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2nd Session, 39th Parliament
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Legislative Assembly of Ontario

Assemblée législative de l'Ontario

The Honourable Steve Peters, MPP
Speaker of the Legislative Assembly

Sir,

Your Select Committee on Mental Health and Addictions has the honour to present its Interim Report and commends it to the House.

Kevin Daniel Flynn, MPP
Chair

Queen's Park
March 2010

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

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2nd Session, 39th Parliament

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LIST OF ABBREVIATIONS

ACT	Assertive Community Treatment
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BCFPI	Brief Child and Family Phone Interview
CCAC	Community Care Access Centre
CMHA	Canadian Mental Health Association
CMHO	Children's Mental Health Ontario
CTO	Community Treatment Order
DART	Drug and Alcohol Registry of Treatment
ER	Emergency Room
FASD	Fetal Alcohol Spectrum Disorder
FHT	Family Health Team
HCCA	*Health Care Consent Act, 1996*
ICM	Intensive Case Management
LHIN	Local Health Integration Network
MCSS	Ministry of Community and Social Services
MCYS	Ministry of Children and Youth Services
MHA	*Mental Health Act*
MOHLTC	Ministry of Health and Long-Term Care
OCAN	Ontario Common Assessment of Need

ODSP	Ontario Disability Support Program
OECD	Organisation for Economic Co-operation and Development
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
OW	Ontario Works
PPAO	Psychiatric Patient Advocate Office
SEEI	Service Enhancement Evaluation Initiative

INTRODUCTION

The Select Committee on Mental Health and Addictions is pleased to present this interim report. Each of our Members volunteered to serve on this Committee because of his or her personal commitment to mental health and addictions issues. Many families have been touched by mental illness or addictions, and no one is immune to the consequences. In our role as representatives for ridings around Ontario, we are also aware of the trials and tribulations of people struggling to obtain care for themselves or a family member, and their joy as someone recovers.

> **"I have learned, in some 30-odd years of caring for my loved one, to serve as a cook, a barber, an errand boy, a nurse, an impromptu social worker and a spur-of-the-moment advocate. I have learned when to rage and when to pray; when to curse and when to hold my tongue. I have learned how to ask—no, to beg—for help, for understanding, for support."**
>
> ***A family member***

The Committee is honoured and encouraged by the enthusiastic reception we have received across the province. We have listened carefully to passionate family members, brave survivors, and dedicated health care providers. We are fully aware that there are significant problems with the existing mental health and addictions system, and know that expectations are high that changes will be made. We hope that our work will help to give a voice to individuals who are so often ignored and stigmatized, and have so poignantly told us that what they need is "a home, a friend, and a job." Their commitment to recovery must be our commitment to help them recover.

This interim report summarizes the work of the Committee to date, giving consideration to both mental health and addictions issues and recognizing their interconnection. The report is structured around major issues in mental health and addictions, and major population groups affected by mental illness and addictions. It also provides some basic information about the Committee's background and mandate, and the dates and locations of its hearings and site visits.

This report also highlights some comments that the Committee has found particularly touching, or particularly helpful in understanding the mental health and addictions system. We have not referred to individuals directly, although we do use the names of some organizations.

> **"In economic terms, mental illness and substance abuse cost Ontario about $34 billion a year. . . . Of course, millions of families in Ontario know that the biggest cost can't be measured in dollars and cents."**
>
> ***Centre for Addiction and Mental Health***

Although there are many proposals in this document, coming from the many witnesses appearing before or submitting briefs to the Committee, we ourselves have tried to remain neutral. Our final report will provide a series of recommendations contributing to the development of the province's mental health and addictions strategy.

One final note: although the Committee represents three political parties, we have enjoyed working in a collaborative, non-partisan fashion. We believe that,

regardless of our political convictions, we each have a commitment to strengthening Ontario's capacity to respond to mental illness and addictions.

