



Anxiety Disorders Association of Canada
Association Canadienne des Troubles Anxieux

Mental Health and Mental Illness

Invited Submission to the Standing Senate Committee on Social Affairs, Science and Technology, prepared by the Anxiety Disorders Association of Canada/Association Canadienne des Troubles Anxieux, June 2003.

“Excluding increased funding, what are the three most important areas of government responsibility (either federal or provincial) that need to be improved to ensure adequate and timely access to needed health services?”

We are of the view that major system redesign is necessary to make accountable and effective mental health services available to Canadians suffering from the most prevalent type of mental illness – anxiety disorders. Our report is organized under three headings: Main Issues, Maintaining Factors, and Recommendations.

Main Issues

Prevalence: Anxiety disorders are the most prevalent mental illness affecting Canadian adults.^{1,2} The 12 month prevalence for any anxiety disorder is over 12%² and one in four Canadians will have at least one anxiety disorder in their lifetime³. There are six recognized anxiety disorders: generalized anxiety disorder (GAD), panic disorder/agoraphobia (PD/A), post traumatic stress disorder (PTSD), social anxiety disorder, obsessive compulsive disorder (OCD), and specific phobia. All are characterized by intense fear, anxious arousal, irrational thoughts and avoidance. Some 3.4% of the Canadian population experiences these disorders at serious and chronic levels⁴, which interferes significantly with quality of life and ability to function in academic, occupational and social contexts^{5,6}. For example, some 58% of OCD clients experience academic underachievement, 47% report occupational impairment, and 40% are unable to sustain long term employment.⁷ Further, anxiety disorders are often concurrent or comorbid with other mental illnesses, notably depression, that are

secondary to an untreated anxiety disorder. In fact, the presence of an untreated anxiety disorder in youth is a risk factor for the development of depression and substance abuse in early adult years.^{8,9} The high rates of comorbidity of anxiety with other disorders is also problematic as people with multiple diagnoses are more disabled and use more medical services than those without concurrent disorders.^{1,10} Anxiety disorders are also more chronic than other groups of mental disorders, including affective disorders and substance use disorders, and disproportionately affect individuals from lower social classes.¹ Finally, anxiety disorders are associated with a ten fold increase in suicide risk.¹¹ In summary, anxiety disorders are common in their severe form, are often chronic, and constitute a substantial social burden.

Economic burden: Only recently have the real costs of anxiety disorders been approximated. Prevalence data were not available in rigorous form, separate costs (e.g., medical over utilization, disability) were not aggregated, and treatment cost-benefit information is relatively recent. The real annual cost to Canada for anxiety disorders is estimated by U.S.-based economic modeling studies to be \$65 billion in 1994 USD including both direct and indirect (e.g., disability) costs.¹² The economic burden of anxiety disorders has been grossly unrecognized and is unsurpassed by other major mental illness groups, including schizophrenia and depression.¹² Anxiety disorders account for the largest percentage (31.8%) of the total costs of all mental disorders, due largely to their high prevalence, young age of onset, and large effects on economic productivity.¹² The indirect costs of anxiety disorders (e.g., costs due to reduced or lost work productivity) are greater than the direct costs (e.g., expenditures related to inpatient/outpatient care of anxiety)¹², primarily reflecting the fact that many people with anxiety disorders are not getting access to treatment. However, this “savings” in direct treatment expenditures is offset many times over by substantially increased costs elsewhere in the system. More than half of the costs due to anxiety disorders are those associated with repeated and ineffectual use of health care services.¹³

The additional costs of under diagnosis and under treatment of anxiety disorders have also recently been documented. People with anxiety disorders are voracious consumers of health care services, including visits to primary care physicians, and specialists, and diagnostic testing, ambulance and emergency room services. The evidence for increased utilization by those with anxiety disorders relative to those without is overwhelming.^{8,14,15,16,17} For example, in a recent study comparing individuals with panic disorder to individuals without panic disorder (controls), it was found that direct costs for those with panic disorder (including primary care visits, specialist consultations, diagnostic tests and ambulance/ER services) were approximately 11 times higher than for controls.¹⁷

In the past several years, there has been increasing pressure to ensure that health care services are efficiently allocated, and with this there has been a desire to identify and selectively target for intervention high utilizers of medical services. In several recent studies, it has become apparent that people with anxiety disorders are the single largest diagnostic group within this class of high utilizers of health care services.^{18,19} Moreover, effective, evidence-based treatments for anxiety disorders exist,^{20,21,22} and there is a

growing literature demonstrating “cost-offset”, that is, lowered medical costs following receipt of evidence-based treatment for anxiety disorders.^{23,24} In fact, evidence-based psychosocial treatments have the advantage of having a higher level of cost-effectiveness than the most widely used medical treatments²⁵. To the extent that much of the cost associated with anxiety disorders results from absent or incorrect diagnosis, and/or inappropriate or inefficient treatment, a substantial proportion of the economic burden of anxiety is avoidable.¹³ To put the magnitude of the problem we face due to the prevalence and neglect of anxiety disorders into perspective, a study by the World Health Organization, Harvard School of Public Health and the World Bank²⁶ has predicted that by year 2020, anxiety disorders will rank as the second highest source of disability amongst neuro-psychiatric conditions, behind unipolar major depression, and ahead of schizophrenia, alcohol use, dementia and drug use.

