

# Mental Health Care How Is Canada Doing?

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## Executive Summary

Mental illness is widely recognized to impact a considerable proportion of the population, perhaps affecting as many as one in five Canadians in any given year (Mental Health Commission of Canada, 2013). The prevalence of mental illness, combined with the now well-understood impacts on employment, productivity, and social engagement for ill individuals, helps to explain the increased attention this area of health care has received in recent years and the numerous calls for additional tax-funded expenditures on mental health care.

While much attention has been paid to the impacts of mental illness on Canada's economy and health care system by the Mental Health Commission of Canada, researchers and various mental health patient advocacy organizations, little information exists on how Canada's current approach to treating mental illness stacks up internationally. Understanding how well Canada is doing today, in comparison with other high-income nations that have similar policy goals, is important for developing an appropriate policy response to commonly voiced concerns about a lack of access to quality, timely treatment.

While statistics on the performance of mental health care systems are more limited than those measuring the performance of the general health care system, the picture painted by an international review of statistics on the performance of Canada's mental health care system is not an overwhelmingly positive one. The proportion of health expenditure estimated to be allocated to mental health in Canada ranks highly when looking specifically at government expenditures, but ranks slightly lower as a share of total expenditures. At the same time, Canada's mental health care system imposes long delays in accessing care on a considerable number of Canadians and makes fewer medical resources available than might be found in peer nations. There is also evidence that access to mental health care services in Canada has declined over time, particularly in terms of delays imposed on patients in need of services.

The combination of high levels of mental health care needs with low availability of physicians, psychiatrists, psychologists, and facilities suggests Canada's provinces may find value in policy structures that both allow better use of and access to existing

and also improve access to care through innovative new approaches. Making better use of limited resources, with a focus on improving the availability of services over time, is essential if we are to address Canada's mental health care gap.

## Introduction

Mental illness is widely recognized to impact a considerable proportion of the population, perhaps as many as one in five Canadians in any given year (Mental Health Commission of Canada, 2013).<sup>1</sup> The prevalence of mental illness, combined with the now well-understood impacts on employment, productivity, and social engagement for ill individuals, helps to explain the increased attention this area of health care has received in recent years and the numerous calls for additional tax-funded expenditures on mental health care. There is also a potentially considerable shift in rates of mental illness on the horizon following the COVID-19 pandemic and governmental responses to it.

While much attention has been paid to the impacts of mental illness on Canada's economy and health care system by the Mental Health Commission of Canada, researchers and various mental health patient advocacy organizations, little information exists on how Canada's current approach to treating mental illness stacks up internationally. Understanding how well Canada is doing today, in comparison with other high-income nations that have similar policy goals, is important for developing an appropriate policy response to commonly voiced concerns about a lack of access to quality, timely treatment.

This paper attempts to answer the question of how good Canada's approach to mental health care is in an international comparative sense. The first section briefly reviews the current approach to the treatment of mental illness in Canada. Section two reviews measures of mental health system performance in Canada with those of other nations that share our goal of universal access to care, in terms of prevalence, experience, and resources. A discussion follows.

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1 This level of prevalence is similar to that experienced across OECD countries (OECD, 2021a; OECD, 2012).

## Mental Health Care in Canada

The terms mental health and mental illness are sometimes used interchangeably, but they have distinct meanings. It is valuable to distinguish those meanings in the context of providing health care. Mental illness is a diagnosable disorder or condition that involves significant changes in behaviour, thinking, or emotion, or some combination. Mental health is a concept of well-being that is more than the absence of mental disorders, and includes emotional, physical, and social wellness.<sup>2</sup>

In Canada, provincial and territorial governments are primarily responsible for their populations' health care needs. Mental health resources and services are therefore provided by provincial and territorial governments. Services provided by physicians and those provided in hospitals are generally publicly funded and fall under the purview of the federal *Canada Health Act*, although provincial governments are free to determine which physician and hospital services are covered under the universal medicare scheme (see, for example, Emery and Kneebone, 2013). Services provided by psychologists and allied health professionals (professionals not part of the medical or nursing profession) outside hospital settings generally fall outside the *Canada Health Act's* cost-sharing arrangement and the associated restrictions on provincial policy making. These services may also be privately funded.<sup>3</sup>

General practitioners are often the first point of contact for patients seeking health care services for mental health and mental illness in Canada. They also provide a number of mental health care services, including consultations and therapy, as well as referrals to medical specialists, specialized programs, and hospital care (College of Family Physicians of Canada et al., 2020; CIHI, 2019a; Lesage et al, 2006; Marchildon et al., 2020; OECD, 2021a). Patients may also access services on an urgent or emergency basis, without a referral, in hospitals.<sup>4</sup>

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2 See, for example, Canadian Mental Health Association, 2020; Canadian Mental Health Association, British Columbia, 2015, and American Psychiatric Association, n.d.

3 For more on how the *Canada Health Act* restricts provincial policy reform options, see Esmail and Barua, 2018.

4 Services provided on an immediate, emergent, or short-term basis are typically provided in the predominantly publicly owned/operated hospital sector. For more on the ownership of hospitals



Public funding is available for a range of community mental health and mental illness service programs in every province. Canada's provinces largely provide a similar range of services, although the details of service provision and the referral pathways patients must follow to access particular services varies (CIHI, 2018; CIHI, 2017). Many community service programs are provided by private-donor-funded/taxpayer-supported not-for-profit providers, rather than by governments directly. The publicly funded umbrella for mental health care services in Canada in each province includes (CIHI, 2018; CIHI, 2017):

- Confidential phone lines (either dedicated or as part of provincial telehealth programs) and dedicated websites or phone applications providing information and referrals;
- Outpatient or day programs provided in or by hospitals or in other facilities such as community health centres or community mental health clinics. Programs include individual and group counselling, specialized clinics (for eating disorders, for example), and day hospital care;
- Crisis services, including short-stay facilities/units and crisis phone lines (suicide hotlines, for example);
- Mental health promotion and education programs in schools and in the community;
- Case management programs that help coordinate care for patients and connect patients with the resources and support required for their particular condition;
- Concurrent disorder programs specifically designed to support those living with both mental illness and addiction;
- Early detection/intervention programs providing support to those showing early signs of mental illness that aim to improve outcomes and either prevent or manage progression;
- Outreach programs that engage with those who have a mental illness or who are at risk of mental illness and connect them to treatment and support programs;
- Legal orders or certificates issued either by physicians or the justice system that enforce compliance with treatment programs in the community with defined consequences for noncompliance, including apprehension and presentation to a physician or treatment centre;

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in Canada, see Barua and Esmail (2015). Longer term services, including institutionalization in a specialized psychiatric hospital/facility or attachment to a community services, are not necessarily provided in a publicly owned/operated facility. No specific data are available on the number or proportion of psychiatric-care or mental-health-care providers that are privately owned/operated, either on a for-profit or a not-for-profit basis.

- Peer, family, and self-help groups operated by those affected by mental illness or addictions providing information, education, and support (not provided in PEI)
- Home-based mental health or addiction services provided either in the patient's home or in a client-preferred nonhospital/clinic setting (a public meeting place, for example);
- Residential programs providing a non-permanent supportive living arrangement that prepares clients for transition to community living (not provided in NS and SK);
- Skills training programs teaching behavioural or cognitive skills that help individuals manage the effects of their mental illness, including recognizing warning signs of their disorder for proactive self-management, coping skills, social skills, and communication skills (not provided in QC);
- Housing programs, including supportive living, supportive group homes, subsidized housing, special financial programs for housing such as rent supplements, and assistance with finding/obtaining suitable housing for those with mental illness (not provided in NB);
- Shared care programs that encourage and facilitate collaboration between general practitioners and other mental health or addiction specialists, including psychiatrists, such as co-location and dedicated phone lines (not provided in NL and PEI);
- Vocational training and rehabilitation programs that provide training, education, and support with additional coping skills to help those with mental illnesses or addictions secure meaningful employment; and
- Telepsychiatry programs delivering care to patients using phones or videoconferencing (not provided in PEI).

Many provinces also provide:

- Care programs that support patients' transition from inpatient care or residential programs to living in the community (provided in all provinces except NL, PEI, and NB);
- Multi-disciplinary assertive community treatment programs targeted at those who have more serious and persistent illnesses/impairments that provide treatment, assist clients with activities of daily living, and provide a case management service (provided in all provinces except PEI, NS, and SK); and
- Respite care programs that provide temporary relief to caregivers by admitting those with mental illness or substance use disorders for defined periods of time (only provided in QC, MB, SK, and BC).

The range of services provided by provincial governments across Canada appears to be broadly consistent with the range of services covered in other developed nations'

universal access health care systems (Table 1).<sup>5</sup> While several nations provide full coverage for services covered only partially in Canada, the Canadian approach resembles those in a number of other developed nations including Belgium, Iceland, Japan, Luxembourg, Norway, and Switzerland (OECD, 2021a).<sup>6</sup>

**Table 1: Mental Health Services Covered In Full or In Part by Basic Health Insurance/the National Health System**

	Psychological therapies delivered by a psychologist	Psychological therapies delivered by a mental health professional other than psychologists	Counselling	Alcohol counselling	Drug or substance abuse counselling	Outpatient services
Australia	●	●		○	○	●
Austria	○	○	○	●	●	●
Belgium	○	○	○	○	○	○
Canada	○	○	○	○	○	○
Czech Republic	●	●	●	●	●	●
Denmark	○	○		●	●	●
Greece			○	●	●	○
Iceland	○	○	○	○	○	○
Ireland	●	●	●	●	●	●
Israel	●	●	●	○	○	●
Italy	●	●	●	●	●	●
Japan	○	○	○	○	○	○
Korea	●	●	○	●	●	●
Latvia	●	●	●	●	●	●
Lithuania	●	●	●	●	●	●
Luxembourg	○	○	○	○	○	○
Netherlands	●	○	○	●	●	●
Norway	○	○	○	○	○	○
Slovenia	●	●	●	●	●	●
Switzerland	○	○	○	○	○	○
United Kingdom	●	●	●	●	●	●

● denotes full coverage, ○ denotes partial coverage. Source: OECD, 2021a

<sup>5</sup> See the next section for a discussion of how these nations were selected. Data were not available from the original source for some of the nations identified as peer nations with universal-access health care systems.

Publicly funded mental health care in Canada being delivered by general practitioners, medical specialists, and in hospitals, primarily fall under the purview of provincial ministries of health. Given the scope of the services available to those with mental health and mental illness concerns, the provision and oversight of some mental health care services is sometimes shared with other provincial ministries. For example, ministries of education may be involved in health promotion and in-class education programs, specialized school programs, and early detection programs. Ministries of justice may be involved in programs for inmates, programs focusing on mental health in the community and among homeless populations, as well as services provided for those who must be treated involuntarily. To enhance mental health provision and oversight, some provinces have created dedicated portfolios. These include the BC Ministry of Mental Health and Addictions, the Alberta Ministry of Mental Health and Addiction, and the Manitoba Ministry of Mental Health and Community Wellness.<sup>6</sup>

Patients seeking care privately can access mental health care services through counsellors, psychologists, psychiatrists in private practice, as well as private mental health and mental illness programs such as addiction services. Patients seeking mental health care services privately sometimes pay directly for services out-of-pocket. Patients may also have services partially or fully funded through insurance, either secured individually, through a government program for identified populations (low-income or old age extended health benefits, for example), or through their employer.<sup>7</sup>

The provincial governments' performance in providing mental health care has received considerable criticism from researchers, physicians, and mental health advocates. Patients, both adults and children, have been found to be subjected to significant delays in accessing physician, specialist, and hospital services across Canada (see, for example, Loebach and Ayoubzadeh, 2017; Moroz et al., 2020; Children's Mental Health Ontario, 2020; Moir and Barua, 2022). Lack of access to appropriate treatment, low rates of post-hospitalization follow up, relatively poor access to care in rural areas, and a lack of practitioner-physician preparedness for dealing with mental health conditions and

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6 The federal government has also created the Minister of Mental Health and Addictions portfolio to oversee and support federal public health measures related to mental health and addictions, work with other departments toward a special financial transfer to the provinces focused on first dollar coverage for mental health care services, and support other departments in the direct delivery of services to those under federal jurisdiction (armed forces members, veterans, indigenous peoples, and federal employees).

7 While this care may be provided in privately owned and operated facilities, there are no specific data available on the number of private for-profit providers of mental health care services in Canada, or the proportion of providers (either facility-based or community-based) that are private enterprises, both for profit and not for profit).

mental illness have also been raised as important shortcomings of the Canadian approach (Gratzer, 2020; Kurdyak and Sockalingam, 2014; CIHI, 2019a; Marchildon et al., 2020).

A closer examination of delays in accessing services in Canada is possible using the Fraser Institute’s annual report of wait times for access to psychiatry services, which is done as part of the annual *Waiting Your Turn* measurement of wait times for medical services across Canada.<sup>8</sup> The Fraser Institute data show both long and variable delays in access to psychiatric care in Canada, and they also show some deterioration in access over time, mirroring the state of access to care for medical services generally. From 2003 to 2005, the wait time for seeing a psychiatrist on an urgent basis after GP referral averaged 2.0 weeks, and grew to 2.6 weeks between 2020 and 2022 (Table 2).<sup>9</sup> For non-urgent patients, the wait time averaged 8.0 weeks from 2003 to 2005, and deteriorated to 9.2 weeks between 2020 and 2022 (Table 3). For treatment on a non-urgent basis after an initial consultation, Canadians could expect to wait an average of 10.4 weeks between 2003 and 2005, and an average of 15.5 weeks between 2020 and 2022 (Table 4). Overall, the total wait time from GP referral to treatment by a specialist deteriorated from 18.3 weeks between 2003 and 2005 to 24.7 weeks between 2020 and 2022 (Table 5).

**Table 2: Psychiatry – Average of Median Waits To See A Specialist After Referral from a GP (Urgent)**

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
2003-05 Average	2.0	2.0	2.1	2.0	2.0	1.8	3.6	1.3	—	1.8	2.0
2020-22 Average	2.9	4.3	2.8	3.1	2.3	1.9	2.5	2.8	—	2.6	2.6

Sources: Esmail and Walker, 2003; Esmail and Walker, 2004; Esmail and Walker, 2005; Barua and Moir, 2020; Barua and Moir 2021; Moir and Barua, 2022

8 The Fraser institute report remains Canada’s only national, comparable, and comprehensive measurement of wait times for medically necessary care. The first national measurement of wait times for 12 major physical specialties was conducted in 1993; psychiatry was added as a separate annual measurement in 2003.

9 The averages here are of the first three years of the study (2003-2005), and for the most recent three years of the study (2020-2022). Three-year averages are reported instead of annual figures from the first year and the most recent years of the Fraser’s survey to account for potentially low survey response rates among psychiatrists that may result in large annual swings that are unrepresentative of the true patient experience (for example, the national response rate to the psychiatry survey in 2022 was 2.8% of 4,247 psychiatrists).

