

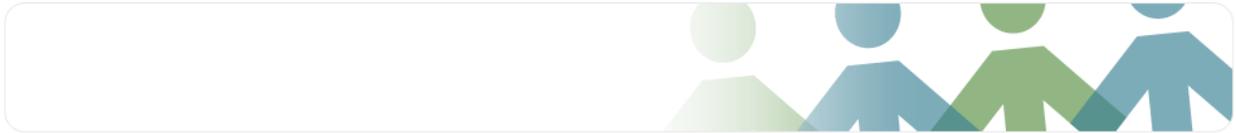


Mental Health Parity in Canada:

Legislation and Complementary Measures

**2019 Position Statement
Canadian Association of Social Workers**

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Founded in 1926, the Canadian Association of Social Workers (CASW) is the national association voice for the social work profession.

CASW has adopted a pro-active approach to issues pertinent to social policy/social work. It produces and distributes timely information for its members, and special projects are initiated and sponsored.

With its concern for social justice and its continued role in social advocacy, CASW is recognized and called upon both nationally and internationally for its social policy expertise.

The mission of CASW is to promote the profession of social work in Canada and advance social justice. CASW is active in the International Federation of Social Workers (IFSW).



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Summary

The impact of opioid use in Canada has reached catastrophic proportions with more than 11,500 apparent opioid-related deaths occurring between January 2016 and December 2018. In 2018 alone, there were 4,460 deaths, meaning that there was one opioid related death every 2 hours in Canada (Government of Canada, 2019). Deaths from overdose have now surmounted those caused by car accidents (Belzak & Halverson, 2018). Although the current situation seems to have progressed rapidly, the lack of support and feelings of isolation among individuals struggling with various mental and physical health conditions resulting in problematic substance use and addiction has been long standing – the reality that the desire to mask pain whether it be emotional, mental, or physical with substance use only appears to have reached mainstream awareness when it became clear that it was reaching all levels of the social spectrum. As explained by Belzak & Halverson (2018), “This is not a problem restricted to persons who use illegal or street drugs; rather, this is a national public health crisis that affects people in communities across Canada, across all ages and across all socioeconomic groups” (p. 224).

Though this paper begins by framing the need for a *Mental Health Parity Act* in the timely – and deeply troubling – issue of responding to the ongoing opioid crisis, the Canadian Association of Social Workers (CASW), recommends this approach as a concrete way forward to more holistic well-being for all those who live in Canada: an approach that will address many of the most pressing issues facing our nation. For instance, in addition to the more recent opioid crisis, our country has been in the midst of a suicide crisis for many years: in 2017, Statistics Canada noted that suicide was the 9th leading cause of death.

To fully introduce the concept of *parity* as it pertains to these recommendations, mental health parity or parity of esteem means “valuing mental health as much as physical health in order to close inequalities in mortality, morbidity or delivery of care” (Mitchell, Hardy & Shiers, 2017). Although Canada has dedicated funding to address disparities in mental health care, we are behind in terms of recognizing the importance of parity through legislation.

The recommendation of a *Mental Health Parity Act*, proposed in conjunction with the complementary measures also proposed here, is aligned with the principles of a preventative and responsive public health approach to policy solutions. Indeed, as a profession, social work has been heavily invested in supporting individuals from all demographics with particular focus on addressing inequity through the recognition of the social determinants of health. Social workers understand that health issues are exacerbated by social inequities that impact certain segments of the population more than others.



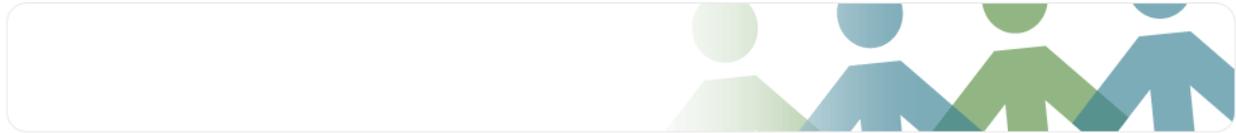
The current approach to the opioid crisis and mental health more generally is lacking when it comes to recognizing health and wellbeing as a human right – acknowledging the importance of mental health care and services for problematic substance use, referred to as addiction services in many regions, is essential for working towards a reduction in health disparities. Specifically, CASW proposes a re-visioning of mental health which recognizes the inseparable relationship with substance use and takes into consideration the structural dimensions limiting access and care.

The purpose of this report is to explore international approaches to mental health parity to inform how this might be implemented in Canada. Finally, our goal is to highlight the need for mental health care and services to address issues related to substance use through the support of a *Mental Health Parity Act*.

