



## The Voice of Family Medicine in Ontario

**The Ontario College of Family Physicians’  
Submission to  
The Ministry of Health and Long Term Care’s  
Discussion Paper:  
*“Every Door is the Right Door-  
Towards a 10 Year Mental Health and Addictions Strategy”***

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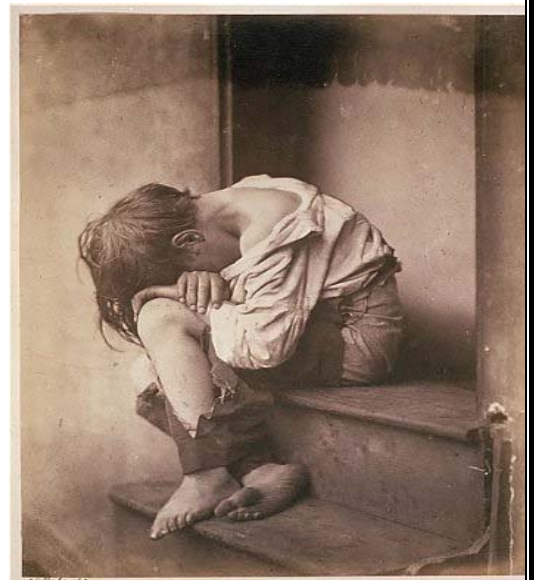
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Oscar Rejlander: Homeless (c. 1860)

## Key Messages

- 1. Mental disorders affect hundreds of millions of people and, if left untreated, create an enormous toll of suffering, disability and economic loss.**
- 2. Despite the potential to successfully treat mental disorders, only a small minority of those in need receive even the most basic treatment.**
- 3. Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need.**
- 4. Primary Care for mental health is affordable, and investments can bring important benefits.**
- 5. Certain skills and competencies are required to effectively assess, diagnose, treat, support and refer people with mental disorders; it is essential that family physicians and other primary care professionals are adequately prepared and supported in their mental health work.**
- 6. There is no single best practice model that can be followed by all countries. Rather, successes have been achieved through sensible local application of broad principles.**
- 7. Integration is most successful when mental health is incorporated into health policy and legislative frameworks and supported by senior leadership, adequate resources, and ongoing governance.**
- 8. To be fully effective and efficient, primary care for mental health must be coordinated with a network of services at different levels of care and complemented by broader health system development.**
- 9. Numerous low and middle income countries have successfully made the transition to integrated primary care for mental health.**
- 10. Mental health is central to the values and principles of the Alma Ata Declaration; holistic care will never be achieved until mental health is integrated into primary care.**

Source: Integrating Mental Health into Primary Care: A Global Perspective  
(WHO/WONCA)

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## **Executive Summary**

The Board of the Ontario College of Family Physicians and several family physician leaders have reviewed the Ministry of Health and Long Term Care's Discussion Paper, "Every Door is the Right Door – Towards a 10 Year Mental Health and Addictions Strategy." The Expert Panel has created an excellent vision for mental health and addiction services; however, it lacks an implementation strategy and is relatively silent on the important role that family physicians play in the current system. The discussion paper seems to suggest that the family physicians' main role is to provide an entry point to the mental health and addictions sector. While we agree that the main door for patients seeking care is the door to the office of their family physicians, the reality is that family physicians are the main providers of care for patients with mental disorders or addictions.

Given the key role that family physicians play in the healthcare system, it is not surprising that the Expert Panel has received multiple expressions of concern that family medicine and the primary care sector in general were given short shift in the discussion paper. Not only do family doctors deliver over 80% of the medical care in this province, that same statistic holds true for the volume of mental health and addiction services that are provided in family practices. Administrative databases demonstrate that patients with some of the most complex problems are effectively cared for by family physicians. The patients of family doctors do not come in nice packages with one problem per package. Family physicians specialize in caring for patients with multiple co-morbidities including patients with some of the most complex mental disorders and addictions (i.e. severe, persistent mental disorders and the dually diagnosed).

