REPORT

MENTAL DISORDERS:
A MODERN PICTURE

SEPTEMBER 2001

CONSEIL MÉDICAL DU QUÉBEC

REPORT 2001-04

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This report arises from a report from the mental health working committee, made up of the following people: Dr. Jean-Marie Albert (Chair), Dr. Joëlle Lescop, Mrs. Micheline Ulrich and Dr. Colette Roberge (coordinator from the *Conseil* office).

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SUMMARY

For many years now, the policies of the *ministère de la Santé et des Services sociaux* (Department of Health and Social Services) regarding mental health care and services have moved towards increased maintenance of patients with severe and persistent mental disorders in the community, much like other Western countries.

In this report, members of the Conseil médical du Québec want to highlight the heavy burden of other mental disorders as shown in recent publications from the World Health Organization, the World Bank and the “Surgeon General” of the United States. In 1998, in developed countries, the burden of mental disorders, evaluated in “lost years of healthy life”, or DALY (disability-adjusted life year), ranks second, right after cardio-vascular diseases and before cancer. Among the top ten diseases that affect young adults most heavily, four are mental disorders and the first is major depression.

Despite recent discoveries about the brain functioning and its interactions with the environment, and despite existing effective treatments, fears, taboos and false beliefs still remain regarding mental disorders. These attitudes foster inaction, discrimination and stigma for people suffering mental disorders and their relatives, and prevent organization and access to appropriate care and services.

That is why the *Conseil* considers the dissemination of research knowledge to be very important in order to better inform the public, facilitate the implementation of relevant and efficient evidence-based approaches for professionals, and improve communications between investigators, professionals, people disseminating information, particularly specialized and mainstream media, administrators and people responsible for policies.

Finally, the *Conseil* proposes organizational structures for medical services using a population-based approach, given the high prevalence, invalidity and indirect costs associated with mental disorders. This organizational model is built on principles of accessibility, evidence-based quality practices and continuity of care associated with service integration.

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INTRODUCTION

This document results from the will of the members of the *Conseil médical du Québec* to assert the importance of acknowledging, diagnosing and treating mental disorders other than severe and persistent, considering the significant burden they impose on people suffering from them, their relatives and the community in general.

In the first chapter, the members of the *Conseil* analyze Murray and Lopez's work, who documented in 1996, for the first time and to every one's surprise, the importance of the burden imposed by mental disorders compared with the burden of a hundred or so other diseases. The authors, in the context of their work promoting the prioritization of investments in health for both services and research, developed a burden of disease indicator for various disorders, DALY (*disability-adjusted life year*), which considers the mortality, invalidity and length of invalidity associated with these disorders. Thus, mental disorders are in second position, right behind cardiovascular diseases and before cancers, considering, among other things, the burden of invalidity they represent, developing early in life and often recurrently or chronically. In addition to reviewing epidemiological data, and more specifically the prevalence of various mental disorders, this report explores the concepts of mental health, mental health problem and mental disorder in order to better define its aim, namely the importance of mental disorders other than severe or persistent, their detection, diagnoses and treatments. The members also studied the nature of associated indirect costs, whose importance is too often neglected.

In the second chapter, the members of the *Conseil*, concerned with the stigma associated with mental disorders, try to understand its multiple facets in order to reduce it. Thus, they review the characteristics of the elements that promote stigma and prevent access to appropriate care and treatments. They investigate beliefs and attitudes fostering myths and prejudices about the causes of mental disorders, but also about the nature, need and effectiveness of their treatments. This exploration tackles beliefs in the general population as well as among healthcare professionals. Inspired by some of the solutions brought forward to fight stigma, they propose a few solutions.

Aware of the importance of disseminating quality information to the population, healthcare professionals, administrators and politicians, the members of the *Conseil* have targeted three goals in the next chapter. The first one shows how the transfer of research knowledge can help improving the general public's knowledge (mental health literacy), and its impact on the ability of the individual to take ownership of his mental health as he is or could be doing, for his physical health. The second goal reviews the conditions for disseminating evidence-based data that promotes the establishment of a consensus among professionals and lead to their implementation for the benefits of patients. Finally, the third goal explores the mechanisms involved in the integration of research knowledge into healthcare policies and management while facilitating communications between researchers, professionals, and people responsible for the dissemination of information, especially mainstream and specialized media, people in charge of policies and administrators.

In the fourth chapter, the members of the *Conseil* discuss the organizational modalities of medical care using a population-based approach, given the high prevalence of mental disorders and the invalidity and costs associated with them. They explore the actualization of medical service hierarchization principles adopted in Quebec, with a special focus on « shared care » models. Their vision is essentially based on principles of accessibility, evidence-based quality practices and continuity of care linked to service integration.

In this report, the members of the *Conseil* propose a reflection and recommendations consistent with several themes used in the World Health Organization (WHO) World Health Report, to be published in October 2001:

- Mental health is a fundamental part of health;
- Mental disorders are common and widespread;
- Mental disorders are a major source of invalidity for individuals, and a burden for families and communities;
- Mental disorders are real, they can be diagnosed and treated;
- Prevention of mental disorders is possible and feasible;
- There is an urgent need for all countries to develop policies and programs that will help overcoming barriers and facilitate access to mental health care and services.

CHAPTER 1
A FEW FACTS

During the last decade, convergence of several scientific developments in medicine highlighted the importance that must be attached to mental health quality and the treatment of mental disorders when they appear.

1.1 The heavy burden of mental disorders

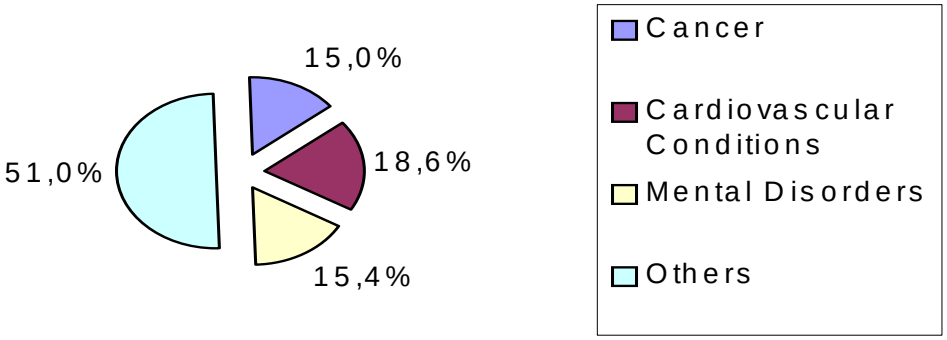
The notion of global burden of disease taking into account the number of lost years of healthy life[2] (DALY, *disability-adjusted life years*) was introduced for the first time in 1993, as reported by the WHO[1]. Developed by the team of researchers of the Harvard School of Public Health[3], this measure is the result of complex analyses integrating, among other things, the burden of premature death as well as the number of years lived with a disability, adjusted for severity. Thus, it allows to assess the global burden of several diseases and to make comparisons between these diseases.

One of the most unexpected results of this study was the high burden of mental disorders, largely underestimated since then, given the low incidence of mental disorders on mortality.

Critical analyses of the methodology conducted by researchers from various countries such as Australia[4] and Holland[5] confirm that it is still one of the best measures to assess and describe the significant burden of mental disorders. Based on this data, the WHO considers that in 2020, ***worldwide***, the global burden of mental disorders will reach **15%** of the total burden of diseases[6] and that depression will the leading cause of invalidity. For ***high-income countries*** such as Canada, this burden was evaluated at **23%** in 1998.

According to Murray and Lopez, authors of the Global Burden of Disease study, the burden of mental disorders including suicide (see table below) rank them second behind cardiovascular diseases, right before cancers. Among them, depression ranks second of all diseases. The United States Surgeon General used this data in his December 1999 report on mental health[7]. The following are extracts of this report:

Table 1. Global Burden of Disease* - DALYs worldwide - 1990**



*** Global Burden of Disease (Murray & Lopez, 1996)**

**** DALYs – Disability-Adjusted Life Years**

Table 2. Disease Burden by Selected Illness Categories in Established Market Economies, 1990
(measured in DALYs*)

	Percent of Total
All cardiovascular conditions	18.6
All mental illness including suicide	**15.4**
All malignant disease (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic disease	2.8
All drug use	1.5

Table 3. The Leading Sources of Disease Burden in Established Market Economies, 1990
(measured in DALYs*)

	Total (millions)	Percent of Total
All Causes	98.7	
1. Ischemic heart disease	8.9	9.0
2. **Unipolar major depression**	6.7	6.8
3. Cardiovascular disease	5.0	5.0
4. Alcohol use	4.7	4.7
5. Road traffic accidents	4.3	4.4
6. Lung & UR cancers	3.0	3.0
7. Dementia & degenerative CNS	2.9	2.9
8. Osteoarthritis	2.7	2.7
9. Diabetes	2.4	2.4
10. COPD	2.3	2.3

Table 4. Mental Illness as a Source of Disease Burden in Established Market Economies, 1990
(measured in DALYs*)

	Total (millions)	Percent of Total
All Causes	98.7	
Unipolar Major depression	6.7	6.8
Schizophrenia	2.3	2.3
Bipolar disorder	1.7	1.7
Obsessive-compulsive disorder	1.5	1.5
Panic disorder	0.7	0.7
Post-traumatic stress disorder	0.3	0.3
Self-inflicted injuries (suicide)	2.2	2.2
All mental disorders	15.3	15.4

* DALYs measure lost years of healthy life regardless of whether the years were lost to premature death or disability.

NIH Publication No. 99-4586

[1] The global burden of disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. (Murray CL, Lopez AD, eds. World Health Organization, World Bank, Harvard University, 1996).

1.2 High prevalence rates

Diagnostic classifications, although contemporary to scientific knowledge and evolving with it, allowed to conduct large epidemiological studies worldwide and in North America. They demonstrated that one in five people (**20%**) will suffer from a clinically diagnosable mental disorder in the course of one year. To illustrate in a detailed manner the prevalence rates of various mental disorders among age groups during one year, the *Conseil* selected the following data, extracted from the report on mental health of the United States Surgeon General, since there are no data as exhaustive in Quebec and in Canada.

Table 5. Mental Health: A Report of the Surgeon General

Table 2-7. Children and adolescents ages 9 to 17 with mental or addictive disorders, * combined MECA sample

	Prevalence (%)
Anxiety disorders	13.0
Mood disorders	6.2
Disruptive disorders	10.3
Substance use disorders	2.0
Any disorder	20.9

* Disorders include diagnosis-specific impairment and Child Global Assessment Scale s70 (mild global impairment).

Source: Shaffer et al., 1996

Table 6. Best estimate 1-year prevalence rates based on ECA and NCS, ages 18-54
Table 2-6.

	ECA Prevalence (%)	NCS Prevalence (%)	Best Estimate**(%)
Any Anxiety Disorder	13.1	18.7	16.4
Simple Phobia	8.3	8.6	8.3
Social Phobia	2.0	7.4	2.0
Agoraphobia	4.9	3.7	4.9
GAD	(1.5)*	3.4	3.4
Panic Disorder	1.6	2.2	1.6
OCD	2.4	(0.9)*	2.4
PTSD	(1.9)*	3.6	3.6
Any Mood Disorder	7.1	11.1	7.1
MD Episode	6.5	10.1	6.5
Unipolar MD	5.3	8.9	5.3
Dysthymia	1.6	2.5	1.6
Bipolar I	1.1	1.3	1.1
Bipolar II	0.6	0.2	0.6
Schizophrenia	1.3	-	1.3
Non-affective Psychosis	—	0.2	0.2
Somatization	0.2	—	0.2
ASP	2.1	—	2.1
Anorexia Nervosa	0.1	—	0.1
Severe Cognitive Impairment	1.2	—	1.2
Any Disorder	19.5	23.4	21.0

* Numbers in parentheses indicate the prevalence of the disorder without any comorbidity. These rates were calculated using the NCS data for GAD and PTSD, and the ECA data for OCD. The rates were not used in calculating the any anxiety disorder and any disorder totals for the ECA and NCS columns. The unduplicated GAD and PTSD rates were added to the best estimate total for any anxiety disorder (3.3%) and any disorder (1.5%).