Background

In 2015, over 3 million Canadians 15 years and older reported that they had experienced suicidal thoughts and had seriously considered ending their lives (Statistics Canada, 2015a). First Nations communities are disproportionately affected reaching suicide rates five to seven times higher for First Nations youth than for non-Indigenous youth – among Inuit youth, the suicide rate is 11 times the national average (Government of Canada, 2018). Historical injustices from colonial policies and practices continue to impact the lives of Indigenous peoples. Racial discrimination and the transgenerational impact of trauma stemming from residential schools are clearly linked with mental health concerns (Allan & Smylie, 2015). According to a Canada wide survey conducted with 500 Indigenous youth between the ages of 11 and 30 years, nearly half reported that drug and alcohol use was the biggest challenge facing their communities, as expressed by one respondent: “Alcohol, drugs, and ultimately a forgotten sense of who we are. We hurt, so we drink, and we raise children who hurt, thus the cycle repeats itself” (Indigenous Youth Voices, 2018, p. 31). Mental health issues and suicide were also reported as major challenges harming Indigenous communities.

The occurrence of mental health issues with problematic substance use has been discussed heavily in the context of the current opioid epidemic in North America (CMHA, 2018a). Between January 2016 and September 2018 there were 10,337 apparent opioid-related deaths, most of which were accidental (93% in 2019) (Government of Canada, 2019). What this implies is that individuals may have taken opioids that were tainted with toxic substances, such as fentanyl, which increased the chances of overdose and death. According to the First Nations Health Authority (FNHA, 2019), First Nations populations are five times more likely than non-First Nations to experience an overdose event and three times more likely to die.



A recent study detailing the situation in Canada from 1990-2014 in relation to mortality and disability from opioid use disorder discovered that the rate of years lost increased by 142.2% during this time period with a 28.2% increase between 2004 and 2014. In 2014, an average of 355.5 out of 100 000 Canadians were affected by opioid use disorder resulting in death or disability, which is much higher than the global rate of 193.2, but lower than the rate of 767.9 in the United States (Orpana et al., 2018).

Concurrent disorders involving mood/anxiety disorder and substance use disorder have been estimated to affect 282,000 Canadians aged 15 to 64 (1.2%) in a single year. Of interest, nearly 30% of people with a concurrent disorder stated that they also had at least two chronic physical conditions and nearly 40% felt that their needs for mental health care were not fully met (Khan, 2017).

CASW commends the federal government for moving towards a public health approach to substance use and addiction services by supporting harm reduction strategies and through the adoption of the *Good Samaritan Drug Overdose Act*. These approaches have saved lives yet much more is needed to address the complexities involved with substance use.

Harm reduction approaches including take-home naloxone kits, overdose prevention/supervised consumption sites, and opioid agonist therapy have decreased the number of potential deaths from opioid overdose with an estimated 3,030 lives saved in BC between April 2016 and December 2017 (Irvine et al., 2019).

Furthermore, the latest findings from the BC Coroners Service (2019) indicate that there were no deaths from overdose at supervised consumption or drug overdose prevention sites from January 1, 2009 to March 31, 2019. However, these approaches have been unable to reliably curb the overall impact of opioids with many individuals using illegal substances alone placing them at increased risk of death from overdose (CMHA, 2018a).

CASW (2018) has urged the government to extend their public health approach to the treatment of problematic substance use through the decriminalization of personal use of psychoactive substances. Such an approach would likely result in fewer deaths and may encourage individuals to use supervised consumption sites and seek support when needed which may prevent the progression to opioid use disorder. More importantly, it would reduce stigma and enhance health equity while sending a message of support.

In response to these dire numbers, in December 2012 *An Act respecting a Federal Framework for Suicide Prevention* came into law which led to the creation of the *Federal Framework for Suicide Prevention* (Government of Canada, 2016). This framework is intended to contribute to the implementation of other mental health initiatives including *the Mental Health Strategy for Canada: Changing Directions, Changing Lives* (Mental Health Commission of Canada, 2012) and *the First Nations Mental Wellness Continuum Framework* (Health Canada, 2015). The



combination of these national frameworks highlights that suicide and problematic substance use are inseparable from mental health.

Provinces and territories have also taken approaches to incorporate problematic substance use as a key aspect impacting mental health, such as the inclusion of a Ministry for Mental Health and Addiction in BC who collaborates with FNHA and the introduction of a central agency to oversee mental health and addictions care in Ontario (Ministry of Health and Long-Term Care, 2019). There are various provincial/territorial frameworks that integrate systems of care (refer to Gouvernement du Québec, 2010), yet these initiatives fall short unless supported and funded appropriately as reflected by the 1.6 million Canadians that feel that their mental health needs have not been met (Statistics Canada, 2015b).

A recent poll with just over 1000 Canadians showed that more than half (55%) were dissatisfied with wait times for publicly-funded mental health care, and that four in ten (42%) reported to have been in a position where their medical expenses were greater than their disposable income (McLeod Macey, 2019). The cost of medications also presents a risk for individuals needing mental health care as psychiatric medications can be very expensive (CAMIMH, 2016). Without stable, permanent employment, and access to private health insurance, individuals struggle to afford valuable mental health services and medications (CAMIMH, 2016; CMHA, 2018b) and may forfeit essential care for other living costs, such as paying rent or buying food. With the rise in precarious employment, such as part-time and temporary positions, it is likely this number will continue to grow (Lightman et al., 2008). According to the World Health Organization (WHO, 2013),

Determinants of mental health and mental disorders include not only individual attributes such as the ability to manage one's thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports. Exposure to adversity at a young age is an established preventable risk factor for mental disorders (p. 7).