**Table 3: Psychiatry – Average of Median Patient Waits To See A Specialist After Referral from a GP (Elective)**

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
2003-05 Average	8.7	8.7	11.3	6.7	7.8	7.3	20.0	7.7	—	9.3	8.0
2020-22 Average	10.0	9.7	5.5	5.7	9.3	6.8	26.0	11.0	—	30.5	9.2

Sources: Esmail and Walker, 2003; Esmail and Walker, 2004; Esmail and Walker, 2005; Barua and Moir, 2020; Barua and Moir 2021; Moir and Barua, 2022

**Table 4: Psychiatry – Average of Median Patient Waits for Treatment After Appointment With a Specialist**

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
2003-05 Average	10.2	12.9	11.8	13.8	10.0	9.1	14.9	13.4	—	11.4	10.4
2020-22 Average	13.6	18.0	7.1	16.6	14.5	16.4	22.1	22.6	—	17.7	15.5

Sources: Esmail and Walker, 2003; Esmail and Walker, 2004; Esmail and Walker, 2005; Barua and Moir, 2020; Barua and Moir 2021; Moir and Barua, 2022

**Table 5: Psychiatry – Average of Median Weeks Waited from Referral by GP To Treatment**

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
2003-05 Average	18.9	21.6	23.2	20.5	17.8	16.4	34.9	21.1	—	20.8	18.3
2020-22 Average	23.6	27.7	12.6	22.3	23.8	23.2	50.0	33.6	—	48.2	24.7

Sources: Esmail and Walker, 2003; Esmail and Walker, 2004; Esmail and Walker, 2005; Barua and Moir, 2020; Barua and Moir 2021; Moir and Barua, 2022

There are noteworthy differences in delay among the provinces. Wait times for access to care tend to be longer in the Atlantic provinces than elsewhere in Canada, and patients in Nova Scotia and Newfoundland also experienced the largest deteriorations in the total wait (after GP referral to treatment by a specialist) over time. Manitoba (9%) saw the smallest deterioration in the total wait times between the periods 2003 to 2005 and 2020 to 2022, while wait times in Saskatchewan improved.

These far-ranging concerns about access to appropriate care and provider preparedness, paired with notable delays, raise important questions about Canada's current approach to mental health care and how policies might be improved. Is the current structure of the mental health system focused on the individual experiencing mental ill-health, i.e., is it patient centred? Are patients in Canada receiving evidence-based services, respectfully, close to their communities, in safe settings, and in a timely fashion, both when in crisis and when not in crisis? Is the current approach to mental health

care encouraging patients to return to work or education? Is it connecting individuals to appropriate services tailored to their specific needs and preferences? Are health care providers in Canada working to also prevent mental illness and promote wellbeing, and are they providing first responders the tools to recognize and respond to mental distress? How easy is it for Canadians to seek help for mental ill health? Is the Canadian system able to innovate and adapt to new research and approaches?

A valuable starting point to answering these broader questions about mental health policy is to address the important and obvious question about how Canada's performance compares with those of other developed nations that share Canada's goal of universal access to health care and health care insurance. How are Canadians faring under the current mental health care system, and what is the demand or need for mental health services in Canada? Are other nations able to deliver more and better care to their populations than Canada is for similar expenditures, or has Canada's approach generated outcomes that are at least equal to those other nations have achieved in the area of mental health care?

## How Good is Mental Health Care in Canada?

Health data from the Organisation for Economic Co-Operation and Development (OECD), the Canadian Institute for Health Information (CIHI) and the Commonwealth Fund permit a comparison of Canada's mental care health system with other mental health care systems in the developed world. It should be noted that these data are neither as comprehensive nor as broad as the comparative data available for comparisons of health system performance as a whole, limiting the ability to build a value for money or spending/performance framework along the lines of Moir and Barua (2021). The information available can nevertheless provide valuable insight into how well Canada's governments have been performing in meeting the needs of those with mental illness or serious mental health concerns, and how well resourced its health care system is relative to those of its peers internationally.

To select a peer group of nations for comparison in the broader data sets from the OECD, this paper follows Moir and Barua's methodology (2021) as employed in their international comparison of the performance of Canada's health care system. In order to be considered a peer nation for Canada and included for comparison, following the Moir and Barua approach, countries must meet the following three criteria:

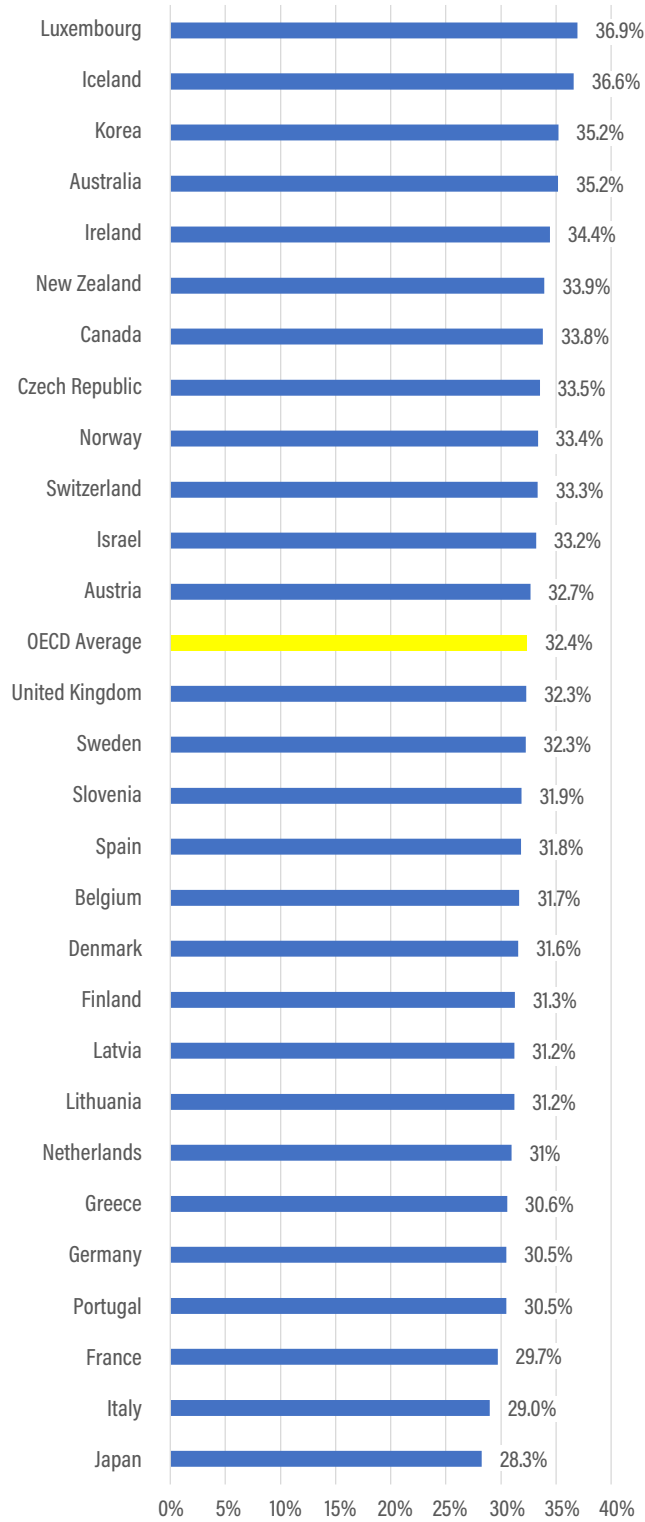
1. They must be a member nation of the OECD;
2. They must have universal (or near universal) coverage for core medical services;
3. They must, according to the World Bank, be considered a higher-income country with a gross national per capita income of at least US\$12,535 in 2019.

In the Moir and Barua comparison, seven of the 36 OECD countries in 2019—Chile, Estonia, Hungary, Mexico, Poland, the Slovak Republic, and the United States—were removed from the comparison because they did not have universal (or near universal) coverage for core medical services. Turkey did not meet the higher-income criteria. This leaves 28 higher-income nations with universal access health care systems that can serve as comparators for the Canadian health care system.

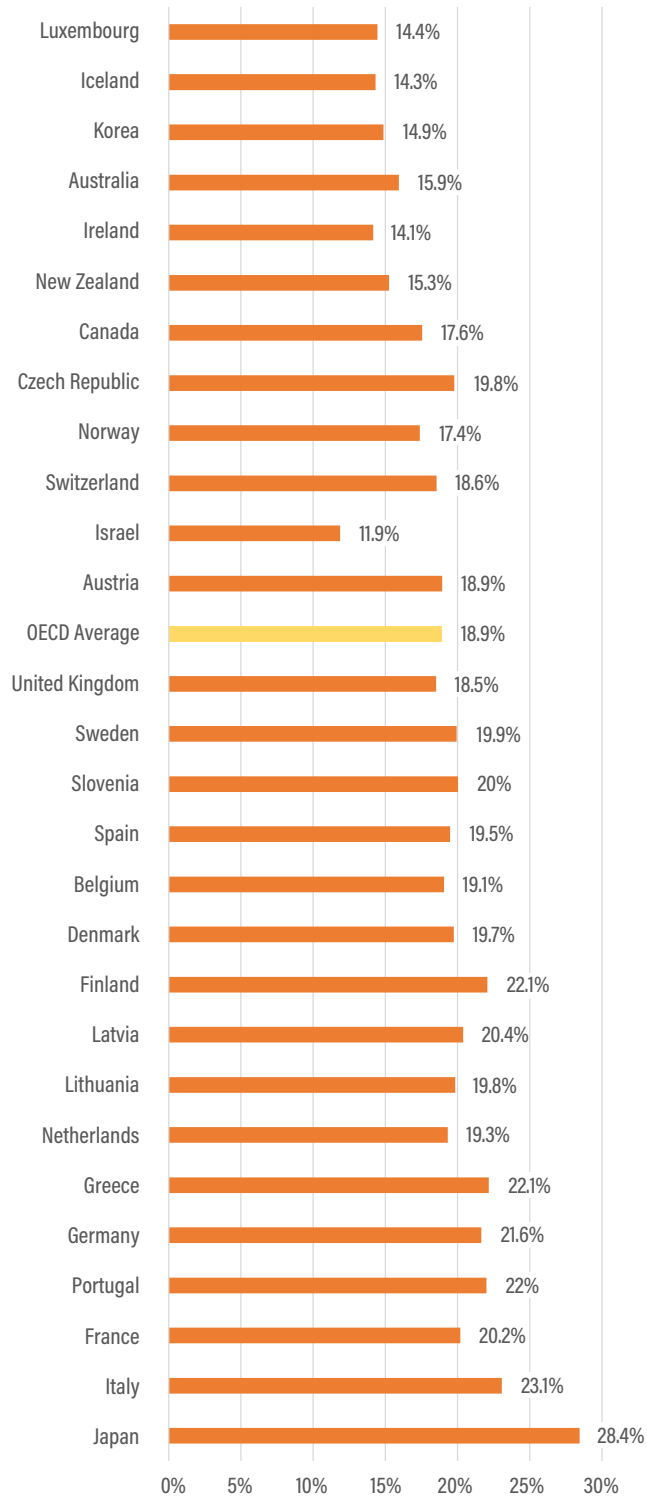


Reflecting the more limited availability of data measuring the performance of mental health care systems, the number of countries reporting data is also often limited for the measures that are available. The Commonwealth Fund and CIHI data focus on the 10 countries with universal health care systems participating in the Commonwealth Fund's International Health Policy surveys: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Switzerland, Sweden, and the UK. The Commonwealth Fund surveys also include responses for the United States that have not been included in the discussion here. Due to survey response sample-size limitations and other survey-related concerns, data are not reported for all 10 countries for all the measures discussed below. The OECD data below are not available for all 28 higher-income nations for all measures due to limitations in data availability and national measurement/reporting. The figures below reporting OECD data include all 28 nations for which data was available for each measure.

Unlike the framework for health system performance in Moir and Barua (2021), measures of resource availability and spending presented in the figures below are not adjusted for differences in the relative ages of national populations. This approach is adopted due to age differences in the higher need or higher demand population for mental health services relative to demand for health services as a whole, as well as in response to the relatively limited availability of data noted above. Moir and Barua correctly adjust broader health spending and access data for the relative ages of populations, recognizing that Canada's relatively young population can be expected to require fewer services, in comparison with the older populations elsewhere in the developed world (Barua and Moir, 2021; Globerman, 2021). This approach cannot be directly replicated here as mental illness and mental health concerns tend to have a higher prevalence among young adults, and the prevalence is lower at more advanced ages (MHCC, 2013; CIHI, 2021; CIHI, 2019a; British Columbia, 2017). An examination of the differences in the higher-need population for mental health services finds less variation between nations than is found among elderly populations: The share of population aged 20 to 44 in the group of peer nations with universal-access health care systems ranges from 28 to 37%, with most nations clustered around the average of 32%, while the averages among old age populations vary from 12 to 28% of the population (chart 1).

**Chart 1a: Population aged 20-44 as a share of total population, 2019**

Source: OECD (nd), calculations by author

**Chart 1b: Population aged 65+ as a share of total population, 2019**

Source: OECD (nd), calculations by author

The international comparisons below are separated into three sections: prevalence, experience, and resources. Prevalence indicators provide insight into the demand for mental health care services, how well those with mental health needs are identified (assuming similar population rates of actual incidence) and, to a lesser extent, the effectiveness of preventative measures and early interventions (which may appear as differences in incidence rates). Experience indicators provide insight into the efficacy of care being provided to those already utilizing the system, as well as those who might benefit from services. Resource indicators provide insight into the physical and human resources available for ongoing care, as well as potential treatment options.

### Prevalence Indicators

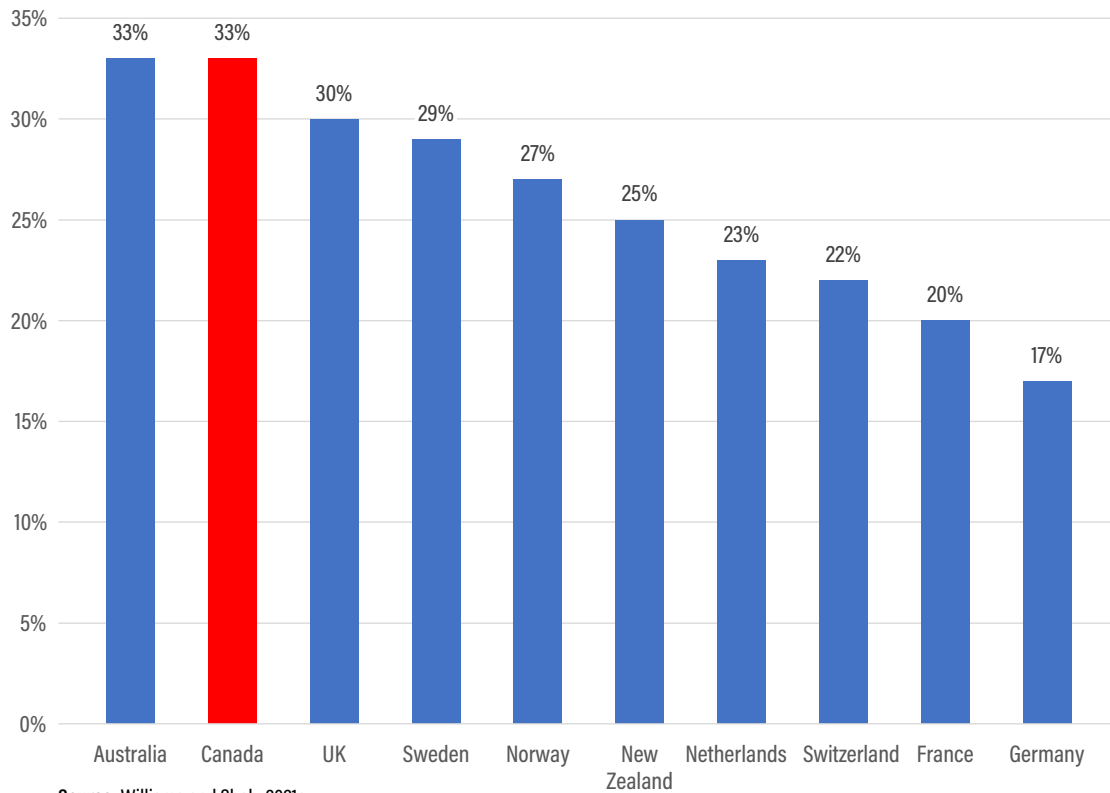
It has been suggested that 1 in 5 Canadians experiences a mental illness in Canada each year,<sup>10</sup> although these may not necessarily be treated or even addressed medically. The prevalence is higher among young adults and those in their early and prime working years. As many as 1 in 2 Canadians reports they have experienced or are experiencing mental illness (not necessarily treated medically) by age 40, while nearly 70% of serious mental health issues become apparent prior to age 25 (MHCC, 2013; CIHI, 2019a; British Columbia, 2017). Data from the Commonwealth Fund's 2020 international health policy survey broadly support these findings, revealing that 33% of Canadians reported a mental health need in 2020, either being told they had depression, anxiety, or other mental health conditions, or having needed to speak with a health care professional about their mental health, in the past 12 months (Chart 2). Canada tied with Australia for the highest rates of the 10 countries studied. Canadians were second most likely (26%) to report having been told by a doctor they had a mental health condition (Chart 3). The largest proportion of Canadians reporting a physician-diagnosed mental health condition came from the 25 to 34 age group (36%), followed by 18 to 24-year-olds (31%) and those aged 35 to 64 (27%). Seniors represented the smallest proportion (14%) of positive responses to this question (CIHI, 2021).<sup>11</sup>

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10 See, for example, Smetanin et al., 2011.