** In developing best-estimate 1-year prevalence rates from the two studies, a conservative procedure was followed that had previously been used in an independent scientific analysis comparing these two data sets (Andrews, 1995). For any mood disorder and any anxiety disorder, the lower estimate of the two surveys was selected, which for these data was the ECA. The best estimate rates for the individual mood and anxiety disorders were then chosen from the ECA only, in order to maintain the relationships between the individual disorders. For other disorders that were not covered in both surveys, the available estimate was used.

Key to abbreviations: ECA, Epidemiologic Catchment Area; NCS, National Comorbidity Study; GAD, generalized anxiety disorder; OCD, obsessive-compulsive disorder; PTSD, post-traumatic stress disorder; MD, major depression; ASP, antisocial personality disorder.

Source: D. Regier, W. Narrow, & D. Rae, personal communication, 1999

Table 7. Best estimate prevalence rates based on Epidemiologic Catchment Area, age 55+

Table 2-8.

	Prevalence (%)
Any Anxiety disorders	11.4
Simple Phobia	7.3
Social Phobia	1.0
Agoraphobia	4.1
Panic Disorder	0.5
Obsessive-Compulsive Disorder	1.5
Any Mood Disorder	4.4
Major Depressive Episode	3.8
Unipolar Major Depression	3.7
Dysthymia	1.6
Bipolar I	0.2
Bipolar II	0.1
Schizophrenia	0.6
Somatization	0.3
Antisocial Personality Disorder	0.0
Anorexia Nervosa	0.0
Severe Cognitive Impairment	6.6
Any Disorder	19.8

Source: D. Regier, W. Narrow, & D. Rae, personal communication, 1999

Among other countries, Australia[8] reports similar prevalence rates for mental disorders that were evaluated in large epidemiological studies, and a rate of schizophrenia and non-affective psychosis similar to the one reported in American studies.

In Canada, the 1996-1997 National Population Health Survey[9] shows that the prevalence of major depression was 4.2% for Canadian men and women aged 12 and over (20,725 households, 58,439 people).

In Quebec, an epidemiological survey conducted in 1993 by the *Régie régionale de la santé et des services sociaux du Bas-Saint-Laurent* (523 people aged 15 and over)[10] revealed an annual prevalence rate of 15% for the following mental disorders:

- 6% affective disorders;
- 3% anxiety disorders;
- 5% alcohol abuse/dependence;
- 1% drug abuse/dependence.

Another epidemiological study conducted in East Montreal (893 people aged 18 and over)[11] shows a total prevalence of 14% over six months for the same mental disorders.

Finally, in 1987, the *Enquête Santé Québec*[12] concluded that 19% of Quebec men and women aged 15 and over had a high psychological distress threshold. The psychological distress scale does not use specific diagnosis[13].

In 1998, the *Enquête sociale et de santé*[14] revealed a similar high rate of psychological distress, 20% in the same population, except for the 15-24 year age group where the rate is at 28% compared to 23% in 1987, after a peak at 35% in 1992-1993. Of note, that year the global rate of psychological distress was also higher (26%).

The Canadian Institute for Health Information (CIHI)[15] noted in 1996-1997 a depression rate of 4% in the Quebec population aged 12 years and over; that rate was similar to Ontario and inferior to other provinces, where the rate was 5%.

The *Enquête québécoise sur la santé mentale des jeunes*[16] (1993), conducted with 2,400 youngsters (6-14 years) and their parents, found the following prevalence of mental disorders in the six month period preceding the survey:

- 14.9% in 6-11 year age group;
- 17.5% in 12-14 year age group, including 8% with one or more adjustment disorders;
- 19.9% according to parents in the 6-14 year age group, including 9.6% with one or more adjustment disorders.

We are forced to recognize that all the epidemiological studies showed relatively similar high prevalence rates. The members of the *Conseil* want to draw attention on the remarkably high number of people that suffer mental disorders each year in Quebec. This is all the more worrying since these disorders are associated with a high rate of invalidity, physical diseases and even mortality, as with anorexia and borderline personality disorder for example.

Epidemiological data concerning ***suicide***[17] in Quebec show a mortality rate among the highest in industrialized countries:

- Quebec: **3rd for men,** Canada 6th, Finland 1st;
- Quebec: **5th for women,** Canada 9th, Finland 1st.

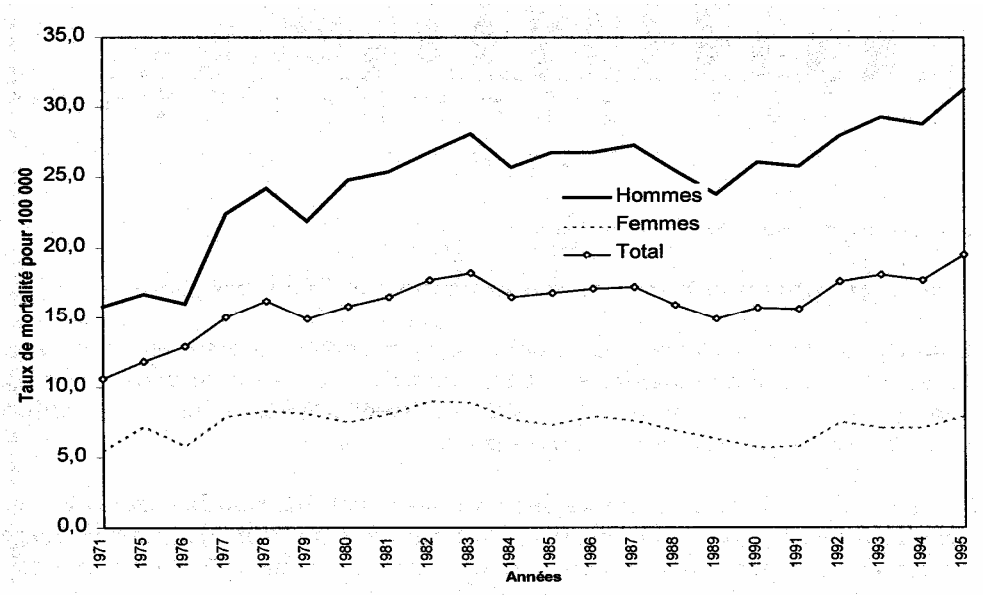
There is an even more alarming feature if you consider the number of years of potential life lost:

- Quebec: **2nd for men**, Canada 7th, Finland 1st;
- Quebec: **2nd for women**, Canada 10th, Finland 1st.

The high number of years of potential life lost confirms that, in Quebec, suicide concerns a younger population, unlike other countries, where suicide mortality increases with age. In addition, this rate continuously progressed from the 1970s until 1996 and slightly decreased in 1997 and 1998 (*MSSS, Direction générale de la santé publique*).

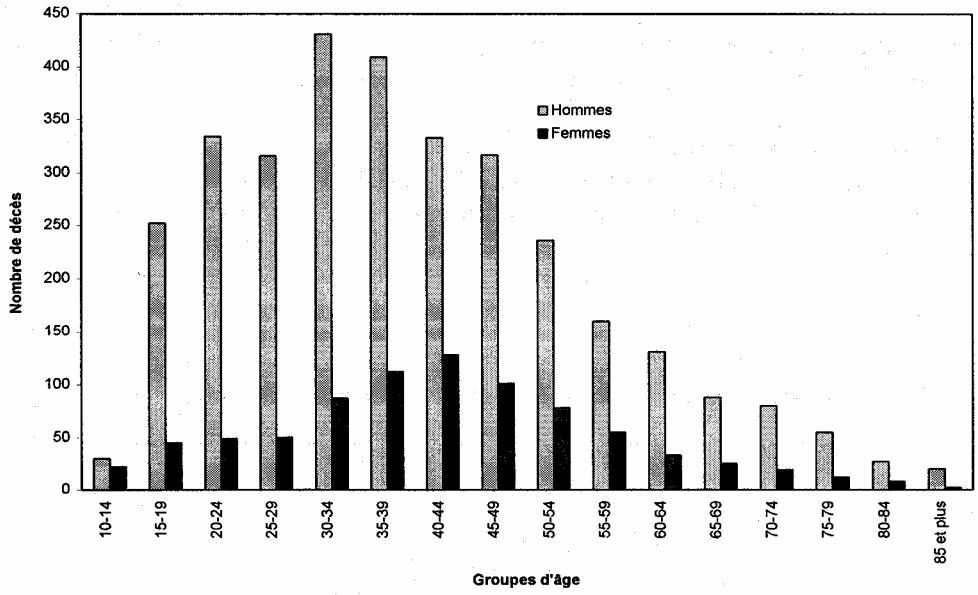
In 1999, according to the Coroner's Office preliminary data, the suicide rate in Quebec would be increasing, being even higher than in 1996. The following tables, extracted from "*S'entraider pour la vie : stratégie québécoise d'action face au suicide*", prepared by the *ministère de la Santé et des Services sociaux*[18], clearly show this fact. They generally unfold risk factors such as male sex and age group.

Table 8. Comparative suicide mortality rates for 100,000 people, Quebec, 1971-1995



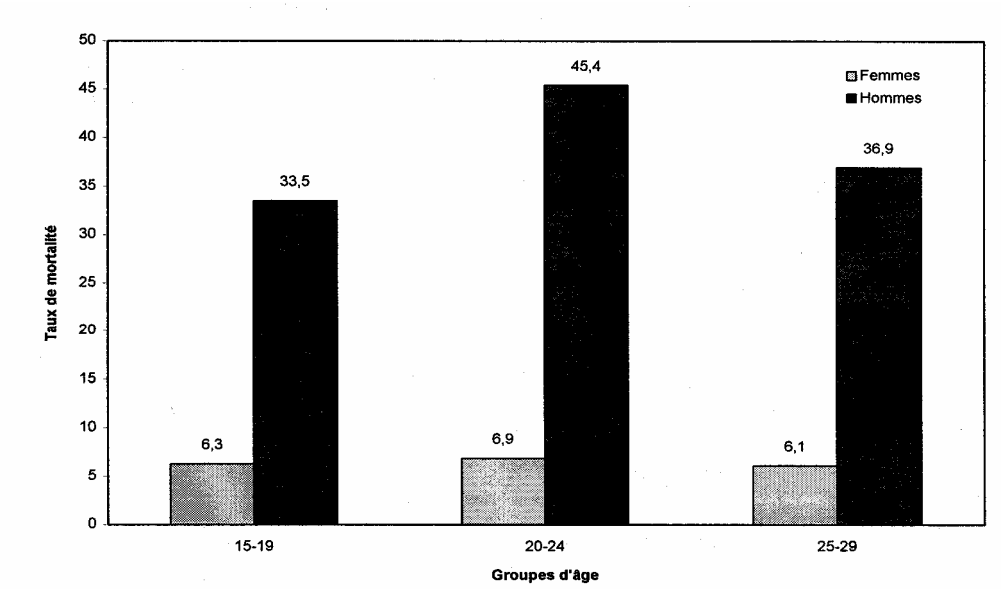
Source : MSSS, Direction générale de la santé publique.

