camh Centre for Addiction and Mental Health

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Thank you very much and thank you all for being here. I'm very grateful to have this opportunity to speak with you today. Influential people have only recently been willing to openly join in on conversations about the health, economic and social justice issue of our time – mental illness.

Mental illnesses – including alcoholism and substance abuse – devastate individuals and families and weaken societies.

Mental illness can be deadly. Nearly four thousand Canadians die by suicide each year – that includes one thousand of our children. For young people, ages 13-34, suicide has now superseded motor vehicle accidents as the number one cause of death. And what's more, the life expectancy of people with complex mental illness is 20 years lower than that of the general population.

Workplace disability statistics and their economic costs have driven great leadership initiatives – like tomorrow's Bell Let's Talk. The suicide statistics and rates of mental illness in teenagers are driving both philanthropic interest and grass roots responses. But – given the magnitude of the health problem – there's been a surprisingly modest government investment.

The promises are there, the intent may be there, but we're nowhere near to achieving the momentum of the war on cancer.

People with mental illness continue a daily fight to have their human rights, their civil rights and their health care rights respected and protected.

Despite the public policy strategies, despite the business & industry leadership and despite the emerging philanthropic interest in mental health, people with these conditions continue to struggle to find their way to care and social supports.

I know that there's no need to describe the current economic climate to this audience. There are plenty of drags our economy right now, but mental illness happens to be one that we can address head on with a modest, rational and effective investment.

Slowing down or turning back on the gains that have been made over the past decade is a poor human choice, a poor social choice and a poor economic choice.

We do need change; but it has to be the change that – in addition to transforming lives – will really transform the way we see, understand and respond to mental illness.

Today, I'll outline three obstacles that we need to overcome to achieve this change. I'll describe the bright spots as well as the mysterious show stoppers that hold us back.

And finally, I'll enlist your support and advocacy for three critical directions – directions that you should support not only for humanitarian reasons, but also because it's just good business.

The obstacles are 1) a science gap, 2) a justice gap and 3) an advocacy gap.

First, the science gap: Illnesses that affect the brain are still mysterious and frightening, a recipe for prejudice and discrimination. Until recently, funding for brain research was poorly aligned with society's burden of neurologic and psychiatric illness.

Next, the justice gap: The mental health sector has been marginalized – held separate from the rest of the healthcare system. The impact of decades of neglect and avoidance has been stagnant investment, innovation and quality of care.

Third, we have an advocacy gap. People with mental illness, as well as those with autism, brain injuries or neurodegenerative conditions like Alzheimer's – can't always provide the compelling advocacy that's needed to create a socio-political movement.

So, back to the future, the Science Gap: Visionary initiatives have started us on the road to closing this gap – creating programs where rock solid investments have delivered measurable outcomes. These initiatives provide object lessons in partnerships – from the national to the local level – that are creating real momentum.

Some examples:

15 years ago, a vision to transform brain research in Canada led to the creation of an organization now called Brain Canada. More recently, the Federal Government committed 100 million dollars to match funds raised by Brain Canada, for a 200 million dollar total investment in brain research. Brain Canada supporters now include private donors, corporations, foundations, research institutes, provincial agencies and NGOs.

Creative thinking and a willingness to challenge anachronistic structures and alliances has led to partnerships with the ALS Society, the Canadian Cancer Society, the Ontario Brain Institute and the CQDM in Quebec. There are lots of wins in this model.

Locally, CAMH recently launched a joint venture with Assurex, a US company that's commercialized genetic testing to advance precision medicine in mental health – matching the right medication for an individual patient based on their genetic makeup.

Assurex is well established south of the border, where this test is reimbursed through Medicare/Medicaid. They've shown that care guided by the testing results in a 70 percent improvement rate for depression symptoms and reduces healthcare costs by 28 percent. At CAMH, we're now conducting a federally funded trial to collect Canadian clinical and economic data.

