



CHAPTER 10

Addressing Structural Inequities: Ethical Challenges in Mental Health Care

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“[M]ental health and substance use health needs are significant and both continue to be orphans of our publicly-funded health care systems when compared to the care we provide for peoples’ physical health.” (Canadian Alliance on Mental Illness and Mental Health, 2021, p. 6)

ONE COMMONLY CITED STATISTIC ON HEALTH in Canada is that approximately 20% of Canadians will experience mental health or substance use issues in their lifetime (Canadian Alliance on Mental Illness and Mental Health [CAMH], 2021). While these challenges occur across all levels of socio-economic status, Canadians in the lowest income groups are three to four times more likely to experience mental illness and substance use issues (CAMH, 2021), reminding us that a greater proportion of the burden of illness is borne by those with fewer resources.

Throughout Canadian history, governments have made decisions that ultimately embedded the causes of inequity in mental health care services directly into health care structures. These decisions were rooted in a particular constellation of social, political, and economic philosophies that continue to shape social policy at local, provincial, and national levels (Morrow, 2009). Advocacy for patient care is foundational to practice in health care professions such as nursing and social work. Advocacy directed at a level of the system where individual health care providers (HCPS) do not have the authority to respond to the request may leave HCPS feeling disheartened and powerless, contributing to the experience of burnout, compassion fatigue, moral distress, and moral disengagement (Rodney et al., 2013). Equipping nurses with knowledge about the history and structures that have created and sustained inequity is crucial to promoting effective advocacy for true systems change.

Our goal in this chapter is to present a case for equitable access to quality mental health care, and to provide nurses with an understanding of barriers to equitable access across levels of the health care system, as prerequisite to effective advocacy and leadership. Thus, we have chosen to focus our attention on these structural underpinnings rather than simply highlighting the numerous ethical challenges that nurses in mental health contexts face on a daily basis. To accomplish this, we begin by introducing concepts taken up by politicians and implemented in ways that create and sustain barriers to adequate funding of the mental health care system and access to mental health services. Central concepts we analyze include neoliberalism and stigma. We discuss the ways neoliberal ideology and stigma are embedded in policies at multiple levels and applied in ways that perpetuate unjust and avoidable barriers to high quality mental health care. Application of these policies contributes to poor outcomes in mental and physical health for people with lived experience of mental illness and substance use. We connect ethical challenges that HCPS confront to policy informed by economic values that conflict with professional values. We also highlight the role of advanced practice nurse leaders in interdisciplinary team-based approaches to addressing the gaps in mental health services. Further, we use Ethics in Practice situations

to explore the complexities and subtleties of stigma and economic barriers to care. We end with practical recommendations that advanced practice nurses (APNs) and other HCPs can take up as they address inequities at micro, meso, and macro levels of health care.

Defining Equitable Mental Health Care

In making the case for equitable and high-quality mental health care, we look to research, practice, and policy leaders such as EQUIP Health Care¹ and the Mental Health Commission of Canada (MHCC) for important definitions and frameworks. The EQUIP Health Care team includes interdisciplinary researchers, knowledge users, and health care partners working together to develop health equity interventions across a range of settings. The EQUIP team provides clear definitions of the key terms “health equity” and “health inequity” that we use in this chapter:

Health equity is defined as the absence of avoidable or modifiable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. *Health inequities* are unjust and avoidable, and represent unacceptable differences in health between and within groups of people. (EQUIP, n.d., emphasis original)

Influence of Historical Funding on Mental Health Care Services

The Organization for Economic Co-operation and Development (OECD) recognizes mental illness as one of the fastest-growing categories of the burden of disease in the world (OECD, 2014). In 2021, the Centre for Addiction and Mental Health (CAMH; n.d.) identified the overall cost of mental illness in Canada as approximately \$51 billion dollars per year. Further, the MHCC (2017) provided estimates of the prevalence of mental illness in Canadians across age groups:

In 2016, more than 7.5 million people in Canada are likely facing one of the common mental illnesses—which is one in five Canadians, or more than the population of our 13 capital cities combined.... Among people under the age of 65, mental illness makes up approximately 38% of all illness. (p. 8)

However, Canada allocates approximately 7.2% of its total health budget to mental illness (Bartram, 2017; CMHA, 2018). The discrepancy between the limited allocation of funding for the mental health system and the actual burden of mental illness in Canada reflects a reluctance to fund mental health care that has existed from the inception of universal health care in Canada. We contend that many of the ethical challenges experienced today in mental health care have arisen from historical underfunding and subsequent fragmentation of mental health services.² To address ongoing issues of underfunding, it is important to understand the mechanisms that established and now maintain the unequal distribution of health dollars. In the next section, we outline the funding relationship between the federal government and the provinces and territories as one of the sources that perpetuates inequities in mental health care services.

Federal, Provincial, and Territorial Funding Relationships Entrenched in Legislation

The federal, provincial, and territorial governments of Canada formally launched universal health care in 1957 as the *Hospital Insurance and Diagnostic Services Act (HIDS Act)*. The *HIDS Act* laid out specific criteria for cost sharing between the federal government and the provinces and territories for medically necessary services delivered by physicians or services delivered in hospitals. The Act also limited care for mental illness in acute care hospitals to 10% of the overall beds (Bartram & Lurie, 2017; Wiktorowicz et al., 2020). The decision to exclude mental institutions from federal funding was widely criticized at the time as being a heavy financial burden on the provinces and territories, given that “68,000 beds in uninsured mental hospitals comprised nearly half of hospital beds in Canada at

the time” (Bartram & Lurie, 2017, p. 8). The federal government’s unwillingness to integrate mental health care into universal health care was debated in the House of Commons in 1957 and seen as a “discriminatory evasion of responsibility” (Wiktorowicz et al., 2020, p. 3). It is important to note that these early attempts to limit financial responsibility for mental health care services, stigma, and jurisdictional politics laid the foundation for the gaps in services we struggle with today, and continue to threaten “meaningful progress” on closing these gaps (Bartram & Lurie, 2017, p. 13).