Table 9. Number of suicide deaths according to sex and age group, Quebec, 1992-1995



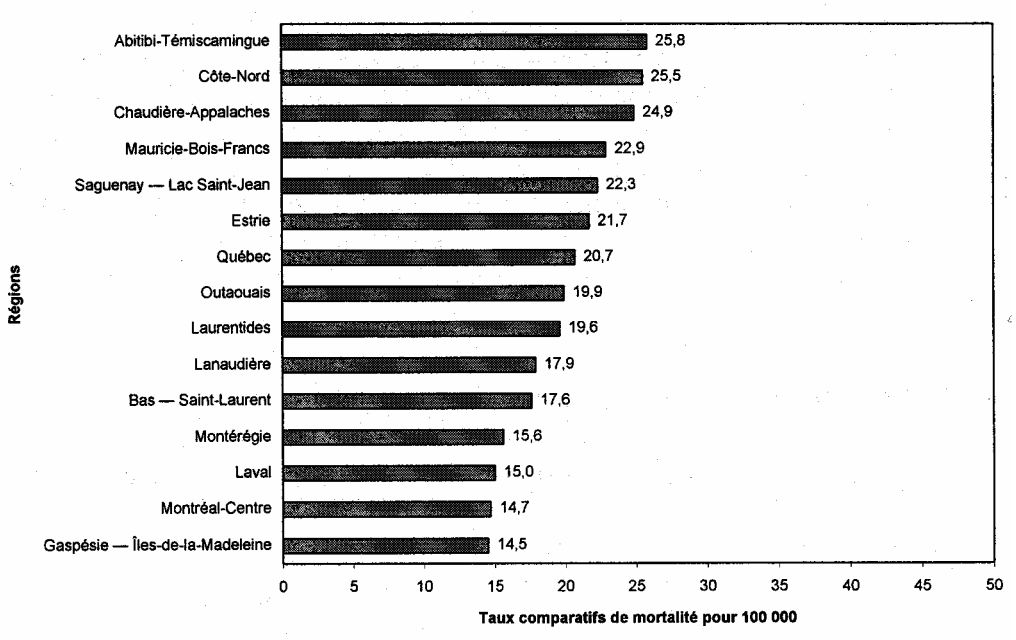
Source : MSSS, Direction générale de la santé publique.

Table 10. Suicide mortality rates for 100,000 people among youngsters, Quebec, 1993-1995



Source : MSSS, Direction générale de la santé publique.

Table 11. Comparative suicide mortality rates for 100,000 people according to the Quebec administrative region*, combined sexes, 1992-1995



Data from the national and international scientific literature shows a consensus around a ***strong relation between suicide mortality and mental disorders***, as well as some indicators associating a ***decrease in suicide rate with improved detection and treatment of depression by family physicians[19].*** Thus, some Swedish studies (Isacsson) report a 25% decrease in the suicide rate associated with an increased use of antidepressants.

Nowadays, it is recognized that at least 35% of suicides are associated with major depression, 20-25% with drug or alcohol addiction and an additional 25-30% with borderline personality disorder [20].

1.3 Costs among the highest: invalidity, premature death, comorbidity with physical diseases

"Stressful and expensive: depression and distress cost Canadians $14.4 billion in 1998[21]". That is the global cost of depression and distress estimated by investigators Thomas Stephens and Natacha Joubert[22], which represent a 71% increase over the previous publication: "Economic Burden of Illness in Canada, 1993[23]". And yet, as the authors indicated, "several data limitations suggest that these are underestimates". This study, which did account for direct and indirect costs (see Table 12), also highlighted the difficulty of assessing the overall indirect costs such as impact on other family members and relatives as well as the cost for the community, employers and insurers.

Table 12. Summary of costs related to mental health problems, Canada, 1998 ($ million)
LLCM refers to « Laboratoire de lutte contre la maladie », *Health Canada*, see reference 23.

	Coût	Source[a]
Traitement		
– des troubles diagnostiqués		
– médicaments	642	LLCM
– médecins	854	LLCM
– hôpitaux	3 874	LLCM
– autres établissements	887	LLCM
– de la dépression et de la détresse		
– professionnels de la santé mentale – non affiliés au régime public	278	Cette étude
Total	6 257	
Baisse de productivité		
– invalidité de courte durée	6 024	Cette étude
– invalidité prolongée	1 708	LLCM
– décès prématuré	400	LLCM
Total	8 132	
Total	14 389	
[a] Estimations du LLCM tirées de la référence 1, ajustées pour tenir compte d=une inflation de 6,68 % entre 1993 et 1998[5].		

For that matter, the human resources consulting group Watson Wyatt[24] states that in 2000, direct costs of absenteeism at work and cases of invalidity account for 7.1% of the total payroll and 17% if you include indirect costs, replacement and foregone productivity. Everywhere, compensation claims for psychological difficulties are increasing. In an informal conversation, the Canadian Life and Health Insurance Association (CLHIA) general director for information told us that of all the payments made according to diagnostic categories[25]:

- 33% concern mental disorders;
- 10% cardiology;
- 17% orthopedics;
- 40% other diagnoses.

The Toronto Business and Economic Roundtable on Mental Health[26] shows similar data, with depression taking a heavy toll. Researchers from Harvard University estimate that in 2020, depression will become the most important

cause of workdays lost owing to invalidity and premature death in high-income countries.

Mental disorders, including anxiety and depression, are often a comorbidity of acute or chronic physical diseases. Undiagnosed and untreated, mental disorders increase healthcare costs and worsen the recovery and survival prognosis of people with these disorders. The following tables[27] illustrate these links:

Table 13. Prevalence of Mental Disorders

	Community	Primary Care	General Hospital
Any trouble	**16%**	**21-26%**	**30-40%**
Major depression	**2-6%**	**5-14%**	**8-18%**
Panic	**0.5%**	**1.1-7%**	***
Somatization	**0.1-0.5%**	**2.8-5%**	**2-9%**
Delirium	***	***	**15-30%**
Subst. Abuse	**2.8%**	**10-30%**	**20-50%**

Source: Régier et al. 1993; Spitzer et al. 1994; Ormel et al. 1994; Cavenaugh et al. 1983; Cohen-Coke, et al. 1993; Moore et al. 1989.

Table 14. Prevalence of mental disorders in patients with chronic physical diseases

Condition	Prevalence (%)
Well	**17.5**
All conditions	**24.7**
Neurologic disorder	**37.5**
Heart disease	**34.6**
Chronic pulmonary disease	**30.9**
Cancer	**30.3**
Arthritis	**25.3**
Diabetes	**22.7**
Hypertension	**22.4**

Source: Wells et al. 1988; prevalence at 6 month, n=2,554.

Similar costs can be found in the American literature. In 1996, it was estimated[28] that:

- the cost treating mental disorders, addictions and dementias accounted for US$99 billion;

whereas in 1990, indirect costs represented US$79 billion, including:

- $12 billion for the cost of premature death;
- $67 billion for the cost of foregone productivity.

On the other hand, if mood disorders, anxiety and depression prove to be the most expensive mental disorders, the efficacy of short-term treatments is good. In 1993, the United States National Institute of Mental Health[29] reported the following rates:

- 80% short term remission for bipolar disorders and panic;
- 65% short term remission for major depression;
- 60% short term remission for obsessive-compulsive disorders and schizophrenia.

However, in the long term, several mental disorders show an evolution marked by relapses and chronicity. These are complex diseases with a low rate of spontaneous remission, and few of them prove to be transient disorders.

1.4 Essential definitions

Several definitions of concepts of mental health, mental health disorders and mental diseases or disorders can be found in the scientific literature. The *Conseil* find it necessary to explain why the selected definitions were adopted since they are essential for the clarity of the discussion and are often controversial.

The *Conseil*, regarding mental health as a fundamental part of total health, adopted the following definition, inspired from the Australian Institute of Health and Welfare's report, "National Health Priority Areas - Mental Health 1998[30]", because it explains all the factors that contribute to shape mental health.

> ***Mental health is the capacity of individuals to interact with one another and the environment, in ways that promote subjective well-being, optimal development, and use of cognitive, affective and relational abilities. Defined in this way, mental health is much more than the absence of mental illness. It is the realization of one's potential, shaped by factors such as biological make-up, gender roles, family life, human relationships, work opportunities, educational achievements and a variety of structural and socioeconomic determinants.***

Several other definitions have been reviewed: that of Rachel Jenkins in "Nations for Mental Health: Supporting governments and policy-makers", published in 1998 under the umbrella of the WHO; of Health Canada (1988) in "Mental Health for Canadians: Striking a Balance", of the *ministère de la Santé et des Services sociaux du Québec* in his *Politique de santé mentale* (1989) and of the *Comité de la santé mentale du Québec* (1994).

When applying the concept of mental health to a health/disease continuum, for example to measure prevalence rates during epidemiological studies and identify needs for services in the organization of care, there are three dimensions to consider: established diagnosis, psychological distress and social functioning. Research teams from Colorado (1992) put these aspects and their relationships into perspective. Thus, during the month before their epidemiological study, 16.3% of the population met the criteria for psychiatric diagnosis, 11% for psychological distress and 11.1% for social dysfunction. The following diagram, extracted from their publication[31], demonstrates the overlap between these dimensions for some people and their relative autonomy for others.

Table 15. Areas of overlap between each dimension of the mental health concept

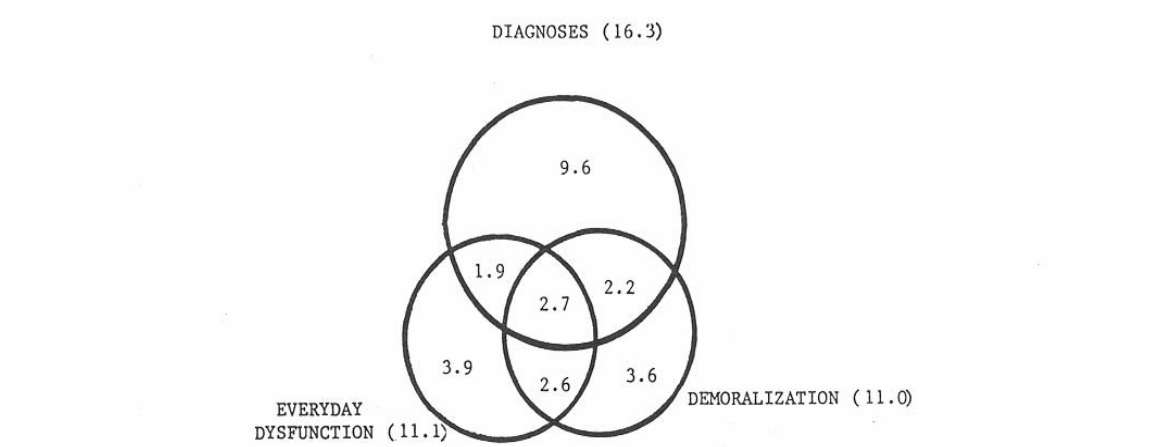


Figure 1. Prevalence rates (in percent) and areas of overlap for three measures of need for ADM services in the *Colorado Social Health Survey* ($N = 4,745$).

“Some people have classifiable diagnoses with no functional repercussion, and conversely, other people show a psychological distress or a dysfunction of psychological origin but have no diagnosis, or at least none of the ones measured in this study[32]”.

The authors consider distress, social dysfunction and psychiatric diagnosis as three aspects of a multidimensional, and possibly hierarchical, concept of mental health needs rather than three types of needs with different etiologies and evolutions.

The use of “classifiable diagnosis” leads to the definition of mental disorder. For that matter, the *Conseil* agrees with the definition adopted by the WHO (1992)[33], which underlies the international classification of mental disorders:

> ***“a set of symptoms and behaviors characterized by alterations of thought, mood or behavior, clinically recognizable, and associated in most cases with distress and interference with personal functioning.”***

That includes depressive disorders, anxiety disorders, schizophrenia, substance abuse, personality disorders and cognitive disorders, among others. Today, two classifications of mental disorders are recognized and used in the clinical and research fields. In the International Classification of Diseases (ICD-10, Chapter V), the WHO described the various mental disorders, and the American Psychiatric Association produced the “Diagnostic and Statistical Manual of Mental Disorders” (DSM-IV). These classifications, which are internationally recognized, allow physicians and other professionals to talk about the same realities, exchange and conduct research on well-defined entities, thus facilitating

the evolution of knowledge. They support the formulation of an accurate diagnosis, guide the choice of the treatment deemed most effective, and allow to follow-up on the outcome, make a prognosis and direct efforts at guarding against associated incapacity and contributing to prevention.