35% of the care delivered by family doctors relates to mental health and additions and that care reflects the problems that arise throughout the life spans of their patients. Fortunately for their patients, they are able to manage most conditions within their practices. When they try to access the other community or hospital-based mental health and addiction providers, they face a system that is fragmented, difficult to access and lacking a sufficient number of providers with the knowledge and skills to provide high quality, evidence-based care that patients and their family members need and want.

The implementation of the vision described in the MOHLTC's discussion paper may result in an even more fragmented system. Frequently, MOHLTC strategies are developed in isolation. Since the mid-nineties, developed and developing countries around the world have been investing, and investing heavily, in their primary care sector and the reason for doing so is simple – better outcomes and less cost. In Canada, the College of Family Physicians of Canada and especially its Ontario Chapter, the Ontario College of Family Physicians have been paving the way for governments at the federal and provincial levels to implement models of care that are aimed at restoring the strengths in the Canadian healthcare system. In Ontario, we have seen the establishment of Family Health Groups, Family Health Networks, Family Health Organizations and Family Health Teams. Currently, over 9,000,000 Ontarians are receiving their care in one of these new care models. The Mental Health and Addictions Strategy should build upon the work undertaken to date in the primary care sector rather than reinforcing the silo model of mental health and addiction services that has failed patients and their families, time and time again.

The growing body of evidence points to the fact that patients with mental disorders and addictions need to receive the majority of their care in their own family physician's office. Not

only are family practices able to normalize the patient and family experiences to reduce the stigma attached to mental illnesses and addictions, they are able to provide the full spectrum of care from health promotion and prevention to early detection to diagnosis, treatment and ongoing follow up for all of the health problems that patients experience. Anchoring the strategy in family practices reduces the need for patients to face the hurdle of trying to bridge the many silos in the current system and it puts patients and their families at the heart of the system – in their own medical home. The model of care that Ontario has been trying to build for several years now is built on the premise that every person in Ontario deserves to have the majority of their care delivered in a family practice by a family physician and a nurse and/or a nurse practitioner plus other members of the primary care team such as social workers/mental health workers, psychologists, dieticians, pharmacists etc. The team members do not have to be embedded in the practice (i.e. a Family Health Team); virtual teams can be created by simply aligning current health care professionals to work with family practices through collaborative partnership arrangements to provide care for patients and their families. Shared-care models and Collaborative Care Networks have proven their value and need to be expanded to every practice in the province.

This model is supported by solid international research. The evidence, in regards to the important role that family doctors and other primary care physicians play in producing better outcomes, is especially strong. The evidence points to the fact that the higher the ratio of family physicians, the better the health outcomes. The opposite is true for our specialist colleagues and specialty services. Positive health outcomes, at a reduced cost, are related most strongly to the ability of the primary care sector to provide comprehensive services and family-centred care. Comprehensive services are defined as the delivery of all services in the primary care sector except those services that are performed so rarely that practitioners would be unable to maintain their skills. Many health care professionals speak about providing patient-centred care without defining the meaning of the term. Family doctors are the only health care providers who have the broad scope of practice to deliver most of the services that patients require, including care for patients with severe persistent mental health problems, the dually diagnosed and those with multiple other co-morbidities. Family physicians deliver care for their patients and family members in their offices, in patient homes, in emergency departments, in obstetrical units, in inpatient units and in long term care facilities. They are the specialists who fully understand the needs of their patients and their family members and developed a trusting and therapeutic relationship with them as they deliver continuity of care and comprehensive services, visit by visit, throughout the life span of their patients.

This document was written to emphasize the need for anchoring care in the primary care sector. The current system has been built to date using a “specialty” mindset that simply does not work the way that it should. By recognizing the fact that the majority of care is already taking place in family practices and shifting resources to provide better supports for family physicians and their patients, government will end up with a system that actually works for the people of this province.

