



Putting the pieces together

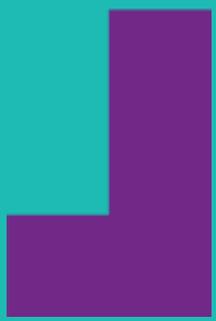
Volume 1

**The (Real) Barriers to
Canada's Mental Health
& Addiction Services**

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The (Real) Barriers to Canada's Mental Health and Addiction Services

Applying a client lens to mental health and addiction services

As Canada works to enhance its delivery of health care services, it is essential that the client perspective remains front and centre. To that end, this Mental Health and Addictions (MHA) report – the first of a three-part series – combines insights from KPMG's extensive work in the healthcare and community services sectors, thereby applying an independent lens on the real-world barriers between Canadians (MHA clients, as well as their families and caregivers) and the MHA services in their communities.

And that perspective is more important than ever. Every year, one-in-five Canadians will experience a mental health and addictions problem, and nearly half of the population will have experienced a mental illness by the age of forty¹. Canada has made considerable strides in enhancing MHA services over the past decade, however many individuals still struggle to

navigate the system and access the services they need for both themselves and loved ones. Real systematic change remains a low priority for the public sector due in no small part to the challenges that arise from large-scale transformations, as well as the traditional stigmas which still linger around mental health issues and addiction.



**Each year, 1 in 5
Canadians personally
experiences a mental
illness or addiction
problem.**

¹ Smetanin et al. (2011). The life and economic impact of major mental illnesses in Canada: 2011-2041. Prepared for the Mental Health Commission of Canada. Toronto: RiskAnalytica.

Nevertheless, the need for more accessible and reliable MHA support persists. Canada has the knowledge and resources to make good on that support, but it also faces significant systemic obstacles, including:

- **Access barriers:** It is not uncommon for individuals living in Ontario to wait six to 12 months for counseling and therapy services;²
- **Funding limitations:** Mental illness accounts for at least 10% of the burden of disease in Ontario (as those with chronic diseases often also suffer from mental health issues, including anxiety and depression), but only receives 7% of healthcare dollars;³
- **Variability in quality of services:** Only about 50% of Canadians experiencing a major depressive episode will receive “adequate” care.⁴ In Ontario, for those individuals that identified themselves as requiring mental health or addictions services, nearly one-third reported not getting any help or having their needs only partially met.⁵

These systemic barriers are important to the discussion, but they do not encapsulate the breadth of real-world challenges that clients and their friends, family members, and caregivers (herein referred to as 'family members') face. In fact, their impediments can vary on many factors, ranging from an inability to navigate the system to a difficulty understanding what services are available, or having trouble accessing those services in their region.

As demand for MHA services continues to grow, and further investments are being made to improve the system, these perspectives should be front and centre in informing Canada's ongoing healthcare strategy.

This brief highlights the six most common “pain points” cited by MHA clients and a “wish list” for building a more client-centric system based on KPMG's recent consultations with hundreds of clients and family members with mental health and addiction experience.

The perspectives ahead come from individuals from three distinct sample populations across the province of Ontario; and as such, are not comprehensive nor generalizable to all client experiences. What they do represent are common themes heard throughout KPMG's numerous stakeholder and client engagements. Our intent is to highlight the most common “pain points” cited during our interviews, and suggest steps that can improve MHA services while also staying true to the client's perspective.

² Office of the Auditor General of Ontario (2016). Annual report 2016, volume 1. Toronto: Queen's Printer for Ontario.

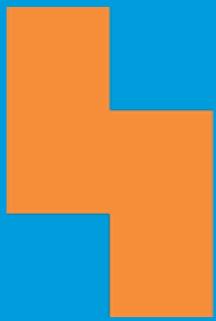
³ Institute for Health Metrics and Evaluation (2015). Global Burden of Diseases, Injuries, and Risk Factors Study, 2013. Data retrieved from <http://www.healthdata.org/data-visualization/gbd-compare>.

⁴ Patten et al. (2016). Major depression in Canada: what has changed over the past 10 years? Canadian Journal of Psychiatry, 61: 80-85. “Potentially adequate treatment” defined as “taking an antidepressant or 6 or more visits to a health professional for mental health reasons.”

⁵ Institute for Clinical Evaluative Sciences (2012). Canadian Community Health Survey Mental Health.



By age 40, about 50% of Canadians will have or had a mental illness – regardless of education, income level or culture



Pain Points: Areas for improvement

System Navigation: Who can help me? Where do I go? What are my options?

MHA services are complex, often times involving different service providers, numerous treatment, and support modalities, and – in many cases – spanning a combination of medical (e.g., clinical therapies, medications) and social (e.g., housing, vocational, justice) services. Clients consistently report challenges with navigating the system, saying they do not know where to go for help, what options they have available to them, or what high-quality care looks like. As well, many report that their primary care providers lack awareness and understanding of the options available for mental health and addictions services and, in some cases, do not know which services or providers are available to them.

