, et. al. Psychosomatic Medicine: The Scientific Foundation of the Biopsychosocial Model. Academic Psychiatry 2007;31(5):388-401.
[3] Ibid.
[4] Mental Health Commission of Canada. Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada. Mental Health Commission of Canada;2009. Available at: http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2009/Mental_Health_ENG.pdf.
[5] Ibid.

partners in their recovery, this may not always be possible. It is the physician's duty to identify the most appropriate line of treatment and engage the patient to the greatest degree possible.

The emphasis on recovery to the exclusion of clinical treatment in the Paper further undermines the fact that mental illness is an actual "illness." We are troubled by the notion that individuals must be redefined "positively" or at all for that matter. Although preventative measures and recovery are important for any illness, it is difficult to imagine similar views being advocated to "reduce a focus on treatment" of other serious medical conditions, such as treating heart attack patients or providing necessary surgery or chemotherapy for cancer patients. The mentally ill are no less deserving of needed medical treatment.

The Paper outlines some of the basic elements of the recovery process; self-determination, self-management, and the development of meaningful social and occupational roles. However, the MHCC notes that there has yet to be a systematic discussion in Canada about the precise meaning of the term.[6] Scientific literature often refers to a model of recovery but no concrete model actually exists or has been implemented in Canada.[7] We are concerned about the reliance placed on the concept of recovery in the Paper given that very few studies have actually examined it in great detail. More questions need to be answered in the interim to construct a theoretical model of recovery. For example, recovery tactics are often used for all serious mental health illnesses without distinction. Does this mean that the process must be the same for those with conditions ranging from mild depression to schizophrenia?[8] How can the model be adapted to the unique circumstances of each patient? What measurable outcomes should researchers focus on? The OMA is willing to collaborate with the MOHLTC to develop a comprehensive model of treatment, care and rehabilitation that embraces a collaborative approach, has clear outcome measures and which identifies recovery as its goal. As suggested by the MHCC, a recovery orientation should not imply taking away existing aspects of service delivery. Medical and other professional treatments including medication can contribute to fostering recovery alongside other programs such as supportive housing and peer support.[9]

[6] Ibid.
[7] Noiseux S, Tribble DSC, Leclerc C, Ricard N, Corin E, Morissette R, et al. Developing a Model of Recovery in Mental Health. BMC Health Services Research 2009; 9(73).
[8] Ibid.
[9] Mental Health Commission of Canada. Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada. Mental Health Commission of Canada;2009. Available at: http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2009/Mental_Health_ENG.pdf.

TRANSFORM THE SYSTEM

Applicability of Chronic Care Disease Management to Mental Health and Addictions

The OMA fully agrees that the current mental health care system is in need of redesign. In light of recent events, we were particularly pleased with the recommendations regarding the Wagner Care Model or the Chronic Disease Prevention and Management model (CDM model). At the annual Canadian Medical Association (CMA) General Meeting that was held this past August, a resolution was passed calling on the CMA to work with the government and other organizations to develop guidelines that would include mental illness under the definition of chronic diseases in fee codes and funding programs. Unfortunately, health policies in most other countries treat serious mental illnesses separately from chronic conditions.[10] However, there are many chronic disease programs and approaches that have been successfully used to improve the management of illnesses such as depression. Some of the salient features of a CDM model that could be applied to mental illnesses include structured diagnostic assessment, care plans, use of a multi-disciplinary team, education for those managing their own health, client information systems, and so on.[11] A more effective general practitioner-psychiatrist interface may also expedite the care for persons with mental illnesses. Incorporating the work of psychiatrists into chronic disease management initiatives in the province would help accomplish this. Perhaps the government can look to the Ontario Diabetes Strategy for guidance. The government invested $741 million in the prevention, management and treatment of diabetes last year. $6 million has been directed to prevention programs and education campaigns to raise awareness of risk factors. Access to team-based care will be increased by mapping the prevalence of diabetes across the province and locating current diabetes programs to align services and address service gaps. The MOHLTC should consider what characteristics of the Diabetes Strategy could be adapted and applied in a mental health care context.