The legislation related to mental health has evolved over time and is included in the *Canada Health Act (CHA)* (Government of Canada, 1985). Since the 1970s, the federal government has backed away from the original cost-sharing agreement of 50% of provincial and territorial total health insurance costs. As the federal share of the costs decreased, provincial and territorial governments gained greater autonomy over how the money is spent (Bartram & Lurie, 2017). The provinces and territories are required to meet the five criteria of the *CHA*—universality, comprehensiveness, public administration, portability, and accessibility—to be eligible for shared funding. As long as the provinces and territories adhere to the *CHA* criteria, they have independence in determining the distribution of federal funding for health care services.

Consequently, community-based services—such as mental health and home care,³ for which funding falls within the sole purview of the provincial and territorial governments—are constrained by the prevailing financial climate of the province or territory. Separating the source of funding (the federal government) from those who make decisions about resource allocation (provincial and territorial governments) creates challenges for effective advocacy. When advocacy groups lobby the federal government for specific services, the federal response is often to deflect back to provincial and territorial decisions on resource allocation. Yet, if these groups lobby at the provincial or territorial level, these governments deflect upwards, claiming that they are not adequately funded by the federal government. Without designated funding, no level of government is actually held accountable for decisions about resource allocation (Wiktorowicz et al., 2020). From the inception of the universal health care system in Canada,

mental health services have been inadequately funded. The gap in funding mental health services created by the *CHA* has never been closed (Bartram & Lurie, 2017).

Legislators outlined the funding relationship between the federal government and HCPS in the *CHA*. In the *CHA*, physicians are recognized as the only HCPS authorized to provide medically necessary treatments. Therefore, physicians alone are able to access guaranteed federal funding through fee-for-service mechanisms. The long-term consequences of embedding this funding structure into legislation continue to reverberate today. Other HCPS, such as advanced practice nurses (APNs), social workers, and psychologists working in the community, require direct funding from the provincial government or direct payment from patients. Hence, access to a wider variety of treatment providers is limited for those who cannot afford to pay out of pocket. This discrepancy establishes a de facto two-tiered system for accessing effective, comprehensive mental health services.

Many of the ethical challenges we confront today in mental health care, such as a lack of effective treatment options and long waitlists, result from governmental attempts to mitigate financial responsibility for health care. The *CHA*'s five criteria of public administration, comprehensiveness, universality, portability, and accessibility are the stated values which have been regularly affirmed by Canadian citizens. Yet, decisions on constraining health care costs are often rooted not in these stated values, but in political concerns and economic influences (Morrow, 2009).

Influence of Neoliberalism on Mental Health and Mental Health Care Services

Government spending, and constraints on spending, are determined by both internal (national) and external (global) forces. Internal factors include the funding structures discussed above. External factors that shape government spending, such as global economic forces, impact the Canadian economy. Socio-political and economic ideologies used by decision makers to frame policy decisions at the *macro level* are distant from actual service delivery, yet they have a profound impact on determining which services will be delivered at

the *micro level* and how these services will be implemented (Bartram & Lurie, 2017). Therefore, HCPS ought to have an awareness of the past and present factors that influence allocation decisions in order to knowledgeably navigate, and ultimately ameliorate, ethical challenges that arise from structural causes.

Globally, since the late 1970s, the tenets of neoliberalism have underpinned discourses and subsequent policies in health care delivery. We define neoliberalism as an economic model in which the market is considered to be the most reliable framework for guiding all human activities. In assessing the impact of neoliberalism on mental health care, we used Steger and Roy's (2010) description of neoliberalism as having "three intertwined manifestations: (a) an ideology, (b) a mode of governance, and (c) a policy package" (p. 11). To their aspects of neoliberalism we add two of our own: deinstitutionalization and the influence of the drive for efficiency.

Ideologies

Ideologies are a shared set of beliefs and ideas that a group holds to be true. These beliefs are value-laden and so deeply embedded that they are often unspoken and operate at a level outside of our awareness (Browne, 2001; Steger & Roy, 2010). Ideologies can also be insidious, colouring our perspectives and how we view others. It is through self-reflection and critical examination of policies that we become aware of how ideologies influence decisions at the micro, meso, and macro levels of health care delivery. Those who adhere to neoliberal ideologies have supported a shift towards primarily a biomedical approach in the treatment of mental disorders. This neoliberal approach is consistent with the *Canada Health Act*, where health services are limited to those provided by physicians (CMHA, 2018; Esposito & Perez, 2014). We further address the impact of neoliberalism on mental health care policy below.

Governance

Social policies are developed and implemented within systems of governance. A definition of governance is how a nation or organization is governed, or, more simply, how decisions are made, including who gets to participate in decision making (Institute on Governance, 2021). Those developing effective government

frameworks, particularly strategies to address mental health, need to attend to the social context in which inequities are embedded (CMHA, 2018). Historically, decision making at meso and macro levels has reflected a paternalistic top-down approach. More recently, we have observed the threads of collaboration and inclusivity running through publications by advocacy groups, and government policy documents calling for consultation with a broader range of stakeholders. For example, a core value of the MHCC (2021) strategic mental health plan, “build a bigger table” (p. 16), incorporates a diverse range of voices with experience of mental health issues in the development of mental health policy and tools.

