



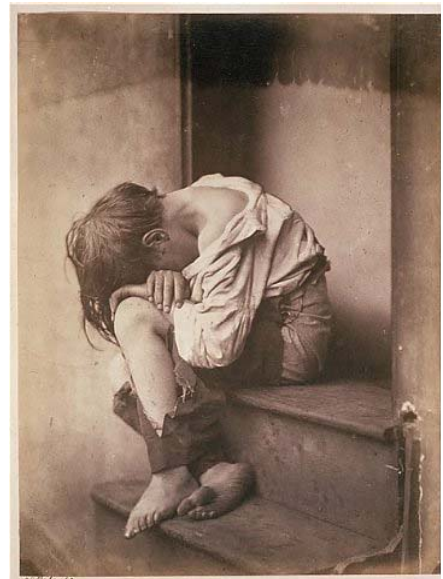
**PRESENTATION TO THE SELECT COMMITTEE
ON
MENTAL HEALTH AND ADDICTION**

BY

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Oscar Rejlander: Homeless (c. 1860)

The Ontario College of Family Physicians (OCFP) is a Chapter of the College of Family Physicians of Canada. Our College was given a Federal Charter to set standards for the practice and education of family physicians. We accredit the seventeen family medicine residency program across Canada and residents must sit our certification examination in order to be licensed to practice in Ontario. Here in Ontario, we work closely with all six Ontario medical universities, conducting research and supporting our faculty members to provide medical students and family medicine residents with a superb medical training. We are also responsible for accrediting and delivering continuous professional development programs to ensure that our Members, all 9300 of them, remain current and able to practice evidence-based medicine.

Family physicians deliver 80% of the medical care in this province and that statistic holds for mental health services, as well. Indeed, 30-35% of a family doctor's time is spent providing care for patients with social, emotional and mental health problems. It is an urban myth that psychiatrists and other mental healthcare professionals are the main providers of these services. It is the family doctor – and they develop a trusting relationship with their patients as they provide care for them throughout their lifespan that is at the heart of a very therapeutic model of care.

Mental health care is not just about severe persistent mental disorders like schizophrenia or bipolar disorder. Anxiety and depression are the most common mental disorders. Family doctors are perfectly situated in the health care system to identify patients experiencing difficulties or are in crisis. We can intervene early and effectively because we already have a trusting relationship to build upon. It is this relationship that is also vitally important when major mental illnesses occur that require ongoing care over the course of time. Throughout the lifespan of our patients, we deal with the following issues:

- Our patients become distressed when they cannot become parents (infertility is becoming a very common problem as young couples delay pregnancy and then have problems conceiving); if successful, they worry terribly during the first trimester of their pregnancy and suffer greatly if the fetus is lost. The sleepless nights and anxiety during the last trimester lead to overwhelming happiness at the beauty of the world's most precious child, but quickly turn to the "maternal blues" or to post-partum depression or psychosis. (Do you know that Women's College Hospital was working on a plan to develop a small facility for post-partum women with rooming-in for the infant capabilities for because there was not one facility that *can* provide rooming

in when a mother requires in-patient psychiatric care? We separate them at the very time when bonding is so vital to both mother and child).

- Having supported parents through preconception, pregnancy and infancy, family doctors are, therefore, the healthcare professionals that they turn to when concerns about autism or other childhood mental disorders first arise or when speech and language, learning problems and behavioural problems are first identified.
- We deal with childhood obesity, acne, bullying and all the trials and tribulations that lead to adolescent angst, lack of self-confidence, lack of school success, eating disorders, alcohol and drugs use, promiscuous behaviours, arguments and violent episodes and subsequent entry into the justice system.
- We support couples when they are having marital difficulties and are the first to know about violence in the home.
- We are the ones patients turn to when the recession hits hard and they have lost their jobs and do not know how they are going to keep a roof over the heads of their families.
- We help them through their middle-life crisis and when they are experiencing empty nest syndrome.
- We identify and intervene early when Alzheimer's Disease is suspected and we care for our patients with dementia in their homes and in long-term-care facilities. As best we can, we try to give them and their loved ones the best quality of life as long as possible.
- We comfort our patients when they have lost their spouse, their parent, or a precious child.
- We are the doctors who are working in the emergency department when a patient is brought in by police after a call from a family member who fears that their loved one is suicidal or homicidal. When the diagnosis is "severe persistent mental disorder" or are addicted to drugs or alcohol or doubly diagnosed, which is often the case, we are frequently left to deal with the patient and family members on our own without the support we need from the system. This is especially true for those of us who practice in the far, remote North, trying desperately to meet the needs of our First Nations People. When the ambulance brings young people in after a suicide attempt, we are often the ones who have to tell the parents that their beloved child was found to late and there was nothing that we could have done to save him or her. That is probably the hardest part of our job.
- We are the coroners who examine them when they have committed suicide and we know that statistics well on how many wonderful young people are lost to us through mental illness.