And lastly, an example from the front end of care: At CAMH's Temerty Centre for Therapeutic Brain Intervention, investigators have modified and evaluated a treatment – magnetic brain stimulation – for use in depression. For the 50% of people whose symptoms don't respond to medication and the many others who abandon treatment because of side effects, this is a game changer.

It's the first new treatment for depression in decades. It's an example of talented innovators partnering with industry and a visionary donor to translate our new knowledge of brain plasticity into better care.

The cost of caring is less than the cost of chronic ill health and the creation of that care through research and innovation is an economic driver, not an economic drain.

Ontario's hospitals directly employ 16,500 researchers and staff, to support a total of 41,000 jobs across the province. That's about half those employed at our largest automotive assembly plants. By one recent estimate, Ontario research hospitals provided a 3:1 return on the investment made in them. Research, innovation and product development are not luxuries – they're an investment in people, in populations and in the economy.

How can we close the science gap?

We need a sustainable research plan for our country that preserves a focus on basic science research. There's been a move in government funding to emphasize patient-oriented research, a very worthy enterprise, but we can't risk losing stable funding for fundamental discovery.

Cures for childhood leukemia and AIDS emerged from the science that defined the biologic mechanisms of these illnesses. In the same way, fundamental research is central to understanding the origins of the brain disorders that take such a toll today.

Furthermore, we need to shave off the speed bumps that are stunting our innovative potential. Today's structures and regulations complicate the pathway to international partnerships. We need better roadmaps and a culture that embraces innovation more energetically.

We can do better…

But only if we attend to the Justice Gap: As a neurologist, I've spent most of my career in the general healthcare system. At CAMH, I've been given the opportunity to shepherd an organization on an upward trajectory – in a field of increasingly recognized importance. But my background's positioned me to appreciate the work needed to make mental health care efficient, effective and more central to healthcare.

Mental Health emerged from behind walls – literally and figuratively – pretty much in this century. Funding, accountability and quality improvement movements that were standard in the general hospital system that I knew – had bypassed us. We'd been left with an under-resourced system in which the bar had been set too low. What's worse, there'd been no sense of urgency to address the mismatch between system resourcing and the suffering caused by mental illness.

Canada allocates only 7% of its health budget to mental health. Despite a call from the Mental Health Commission of Canada and others to increase health and social spending to a level that reflects the burden of illness, we remain well behind the 10% figure of most industrialized countries.

In September 2004, Canada's first ministers agreed to a 10-year healthcare agreement that included a commitment to reduce wait lists for five clinical procedures. It included a federal investment of 5.5 billion dollars for a wait time initiative that in turn spurred provincial investments to meet accessibility targets. The initiative was driven by a public outcry about long waits for several important interventions.

Mental illness wasn't on that list, and despite the development of both federal and provincial strategies for mental health, this purposeful approach has yet to be adopted for the sector. Our federal and provincial Ministers of Health met last week and renewed their relationship. It'll be a grave disappointment to the sector if this relationship fails to result in practical and substantive action on mental health care.

Treatments for mental illness are backed by scientific evidence, and they work with efficacy rates that match and exceed those of treatments for common medical conditions like high blood pressure, heart failure, cancer or epilepsy. The failure to understand this fact stops many people from seeking help.

More importantly, several proven treatments are not insured services in Ontario and there is no mechanism for people – especially those with limited means – to receive them.

For example, cognitive behavioural therapy, or CBT – a proven treatment – is most commonly delivered by non-physicians. It's insured in Ontario only through private insurance providers, or when delivered at a public hospital like CAMH.

A good third-party insurance policy covers about one and a half sessions per year. Think about that – and then think about the absurdity of insuring one and a half sessions of palliative care or one and a half chemotherapy treatments per year.

I receive calls for mental health advice, guidance or navigation at least once a week. The calls come from neighbors, friends and colleagues. They highlight the need to accelerate work on the justice gap.

I'll illustrate this with a tale of two colleagues. The grandchild of 'colleague one' developed Type 1 Diabetes – a critical situation. The family was whisked to SickKids where they were enveloped by a team of experts. The child of 'colleague two' was depressed and

contemplating suicide – also a critical situation. This family was given a yellow sticky note with the names of a few places they might call for help.