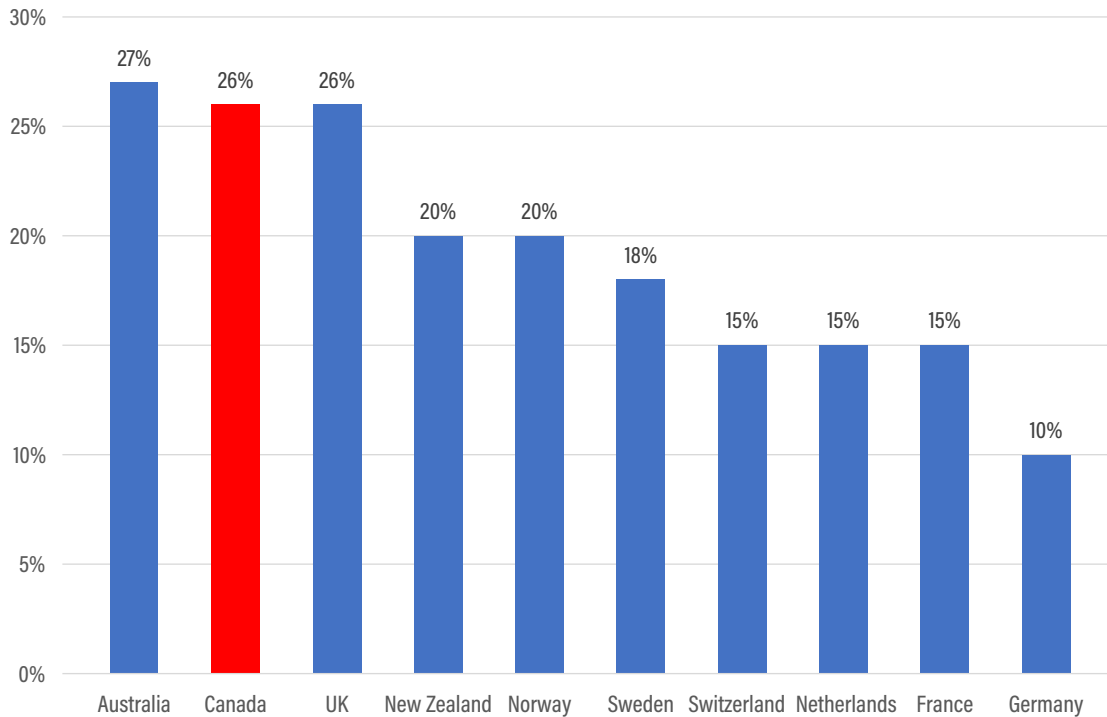
11 This may also reflect differences in willingness to respond to survey questions among different age groups.

**Chart 2: Percentage of adults (18+) who reported a mental health need, 2020**



Source: Williams and Shah, 2021a

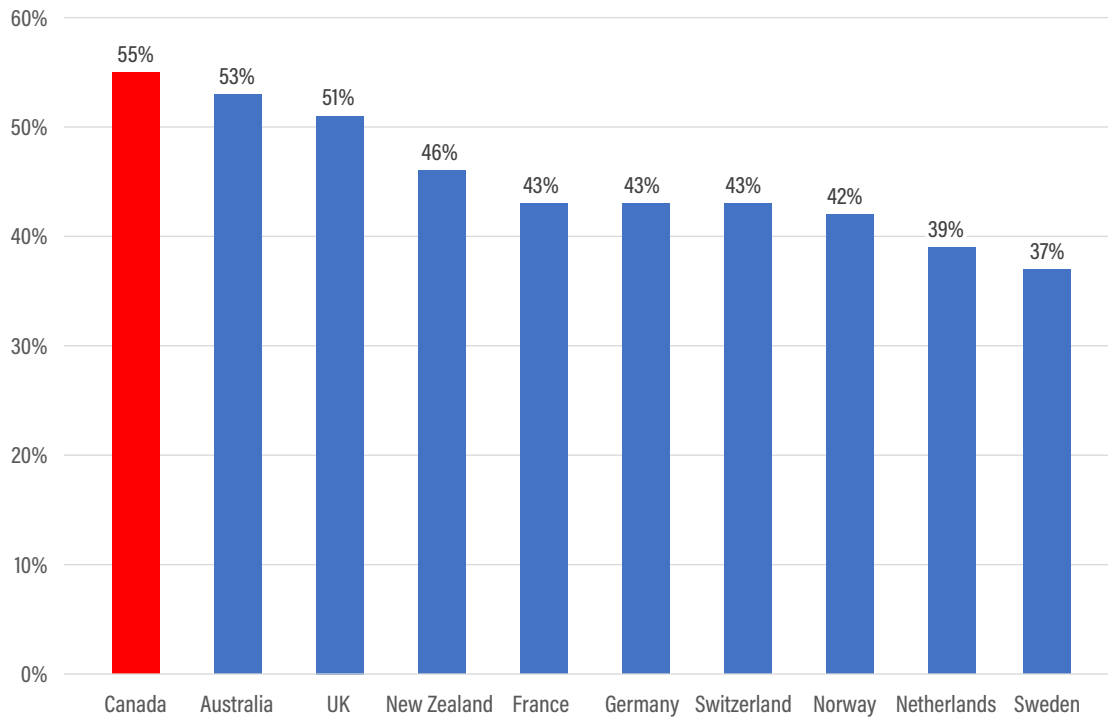
**Chart 3: Percentage of respondents told by a doctor they have depression, anxiety, or another mental health condition, 2020**



Source: CIHI, 2021

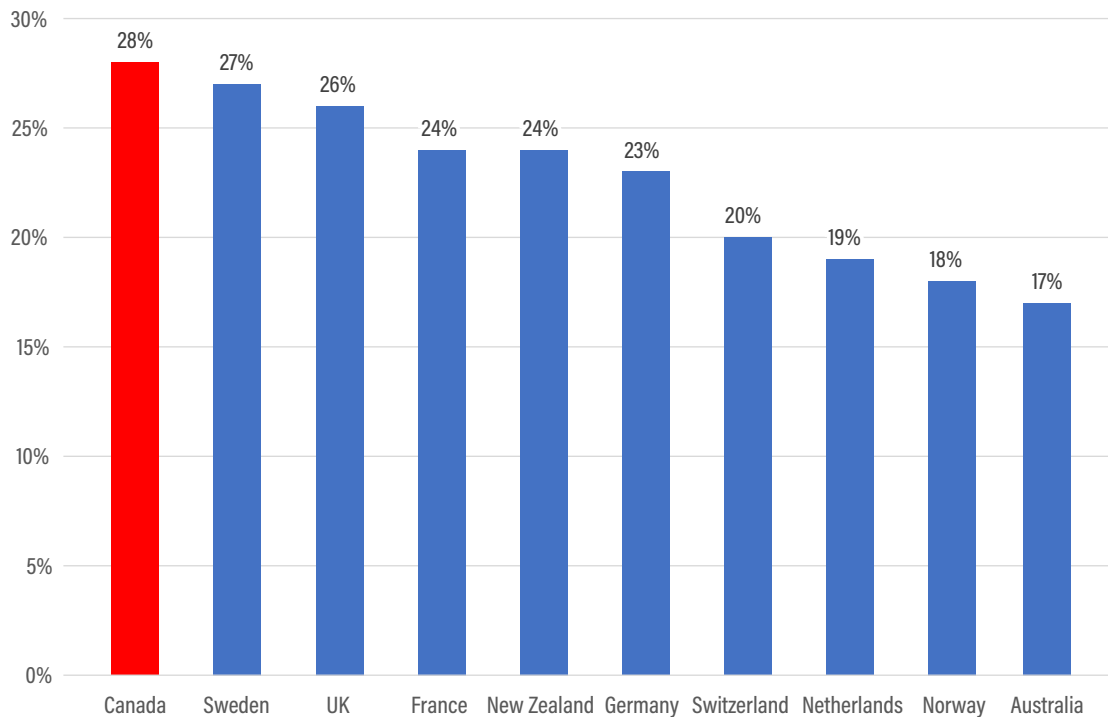
The Commonwealth Fund's survey results indicate that, generally, those reporting mental health needs tend to also experience other chronic conditions and require prescription medications. Specifically, 55% of Canadians with a mental health need reported they had 2 or more chronic conditions in 2020, and 28% reported regularly taking four or more prescription medications (Chart 4 and Chart 5). Again, Canada ranks among the highest of the 10 countries studied by the Commonwealth Fund for these measures.

**Chart 4: Percentage of adults (18+) who had two or more chronic conditions, among those who reported a mental health need, 2020**



Source: Williams and Shah, 2021a

**Chart 5: Percentage of adults (18+) who reported regularly taking four or more prescription medications, among those who reported a mental health need, 2020**



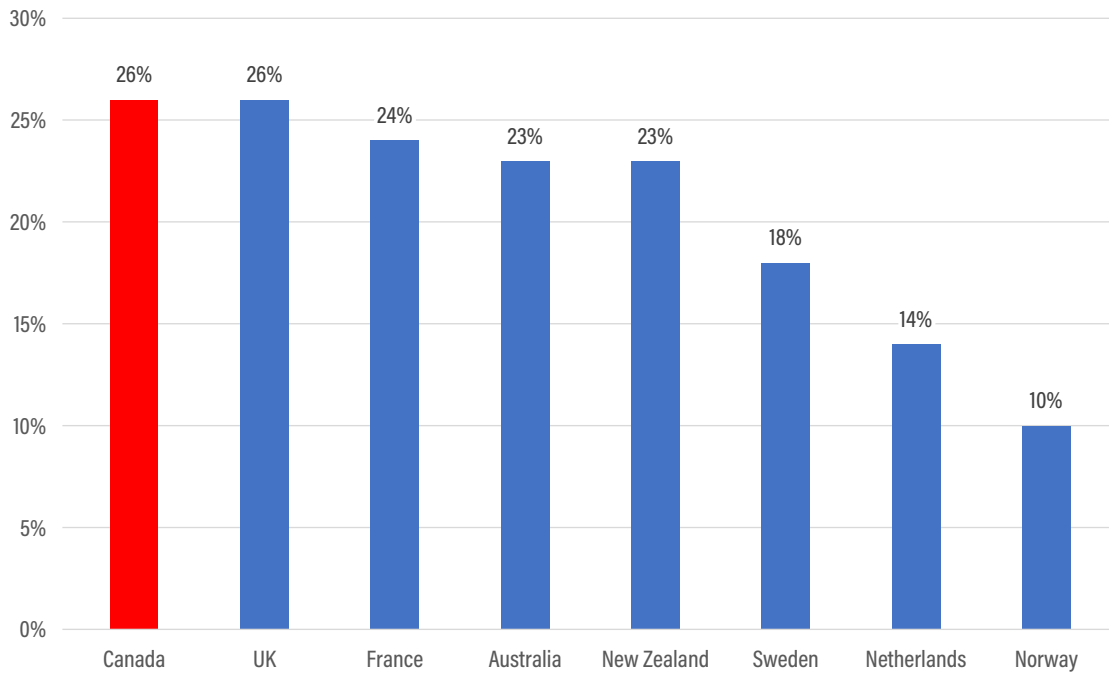
Source: Williams and Shah, 2021a

The Commonwealth Fund survey data was collected between February and May 2020, which allows us to look more closely at the impact of the early pandemic on the health and well-being of individuals.<sup>12</sup> In 2020, Canadians were among those that had the highest percentage of adults to report experiencing stress, anxiety, or great sadness that was difficult to cope with alone (Chart 6). At 26%, Canadians tied with respondents in the UK in being the most likely to report these feelings, while Norwegians (10%), the Dutch (14%), and Swedes (18%) were least likely.

12 This data also allows some insight into the impact of differences between nations' government interventions, including lockdowns and changes in access to physician and hospital health care services, among other interventions.



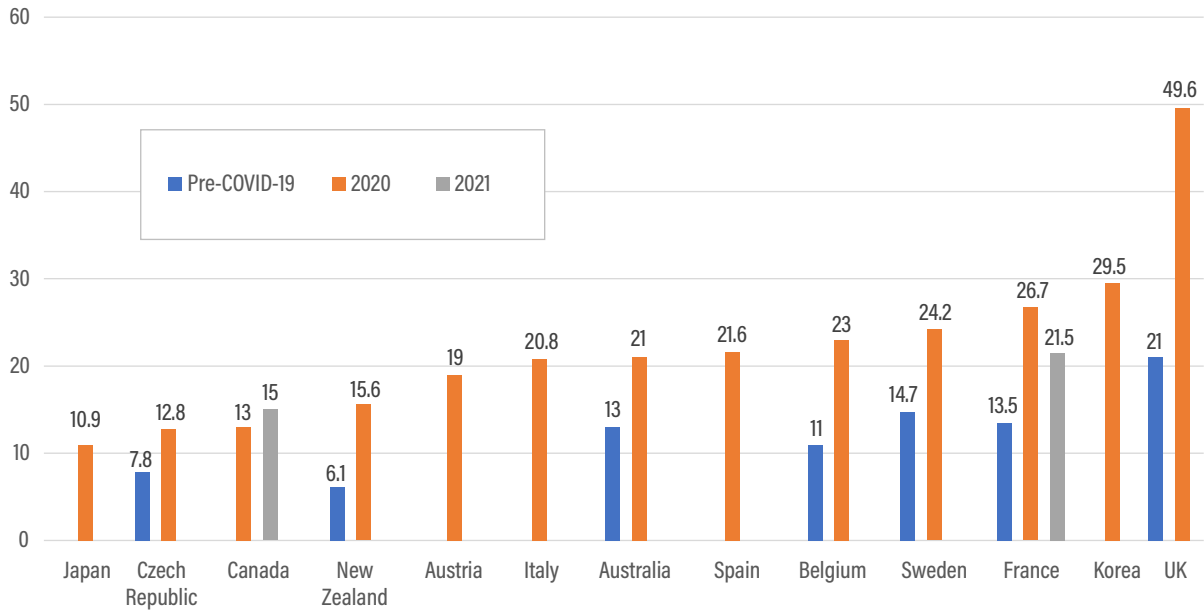
**Chart 6a: Percentage of adults who reported experiencing stress, anxiety, or great sadness that was difficult to cope with alone since the covid-19 outbreak started, 2020**