We do all of this and so much more in a system that is fragmented, hard to access and lacks enough people with the knowledge and skills to provide evidence-based care.

So what has the OCFP done to help our members?

We established the ***Collaborative Mental Health Care Network***. This is a province-wide program that pairs psychiatrists with GP-Psychotherapists to mentor family physicians who receive “Just-in-Time” advice, as well as formal education to increase their knowledge, skills and confidence in providing excellent mental health and addiction care. Family physicians, supported by the program are providing great care to their patients and are keeping them out of emergency departments and hospitals. We have changed the referral to a specialist model of care into a consultation referral. The model has proven to be so successful that it has been established as a permanent program funded by the MOHLTC. We have been invited all over the world to help other Health Ministries set up a similar program and government can take great pride in this program.

The Alzheimer’s Physician Education Strategy has been modeled after the CMHCN but pairs geriatric medical and psychiatric specialists with family physicians who have taken a third year residency program in care of the elderly. They jointly support family doctors to care for patients with dementia and their families. We are helping family physicians to use assessment tools to identify dementias early and intervene when treatment may delay or prevent the devastating symptoms that patients experience. We work with the patient during these early years in their disease trajectory to help them make decisions about their care over time, so that family members do not have to make tough decisions later on and we do practical things like assess their safety to drive. We are helping our medical students and residents to see that the care of the elderly as an exciting and rewarding part of role of the family doctor so that when the baby boomer generation starts to need care, we will have a large number of family doctors well equipped to meet their needs and that of their family caregivers.

The Medical Mentorship for Addictions and Pain has teamed pain specialists with addiction specialists and methadone prescribers to assist family doctors to deal with the care of patients with intractable pain and the sequelae of the use of opioids, such as addiction. Patients often suffer needlessly because of a fear of causing and addiction. 40% of all people who have become addicted to both drugs and alcohol did so because of the pain they were experiencing after an injury or surgery, even as simple as a dental extraction. This project has led us into the realm of drug diversion, with opioids now the street drug as choice.

We have worked hard on developing *Family Health Teams and Share-care Collaboratives* with social workers and mental health workers embedded in the team to assist with the 30-35% of the patients in a practice needing mental health services. Other family practices have been wise enough to partner with their local hospital or community agencies to develop share-care arrangements with specialists in mental health and addictions and partnerships with both private sector and community-based service providers. With practice supports in place, family doctors are much more willing to take hard-to-serve patients into their practice. Otherwise, these patients may receive care in the mental health system but they lack primary care so their physical health is neglected leading to early onset of other chronic disorders. Often, their lifestyle is such that they are the natural candidates for diabetes, cancers and cardiovascular diseases (heart attacks, strokes, etc.) - their eating habits are poor, they get little or no exercise, they chain smoke and the very drugs that keep the symptoms of their mental illness in check, cause changes in body systems leading to chronic diseases.

We have established the *Aboriginal Task Force*. Some of our family physicians live and practice in the remote, northern parts of our province with our First Nations people. Others are linked to outpost nurses in the small, remote reserves and fly into these communities on a routine basis while practicing in larger communities where First Nations people are sent to receive care that cannot be delivered on site in these communities. They struggle terribly to keep up with needed demands but recognize that the living conditions are the root cause of the problems that they face on a daily basis in trying to deliver care. We are working with a federal/provincial group of leaders who are trying to identify the ways in which we can address the issues – but we are moving carefully since it the people themselves who need to direct our efforts, not the other way around. We have learned only too well that well-meaning healthcare workers have tried to use their ways to improve the situation. Our First Nations people, the Chiefs especially, are working with us to inform us of the assistance that we might be able to provide. We will keep the Select Panel informed as we move forward.