Policy Packages

The uptake of neoliberal ideology has contributed to widening social and economic inequities through the application of market values to social policies. Social policy refers to government policies directed at meeting the needs of the population, often referred to as welfare needs (Scott & Marshall, 2009). Social policies strengthen social programs responsible for supporting human flourishing, and include social assistance, health, education, and housing. These areas encompass the social determinants of health (SDOH), which have been directly correlated with rates of mental illness. Steger and Roy (2010) described the rise of neoliberalism as a global economic model, finding that all countries which adopted neoliberalism experienced a rise in inequities in the SDOH.

Efforts to contain health care costs regularly rely on business models that are uncritically imposed in health care processes without consideration of how these models create practice environments that conflict with core values of HCPs. Below, we focus on deinstitutionalization and a drive for efficiency as examples of how neoliberal ideologies contribute to ethical challenges in mental health care.

Deinstitutionalization

In the 1980s and 1990s, mental health system reform included the deinstitutionalization and application of market principles to health care organizations. The arguments for deinstitutionalization were premised on reports that detailed the deplorable conditions and

overcrowding in asylums (Hall, 1964). In a Canadian study, Morrow (2009) examined the intersection of neoliberal ideologies, restructuring of social programs (including health care), and mental health reform in the context of deinstitutionalization. Morrow highlighted that mental health policy is “intimately connected to economic decision making” (p. 40). Morrow situated this critique in the broader context of globalization and social welfare restructuring, where it became more difficult for people with mental illness to access social supports such as “social assistance, public housing, and a whole range of community-based supports” (p. 41). Such difficulties have had several consequences for people discharged from mental asylums. Inability to access social services, such as housing, contributed to increased homelessness for individuals with mental illness, and increasing pressure on acute care services, resulting in a “revolving door syndrome” (Morrow, 2009).

Social welfare reform impacted deinstitutionalization in other ways, as provincial and territorial governments, which have sole jurisdiction for mental health funding, curtailed funding of community mental health services. The potential for more humane treatment of individuals with mental illness through community-based treatment and support was not realized, because the money spent on mental institutions never shifted to community services (Lurie, 2014; Read, 2009; Wiktorowicz et al., 2020). Read (2009) underscored the failure of deinstitutionalization in British Columbia (BC) with the closure of the provincial mental hospital, explaining that monies intended to fund community-based support were never reallocated for community-based programs. Development of policy initiatives that resulted in closure of inpatient treatment facilities, while at the same time decreasing overall funding for community-based services, was not isolated to BC. For example, Bartram and Lurie (2017) outlined a similar occurrence in Ontario in relation to deinstitutionalization.

Influence of the Drive for Efficiency

While efficiency in health care—seen as a combination of quality services and numbers served—is a core value in market-driven systems, measuring improved efficiency is difficult. Such measurements are often limited to the quantification of tasks (Austin, 2011)

and a focus on the costs of services (Kyeremanteng et al., 2019). An example of policy implemented by the provincial governments in attempting to improve quality and efficiency is the introduction of pay-for-performance initiatives (P4P) in Canada (Cheng & Sutherland, 2013). P4P initiatives were introduced into the Canadian health care system in the mid-2000s in an effort to mitigate rising costs and improve the quality of care through the use of evidence-informed practice guidelines (Kyeremanteng et al., 2019). Although a range of P4P incentives currently exists in Canada, the effectiveness of incentive programs in achieving the identified goals is mixed (Cheng & Sutherland, 2013). Financial incentive programs raise unintended ethical pitfalls for HCPs that are difficult to surmount unless they are explicitly addressed in the planning phase and throughout the programs. Ethical pitfalls include the avoidance of patients with complex health issues due to inadequate financial reimbursement for physicians through the fee-for-service model; challenges with measuring outcomes for complex patients; and a focus on outcome scores, rather than the actual patient experience (Kyeremanteng et al., 2019). These pitfalls contribute to increasing inequity in access and quality of care. In Ethics in Practice 10-1, we provide a case study of a P4P initiative for review.

ETHICS IN PRACTICE 10-1

Pay-4-Performance in the Emergency Department

In 2007, the Ministry of Health in BC introduced P4P initiatives in the emergency departments (EDs) of several urban hospitals to see if these initiatives would help decrease wait times for patients while maintaining quality of care. Mindy, a psychiatric liaison nurse, is aware that the hospital will receive financial incentives if patients are seen within recommended time frames based on the Canadian Triage Acuity Scale (CTAS).

Since the P4P initiative was introduced, Mindy has noted some changes in her team's actions, including the need to move people through the ED quickly. Several nurses on her team are doing very brief, sometimes incomplete assessments on presenting patients. Mindy has observed these nurses using information from previous encounters to fill in the assessment forms of patients who are in the ED regularly. She has also noted that when a nurse takes more time with a patient, some colleagues question their competence in completing an assessment. When Mindy questions these

criticisms, she is told that “an efficient nurse can complete an assessment in 10 minutes.” As well, once a patient is triaged, they are moved out of the waiting area and into the treatment area, so that it looks like no individual is waiting to be seen. This practice has led to overcrowding in the psychiatric space, increasing the potential for aggression from patients in acute distress.

