Brief for the Standing Committee on Health

Study: Emergency Situation Facing Canadians in Light of the Second Wave of the COVID-19 COVID-19 pandemic

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The COVID-19 pandemic has had a dramatic impact on Canadians. One area that has received a lot of attention, particularly as the first wave of the pandemic has subsided, is the impact of the pandemic on the mental health of Canadians. This concern is understandable given the confluence of pandemic-related factors known to be risk factors for mental illness, including an increase in stress due to social isolation, financial and employment stressors, concern about becoming infected and long-term health consequences, among others.

The areas of interest of the Committee included in the invitation are related to population mental health impact (Areas 1 and 2), access to interventions to address population need (Areas 3 and 4), and federal support to provincial and territorial efforts to address increases in mental health and addiction-related demand (Area 5). The interest in population mental health impact and access to interventions highlights the fact that such information is not readily available. The implications of not knowing population-based mental health or addiction needs or the services required to meet such needs is not restricted to the COVID-19 pandemic; we have never known much about the mental health status of the Canadian population or the services that exist to meet such need. The availability of such information is required to monitor mental health system performance, and the absence of such information means that policymakers will not know how to adequately respond to need. In other words, the questions posed by the Standing Committee not only reflect the need to understand what is happening during a pandemic, but also reveal how little infrastructure exists to support evidence-informed mental health system development in Canada. The very fact that we need experts to speculate on what is happening to Canadians with mental illnesses and addictions during the COVID-19 pandemic serves to underscore that critical mental health system measurement that would be able to routinely provide such information is missing.

Historically, population mental health need in Canada has been ascertained by surveys. For example, Statistics Canada has implemented a mental health-focused survey in 2002 and 2012. These surveys were well-designed, and provided a measure of prevalence of the common mental disorders in Canada. Other Statistics Canada surveys often include less detailed measures of mental wellbeing. These surveys are too infrequent to provide meaningful information on an issue as dynamic as the mental health consequences of a pandemic. Surveys, by design, measure a population at a point in time and are not useful for studying change in population need during a pandemic unless surveys are administered rapidly and repeatedly. Understanding population needs during a pandemic requires much more dynamic and timely information. In the information void, a number of surveys and polls have generated information that has been sensationalist by extrapolating stress responses to the COVID-19 pandemic (a stressful situation) to increased prevalence of mental disorders. My colleagues, Dr. Scott Patten and Senator Stanley Kutcher, have written a commentary on the limitations of these efforts. In this commentary, they warn against the use of low quality surveys that have proliferated during the COVID-19 pandemic.

In 2015, ICES launched its Mental Health and Addictions Research Program. This program, which is both grant-funded and receives annual funding from Ontario's Ministry of Health and Long-term Care, has a core team of scientists, epidemiologists and data analysts who have developed standardized approaches and methods for using Ontario's health administrative data with the goal of understanding mental health system performance. This team works in close

collaboration with Ontario's Ministry of Health and with the newly established Mental Health and Addiction Centre of Excellence within Ontario Health. The goal is to develop evidence to inform policy-making. Since its inception, the team has published hundreds of studies and multiple scorecards, including a report on the child and youth mental health system. These scorecards document issues related to access to and quality of services. Some of the concerning highlights: the rate of mental health and addiction-related Emergency Department visits nearly doubled between 2009 and 2017 in transitional age youth (16 to 24); nearly half of youth who have a mental health or addiction-related Emergency Department visit have had no prior mental health or addiction-related outpatient access (suggesting the Emergency Department is the only "open door"); and only 2 out of 5 individuals who visited an Emergency Department for a suicide attempt saw a psychiatrist within 6 months.

These are all troubling findings, but it is important to note that prior to the establishment of the ICES Mental Health and Addictions Program, none of these issues were known. The work at ICES has made the invisible visible, at least in areas where data are available (physician visits, Emergency Department visits, and hospitalizations). We are also very busy generating new evidence that measures the impact of the COVID-19 pandemic on continuity of care (among those in care, who was lost to follow-up and who continued in care virtually?), on new care (what is the increased demand for services post-pandemic and over time), and any changes in Emergency Department visits for suicide attempts. This measurement capacity at ICES developed with a relatively small investment. Each province and territory has similar data that could be leveraged to the same effect. These data in each province are not being exploited to understand mental health system performance, but could be developed with federal oversight and coordination through agencies like the Canadian Institute for Health Information (CIHI). Moreover, initiatives like the Health Data Research Network, an agency that brings together health administrative data from all provinces and territories to support knowledge creation to help decision-makers, is an interesting development that could serve to support a nation-wide mental health system research agenda. Importantly, CIHI and Statistics Canada are supporting members of the Health Data Research Network.

Moving forward, infrastructure must also be developed that will augment capacity to measure multiple aspects of the mental health system. This includes standardizing the information collected at each point of contact and establishing regional centralized access points (including virtual access points). In Ontario, we are determining how to establish regional access points and to standardize the information collected at point of access. These will serve a number of functions: 1) one central place individuals can access for their mental health needs (instead of having to understand the various services and their niche patient populations); 2) over time, the characterization of the populations seeking care so that need can be measured dynamically; 3) once need is understood, a determination of whether the services in a given region are capable of meeting need, and an opportunity to realign services. This will not be straightforward because the array of mental health services to meet the needs of Canadians is diverse. However, infrastructure to collect information to understand population need and to support iterative quality improvement is in place for cancer, cardiac and stroke care in most provinces. Moreover, in a short period of time, provinces have developed a comprehensive understanding of the population distribution of the COVID-19 pandemic from an infectious disease perspective. There is growing public interest (and concern) about mental illness and addiction generally, and about

the impact of the COVID-19 pandemic on mental illness and addiction specifically. If we believe mental health is a priority, we need to commit to developing infrastructure that has resulted in developing world class health systems in other areas of the health care sector, and apply such knowledge and expertise to the mental health system.

It is likely that individuals with pre-existing mental illnesses are at increased risk during the COVID-19 pandemic. It is also likely that all Canadians are at increased risk of developing mental illnesses and addictions as a result of the COVID-19 pandemic. The magnitude of these risks is unknown. Historically, in the mental health sector, we have addressed problems by funding interventions and building programs and hoping they are meeting needs as designed. What we have not done is systematically measure population-based need for these interventions and programs. We have also not systematically measured whether the funded interventions achieved outcomes as intended. If we proceed with responding to mental health and addiction-related needs of the COVID-19 pandemic based on hypothetical needs and with no measurement framework in place, we run the risk of propagating an already fragmented response to the mental health needs of Canadians. Canadians with mental illnesses and addictions deserve a mental health system that is responsive to their measured needs and accountable for achieving certain outcomes. The only way this will happen is by developing system-building infrastructure that has occurred in other areas of the health care sector. Avoiding this critical step will result in responses to need based on conjecture and advocacy, with no capacity to measure the impact of such investments.