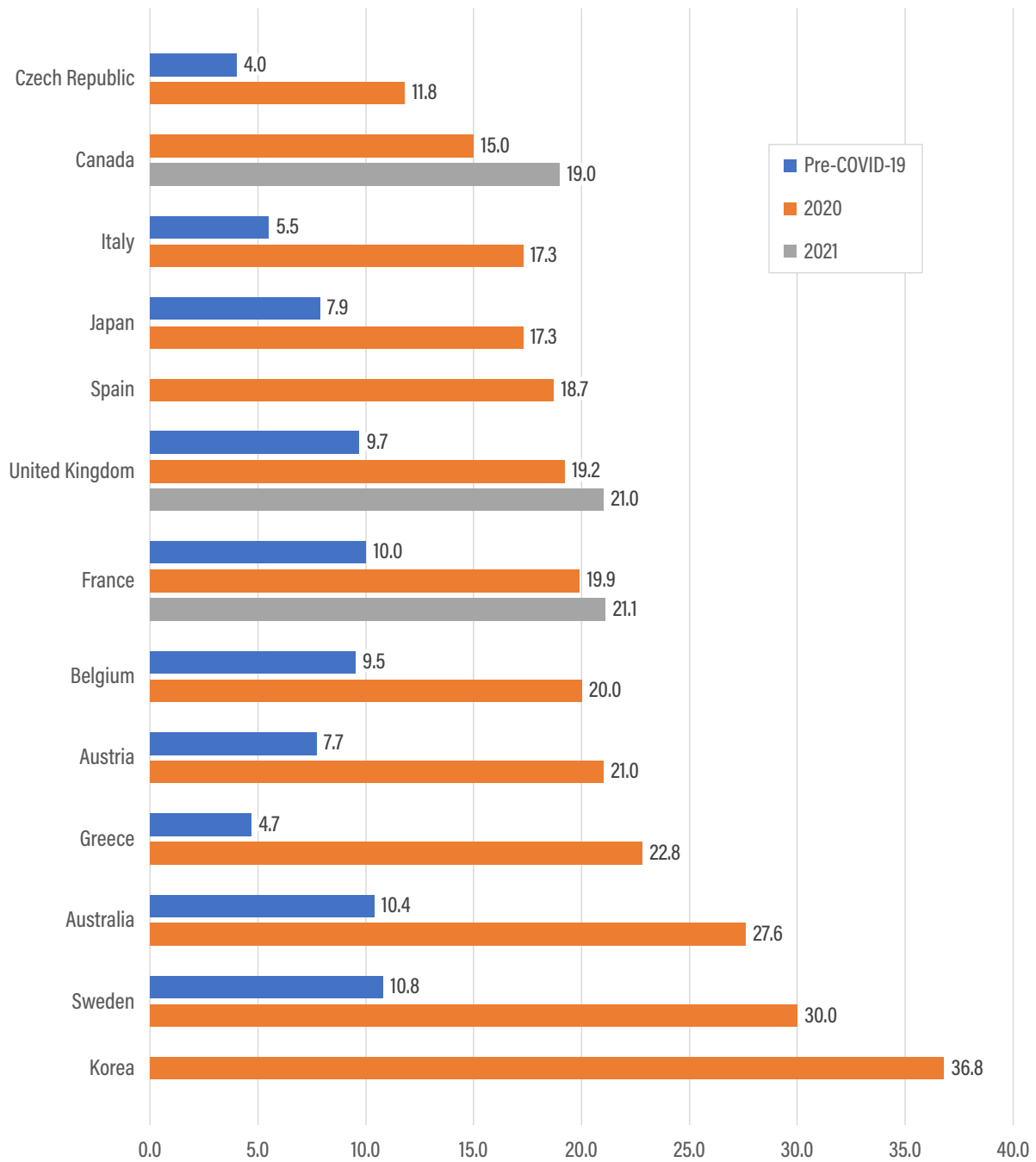
Source: Hostetter, 2021

Data from the OECD provides additional insight into changes in the estimated prevalence of anxiety and depression among residents of developed nations with universal-access health care systems around the COVID-19 pandemic. In nearly all of the nations studied for which data were available, with the notable exception of anxiety in France, the estimated prevalence of symptoms of anxiety and depression increased between the pre-COVID-19 period, 2020 and 2021 (Chart 6 and Chart 7). In this comparison of national data sources compiled by the OECD, Canadians were among the least likely in each of the years studied to experience depression or anxiety, in comparison with their counterparts in other developed nations.

**Chart 6b: National estimates of prevalence of anxiety or symptoms of anxiety, pre-COVID-19 in 2020, and 2021**



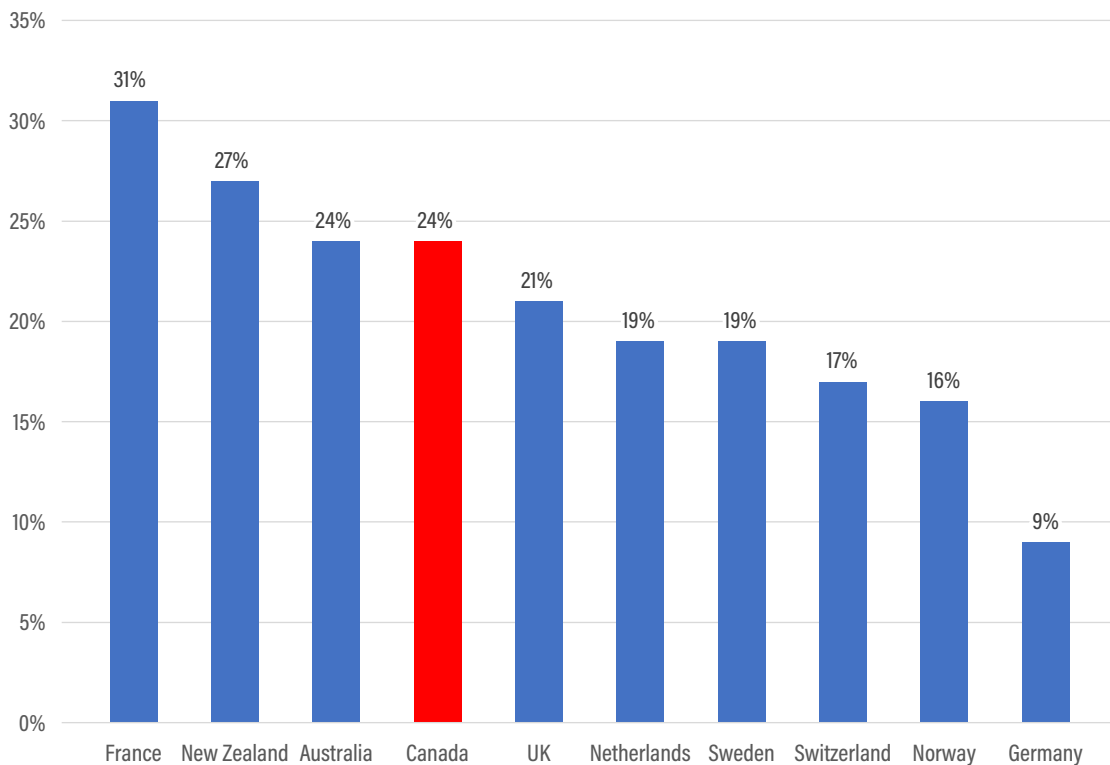
**Chart 7: National estimates of prevalence of depression or symptoms of depression, pre-COVID-19 in 2020, and 2021**



Source: OECD, 2021b

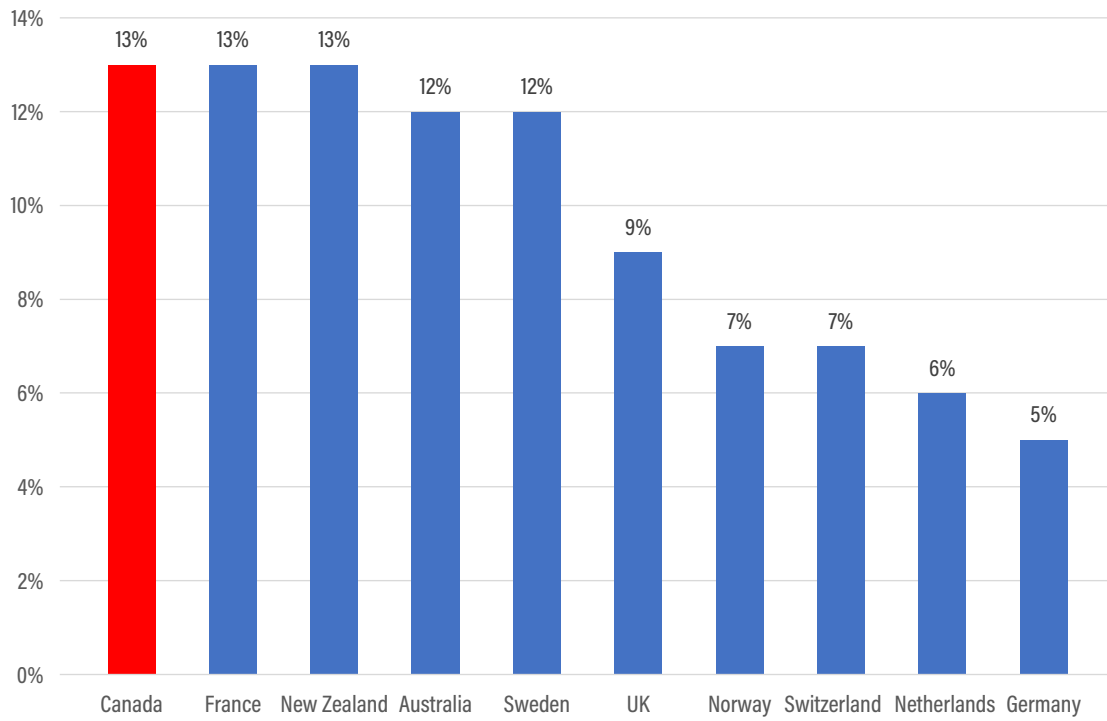
Canada’s seniors overall appear to be doing better than the Canadian population as a whole, in comparison with their peers in other higher income nations. The Commonwealth Fund’s 2021 survey of older individuals found that Canadian seniors (those aged 65+) ranked mid-pack in their reporting of mental health needs (Chart 8), ranked close to several nations in their reporting of being told by a doctor they have a mental health condition (Chart 9), and ranked mid-pack in reporting facing emotional distress that was difficult to cope with alone in the past 12 months (Chart 10). Canadian seniors with mental health needs did report relatively greater worry about their financial position, however, with 12% of adults over 65 in Canada reporting being usually or always worried or stressed about material hardship (Chart 11). This compared with 20% of Swiss respondents at the upper end, and to 4% of respondents in the UK and the Netherlands, and 5% in Germany, at the low end.

**Chart 8: Percentage of adults 65+ who reported a mental health need, 2021**



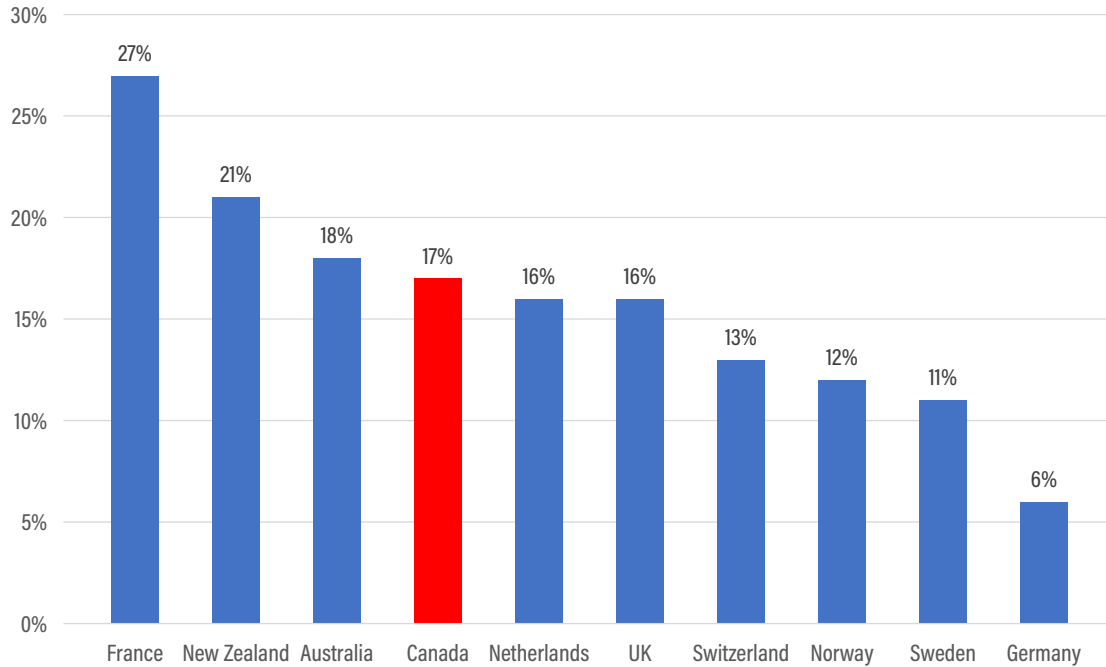
Source: Gunja, Shah, and Williams, 2022

**Chart 9: Percentage of adults 65+ who were told by a doctor they have depression, anxiety, or other mental health conditions, 2021**



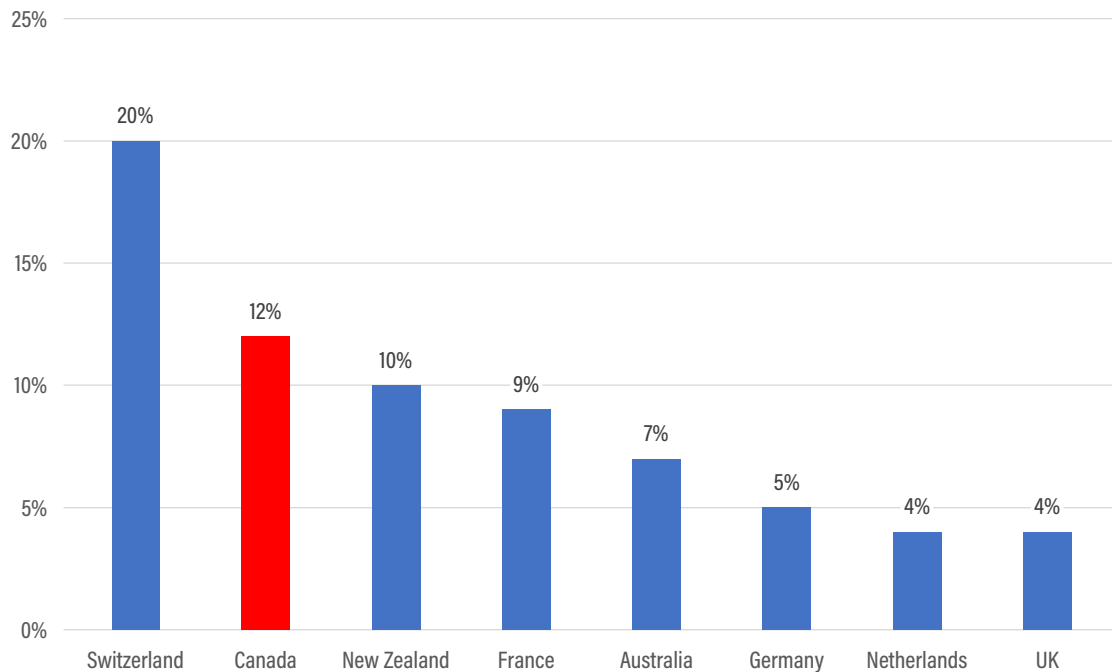
Source: Gunja, Shah, and Williams, 2022

**Chart 10: Percentage of adults 65+ who reported experiencing emotional distress such as anxiety or great sadness that they found difficult to cope with by themselves in the past 12 months, 2021**



Source: Gunja, Shah, and Williams, 2022

**Chart 11: Percentage of adults 65+ with a mental health need who reported being always or usually worried or stressed about a material hardship in the past 12 months, 2021**



Source: Gunja, Shah, and Williams, 2022

Overall, the comparative data on prevalence from the Commonwealth Fund point to a large number of Canadians who are either actively seeking treatment or who may benefit from it. These patients are also likely to have complex general health needs in combination with their mental health needs. This is noteworthy as those with mental health needs have been found to be less likely to seek and receive necessary medical care generally (see, for example, Colton and Manderscheid, 2006; Mitchell et al., 2009; and Knaak et al., 2017).

