MENTAL HEALTH, MENTAL ILLNESS AND ADDICTIONS

A BRIEF TO THE

Standing Senate Committee on
Social Affairs, Science and Technology

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SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

Mental Health, Mental Illness and Addictions

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EXECUTIVE SUMMARY

The Canadian Psychological Association applauds the Standing Senate Committee on Social Affairs, Science and Technology for undertaking this important study on mental health, mental illness and addictions in Canada. The Standing Senate Committee's report has the potential to be a touchstone document marking a dramatic shift in the way Canadian society and societal systems deal with mental health, mental illness and addictions. It is this fundamental change in the basic societal structures of health, education, criminal justice, social welfare, the workplace, individuals and families that will be its enduring legacy.

Mental illness and addictions know no boundaries. They strike at any age and in any population. Their personal, social and economic burden is staggering. The World Health Organization estimates that five of the ten leading causes of disability world-wide in both developed and developing countries are mental illnesses.

Psychologists make up the largest group of scientists and specialist-regulated health professionals in the mental health, mental illness and addictions field in Canada. They provide services in the health, education, criminal justice, social welfare and workplace domains through both the public and the private sectors.

The Canadian Psychological Association is the national organization that represents the science, education/training and practice of psychology in Canada. The Association is the national voice of psychology internationally and represents the discipline to such organizations as the International Union of Psychological Science and the World Health Organization.

The core business of psychology is the biological, cognitive, affective, social, cultural and environmental determinants of behaviour. That is to say, psychologists are concerned with how people think, feel and behave in their social and physical environments. This is psychology's unique contribution. Psychologists work from a "scientist-practitioner" model, meaning they are skilled in both research and clinical practice.

The mental health field is becoming more integrated and assertive. Patients and providers are working together as never before to advance the agenda. Governments and others are more aware of the importance and impact of mental health, mental illness and addictions.

Mental health, mental illness and addictions have always been and continue to be the "poor and forgotten cousins" of human service systems and the workplace. This must and will change. To do otherwise results in unacceptably high levels of suffering, inefficiency and costs to individuals, families, business, industry and society.

This brief offers 36 recommendations for change. These recommendations support the positions taken by other groups appearing before the Committee. Three important themes emerge from this document which respond to the three questions put forward by the Senate Committee in its letter to the Canadian Psychological Association.

1. Reduce marginalization and stigmatization.

Individuals with mental illnesses or psychological disorders are often dismissed and reviled. Services are frequently unavailable or inadequately funded. Biomedical instead of more balanced biopsychosocial paradigms dominate the health care sector in both research and practice.

The same marginalization occurs in criminal justice, education, social welfare and the workplace. Governments, system administrations and public policy planners need to develop models that appropriately include mental health, mental illness and addictions in proportion to their prevalence and burden in society. Representatives of this sector must be included as a matter of course around important policy and planning tables in institutions and organizations, communities, regions, provinces and at the federal level. A national action plan such as the one developed by the Canadian Alliance on Mental Illness and Mental Health as a template for action needs to be adopted.

2. Provide more balance in research and services based on prevalence, burden, efficacy and population health models.

The mental health, mental illness and addictions field is all too often thought of exclusively in terms of the severely and chronically disordered and disabled. This is an important constituency that has not been well served.

In addition, however, there are other important constituencies. These include but are not limited to the behavioural or psychological components in wellness, injury and illness prevention, diagnosis and treatment, rehabilitation and relapse prevention, chronic disease and disability management, and palliation. Healthy workplaces and the mental health and addictions issues of workers have a huge impact on the Canadian economy. Early intervention in school-aged children aids learning and positive school outcomes. Effective criminal justice programs reduce crime and increase safety in communities.

Services need to be provided based on an expanded understanding of mental health, mental illness and addictions in concert with prevalence, burden and efficacy data within a comprehensive biopsychosocial population health model.

3. Reduce the negative impacts of administrative silos.

Mental health, mental illness and addictions issues and concerns cross many administrative boundaries. As such, services, when available, are all too often uncoordinated.

Many patients and families report high levels of frustration with the lack of available services, the lack of access to appropriately trained providers and the lack of co-ordination between government departments, providers and agencies. This situation squanders a precious and largely unavailable resource. The results include, for example, unnecessary damage to individuals and families caused by a lack of timely treatments, increased waiting periods for scarce services, inappropriate and less efficient utilization of human services systems such as emergency rooms, family physicians and inpatient beds, and increased costs to Canadians.

INTRODUCTION

The Canadian Psychological Association applauds the Standing Senate Committee on Social Affairs, Science and Technology for undertaking this important study on mental health, mental illness and addictions in Canada. As a nation, we are becoming increasingly aware of the fundamental importance of mental health to Canadians. A national survey conducted for the Canadian Mental Health Association by Compass Research (2001) determined that 91% of Canadians think maintaining mental health is very important. Research continues to demonstrate the heavy toll mental illness takes on individuals, families, the workplace and society. We strongly support this initiative undertaken by the Standing Senate Committee to conduct a comprehensive examination of mental health, mental illness and addictions in hopes of improving the lives of all Canadians.

Mental illness and addictions know no boundaries. They can strike at any age and in any population. For example, from 18% to 24% of Canadians experience mental health disorders (Coalition of Mental Health Stakeholders, April 2000). Although not random in their distribution, no one is immune. From the limited Canadian data available, the prevalence of attention deficit/hyperactivity disorder among children has been estimated to be 3 to 5% (National Institute of Mental Health, 2000) and conduct disorder 5.4% (Ontario Child Health Study, 1989). Among adults, the estimated one-year prevalence rates of anxiety disorders is 12.2 %, schizophrenia is 0.3%, and major depression ranges between 4.1% and 4.6% (Health Canada, 2002). The addictions literature suggests that 12.9% of adults participate in hazardous or harmful drinking (Centre for Addictions and Mental Health, 2000), and the infants of mothers suffering from alcohol addiction can have devastating lifelong disabilities such as Alcohol Related Brain Disorder. In geriatric populations (adults over the age of 65), the prevalence rates of Alzheimer's Disease, only one form of dementia, are estimated to be 5% (Health Canada, 1996). In addition, issues are emerging, such as child and youth gambling, bullying, the effect of violent video games and the impact of pornography available on the internet for which we have very limited estimates of prevalence, impact and burden.