Service hours: Timing is everything

With the exception of certain high-intensity mental health services, e.g., Assertive Community Treatments Teams (ACTT), most publicly-funded MHA services offer limited evening hours. This limitation may restrict or delay access to services for clients with full-time jobs, demanding academic schedules, or parental obligations. Delays in accessing the right care may influence prognosis, in addition to affecting other systems within healthcare, such as the Emergency Department. “About 35% of people with anxiety disorders or addictions have their first mental health or addictions contact in the emergency department, compared to 13% of those with schizophrenia. Men are more likely than women (36% vs. 30.5%) to have first contact with the mental health and addictions system in the emergency department.”⁶

“The onus is on the mentally unwell individual to find their own help, which is a deterring factor in and of itself. We need hands-on direction, similar to what we would receive if we had a broken bone or some other physical health condition. It's difficult and dangerous to leave [system navigation] solely in the hands of the client.”

– Client Quote

“Hours of service need to change. I don't know about you, but I can't tell myself to only have mental health problems between 9am and 5pm”

– Client Quote

⁶ Taking Stock: A report on the quality of mental health and addictions services in Ontario. Issued by Health Quality Ontario and Institute for Clinical Evaluative Sciences. 2015.

Nevertheless, having immediate access to services is particularly important for both individuals with MHA challenges and family members seeking support on their behalf. That said, it is reported that Canadians often have difficulties engaging in the system and may be unwilling to seek help as a result.⁷ A common suggestion among clients and families is to create a “critical window” of time in which these individuals may be more willing to seek services. If they are not serviced during this critical window of opportunity, they may not seek or return for services at all. Herein, conditions can worsen, negatively impacting an individual's ability to function at their job, school, or home life.

One size does not fit all: Lack of alternative health and culturally-grounded services options

Mental illness affects people of different ages, education levels, socioeconomic status and cultures.⁸ Yet many services are delivered through a “one-size-fits-all” approach.

This lack of choice becomes particularly problematic when cultural influences and sensitivities come into play. Having a limited grasp of English, for example, has been found to be an important contributor to disparities in accessing services and health outcomes; while lack of culturally grounded options (e.g., traditional healing practices, religious/ cultural engagement) has led some clients to discontinue their participation in programs and discourage them from attempting to access those services again in the future.

Families and caregivers: Underutilized assets

“Family members don’t need to know the nuances of their loved one’s health and treatment, but they do want to know the broader mental health issues so that they can keep their family member safe.” – Family Member Quote

Family members and caregivers are among the system’s most valuable assets, yet their roles are often overlooked. It is important to recognize that family members are affected in their own way and each has a part to play in encouraging those with mental illness and/ or addictions to seek initial assessment, supporting them throughout treatment, identifying warning signs of relapse, and helping them access services at times of crisis.

Today, the Ontario Mental Health Act and Personal Health Information Protection Act limit how much family members can play that vital support role. These laws are in place to ensure individuals can both make decisions for themselves and control their personal medical information; however, many family members express frustration with their inability to obtain the information and authority they need to adequately support their loved ones with MHA challenges.

Geographic disparity: Disparities in rural communities

The basket of services for mental health and addictions is less comprehensive and less accessible in rural and Northern Ontario relative to urban areas in the province.⁹

Many clients and families residing in Ontario's rural communities believe that the quality and accessibility of MHA services are lower than those in urban centres. This perspective is supported by Ontario LHIN stats which indicate rural communities demonstrate higher rates of mental health illness and addictions behaviour than urban centers in the province. Despite the higher demand for mental health services, clients in rural communities also experience the longest wait times and lowest rates of mental health outpatient visits across all service types, primarily due to the relative shortage of available services. There is a clear misalignment between client needs for MHA services and availability of appropriate services across Ontario.

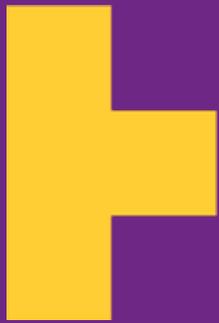
Consistency in Care and unclear outcomes: What should I expect?

Clients and families are concerned about the services they receive and have indicated that their treatment goals are not always clear, particularly for those who have been in treatment for a long period of time. This concern is shared among those involved in case management, which tends to be an all-encompassing service that organizations provide. The issue is that those services are not consistent across different organizations due to lack of standardization. Similarly, outcome measures are not evaluated in a consistent manner or across organizations. Lastly, as the information is not publically reported, clients do not know what services are providing best patient outcomes.

⁷ Mojtabai, R. et al. (2016). Psychiatric Services. Attitudes toward mental health help seeking as a predictor of future help-seeking behavior and use of mental health treatments..