In summary, the economic costs of under diagnosing, misdiagnosing and inappropriate treatment of anxiety disorders are increasingly well known and largely avertable. Clearly, in light of the economic costs associated with untreated anxiety disorders, the availability of effective interventions, and the demonstrated cost-offset effects associated with these treatments, we ignore these disorders to our collective economic peril.

Service Gap: Mental health services in Canada are available as a direct function of illness visibility. Therefore, schizophrenia, by virtue of behavioral disturbance, is most resourced, followed by mood disorders, organic brain disorders, eating disorders, addictions, and personality disorders. Those suffering from anxiety disorders do not tend to attract attention, are secretive, embarrassed and highly avoidant. Further, the detection rate for anxiety disorders amongst primary physicians is well below 50%,^{27,28,29} a fact that clearly needs to be addressed through increased awareness of anxiety disorders at all levels of health care. Moreover, few mental health practitioners are trained in effective treatments for anxiety disorders and there are virtually no specialty treatment programs for anxiety disorders in Canada. The combination of self-stigma on the part of sufferers and poor recognition and treatment skills on the part of health care practitioners results in a large service gap between need and resource availability. This unfortunate reality is ironic, since the anxiety disorders are among the most treatable of all mental disorders.^{21,22,23}

System Indifference: One would expect that the professional managers and policy people in Canada’s mental health delivery systems would be knowledgeable about mental illness prevalence rates, the almost complete lack of services for those suffering from anxiety disorders, and the relative effectiveness of evidence-based treatments for anxiety disorders. Logically, such awareness would be reflected in service delivery for purposes of cost effectiveness, but this is not the case. The question is, “Why isn’t it?” We believe that there are several reasons. First, mental health managers are not subject to market forces and appear motivated primarily by the twin requirements of staying within budget and avoiding adverse media. There are few, if any, system incentives to otherwise be efficient, effective or preventative in managing mental illness. Second, anxiety disorders are relatively ‘invisible’, in that those with anxiety disorders tend to suffer in secret and

are not overtly deviant. A final reason for the widespread lack of recognition for this class of mental illness is that both the public and many mental health professionals confuse anxiety disorders with excessive stress. Stress is typically a normal reaction to life circumstances and represents an overload condition. In contrast, anxiety disorders involve psychopathology. It is disturbing that the most immediate form of discrimination against Canadians with anxiety disorders comes from the very source that is supposed to understand and be responsive to their plight, the mental health delivery system itself.

Maintaining Factors

Low Diagnostic Sensitivity: Anxiety disorders frequently go unrecognized. Less than 50% of patients with anxiety disorders are recognized as having any kind of “psychological problem” by their primary care physicians and of these, fewer than one-third will receive the correct specific anxiety disorder diagnosis. This may partly reflect the fact that individuals with anxiety disorders tend to experience and present to primary care with a variety of physical complaints associated with anxiety (e.g., gastrointestinal complaints, heart palpitations), rather than complaining of “anxiety” per se. If the anxious person presents with physical complaints, the rate of detection for the anxiety syndrome is further lowered,²⁷ suggesting that primary care physicians are more attentive to physical symptoms than to psychological distress or underlying psychological causes. These diagnostic errors result in unnecessary and often costly, diagnostic investigations and/or referrals to specialists (e.g., gastroenterologists, cardiologists) in an attempt to identify nonexistent organic disorders.^{16,18,30,31} Even if primary care physicians do recognize an anxiety disorder in a patient during a particular visit, there is only a 59% chance that treatment will be offered for the anxiety disorder.³² Similarly, community mental health workers are not skilled in detecting specific anxiety disorders, as formal training in conducting structured clinical diagnostic interviews is not the norm. Also, for most community mental health workers, making a correct diagnosis does not matter, since clients are usually treated for their symptoms even if they do not meet criteria for a specific disorder.