The personal, social and economic burden of mental illness and addictions is staggering. According to the World Health Organization, it is estimated that in terms of the global burden of disease, five of the ten leading causes of disability worldwide in both developed and developing countries are mental illnesses (World Health Organization, 2002). The Canadian Mental Health Association (2002) indicated mental illnesses and addictions were among the top ten billing items for family practitioners in Canada. The Global Business and Economic Roundtable on Addiction and Mental Health (Scientific Advisory Committee, 2002) suggests that the burden of mental illness and addictions costs Canadian business 14 billion dollars per year in lost productivity. They note that this is a conservative estimate and the costs are rising. Psychiatric disorders account for 47.2% of all years lived with disability in developed countries (Bland, 1998) with levels greater than those associated with hypertension, diabetes, arthritis and back pain (WHO, 1995). The effective treatment of mental disorders and addictions has significant impact on society in terms of direct and indirect costs to health and health care, education, community/social services and justice systems.

The contribution of psychology to the continued development of health care in Canada cannot be underestimated. Behavioural change plays a pivotal role in mitigating the risk factors in many diseases and medical conditions including hypertension, high cholesterol, heart disease, obesity, and addictions. Modest improvements in risk factors result in large benefits with regard to improved individual and population health. For example, there are effective treatments available for scores of physical and mental disorders comparable in effectiveness with drug treatments, while the cost is approximately one third less. Psychological treatments can reduce health care costs by 20% to 30% (Canadian Psychological Association, 2002).

Commissioner Roy. J. Romanow aptly named mental health the "orphan child" of the health care system in his final report from the Commission on the Future of Health Care in Canada (2002). The Canadian Psychological Association could not agree more. Not only is this comment reflective of the current state of affairs, but it has always been the case.

The Standing Senate Committee's report has the potential to be a touchstone document marking a dramatic shift in the way Canadian society and societal systems deal with mental health, mental illness and addictions. It is this fundamental change in the basic societal structures of health, education, criminal justice, social welfare and the workplace, as well as individuals and families that will be its enduring legacy.

A WORD OF CAUTION

There is a serious danger that needs to be addressed at the outset. This examination of mental health, mental illness and addictions as an issue on its own can have the unintended effect of once again marginalizing this domain, placing it back in the asylum as opposed to in the main stream.

The Standing Senate Committee on Social Affairs, Science and Technology tabled the final volume of its comprehensive report on the Canadian Medicare system in October 2002. The Committee set aside Aboriginal health and mental health to subsequent investigations because of the difficulty of effectively integrating them into their examination of the health system. This is a dramatic indication of the lack of coordinated services and the inadequate integration of psychological health and mental illness services into our current primarily biomedically focused system. Once again, the needs of Canadians with behavioural health problems, mental illness and addictions were marginalized. However, the Standing Senate Committee took the responsible decision to conduct the investigation we are participating in today.

The situation is clear. This Senate investigation is a golden opportunity to change archaic views of mental health, mental illness and addictions and to prevent further marginalization. It is hoped this brief, and others that will be presented to the Senate Committee, will give the Committee the information it needs to make the irrefutable case that psychological factors are central and not peripheral issues in health, education, social welfare, the workplace, criminal justice, etc. and the lives of Canadians.

People acquire diseases; diseases do not acquire people. It is people that get healthy, stay healthy, and manage illness and disability. Human health is more than organs, genes, tissues and

blood. Psychological health must be integral in health care and an equal partner in government policy, research, service delivery and funding.

TREATING PROBLEMS: PSYCHOLOGY WORKS

The core business of psychology is the biological, cognitive, affective, social, cultural and environmental determinants of behaviour. That is to say, psychologists are concerned with how people think, feel and behave in their social and physical environments. This is psychology's unique contribution. Psychologists work from a "scientist-practitioner" model, meaning they are skilled in both research and clinical work. A brief summary of the skills psychologists offer is provided in the following table.

Table 1

Psychologists :	**In Research**	**in Practice**
Assess	- study basic psychological processes (biological, cognitive, affective, social, cultural and environmental determinants of behaviour) - develop assessment and diagnostic tools	- diagnose mental disorders - assess thinking, emotions, behaviour and social relationships
Consult	- teach students of all health professions - train other professionals - participate in and lead interdisciplinary research teams	-consult with patients, families, educators, professionals, the workplace, etc. -consult with communities, agencies and governments - advocate for psychological health
Treat	- research best practices - evaluate interventions and programs	- prevention - education - therapy - rehabilitation - remediation - chronicity and disability management

Table 1 developed by Angela Digout, Canadian Psychological Association Parliamentary Intern, Clinical Psychology Intern, Children's Hospital of Eastern Ontario, and Clinical Psychology Doctoral Student, Queen's University.

The Canadian Psychological Association is the national organization that represents the science, education/training and practice of psychology in Canada. The Association is the national voice of psychology internationally and represents the discipline to such organizations as the International Union of Psychological Science and the World Health Organization.

Approximately fourteen thousand psychologists are registered as regulated health professionals by the provinces in Canada. As such, psychologists make up the largest group of scientists and specialist providers in the mental health and addictions field in the country. In addition, there are an additional two to three thousand faculty members, scientists and those that work in fields that do not require provincial registration. Psychologists offer psychological services in such areas as.....

…education:

It is inconceivable to think that effective student outcomes based on psychological information are not the core business of any classroom, school or school system in Canada. Research shows that for many learning problems, there is a small window of opportunity for maximum benefit. The children who cannot take advantage of this period of optimal treatment efficacy may suffer irreversible damage. Academic failure can lead to underachievement, premature school leaving, underemployment and reliance on the social welfare system. Educational achievement is one of the most robust predictors of success in life.

®CANSTART is a good example of a successful early childhood education program based on research. Developed by Dr. Marvin Simner and published by the Canadian Psychological Association and the Canadian Association of School Psychologists, ®CANSTART provides tools to teachers and parents for early identification of learning problems and suggestions for remediation. (Simner, 1998)

Classroom teachers face a myriad of challenges. Many are behavioural in nature. Since psychology's core business is behaviour, teacher support can mean the difference between success and failure for many children. It can also mean reduced stress and burn out for the teacher and a more efficient learning environment for the whole class.

…criminal justice:

Childhood behaviour problems are often considered precursors of juvenile delinquency. The Montreal Prevention Experiment is a robust intervention system for children and adolescents that has been shown to have very positive effects (Tremblay, Masse, Pagani, & Vitaro, 1996)

Canada incarcerates a high percentage of its population and a very high percentage of its children and adolescents at significant expense in dollars and human capital. An increased emphasis on the psychological factors involved in the path to jail results in lower incarceration rates, reduced criminal activity, less victimization and lower costs to victims, society and perpetrators. More emphasis on post incarceration programs reduces recidivism.