⁸ Canadian Mental Health Association (2018). Facts about mental illness: <https://cmha.ca/about-cmha/fast-facts-about-mental-illness>

⁹ Canadian Mental Health Association Ontario (2018). Rural and Northern Community Issues in Mental Health. <https://ontario.cmha.ca/documents/rural-and-northern-community-issues-in-mental-health/>



Wish List: What clients really need

KPMG spoke with hundreds of healthcare clients and families about how MHA service delivery can be improved notably. The resulting “wish list” includes a number of suggestions that are both highly practical and generally feasible.

- **Access to 24/7 coordinated access and crisis lines with immediate response, managed by highly skilled staff and supported by individuals with “lived experience”**

When implemented effectively, MHA coordinated access that encompasses crisis lines can be highly effective in providing prompt and timely access to services. Given that a crisis can happen at any time, these lines must be operational 24/7 with rapid call response time (~15- to 30-second wait times). Ideally, they should also be staffed by highly skilled clinicians that are able to support an individual in crisis, who are accompanied by an individual with lived experience to provide value-added peer support.

- **Better co-location of services to minimize client travel requirements.** A “one-stop shop” model for delivery of comprehensive MHA and related services (including virtual care) at one location has the potential to reduce the transportation barriers faced by some clients, particularly for those living in rural and remote areas.

- **Greater access to mental health and addiction walk-in clinics.** The “walk-in” clinic model (not to be confused with the GP walk-in clinic) provides clients with timely access to brief intervention and on the spot services and navigation support. For some clients, one-time support through a clinic without having to have an appointment may provide life-changing help. Additionally, this model provides clients that require long-term services with an opportunity to receive periodic care in the interim while on a wait list. In turn, this may reduce the incidence of inappropriate hospital and Emergency Department admissions. This model tends to be highly effective for individuals who are using substances and require immediate intervention when they are motivated to seek treatment.
- **Consistent and standardized implementation of mental health first aid training.** All healthcare professionals and services professionals who may come in contact with an individual in crisis (e.g., school teachers, guidance counsellors and police officers) should receive education and training on mental health first aid so they are better equipped to support an individual in crisis, and can help in reducing the stigma associated with MHA-related issues.
- **Standardized Care across service providers:** Regardless of which service a client and family access, they wish to know that they are receiving the same high standard of quality care, which is evidence based with demonstrated positive outcome measures.

- **The incorporation of alternative therapies and healing practices into the “traditional” model of services.** Better integration of shared decision-making in MHA treatment and services plans would provide clients with an opportunity to incorporate alternative therapies (e.g., nutraceuticals and physical therapies) and traditional healing practices into their services journey.
- **Enhanced public outreach to improve awareness of privacy laws and family rights.** Better education and awareness around key pieces of legislation like the Mental Health Act and the *Personal Health Information Protection Act*, as well as the implications of these laws on family member involvement in the services of their loved ones is required. Resources should be more easily accessible, available in multiple languages and developed at an appropriate literacy level.
- **Greater investment into peer and family supports.** Peer and family supports should be available to provide clients and families with education and support. Family Support workers are particularly important to provide support to family members, given the emotional and physical toll that caring for a loved one may have on family members themselves.
- **Leveraging and (further) empowering educational institutions for mental health awareness, education, and early identification:** Given that one in five children and youth in Ontario will experience a mental health problem¹⁰, there is significant opportunity for educational institutions (e.g., schools, universities and colleges) to play a critical role in mental health promotion, education and awareness, early identification, and (in some cases) providing intervention and support services. Such an initiative would require the development of a standardized provincial mental health curriculum and public health awareness campaign as well as a greater investment in mental health and addictions resources in our educational institutions.



Final thoughts

There is no disputing the strength of Canada's healthcare professionals; and indeed, when it comes to knowing what's best for the client, their skills and knowledge are invaluable to the conversation. As with all complex and wide-reaching health care issues, however, addressing Mental Health and Addiction requires a deep understanding of the client themselves. That includes understanding their experience, acknowledging their challenges, and addressing the real world barriers that can often separate MHA clients between them and their much-needed healthcare services.

It is promising that mental health and addictions have been identified as a strategic priority at both the provincial and federal levels. Moreover, it's good to know that strategic decisions and investments will be made in the near future to enhance the delivery of these services. If those strategies are to have an impact, however, they will need to include the client perspective – not merely in the planning stages, but throughout the entire process. After all, investments in the healthcare system will only make a difference if they are informed by the Canadians who rely on it.

Identifying those real-world barriers is only the first step. The next step is to take action on a systematic scale to address the timing, accessibility, and social stigma-related issues identified in this study. To that end, we invite you to take the conversation further in reach part two of our brief, **In Search of the Perfect Mental Health System.**



¹⁰ MHASEF Research Team. (2015) The Mental Health of Children and Youth in Ontario: A Baseline Scorecard. Institute for Clinical Evaluative Sciences.)

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