## **Main Recommendation**

***Anchor the 10 year Mental Health and Addictions Strategy in the Primary Care Sector. Provide every person in the province with a medical home (i.e. their own family physician's office)***

### ***Other Recommendations to Enhance the 10 Year Mental Health and Addictions Strategy***

Our recommendations for enhancing the 10 Year Mental Health and Addiction Strategy are as follows:

- ***Recognize that the Main Door to Mental Health and Addiction Services is through the Door of Family Physicians' Offices***

The entry door to care for patients and their families is the family doctor's office. This will become an even more important door as government continues to invest in family medicine and the primary care sector. While the Expert Panel may wish to imply that the healthcare system of the future will be anchored in "family health providers", the language is seen as an attempt to diminish the role that family physicians play in the system. Currently, 9,000,000 people are formally enrolled with their own family doctor, rather than a "family health provider" or a "team". Health Care Connect was established to ensure that all people in the province are supported to enroll with a family physician. The language in the document should reflect this Ministerial direction. The document needs to be reformatted to be consistent with the advice received throughout the consultation process to firmly anchor patient care in primary care/family medicine. All healthcare providers need for every patient to have a family doctor, especially those with a mental health or addiction problem. The document should also help them to understand the role that family physicians play in the system and the importance of the primary care sector.

- ***Emphasis that the prevention of mental health and addictions should be the first priority of the 10 year strategy.***

It should acknowledge the fact that prevention of mental healthcare happens every day in the family doctor's office and in the activities that are conducted in communities throughout the province by Medical Officers of Health and public health nurses. Instead of flowing more funds to mental health and addiction service providers, provide sufficient funds for public health units to have a strong presence in schools, in the workplace and our family practices. The strategy will not have any impact until a concentrated effort is made in communities and throughout the healthcare system to address the determinants of health in a concentrated manner.

- ***Commit to strengthening the ability of every family physician in the province to deliver interprofessional, team-based care***

The number of FHTs and CHCs that government has committed to creating 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 listen to the research evidence and invest in family practices - and invest heavily.*** To get the best outcomes, we need family medicine as the healthcare system's strong foundation and family doctors need interprofessional team supports (virtual or embedded teams), excellent continuing education programs and electronic medical records to achieve the best results possible for their patients.

▪ ***Take advantage of the work of the Expert Panel on Rural and Northern Health***

All too frequently, strategies are developed in isolation of one another. The Expert Panel on Northern and Rural Health should be requested to address the lack of mental health and addiction services in rural and northern communities.

▪ ***Emphasis the fact that the best way to reduce the stigma of mental illnesses and addictions is provide the services in family practices.***

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's Collaborative Care programs.* Ensure that community-based mental health and addiction service providers are attached to family practices and not free-floating. If care is provided by hospitals or community-based service providers, ensure that they have 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? Given the role that the CCAC's play in discharge planning from hospitals and in helping family doctors and their patients to access and navigate community-based services, homecare services and placement in a variety of community-based residential and long term care facilities, consider expanding their mandate to provide similar services for the mental health and addiction sector.

▪ ***Create a "Cancer Care Ontario" for the Mental Health and Addiction sector***

We need an organization in place that undertakes research to identify best practices/evidence-based mental health and addiction care and measures the performance of every service provider to ensure that they are providing high quality care. Family doctors are uncomfortable referring to community-based providers because of the lack of 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.

▪ ***Ensure inter-ministerial/inter-governmental co-operation***

The strategy will not be successful unless every ministry within the government is committed to the strategy by establishing a process so that every policy decision by the various Ministries considers the impact that their policies will have on creating a province-wide

environment that *enhances social, emotional, mental and physical health in the province*. Seek the support of the federal government and the municipalities and co-ordinate efforts with the Mental Health Commission of Canada.

▪ ***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 needed to offset chronic disorders, including mental health and addictions. The government can choose to invest in children and adolescents or end up paying later 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. Service provision in the absence of the basic necessities of life is simply money wasted.

▪ ***Shore up the Employee Assistance Programs***

Embedding the principles of a *healthy workplace environment* in every organization in Ontario and making it a government priority.