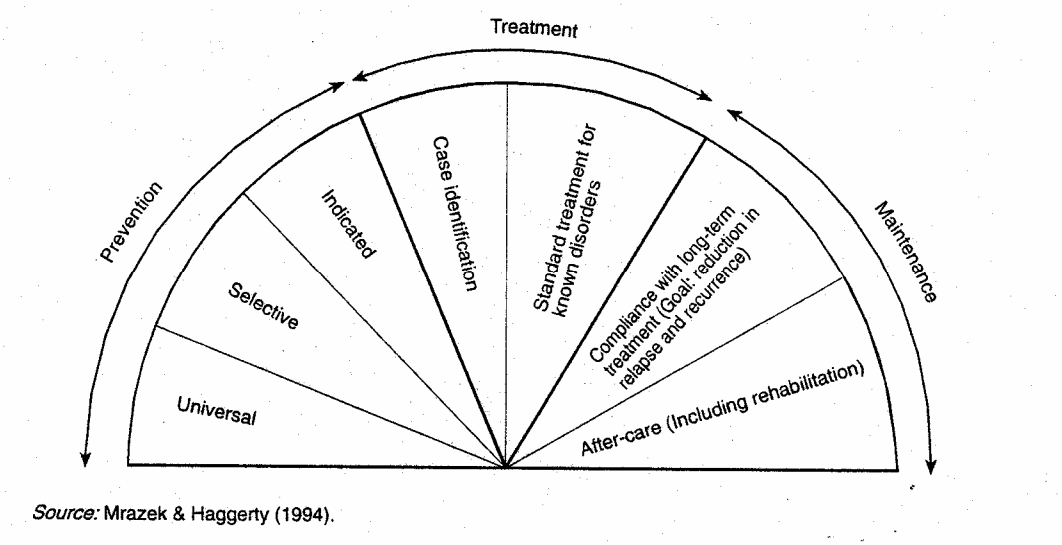
The term “mental health problem”, as defined by the Australian Institute of Health and Welfare[34], refers specifically to common mental signs and symptoms. It includes the mental ill health occasionally experienced by healthy people in relation to normal life stresses. It may also refer to signs and symptoms of mental disorders. The distinction between mental health problem and mental disorder is not clear and is based on the severity and duration of illness. There is some overlap between the two categories. A mental health problem may refer to signs and symptoms of a mental disorder, whether or not the criteria for clinical diagnosis are met. It is thus subclinical states requiring early detection and intervention to avoid deterioration. The term “mental health problem” becomes ambiguous when describing a state including signs and symptoms classifying for mental disorder. Such is the case for “transient disorders”, which can hide a mental disorder in which only exacerbations occurring during a crisis are recognized.

It is the *Conseil*’s opinion that this confusion contributes to perpetuate taboos regarding mental illness, by minimizing the importance of mental disorders, with foreseeable consequences on the access to care and services as well as on their organization. The *Conseil* feels it is important that a general effort be made to refer to each disorder by its own name as it is done with other diseases. Generally, no one speaks of having a physical health disorder, but rather of diabetes or hypertension. By calling, for example, a depression by its name, it will be easier to prevent, detect and treat this condition with a treatment known to be

effective and prevent its chronicity while implementing a care organization that meet prevention, detection, treatment and rehabilitation needs.

Since identifying needs requires the organization of services, the *Conseil* reviewed how the Australian government, specifically, tackles the various issues associated with the burden of mental disorders. It implemented, in the early 90s, an initiative called National Health Priority Areas, aiming at improving the health of citizens by targeting diseases that impose a great social and economic burden as well as interventions with significant potential health gains. This initiative aimed at identifying the most appropriate strategies for the prevention and treatment in selected areas. Five priority areas were selected, including mental health. They established a five-year action plan coordinating actions to be taken stated in their mental health policy. Based on a strong database, this plan proposes strategies implicating all participating actors and allows to organize resources around common goals, each one of them in its own field of expertise. Thus, the second plan[35] targets depression, and the following table, extracted from this publication, illustrates all the efforts that need to be invested to tackle this problem efficiently.

Table 16. The mental health intervention spectrum for mental disorders



Source: AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE. *National Health Priority Areas Report. Mental Health: A Report Focusing on Depression*, Canberra, Australian Institute of Health and Welfare, 1998, p. 61.

In Quebec, the actualization of the *ministère de la Santé et des Services sociaux*[36] 2001-2004 strategic plan provides for the renewing, during the next decade, of the *Politique de la santé et du bien-être* (1992) goals and strategies. However, to this day, no global strategy regarding prevention, treatment and rehabilitation for all mental disorders have been developed. Following the directions of the 1989 *Politique de santé mentale*, mental health services for people with severe and persistent troubles (2.3% of the 20% of people in need of services) underwent the required reform.

It thus becomes important to actualize the *Politique de santé mentale* today in the light of scientific knowledge acquired during the last decade.

This policy will then be able to support a global strategy for mental health that will allow to transform services based on improved scientific knowledge and to promote mental health.

***The Conseil feels it is the right time to recommend*:**

- ***To actualize the* Politique de santé mentale *(1989) in the light of the scientific knowledge acquired during the last decade, "defining a vision for the future that helps establishing landmarks for the prevention, treatment and rehabilitation of mental disorders, as well as for the promotion of mental health[37]"***

- ***To develop a five-year action plan and identify, among other things, measurable quality and efficacy goals for prevention, treatment and rehabilitation clinical activities, and for the organization of implemented services;***

- ***To target depression and suicide, given their burden;***

- ***To draw upon a group of experts for this initiative coming from the mental health epidemiological research field and from primary, secondary and tertiary care clinics, as well as representatives of service users and the general population.***

CHAPTER 2
TABOOS, PREJUDICES AND STIGMA: BELIEFS TO MODIFY

Despite the high prevalence of mental disorders, associated taboos and negative prejudices still remain. Discrimination and stigma add to the already heavy burden of these diseases.

The WHO[1] defines stigma as any mark of shame, disgrace or disapproval, which results in an individual being shunned or rejected by others. The stigma associated with mental illness is always strong but generally increases the more an individual's behavior differs from that of the norm. Stigma implies attitudes, feelings and behaviors. It translates into disrespect[2] and creates barriers that discourage individuals from getting the help they need. A lot remains to be done in this regard.

Although disease per se is not generally regarded as stigmatizing, some sociologists interpret it as a form of deviance, an imperfection or a problem requiring treatment that, more often than not, forces a person to defer to an expert's opinion and advice[3]. But well before healthcare professionals intervene, relatives such as family members, fellow employees or the person himself/herself have evaluated the early signs of the disease and made a decision regarding what needs to be done or not. However, the history of psychiatry shows[4] that cultural conceptions of mental illness have serious consequences on the presence of clichés and stereotypes, on the search for help as well as on the nature of existing treatment structures. Negative prejudices lead to harmful social and personal consequences and distress in people suffering from these

diseases. They are confronted with additional obstacles that complicate their recovery, which go from fear to ask for help, fear to be stigmatized, difficult access to services to the possibility to receive the most adequate treatment for their conditions. These people generally sense a lack of support and acceptation around them and their rejections affect their family, their relatives and even the organization of required services.

But where do these prejudices come from? Why should people with mental disorders be confronted with additional difficulties that do not exist with other illnesses?

We will see that everyone has these prejudices, including the population, healthcare professionals and physicians. Nowadays, at a time where we try to overcome taboos and prejudices related, for example, to sexually transmitted diseases and homosexuality, the *Conseil* believes the same can be done for mental illnesses.

2.1 Popular beliefs: diseases or states of mind

A recent publication from the British Royal College of Psychiatrists[5] about a public opinion survey on mental illnesses proved to be full of lessons. The goal of this study was to support the five-year campaign entitled “Changing Minds: Every Family in the Land[6]” aiming at reducing the stigma and discrimination facing patients with mental illness. Psychiatrists wanted to assess the evolution in public opinions since the work of Hayward and Bright (1997)[7]. Hayward and Bright concluded, from a review of previous literature, that people with mental diseases were perceived as being dangerous and unpredictable, being difficult to talk with, having only themselves to blame, having a poor outcome and responding poorly to treatment. Their conclusions prove that, in 2000, negative opinions about

common mental disorders, such as severe depression, panic attacks, schizophrenia, dementia, eating disorders, alcoholism and drug addiction are still prevalent in the population. The most negative opinions relate to people with schizophrenia, alcoholism and drug addiction, with more that 70% of respondents considering these people to be dangerous to others and unpredictable. These opinions are consistent with the views often expressed by the media.

In addition, it is estimated that alcoholics, drug addicts and people with eating disorders are to blame for their problems. Although the mortality rate among people with eating disorders is 15%, this illness is minimized. As for people with depression, 62% of respondents indicated they were hard to talk to, and to a lesser degree, that they were dangerous to others and that they would not eventually recover. Finally, more recently, the National Mental Health Association[8] indicated that nearly one in three Americans believes depression is a state of mind rather than a disease. “You would never hear 31% of the population say that diabetes and heart disease aren’t real. Wrong beliefs about depression fuel stigma, bad public policies and poor personal choices from those living with the illness and may impede their recovery,” indicated its President.

In Quebec, we found three older but very interesting studies[9,10,11] about the social representation of normality and abnormality related with mental disorders. They reveal that the term “mental illness” is reserved for severe pathologies, whereas different expressions such as “nervous, instability, phobia, overstress, excessive thoughts” are used to describe conditions considered to be between normality and pathology, indicating that one can recover. The second annual America’s Mental Health Survey[12] suggests that the following beliefs are the most common barriers to diagnosis and treatment:

- ***Symptoms are not associated with a disorder:*** 93% of undiagnosed people do not associate their symptoms with a mental disorder even though nearly half of them admit their symptoms cause them distress and restricted social function;

- ***Symptoms can be self-treated:*** nearly half of undiagnosed people will not go to a health care professional since they believe their symptoms are self-manageable. They would rather utilize self-help techniques such as prayer, rest, exercise, sleep or emotional support from family and friends;

- ***The diagnosis, itself, is stigmatizing:*** nearly half of people with a formal diagnosis say they are embarrassed by their symptoms, compared to 17% of those undiagnosed. Twice as many people with a formal diagnosis are afraid to talk to their friends about their mental health problems, and only 40% of them believe their symptoms mean they have a mental disorder.

2.2 Popular beliefs: treatments

In 1997, Australian investigators interviewed 2,031 households to assess the ability of the public to accurately recognize mental disorders as well as beliefs about the effectiveness of various treatments[13]. They concluded that the public's general knowledge of mental illnesses is good, but that the understanding of their specific characteristics is more limited. As for beliefs regarding treatments, the study results are surprising: non-standard treatments such as increased physical or social activity, relaxation, stress management, reading about people with similar problems were rated highly, whereas psychiatric treatments such as medication or hospitalization were rated as harmful. Similarly, vitamins and special diets were more often rated as more helpful than were antidepressants and antipsychotics.

The National Mental Health Association Survey, mentioned earlier, also indicated significant differences between the public's perceptions and that of people under treatment. Whereas in the public's opinion, regular exercise, healthy eating and psychotherapy are superior to medication to prevent future episodes of depression, people under long term treatment and physicians consider medication to be the most effective way of preventing relapses, even if you add psychotherapy and healthy lifestyle choices.

Other studies[14] also tried to understand the impact of the socio-cultural context, particularly the influence of public opinion on the choice of an appropriate treatment, acceptation of various psychiatric treatments and, consequently, patient compliance. These studies, conducted in Germany, show that the general public regards psychotherapy very highly, whereas most respondents reject psychopharmacology for all the types of disease evaluated in the survey. Psychotherapy is seen as a complex treatment that allows to find the cause of a

problem and to solve it at its origin. Psychopharmacology, on the other hand, is perceived as typically sedative, only alleviating symptoms without treating underlying problems, leading to addiction and severe side effects. These very studies reveal, as we will see later, significant gaps between popular conceptions and that of psychiatrists regarding the type of treatment considered adequate for various mental disorders.