Mindy has also observed a disturbing trend in which more complex patients, such as individuals with a concurrent disorder, a history of trauma, or a dual diagnosis, are being deflected out of the ED by some members of her team. Finally, Mindy has noticed that individuals presenting in the ED with physical complaints, but who also have an existing psychiatric diagnosis, are being under-triaged and directed to the psychiatric area of the ED. On her last shift, a patient with a fentanyl overdose was admitted to the medical area of the ED. Shortly afterwards, the patient’s CTAS score was downgraded so they could be transferred to the psychiatric area. Tragically, the patient later died in the seclusion room from the effects of their overdose because the psychiatric area had minimal medical equipment.

REFLECTIVE QUESTIONS

As you think about Mindy’s experience and observations, consider your own practice environment and reflect on the following questions:

1. *How is the need for efficiency and quality care balanced in your clinical area?*
2. *Are you aware of any P4P initiatives in your organization?*
3. *What are some of the consequences in your practice area that result from the need for efficiency being taken up uncritically?*
4. *What leadership initiatives could advanced practice nurses promote to improve the quality of care for people in EDs with mental illness?*

Governments have taken up a mantra of improving efficiencies as one of the measures to decrease costs. While improving efficiencies can be effective in decreasing spending and improving quality, without thoughtful consideration of how efficiency is being envisioned and measured in health settings, efficiency foci can contribute to values conflicts for direct care providers.

Our purpose in beginning with a discussion on neoliberalism is to make the connection clear between economic ideologies and subsequent health care policies that contribute to or create ethical conflicts in clinical practice. As we move forward in this chapter, we

highlight the synergistic relationship between stigma and neoliberal policies. Neoliberal policies alone do not account for the political reluctance to include mental hospitals in universal health care. Early on in the process of negotiating universal health care, stigmatizing attitudes towards mental illness played a key role in limiting funding for mental health (Bartram & Lurie, 2017; Wiktorowicz et al., 2020).

Impact of Mental Illness-Related Stigma

Stigma, as a concept applied to those with mental disorders, is pervasive, and has a long history. Our understanding of the stigma deeply embedded in our political and social structures has grown, and we now see stigma as a central barrier to equitable access to services (Livingston, 2013). Yet, increasing awareness alone has not contributed to positive changes in resource allocation or greater integration of services. Below, we provide a brief history of stigma and outline our current understanding of the concept. The MHCC has conducted extensive work on the concept of stigma in order to develop strategies and tools to address it. Because of this leadership, MHCC's work is central to our discussion and recommendations for change.

Stigma and Mental Illness

Stigma is a phenomenon that is constructed psychologically and socially (Arboleda-Florez & Stuart, 2012). We use the definitions and descriptions of stigma put forth by the MHCC, as they capture a current and nuanced understanding of the experience and consequences of stigma at individual, interpersonal, and structural levels, while also accounting for the impact of intersectionality (Livingston, 2020). The MHCC explains:

[Stigma] is first and foremost a social process that aims to exclude, reject, shame and devalue groups of people on the basis of a particular characteristic. ... Therefore, stigma reveals more about society than it does about individuals who carry stigmatized characteristics or persons who harbour negative beliefs about others. (Livingston, 2013, p. 6)

With respect to mental illness, the roots of stigma go back centuries in Western discourses. From descriptions of madness in ancient Greek texts to the persecution of “witches” in Christian cultures in Europe and North America, stigma has evolved and changed, and has carried various religious and moral associations over time (Arboleda-Florez & Stuart, 2012). Despite a more nuanced modern understanding of mental illness as influenced by complex biological and environmental factors, shadows of earlier belief systems can be found in our current discourse.

Influences of Stigma on Mental Health Services

In the following sections, we discuss stigma at the individual, interpersonal/social, and structural levels as a foundation for discussing recommendations to lessen the negative impacts of stigma across these various levels. Since stigma impacts a person’s self-concept, as well as their interactions with HCPS, health systems, and society at large, solutions must take this full range of experiences into account.

Self-stigma

For those living with mental illness, internalized or self-stigma is a set of negative beliefs about oneself, alongside lived experiences that solidify these beliefs. Self-stigma often includes shame and acceptance of the idea that mental illness is less valid than other health issues, often resulting in a sense of isolation, low mood and low self-esteem, and a limited sense of autonomy (Henderson et al., 2016; Livingston, 2013). These negative self-beliefs are frequently reinforced by stigmatizing experiences in the community and when seeking health care, leading to individuals fearing and avoiding engagement with HCPS and support systems. Because mental illness influences mood, cognition, and behaviours, a person’s identity is at risk of being superseded by their condition. This fusion of illness with identity complicates attempts to effectively advocate against stigma because those with mental illness “risk having their resistance disregarded, silenced, and pathologized (e.g., ‘she’s angry because she’s not taking her medications,’ or ‘his personality disorder causes him to act out’)” (Livingston, 2013, p. 8).

Interpersonal or Social Stigma

Mental illness and substance use challenges are just two facets of identity for which a person may experience stigmatization. Stigma and discrimination are also directed towards racial and ethnic identity, gender, sexual orientation, socio-economic and educational status, and health conditions such as HIV, among other stigmatized characteristics or identities. Intersectional stigma refers to the ways individuals or groups experience the negative impacts of having multiple stigmatized identities. Many people with mental illness face the compounded challenges of intersectional stigma as they attempt to access care (Turan et al., 2019).