CASW views mental health care as a foundational human right as it is the premise under which every individual is treated with dignity and respect. In this regard, CASW supports structural changes that address social inequities to improve the wellbeing of all individuals: these are foundational components of the CASW Code of Ethics, one of our profession's key guiding documents.

In Canada, mental health care is delivered by a range of providers, such as social workers and other mental health professionals. However, unlike physical health, mental health care is not always covered by publicly funded health insurance plans.



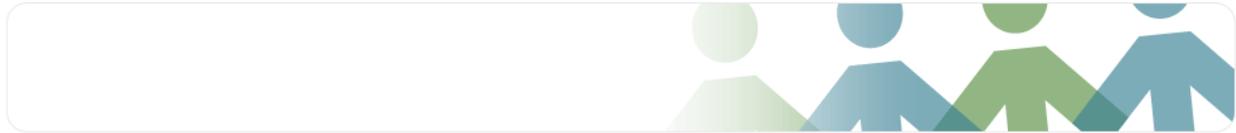
A 2012 report highlighted that Canadians 15-24 years of age were more likely to resort to informal supports for mental health and emotional problems, including problems with substance use in comparison to support from health care professionals, including social workers, 27% and 12% respectively. More troubling is the finding that 71% had not sought any support for mental health problems in the past year (Findlay & Sunderland, 2014). Public health insurance does not cover many mental health services, while the private health insurance plans also put caps on coverage making it too low for having meaningful amounts of service.

More recently, it has been reported that the majority of Canadians consult their family physician when seeking support for mental health issues and only 22% seek support from social workers (Statistics Canada, 2015). This is likely explained by the current approach to mental health care in Canada wherein only services obtained with a family physician or in a hospital setting tend to be covered under public health. Of course, there are many regional differences, with many areas throughout Canada offering strong community mental health programs, but this paper is deliberately taking a high-level, big data approach in order to address Canada-wide trends and concerns. The federal government's commitment to investing \$5 billion over 10 years for provinces and territories to improve access to mental health services is encouraging yet this does not result in structural changes (Government of Canada, 2017). As a profession whose primary mandate is to support individuals and improve lives by addressing the social determinants of health, it is concerning that our skills are not reaching most Canadians seeking support.

International Models of Mental Health Parity

To provide a reintroduction to this paper's essential tenet, mental health parity or parity of esteem means "valuing mental health as much as physical health in order to close inequalities in mortality, morbidity or delivery of care" (Mitchell, Hardy & Shiers, 2017). Although Canada has dedicated funding to address disparities in mental health care, we are behind in terms of recognizing the importance of parity through legislation. At this juncture, it is important to note that CASW does not recommend or endorse the models discussed here. These countries provide on the ground examples of how the concept of Parity is being implemented, and these are used in this paper as vectors for discussion.

In the United States, parity became law in 1996 under the Mental Health Parity Act (MHPA) and later under the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Similarly, the United Kingdom, passed the Equality Act in 2010 which placed a legal responsibility on health services to guarantee that people with severe mental illness could access healthcare to the same degree as the general population. This in turn led to a foundational report in 2011 *No Health Without Mental Health* which made reference to parity of esteem for the first time and was later incorporated into the 2012 Health and Social Care Act (Mitchell et al., 2017; Mental



Health Foundation, 2019). All nations within the UK have their own separate public health system along with an emerging private health sector. The National Health System (NHS) is responsible for the public health care sector and is funded primarily through national taxation. In the following section, we will focus on England's public health system.

England

Following the introduction of the Health and Social Care Act in 2012, Clinical Commissioning Groups (CCGs) were created as the clinical bodies responsible for the planning and commissioning of health care services for their local region. There are approximately 191 CCGs in England (NHS Clinical Commissioners, 2019). Changes made to mental health services under the Health and Social Care Act (2012) have been associated with fewer incidences of suicide with the most meaningful aspects related to increased availability of specialist community services, improved understanding of patients with co-morbidities (ie, drug or alcohol misuse as well as major mental illness), and effective communication and information sharing with families after suicide. The introduction of policies to help manage the transition to adult mental health services for young people and the implementation of evidence-based guidelines on depression were essential structural factors associated with the decline. However, despite a greater emphasis on the importance of addressing mental health, there continue to be gaps in service delivery (Mitchell et al., 2017).

The latest recommendations from the independent Mental Health Task Force, a group formed in 2015 of leading health care experts and individuals with lived-experience, proposed a set of recommendations to the National Health System (NHS) in England titled *Five Year Forward View for Mental Health for the NHS in England* (Mental Health Taskforce, 2016). The 82-page report details recommendations for improving mental health care across departments responsible for addressing housing, education, employment, and health concerns through the integration of services and active collaboration.