What are the factors underlying the negative perception about drugs used in psychiatry or *psychotropic drugs* (other than the ones used to treat a physical disease that have an effect on the brain or non subscription substances such as alcohol)? Understanding this seems important to us since developments in modern psychopharmacology lead to major progresses in the treatment of mental disorders and reduction of the associated invalidity. Recent discoveries about the functioning of the brain make us optimistic: in 2000, the Nobel Prize in Medicine was awarded to three brain research pioneers, and modern technology allows to study the metabolism of the brain reacting to environmental as well as chemical stimulation. Psychoactive drugs are often not well received by patients, their families, the population and even some healthcare professionals. To better understand this phenomenon, other researchers[15] reviewed the perceptions of 2,176 people about psychotropic drugs compared with cardiac medications. They concluded that psychotropic drugs were generally not well received for all mental illnesses but schizophrenia. Their conclusions show that the severity of mental illnesses is underestimated, they are considered mental health problems rather that serious diseases and people think they don’t need treatment (see Table 17). The cost-effectiveness ratio of psychotropic drugs for an individual is also negatively interpreted: it is associated with severe side effects and great fears of losing self-control.

Table 17. Views on the Appropriate Treatment of Various Diseases

	"Best possible treatment"					
	Drugs %	Psychoanalysis Psychotherapy %	Treatment pointless %	Nature cure %	No treatment Required %	No statement %
Sudden heart attack	92	1	3	2	X	3
Diabetes	88	1	2	4	1	4
Hypertension/high blood pressure	73	1	x	21	x	4
Arthrosis/joint disease/ "Rheumatism"	67	2	2	25	x	4
Insomnia/sleep disturbances	20	15	2	49	12	3
Drug addiction	26	47	17	3	1	5
Alcoholism	14	61	14	4	3	5
Addiction to prescribed drugs	9	65	9	9	3	5
Paranoia	8	76	6	2	4	4
Depression	4	64	5	8	15	4
Mania	4	61	10	5	16	4
Social phobia	4	68	7	6	10	5
Alzheimer's disease	36	6	48	5	1	5
AIDS	30	2	63	1	x	4

x = less than .5%

Source: BENKERT O., *et al.* "Public opinion on psychotropic drugs: an analysis of factors influencing acceptance or rejection", *Journal of Nervous and Mental Disease*, vol. 185, n° 3, 1997, p. 154.

And media[16], when presenting these subjects, play a crucial role since they prove to be the primary source of information for a great part of the population. People tend to limit discussions about mental illness and its treatment to family and very close friends. The influence of media on the acceptation or rejection of psychotropic drugs is even stronger than the influence of the individual's own values.

In order to better understand the factors affecting the search for help of a person with psychological distress, other authors[17] reviewed the role of belief systems and attitudes regarding that issue. Initially, it is how the individual defines his problem that leads him/her to ask for help, but rapidly his perception of the cause of the problem becomes involved. If the person feels he/she has no control over the cause, e.g. biological or supernatural factors, he/she tends to turn to professional help. If the causes are perceived to be social (poverty, unemployment, family distress, isolation, alcohol and substance abuse), he/she will rather look for help in a confidant or a self-help group. For problems related to psychosocial stress, confidants and family physicians are the preferred interlocutors. Then there is the perception of the prognosis: the poorer the prognosis, the less the inclination to choose a confidant. Finally, the perception about the source of help plays a role in the process. The authors noted that typically, for depression, people first consult a confidant, which is consistent with epidemiological studies, which show that only 25-33% of depressed people turn to professional help. This also helps us understanding the amount of distress supported by the confidant system, primarily relatives and families, and directing education and prevention efforts.

As stated previously, the general public's beliefs about the causality and treatment of mental disorders differ greatly from that of mental health professionals and particularly psychiatrists[18]. The belief and attitudes about mental disorders limit the optimal use of available services and should be considered in the organization of these services[19]. Even in the health care network, these divergences prevail. The *Commission d'étude sur les services de santé et les services sociaux*'s report, in the chapter about the organization of services, makes different recommendations for patients with major mental health problems and for patients with complex and often chronic diseases, such as cancer, heart failure, asthma and diabetes. Mental disorders are also complex

and often chronic diseases. Even within the mental health network, beliefs regarding the indications, choices and effectiveness of treatments are far from being homogenous[20] between the various groups of professionals. ***Acknowledging this reality is of vital importance for the implementation of quality integrated healthcare networks.***

The *Conseil* is all the more convinced of the importance of fighting these prejudices since a growing number of people are exposed to their consequences. Stigma hurts them, causes them discouragement and anger, and seriously affects their self-esteem. It forces them to hide their psychiatric history and dissimulate information when requesting a job, adding to the pain and stress of the disease a constant fear of being discovered. These people rightly fear to be discriminated against at work and in insurance coverage. They are often subject to negative comments and suffer from that situation. This stigma, when resulting from rejection behaviors and depreciating comments from healthcare professionals, is even more unacceptable since, because of their training, these professionals are the very persons to whom people with mental disorders turn to for help and support.

Finally, one must remember that stigma also affects families and relatives of people with mental disorders. Feelings of being rejected or pushed away and the need to hide the relative's disease also haunt families and contribute to reducing the social support they so badly need. This is even truer when the patient is the partner, since he/she usually is the key person in the couple's or the family's social support.

2.3 Solutions

Prejudices against mental illnesses are ubiquitous and, as Byrne[21] so well put it, there are no words describing the prejudice against mental illness whereas we have terms such as racism, sexism, ageism and homophobia to describe other prejudices. Should we use the term psychophobia?

Despite a clear improvement in the public's understanding of mental illnesses and their treatments between 1950 and 1996, some studies[22] show an increase in prejudices regarding the perceived violence associated with each mental illness and in the desire for social distance from mentally ill people, among others, because of this perception. Media often contribute to perpetuating these opinions because the way they present these subjects. Thus, the predominant role of media is to be taken into serious consideration and the means to be implemented to fight these prejudices will have to take them into account.

Initiatives proposed by several organizations include the World Psychiatric Association[23]'s Anti-Stigma Campaign, which was first implemented as a pilot site in Calgary (Alberta). Supported by an international network of experts and centers united in their determination to give people with schizophrenia an acceptable quality of life, this program has a triple mission:

- Increase the awareness and knowledge of the nature of schizophrenia and treatment options;
- Improve public attitudes about those who have schizophrenia and their families;
- Generate action to eliminate discrimination and prejudice.

This campaign, based on existing local programs coordinated by a committee made up of people from the field, targets groups in which intervention is needed: emergency room staff, medical student, politicians, teenagers, clergy, business leaders, journalists, general public. The committee implemented a project with several steps, from analysis of the needs of the different groups to analysis of the results and follow-up to maintain the learnings.

In England, the Royal College of Psychiatrists elaborated a five-year information campaign, entitled “Changing Minds: Every Family in the Land” aiming at:

- Increasing the public’s and professional’s understanding and knowledge of mental health problems;
- Reducing stigma and discrimination against people with these problems;
- Closing the gap between the different beliefs of healthcare professionals and the public regarding useful treatments and interventions.

Other programs chose to take action at the media level by publicly criticizing them when they give a negative representation of mental illness, or even better, by supporting quality journalistic information and granting awards for excellence in journalism (The Rosalynn Carter Fellowships for Mental Health Journalism). Other programs prefer to act by presenting bills, such as the “Mental Health Early Intervention, Treatment and Violence Prevention Act of 2000” in the United States, that includes, among other things, an anti-stigma campaign to educate the population regarding the causes of mental illness, effective treatments and available resources for patients and their families.

Finally, in Canada[24] and in Quebec, several local or national interest groups, such as the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) and the *Association des dépressifs et des maniaco-dépressifs (ADMD)* are very active and well organized in their public and politic actions as well as in their initiatives with people living with mental disorders and their families.

In order to maximize the scope of the actions already taken and because of the burden of mental disorders for public health, ***the* Conseil *recommends:***

- ***To implement an information campaign to improve the population's knowledge of the most common mental disorders, their prevention and effective treatments;***

- ***To spread this campaign over several years and to make sure there are local programs to support the campaign;***

- ***To convey targeted messages for the public and various professional groups, particularly groups from the media, academic, justice and work fields;***

- ***To develop messages after having analyzed the perceptions in the Quebec population;***

- ***To focus on a strong implication from the community and media, including Internet.***

CHAPTER 3
DISSEMINATING INFORMATION:
AN INESCAPABLE FACT

In order to analyze the basis for the dissemination of information regarding the recommendations stated in the previous chapter, the *Conseil* studied the necessary conditions for the dissemination of evidence-based scientific data. It reviewed the issues of disseminating information to the general public, healthcare professionals as well as administrators and decision makers.

3.1 Facilitate the dissemination of evidence-based data to better inform the public

The primary goals of knowledge transfer from the research field to the general population are to allow the acquisition of evidence-based mental health information and reduce associated false beliefs and attitudes. Disseminating this knowledge also contributes to improving the ability of people to deal with their own mental health and, indirectly, to reducing stigma.

It is recommended to implement simple measures that facilitate the assimilation of knowledge so that people can:

- Recognize the most common mental disorders;

    - Discriminate between beliefs and current scientific knowledge regarding causes, possible treatments, their advantages and limitations;
    - Discriminate between beliefs and current scientific knowledge regarding the nature of self-helps and attitudes contributing to improve mental health.

The acquisition of mental health knowledge may help people deal with a potential problem for themselves, their families or their environments, and feel more comfortable talking about it. Since only a minority of people meeting the diagnostic criteria of mental disorders turn to professional help, information about appropriate and beneficial self-help should be available. For those choosing to consult a professional and be treated, this information will help detecting and diagnosing the disorder, and will act in synergy with the treatments prescribed by healthcare professionals. It will also help establishing a partnership between the patient and the physician, support informed consent to the proposed treatment and improve results in the diagnosis, care and compliance with the selected treatment.

Mental health education can take several forms. The *Conseil* selected the following examples as they are original and easy to apply. A group of investigators from the Australian National University[1] developed a mental health first aid course integrated in the physical health first aid training. The purpose of this 6-hour training is to provide participants with the knowledge and skills to act

in a crisis situation and provide help to a person experiencing a mental health crisis or a mental health problem such as depression, anxiety, early stages of psychosis or substance abuse. In addition to being original and easy to implement, this approach allows the integration of physical and mental health and, by penetrating various fields, helps reducing the stigma associated with mental illness. In Quebec, one of the eight major directions proposed by the *Comité national sur la révision des services préhospitaliers d'urgence* in his report, *Urgences préhospitalières, un système à mettre en place* (pre-hospital emergencies, a system to implement), was that *every intervention should be guided by a training and continued quality improvement program for the clinical and administrative aspects.*

The* Conseil médical *recommends:

- ***To make sure that any basic first aid training includes a mental health first aid course.***

The American Medical Association Foundation oversees a national campaign entitled "Partnership in Health: Improving the Patient – Physician Relationship Through Health Literacy" whose goal is to help the general population acquire the necessary knowledge in order to make a better use of available information and access relevant health services, get adequate diagnoses and treatments, and understand the proposed medical recommendations[2]. Despite its general focus, this orientation takes into account the actual and often unknown difficulties, beyond illiteracy, of being understood during a consultation, discussing with the physician and understanding the modalities of the proposed treatment. This approach also helps improving the quality of care and patient satisfaction and reducing stigma.

Like popular programs in the United States, McGill University introduced a series of courses similar to medical classes and aiming at the general population. This approach is consistent with the interest shown by people in their own health and allows them to get a basic medical education and become aware of the work of research. This approach has a very high potential since it can easily be integrated in teleuniversity. Let's hope mental health acquisition will be part of the program.

The Government of British Columbia[3] chose a multimodal approach in a pilot project to educate the general population that promotes self-care for common physical health problems, but not mental health. "Partnerships for Better Health, a Self-Care Pilot Project" consists of three components: a telephone information line (BC HealthGuide NurseLine), a handbook (BC HealthGuide Handbook) and a Web site (BC HealthGuide Online). In addition to promoting problem resolution, this program tries to make suggestions as to when to ask for emergency services or see a health professional. The final evaluation of this pilot project[4], in May 2000, showed a reduction in the use of emergency services as well as a more appropriate use of medical services. The report concluded that:

- The handbook provided information that was easy to read and straightforward instructions that participants in great numbers utilized for treating minor time limited health issues and engaging in preventative exercises.

- The number of participants who intended to engage in self-care increased consistently every month during this project.