Committee Mandate

On February 24, 2009, the Legislative Assembly of Ontario gave unanimous consent to a motion to appoint a Select Committee on Mental Health and Addictions that would consider and report its observations and recommendations concerning a comprehensive provincial mental health and addictions strategy. In order to develop its recommendations, the Committee would:

- work with consumers/survivors, providers, experts and other interested parties to determine the needs that currently exist in the province;
- consider the mental health and addictions needs of children and young adults;
- consider the mental health and addictions needs of First Nations (on- and off-reserve), Inuit and Métis peoples;
- consider the mental health and addictions needs of seniors;
- identify ways to leverage existing opportunities and initiatives within the current mental health and addictions system;
- explore innovative approaches to service delivery in the community;
- identify opportunities to improve coordination and integration across the sectors for all people including those with concurrent mental health and addictions problems;
- recognize the importance of early intervention and health promotion with respect to diagnosing and treating mental health and addictions issues;
- consider the mental health and addictions needs of Francophone and ethnic minorities facing linguistic and cultural gaps;
- examine access to care issues for persons with mental health and addictions issues including primary and emergency care; and
- examine the existing continuum of social services and support for those with mental health and addictions issues. This would include justice, supportive housing, education and vocational support.

The Committee was to release its final report to the Assembly by the end of the spring 2010 sitting period; however, if it determined that more time was required, it could, by motion, extend its deadline by no more than three months.[1]

The Committee has decided that it would like more time to prepare its final report and has passed a motion extending its deadline by three months to September 3, 2010.

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[1] Ontario, Legislative Assembly, *Votes and Proceedings*, 1st Sess., 39th Parl. (24 February 2009): 3; and Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, 1st Sess., 39th Parl. (24 February 2009): 5006.

Preceding Developments

The Committee is very much aware and appreciative of the thoughtful work that has preceded its own consideration of mental health and addictions. Among the more recent of these undertakings are the Standing Senate Committee on Social Affairs, Science and Technology's seminal 2006 report, *Out of the Shadows At Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*; the Ontario Ministry of Children and Youth Services' *A Shared Responsibility: Ontario's Framework for Child and Youth Mental Health*, released in November 2006; Roy McMurtry and Alvin Curling's 2008 report, *The Review of the Roots of Youth Violence*; and the Mental Health Commission of Canada's *Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada*, released in 2009.

Two Ontario developments are particularly noteworthy: creation of the Minister's Advisory Group and passage of a Private Member's motion. The former Minister of Health and Long-Term Care established the Minister's Advisory Group on Mental Health and Addictions in October 2008. The membership of the Minister's Advisory Group, which includes people with lived experience of mental illness and addictions, family members, service providers, and researchers, will help to develop a new 10-year strategy for mental health and addictions services. As a first step, the Minister's Advisory Group released a consultation paper, *Every Door is the Right Door*, at a Summit on Mental Health and Addictions held in Toronto in July 2009. The Minister also established an inter-ministerial group that contributes to the development of the strategy.[2]

On December 4, 2008, Christine Elliott (PC – Whitby-Oshawa) moved that the Legislative Assembly immediately establish a select committee "to develop a comprehensive Ontario mental health and addictions strategy." The Committee was to focus on a number of issues, including the needs of children and residents of long-term care facilities, and the lack of inter-ministerial coordination in the delivery of services. The motion carried unanimously.[3] (See Appendix A for the motion's complete wording.)

Committee Meetings

The Committee met for the purpose of organization and to discuss business matters in March and early April 2009. Public hearings were held in Toronto and various other locations, beginning in mid-April and ending in early December. The spring hearings in Toronto involved presentations by government ministries which play a role in the delivery of the province's mental health and addictions services. The Auditor General of Ontario spoke about relevant audits which were reported in his *2008 Annual Report*. Also appearing during this period were

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[2] Ontario, Ministry of Health and Long-Term Care, Minister's Advisory Group on Mental Health and Addictions, *Every Door is the Right Door-Towards a 10-Year Mental Health and Addictions Strategy: A discussion paper* (Toronto: Queen's Printer, July 2009), pp. 4 and 6.

