

MENTAL HEALTH SERVICES

CNA POSITION

The Canadian Nurses Association (CNA) believes that mental health¹ services must be an integral component of the health system. For the association, mental health services include prevention, health promotion, detection, diagnosis, treatment/intervention and rehabilitation.

CNA believes that accessing appropriate mental health services supports the physical, mental and emotional well-being of individuals, families and communities. From the perspective of the association, mental health services are appropriate when they have the flexibility to respond to the varying needs of individual patients/clients. Further, the association believes that appropriate mental health services are delivered in such a way as to respect the cultural beliefs and preferences of the individual patients/clients, their families and caregivers.

CNA recognizes that individual patients or clients who require mental health services are partners in decision-making about their health care. Where appropriate, this partnership extends to the individual's family, caregivers and support networks.

CNA believes that health professionals must communicate to individuals, families and caregivers the range of mental health service options, both within the publicly funded health and social welfare systems and those options that are privately funded.

CNA believes that access to appropriate mental health services can be strengthened through effective collaboration among health professionals, individuals, families and caregivers. CNA has elaborated its position of effective collaboration in a separate position statement.²

CNA recognizes that access to mental health services in primary care settings must be improved. The association agrees to work with other health stakeholders to support the development of policies, legislation and funding mechanisms that facilitate access to mental health services.

BACKGROUND

According to Health Canada's *A Report on Mental Illnesses in Canada* (2002), one in five Canadian adults will personally experience a mental illness during a one-year period.³ Kasman and Hay conclude that only 61 per cent

¹ The statement refers to both mental health (which is defined as comfort with one's person and security within interpersonal relationships) and mental illness (which is a diagnosable disorder characterized by alterations in mood, behaviour, thinking, or some combination thereof, associated with distress and impaired functioning over a period of time).

² (see CNA, 2006)

³ (Health Canada, 2002, p. 17)



of individuals who had a self-reported mental health problem or disorder consulted a professional for their problem during their lifetime.⁴

Mental health concerns can include a number of issues from addictions and substance use, depression and anxiety, to psychosis. Mental health problems can co-exist with, or be related to, physical problems.

Recent data from *A Report on Mental Illness in Canada* indicates that up to 70 per cent of all visits to primary care providers are for problems related to mental health.⁵ This suggests the important role primary care can play in identifying and treating the mental health problems of Canadians.

The World Health Organization's 1983 Alma Alta Declaration provided the impetus for the integration of mental health and primary care.⁶ Although both rich and poor countries have examined this issue at the national policy level, some of the most developed models of primary care related to mental health are found in low-income countries where its organization is closely aligned with the implementation of a public health paradigm.⁷

The rationale for integrating primary care and mental health care is a frequent subject of the literature. Blount (1998) and Lester et al. (2004) discuss how this integration uses the strengths of primary care, avoids the mind-body dichotomy and encourages a new way of thinking about mental health. The reasons for integration may be clustered into three broad categories: the individual patient/client, the local system or community and the broader system. Primary care related to mental health has the potential to treat, in one place, multiple dimensions of an individual's problems, and many come to primary care with mental health issues, although they may not be aware that their problems are psychological or mental.⁸ Treatment responses that better fit the patient/client's distress result in better adherence to treatment.⁹ Patient/client outcomes are better because their care is improved by the consistent communication among team members and the coordination of clinical care according to needs, which are characteristics of collaborative care.¹⁰

Collaborative care improves the quality of care because primary care personnel focus their concern on the functional status of patients/clients, rather than merely on their symptoms.¹¹ Using teams to deliver mental health care is an established practice of many jurisdictions.¹² This approach has been used in the United States, Australia, Canada and Great Britain to deliver specialized mental health care (e.g., assertive community treatment). The team approach has also been extended to primary care related to mental health, particularly in England. The literature points to a number of advantages of mental health teamwork in primary care.¹³

Over 12,000 registered nurses working in communities, hospitals, prisons, homeless shelters and on the street offer care and expertise related to mental health, mental illness and addictions.

⁴ (As cited in Gagné, 2005, p. 2)

⁵ (Health Canada, 2002)

⁶ (Jenkins, McCulloch, & Parker, 1998; Jenkins & Strathdee, 2000)

⁷ (Jenkins & Strathdee, 2000)

⁸ (Peek & Heinrich, 1995)

⁹ (Blount, 1998; Bazelon Center for Mental Health Law, 2004)

¹⁰ (Dea, 2000)

¹¹ (Badger & Nolan, 2002)

¹² (Freeman et al., 2002)

¹³ (Buszewicz, 1998; Borrill et al., 2000; Hart, 1999; Badger & Nolan, 2002; Zeiss & Gallagher-Thompson, 2003)

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Nursing involvement in a variety of collaborative models is described in numerous articles. McCann and Baker (2003), Badger and Nolan (1999), and Roberts and Priest (1997) describe specialist-liaison models in which nurses who were members of community mental health teams collaborated with general practices about individuals with mental health needs. McCann and Baker (2003), Shannon-Jones et al. (2003), and Badger and Nolan (1999) describe programs in which community-based nurses had close contacts with general practitioners while managing patients/clients experiencing acute episodes of mental illness. Lyles et al. (2003), and Badger and Nolan (1999) discuss replacement models in which nurse practitioners assumed responsibility for delivering multi-faceted interventions directly to patients/clients with somatic issues with backup support from doctors and other professionals. Hales et al. (1998) describe a similar model in which nurse practitioners directly managed a caseload of mental health clients/patients. Other professionals, such as doctors, appreciate the role and involvement of nurses in collaborative care.¹⁴

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¹⁴ (Atkin & Lunt, 1996; Badger & Nolan, 1999; Walker, Barker, & Pearson, 2000)

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