Again, it is hard to imagine human behaviour not being part of the core business of a 21st century comprehensive criminal justice system. Psychological services are over demanded in Canadian jails. Most violent and sex offending prisoners receive a psychological assessment in order to inform prisoner management, rehabilitation, treatment and parole. This enlightened policy is an example of the marriage between rehabilitation and punishment in the Canadian criminal justice system. As well, although many prisoners are

assessed, it does not mean that the recommended treatment programmes will be available. The irony is that once released, it is far more difficult to see a psychologist or other mental health professional in the community than while in jail.

…the workplace:

A healthy workplace is fundamental to productivity, innovation and the bottom line. This concept has two components. The first is an organizational perspective which focuses on effective administrative and governance systems, productive supervisory relationships, the building of effective work teams, fair and effective assessment of employee performance, goal setting, crisis management, life/work balance, and so on. Research shows that the most effective companies over the long term are the systemically healthier workplaces.

Work supervisors' self-efficacy was significantly higher when they engaged in mental practice or were associated with a commitment to workplace goals. (Morin & Latham 2000).

In addition, employee assistance programmes (EAP), also known as employee and family assistance programs (EFAP), help workers struggling with, for example, anxiety, depression, substance abuse, gambling problems, stress, burn out, marital problems and family conflicts. As noted previously, it is conservatively estimated that mental health problems cost Canadian business billions of dollars per year. EAPs significantly reduce benefit utilization and quality control problems while increasing efficiency, all of which positively affects the bottom line.

…social welfare:

The Better Beginnings, Better Futures project is a longitudinal demonstration project created in partnership between government and community, designed to prevent young children in low income, high risk neighbour-hoods from experiencing poor developmental outcomes (Peters, Petrunka, & Arnold, 2003)

Social welfare agencies deal with some of our most vulnerable citizens. For example, children who are placed in foster homes on a temporary or permanent basis often come from highly problematic families and have significant issues to deal with. They need a number of support systems including those for their psychological health. All too often timely access to appropriate services is not available for these children. This puts greater strain on the child, their original or temporary families and the agency. It results in higher levels of failure and recidivism. On the other hand, early mental health interventions for children and families can enhance parenting skills and avoid family breakdown.

The issues that face Canada's adults in the social welfare system are significant. Many families live in poverty. Many Canadians live on the streets or in housing conditions that are highly problematic. Research demonstrates that health status is tied to income. Canada's social welfare recipients receive limited public mental health services and cannot afford private practice.

…health:

Human behaviour is at the heart of health care. It is impossible to think of wellness, injury and illness prevention, assessment, diagnosis and treatment/cure, management of chronic illness and disability, rehabilitation, relapse prevention or palliation without appreciating the fundamental role of human behaviour.

Behaviour in no small measure determines health outcomes for the individual and for society. Chronic diseases currently have one of the highest cost structures in the Canadian health system. Diabetes is a perfect example. Once the correct diagnosis is made, much of the treatment is behavioural involving, for example, attention to diet, possible daily medication and testing, attention to physical activity and sleep, and so on. This is a regime that can involve significant behaviour change. Add to it the developmental and familial/parental dynamics of a 12 or 14 year old with diabetes, and you can significantly increase the behavioural challenges. A lack of successful adherence can have serious consequences such as amputation, blindness and death.

Recent research in Calgary showed that a group psychosocial intervention for women being treated for breast cancer reduced overall amounts billed to the health system by 23% percent over two years and had lasting positive effects on the participants' quality of life (Simpson, Carlson, & Trew (2001).

Eighteen to twenty four percent of adults and children will experience a mental health disorder (Coalition of Mental Health Stakeholders, April 2000). Untreated disorders such as significant disruptive disorder and social problems in adolescents are precursors to adult aggression and violent crime (Locher et al, 1998), peer rejection, academic impairments, higher rates of physical problems, family problems, mood problems and automobile accidents (Locher, 1998, Weiss and Hechtman, 1993). In addition, those with a mental health diagnosis access the physical health system at a high frequency.

It is clear from these examples and the information contained within this brief that behavioural issues are an integral part of health, education, criminal justice, the workplace and social welfare. The problem is we expend huge amounts of resources on traditional medical services and activities, and pay but lip service to the mental health and addictions side of the equation. We are confident that this and other representations to the Standing Senate Committee will give the Committee the information it needs to send a clear and unequivocal message that psychological health is inextricably interwoven with somatic health as equal partners. This message will serve as a clarion call to action in the service of the health of Canadians.

Section 1 – WHERE WE ARE

THE PUBLIC POLICY NEGLECT OF MENTAL HEALTH, MENTAL ILLNESS AND ADDICTIONS

Between the years 2000 and 2002, several provinces published reports on their investigations into their health systems. Unfortunately, these otherwise excellent reports generally did not deal with mental health, mental illness and addictions.

This lack of specificity has had several negative outcomes. First, the reports do not make explicit the urgent need to develop comprehensive service models that include mental health as a fundamental partner across the continuum of activity in each relevant government department and the workplace. Second, the reports inadvertently reinforce the separation of these areas into independent "silos" of activities. Third, there was no clarion call for the development of a comprehensive framework for the integrated delivery of mental health services across a community or region. Fourth, the lack of adequate consideration of mental health, mental illness and addictions issues keeps them off the radar screen of public policy debate. Finally, the impression can be left that health psychology, mental health, mental illness and addictions are not important parts of provincial human service systems.

In November 2002, Mr. Romanow stated that mental health was the "orphan child" of the Canadian healthcare system (Final Report Commission on the Future of Healthcare in Canada, 2002). In fact, the report only mentions mental health as part of acute home care and suggests mental health become a research institute in the second round of institute development. At no time did Mr. Romanow adequately consider the psychological or mental health aspects of health, or attempt to weave them into the fabric of health and health care in Canada. Rather, he essentially overlooked them and offered no explanation.

It is ironic that the orphan of Medicare was also an orphan in the Commission's report. The omission was in spite of a tremendous advocacy effort that provided the Commission with reams of information from professional groups, patients and their families. Mr. Romanow's report has had a negative impact on the mental health and addictions sector.

