



January 26, 2017

The Hon. Dr. Jane Philpott, P.C., M.P.  
Minister of Health  
House of Commons  
Ottawa, Ontario, K1A 0A6

Dear Minister Philpott,

The Government of Canada's recent offer of dedicated funding for mental health as part of the Health Accord negotiations with provincial governments is a welcome and much needed development. The awareness of the burden that poor mental health places on many Canadians, and by extension onto our health system as a whole, has expanded in recent years and it is now widely recognized as a concern that warrants a substantial, sustained and co-ordinated response from governments. The College of Family Physicians of Canada (CFPC) and the Canadian Psychological Association applaud the federal government for meeting this need with substantial new money to commit to mental health services.

Given the myriad demands on funding for health care, it is important to allocate federal funds efficiently and effectively. It is widely recognized that Canada has made insufficient investments in mental health care. We have mental health treatments that work and the time is now to make investments that lead to better mental health outcomes for all in Canada.

As organizations representing professionals providing mental health care to Canadians, we jointly call on the Government of Canada to set parameters on the allocation of spending to better deliver mental health services in primary care and community settings.

Integrating mental health services into primary and community care ensures that:

- Access to services is improved for patients, irrespective of age, location and ability to pay;
- Mental health problems and disorders are more likely to be identified and treated earlier; and
- Co-morbid physical and mental health conditions are better managed.

Funding community-based mental health services and services that provide collaborative care for mental health problems and disorders, is the most prudent way to provide broad access to services that can be very effectively delivered in communities as compared to funding high cost psychiatric hospitals and centralized treatment facilities.

Furthermore, the integration of such services at the primary care level and in family practice allows for improved access, increased collaboration with a wide range of providers and better engagement with patients and their support networks; one way to achieve this is through the Patient's Medical Home model of care.

Examples from similar international jurisdictions such as Australia and the United Kingdom tell us that such a structure is an effective model.

In Australia, the 1992 Mental Health Policy re-oriented mental health services delivery to a community model from an institutional one. This policy empowered primary care practitioners to deliver quality mental health

services. Between 1992 and 2007 the number of mental health service providers working in primary care settings increased by 51%. The proportion of mental health services funding allocated to primary and community-based care grew from 29% to 53% over the same period. In that time, family physicians have assisted in developing 1.3 million mental health care plans for Australians and 4.95 million mental health services were provided by psychologists and other mental health specialists in primary care settings.

In the United Kingdom (UK), the Mental Health National Services Framework has strengthened the provision of mental health services in primary care settings. Under the Framework, the majority of mental disorders are assessed in the primary care context and treated there wherever possible with specialist support available as required. Funding under the associated Quality Outcome Framework adopted in 2003 encourages primary care practitioners to provide a range of services to manage mental illness such as through health promotion plans and co-management of mental and physical ailments where appropriate.

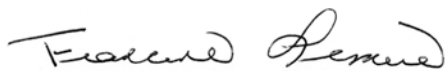
The UK has also developed and funded its Improving Access to Psychological Therapies (IAPT) programme led by psychologists but situated in clinical commissioning groups typically led by family physicians. The success of the IAPT programmes are well known; recovery rates now approach 60%, over 90% of all sessions are evaluated and more than 45,000 people treated have moved off sick pay and benefits. As is well known to the Minister, IAPTs can be flexibly adapted for Canada to meet the needs of a variety of patient groups and/or mental disorders.

Policy commitments that adopt similar structures proven to be effective in similar jurisdictions will serve Canada's mental health needs and ensure a well-connected approach between physical and mental health care. They will require investments which include the integration of non-physician mental health providers, like psychologists, into primary care again with the focus on improving access to mental health care.

We look forward to working with the government to ensure that mental health services in primary and community care settings are funded and structured to deliver clinically effective care. Our organizations are ready to assist the government to align funding to achieve the best possible outcomes for those requiring mental health services across Canada, now and into the future.

Given the urgency of this discussion, we would appreciate an opportunity to jointly meet with you at your earliest convenience to provide further recommendations.

Yours Sincerely,



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cc: Dr. Patrick Baillie, President-elect, Canadian Psychological Association  
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