### Experience Indicators

Suicide rates can provide some insight into the state of mental health and illness in a population. While suicide is not a proxy for mental illness, and suicide rates are not driven only by mental health and untreated mental ill-health, suicide can also result from psychiatric disorders and psychological traits. Mental health and illness interventions (both medical and nonmedical) may have a positive impact on individuals at risk of self-harm, and administering to individuals' mental health needs has contributed to

improved outcomes for those at risk of self-harm.<sup>13</sup> Notably, most developed nations maintain suicide prevention or reduction plans and programs, either as a standalone project or as part of mental health plans and policies (OECD, 2021a).

In comparison with other higher income developed nations that share Canada's goal of universal access to care, the suicide rate among Canadians was statistically not different from the average in 2019 (Chart 12). However, the rate of improvement in the suicide rate in Canada between 2009 and 2019 was below the average, with an 8% improvement over that time frame compared with the average improvement of 11% (Chart 13).<sup>14,15</sup> Canada also does not compare well with other developed nations in the rate of inpatient suicide among patients with a psychiatric disorder, a “never event” that should be preventable through organizational processes, designs, checks, and balances (Chart 14).

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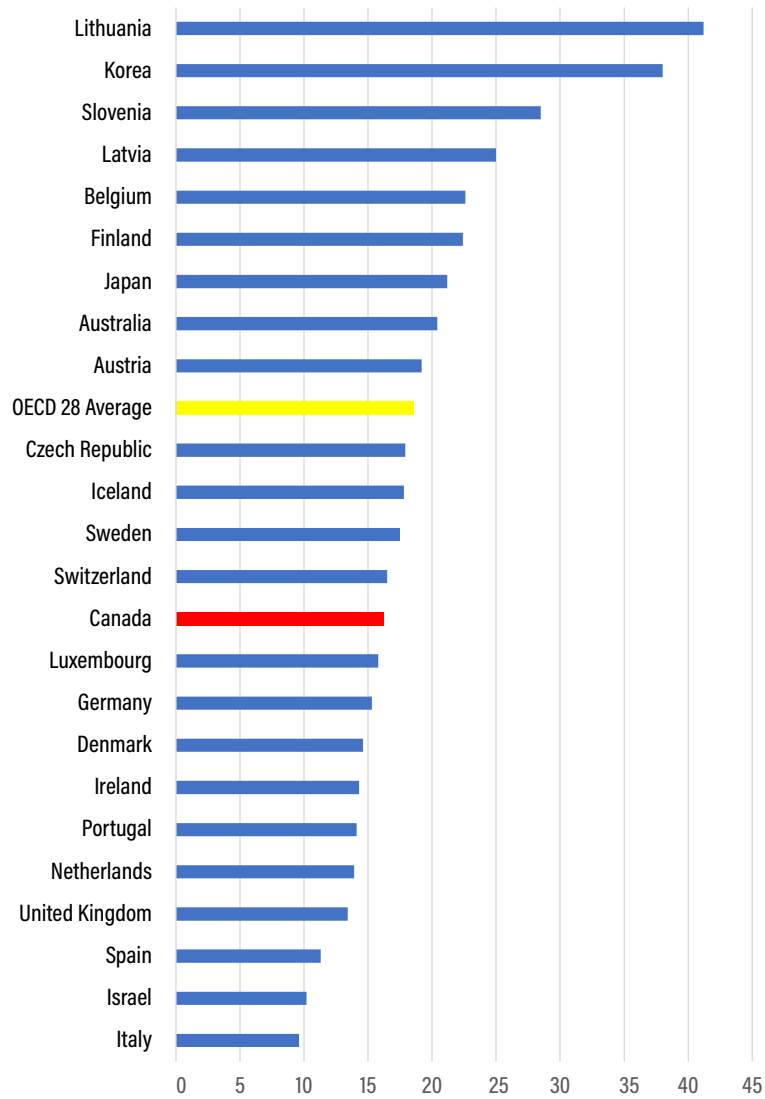
13 Suicide rates are also positively correlated with a number of other important individual characteristics, including being male, being from an ethnic minority or indigenous, and identifying as LGBTQ+ (MHCC, 2018).

14 The OECD defines suicide rates as “deaths deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome” (OECD, n.d). As nations vary in their determination of intent, the application of forensic investigations, confidentiality provisions, and responsibilities for recording, there may be variations in suicide rates that are the result of differences in measurement rather than differences in self-harm rates.

15 This below-average performance in the rate of change over time was also calculated over a longer time horizon, between 1998 and 2018, when the Canadian rate improved by 10%, compared with the average among peer nations of 23% (OECD, 2021a; calculations by author).

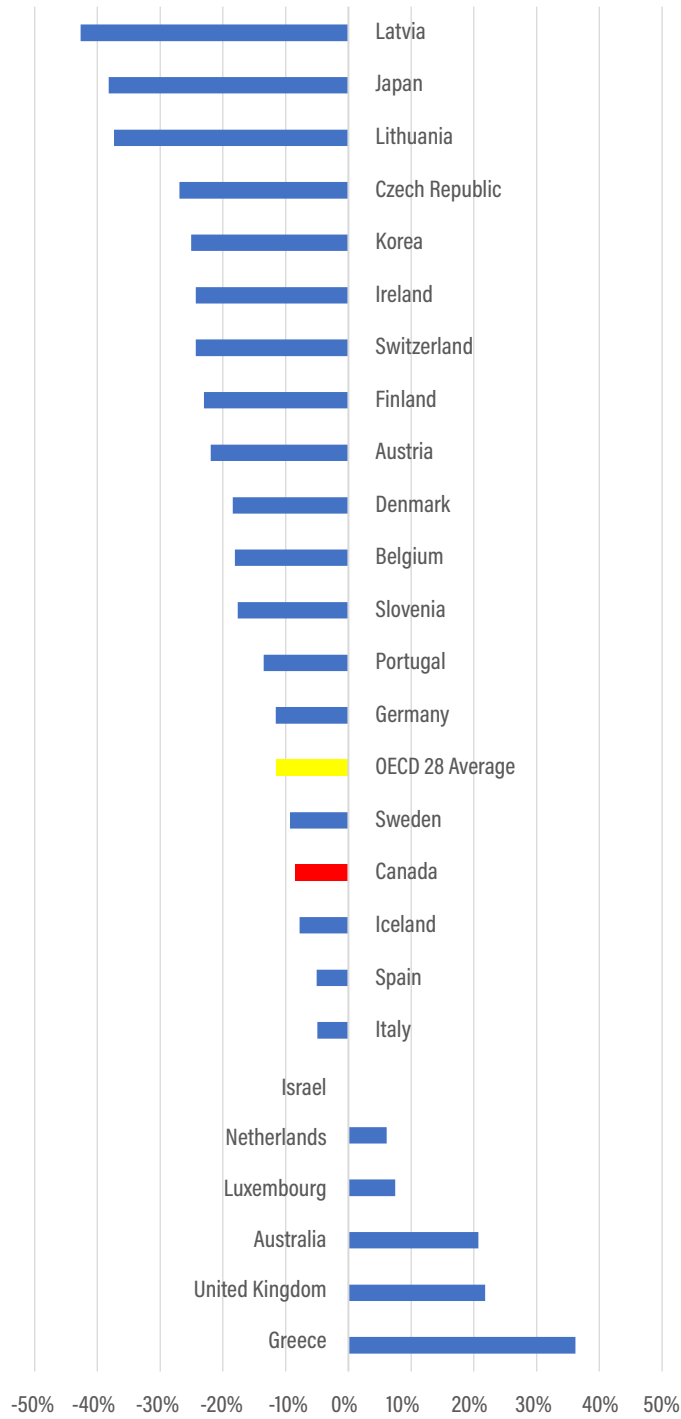


**Chart 12: Suicide rate per 100,000 persons, 2019 or nearest year**



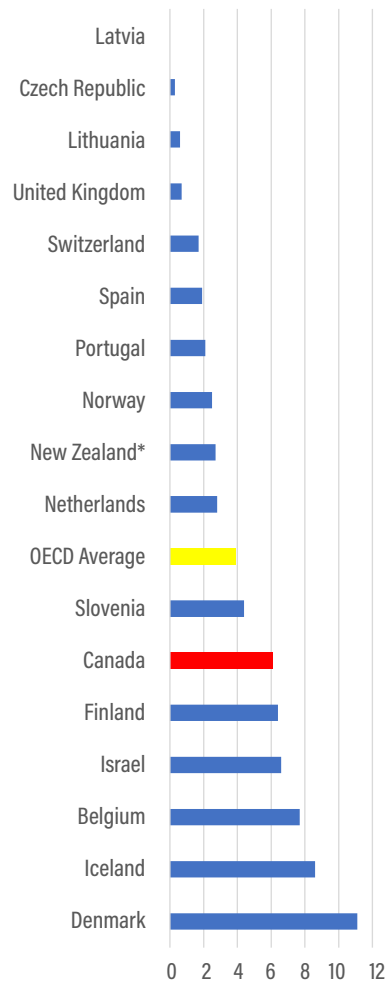
Source: OECD (nd)

**Chart 13: Change in suicide rate, 2009 to 2019 (% change)**



Source: OECD (nd)

**Chart 14: Suicide among in-patients with a psychiatric disorder, age-sex standardized three-year average, 2015-2017**



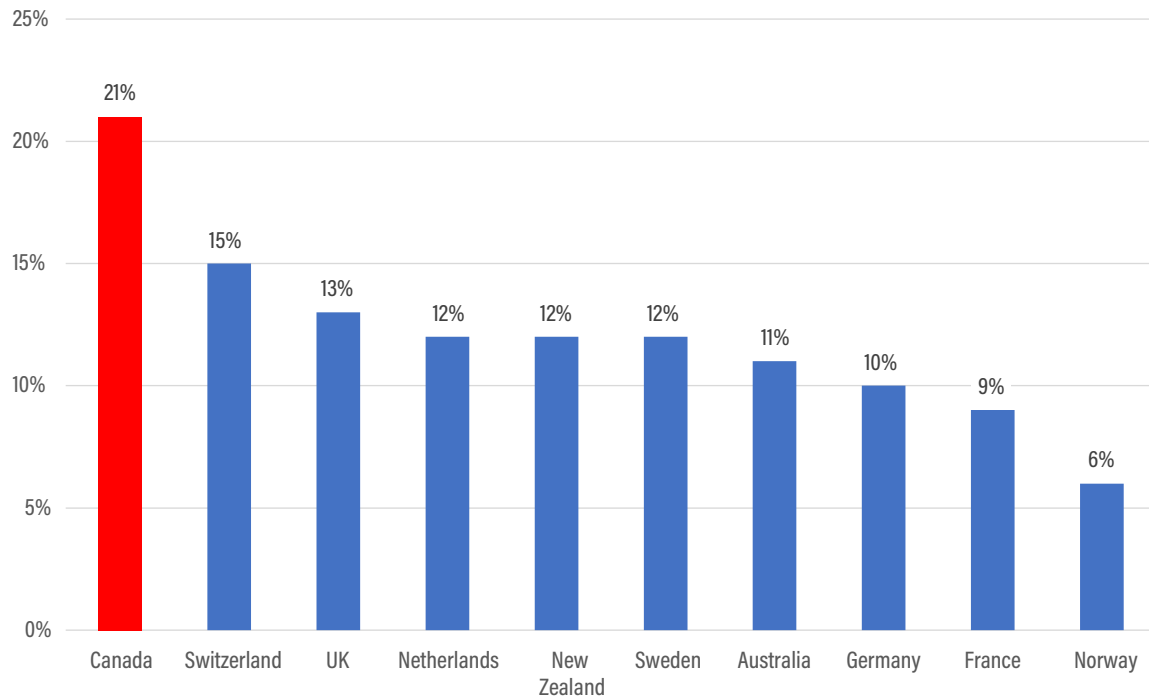
Source: OECD, 2021a

\* New Zealand data are not a three year average

Canadians who reported a mental health need were far more likely than their peers, according to the international Commonwealth Fund survey, to report using the ER for care that could have been provided by their regular doctor (Chart 15).<sup>16</sup> Twenty-one percent of Canadians reported seeking care in the ER, compared with 15% of Swiss respondents, 10% of German respondents, 9% of French respondents, and 6% of respondents in Norway.

16 This finding echoes Canadians' relatively higher reliance on emergency rooms for primary care in general health services (CIHI, 2021).

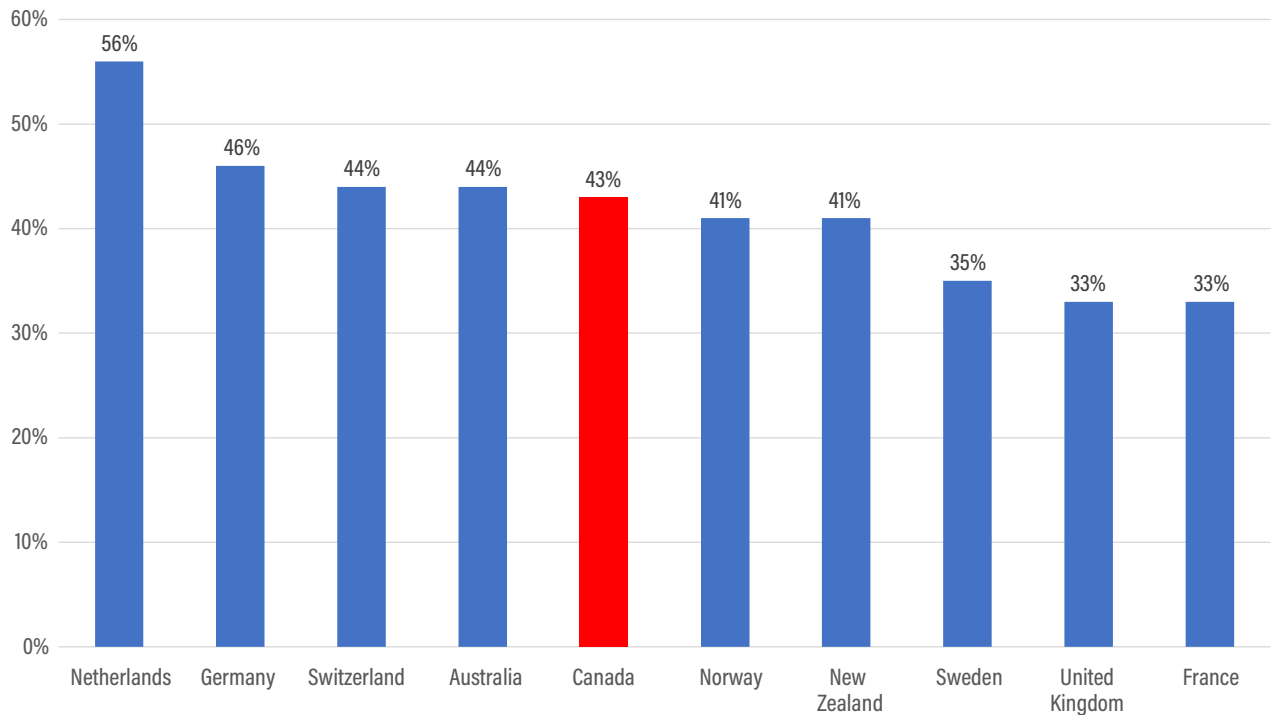
**Chart 15: Percentage of adults (18+) who used the emergency room for care that could have been provided by a regular doctor or place of care, among those who reported a mental health need, 2020**



Source: Williams and Shah, 2021a

Canadians ranked mid-pack when it came to the question of receiving treatment for their mental health need, with most nations reporting figures similar to the Canadian percentage (Chart 16). In 2020, 43% of Canadian respondents who reported a mental health need reported receiving counselling or treatment, compared with 56% of Dutch respondents, at the high end, and 33% of respondents in the UK and France, at the low end.