Lack of Accessibility to Evidence-Based Treatments: Evidence-based treatments (also referred to as empirically-supported treatments) are evolved from theory and then developed and refined into treatment protocols that are independently assessed in random controlled clinical trials. In other words, they are scientifically based. While this is normal procedure for developing and evaluating psychopharmacological agents, it is not a widespread practice in psychotherapy. As a result, there are a wide range of nonspecific verbal therapies in routine use by all level of practitioners, supported by public funds, that have not established themselves as being more effective than placebo in the treatment of mental illness, or indeed as having any impact on the course of the illness.³³ Standards are low and both regulatory bodies and mental health managers rarely enforce any standards that may be present. In the case of anxiety disorders there are two types of treatment that are accepted as evidence-based (i.e., demonstrably effective). They are cognitive behavior therapy (CBT) and psychopharmacology.³⁴ These treatments are applicable to all anxiety disorders, although the treatment protocol usually is disorder specific, and are used either alone or in combination. However, as practitioners are paid

on the basis of time spent with patients/clients, regardless of outcome, there is little incentive to develop effective psychotherapy skills. The system's tolerance for low quality standards in knowledge and skill for mental health practitioners in Canada has the effect of prolonging illness, discouraging patients from publicly funded services, and allowing practitioners to deliver well-meaning, but ineffective treatments at public expense.

Inequity in Funding between Disorders: Visibility of symptoms has been the historic basis of funding mental illness diagnostic groups. Schizophrenia carries the highest visibility, by virtue of having psychotic symptoms as its defining feature. Mood disorders, starting with bipolar depression, comes next, followed by major depressive disorder, eating disorders, addictions, personality disorders, and finally, if at all, anxiety disorders. By definition, those with anxiety disorders are avoidant and secretive about their symptoms and give the appearance of normality, even if they receive disability payments and live as an adult in their parent's basement. This rank ordering of mental illness diagnostic groups according to visibility of symptoms does not translate into severity or duration of illness. The Provincial Anxiety Disorders Strategy⁴, released by the Government of British Columbia in 2002, identified 2.2% of the general population as having one or more chronic anxiety disorders, with symptoms present for at least a year and some associated impairment, and 1.2% as suffering from a serious anxiety disorder with significant disability. Because of relatively higher prevalence rates though, anxiety disorders are responsible for as much impairment and disability as depression, and schizophrenia.³⁵ A more equitable distribution of resources would have the potential to effectively treat anxiety disorders and therefore avoid medical over utilization in the form of primary physician, specialist and emergency room visits and hospitalization.

Lack of Consumer Choice: Most consumers appreciate the opportunity to have a collaborative relationship with their health provider in selecting the optimal treatment for their condition. Some prefer either psychopharmacological or psychological treatments, while others make their treatment decisions on the basis of information provided about treatment effectiveness, availability, cost, convenience, safety, and length of treatment. A recent treatment preference study of adults with an anxiety disorder who presented to a primary care setting and received an unbiased, balanced description of antidepressant therapy and cognitive behavioral therapy for anxiety, found that 60% of patients preferred psychological treatment as their first choice, compared to 31% who preferred pharmacological treatment.³⁶ The problem is that primary care physicians are not trained in psychological therapy and when medical specialists deliver psychological treatment, they are not required to make it evidence based. As pointed out in the Provincial Anxiety Disorders Strategy report for British Columbia⁴, "Meaningful choice and subsequent informed consent requires that consumers have access to different treatment avenues and have accurate information on which to base treatment decisions." (p. 10).

System Disincentives: There are a number of systemic issues in mental health care delivery in Canada that discourage cost-effective service delivery. Some of these issues are as follows: (a) Since there is no requirement for an evidence-based standard in the treatment delivery for psychological treatments, there is a poor relationship between

expenditures and treatment effectiveness. (b) The emphasis on physician services, by virtue of exclusive billing privileges in mental health program delivery, prevents the benefits of competition, including innovation, patient choice and price control. (c) Program costs, such as hospital programs, physician billings, disability, and community mental health, are not integrated. Hence, CEOs of health authorities have little motivation to control costs incurred in their jurisdiction, if these costs are being paid by a program outside of their jurisdiction and budget. (d) We have an acute care bias in Canada, which in the case of mental health, means that we have to ‘grow’ the problem until it is severe enough to warrant acute care. There are few incentives for more cost effective, early intervention programs. (e) Mental health funding from the provinces is often not targeted and therefore regional health authorities are free to divert these resources to physical health areas. Taken together, these structural issues guarantee that mental health expenditures will rise throughout Canada while service declines.

Recommendations

We are of the strong opinion that system reform is necessary to bring needed and effective mental health services to Canadians and offer three recommendations to bring this about. It is our view that if these recommendations became policy, significant cost savings would result.

- Make evidence-based assessment and treatment services a universal requirement for publicly funded care.
- Provide patient choice by funding non-medical, psychological treatment. This could be done in a restricted manner to ensure standard of provider and cost offset.
- Create System Incentives for Cost Effective Management Policies. These might include: The allocation of resources to mental health disorder groups based on consideration of prevalence, severity and treatment response; Early intervention rather than defaulting to acute care; The encouragement of innovation to address barriers to care in mental health through the development of public-private partnerships; and, The protection of mental health budgets by targeting funds when transferred from provincial to regional health authorities.

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