- Participants reported that they now were more engaged in discussions with their physicians and prepared a list of questions for their visits to their physicians.

- The Handbook was extremely well received. Participants who had the book shared the knowledge with their neighbors and friends; teachers used it in their classrooms; families made it part of their first aid kits.

It would be easy to integrate mental health notions in this program, which would help decrease stigma and recognize mental health as a fundamental aspect of one's health.

It is impossible to talk about disseminating information without mentioning the Internet. This resource offers multiple advantages despite its limitations and potential dangers[5]. Considering its easy access at any time and its capacity to disseminate information rapidly, it is a particularly useful way of supporting mental health literacy[6]. It allows to reach people that would not seek professional help or do not have access to such help because of their remoteness, isolation or lack of mobility. For the general population, it means better access to the necessary knowledge to identify the most common mental disorders and treatments recognized to be effective. It also proves to be useful to educate patients and families, and allows them to express their needs and opinions.

However, overload and quality of information circulating on the Internet are important issues. Every year, over four millions scientific articles are added to the medical literature, how can we make sense of all this? Convinced that it is impossible for the general public to evaluate the quality of available information regarding its fidelity to scientific evidences or to recognized clinical practice guidelines, ***the* Conseil *recommends*:**

- ***To mandate the* Institut national de santé publique du Québec *(INSPQ) in collaboration with the* Agence d'évaluation des technologies et des modes d'intervention en santé *(AETMIS) and the* Conseil consultatif de pharmacologie *to implement a quality mental health information Web site that the public could consult with confidence;***

- ***To make sure they receive the necessary collaboration from the mental health research field, the academic field and professional associations.***

One role of the Internet that is less exploited is as a treatment and self-help support. It contains a wide variety of information: some sites offer self-monitoring and are excellent, others are not; some sites provide counseling and therapy for compensation; one can also buy a computer-administered treatment program, or participate in a group therapy with or without professional support, and all kinds of drugs can be bought on the Internet. There are very few evaluations of the mental health therapeutic possibilities offered by the Internet: a study mentions some advantages for self-monitoring[7], another one for computer-administered treatment programs[8]. In order to make use of every modern means of support, ***the* Conseil *recommends:***

- ***To mandate the* Agence d'évaluation des technologies et des modes d'intervention en santé *(AETMIS) to evaluate the capacity of the Internet to contribute to the detection and treatment of the most common mental disorders, particularly in association with telepsychiatry.***

The Internet can also be very useful when promoting various partnerships[9]. It gives the opportunity to build strong partnerships between patients and clinicians, and could stimulate the collaboration between consumer groups and professional organizations. However, to be effective, information systems must be easy to access and use and must provide rapid access to appropriate information.

Finally, the Cochrane Group[10], when developing evidence-based clinical practice guidelines, created a consumer association to help people making well informed decisions about health care by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions.

Although the Internet, particularly for therapeutic purposes, must be used in the context of a serious professional assessment and a care plan established during an in-person consultation, and as a complement to the treatment, it still remains a promising tool that needs to be well evaluated, marked out and used to:

- Promote mental health;
- Prevent mental disorders;
- Help detect and accept a diagnosis;
- Know and evaluate potential treatments and choose them;
- Improve self-care and follow-up one disease evolution and recovery.

3.2 Facilitate harmonization of research-based knowledge with effective and relevant approaches and interventions, targeting evidence-based data for healthcare professionals: clinical practice guidelines

Popularized by the Internet and considered by healthcare administrators as a way of improving the quality of care and reducing healthcare costs, clinical practice guidelines prove to be, upon analysis, a very complex topic. They are defined here as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances[11]”. The *Conseil* acknowledges their ability to bring together mental health professionals and the general public, promote agreement to common current research-based scientific knowledge, and optimize clinical practices for the best interest of patients and their families. They can also be used to evaluate the quality and effectiveness of clinical practices as well as the organization of services. The *Conseil* reviewed clinical practice guidelines in view of the following elements: development and quality criteria, dissemination and implementation criteria and role played in evaluating the quality of care.

3.2.1 Development and quality criteria

The quality of clinical practice guidelines is of primary importance since, as we mentioned earlier, over four million medical articles are published every year and medical knowledge evolve rapidly.

Clinical practice guidelines that answer questions about a specific clinical situation and that are based on the best available information evaluated for its validity, relevance and clinical applicability[12] are considered high quality guidelines. Given the amount of information available that needs to be evaluated, it is impossible to expect a clinician to evaluate and choose one of these practice guidelines even if he has access to an excellent appraisal instrument[13]. That is why the *Conseil* supports and associates with the recommendations included in the report *Élaboration et application de lignes directrices pour l'optimisation des pratiques médicales : Résultats d'une expérience québécoise*[14] ***and recommends*:**

- ***To support the* Collège des médecins' *leadership, in collaboration with implicated professional associations and with the support of research and evaluation resources, in the development, implementation and updating of medical practice guidelines for the detection, diagnosis and treatment of mental disorders;***

- ***To ensure that necessary technical and human resources for the development of these guidelines are adequately funded;***

- ***To ensure that patient and/or public representatives are involved.***

3.2.2 Dissemination and implementation criteria

The way practice guidelines are disseminated is crucial in their adoption and application by professionals. The conditions for a successful dissemination have been far more studied, and strategies divide in two categories: “primary strategies involving mailing or publishing guidelines and secondary interventional strategies to reinforce the guidelines[15]”. These interventions were reviewed according to their ability to induce changes in practice, and the best ones included reminder systems, academic detailing and multiple interventions. However, a literature review about dissemination and adoption criteria showed the very moderate role played by practice guidelines in inducing practice changes and maintaining these changes. In order to create good conditions for the implementation of clinical practice guidelines developed at the provincial level, ***the* Conseil *recommends*:**

- ***To support, at the regional level, a formal organizational structure for the implementation of mental health medical practice guidelines;***

- ***To ensure that there is a partnership between representatives of the* Conseil de l’éducation médicale continue du Québec*, the* Collège des médecins *and regional representatives to maintain a continuity between the development of guidelines, their relatively uniform implementation and their evaluation;***

- ***To ensure necessary technical and human resources for the implementation of these practice guidelines are adequately funded.***

3.2.3 Monitoring results

Since the ultimate goal of clinical practice guidelines is help improving care by optimizing practices, they obviously must stick to the reality of various clinical needs. The idea of involving regional authorities is to modulate the prioritization of guideline topics, support an implementation promoting improved results according to health gains for patients and their families, and appraise results based on the improvement of practices and service organization. Needless to say that a tradition of relevant data collection must be establish in order to measure the achievement of targeted goals and include all regionally available research resources.

To achieve these goals, ***the* Conseil *recommends:***

- ***To ensure, at the regional level, that continuous evaluation activities are implemented, targeting:***
    - ***Processes: adapting practices to guidelines, maintaining practice changes;***
    - ***Results: health gains for patients and improvement of quality and organization of care;***
- ***To ensure the availability of necessary technical and human resources to conduct these activities.***

3.3 Facilitate the integration of research-based knowledge in healthcare policies and management by improving communications between all implicated partners

"Evidence-based decision making became part of the health sector's lexicon during the 1990s. It was a logical extension of the interest in and resources committed to evidence-based medicine, expecting those managing and making the policies for the health sector to operate under the same rules as those delivering the services[16]". As one of the four themes upon which the National Forum on Health focused, evidence-based decision making is defined as:

> ***"The systematic application of the best available evidence to the evaluation of options and to decision making in clinical, management, and policy settings."***

The Canadian Health Services Research Foundation's definition illustrates the various elements interacting in the decision-making process depending on the environment: clinical, management or public. It shows how decision-makers and administrators, in their work, must compromise with various value systems and not just with scientific facts, no matter how good these are. Hence the necessity for them to value and have access to the best evidence-based scientific knowledge as a starting point for their decision-making process. In this context, communication between these partners becomes really important for the sake of the patient's wellness.

Over and above the analysis of the relationship between researchers and decision-makers, this study shows very relevantly the influence of “knowledge purveyors”, represented as a very heterogeneous group including public relation organizations, media, foundations, think tanks, representatives from the commercial sector and from various scientific publications.

All these authorities offer decision-makers information that span a continuum, ranging from “scientific fact” to stories based on personal experience, anecdote, needs, interests, values, myths and hypothesis. “Moving more to evidence-based decision making will involve tempering these anecdotes and stories from various interests with facts and evidence from research[16]”. The *Conseil* feels the implementation of the measures proposed in this chapter will help improving evidence-based decision making.

CHAPTER 4
MEDICAL SERVICES AND PSYCHIATRY

Aware that several models of organization have been proposed for mental health care and services, in this chapter, the members of the *Conseil* consider the needs for medical services with a population-based approach given the high prevalence of mental disorders and the invalidity and costs associated with them.

They took into consideration the opinions expressed by the *ministère de la Santé et des Services sociaux*[1,2,3,4] and professional organizations such as the *Association des médecins psychiatres du Québec*[5,8], the *Collège des médecins du Québec*[6], the *Fédération des médecins omnipraticiens du Québec*[5], the College of Family Physicians of Canada[7], the Canadian Psychiatric Association[7], the Quebec Hospital Association[9], as well as previous recommendations from the *Conseil médical du Québec* regarding the hierarchical organization of services[10,11], also used in the Clair Commission report (*Commission d'étude sur les services de santé et les services sociaux*)[12].

The members analyzed the contribution of first and second-line medical services in reducing the burden of mental disorders, based on principles of accessibility, evidence-based quality practices and continuity of care associated with service integration.

4.1 Primary care: accessibility, inclusiveness and continuity of general medical care

4.1.1 Role of the primary care

As we saw previously, people's attitudes, beliefs and preferences lead them to see a family physician first when they experience various mental health disorders. What are their expectations and how do they express their needs? What are these needs and what are the goals of primary psychiatric care services?

First, patients want communication and partnership with their family physician. They expect to receive health promotion information, have their problem examined and, finally, get a prescription[13]. As for how needs are expressed, several studies[14,15] cast a very interesting light on this issue, including Ian B. Hickie in "Primary care psychiatry is not specialist psychiatry in general practice[16]". Thus, when they consult their family physician, most patients with mental health disorders have physical complaints (fatigue, insomnia, pain) rather than psychological symptoms (5.3%). This is often accompanied by physical diseases (47%), whereas other patients have unexplained physical symptoms and require long-term follow-up (e.g. chronic fatigue syndrome). That is why the dichotomy "it's either physical or mental" proves to be inappropriate[15].

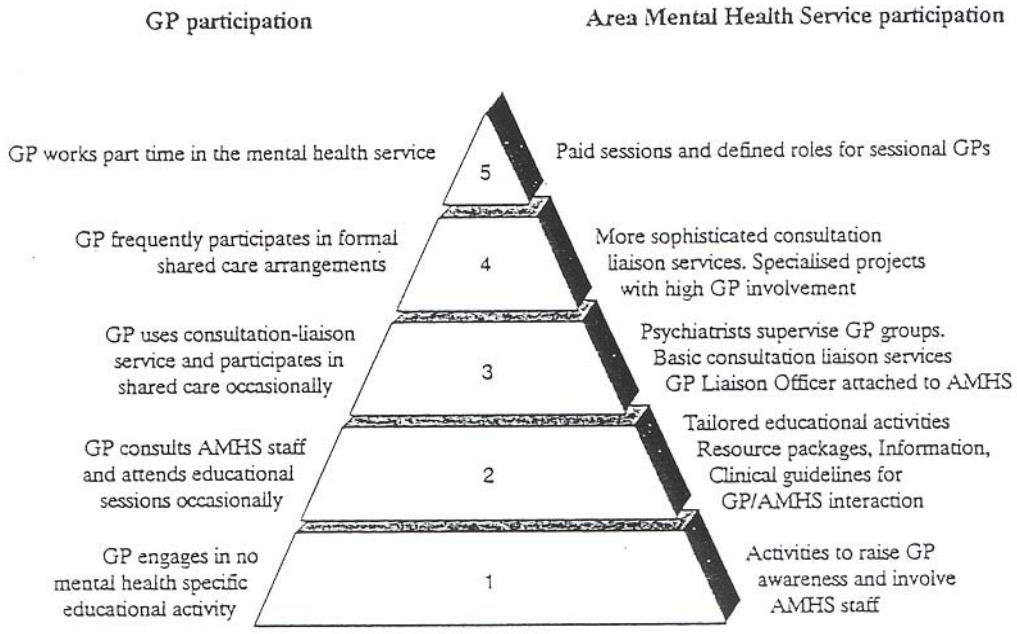
In this context, a family physician should pay careful attention to the detection of mental disorders, in addition to contributing to health promotion and disease prevention. Studies show that at least 25-30% of patients seeing a family physician meet recognized diagnostic criteria (ICD-10, DSM IV) and another 10% have subclinical disorders. Focus on detection will be very important since invalidity increases proportionally with symptoms and reach a peak 6.2 days in the month preceding the mental disorder diagnosis[14,15]. Occupational incapacity seems to be a bigger issue with mental health problems than with physical disorders.