**Seven good reasons for integrating mental health into primary care**

1. **The burden of mental disorders is great.** Mental disorders are prevalent in all societies. They create a substantial personal burden for affected individuals and their families, and they produce significant economic and social hardships that affect society as a whole.
2. **Mental and physical health problems are interwoven.** Many people suffer from both physical and mental health problems. Integrated primary care services help ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders.
3. **The treatment gap for mental disorders is enormous.** In all countries, there is a significant gap between the prevalence of mental disorders, on one hand, and the number of people receiving treatment and care, on the other hand. Primary care for mental health helps close this gap.
4. **Primary care for mental health enhances access.** When mental health is integrated into primary care, people can access mental health services closer to their homes, thus keeping their families together and maintaining their daily activities. Primary care for mental health also facilitates community outreach and mental health promotion, as well as long-term monitoring and management of affected individuals.
5. **Primary care for mental health promotes respect of human rights.** Mental health services delivered in primary care minimize stigma and discrimination. They also remove the risk of human rights violations that can occur in psychiatric hospitals.
6. **Primary care for mental health is affordable and cost effective.** Primary care services for mental health are less expensive than psychiatric hospitals, for patients, communities and governments alike. In addition, patients and families avoid indirect costs associated with seeking specialist care in distant locations. Treatment of common mental disorders is cost effective, and investments by governments can bring important benefits.
7. **Primary care for mental health generates good health outcomes.** The majority of people with mental disorders treated in primary care have good outcomes, particularly when linked to a network of services at secondary level and in the community.

## 1.0 Introduction

The Ontario College of Family Physicians (OCFP) is a Chapter of the College of Family Physicians of Canada (CFPC). The College was given a federal charter to set standards for the practice and education of family physicians across Canada. The National College accredits the seventeen family medicine residency program across in Canada's medical universities and residents must sit the CFPC's certification examination in order to be licensed to practice in Ontario. All specialists in family medicine and general practitioners must meet the criteria of the CFPC's Maintenance of Proficiency program annually to demonstrate their commitment to continuing professional development as the cornerstone of the CPSO's physician quality assurance program. The OCFP works 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 9300 members remain current and able to practice evidence-based medicine. With an attrition rate of 0.8% and new residents joining our ranks every year, we continue to grow in numbers and strength and are recognized by our members as the Voice of Family Medicine in this province.

The OCFP asked our Board members and key family physician leaders (approximately 50 family physicians) to review the MOHLTC's visioning document. The most frequent comment was that the document is strong on a vision for the future system; however, it lacks an implementation plan. It was also pointed out that the government will not be able to implement the Vision without a firm commitment to enhancing the supports provided for every family physician in this province. In addition, government needs to commit to a strong public health and community sector. The work that needs to be undertaken cannot be invested in the Ministry of Health and Long Term Care, alone. The work that needs to be undertaken requires the full co-operation of the Ministry of Health Promotion, the Ministry of Children and Youth, the Ministry of Community and Social Services, the Ministry of Aboriginal Affairs, Seniors Affairs, the Ministry of Municipal Affairs and Housing (and regional and municipal governments throughout the province), to name just a few. It also needs to be co-ordinated with the work currently underway at the national level by the well-respected Mental Health Commission of Canada. While the document addresses linguistic and cultural barriers to care, it is silent on geography as a vitally important barrier. The lack of services in small communities and especially in northern, rural and remote communities needs to be addressed in the strategy.

***The strategy should not be about the “mental health and addictions sector(s)” but rather about patients and their families that require support throughout their life span to remain as emotionally, mentally and physically healthy as possible.***

***Our key recommendation is to stop treating mental health and addictions as if they should be addressed by a separate healthcare care sector. Patients do not come in nice neat boxes with physical problems in one box and mental health/addiction problems in another. Yet, the current mental health and addictions sectors deliver “box-like” care. It is only in family practices that the patient and family members receive family centered, continuous and comprehensive care.***

## 2.0 Family Medicine – At the Heart of the Strategy

Our respondents noted that the document was crafted by an Expert Panel that did not include even one family physician. It is, therefore, not surprising that the document barely mentions the contributions of our Members. Nor is it surprising that the consultation process has consistently identified the key role that family physicians play in the system and the need to anchor the 10 year Mental Health and Addiction Strategy in the primary care sector.

The document refers to “family health providers” and “the primary care sector” delivering mental health and addiction services. Administrative data demonstrates that it is family physicians who deliver 80% of the medical care in this province and that statistic holds for mental health services, as well. The 20% provided by other specialists, such as psychiatrists are often delivered in collaboration with the family doctors. 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, other mental healthcare professionals and professionals working with family doctors are the main providers of these services. ***It is the family doctor*** – and they are especially successful in doing so because of the trusting relationship that they develop with their patients and the patient’s family members as they provide care for them throughout their lifespan.