Improvements to mental health services are centered around prevention, access, integration, quality, and a positive experience of care which were priorities brought forward by those with lived-experience. NHS has agreed to adopt the recommendations and has put in place an implementation strategy detailing increased access to services and a commitment to bringing various health care providers together to deliver essential mental health services. A range of targets have been set for 2020/21, including:

1. reaching at least 70,000 more children and young people annually which will increase access from 28% to 35%;
2. providing an additional 1,700 more therapists and supervisors;
3. reaching an additional 30,000 women to provide perinatal mental health services;
4. increasing access to psychotherapies, reaching an additional 25% of the adult population with common mental health conditions;



5. prioritizing early access to care, wherein 75% of individuals will receive mental health support within 6 weeks, and 95% will receive support within 18 weeks;
6. supporting community mental health services resulting in 60% of individuals receiving immediate evidence-based support following a psychotic episode;
7. promoting continuity of care for individuals involved with the correctional system through liaison and diversion practitioners to ensure mental health supports following release;
8. reducing the number of suicides by 10%.

More importantly, all of these objectives are supported with increases in mental health care providers along with funding. A description of the required changes to the current infrastructure to deliver these services is aligned with mental health priorities and transparency is supported through the creation of a new senior responsible officer and three groups central to overseeing the delivery of recommendations. Core to this report is the need for integration of physical and mental health care through collaboration among sectors, including local government, housing, education, employment, and the voluntary sector. However, there is little discussion relating to accountability from local authorities responsible for delivering the services.

Despite the development of an encouraging framework for the delivery of mental health services, there seems to be a disconnect between what is being discussed from the top with what is taking place at the front-line with a decline in mental health providers largely due to insufficient wages and inadequate funding to meet the expanding needs of the population (Campbell, 2018).

According to a 2016 Organisation for Economic Cooperation and Development (OECD) review of health care quality in the UK, “To make further quality gains, each system needs to find an appropriate balance between top-down regulatory approaches to quality management, and a bottom-up, locally-led model of quality improvement” (p. 21). It is not possible to delegate mental health services from the top with little understanding of the challenges and barriers facing those delivering those services.

In January 2019, NHS released a 10-year long-term plan following the Prime Minister’s announcement of a 3.4 per cent average annual increase in NHS England’s budget between 2019/20 and 2023/24 (a £20.5 billion increase over the period) to address the emerging healthcare crisis (Siddique, 2019). Mental health continues to be a priority, and although there has been discussion centered on prevention approaches to health, these appear to be largely related to individual behaviour rather than focusing on systemic inequalities (Boseley, 2019).

The public health system in the UK doesn’t cover the full costs of prescription medications, dental care, optical care, and wigs and fabric supports (NHS, 2016). However, there are various exemptions where individuals are not required to pay or pay a reduced rate, such as in the case



of families living in low-income circumstances. Furthermore, there are several exemptions for free prescriptions, which includes children under the age of 16, adults above 60 years of age, and pregnant and new mothers. Private health insurance is also available and is often provided through employment benefits. It is also possible to pay for care through the private health system however, it is much smaller than the public system.

United States

The health care system in the United States is composed of both private health insurance and public coverage through federal and state government-funded programs, such as Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). Medicare is a federal social insurance program for adults 65 and older and some individuals with disabilities; whereas Medicaid and the CHIP are geared to very low-income families and jointly funded by federal and state governments (The Commonwealth Fund, 2019).

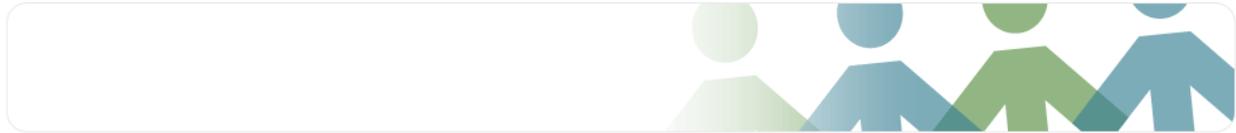
Most Americans obtain private health insurance through their employers. Additionally, there are public hospitals owned by local governments or special authorities such as cities, counties, or special districts in some urban centres that provide health care to those who are not insured, obtain Medicaid, or are otherwise unable to afford services and are most often from ethnic/racial minority groups.

For example, at Parkland Memorial Hospital in Dallas, Texas, patients speak over 54 different languages or dialects. Urban public hospitals evolved from social housing facilities, “poorhouses”, to academic medical centre, to now representing a form of community development through engagement with patient populations to address the social determinants of health (Anderson et al., 2004). However, public hospitals are susceptible to closure from funding cuts and require support from the populations they serve to resist emphasis towards private care (Ko et al., 2014).