STRENGTHEN THE MENTAL HEALTH AND ADDICTIONS WORKFORCE

Peer Support/Professional Treatment

The Paper thoroughly explores the need for enhanced peer support and the leadership role it should take in the development of mental health services in Ontario.[12] The MOHLTC suggests taking a “competency-based approach” which would identify core competencies for all types of

[10] Canadian Mental Health Association. What is the Fit Between Mental Health, Mental Illness and Ontario’s Approach to Chronic Disease Prevention and Management? Canadian Mental health Association: 2008. Available at: http://www.ontario.cmha.ca/admin_ver2/maps/cmha_chronic_disease_discussion_paper.pdf.

[11] Canadian Mental Health Association. Mental Health, Mental Illness and Chronic Disease Policy. CMHA National Conference Presentation: 2008.

[12] We appreciate the change in terminology when referring to individuals who have battled with mental illness. The Paper refers to people “with lived experience” rather than “survivors”, which engenders mutual respect and co-operation.

service providers, including peer support workers, volunteers, and health care professionals. From our perspective, the Paper blurs the provision of social supports with the provision of treatment and diminishes the unique contributions made by psychiatrists, GPs, and other mental health professionals. Persons with "lived experience" do offer a necessary, but specific point of view with respect to the care of those with mental illness. They are not trained to perform assessments and/or provide clinical treatment. All members of a well-developed interdisciplinary treatment team are valuable and contribute in their own way to successful outcomes for persons with mental illnesses and their families. However, clear role definition of each team member and the responsibilities that they assume as part of this collaborative approach to care is necessary to make this happen. The diagnostic, consultation and treatment services provided by community-based psychiatrists and GPs should not be overlooked when transforming the system.

On page 29, the Paper indicates that persons with mental illness benefit greatly from peer-based assistance. However, the advantages of peer support are rather overstated. Davidson et al. notes that peer support is still early in its development as a mental health service and further evaluation is required.[13] This is complicated by the many definitions of "peer support" that are used and how little the term actually tells us about the person offering the support. The fact that a person is in recovery does not reveal much about how he or she functions in the role of service provider.[14] Davidson wisely advises that the current "enthusiasm about peer support needs to be matched by a commitment to establishing an evidence base for what is involved in the process and what outcomes can be expected."[15] Furthermore, peer support should not be seen as a substitute for treatment delivered by appropriately trained professionals. Peer support is not equivalent to psychiatric practice.[16] We must ask what specific contributions peer workers make due to their personal histories and how such assistance differs from conventional clinical and rehabilitative practices. On page 26, the Paper states that mental health and addiction treatment services are *usually* provided by people with specialized mental health and addictions skills. We would argue that such services should **always** be delivered by those with the appropriate skill set. The 10 year mental health strategy should draw a clear distinction between "treatment" and "support", while affirming the need for integration between the two.

The characterization of medical mental health services on page 19 is inaccurate. The traditional mental health system is neither narrow nor separate from other services. Family physicians are the most commonly contacted health provider by people with mental health needs.[17] A review commissioned by the Canadian Collaborative Mental Health Initiative (CCMHI) found that of the 61% of Canadians who consulted a professional for a mental health disorder, 45% consulted a family physician.[18] In addition, family physicians delivered mental health and addictions services

[13] Davidson L, Chinman M, Sells D, Rowe M. Peer Support Among Adults with Serious Mental Illness: A Report from the Field. Schizophrenia Bulletin 2006; 32(3): 443-450.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Institute for Clinical Evaluative Sciences (ICES). Primary Care in Ontario: Chapter 9. ICES; 2006. Available at: http://www.ices.on.ca/webpage.cfm?site_id=1&org_id=67&morg_id=0&gsec_id=0&item_id=3655&type=atlas.
[18] Gagne, Marie-Anik. Advancing the Agenda for Collaborative Mental Health Care. Canadian Collaborative Mental Health Initiative; 2005.

well before the advent of family health teams (FHTs). Although FHTs may foster greater integration, they are not the first instances of GP based mental health care.

Given the essential part physicians play in the mental health care system, we hope that the 10 year mental health strategy will encourage greater resource support for the medical profession. This could include funding educational initiatives for family physicians focusing on psychotherapy and communication skills, particularly in relation to vulnerable populations (children, the elderly, etc.). The government may wish to examine some of the existing programs available to family physicians offered by the Ontario College of Family Physicians or the General Practice Psychotherapy Association. Additionally, the 2007 National Physician Survey reports that over 60% of family physicians across Canada rate access to Psychiatrists as fair or poor, with Ontario as the worst province for this. Addressing this need will require more residency positions for Psychiatry programs in the province's medical schools. Moreover, integration between support services and clinical treatment can be facilitated by implementing Shared Care Teams province wide rather than through pilot studies. Lastly, the government should enhance and develop opportunities for the joint training of medical specialties (ex. Paediatrics and Psychiatry, Geriatrics and Family Medicine) to improve skills across the medical spectrum. These are only our preliminary thoughts on the subject. We would be more than willing to work with the MOHLTC to develop these ideas further.