So what should government do to improve the current system? Our recommendations are as follows:

- The current commitment to the number of FHTs and CHCs is not enough – every person in this province deserves to have their care needs met in a family practice by a family physician in collaboration with nurses/NPs, social workers/mental health workers and other interprofessional team members. We do not necessarily need to invest in formal structures like FHTs and CHCs, we just need to get family doctors, nurses/NPs, social

workers/mental health workers and other healthcare professionals working in real or virtual teams. ***The best message we can deliver is to invest in the primary care sector and invest heavily.*** The evidence is clear that countries that have the strongest primary care sector have the best health outcomes with the least expenditure of their GDP – and those findings correlate best with the number of family physicians per 100,000 population. When the number of family doctors is higher, the best results are achieved. Unfortunately, for our specialist colleagues, the opposite is true. To get the best outcomes, we need family medicine as the healthcare system’s strong foundation and family doctors need interprofessional team supports and electronic medical records to achieve the best results possible for their patients.

- If you want to invest in ***preventive mental health***, support family doctors since preventative mental healthcare happens every day in the family doctor’s office. If you want to reduce the ***stigma of mental illnesses*** and addictions, invest in family medicine. Patients do not want to be seen in an environment labeled “Psychiatric Hospital” or Mental Health Clinic” or “Addiction Outpatient Clinic” or “Methadone Clinic”. Bring the expertise to family practices rather than sending the patients to the black box of psychiatric care. Support shared-care in mental health programs and the OCFP Collaborative Care model. Ensure that community-based mental health and addiction service providers are attached to family practices and not free-floating. Ensure that every provider of mental health and addiction services has a process in place to have the family doctor as the key member of their patient’s healthcare team, not an outside observer relying on the patient and family to convey information to his or her own doctor.
- ***Create a single entry point*** into an integrated mental health and addiction program – if family doctors cannot find their way into the system, how do we expect unattached (often the most needy of patients) to find their way into the system?
- ***Create a “Cancer Care Ontario” for the mental health sector*** that undertakes research to identify best practices/evidence-based care and measures every service provider to ensure that they are providing high quality care. We are uncomfortable referring to community-based providers because of the lack of a confidence in their abilities to deliver the care that we know is available amongst our psychiatry colleagues but their wait-times are so long that, by the time the patient is seen, the crisis is usually over. If we cannot wait, we send the patient to the emergency department – probably the worst place for a person in crisis.
- ***Invest heavily in the “Early Years”*** (zero to six). This is the stage in life when good nutrition, excellent parenting , early childhood education and

protection from environmental harm builds in the resilience that is need to offset chronic disorders, including mental health and addiction services. Put public health nurses back into our schools to better access our children and adolescents during their formulative years. You can invest in children and adolescents or you can pay for an expanded justice system and poor productivity in the workforce of tomorrow.

- ***Address childhood poverty***; indeed, poverty in general. At a minimum, ensure that everyone has a roof over their heads and sufficient food to eat.
- Shore up the Employee Assistance Programs by embedding the principles of a ***healthy workplace environment*** in every organization in Ontario and making it a government priority.

In summary, our healthcare system was built on the ***principle of equity***, that is, the most care for those most in need. Patients with mental health and addictions problems are some of the neediest patients in province but instead of providing them with equitable access, we do not even provide them with equal access. That great Canadian philosopher, Rex Murphy, once said that the Canadian Healthcare system is so cherished by the public because it is the best expression of Canadian values of all of our social programs. He went on to say that no where in the healthcare system do you see those Canadian values translated into action more fully than in the family doctor's office. The mental healthcare system has been built to date using a "specialty model" that just doesn't work the way that it should. Restructure the system to focus on the delivery of the majority of those services in the primary care sector and you will end up with a system that actually works for the people of this province.

Thank you so much for inviting me to meet with you. I would be happy to answer any questions you may have.