In the United States, parity became law in 1996 under the Mental Health Parity Act (MHPA) and later under the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. The MHPAEA requires that insurers provide the same coverage for mental health care and substance abuse, referred to as “behavioural health” (Barry and Huskamp, 2011, p. 973), as physical health care.

However, the MHPAEA doesn’t guarantee that mental health care and substance use disorder treatment will be implemented into insurers policies. Coverage is required to be on par with medical and surgical benefits when it is already incorporated into a plan or policy (Beronio et al., 2014).).

This gap in care was addressed with the 2010 Patient Protection and Affordable Care Act (ACA), commonly referred to as *Obamacare*, which was enacted to ensure that every American has access to affordable health insurance. The ACA mandated that every American citizen purchase



health insurance and held three primary goals (U.S. Centers for Medicare & Medicaid Services, 2019):

1. Make affordable health insurance available to more people. The law provides consumers with subsidies (“premium tax credits”) that lower costs for households with incomes between 100% and 400% of the federal poverty level.
2. Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level.
3. Support innovative medical care delivery methods designed to lower the costs of health care generally.

It has been argued that the full impact of the MHPAEA only came into effect with the implementation of the ACA, as it provided guidelines for greater access to mental health and substance use services through the creation of a “national coverage mandate” (Frank, 2018, p. 616). The limitations of the MHPAEA were addressed by the ACA by providing coverage to those most marginalized by insisting that insurers provide coverage to those with a pre-existing health condition (including pregnancy) without increasing coverage fees and by encouraging smaller businesses to provide employee health insurance through the creation of tax credits (Galan, 2018). The MHPAEA did not cover individual and small group plans (2 to 50 individuals), which only came into effect in 2014 with the requirements set out in the ACA (Kennedy-Hendricks et al., 2018; Custer, 2015).

Kennedy-Hendricks et al. (2018) compared the costs and access to mental health care services for families with children with mental conditions before (2008-2009) and after they were subject to parity under the MHPAEA (2011-2012) with families who were not (ie. enrolled in small group plans). The analysis involved 69 233 children with mental health conditions and included a separate analysis for 4 292 children with excessive health care costs.

Prior to parity, health care costs averaged \$824 (\$327 out of pocket) per year. Families with excessive costs spent on average \$5 453 (\$1 603 out of pocket) annually. Through the analysis of inpatient, outpatient, and pharmaceutical claims, they discovered that families with children with mental conditions saved on average \$140 annually when subject to parity.

Furthermore, families with excessive mental health care costs saved on average \$234 per year following MHPAEA implementation. The authors conclude that although parity is associated with financial protection for families with children with mental health conditions, the savings may not be sufficient in lightening the financial burden for families facing excessive mental health care needs.

Li and Ma (2019) explored access and use of mental health services among middle income children and youth living in states with parity laws in comparison with children and youth living in states without parity laws in 2007. They discovered that in states with parity laws there was



an increase in the use of mental health services and diagnoses of anxiety disorders. According to the authors, these findings suggest that mental health parity laws increased access which likely contributed to the identification of mental health conditions that may have otherwise gone undetected. They go on to discuss the implications with repealing the ACA which supports the requirements set out in the MHPAEA that mental health coverage be provided by insurers.

Specifically, children and youth struggling with mental health problems, especially anxiety, may not receive the support and care they need resulting in life-long challenges. Furthermore, this may result in undiagnosed mental health conditions which would underestimate the prevalence and need for government support.

The ACA emphasized the importance of integrated and comprehensive systems of care and recognized that the most effective way to address disparities in mental health was to reach out to those most in need and to acknowledge how intimately it is connected to physical health (Barry, 2011). The ACA also allowed children to stay on their parents' insurance plans up until the age of 26. The combination of the ACA with the MHPAEA appeared to fill many of the gaps in mental health care and addiction services as it provided access to families who either couldn't afford health insurance or had plans that didn't address mental health.

Although emphasis has been placed on the ACA's capacity for improving health care for lower-income families, it also supported middle and higher income families with mental health conditions and substance use disorders by insisting that insurers provide mental health coverage and by no longer allowing pre-existing conditions as a reason for refusal (Beronio et al. 2014). The benefits were in one respect, universal. However, a change in government led to less investment directed towards funding affordable health insurance, and the incentive to purchase health insurance as dictated under ACA weakened when it was found unconstitutional (REF). It is discouraging to note that the ACA is currently being brought to the federal appeals court and threatens to be overturned (de Vogue & Luhby, 2019).

Canada's Healthcare System and Mental Health Parity

Canada's universal healthcare program falls under the *Canada Health Act* (CHA, 1985) which assures shared coverage from the federal and provincial/territorial governments for hospital and physician health services deemed medically necessary. Under the CHA, Canadians are intended to have reasonable access to insured health services on a prepaid basis. Canada's publicly funded health care system, *Medicare*, functions as a private fee-for-service practice for the majority of physicians (Hutchison et al., 2011).