All international[14], Autralian[16] and American[17] studies show an important primary care sub-diagnosis problem, both in the adult and child and teenager populations[18]. In addition, according to these studies, when these problems are adequately diagnosed, an important number of patients receives no treatment or does not receive the adequate treatment. It is now recognized that early detection and intensive treatment, based on best-practice data, are essential to recovery and to avoid chronicity and loss of autonomy, for both mental and physical disorders[19, 20, 21, 22, 23].

The family physician must establish an accurate diagnosis to choose the necessary treatment and give the patient an effective and specific treatment[23]. As most cases will continue to be managed by the primary care network, he needs an in-depth knowledge of the specificities of effective treatments (drug treatments, psychotherapies, etc.) to ensure a follow-up alone or in collaboration with competent professionals. Finally, he will have to establish functional relationships with psychiatrists to ensure the continuity of care according to the complexity of the cases and the variations in the needs for diagnosis, treatment and patient management. This collaboration is also essential to meet his needs for advice in the context of a clinical practice based on shared care.

Table 18, extracted from Dr. Graham Meadows' work (1997), illustrates all the possible levels of interaction between family physicians and psychiatrists.

Table 18. Model of interaction between general practitioners (GPs) and local area mental health service (AMHS), based on varying levels of interest, resources and need on both sides



4.1.2 Barriers to primary care diagnosis and treatment

There are several barriers to the primary care diagnosis and treatment of mental health disorders. Analyzing these barriers allows us to identify the necessary conditions to improve detection, reduce the burden of these diseases and better answer the needs of consulting patients. Three types of factors are instrumental in the difficulties to establish a diagnosis:

- **Patient-related factors**

  The somatic rather than psychological mode of presentation of symptoms and the different causal attributions for symptoms[24] play an important role. Whereas some patients find physical explanations to their problems, others minimize their problems by finding explanations in their daily life (e.g. exhaustion due to overwork which, for example, confuses the path to the diagnosis of depression). The simultaneous presence of physical and psychological problems, stigma associated with the psychiatric diagnosis and treatment, and patients' beliefs and preferences regarding treatments also contribute to these difficulties.

- **Family physician-related factors**

  A family physician may not have all the necessary knowledge and skills to detect, diagnose and treat various mental disorders. This may be due to a lack of basic training related to the content of pre-doctoral study programs or to a lack of participation in continuing education activities. He may not have enough time for these long diagnostic and therapeutic procedures

considering his workload and/or the available medical staff. He may also not be interested in these problems or have negative bias towards mental disorders.

- **System-related factors**

  The organization of services does not always bring the family physician the support he needs from other professionals as well as from secondary care specialists and multidisciplinary teams. In addition, there is currently no appropriate remuneration provided for this type of practice in private practice, where 80% of patients consult. Primary care psychiatry requires a much longer duration for these visits than the amount of time normally required for an average visit.

4.1.3 Primary care physician needs

As it is now admitted that mental and physical health care should be integrated in the same service structures (mainstreaming concept), the family physician needs more time and an adequate remuneration for these clinical activities. Developing this integrated service approach clearly affects how the required workforce is calculated. In addition, the physician needs a diagnostic grid adapted to the specific needs of his practice (ICD-10 PHC, DSM-IV PC). He will also appreciate the availability of relevant and patient-friendly detection tools in order to maximize the time available for diagnosis and treatment. He will benefit from the effects of an anti-stigma program and public information and education efforts, as previously proposed.

The psychiatrist that will work with his colleague at the interface between primary and secondary mental health services[25] should pay attention to every particularity of primary care psychiatry. This knowledge will prevent him from carrying on atypical or undifferentiated diagnoses of mental disorders, as these imprecise diagnoses reinforce the impression that mental disorders are not serious, do not deserve treatments or systematic studies and research, and give the family physician the feeling that he is not taken seriously.

4.2 Models of working at the interface between primary and secondary mental health services: consultation, liaison and shared care

Joint documents from the *Association des médecins psychiatres du Québec* and the *Fédération des médecins omnipraticiens du Québec* (1990) as well as from the Canadian Psychiatric Association and the College of Family Physicians of Canada (1997), previously mentioned, give a good description of the nature, objectives and strategies of the development of a collaboration between primary and secondary mental health care physicians.

The “shared care” concept is defined as a collaboration process between the family physician and the psychiatrist, during which clinical responsibilities are shared according to diagnostic and treatment needs of patients at the different stages of the disease as well as according to each professional’s skills. In the context of hierarchization of medical care, this clinical modality becomes the keystone where links between primary and secondary care services materialize.

4.2.1 Models

In order to bring out a functional vision from this collaboration between primary and secondary care services, members of the *Conseil* analyzed the advantages and limitations of the most known models.

- **First model: multidisciplinary community mental health teams**

These teams, of secondary level of care acting in the community, offer several advantages at the primary care level:

  - Single reference point for multidisciplinary specialized care;
  - Single discussion point for primary care referrals;
  - Possibility of various integration models and answers to primary care needs;
  - Potential basis for a consultation-liaison approach.

- **Second model: community-based outpatient clinic**

In this model, only the psychiatrist sees new patients and does the necessary follow-up in the offices of a primary care clinic. This model does not require regular meetings between the family physician and the psychiatrist. Contacts are informal and random, but may allow an occasional consultation-liaison approach.

- **Third model: professionals from the psychiatric team associated with a primary care clinic**

After the reform of psychiatric services, nurses, psychologists and social workers from psychiatric hospitals have been assigned to primary care clinics. The proximity of secondary care professionals fosters a tendency to consider these people as extended primary care resources, and they rapidly come to manage primary cases. This is in direct conflict with secondary care needs. However, when these professionals give consulting services rather that direct primary care services, their presence greatly supports the continuity of care. It seems however that this consulting role is difficult to preserve.

- **Fourth model: consultation-liaison**

This model, based on establishing close links between the primary care level, the psychiatrist and the specialized multidisciplinary team, aims at:

- Reducing secondary care referrals for non-complex cases;
- Encouraging referrals for complex cases;
- Supporting detection and follow-up of primary care cases.

In its full application, this model has the following characteristics:

- Regular direct meetings between the psychiatrist, the family physician and implicated professionals, at least once a month;
- Patient referrals are discussed during these meetings;
- There is room for advice regarding patients not referred but receiving primary care;
- After the patient has been evaluated, primary care follow-up is discussed and maintained.

- **Fifth model: consultation-liaison and shared care**

The consultation-liaison model can also be associated with a shared care approach in which some patients receiving secondary care are referred for management to primary care services. The psychiatrist and the specialized multidisciplinary team still have the responsibility to make sure the patient receives appropriate follow-up and can easily go back to secondary care management if necessary.

Two shared care models came to the *Conseil*'s attention: one proposed by Dr. N. Kates team, from McMaster University (Ontario)[31] and one from Dr. G. Meadows, from Melbourne University (Australia)[32,33]. These two models favor the consultation-liaison approach and its goals as the basis of collaboration between the family physician and the psychiatrist. This type of practice is consistent with the needs of patients visiting the family physician on their own initiative and whose most common diagnoses include depression, anxiety disorders and somatoform disorders.

The Ontarian approach makes no distinction between primary care patients and patients transferred from secondary care services since, in participating clinics, both types of patients are registered and physicians are paid on a capitation basis.

The Australian approach makes a distinction between the psychiatrist's consultation-liaison activities regarding all requests from the family physician and the "shared care" portion. This last portion comes from the transfer of some patients seen by the psychiatric team and referred for a global management, both physical and psychological, to the family physician that accepted the transfer in the context of this agreement. A secondary care team including a psychiatric nurse, acting as a case manager, and a psychologist, coordinating the project, collaborate by making sure transferred patients agree with the transfer and have the necessary characteristics for primary care follow-up. The team remains available to ensure, if necessary, the harmonious return of the patient to secondary care. In the context of this project, approximately 2 patients are referred by general practitioners for consultation with a psychiatrist for every patient referred by psychiatric services to the family physician. Finally, both the Ontarian and the Australian groups report that approximately 5-6% of the consultation-liaison patients need secondary care.

- **Other models**

Other more technical models of data exchange came into focus rather as a support to clinical practice at the interface between both lines of services. They include exchange of hand written consultation reports, implementation of a patient-managed health records, computerized data exchange and, finally, single

electronic record accessible by all professionals. The *Conseil* did not look into these aspects in the context of this report.

4.2.2 Impacts of consultation-liaison and shared care models

The McMaster University and Melbourne groups[34,35] as well as other investigators[36,37,38] conducted studies evaluating the impacts of consultation-liaison and shared care models that cast an interesting light on the advantages and requirements of these collaboration models.

- For patients, there are numerous positive impacts:
    - High level of acceptability since this approach respects their choice of consulting first with their family physician;
    - Good level of satisfaction expressed;
    - Comprehensiveness of physical and psychological care;
    - Improved accessibility to psychiatric care;
    - Local provision of mental health care and a greater flexibility;
    - Answer to all levels of mental health care needs and harmonious transition from one level of care to the other;
    - Improved management of patients with physical and psychiatric comorbidity;
    - Improved quality of care.

- For family physicians, these collaboration models:
    - Help obtaining a psychiatric consultation and/or supervision and allow to discuss cases;
    - Allow continuing medical education (CME) activities that may change practices;
    - Bring support from a specialized mental health care team and give access to the knowledge of community resources;
    - Facilitate communications and relationships with psychiatrists, and increase their satisfaction;
    - Allow to change secondary care referral modes.

- For psychiatrists, these practice models require:
    - To be a general practitioner in psychiatry capable of assessing patients from different age groups;
    - To take into consideration the specific needs of primary care services: presentation of problems, high amount of patients with little time available. Psychiatrists should be efficient, realistic, practical, and establish an immediate intervention plan and formulate their recommendations in a language that can be understood by patients and used by family physicians;
    - To know the most common physical pathologies, their medications, drug interactions and impacts on the presentation and/or development of mental disorders;
    - To be aware of community resources;
    - To be able to integrate a biopsychosocial model;
    - To be flexible;

- That emergency teams, general or specialized outpatient and inpatient resources give their support.

These collaboration models for the interface between primary and secondary care services are consistent, under certain conditions, with the objectives of accessibility, quality and continuity of care.

4.2.3 Costs and cost-effectiveness ratio?

The Australian study[39] evaluated the financial aspects of its project. It concluded that the cost on the budget of secondary care services is neutral, i.e. all the costs of consultation-liaison and shared care are equivalent, at the psychiatry level, to the cost of providing secondary care to patients referred to primary care services, considering that 80% of the patients in this group only require a low intensity of contacts with secondary care services before their transfer while that the other 20% require a moderate intensity. However, this study did not assess the cost of treating these patients in primary care.

Collaborative models have also been extensively studied, particularly in the United States, in relation with the depression diagnostic[40,41]. These assessments lead to similar conclusions, namely that these types of practice increase beneficial results for patients as well as the care cost-effectiveness ratio, but increase the total cost of treatment because of the improved screening and intensified interventions.