This – my friends – is the definition of injustice. Both children had life threatening conditions. Both children deserved timely, comprehensive care. It was available for only one of them.

On the bright side, those of us working in the mental health sector – hospital and community – are laying the groundwork to demonstrate the effectiveness of our work.

Four mental health hospitals, CAMH, The Royal in Ottawa, Waypoint in Penetanguishene and Ontario Shores in Whitby, are standardizing best care practices, and aligning reporting and measurement for better patient outcomes. With modest provincial government funding, we've begun a small wait time demonstration project that could stimulate a national approach to mental health wait times.

But our hospitals, our community programs, our housing providers and our school mental health workers – to name a few, need to see and feel a commitment to our work.

There are several system examples of models for implementing strategic change. The mental health sector expects no less – a nimble structure with a clear mandate and appropriate resourcing to create a better system of care for those we serve.

Which brings me to the third obstacle: the Advocacy Gap. The good news: Corporate leadership has been central to the success of reducing the fears and misperceptions surrounding the topic of mental illness.

The transformational advocacy initiated by George Cope and Mary Deacon at Bell continues to galvanize all of us in addressing the hidden nature of mental illness. It's also shed light on the economic impact of mental illness in the workplace. Depression is the number one

reason for workplace disability claims and several forward thinking companies are walking the walk with projects that are making a difference.

But – here's a common story. I have a patient who was experiencing a major loss in her life. She works for a large business that's actually represented here. We talked about the possibility of psychotherapy to support her through her stressful time and I asked if she had insurance.

She said yes, her workplace policy did cover therapy, but she would never in a million years access that benefit.

Why? Because she feared that her career advancement would be compromised if it became known that she was depressed.

We know that safe workplaces are central to seeking care and experiencing recovery – and the evidence is clear – workplaces that are both safe and well – are good for the bottom line.

People with the experience of mental illness – either their own or that of a loved one – who've found the courage to share their experience publicly have opened the door to our enlightenment.

These individuals have bravely put a human face on mental illness. Their strength has encouraged others to seek care and to have hope.

But powerful advocates like Clara Hughes, Michael Landsberg, Eric Windler and Michael Wilson are few and far between. What if there were more of them?

What if the 6.7 million Canadians with mental disorders were to rise up in protest about their year-long wait for a specialist appointment?

What if the 600,000 Ontarians with depression were to go to the press because an effective treatment isn't covered by their healthcare system?

What if the 10,000 people in Toronto who are on a waiting list for supportive housing were to descend on Nathan Phillips Square and stop traffic at Bay and Queen?

What if the moms and dads who've lost 1,000 Canadian children to suicide were to march on the Hill – their grief on display for us all to see?

What if?

It's up to all of us to help amplify the soft voices and carry the hope that's emerging as we close the science gap, challenge the justice gap and bridge the advocacy gap.

I'm calling on the influential people in this room to demand better. I'm asking you to agree with me that the time for talking strategy is gone. It's time to act. To eliminate the three gaps I'm asking you to:

First: use your political influence to motivate governments and industry to invest in the fundamental neuroscience research that will help us understand conditions like schizophrenia, autism and dementia.

Second: demand action in operationalizing provincial and federal mental health strategies, including a real wait times initiative like that delivered through the 2004 accord; one that improves access to specialty consultation, proven treatments, and secure housing for people with mental illness.

Third: commit – in words and deeds – as well as by good intentions – to workplace standards for mental health that include education and exposure to real people who live with mental illness – that's the way to overcome the prejudice and discrimination that live with fear and ignorance.

There are no degrees of separation between anyone in this room and someone with mental illness.

A year ago, I met Gail Bellissimo, who is here with us today. Gail's a mother of four who'd suffered for a decade with severe, treatment-resistant depression. Within weeks of beginning brain stimulation treatment at CAMH, her symptoms had dramatically improved. She speaks for herself now and this is what she says: "I have the right to joy in my life, the right to realize my dreams…"

Gail, I agree. Thank you.