Having identified the orphan, it would have been helpful for Mr. Romanow to outline in detail the adoption plan. The Commission's oversight was not, in all likelihood, because they considered the area irrelevant or unimportant. Rather, it speaks to the relative imbalance between the mental health and biomedical domains and the ease with which the former can be overlooked and "left out". It underlines the necessity of moving from the current biomedical model to a biopsychosocial model as outlined by Engel in *The Need for a New Medical Model; A Challenge for Biomedicine* (Science, 1977).

The Public Policy Forum hosted a meeting (December 2002) to discuss the Standing Senate Committee's and the Romanow Commission's reports and to make recommendations to governments. The Ministers of Health for Canada and Alberta received the recommendations on behalf of the Council of Health Ministers. Senator Kirby was invited to discuss the work of the Standing Senate Committee. The meeting was attended by dozens of representatives of health

organizations from the public and private sectors. At the beginning of these two days of deliberations, mental health, mental illness and addictions and Aboriginal health were respectfully put aside because the majority of participants thought it impossible to weave them effectively into the discussion and recommendations in such a short period of time.

As these examples demonstrate, mental health, mental illness and addictions are generally not viewed as part of the core business of health. This can also be said for education, social welfare, criminal justice and the work place. This is a pervasive problem throughout Canadian society.

Mental health is at the core of a healthy society. The prevention and treatment of mental illness and addictions require the same attention and resources as any other disease based on prevalence, burden and outcomes research. Health and health care, education, criminal justice, social welfare, business and industry can all benefit from the integration of existing psychological knowledge, the results of research and the continual measurement of outcomes. **The promotion of good mental health is everyone's business.**

"It's déjà vû all over again." (Yogi Berra) Mental health, mental illness and addictions have been addressed sporadically over the decades. Reports have been written and initiatives undertaken. Since the Lalonde report's conceptualization of health policy beyond health care (Health and Welfare Canada, 1974) and the broadened definition of mental health provided in Mental Health for Canadians – Striking a Balance (1988), the problem has always been a lack of sustained traction. Mental health and addictions issues appear and disappear from the radar screen of Canadian public policy. **Mental health, mental illness and addictions must become an ongoing passion and not just a passing fancy.**

Recommendation 1*: Mental health, mental illness and addictions prevention, treatment and chronic care services must become core partners in health, education, social welfare and criminal justice systems as well as in the workplace. This partnership needs to be based on factors such as prevalence, burden and research.*

Recommendation 2*: Mental health, mental illness and addictions prevention, treatment, chronic care services and research must be funded in proportion to their prevalence and burden in Canadian society.*

MENTAL HEALTH IS MORE THAN HEALTH

Mental health and addictions services are under funded to begin with and cut when times get tough. Despite the demonstrated negative impacts of mental health issues on physical health and disability rates, the low funding levels demonstrate they are peripheral concerns in Canada's human service systems.

Mental health and addictions services are an afterthought (if thought of at all). This marginalization means that other services develop more quickly and effectively. As a result, there are often no strategic plans for the appropriate development, expansion and integration of mental health services within these systems nor are there effective plans to integrate systems and bridge the silos or to interact effectively with private practice.

Building systems with mental health services as an integral partner in the core operations of the system requires a commitment to providing people with the services they need based on the prevalence, burden and outcomes data from their sector. With this as a guiding principle, it is then possible to develop balanced and responsive community-based systems that include an appropriate level of mental health, mental illness and addictions services.

Recommendation 3*: Each departmentally driven human service (education, social welfare, criminal justice and health) and the workplace adopt the principle that mental health, mental illness and addictions prevention programs and services are an integral part of their core business.*

Recommendation 4*: Each departmentally driven human service (education, social welfare, criminal justice and health) and the workplace develop and adopt a strategic plan for the development and delivery of mental health, mental illness and addictions services as an integral part of their core activity based on a population health framework, treatment efficacy research and outcomes data.*

Recommendation 5*: Each departmentally driven human service (education, social welfare, criminal justice and health) and the workplace develop and adopt the necessary budgeting processes that ensure adequate resources over the short and long terms to realize the goals of the strategic plans.*

TREATING THE SYSTEM: TWO-TIER CARE IN CANADA

Increasingly, services are being offered in the private sector. In the 1970s and 1980s, anecdotal data suggests that approximately 90% of psychological services were offered through the public systems in Canada. The elimination, downsizing and slow growth of psychology services in hospitals and school districts along with deteriorating working conditions (Canadian Psychological Association, 2002) have created a vacuum that is being filled by private services, affordable by some but not all of the Canadian population. If current trends continue, as much as 70% of psychological services may be delivered in the private fee-for-service system by the year 2020.

There appears to be little concern about this privatization trend by most governments. Passive privatization of psychological services in health and education in particular has been a result of government neglect and a means of reducing the size of the public sector.

This has resulted in a thriving private practice sector for psychology as well as other professions such as occupational therapy and physiotherapy. Private practice works well for both the professional and the patients that can afford services. The dark side of the equation is the fact that Canadians of lower incomes have limited or no access to psychological services.

If the services were not effective, people would not pay for them out of their own pockets. The for-profit health system in the United States continues to demonstrate that behavioural health, mental health and addictions services are effective and save money. If these services did not work and they did not satisfy policy holders, they would not be offered by the for-profit companies. In

Canada, it is unacceptable that these valuable services are increasing available only to those that can afford them and increasingly unavailable to millions of Canadians.

<u>Recommendation 6</u>: ***Governments must provide lower-income Canadians appropriate access to mental health services through an expansion of the public system and financial support to access the private practice sector.***

Section 2 – WHAT NEEDS TO BE DONE

FIGHTING DISCRIMINATION

As discussed above, mental health patients and services are not seen as an integral part of the core business of the major systems in which they participate but rather as allied or adjunct services to the core or real business of the day. Nothing could be farther from the truth yet this situation sadly prevails in Canada.

Congressman Edward Kennedy of Rhode Island stated in a recent speech (March 2003) at a meeting of the American Psychological Association that mental health and addictions experience systemic discrimination in the United States. The solution, he opined, was to address the issues much like one addresses systemic discrimination based on other factors such as sex, race, religion, ethnic background, sexual orientation, language, and so on. This discrimination includes the language used to describe people (stigma), the relative imbalance of resource allocation, the absence of adequate representation at the highest levels of policy deliberation, the taking of decisions for the sector and in the sector's best interests by those without adequate knowledge, and so on.