4.2.4 Conditions for success and implementation strategies

As with any change in the organization of services, implementing a collaborative care model should first take into consideration the necessary conditions for a smooth and efficient implementation as well as implementation strategies, including:

- Voluntary participation of family physicians and psychiatrists;
- Considering time, space, professional and support staffing requirements;
- Implementing the necessary technical support for the records and their storage at the family physician's office;
- Implementing practice guidelines;
- Coexistence of targeted, efficient and structured continuing medical education (CME) activities;
- Simultaneous evaluative clinical research to collect necessary data to assess the impact of such projects on accessibility, quality and continuity of care and on financial and workforce needs;
- Collecting the necessary data for the assessment of needs and levels of need of patients depending on the prevalence of the various mental disorders.

Regarding the implementation strategies for these services, more information can be found in the documents produced by the Canadian Psychiatric Association and the College of Family Physicians of Canada, previously cited, as well as the Australian project application manual (project CLIPP), available on the Internet at the following address: http://www.health.vic.gov.au/mentalhealth/publications/clipp.

Numerous collaborative care models are already established in Quebec, including some with CLSC mental health teams, others with family physicians in private clinics. The *Conseil* favors models integrating consultation-liaison and shared care, but is aware that their intensity will vary depending on the area and that these are not a solution for all problems in the organization of services. *That is why* ***it recommends:***

- ***To assess, when implementing family medicine groups and primary care group practices, the necessary conditions to improve the screening, diagnostic and treatment of mental disorders;***

- ***To analyze the necessary conditions to implement consultation-liaison and shared care models between family physicians and psychiatrists;***

- ***To ensure these evaluations include the inventory of human resource requirements, particularly medical staff considering the time demands of these approaches;***

- ***To ensure these evaluations take into account the parity of mental health care and physical health care remunerations, like other chronic diseases such as asthma and hypertension, in order to reduce barriers to service accessibility for people with mental disorders;***

- ***To give the director of the*** **département régional de médecine générale** ***(DRMG) and the head(s) of psychiatric departments the leadership for these evaluations, in collaboration with public health***

resources, and to ensure the support of necessary financial, technical and human resources.

4.3 Secondary care services: specificity, complexity, accessibility through referral, specialized diagnostic and treatment, specialized multi-disciplinary management

Beyond the collaboration with primary care services, the *Conseil* considered secondary care services in psychiatry and particularly the organization of outpatient clinic activities based on the needs of patients referred there. In its report on the hierarchization of medical care, the *Conseil* defined its characteristics, and the report of the *Commission d'études sur les services de santé et les services sociaux* (*Commission Clair*) used the concept of service hierarchization and added:

- Designation of hospital territories;
- Formal contracts of service corridors including, among other things, the development of specific programs and continuing medical education.

The *Conseil* chose to investigate further some characteristics of specific programs in psychiatry. In this context, the complex nature of mental disorders as well as the frequent relapses and chronicity that often accompany mental disorders such as depression, anxious disorders, etc. have to be taken into consideration. As always in the medical field, an integrated clinical approach for the diagnostic and treatment of mental disorders yields better results on the patient's health and proves to have a better cost/effectiveness ratio[42]. That is also what the *Commission d'étude sur les services de santé et les services sociaux* proposes for people with complex and often chronic diseases. Thus,

secondary care services participate in the general goal of reducing the burden of mental disorders by establishing a proactive clinical organization able to rapidly assess and treat complex mental disorders and give the opportunity to take specific actions in order to reduce relapses and chronicity. It should also maintain an efficient database allowing to make sure that patients referred to primary care services in their community receive the appropriate treatment and follow-up for their clinical condition[43].

Studies[44,45] that tried to identify the efficient components of these clinical organizations concluded that regular medical services did not meet the needs of patients with relapsing or chronic mental disorder, even if they were part of an integrated system. To be efficient, the characteristics of these organizations need to:

- Use evidence-based planned care;
- Reorganize practice systems and professional roles and implement a more complete follow-up (call back);
- Improve support to patient self-care;
- Increase access to expertise;
- Facilitate availability of clinical information.

Much like hypertension, asthma, diabetes and chronic obstructive lung disease clinics, secondary care psychiatry will be responsible to create clinics specialized in affective disorders, psychotic disorders and other mental disorders as well as specialized programs of a more global orientation including, among other things, consultation-liaison and shared care with the primary care level. All these clinics will be responsible to meet specialized diagnostic, treatment and management needs, to contribute to the implementation of evidence-based practice guidelines for acute episodes as well as maintenance treatments and management of

relapses. They will participate in the diffusion and updating of education materials for patients and their families, material about signs and symptoms of these diseases, on early signs of relapse, on drug treatments and psychosocial approaches contributing to recovery.

If ***primary care*** is the ***gateway*** of the care system as the point of general medical care, ***secondary care*** is the ***place for specialized care,*** working at the interface with the primary care level for the screening of complex mental disorders that concerns it and the accessibility of its services, as well as its treatments, giving support and returning patients to primary care level when appropriate. It provides all the specialized, global and specific, inpatient and outpatient, multidisciplinary services, necessary for the diagnostic and treatment, and for the direct or indirect patient follow-up. If need be, it provides referral to third-line care. The *Conseil* believes that secondary care services should have a responsibility constant but of variable intensity towards the patients it treats, has treated and must see again, in a fast and easy manner when necessary. This is why the secondary care level is responsible to implement specific programs, participate in the continuing medical education (CME) and improve the quality of services in its own specialty.

Thus, it will be necessary to ensure the availability of human, technical and financial resources for the actualization of these responsibilities. ***A comprehensive examination of the situation of outpatient clinics and ambulatory psychiatric services in specialized and general care hospitals is mandatory, since these structures are under pressure from all parts with no global vision being developed for their complex mission of specialized care****.*

That is why the **Conseil *recommends:***

- ***To develop second-line services in accordance with the recognized model of physical and mental health service integration (mainstreaming);***

- ***To develop the mission of specialized ambulatory services according to the needs of the patients they will provide services to;***

- ***To pay special attention, in the organization of specialized ambulatory services, to the balance to be maintained between decentralized activities and institution-centralized activities, in order to ensure the necessary uniformity for the quality of practices and the cohesion of services;***

- ***To ensure, at the secondary level, the availability of multidisciplinary specialized human resources as well as the necessary administrative and logistic support to provide services inside and outside the hospital setting.***

CONCLUSION

Mental disorders are real diseases, have a high prevalence and a low spontaneous remission, and are associated with a high invalidity rate. Since effective treatments are available, it is important to deal with these disorders and do every effort to detect them early, diagnose and treat them adequately.

This is the message the *Conseil* chose to convey in this report, highlighting the multiple aspects of the burden of mental disorders as well as the factors that create false beliefs, negative prejudices and stigma. The *Conseil* analyzed the means to improve the diffusion of research knowledge so that everyone, according to their skills, can contribute to prevent mental disorders, detect them and take early actions to avoid chronicity and the adverse consequences for the patients, their relatives and the community. It also examined the contribution of family physicians and psychiatrists to the goals of ***preventing***, ***detecting early***, ***diagnosing*** and ***treating efficiently,*** targeting only the organization of medical services. That is why it explored the specific characteristics of psychiatric clinical activities, at the primary and secondary levels and at their interface. Specifically, it studied the conditions to implement successfully consultation-liaison and shared care practice models.

Finally, the *Conseil* hopes that its thoughts will contribute to the development of a consensus for a renewed mental health policy and a national action plan. This policy and its strategy would build on the latest data from the research on mental disorders and their influencing factors. They would allow to direct the organization of services and to target measures to implement, at every level, in order to effectively prevent, detect, diagnose and treat mental disorders and promote mental health.

RECOMMENDATIONS
CHAPTER 1

The Conseil recommends:

- ***To actualize the* Politique de santé mentale *(1989) in the light of the scientific knowledge acquired during the last decade, "defining a vision for the future that helps establishing landmarks for the prevention, treatment and rehabilitation of mental disorders, as well as for the promotion of mental health[37]"***

- ***To develop a five-year action plan and identify, among other things, measurable quality and efficacy goals for prevention, treatment and rehabilitation clinical activities, and for the organization of implemented services;***

- ***To target depression and suicide, given their burden;***

- ***To draw upon a group of experts for this initiative coming from the mental health epidemiological research field and from primary, secondary and tertiary care clinics, as well as representatives of service users and the general population.***

CHAPTER 2

The Conseil recommends:

- ***To implement an information campaign to improve the population's knowledge of the most common mental disorders, their prevention and effective treatments;***

- ***To spread this campaign over several years and to make sure there are local programs to support the campaign;***

- ***To convey targeted messages for the public and various professional groups, particularly groups from the media, academic, justice and work fields;***

- ***To develop messages after having analyzed the perceptions in the Quebec population;***

- ***To focus on a strong implication from the community and media, including Internet.***

CHAPTER 3

The Conseil recommends:

- ***To make sure that any basic first aid training includes a mental health first aid course;***

- ***To mandate the* Institut national de santé publique du Québec *(INSPQ) in collaboration with the* Agence d'évaluation des technologies et des modes d'intervention en santé *(AETMIS) and the* Conseil consultatif de pharmacologie *to implement a quality mental health information Web site that the public could consult with confidence;***

- ***To make sure they receive the necessary collaboration from the mental health research field, the academic field and professional associations;***

- ***To mandate the* Agence d'évaluation des technologies et des modes d'intervention en santé *(AETMIS) to evaluate the capacity of the Internet to contribute to the detection and treatment of the most common mental disorders, particularly in association with telepsychiatry;***

- ***To support the* Collège des médecins' *leadership, in collaboration with implicated professional associations and with the support of research and evaluation resources, in the development, implementation and updating of medical practice guidelines for the detection, diagnosis and treatment of mental disorders;***

- ***To ensure that necessary technical and human resources for the development of these guidelines are adequately funded;***

- ***To ensure that patient and/or public representatives are involved;***

- ***To support, at the regional level, a formal organizational structure regarding the adoption and implementation of mental health medical practice guidelines;***

- ***To ensure that there is a partnership between representatives of the* Conseil de l'éducation médicale continue du Québec*, the* Collège des médecins *and regional representatives in order to maintain a continuity between the development of guidelines, their relatively uniform implementation and their evaluation;***

- ***To ensure necessary technical and human resources for the implementation of these practice guidelines are adequately funded;***

- ***To ensure, at the regional level, that continuous evaluation activities are implemented, targeting:***
    - ***Processes: adapting practices to guidelines, maintaining practice changes;***
    - ***Results: health gains for patients and improvement of quality and organization of care;***

- ***To ensure the availability of technical and human resources necessary to conduct these activities:***

CHAPTER 4

The Conseil recommends:

- ***To assess, when implementing family medicine groups and primary care group practices, the necessary conditions to improve the screening, diagnostic and treatment of mental disorders;***

- ***To analyze the necessary conditions to implement consultation-liaison and shared care models between family physicians and psychiatrists;***

- ***To ensure these evaluations include the inventory of human resource requirements, particularly medical staff considering the time demands of these approaches;***

- ***To ensure these evaluations take into account the parity of mental health care and physical health care remunerations, like other chronic diseases such as asthma and hypertension, in order to reduce barriers to service accessibility for people with mental disorders;***

- ***To give the director of the*** **département régional de médecine générale** ***(DRMG) and the head(s) of psychiatric departments the leadership for these evaluations, in collaboration with public health resources, and to ensure the support of necessary financial, technical and human resources;***

- ***To develop second-line services in accordance with the recognized model of physical and mental health service integration (mainstreaming);***

- ***To develop the mission of specialized ambulatory services according to the needs of the patients they will provide services to;***

- ***To pay special attention, in the organization of specialized ambulatory services, to the balance to be maintained between decentralized activities and institution-centralized activities, in order to ensure the necessary uniformity for the quality of practices and the cohesion of services;***

- ***To ensure, at the secondary level, the availability of multidisciplinary specialized human resources as well as the necessary administrative and logistic support to provide services inside and outside the hospital setting.***

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CHAPTER 1

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