Numerous reviewers of the literature point to a pattern of problematic interactions between HCPS and those with lived experience of mental illness and substance use. As Knaak et al. (2017) described, “people with lived experience of a mental illness commonly report feeling devalued, dismissed, and dehumanized by many of the health professionals with whom they come into contact” (p. 111). Stigma enacted by HCPS may manifest as having demeaning or paternalistic interactions with patients, giving limited or incomplete information regarding diagnoses and treatment options, or using the threat of coercive treatment to steer plans of care. Further, many providers lack confidence in the efficacy of interventions for mental illness and substance use challenges. This “therapeutic pessimism” often creates a self-reinforcing negative cycle where providers are not confident of a positive outcome, and thus withhold or limit access to potentially helpful treatment options (Knaak et al., 2017). For people who have multiple stigmatized identities—for example, a racialized person without stable housing experiencing a mental illness—intersectional stigma can significantly and negatively impact both mental and physical health outcomes (Turan et al., 2019).

Structural Stigma

Mental illness-related stigma at the structural level has perhaps the most profound impact on equitable provision and accessibility of health care. Health care systems have been consistently identified as contributing to and reinforcing structural stigma by limiting access

and rendering poorer quality services to those with mental health and substance use issues. The MHCC points to three key challenges to equitable access to care for those with mental illness and substance use issues: (a) under-resourcing of services; (b) de-prioritization, under-treatment, and denial of service; and (c) separation of mental health, substance use, and physical health services (Livingston, 2020).

Under-resourcing manifests in many ways, including chronic governmental underfunding of resources to support services for, and research about, mental illness and substance use issues relative to their burden of disease. Under-resourcing also manifests as lower reimbursement rates for mental health care services by both publicly funded and private health insurers. Under-treatment and de-prioritization in the form of diagnostic overshadowing is common when those with mental illness and/or substance use issues present for health care (Henderson et al., 2014). Overshadowing happens when HCPS minimize or neglect the physical health concerns of people with mental health and substance use challenges, which can lead to missed diagnoses, delayed care, and worse health outcomes.

In addition to inequitable access, structural stigma also leads to poorer quality of care. Stigmatizing attitudes and behaviours of HCPS, coupled with an over-reliance on coercive treatment, negatively impacts the quality of care received (Henderson et al., 2014; Livingston, 2020). Since HCPS shape the culture, norms, and practices of the systems where they provide care, their beliefs and actions directly impact structural stigma. In Ethics in Practice 10-2, we provide a case study on stigma.

ETHICS IN PRACTICE 10-2

Stigma

Kate is a 30-year-old woman who belongs to a racialized group. She is a single mother who is on social assistance and lives in a subsidized housing complex. Kate presents at the mental health centre for assistance with worsening mood and suicidal ideation. Kate has been previously diagnosed with depression, post-traumatic stress disorder (PTSD), and chronic widespread pain. She has a past history of polysubstance misuse; however,

she states that she has not used substances in the past three years. Kate's elementary school-aged son has been diagnosed with fetal alcohol spectrum disorder (FASD). Kate often feels overwhelmed by his needs and challenging behaviour, which can also trigger her PTSD symptoms. She feels significant guilt and shame about his diagnosis. Kate has limited social supports and no extended family involvement due to her history of childhood trauma.

The mental health team offers psychiatry appointments and group therapy for depression. Kate was registered for a depression group in the past and there are a number of late cancellations and no-shows on her file. A note on Kate's file states a "lack of follow-through." The Mental Health Centre has now instituted a "three no-shows and you are out" policy. Although Kate is interested in group therapy, she struggles to attend the sessions due to the needs of her son. Kate's son's needs are under-resourced in the school system and Kate is often called to pick him up early. Kate knows that she could increase resources for him at school; however, it would require her to disclose the diagnosis of FASD to the school board. Kate also struggles to attend sessions when her pain levels are elevated. Kate is interested in specific therapy for PTSD but she has been unable to access this type of therapy in a free or low-cost setting.

REFLECTIVE QUESTIONS

As you think about Kate's situation, consider your own practice environment and reflect on the following questions:

1. *What assumptions might you make about patients who do not follow through with treatment?*
2. *How does your viewpoint change when you learn details of Kate's context?*
3. *How has Kate experienced stigma at individual, interpersonal, and structural levels?*
4. *What policies exist in your workplace (such as the "three no-shows and you are out" policy) that may create barriers for patients who are already experiencing inequitable access to health care?*
5. *We suggest you watch the brief video Beyond Stigma (Subject Matter Lab Health Research Lab, 2021) (see References). After watching the video, consider how including the patient in a team approach can reduce stigma.*
6. *What strategies could an APN use to foster a person-centred approach to Kate's situation?*

We have argued that stigma and neoliberal ideology are intertwined. In societies influenced by neoliberal ideology, individuals

who are viewed as flawed are both inherently less valued and also left on their own to “fix” the parts of themselves that are deemed unworthy by society. Stigmatizing attitudes towards mental illness have contributed to the underfunding of mental health care in Canada’s universal health care system, and continue to pervade subsequent mental health care policy decisions. We have argued that in mental health care, neoliberalism and stigma at individual, interpersonal, and structural levels combine to (a) create barriers to accessing care; (b) contribute to poorer quality of care; and (c) cause poorer mental and physical health outcomes for people with mental illnesses and/or substance use challenges.