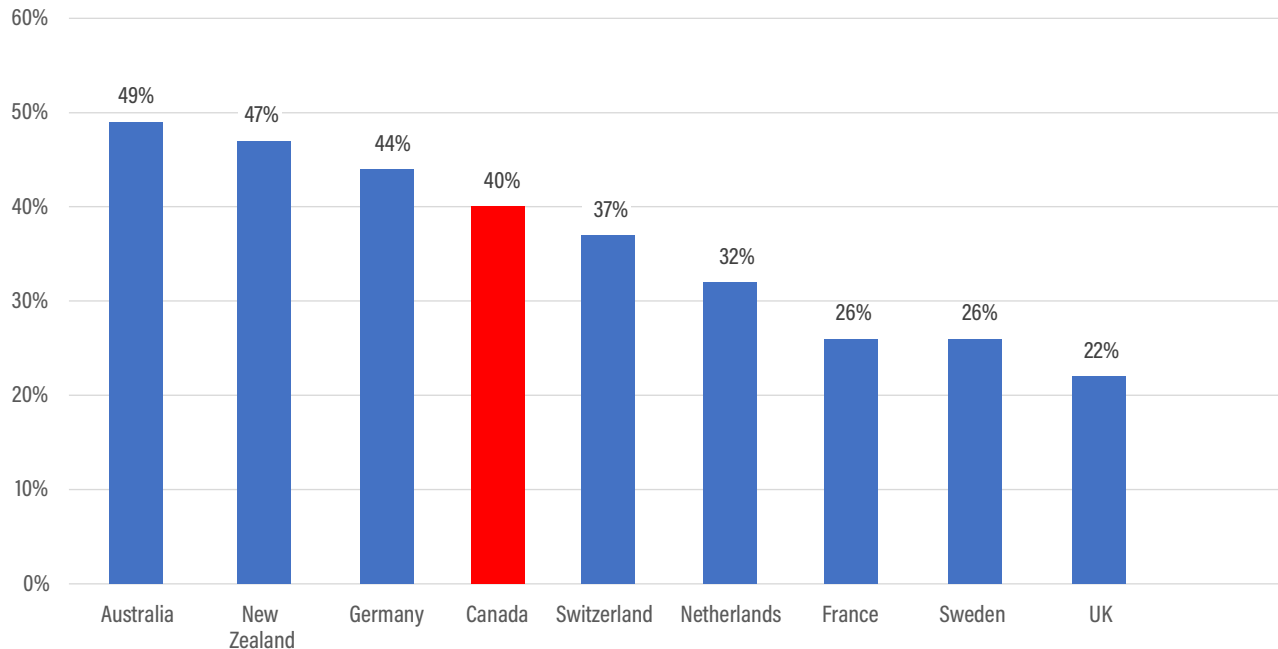
**Chart 16: Respondents who received any counselling or treatment for mental health, among those who reported a mental health need, 2020**



Source: CIHI, 2021

Canadian seniors also ranked mid-range in their use of professional services. Among Canadian seniors, 40% reported having received help or currently seeing a professional for depression, anxiety, or other mental health conditions in 2021 (Chart 17). This placed Canada 5<sup>th</sup> of the 9 nations for which data were reported from the survey, with Australians (49%) being most likely to have received or be receiving help, and residents of France and Sweden (26%) and the UK (22%) being least likely.

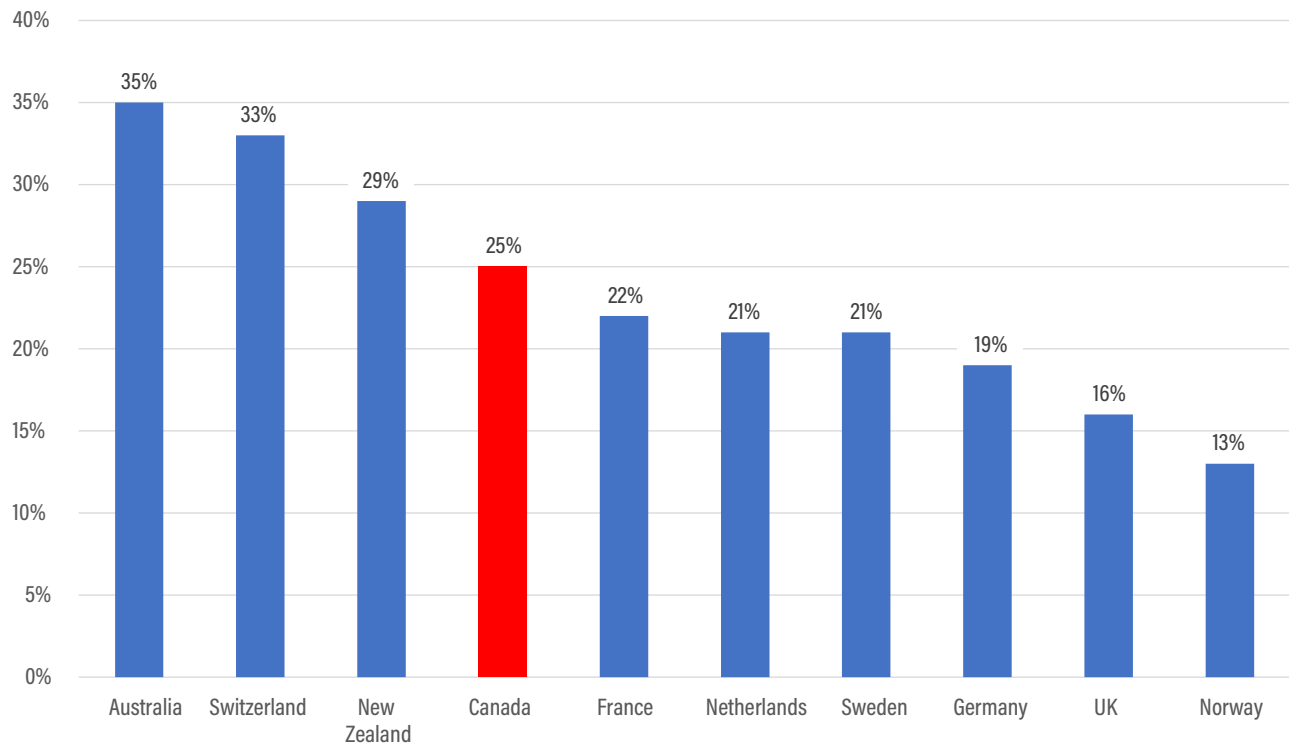
**Chart 17: Percentage of adults 65+ who have received help from a professional when they experienced emotional distress, or are currently receiving treatment or seeing a health professional to help manage depression, anxiety, or other mental health condition, 2021**



Source: Gunja, Shah, and Williams, 2022

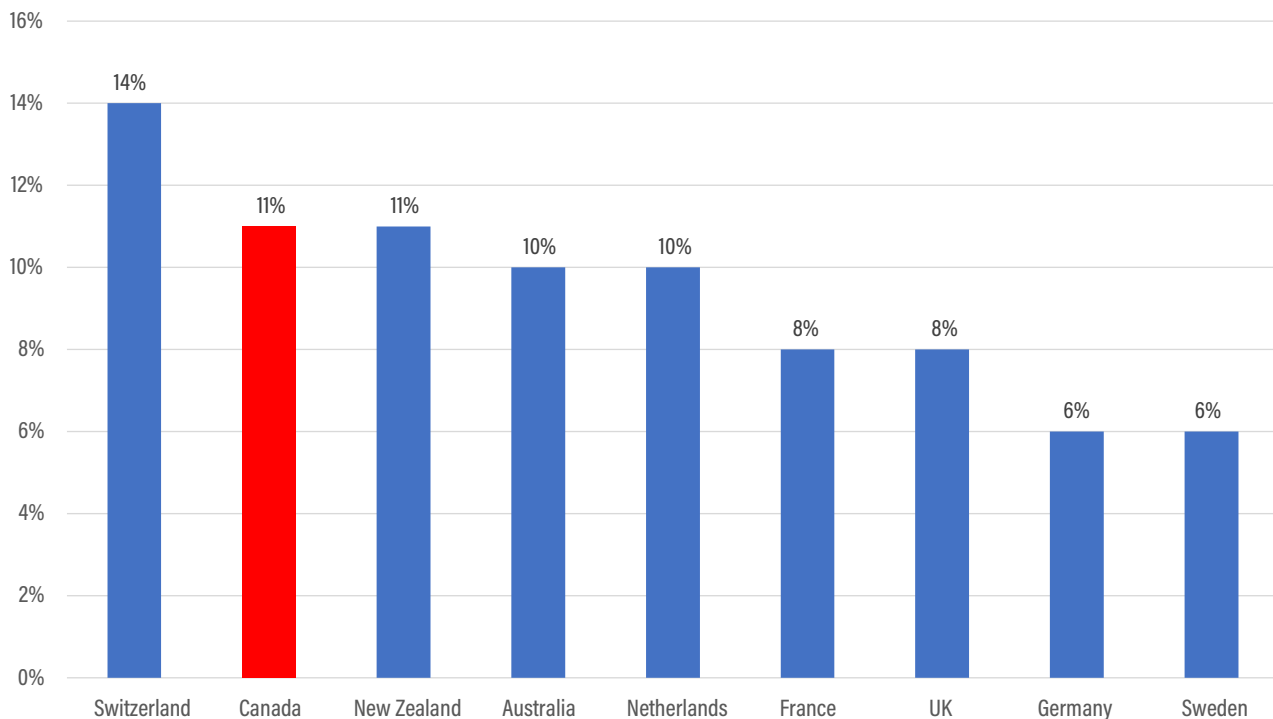
Canadians ranked mid-pack according to the Commonwealth Fund surveys for reporting cost-related health care access problems, both among the general adult population and among seniors specifically. Twenty-five percent of Canadian adults with a mental health need reported cost-related access problems in 2020, compared with 35% of Australian respondents, 19% of German respondents, 16% of UK respondents, and 13% of respondents in Norway (Chart 18). Among Canadian seniors, 11% reported similar concerns, compared with 14% of Swiss seniors, 8% of UK seniors, and 6% of seniors in Germany and Sweden (Chart 19). Canadian seniors with a mental health condition were more likely than those with no mental health condition to report cost barriers and financial distress in 2020 (CIHI, 2021).

**Chart 18: Percentage of adults 18+ with a mental health need who reported any cost-related health care access problem, 2020**



Source: Williams and Shah, 2021a

**Chart 19: Percentage of adults 65+ with a mental health need who reported any cost-related health care access problem, 2021**

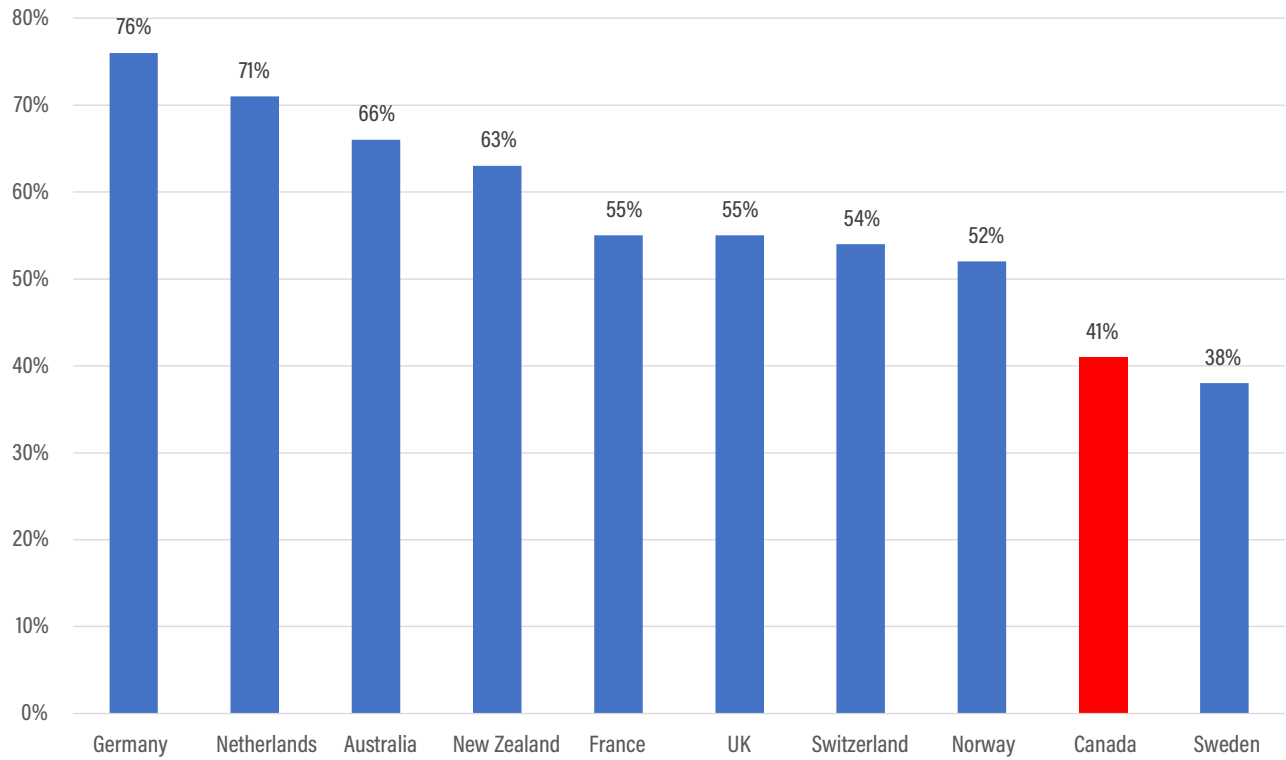


Source: Gunja, Shah, and Williams, 2022

Delays in accessing health services generally have long been identified as an important shortcoming of the Canadian health care system (see, for example, Moir and Barua, 2021). While there is a dearth of international comparative data on delays in accessing mental health care services specifically, some data are available regarding timely access to primary care services, the most common point of first contact for those seeking mental health care. It is also the level of care at which a sizable portion of mental health care services are delivered in Canada. Survey data from the Commonwealth Fund shows Canadians were the 2nd least likely among respondents from 10 higher-income countries to report being able to get a primary-care appointment on the same day they are sick (Chart 20), and the 3rd least likely to find care after hours (Chart 21). Canadians were also the least likely to receive a same day callback from their regular physician's office when reporting a concern during regular office hours (Chart 22).