Provincial and territorial governments are responsible for the delivery of health care and social services. For the delivery of health care services, they are expected to follow the principles set out in the CHA in order to receive federal funding through the Canada Health Transfer (CHT),



which include: (a) public administration; (b) comprehensiveness; (c) universality; (d) portability; and (e) accessibility (CHA, 1985).

Currently, there are no set principles for the delivery of social services (refer to CASW, 2018 for an overview). Furthermore, what is considered medically necessary is open to interpretation with provincial/territorial governments deciding which extended services receive coverage. There are special populations that fall under the jurisdiction of the federal government when it comes to health care, these include: First Nations people living on reserves, Inuit, serving members of the Canadian Forces, eligible veterans, inmates in federal penitentiaries, and some groups of refugee claimants (Government of Canada, 2016b).

Prescriptions are not covered unless administered in a hospital setting, through disability support programs or under various provincial programs (CMHA, 2018b). Accordingly, there are more than 100 public and 100,000 private insurance plans for prescription coverage (The Advisory Council on the Implementation of National Pharmacare, 2019). According to 2019 survey, 71% of Canadians pay at least partly out-of-pocket for prescription drugs and spend an average of \$500 per year (McLeod Macey, 2019). The implementation of a National Pharmacare Plan is currently being explored with the support of almost all Canadians, however, how the system will be delivered is being heavily debated (Department of Finance, 2019).

The health care system experienced severe federal funding cuts during the 1980s-1990s with the collapse of the Canada Assistance Plan (CAP), which was replaced with the Canada Health and Social Transfer (CHST) (CASW, 2018). Limited health care spending in the 1990s resulted in a lack of innovation, quality improvement, and access to primary health care (Hutchison et al., 2011).

Since the 2000s there has been more steady investment into health care, however, Canada appears to be trailing behind when it comes to acknowledging mental health as a right enshrined in legislation with investments dedicated to supporting secondary care. There is concern that primary care through family physicians does not offer adequate resources to deal with the growing demands of mental health care. Specifically, approaches geared at addressing the complex nature of mental health require a holistic framework with various health care providers, including those with expertise in the social determinants of health.

Despite advances with the creation of the *Mental Health Commission of Canada* (MHCC) in 2007 which delivered a strategy to address the mental health needs of Canadians, mental health services continue to be delivered in a fragmented system without adequate funding (CMHA, 2018). Canada's mental health strategy, *Changing Directions, Changing Lives* (2012), outlines six strategic directions to address the mental health care needs of Canadians:



1. Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible.
2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.
3. Provide access to the right combination of services, treatments and supports, when and where people need them.
4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
5. Work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures.
6. Mobilize leadership, improve knowledge, and foster collaboration at all levels.

Changing Direction, Changing Lives (2012) is comprehensive and clearly articulates the mental health concerns that are salient to the Canadian context, such as addressing social and economic disparities to reduce the risk of suicide which disproportionality affects specific populations including, older men, First Nations and Inuit youth, and lesbian, gay, bisexual, and transgendered youth (p. 17).

Furthermore, emphasis is placed on preventative approaches while recognizing the ongoing challenges facing individuals with mental health problems and illnesses with a call for various sectors and departments to engage including: education, justice, corrections, social services and finance.

The detailed overview of the complex nature of mental health and wellbeing along with the required recommendations for Canada's health care system is supported by a statement for improved federal funding (p. 13):

- increase the proportion of health spending that is devoted to mental health from seven to nine per cent over 10 years;
- increase the proportion of social spending that is devoted to mental health by two percentage points from current levels;

In 2017, the MHCC presented a follow-up report detailing the economic advantages of investing in mental health, *Strengthening the Case for Investing in Canada's Mental Health System: Economic Considerations*. In the report, it is noted that England dedicates approximately 13% of its budget to mental health care, which is still considered low as mental illness represents 23% of the total disease burden (cited in Canadian Mental Health Association, 2018).

A 2018 MHCC report provides recommendations regarding the expansion of psychotherapy services in Canada from highlighting programs in the UK and Australia. The UK implemented *Improving Access to Psychological Therapies* (IAPT) in 2008, a grants-based program targeting the treatment of depression and anxiety; whereas Australia initiated the *Better Access to*



Psychiatrists, Psychologists and General Practitioners (Better Access) in 2006, an insurance-based approach where general practitioners refer patients to health care providers delivering subsidized mental health services (MHCC, 2018).

An external review of federally-funded pan-Canadian health organizations (PCHOs) initiated by the federal Health Minister Ginette Petitpas Taylor in 2018 determined that “what has helped advance Canadian health systems to where they are today is not what will take them where they must go in the future” (Forest and Martin, 2018, p. X).

Pan-Canadian health organizations are self-governed non-profit organizations that function at arm’s length from the Canadian government despite receiving federal funding. They were developed between 1988 and 2007 to address health related policy concerns, and presently include the Canadian Centre on Substance Use and Abuse (CCSA); and the Mental Health Commission of Canada (MHCC) among others.