The COVID-19 pandemic may have unexpected benefits in addressing stigma for mental health care. As we discuss below, the pandemic has brought mental health promotion and prevention to the forefront of health discussions, particularly as we consider the impact of the pandemic on HCPs. In giving serious consideration to supporting the mental well-being of all Canadians, we need to maintain a level of critical awareness so that we do not create a two-tiered mental health response; that is, we do not want to create one response for individuals whom we might view as “like us,” who are struggling to manage chaotic external circumstances, and a second response for individuals struggling with chronic mental illness.

Changes to Mental Health Care Services

Over the past six decades, the federal, provincial, and territorial governments of Canada have sought to address gaps in mental health services. Below, we highlight some of the changes brought about by the work of the MHCC and other advocacy groups; comment on how the COVID-19 pandemic has impacted mental health services; and discuss the potential for APNs to address service gaps.

Mental Health Spending Parity

Several mental health advocacy bodies have noted the discrepancy in funding between mental health issues and physical health issues. The MHCC (2017) made the case for increased spending on the mental health system, stating that “the impact of mental health

problems and illness is more than one-and-a-half times that of all cancers” (p. 10). Yet, funding for mental illness remains well below recommended levels. Globally and nationally, there are increasing calls for parity in government health spending between mental illness and physical illness (Canadian Alliance on Mental Illness and Mental Health [CAMIMH], 2021; CMHA, 2018; Pan American Health Organization, 2018).⁴

Addressing Inequity Through Increased Funding

In 2017, the federal government moved to address funding inequities in mental health services by adding five billion dollars in targeted funding dedicated to improving mental health outcomes (Department of Finance Canada, 2017). The increased funding was to be directed towards improving community-based services, giving access to psychotherapies, decreasing wait times for services for young Canadians, and improving accountability in reporting on investments in the health care system. The added funding was an incremental step towards the MHCC recommendation that Canada increase mental health funding from 7.2% to 9% of the overall health budget to improve mental health outcomes through increased access to services (Bartram, 2017).

That same year, the federal government proposed an additional \$204 million over five years to increase mental health services for First Nations and Inuit Peoples, expanding services to include a greater diversity of mental health professionals as well as Traditional Healers (Department of Finance Canada, 2017). However, increased funding will not improve inequities without the concurrent development of accountability frameworks and indicators in order to measure improvement in quality and access (Bartram, 2017; Follwell et al., 2021). In Ethics in Practice 10-3, we provide a case where we highlight the complexity of addressing inequities in access to services.

ETHICS IN PRACTICE 10-3*Addressing Inequities*

Addressing inequities in access to mental health care services is complex, and requires more than added funding and increased services. Bartram (2017) pointed to examples of significant financial investment in mental health services in the United Kingdom (UK) and Australia. Enhanced funding was aimed at increasing access to services and improving client outcomes.

The Australian government amended their funding mechanisms so that individuals with mental health issues could access a broader range of mental health professionals (for example, psychologists), thereby improving access to services. Subsequently, the Australian government reported that treatment rates for individuals with anxiety, depression, and substance use rose from 38% to 46% (Meadows et al. 2015).

The UK developed a program called “Improving Access to Psychological Therapies” (IAPT) to decrease waitlists and improve access to services for people with common mental health problems such as depression and anxiety. Since initiation of the program in 2008, the National Health Service (NHS) in the UK reported strong overall outcomes, with 50% of the patients enrolled in the program no longer meeting the clinical criteria for depression and anxiety (Bartram, 2017.) Significantly, a closer look at the statistics related to the use of enhanced services revealed that the greatest benefit of improved access to mental health services was experienced by the most socio-economically advantaged (NHS Digital, 2016; Meadows et al., 2015). In fact, in their examination of usage rates following the increase of mental health service providers in Australia, Meadows et al. (2015) stated

These results are consistent with a multi-tier system, where people living in more disadvantaged and more rural areas will typically receive a service model in response to mental health needs that is characterized by lower volumes of services, provided possibly by less highly trained providers. (p. 193)

Meadows et al. (2015) and Bartram (2017) demonstrated that simply increasing funding or expanding services without attending to the inherent complexity that contributes to inequities—such as limited access to health care in rural/remote areas and complex chronic concurrent disorders—will not succeed in closing gaps in services.

REFLECTIVE QUESTIONS

Consider the following questions as you think about using increased funding to address inequities in access to mental health care services:

1. *What inequities in access to mental health care services do you see in your area of practice?*

2. *What innovations in your practice area are directed at improving access to treatment? Do you think they are effective?*
3. *What factors need to be considered to ensure equity when evaluating the efficacy of programs or initiatives?*
4. *Identify areas where the leadership of APNs can be effective in improving access to mental health services.*
5. *What actions can APNs take to be part of closing the gaps in mental health care services?*

Addressing Inequity Through Collaboration

Recognizing the importance of working collaboratively to improve access in two priority areas (home and community care, and mental health and addictions), the federal, provincial, and territorial (FPT) governments worked together and created *A Common Statement of Principles on Shared Health Priorities* to guide actions (Canadian Institute of Health Information [CIHI], 2017). The stated principles included collaboration between federal, provincial, and territorial governments; innovation; and accountability. Subsequently, the FPT governments and sector stakeholders worked with CIHI to develop indicators to measure the shared priorities. Indicators were developed across five themes: access, quality of care, spending, health promotion and disease prevention, and health outcomes. In 2019, CIHI began to report on additional indicators as they were being developed. Significantly, mental health advocacy groups and government agencies have recognized the importance of including people with lived experience (PWLE) of mental illness and substance use in the development of policy. These collaborations are important for developing mental health care policies that effectively address inequities.