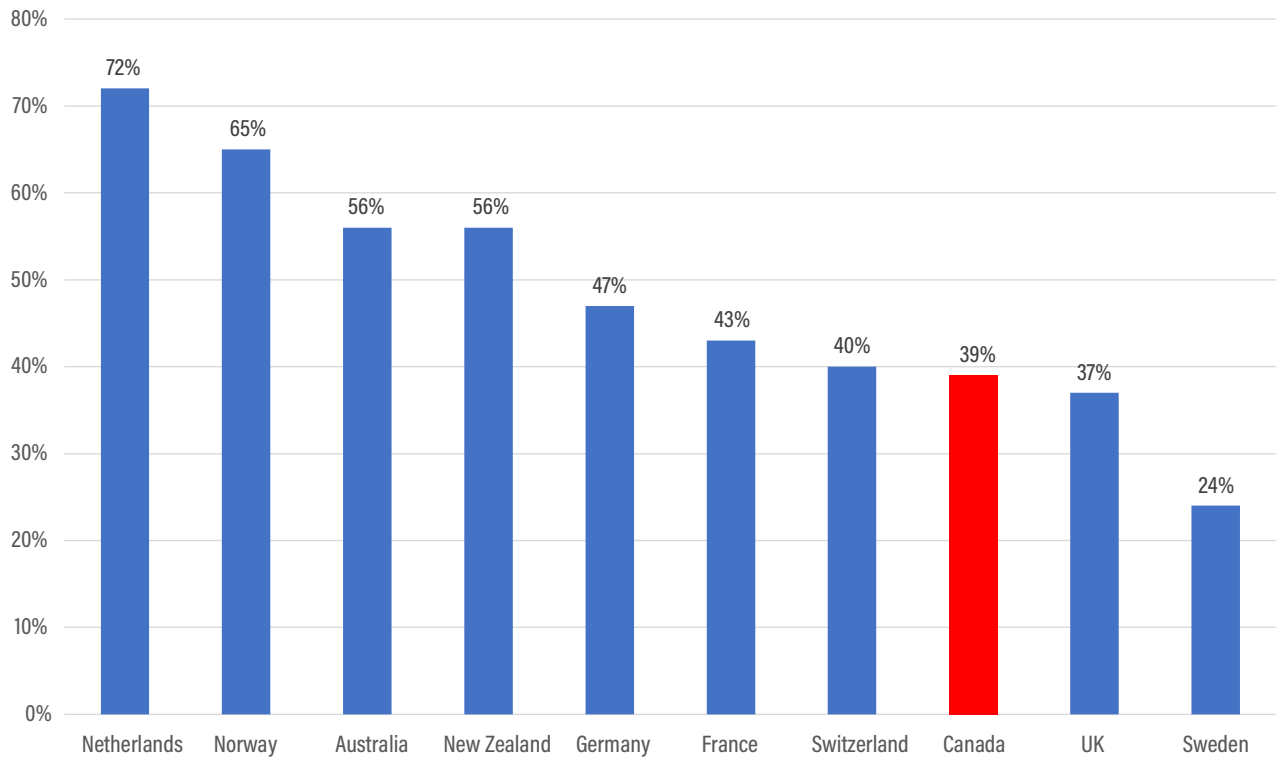


**Chart 20: Percentage of respondents who were able to make a same- or next-day appointment when sick, 2020**



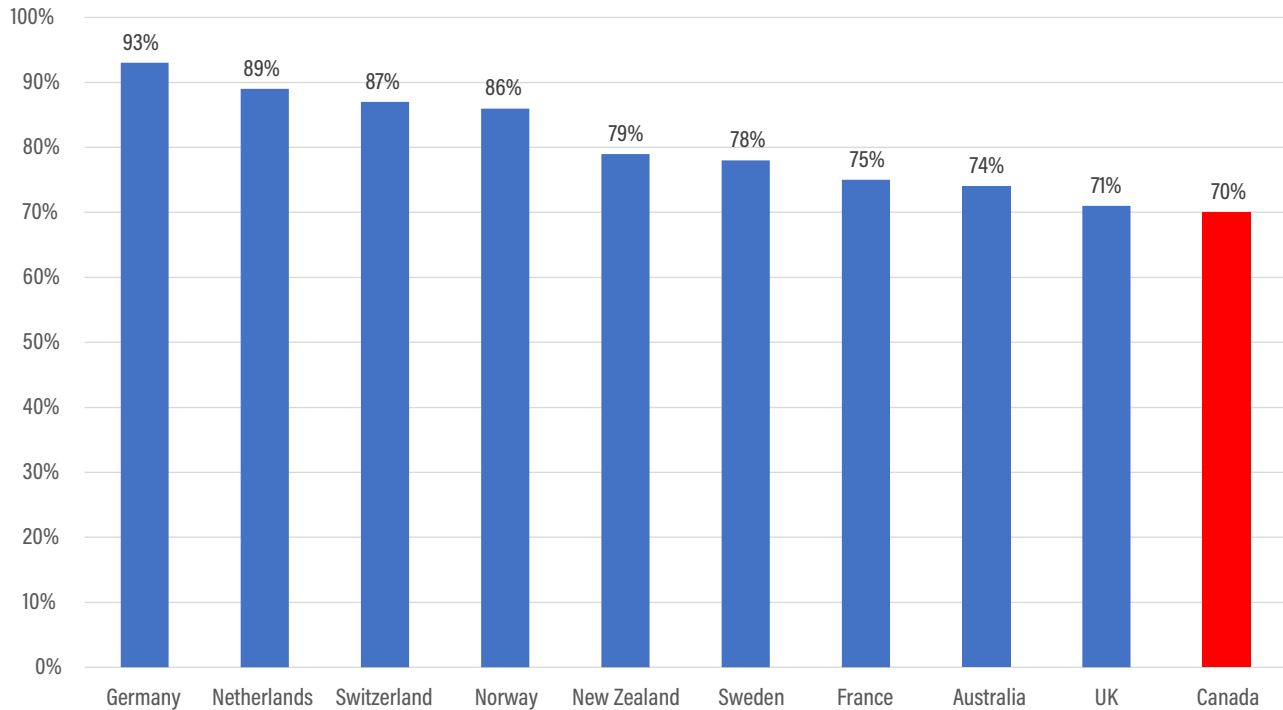
Source: CIHI, 2021

**Chart 21: Percentage of respondents reporting it was very or somewhat easy to find care after hours, 2020**



Source: CIHI, 2021

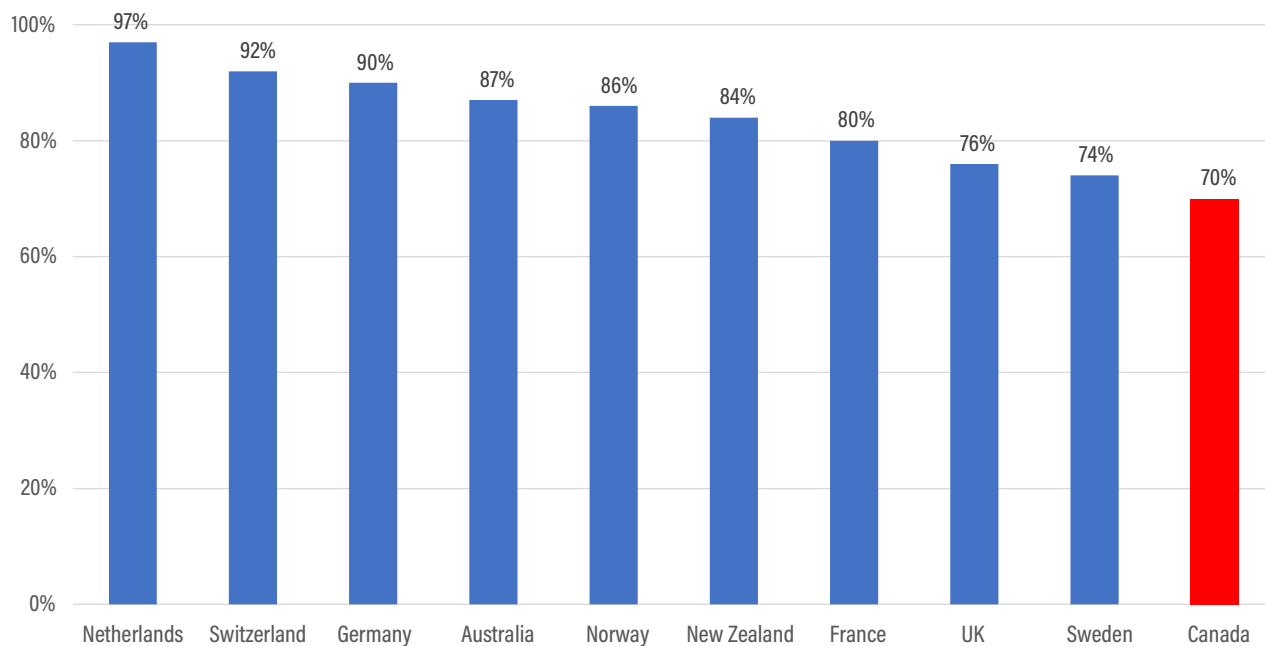
**Chart 22: Percentage of respondents reporting they often or always receive same-day callback when calling regular doctor's office with a medical concern during regular hours, 2020**



Source: CIHI, 2021

Delays in accessing emergency care generally may also be relevant for inferring access to care for mental health care services, as Canadians were more likely than respondents in the other nations surveyed by the Commonwealth Fund to report using the emergency room for care that could have been provided by a regular care provider. Delays in accessing emergency care in Canada are longer than in the other nations, found the Commonwealth Fund survey: 70% of Canadians reported receiving care within 4 hours at the emergency department, compared with over 90% in Germany, Switzerland, and the Netherlands (Chart 23).

**Chart 23: Percentage of respondents reporting they received treatment within 4 hours the last time they visited the emergency department, 2020**



Source: CIHI, 2021

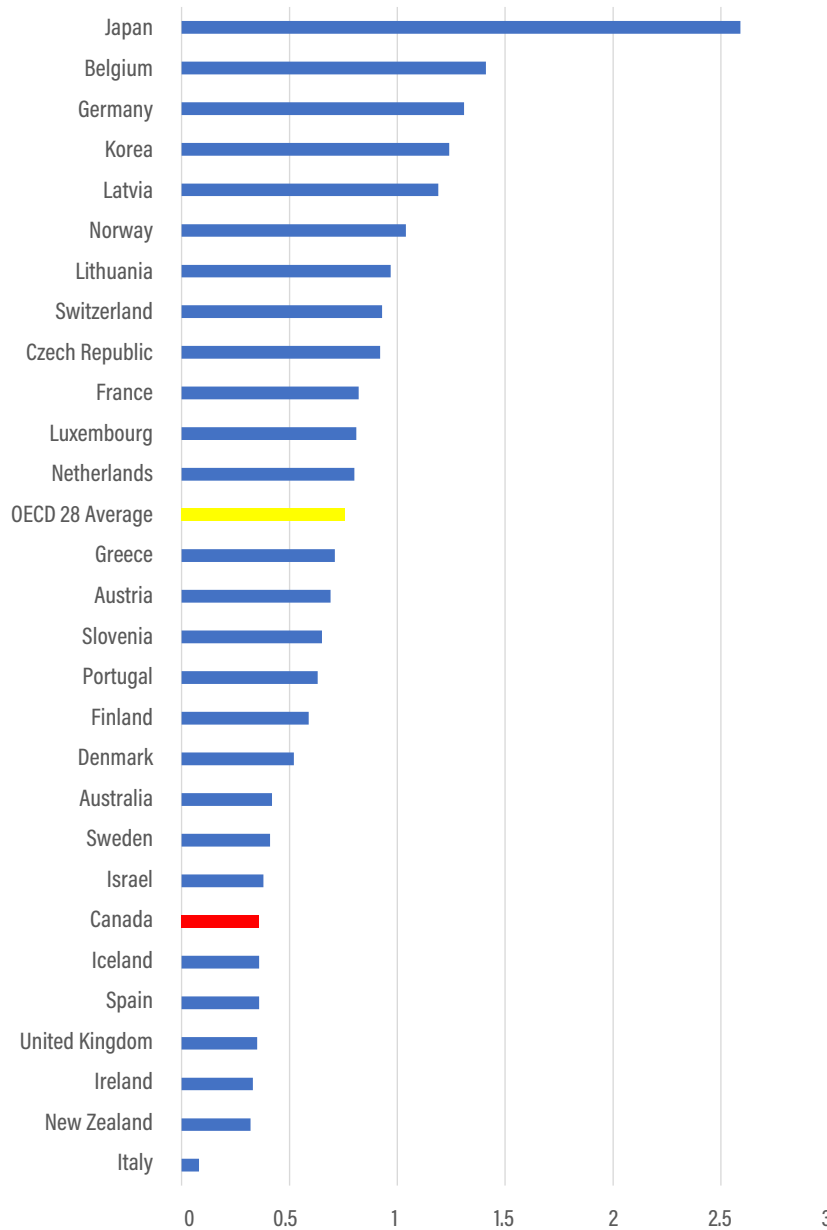
## Resource indicators

Canada is generally recognized to be a relatively high spender on health care and to have a relatively low level of access to medical services (Moir and Barua, 2021). In particular, for world-leading levels of health care expenditures, Canadians endure bottom-ranking availability of physical resources, including practicing physicians, medical technologies, and acute-care hospital beds. The state of affairs with respect to the availability of resources for mental health care services does not depart from this general reality.

In 2019, Canada ranked 23<sup>rd</sup> out of 28 countries for the availability of psychiatric care beds per 1,000 population (Chart 24). Canadians had access to 0.36 psychiatric care beds per 1,000 population, while patients in Japan had access to 2.59, patients in Belgium had access to 1.41, and patients in Germany had access to 1.31. The average developed nation maintained 0.75 beds per 1,000 population, more than double the number in Canada. While there may be important differences in care approaches among nations,

in particular — by design in some nations — a much greater reliance on outpatient care that results in the need for fewer hospital beds, Canada nevertheless has relatively fewer resources available for patients needing hospitalization than the average developed nation with a universal-access health care system.