There are many examples of systemic discrimination. The women's movement is a good template for the purposes of this discussion.

Before the women's movement, women were demeaned (stigma: e.g., women have an important but separate role, women are different than men, "don't you worry your pretty little head"), restricted in terms of life opportunities (e.g., not allowed access to work, difficulty owning property and developing financial independence, unable to vote) and never seen at the highest and most influential decision-making tables. For the most part this discrimination was not based on hatred of women but on the weight of tradition, a fear of change and inappropriate beliefs. It takes considerable effort and sacrifice to change systems, and the struggle continues today.

Examples of effective remedies include the development of harassment policies designed to address inappropriate language and behaviour, equity legislation to address equal pay for work of equal value, affirmative action to break the glass ceilings, and human rights legislation eliminating discrimination on the basis of sex. These public policy initiated systemic changes have resulted in many improvements. Perhaps the most meaningful for long-term change is the fact that women are increasingly involved in decisions at the highest levels that directly affect their lives.

The solution for mental health, mental illness and addictions is multifaceted. It requires affirmative action.

Affirmative action requires appropriate resource allocation. As previously discussed, there is a serious imbalance in resource allocation to mental health and addictions in the human service sector and the workplace. This must be addressed over time to allow these systems to better reflect the realities of the lives of Canadians. As provincial and federal spending increases in key human service areas, an increasing proportion of these resources must be allocated to mental health and addictions services to affect the necessary balance. This may mean slower growth than anticipated in more traditional areas to allow for the required but modest growth in mental health, mental illness and addictions.

There are very few magic bio-medical bullets yet enormous resources are allocated to the ongoing search for breakthroughs in this area**.** At the same time, psychological factors are the bedrock of every individual's daily existence. As mentioned above, psychology's core business is human behaviour. How people think, feel, act, the decisions they take and the quality of their social networks in no small measure determine their health, education and workplace outcomes. Canada spends billions of dollars on world class and excellent biomedical research. There is no question this is essential and exciting work.

The problem is that Canada makes relatively little investment in the behavioural and psychological aspects of living with an addiction, a physical illness, a learning problem, a mental illness or a disability. From an objective perspective, this imbalance in research, which is reflected in service delivery, is illogical, unworkable and expensive. A balanced investment strategy to sustain the health of Canadians in a biopsychosocial perspective while searching for major discoveries is essential.

Recommendation 7*: The Canadian Institutes of Health Research, other granting agencies and the national charities allocate research funding for mental health, mental illness and addictions research in accordance with prevalence, burden, outcomes and basic research data.*

Recommendation 8*: The Canadian Institutes of Health Research allocate funding for mental health, mental illness and addictions research across all thirteen institutes in accordance with their contribution to the issues addressed in each institute as measured by prevalence, burden, outcomes and basic research data.*

Recommendation 9*: The Canadian Institutes of Health Research develop a systemic vehicle to ensure the incorporation of the behavioural and social sciences in the work of all thirteen institutes (e.g., Office of Behavioural and Social Sciences, Special Consultant to the President for Behavioural and Social Sciences).*

Affirmative action requires the elimination of stigma. The prevalence and impact of stigma has been well documented for the Standing Senate Committee. The systematic discrimination against psychological health, mental illness and addictions is based in part on fear and misunderstanding. It is the result of poor information and a power structure that has little incentive to change.

Another more specific example of stigma that may not have been discussed to date with the Standing Senate Committee is the label Allied Health Professional and its institutional consequences. This nomenclature is widely used to describe non nursing and non physician health professionals. It is a demeaning term that suggests psychologists, physiotherapists, occupational therapists, etc. are somehow allied or aligned to that which is centrally important. They are not at the centre of the action but rather in a supporting or allied role. **The term "Allied Health" implies they are valuable but optional.**

The term also suggests these regulated professions are very similar in their interests and competencies and therefore logically fall within the same category. Again, nothing could be further from the truth.

What is common, however, is their relative lack of effective voice in the organizational structures within which they work. This is perhaps the most common factor that binds them together in one category. Mental health professions such as psychology, social work and occupational therapy, unlike nursing and medicine, do not have equal and effective access to the highest levels of decision making. This is also true for psychologists working in other systems such as education and criminal justice. This lack of voice results in policy decisions being taken at the highest levels that ignore or do not effectively take into consideration psychological health, mental health, mental illness and addictions. The consequences can be severe in terms of inclusion or exclusion in short- and long-term planning, resource allocation, and so on.

Exclusion occurs in the public policy realm as well. Decisions concerning the development of human service systems and the allocation of funding all too often do not include any or adequate representation from the patients and providers in this sector. As a result, systems are designed and financed that misrepresent the needs of Canadians.

Recommendation 10*: The self-regulated professions have equal and effective access to the highest levels of institutional and governmental decision-making processes in the human service systems in which they provide services.*

Affirmative action requires the change of debilitating laws, regulations, rules and practices. Self-regulating professions provide services directly to the public in both private and public settings. Laws, regulations, rules and practices at the provincial level often do not allow psychologists, for example, to admit patients to hospital, to follow their patients once in hospital or to prescribe psychotropic medications. Many public services such as hospitals and clinics do not offer psychological services. Many that do have low complements and restricted roles and applications. Provincial plans do not assist low-income Canadians in accessing these services outside of these settings.

Recommendation 11*: An inventory of laws, regulations, rules and practices that impede access to and the efficient delivery of mental health services be conducted.*

Recommendation 12*: The laws, regulations, rules and practices that impede access and effective mental health service delivery be changed by provincial governments.*

Affirmative action requires appropriate and meaningful inclusion. Governments are embracing the population health and the determinants of health frameworks to drive health policy and health expenditures. This is to be strongly encouraged. However, they define and implement this paradigm too narrowly. To use the framework more robustly and as was intended, governments need to invest more heavily in research and services in the mental health, mental illness and addictions domains. The burden, prevalence and impact data is staggering when compared to the minuscule investment. This goes to show that currently in Canada these frameworks are more properly labelled 'population biomedical health' and the 'determinants of biomedical health'.

Recommendation 13*: Governments and planners develop models that integrate mental health and addictions effectively and appropriately into comprehensive strategic plans using population health frameworks.*

Inclusion means being counted. If you are not in the data, you are invisible. Governments and human service managers are increasingly relying on data to drive decisions. This is an important trend that will strengthen over the coming decades. Mental health and addictions researchers and service providers welcome and support this initiative. However, at the same time, mental health and addictions services are all too often not part of the data set.