In their review, Forest and Martin (2018) recommended that CCSA and MHCC evolve into something new to address the disparities central to issues related to mental health and substance use. Furthermore, in terms of mental health care, it is proposed that equity be pursued by integrating mental health care into Canada’s public health systems, and that evidence-based mental health services and treatment be delivered beyond the hospital setting and physician care. Furthermore, it is clearly stated that mental health must be combined with physical health in primary care.

The motivation to improve access to mental health services and enhance the wellbeing of Canadians is reflected in the various strategies developed, and the government’s direction towards a more public health approach to substance use.

Despite this progress, nearly 50% of Canadians consider access to mental health services poor with 62% feeling nervous, afraid and distressed when contemplating the future of health care in Canada (Colledge, 2019). Without principles directing provincial/territorial governments towards mental health spending and limited oversight when it comes to adhering to the mental health strategy, it is unlikely that there will be any consequential change: the following recommendation and complementary measures represent CASW’s plan of action in the face of this inertia.



RECOMMENDATION:

1. *Recognize mental health as a human right through the legislation of a Mental Health Parity Act:*

The most influential action on the part of the federal government would be to legislate a *Mental Health Parity Act* to initiate mental health parity – without guidelines in place, the discussion falls short and action appears to be restricted to raising awareness rather than creating change to move towards health equity.

The government has a duty to continue to work with all partners to address the problem although provinces and territories have constitutional responsibility for health care, changes are needed at the federal level.

A change to legislation that results in a more holistic, collaborative health care system and mental health parity would recognize the importance of secondary care, which registered social workers most often fall within. Many frontline registered social workers and counsellors fall within this domain and offer the needed supports and resources to those dealing with mental health issues.

To support the success of such an Act, CASW recommends the following complimentary measures:

1.1 Ensure equitable access to mental health care and services to address problematic substance use, and ensure accountability through the creation of a Minister for Mental Health and Wellbeing:

Presently, there are no federal departments or agencies that specifically address mental health and substance use issues. Given the seamless relationship between the two, there needs to be a shift from addressing mental health and problematic substance use in isolation to a joint approach towards overall mental wellness. For example, pan-Canadian health organizations should reflect the contemporary understandings and knowledge regarding mental health and substance use through merging these central aspects of health care.

CASW proposes that the creation of a federal Minister of Mental Health and Wellbeing would highlight the importance of considering the various factors contributing to mental health and wellbeing, including the role of substance use. Furthermore, the creation of such an office would affirm, complement, and support the many excellent initiatives ongoing in different provinces and territories to address mental illness, support mental health and recovery, including dedicated strategies and plans to address suicide and the opioid crisis. The federal government has a responsibility to provide a coordinated vision and leadership – not lag behind – the provinces' and territories' work in this area.



Additionally-- and following the impressive examples found in many areas of Canada – the development of a *Minister for Mental Health and Wellbeing* would cement mental health as a fiduciary, social, and philosophical priority in our country as a whole. Mental health must be made a priority; a new *Minister* will guarantee it cannot be overlooked.

Beyond providing funding through the CHT to provincial/territorial governments, the federal government is also responsible for the management and delivery of health and social services to specific populations (ie. First Nations peoples living on reserves, Inuit, serving members of the Canadian Forces, eligible veterans, inmates in federal penitentiaries, and some groups of refugee claimants) making it the third largest health care distributor. The federal government can lead the way in addressing the mental health needs of Canadians, as explained by Forest and Martin (2018):

If equity is a focal goal of health care, the federal government has an important role to play in reaching it. This is because the federal government is ultimately responsible for defining what citizenship entails for all Canadians: their rights, their freedoms, their responsibilities. (p. 104). The current debate in relation to the implementation of universal pharmacare frames the question facing mental health parity: How would it best be managed and delivered in the Canadian context? Based on the overview of selected international models, there are two proposed directions for mental health care service delivery:

1 – Public Health Approach: Embed mental health services into the universal public health system through the initiation of integrated and collaborative systems of care. Provide grants to publicly funded health care and social service programs to enable them to hire additional registered providers of counselling, psychotherapy and psychological services.

Include referrals from physicians for outpatient services that cover mental health services, wherein privately employed registered providers of counselling, psychotherapy and psychological services bill government for their services. This approach would resemble what has been initiated in England.

2 – Blend of Private and Public Health Approach: Continue to provide mental health services in hospital settings and through physician referrals while providing access to private insurance coverage for those requiring additional care who otherwise could not afford it.

Mandate that insurers value mental health and substance use services to the same degree as physical health. This approach would extend Canada's current mental health services delivery and would resemble what was initiated in the United States.

The MHCC (2018) provides a detailed review regarding these different approaches in relation to improving access to psychological services, which would apply to mental health parity –



However, CASW encourages the government to move beyond the development of project-based approaches to mental health services and to integrate these needs into a comprehensive and integrated system of care.