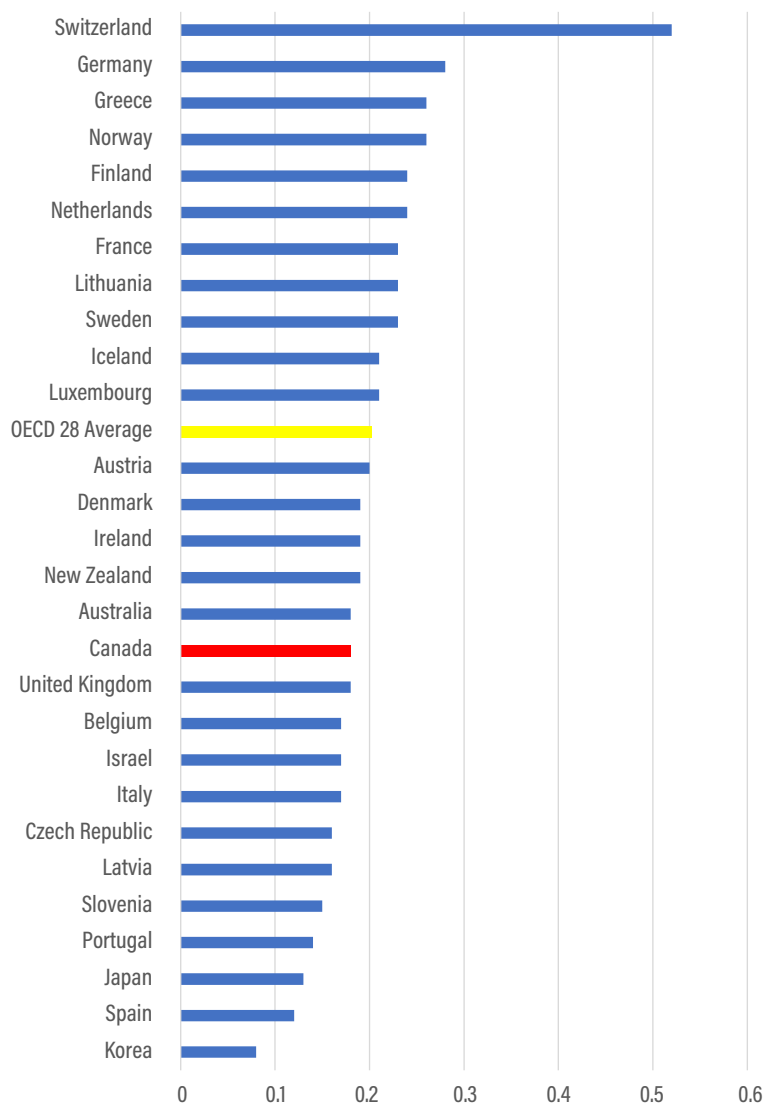
**Chart 24: Psychiatric care beds per 1,000 population, 2019 or nearest year**



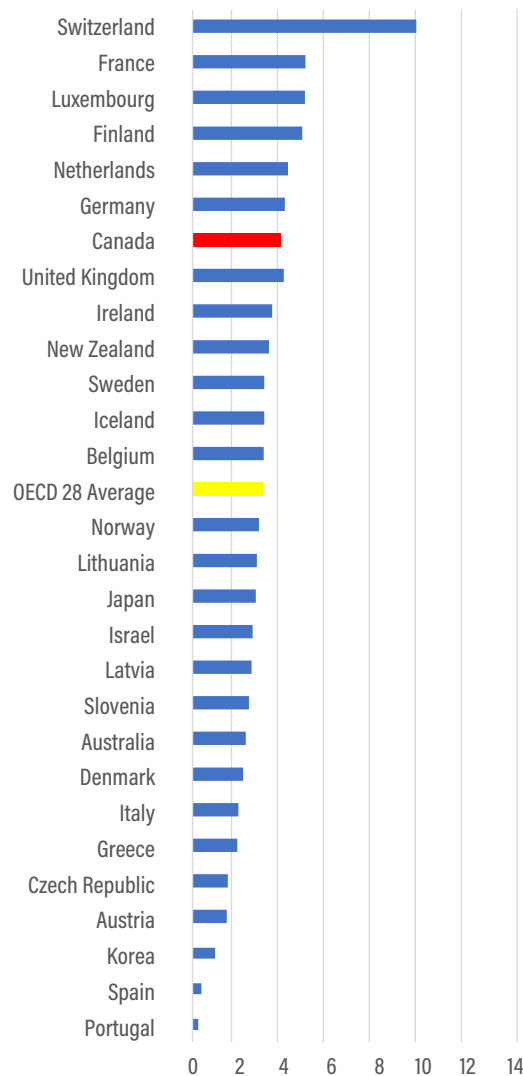
Source: OECD (nd)

In 2019, Canada ranked 16<sup>th</sup> of 28 countries for the number of psychiatrists per 1,000 population (Chart 25). Canada's 0.18 psychiatrists per 1,000 population compares with 0.52 in top-ranked Switzerland and 0.28 in second-ranked Germany. Conversely, a higher proportion of Canada's physician supply is focused on mental health care than in the average high-income universal-access health care nation (Chart 26). Canada ranks 7<sup>th</sup> in the proportion of physicians who are psychiatrists, at 6.29%, although it still lags behind leading Switzerland (12.04) and France (7.21).

**Chart 25: Psychiatrists per 1,000 population, 2019 or nearest year**



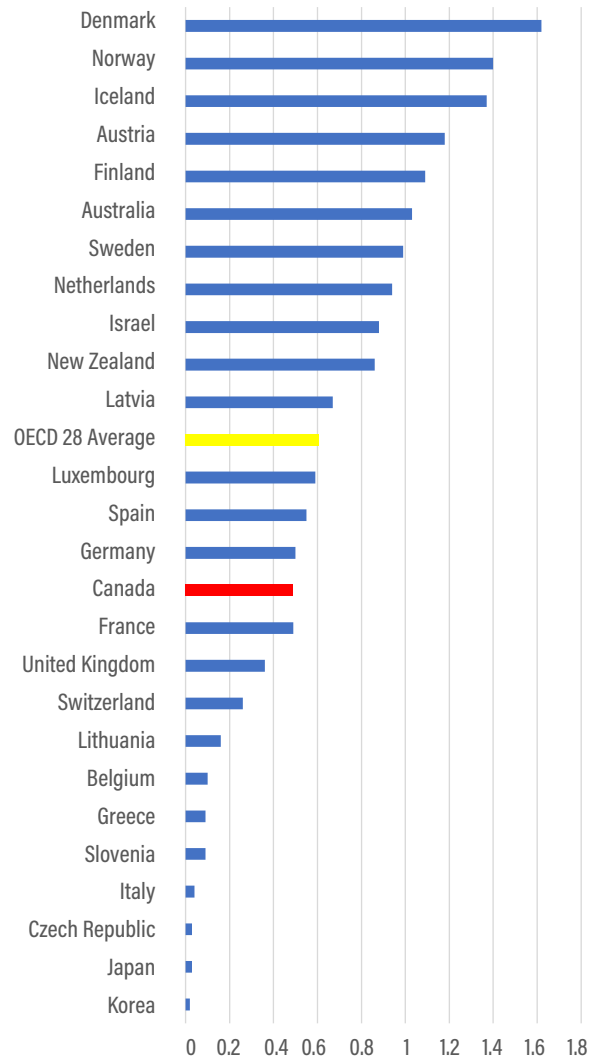
Source: OECD (nd)

**Chart 26: Psychiatrists as a percentage of physicians, 2019 or nearest year**

Source: OECD (nd)

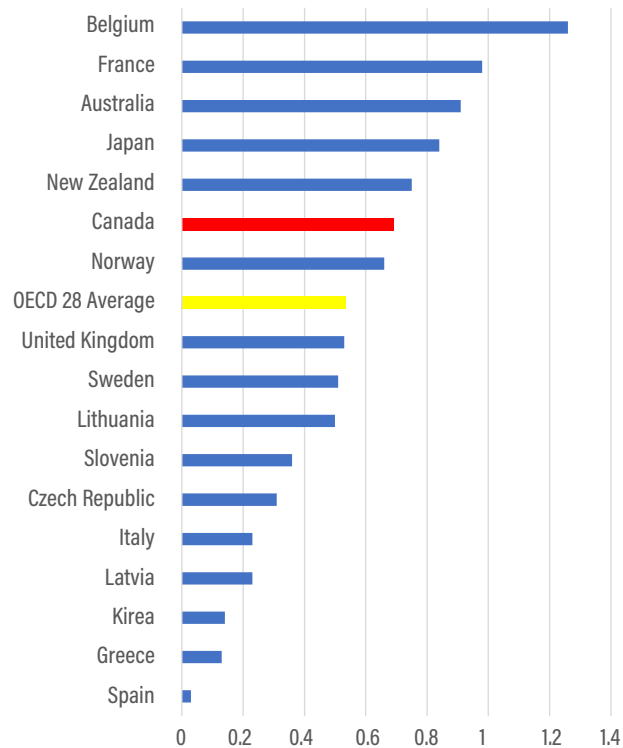
Canada also ranks slightly below average in the number of psychologists per 1,000 population (Chart 27), but ranks above the average in the number of mental health nurses per 1,000 population (Chart 28). Canada's 0.49 psychologists per 1,000 population compares with 1.4 in Norway and 1.62 in Denmark, and a high-income universal-access health care average (those countries for which data is available) of 0.61. Conversely, Canada's 0.69 mental health nurses per 1,000 population ranks ahead of the high-income universal health care access average (among those countries for which data are available) of 0.53, but still ranks behind top-ranked Belgium (1.26) and second-ranked France (0.98).

**Chart 27: Psychologists per 1,000 population, 2018 or nearest year**



Source: OECD (2021a)



**Chart 28: Mental health nurses per 1,000 population, 2018 or nearest year**

Source: OECD (2021a)

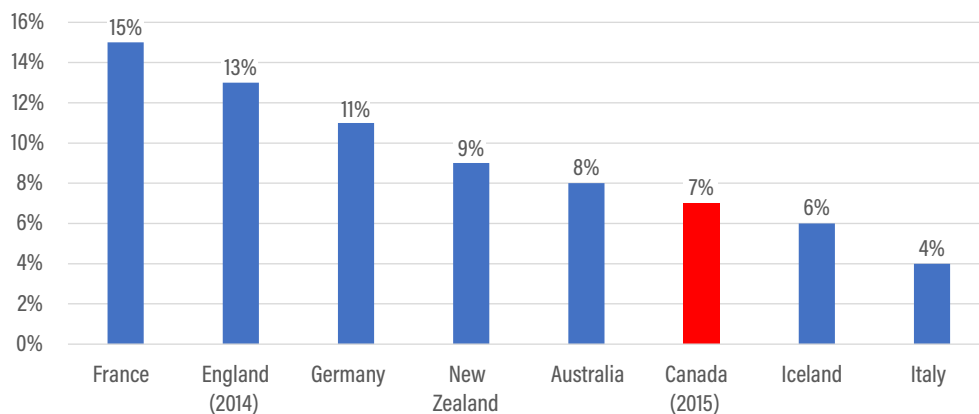
### Expenditures on Mental Health Services

Canada spends more on health care overall than the majority of high-income OECD countries with universal health care systems (Moir and Barua, 2021). The proportion of health expenditure estimated to be allocated to mental health in Canada also ranks highly when looking specifically at government expenditures, but ranks slightly lower as a share of total expenditures.

In 2015, 7% of Canada's total health expenditures went to mental health services, compared with as much as 15% in France, 13% in England, and 11% in Germany in similar years (Chart 29). Looking more closely at government health spending, Canada ranked 4th among developed nations with universal-access health care systems (Chart 30). In 2018, 10.6% of government health spending in Canada was estimated to be focused on mental health, compared with an average of 7.4% among comparable nations (those for which data were available).

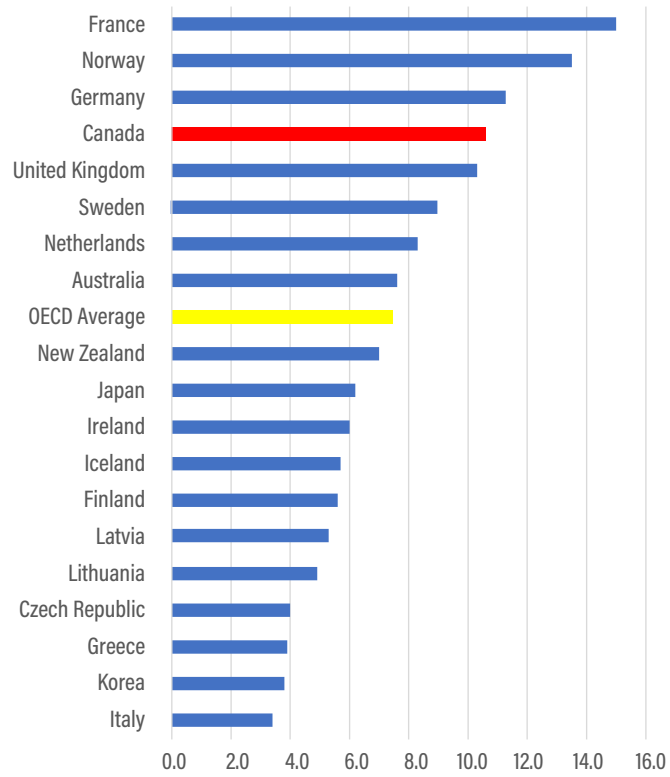
This difference in ranking between shares of government and total (including private) expenditure may be in part driven by the extent of governmental coverage for health services in Canada relative to those in other developed nations, rather than necessarily being an example of a greater governmental commitment to funding mental health services in Canada. The Canadian health care system provides first dollar coverage for physician and hospital services in a virtual public monopoly, but allocates more limited funding for other health services, including pharmaceuticals and dental care. Universal access health care systems in other developed nations tend to have broader coverage under their universal schemes, including pharmaceuticals, but they also allow private purchases of physician and hospital services covered by those schemes (see, for example, Gliberman, 2013).

**Chart 29: Portion of total health expenditure on mental health, 2017**



Source: CIHI (2019a)

**Chart 30: Estimated mental health spending as a percentage of total government health spending, 2018 or nearest year**



Source: OECD (2021a)

## Discussion

Statistics on the performance of mental health care systems are more limited than those measuring the performance of the general health care system, which limits the inferences that might be drawn from a broad examination of the available relevant data. Nevertheless, the picture painted by an international review of statistics on the performance of Canada's mental health care system is not an overwhelmingly positive one. Along with the mixed picture with respect to the proportion of health expenditures focused on mental health, Canada's mental health care system imposes long delays in accessing care on a considerable number of Canadians and makes fewer medical resources available than might be found in peer nations. There is also evidence that access to mental health care services in Canada has declined over time, particularly in terms of delays imposed on patients in need of services. It would seem the mental health care system in Canada shares its shortcomings with the Canadian health care system overall.

The number of Canadians being impacted by the performance of the mental health care system is considerable, with more than one-quarter of Canadians reporting a mental health condition. Many of these impacted individuals are younger Canadians or those in their prime working years (MHCC, 2013, CIHI, 2019a). That will undoubtedly have an impact both on individual productivity and also on the economy as a whole: One study has estimated the cost of lost productivity associated with mental illness to be \$6 billion annually (MHCC, 2013).<sup>17</sup> While many mental illnesses can be treated effectively today through either pharmaceutical or professional interventions, or a combination of the two (Incel, 2022; Gratzner, 2020), the issue of course is ensuring patients have access to these treatments and the practitioners that deliver them.

Individuals experiencing mental illness or mental health problems also tend to have relatively medically complex health needs: over half of the Canadians reporting a mental health need in 2020 also reported two or more chronic conditions. More than

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17 The economic cost of mental ill health overall, including lost productivity as well as lower employment and investment in mental health care, has been estimated to be between 3 and more than 4% of GDP in the European Union (OECD, 2012; OECD, 2021a).

one-quarter also reported regularly taking four or more prescription medications (Williams and Shah, 2021a). At the same time, Canadians with mental health conditions and at least one chronic condition were less likely to report receiving as much support as they needed to help them manage their health problems in 2020 than those who did not have these more complex needs (CIHI, 2021). Clearly, there is a need for better coordination and support for those with multiple conditions including a mental health condition, both to improve care for those with mental illness and to ensure those with mental illness receive necessary medical services.

The combination of high levels of mental care needs with low availability of physicians, psychiatrists, psychologists, and facilities suggests Canada's provinces may find value in policy structures that both allow better use of and access to existing resources and also improve access to care through innovative new approaches. Making better use of limited resources, with a focus on improving the availability of services over time, is essential if we are to address Canada's mental health care gap.

## Conclusion

Mental illness affects a large number of Canadians annually, affecting employment, productivity, and social engagement for those afflicted. Canadians have access to mental health care services through the universal scheme, through various provincial programs and through private options. Nevertheless, an international comparison of Canada's mental health care system, although less complete because of limits in data availability, finds those who need care endure relatively poor access to medical services, partly as a result of the limited supply of resources, leaving many Canadians with unmet mental health care needs.

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