Addressing Inequities Through Integrated Care Teams

Researchers have provided evidence connecting an integrated care approach to improved patient outcomes, decreased costs, shorter wait times for services, and shorter times in treatment, along with

other benefits (Durbin et al., 2016). Initiatives directed at greater integration of services through primary care teams already exist in Canada through Integrated Youth Services (IYS), meaning that mental and physical health and social care all occur at one location (Hetrick et al., 2017). This is one example of how an interdisciplinary team can address mental health issues in youth earlier to improve outcomes (Halsall et al., 2019). Another example of using an integrated care approach to improve health outcomes is seen in the way professional nursing organizations advocate for APNs to be deployed to improve access to health services in general, and mental health specifically, through the integration of NPs into community mental health teams (Kant et al., 2019). However, several barriers constrain expansion of interdisciplinary integrated care teams, including the funding model established in the *CHA* (discussed in the early section of this chapter entitled “Federal, Provincial, and Territorial Funding Relationships Entrenched in Legislation”; Durbin et al., 2016).

With the rapid rise in deaths related to the toxic opioid drug supply, APNs, such as NPs, are being asked to fill gaps in access to substance use treatment. However, limited education about mental health care serves as a barrier to NPs working with individuals who have mental illness and substance use challenges (Creamer & Austin, 2016; Kant, 2019). Addressing opioid use includes giving NPs (and registered nurses or registered psychiatric nurses in some provinces) the ability to prescribe methadone and buprenorphine-naloxone—medications used in the treatment of opioid use disorder (OUD)—and education about these drugs. In a recent study, researchers in Nova Scotia highlighted that NPs felt uncomfortable prescribing methadone due to a lack of education about mental health care and limited practice support (Bates & Martin-Misener, 2021). Such barriers are particularly detrimental for NPs working with individuals who have mental illness and substance use challenges (Creamer & Austin, 2016; Kant, 2019). Patients at highest risk for overdose death were also navigating the impacts of trauma, mental illness, poverty, and other related challenges (Tyndall, 2020). NPs and HCPS prescribing opioid agonist treatments, therefore, need additional education in mental health care and more comprehensive supports to provide adequate care for the whole person.

In response to the challenges noted above, Project ECHO (Project Extension for Community Health Care Outcomes) is being implemented in provinces and territories across Canada to improve health outcomes for Canadians, particularly in underserved populations. Project ECHO is an interdisciplinary, virtual, case-based learning community. Providers can bring complex patient presentations for discussion and care planning, learn from each other, and increase their capacity to care for these complex patients. Project ECHO has been effective in improving provider competence, changing provider practice, and improving outcomes (Sockalingam et al., 2018).

Other suggestions to support APN education in mental health and substance use treatment include intensive clinical experiences for HCPs, with early exposure to treatment for addiction, ongoing clinical supervision, workshops, attending interdisciplinary rounds, and the development of a formal specialty role for NPs in mental health care (Bates & Martin-Misener; Kant et al., 2019). Additionally, an APN can join an Adaptive Mentorship Network (see Appendix 10-1) designed to connect health care provider mentees with mentors in a supportive networking environment with group-based mentoring and learning opportunities, and on-demand one-to-one mentoring conversations. The networks are intended to build knowledge, skills, and resiliency of HCPs, while also developing capacity to meet the needs of complex patient populations.

Ethical Challenges and Opportunities Arising From the Pandemic

Notwithstanding the progress we have noted above, the COVID-19 pandemic has exposed the gaps in mental health care as countries imposed varying degrees of restrictions to limit the spread of SARS-CoV-2. Restrictions included a rapid reduction of support services for individuals involved in the mental health care and substance use system (CCSA, 2020). While the full impact of pandemic measures on those living with mental illness is not yet known, researchers highlighted the disproportionate impact of the pandemic on populations experiencing pre-existing health and social inequities (CMHA, 2020; MHCC, 2021). The most enduring consequences of the pan-

demic have been the psychological trauma, mental illness, economic injury, and burnout it has fuelled (Tseng, 2020). In Canada, the impacts of these traumas have been particularly evident in HCPS, as indicated by their increasing requests for mental health services and a rise in substance use (CMHA, 2020). This has prompted federal, provincial, and territorial governments to fund initiatives that support the mental well-being of HCPS and frontline workers.

Governments at all levels have moved quickly to upscale service initiatives that already existed in mental health; for example, telehealth, virtual health care, and mental health apps (Moreno et al., 2020). Ethical concerns regarding equitable access to technology, technological proficiency, privacy, confidentiality, funding, and evidence of quality need to be considered as these initiatives become part of ongoing practices. Given the rising cost of service delivery, HCPS need to attend to the warning that “[l]ow-quality mental health care based on affordability without assessment of quality or monitoring of needs and efficiency will only contribute to increasing inequalities and worsening mental health globally” (Moreno et al., 2020, p. 820).

Recommendations

The issues that we have described throughout this chapter create, magnify, and reinforce multiple complex challenges to delivering equitable, high-quality mental health care. Multi-pronged, collaborative, inclusive, and sustained efforts towards improvement are needed. Understanding the intersection of politics, economic ideologies, and societal values facilitates knowledgeable action at all levels of the health care system. Evidence also supports the importance of collaboration and inclusiveness in improving mental health outcomes (CMHA, 2016).