The Canadian Institute for Health Information (CIHI) is a case in point. CIHI publishes a great deal of excellent information on health and health care. CIHI's reports contain little information on the prevalence and treatment of mental health, mental illness and addictions. One reason is the data is not available from provincial health system sources.

Institutions collect data that does not effectively code mental health services and their activities. Human resource data is problematic as well. No province is collecting data on the activity in the mental health private practice sector. Important data is lost that is needed for effecting planning, efficacy studies and determining the place of mental health and addictions services in community, regional and provincial human service systems.

Efforts need to be taken to develop data systems that accurately reflect this important sector. Without this information, mental health and addictions research and services will continue to be virtually invisible.

Recommendation 14*: Human service data systems accurately capture mental health services.*

Recommendation 15*: Human service data systems accurately code mental health professionals when tracking service delivery activities.*

Recommendation 16*: Human service data systems develop methods of accurately capturing the activity in the mental health private sector.*

Recommendation 17: *Provincial governments, regional health authorities and organizations such as the Canadian Institute for Health Information develop systems that accurately capture mental health services in the public and private systems.*

Inclusion means reasonable access to services. Biomedical research and services have always been the core of the Canadian Medicare system. It was designed originally to eliminate the catastrophic costs associated with hospital and physician services to ensure no Canadian would go without basic medical treatment. **Ironically, the problems Mr. Tommy Douglas fought so hard to eliminate in Canada are the reality for many Canadians with behavioural health problems, mental illnesses and addictions today.**

FIGHTING MARGINALIZATION: MENTAL ILLNESS AS THE UNDERCLASS

One way to underscore the impact of the marginalization of the mental health and addictions community is to view the sector as an underclass. Some of the features of an underclass include reduced self-efficacy and self-esteem, self-causation (its their own fault or "blame the victim"), limited resources, limited direct power, a limited ability to effect change, etc. Their features go hand-in-hand with the aforementioned systemic discrimination.

As with any underclass, the field may appear chaotic, disorganized, and fractionated. Groups may seem to be fighting amongst themselves. It can be very confusing and frustrating to those on the outside such as the Standing Senate Committee members who are attempting to make sense of the situation.

The features of an underclass are exactly what one should expect. If one is continually poorly resourced, stigmatized, under represented and on the outside looking in with one's nose firmly pressed against the windowpane, then one behaves as best one can under these adverse conditions.

One method of dealing with this Canadian resource allocation issue is to provide protected funding envelopes tied to strategic plans for mental health, mental illness and addictions. These envelopes would need to focus on making up for traditional under funding and providing for reasonable growth based on prevalence and burden data.

Recommendation 18*: Governments fund behavioural health, mental health and addictions services in proportion to their prevalence, burden, outcomes and research data.*

Recommendation 19*: Governments provide these funds for behavioural health, mental health and addictions services in protected funding envelopes*

Recommendations 20*: The protected funding envelopes in each department be tied directly to the continuously evolving strategic plans for behavioural health, mental health and addictions services.*

Recommendation 21*: The protected funding envelopes in each department be developed and implemented to effectively interface with the strategic plans and actual services offered by the other departments.*

Recommendation 22*: Governments ensure access for all Canadians by expanding mental health and addictions services available in the public system and with programs to facilitate access to the private practice system.*

Recommendation 23*: Governments ensure access for all Canadians by implementing provincial mechanisms to fund psychological services in the private sector for those Canadians who cannot afford them.*

MENTAL HEALTH HUMAN RESOURCES

There is a serious health human resource issue to be faced. Many health professions are experiencing and predicting shortages. The situation will only be exacerbated over the next ten to fifteen years. The Canadian Institute for Health Information in its 2001 Report: Canada's Health Care Providers, demonstrated that psychology had the highest mean age of the regulated health professions. Once the baby boomers enter retirement, the supply side of the supply and demand equation will diminish even further putting more strain on the system.

The prospect of decreasing numbers of psychologists over the next two decades is a sobering reality. Psychiatrists are also in short supply with little change in sight. The dearth of professionals will seriously erode the capacity to deliver high-quality mental health services to Canadians. This lack of professionals comes at a time of steadily increasing understanding of the fundamental contribution of psychological factors in all aspects of health and health care, education, criminal justice, social welfare and the workplace. For example, school psychologists are already in very short supply in many provinces.

The costs could be stunning. Family practice will be stretched further. Studies show that between 30% and 60% of family practice patient visits are because of a psychological or psychiatric problem or said problem is a significant contributing factor to the diagnosis. Educators will be stretched further to provide for the learning and behavioural needs of students. Offenders will receive fewer services while in jail or in the community. Children in protection and their caregivers will have even fewer resources at their disposal. Untreated individuals with mental health disorders will draw heavily on the health care, social welfare, and criminal justice systems. Benefit utilization and quality control problems will increase putting significant negative pressure on the bottom lines of business and industry.

There is a desperate need to increase enrolment in the mental health professions. In the case of psychology, hundreds of deserving students are turned away each year from graduate programs in Canada. What is the sense in artificially limiting access to psychological training? Increasing the number of clinicians to work in the various areas described in this document would go some distance in proactively dealing with the human resource problem that is coming quickly. Increasing the basic and applied research capacity in this area is essential.

Graduate training in psychology requires internship experience in order to be registered as a practitioner in any province in Canada. The slow expansion of Canadian Psychological Association

Accredited internship settings and the loss of others, particularly in Ontario, further compromise the education and training of future professionals. In addition to training the professionals of tomorrow, research has shown that internships are a cost-effective method for delivering services (Schauble et al, 1989, Greenberg et al, 1998.)

Recommendation 24*: Governments increase substantially the funding for graduate training and internships in psychology and other regulated mental health professions as needed.*

Section 3 – WHERE WE'RE HEADED

PRIMARY CARE AND MENTAL HEALTH – CHANGING THE SYSTEM

Primary health care has principally involved individual health practitioners or groups of practitioners working in relative independence and isolation. It includes provincially regulated professions such as psychology, medicine, occupational therapy and physiotherapy whose practitioners see patients upon referral or directly without an intermediary.

The mental health, mental illness and addictions demands on primary health care are enormous. Surveys suggest between 30% and 60% of patient concerns in primary care have either a primary diagnosis of a psychiatric or psychological disorder or they are a significant contributing factor.