It is the trusting patient-physician relationship that is at the heart of family medicine and our effective therapeutic and cost-effective model of care. The international evidence from Dr. Barbara Starfield and other highly respected researchers demonstrates that those countries and regions within a country that have the highest ratio of family physicians/primary care physicians per 100,000 people have the best health outcomes with the lowest costs. The opposite is true in models that rely on specialists and specialty services. Dr. Starfield’s work indicates that the benefits of a strong primary care sector are positively correlated with practices that embrace “family-centred care” and “comprehensiveness of care”. While other disciplines describe themselves as delivering “patient-centred care” without defining the meaning, the practice of family medicine is anchored in continuity of care that translates the meaning of “patient-centred” and “family centred care” into demonstrable actions that are seen in the day-to-day life of a family doctor as he or she provides care in the office, in the patient’s home, in the emergency department, in inpatient units and in long term care facilities. Dr. Starfield defines “comprehensiveness” as the ability to deliver all services in the primary care sector except those that are so rare that practitioners would not be able to maintain their skills.

***No other healthcare professional has the scope of practice to deliver family-centred continuity of care and comprehensive services – only the family doctor. No other healthcare professional has the scope of practice that allows them to deliver care to patients with multiple comorbidities – only the family doctor. No other healthcare professional is able to deliver care for their patients in multiple healthcare settings – only the family doctor.***

*A growing body of evidence supports the premise that the family doctor can provide a higher level of care when supported by a real or virtual team of nurses, social workers/mental health workers, pharmacists and other healthcare professionals. The model is strengthened when psychiatrists, FP-psychotherapists psychologists and other specialists in mental health and addictions are aligned with family practices in shared-care or Collaborative Care Networks. It is for this reason that the 10 year mental health and addiction strategy needs to be aligned with primary care renewal initiatives.*

The two overriding priorities for family physicians in the delivery of care to their patients and family members are **quality** and **equity**.

*Quality is a value that is given to the best care possible and usually involves a process of continuing practice improvement with attention to measuring the performance of all dimensions of family-centred care. Since the ability of the family physician to provide quality of care for his/her patients and family members is impacted upon by local, regional and provincial factors, advocacy at all levels is an important role that family physicians fill in assuring quality in their family practices. Family physicians especially advocate for their most vulnerable patients – and they are often those with mental disorders and addictions.*

*Equity assures the greater good for all patients and their providers and it is achieved when family physicians work collaboratively together in group practices with other healthcare professionals and the entire community for the greater good of our patients.*

Quality and equity are demonstrated best in the following six areas of primary care renewal:

1. access to comprehensive care;
2. care by collaborative teams;
3. continuity of the patient-physician relationship;
4. community responsiveness using a population approach;
5. sufficient infrastructure and support; and,
6. support for quality of work life for professionals and staff.

*The ideal mental health and addictions system is one that is embedded in a family practice that provides each Ontarian with a “medical home” that is accessible through a variety of means. Family practices provide a comprehensive range of services that can be delivered by collaborative teams across many settings including family practice offices, patients’ homes, long term care facilities, hospitals, emergency departments and maternity care settings. These services are provided to patients of all ages and stages in life to ensure equitable access to a full spectrum of health services to meet the needs of patients, families and the community.*

### **3.0 Family Practices are the “Main Door” to the Provision of Mental Health and Addiction Services**

Mental health care is not just about inpatient and outpatient services for patients with severe persistent mental disorders, like schizophrenia or bipolar disorder. Addiction services are not just about the need for a detox centre or an outpatient rehab program or another Methadone Clinic. Anxiety and depression are the most common mental disorders. Moreover, the system should not start with a focus on early detection but rather on addressing the determinants of health that are crucial to the prevention of many problems in the first place. Family doctors are perfectly situated in the health care system to prevent problems from becoming an issue, to identify patients experiencing difficulties or are in crisis as soon as possible and to treat a wide variety of social, emotional and mental health problems. We can intervene with families before children are affected and when we do need to intervene we can do so 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 or addictions occur that require ongoing care over the course of time. Throughout the lifespan of our patients, we deal with the following issues:

- Our work begins in the preconception stage of life as we guide parents to be as healthy as possible and to avoid environmental contaminants and medications that may impact upon lifelong health of the fetus they are trying to conceive.
- 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. The family doctor provides a calming presence during this trying time.
- If the couple is 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 can quickly turn to the “maternal blues” or to post-partum depression and psychosis. While family physicians understand the importance of bonding between the newborn and the mother and family, the mental health system has failed to develop even one facility for post-partum women with capabilities for rooming-in for the infant when a mother requires in-patient psychiatric care. The system separates them at the very time when bonding is so vital to the health of both the mother and her infant.
- 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 for our teenage population.
- We support couples when they are having marital difficulties and are often the first to know about violence in the home. We are the healthcare professionals they turn to when stress at work becomes overwhelming.
- We are the ones patients turn to when a 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, menopausal symptoms and when they are experiencing empty nest syndrome or the lost esteem that often accompanies retirement from the workplace.
- We deal with the emotional overlay that naturally occurs when a patient is diagnosed with a major chronic disorder, as well as the impact of the diagnosis on family members.
- 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 and are called upon to support them through the grief process.
- 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. We see the Psychiatric Crisis System first hand and wonder why patients and families keep falling through the cracks.
- When the diagnosis is "severe persistent mental disorder" or the patient is found to be addicted to drugs or alcohol or dually 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.
- Unfortunately, many patients who have a mental health or an addiction problem receive care in hospitals and through community-based mental health and addiction services. Lacking a family doctor, they often do not receive primary care services. Given their lifestyles and the impact of medications on health, they are at risk for early onset of chronic disorders. As we receive referrals from HealthCare Connect, family physicians try to take hard-to-serve patients into their practices.
- When the ambulance brings young people into our Emergency Departments after a successful suicide attempt or a drug/alcohol related event, we are often the ones who have to tell the parents that their beloved child is dead 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 or die in a motor vehicle collision and we know that statistics well on how many wonderful young people are lost to us through mental illness, addictions and drunk driving.

***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.***

## 4.0 The OCFP's Efforts to Improve the System: Building on Successful Innovations

With the support of the Ministry of Health and Long Term Care, the OCFP has established the following programs:

- ❖ ***Collaborative Mental Health Care Network.*** This is a province-wide program that pairs psychiatrists with FP-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.
- ❖ ***The Healthy Child Development Program*** is anchored in the lessons learned from the Mustard and McCain reports on the Early Years. Our educational programs are anchored in providing family physicians with a through understanding of the biological processes that occur during preconception, the prenatal, infancy, pre-school and kindergarten stages of life. Good parenting and nutrient, early childhood learning and protection from environmental

contaminates have the potential to build in reticence to chronic diseases including mental health and addictions. The assessment tools used in the program provide family doctors with the supports needed to identify problems and arrange interventions as early as possible.

- ❖ The OCFP has also worked in collaboration with the Ontario Medical Association and the Ministry to develop the model for the *Family Health Teams and Share-care Collaboratives*. This work and our efforts to support the rollout of the models has supported the development of interdependent family practices so that nurses/NPs, social workers and mental health workers, pharmacists and other healthcare professionals are embedded in the practices to assist family physicians to deliver exceptional care for the 30-35% of the patients 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.
- ❖ Recently, we 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. The Chief's Health Committee has agreed to develop a partnership with the OCFP and to work with us on a strategic planning day to identify the joint projects that we can undertake to address issues the many health issues facing First Nation populations in Ontario, including Mental Health and Addiction problems.

***Given the quality of the OCFP's programs, the Ministry should continue to transform them from pilot projects to comprehensive programs that support family doctors to deliver the care that patients need and want in a setting that addresses the stigma of mental health and addiction problems and addresses all of their healthcare needs.***

## 5.0 Summary

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 addiction 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 simple does not work the way that it should. If the restructured system is shifted to focus on the delivery of the majority of mental health and addiction services provided in the family practices with the supports in place for family physicians to provide the level of care that patients and their family members require, government will end up with a system that actually works for the people of this province.