It is unclear how the identification of core competencies will be applied to physicians or other regulated health professionals as this falls under the discretion of the appropriate regulatory college. The competency based approach may be more appropriate for those engaged in support, rather than clinical treatment. This is an area where the separation of support and treatment will be significant.

STOP STIGMA

Mental Illness is a Clinical Condition

The discussion regarding stigma in the Paper is somewhat contradictory. The Paper explains that stigma can only be reduced when mental illness is treated like any other disease. However, it then states that mental illness should be "normalized." The proposed movement away from treatment also serves to minimize the fact that mental illness is a clinical condition. The first step towards eradicating stigma is to acknowledge mental illness as an actual illness. This conception should be at the forefront of public awareness campaigns.

The OMA agrees that improving mental health literacy can assist individuals in recognizing conditions of poor mental health. It also allows people to feel more at ease when seeking help.[19]

[19] Canadian Mental Health Association. What is the Fit Between Mental Health, Mental Illness and Ontario's Approach to Chronic Disease Prevention and Management? Canadian Mental health Association: 2008. Available at: http://www.ontario.cmha.ca/admin_ver2/maps/cmha_chronic_disease_discussion_paper.pdf.

Lessons can be learned from the Ontario Stroke System's public knowledge transfer activities and the campaigns undertaken by the Heart and Stroke Foundation of Ontario. They have focused on informing the public about the signs and symptoms of stroke through television ads and other forms of media. However, we are troubled by the expectations placed on those working in community and social services. On page 39, the Paper recommends all such workers have the capacity to identify the signs and symptoms of mental illness and addictions and intervene appropriately. This is a lot to ask, especially of those who are volunteering their time and may not have the requisite knowledge to make such a determination. Having a suspicion of mental illness is not equivalent to a diagnosis. Significant problems could arise if teachers, social workers and other service providers jump to conclusions based on a very elementary understanding of mental disorders.

It is often suggested that physicians perpetuate stereotypes by treating patients with mental illnesses differently. This is not necessarily the case. The unfortunate truth is that these individuals can be very difficult to treat, especially in light of funding cuts and institutional closures that have left patients out of the system. The 10 year mental health strategy should concentrate on securing sufficient resources so physicians can administer care in a timely, appropriate and fair manner.

BUILD COMMUNITY RESILIENCE

The Paper's vision of Ontarians with mental illness and/or addiction participating in welcoming, supportive communities is appealing. It imagines communities as a driving force in building personal strength and giving those with lived experience a sense of purpose. However, these notions are also somewhat idealistic. Society is currently facing a problem that goes beyond mental illness – the erosion of what is considered a "community." There is no tight infrastructure in which the mentally ill are the only ones not fitting in. Communities are often fragmented for many different reasons and it is simplistic to reduce the problem in these terms. In many instances, the community may be unable to assist persons who struggle with mental disorders and who do not want to change or seek assistance. The idea of community support as a form of protection has some potential but the exact forms of support and the capacity of communities to offer help should be clearly articulated in the 10 year mental health strategy.

SUPPORTING FRAMEWORKS

The OMA is encouraged by the proposed inter-ministerial co-operation regarding definitions, protocols and eligibility criteria as described on page 48. The government may also wish to consider eliminating all but essential criteria as a condition for funding of various support and treatment programs. This could expedite access to appropriate care for those that need it.

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CONCLUSION

As we understand it, the principles and objectives outlined in this Paper are the first step towards a detailed, concrete framework for service delivery in the province. It is important that the concepts upon which the strategy is based are accurate and in the best interests of people dealing with mental illness. This is the spirit in which our observations are made. Although we may have a difference of opinion in some respects, it is promising that the government and the OMA are dedicated to this project and a positive outcome for all. We look forward to further dialogue with the MOHLTC and working towards implementing the ideas expressed in this submission. Thank you for your consideration.

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