Governments, patients and many professionals would like to participate in meaningful primary health care reform. This would mean interdisciplinary care being offered in a coordinated manner thereby increasing efficiency and quality while reducing barriers to access.

Psychologists are primary care providers. As regulated health professionals, they see patients directly or upon referral. The Canadian Psychological Association is working with other professional and patient groups to develop frameworks to improve interdisciplinary collaboration and co-ordination in a reformed primary care system. These activities will result in improved quality of care and cost effectiveness. Patients with a mental health concern, be it a primary diagnosis or a significant contributing factor to a physical illness, will have increased access to the services they need.

In terms of mental health services, the collaborative interdisciplinary primary care concept could be expanded to include the broader scope of mental health services across the community as an effective way to increase access and efficiency. In other words, virtual community mental health and addictions networks could be developed that include the relevant professionals in health, education, social welfare, criminal justice, the workplace and private practice. These networks would cross departmental boundaries by using commonly agreed upon frameworks for practice. These practice frameworks would include agreed upon common elements for intake, diagnosis, reporting, etc. They would require greater degrees of collaboration and co-operation. At the same time, the independent mandates of the participating departments (health, criminal justice, social welfare, education), private practice and the workplace would be preserved.

These community networks would allow patients and clients to move more seamlessly from one practitioner to another and from one service to another in a more timely and efficient manner. They would help reduce parallel treatment and redundancy while improving coordination and communication. For example, once a patient has accessed the system at any point of entry, common mental health intake, assessment, diagnosis and treatment summary data would exist and could be accessible with client or patient permission by other members of the system. When transferred to another professional or service, this information would precede the patient reducing the paper work needed at the next site. Access to the information would increase cooperation between professionals and sites. The concept encourages communities to act as efficiently as departments who effectively use interdisciplinary teams. Issues of professional and institutional liability and client/patient confidentiality would need to be resolved.

Networks would include all the relevant regulated professionals in the community. Some would work for revamped primary health care systems while others would work for the agencies or departments, workplace employee assistance programs or in the private sector.

The virtual community networks would have the added advantages of coordinating community-based planning of mental health and addictions services and collecting demographic and treatment data to assist in evaluating the effectiveness of services. This data would support local planning and resource allocation. Data collection becomes meaningful when there are agreements to collect similar data across different settings and agreements to share information on a community-wide basis.

Another benefit of the community network concept is a single point of access or entry into the community-wide mental health and addictions services. This single entry point will save money, time and client aggravation while improving the quality and timeliness of services.

Recommendation 25*: Virtual community-based mental health and addictions networks be established with commonly agreed upon protocols, processes and procedures to improve treatment coordination, communications and access of patients and clients to all aspects of the system.*

Recommendation 26*: Each community or region develop and adopt an interdepartmental strategic plan to interface the services of each human services system with the other human services systems, the workplace and the private sector providers. These plans will be a central component of the operational frameworks of the virtual community mental health and addictions networks.*

Recommendation 27*: The protected funding envelopes for mental health and addictions services be designed to facilitate and not impede access through virtual community care mental health and addictions networks.*

Provinces have the responsibility to deliver the vast majority of mental health services. The community networks will need to be developed in synergy with the provincial strategic plans for health, mental health and addictions. Each province would profit from the guidance offered by a

mechanism such as a Provincial Mental Health and Addictions Council. The Council would be comprised of representatives of patients, appropriate human service departments, providers and the workplace. The Provincial Councils would be an excellent vehicle to push for balance in the human service systems, to increase cooperation between departments, the workplace and the private practice sector, to effect more coordinated planning and to provide frameworks to support these community mental health networks. Some provinces are developing mechanisms with similar representation to that suggested above.

Recommendation 28: ***Provinces develop a mechanism (such as a Provincial Mental Health and Addictions Council) to provide integrated planning for mental health, mental illness and addictions services in the province.***

Recommendation 29: *Provinces develop a mechanism (such as a Provincial Mental Health and Addictions Council) to provide support for the implementation and ongoing development of virtual community mental health networks.*

CANADIAN MENTAL HEALTH AND ADDICTIONS COUNCIL – LEADING THE WAY

In order to facilitate the development of the community networks, a Canadian Mental Health and Addictions Council could be assembled. It would be a small working group of a maximum of 20 patients, provincial government officials, mental health providers, workplace representatives and Health Canada. This panel of experts would facilitate the development and continuous quality improvement of the frameworks needed to implement and operate the virtual community mental health and addictions networks. A meaningful process of consultation and collaboration would be required. The Council's outputs would be framework guidelines to be used by communities to implement and continue to develop their virtual community mental health and addictions networks. The Council would liaise with other bodies such as the Provincial Mental Health and Addictions Councils, the Councils of Ministers of the appropriate human services, the Canadian Institute for Health Information, the Canadian Institutes of Health Research and the Canadian Health Council, recommended by Mr. Romanow, now being implemented by the provinces and territories and the federal government.

A Canadian Mental Health and Addictions Council could also be responsible for developing a more detailed national framework for mental health, mental illness and addictions in Canada. The Canadian Alliance on Mental Illness and Mental Health's (CAMIMH) document entitled "Building Consensus for a National Action Plan on Mental Illness and Mental Health" (2000) is an excellent foundation upon which to build a more detailed Canadian plan. The CAMIMH brief to The Standing Senate Committee will speak eloquently and in detail to these issues.

The Council will need to be an arms length honest broker. It must have the same qualities of legitimacy, independence, transparency, credibility and permanency recommended by the Canadian Medical Association for the Canadian Health Council. It would operate best by commissioning reports and developing materials using the best available resources in Canada. A process of consultation would precede the development of work projects and follow their completion. Co-ordination, leadership and the development of useable products would be the goals.

Recommendation 30*: The establishment of a Canadian Mental Health and Addictions Council.*

Recommendation 31*: The Canadian Mental Health and Addictions Council develop standard templates for use by virtual community mental health and addictions networks.*

Recommendation 32*: The Canadian Mental Health and Addictions Council develop a national action plan for mental health, mental illness and addictions in Canada.*

Recommendation 33*: The Canadian Mental Health and Addictions Council be linked to relevant political and non political bodies, including the provincial mental health and addictions councils or their equivalents, the relevant councils of ministers and the Canadian Health Council.*

MENTAL HEALTH AND THE CANADIAN HEALTH COUNCIL

The best predictor of future behaviour is past behaviour. In terms of the Canadian Health Council, Council members must have an understanding of and a commitment to health psychology, mental health, mental illness and addictions as a necessary condition for membership. Without this commitment, the Canadian Health Council runs the very real danger of becoming primarily biomedically focused. Unless mental health, mental illness and addictions are an interest of each member of the Council, this area runs the risk of being marginalized once again.