According to a May 2019 survey conducted with 1,500 Canadian residents aged 18 and over, 56% strongly agreed that mental health care should be covered by provincial or territorial health insurance plans to the same extent as is a visit to a family physician or community medical clinic (Abacus Data, 2019).

Considerations

Regardless of the approach pursued, it is important to highlight the barriers to effective access and treatment seen in England and the United States. Although health care spending is typically associated with increases in life expectancy, this is not always the case. For example, the United States spends more per person than any other OECD country (\$9.4K USD per capita), yet increases to life expectancy have been slower (OECD, 2017). Funding alone is not enough to guarantee improvements. Successful implementation will require the following considerations:

- **Funding at all levels of care:** The issue of staff shortages facing England's health care system highlight the importance of dedicating funding at all levels of care – pouring money into infrastructure without adequately paying those expected to deliver the services will result in empty hospital beds.
- **Time and support from all political parties:** Structural changes take time to reach their optimal efficiency. Too often health is seen as a partisan issue rather than a human right, and goals for health equity are cut short for political gain. Transformative change takes courage and will require support from all political parties over time.
- **Accountability and oversight:** It is imperative that a system exists to track whether changes lead to improved access to mental health services, especially among the most marginalized populations. Furthermore, governments will need to be held accountable for the distribution of funds to ensure that they are being distributed to the appropriate support services.

1.2 Work towards health equity through the implementation of a universal Basic Income Guarantee (uBIG):

CASW encourages the federal government to work towards health equity by addressing the social determinants of health. Poverty is known as a leading factor influencing health, with the most significant impacts facing those at the lowest end of the SES spectrum (OECD, 2017).



In 2017, CASW proposed that the federal government create a universal basic income guarantee to provide consistent income support for all Canadians. As stated in our report, *Universal Basic Income Guarantee: The Next 'BIG' Thing in Canadian Social Policy (2017)*:

It has been discovered that universal, unconditional programs are more effective in regard to combatting adverse health conditions than conditional programs with extensive eligibility criteria (p. 7).

1.3 Expand public health approach to decriminalize the personal use of psychoactive substances:

As described in Canadian Public Health Association's (CPHA) 2014 Discussion Paper, the use of illegal psychoactive substances (IPS) in Canada persists despite ongoing efforts to limit their consumption.

Criminalization of those who use these substances remains the principal tool to control their use which leads to stigmatization and is inherently unsupportive. The effect of this criminalization does not often reflect the severity of the crime.

For example, the current structure of fines and incarceration causes most harm to those at the lower end of the social gradient, which results in greater health inequity. In response to the current opioid epidemic, CASW urges the federal government to send a message of support which highlights that problematic substance use as a public health issue which is often connected with various forms of trauma.

1.4 Adopt a *Social Care Act* to outline the principles in relation to social services:

Health care in relation to mental wellness cannot be separated from other social influences. CASW has proposed the federal government implement a Social Care Act to set principles for the delivery of social services. As explained in *A new social care act for Canada: 2.0*:

Social care refers to more traditional services such as child care, child welfare and services for people with physical, developmental and psychiatric disabilities. It also encompasses services for homeless people, for people who are seeking shelter from abusive relationships, for the LGBTQ2+ population, for youth, for people experiencing issues related to substance use, for families, for immigrants and migrants, for seniors, and for anyone in the community who is in need of special assistance. Services for people who are poor or who are likely to become poor are an important part of social care.

Disparities in health reach every dimension of care, CASW urges the government to take a more holistic approach to health and acknowledge the importance of social support.



Conclusion

Describing the complexity of Canada's health care system is beyond the scope of this paper, however, our goal was to target one area that lacks support: mental health care and problematic substance use services. . In the same way, there are many other – some practical, and some philosophical – changes that CASW would like to see materialize in Canada's health care system: we outline these recommendations elsewhere, and chose to focus this paper specifically on the concept of a *Mental Health Parity Act* for clarity and impact.

Canada requires a re-visioning of mental health which recognizes the inseparable relationship with substance use and takes into consideration the structural dimensions limiting access and care, something CASW believes can be addressed through this paper's recommendation of a *Mental Health Parity Act*, ideally enhanced and facilitated by the *complimentary measures* provided.

This requires the acknowledgment of mental health concurrently with physical health, as a foundational human right through the legislation of a *Mental Health Parity Act* and through the creation of a *Minister for Mental Health and Wellbeing* as we work towards health equity.



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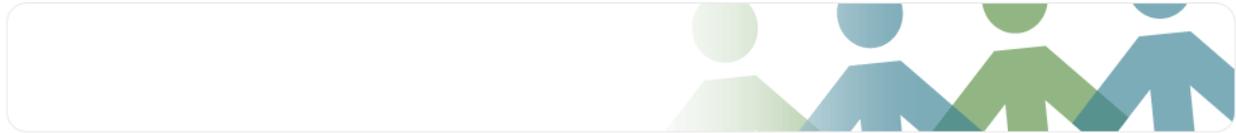
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