Working in any part of the mental health care system can feel overwhelming for health care providers, given limited resources and the complexity of the issues. However, we believe that all efforts to move towards equity and quality in mental health care are valuable. We present the recommendations below so that each HCP can decide which levels of action they want to take. Being aware of the available resources and the range of mental health advocacy groups

may decrease the sense of isolation HCPS experience. Further, knowing the appropriate level at which to direct advocacy efforts increases the possibility of success. Our recommendations are, therefore, directed at action and advocacy for mental health policy and practice at micro, meso, and macro levels. Mental health advocacy groups have developed excellent resources for issues at all levels of the system (see Appendix 10-1 for a list of online resources).

Micro Level

We encourage APNS and mental health practitioners to

- use evidence-informed literature and policy briefs for self-reflection on how their own beliefs and assumptions inform their practice;
- seek out the perspectives of people with lived experiences of the services provided and reflect on how the actions of APNS and mental health practitioners influence their experiences;
- share their learning with colleagues to promote discussions of current policies and practices in their clinical settings;
- organize regular patient discussions/rounds where all professionals involved can meet to discuss specific complex patient situations;
- involve patients/ clients in care planning to foster an understanding of their priorities as well as an understanding of what they perceive as barriers; and
- seek out mentors in specific practice areas to decrease individual providers' sense of isolation in practice, including through an Adaptive Mentorship Network.

Meso Level

APNS, HCPS, and leaders can

- seek out and participate in ongoing education in mental health and substance use, regardless of their area of practice or specialty, as mental health and substance use can impact anyone in their care;
- join a Project ECHO;

- include PWLE on practice and policy committees;
- use evidence-informed research, integrated reviews, policy briefs, and toolkits to inform organizational policy and clinical practice;
- incorporate more content related to mental health and substance use into the curricula for APNs and other HCPS;
- include community stakeholders and patient partners in health care unit and organizational policy discussions;
- support interdisciplinary opportunities for learning together and sharing clinical approaches, including team case consultation;
- lead and participate in quality improvement initiatives, or research on interventions in mental health care; and
- consider how practices and policies in specific practice environments (for example, the need to call ahead and confirm appointments, or missed appointment policies) may create barriers to health care access.

Macro Level

APNs, HCPS, and leaders can

- foster interprofessional, interagency, and interprovincial collaboration to advocate for parity in spending for mental and physical health;
- use evidence-informed research to advocate for changes in policy directed at resource allocation on a population level (see Appendix 10-1 at the end of this chapter);
- become involved in local, provincial, or national professional associations, and engage in related interprofessional writing; including, for example, blogs, policy briefs, and opinion pieces for the media; and
- advocate for recognition of mental health as a health care specialty, and for provincial and national funding for educational programs specific to mental illness, substance use, and concurrent disorders.

Conclusion

It is important to recognize that working in any part of the mental health care system can feel overwhelming, especially given limited resources and the complexity of the issues being faced. In this chapter, we presented recommendations to encourage APNs and other HCPS to consider key actions to advocate for change. Being aware of available resources, such as mental health advocacy groups, can also decrease the sense of isolation APNs and other HCPS may experience. Knowing the appropriate level at which to direct advocacy efforts will increase the possibility of success for APNs and other HCPS, building a sense of competency that can lead to progressive change in mental health care from individual to systems levels.

QUESTIONS FOR REFLECTION

1. *How do you see impacts of neoliberal ideology and stigma affecting mental health care in your practice or educational settings?*
2. *Considering the recommendations, which level of advocacy and action seems most feasible to you right now? What are immediate actions you can take?*
3. *What are some of your future goals for advocacy?*

Endnotes

- 1 EQUIP stands for Equipping Health & Social Services for Equity. EQUIP Health Care is a broad program of research that brings together a range of stakeholders. The emphasis is on implementing interventions, across health care settings, which build organizational capacity to provide equity-oriented health care.
- 2 See Chapter 3 in this textbook for a more detailed discussion of the historical implications of how mental health care was funded.
- 3 See Chapter 13 in this textbook for a full discussion of home health care.
- 4 The calls for parity in mental health care spending have been around for a while but it is only more recently that they have gained traction. In Canada, the creation of the MHCC and their published work has elevated the importance of spending in mental health care. Globally, the pandemic has brought a higher level of credibility, and urgency, to the idea of parity in mental health spending.

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APPENDIX 10-1

Online Resources for Mental Health

A Common Statement of Principles on Shared Health Priorities (CIHI, 2017)

<https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/principles-shared-health-priorities.html>

From Out of the Shadows Into the Light ... Achieving Parity in Access to Care Among Mental Health, Substance Use and Physical Health (CAMIMH, 2021)

https://www.camimh.ca/_files/ugd/b625ef_03591e97cob948f9af25c07b986e1c28.pdf

Action Framework for Building an Inclusive Health System (Public Health Agency of

Canada, 2019) <https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-action-framework-infographic.html>

A Framework for Assessing Structural Stigma in Health-Care Contexts for People with Mental Health and Substance Issues (Livingston, 2021)

https://mentalhealthcommission.ca/wp-content/uploads/2021/09/Structural_Stigma_Assessment_Report_eng.pdf

Project ECHO (n.d.) <https://www.echocanada.net/>

Adaptive Mentorship Networks

BC Adaptive Mentorship Network for Pain, Mental Health and Substance Use (Pain BC, n.d.) <https://painbc.ca/adaptive-mentorship>

Atlantic Mentorship Network: Pain & Addiction (Atlantic Membership Network, n.d.) <https://www.atlanticmentorship.com/>