Recommendation 34: The Canadian Health Council members have, as a necessary criteria for membership, a commitment to and an understanding of the contribution of mental health, mental illness and addictions to health and health care in their area of interest and in general.

Recommendation 35: The Canadian Health Council members have a broad appreciation of the important and potential contributions to health and healthcare of the other human services systems (education, social welfare, and criminal justice), the workplace and private practice.

Recommendation 36: The Canadian Health Council have a designated seat for a person representing behavioural health, mental health, mental illness and addictions.

CONCLUSION

Although the challenges are great, there are solutions at hand. Research and clinical experience show the phenomenal resiliency of individuals. When faced with some of the most tragic life events such as war, abuse, or natural disasters, it is amazing how well Canadians do cope. Canadians' ability to manage a major mental illness is remarkable. This resiliency is a true testament to the strength of the human character.

Over the last two decades, we are reaping the benefits of the original research begun decades ago in mental illness and addictions. Medications are greatly improved. Psychological interventions with individuals and families have been shown to be very effective over the short and long terms. Diagnosis and treatment are improving. Mental health professionals are well trained.

We know that psychological interventions are cost-effective, reducing future health utilization costs to a level that more than covers the cost of the initial interventions. The data is compelling and accumulating as we speak. Timely and effective interventions improve life chances, reduce suffering, reduce system utilization and save money.

People's attitudes are changing. Stigmatization is much less acceptable. It is becoming just as repugnant to label a person a psycho, wacko, nut, or retard as it is to call someone a kike, broad, nigger, queer, honky, chink or injun. Mental health oriented consumer groups are growing in numbers and assertiveness. Patients are less embarrassed about their conditions. Governments and planners are more willing to talk about the importance of mental illness and business is recognizing the tremendous impact on productivity, efficiency and the bottom line.

Professionals are co-operating like never before. Psychologists, psychiatrists, educators, family practitioners, nurses, and social workers work closely together. Medical specialists appreciate the impact of psychological factors on their defined patient populations. Educators are increasingly appreciative of the psychological contributions that enhance student outcomes. Research has shown that interventions can be extremely helpful in certain criminal justice populations.

The Canadian Alliance for Mental Illness and Mental Health is an excellent case in point. It brings together patient groups, the Canadian Mental Health Association and providers' groups. Another example is the Interdisciplinary Working Group on Collaborative Care in Mental Health which includes social work, nursing, family practice, psychiatry, psychology and occupational therapy. This group has applied to the Primary Health Care Transition Fund for support to examine mental health in primary health care in Canada. In another project, ten professional organizations have applied to the Primary Health Care Transition Fund to examine the issue of interdisciplinary collaborative care in primary health care.

The Mental Health Support Network of Canada, started by the Canadian Medical Association, the Canadian Psychiatric Association and the Canadian Psychological Association in response to September 11 and the anthrax scare, has most recently provided information to the public and health professionals on the psychological or mental health impact of Severe Acute Respiratory Syndrome (SARS).

The Health Action Lobby has been one of Canada’s leading voices in health and health care over the past decade and includes over two dozen professional, service provider, and consumer organizations.

The opportunity is now. The Standing Senate Committee can make an important contribution to the advancement of the health of all Canadians through this investigation and report. Leadership is needed. Important changes are required. The Canadian Psychological Associations looks forward to the opportunity to work closely with the Standing Senate Committee to help ensure success.

SUMMARY OF RECOMMENDATIONS

Recommendation 1*: Mental health, mental illness and addictions prevention, treatment and chronic care services must become core partners in health, education, social welfare and criminal justice systems as well as in the workplace. This partnership needs to be based on factors such as prevalence, burden and research.*

Recommendation 2*: Mental health, mental illness and addictions prevention, treatment, chronic care services and research must be funded in proportion to their prevalence and burden in Canadian society.*

Recommendation 3*: Each departmentally driven human service (education, social welfare, criminal justice and health) and the workplace adopt the principle that mental health, mental illness and addictions prevention programs and services are an integral part of their core business.*

Recommendation 4*: Each departmentally driven human service (education, social welfare, criminal justice and health) and the workplace develop and adopt a strategic plan for the development and delivery of mental health, mental illness and addictions services as an integral part of their core activity based on a population health framework, treatment efficacy research and outcomes data.*

Recommendation 5*: Each departmentally driven human service (education, social welfare, criminal justice and health) and the workplace develop and adopt the necessary budgeting processes that ensure adequate resources over the short and long terms to realize the goals of the strategic plans.*

Recommendation 6: *Governments must provide lower-income Canadians appropriate access to mental health services through an expansion of the public system and financial support to access the private practice sector.*

Recommendation 7*: The Canadian Institutes of Health Research, other granting agencies and the national charities allocate research funding for mental health, mental illness and addictions research in accordance with prevalence, burden, outcomes and basic research data.*

Recommendation 8*: The Canadian Institutes of Health Research allocate funding for mental health, mental illness and addictions research across all thirteen institutes in accordance with their contribution to the issues addressed in each institute as measured by prevalence, burden, outcomes and basic research data.*

Recommendation 9*: The Canadian Institutes of Health Research develop a systemic vehicle to ensure the incorporation of the behavioural and social sciences in the work of all thirteen institutes (e.g., Office of Behavioural and Social Sciences, Special Consultant to the President for Behavioural and Social Sciences).*

Recommendation 10*: The self-regulated professions have equal and effective access to the highest levels of institutional and governmental decision-making processes in the human service systems in which they provide services.*

Recommendation 11*: An inventory of laws, regulations, rules and practices that impede access to and the efficient delivery of mental health services be conducted.*

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Recommendation 23*: Governments ensure access for all Canadians by implementing provincial mechanisms to fund psychological services in the private sector for those Canadians who cannot afford them.*

Recommendation 24*: Governments increase substantially the funding for graduate training and internships in psychology and other regulated mental health professions as needed.*

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Recommendation 35: The Canadian Health Council members have a broad appreciation of the important and potential contributions to health and healthcare of the other human services systems (education, social welfare, and criminal justice), the workplace and private practice.

<u>Recommendation 36</u>: The Canadian Health Council have a designated seat for a person representing behavioural health, mental health, mental illness and addictions.

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