[3] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, 1st Sess., 39th Parl. (4 December 2008): 4489; and Ontario, Legislative Assembly, *Votes and Proceedings*, 1st Sess., 39th Parl. (4 December 2008): 6.

invited guests who attended as individuals or representatives of stakeholder groups (for example, former Senator Michael Kirby on behalf of the Mental Health Commission of Canada).

In the weeks following, the Committee heard from individual consumers/survivors, family members, health care and social service professionals, and related organizations.

All told, the Committee held 25 public hearings during which it received the testimony of more than 200 individuals and organizations. It had received more than 30 written submissions by December 31, 2009, and many articles and other items of interest pertaining to mental health and addictions. The Committee's schedule of public hearings and a list of witnesses and submissions are found in Appendix B.

Readers are cautioned that many of the comments and recommendations received by the Committee are not directly discussed in this document. In particular, statements pertaining to specific organizations are generally absent. However, this does not mean that these comments are being overlooked or ignored.

The Committee would like to thank everyone who participated in its hearings and those who made written submissions for their considerable time and generosity of spirit.

Site Visits

The Committee went beyond the traditional hearings venues and made site visits to various locations in order to gain a greater understanding and appreciation of how Ontario's mental health and addictions system operates and responds to the needs of its clients. Time was spent touring facilities and interacting with staff at the Centre for Addiction and Mental Health's Queen Street West location in Toronto, Regional Mental Health Centre in St. Thomas, and Eva's Phoenix, part of Eva's Initiatives, in Toronto.

The Committee was also pleased to visit several First Nations communities and health care organizations. Sandy Lake First Nation, the Oneida Nation of the Thames, and Six Nations of the Grand River graciously accepted the Committee's invitation to discuss their mental health and addictions issues. Representatives of Weeneebayko Health Ahtuskaywin, Weeneebayko Area Health Authority, and James Bay General Hospital welcomed the Committee to the Weeneebayko General Hospital in Moose Factory. Finally, representatives of Nodin Child and Family Intervention Services, a branch of the Sioux Lookout First Nations Health Authority, shared their expertise with the Committee on site in Sioux Lookout.

We now turn to the main purpose of this interim report, a summary of the proceedings of our hearings and the many written submissions presented to the Committee.

ADDICTIONS AND CONCURRENT DISORDERS

> **"One in five Ontarians at some point in their lives will experience a level of alcohol and drug abuse that requires treatment. For 2% to 3% of the province's population, it becomes a chronic problem."**
>
> ***Hope Place Centres***

The Committee received a large volume of testimony pertaining to various types of addiction. Some witnesses publicly spoke of their personal struggles. Witnesses identified a severe shortage of addictions services, particularly for those concurrently suffering from mental health issues. There is often a brief "window of opportunity" for individuals who are finally ready to face their addiction. If this window closes, it is possible that the individual will never seek assistance again. Similarly, severe delays in the transition between the various stages of addiction treatment mean that many individuals relapse unnecessarily.

The Auditor General echoed this concern, noting that long wait times particularly affected some areas of the province. Programs of all types—including in-home, institutional, drop-in, residential, outpatient, and pre- and post-treatment—are required. There were also requests for more outreach, longer treatment programs, and permanent Ministry of Community and Social Service (MCSS) funding for the Addiction Services Initiative for Ontario Works (OW) recipients.

Witnesses stressed the need for service integration across mental health and addictions services. Presently, potential clients are often informed that they must address their addiction before they can access other mental health services. Service providers sometimes confessed that they feel they have no choice but to restrict access because of a shortage of funds. Because so many individuals dealing with an addiction also have mental health issues, this lack of integration has serious consequences.

The DART[4] database, which provides information on addictions programs across the province, was praised. However, witnesses suggested that it is too complicated and does not necessarily improve access because clients are excluded from programs for many reasons. It was recommended that Ontario's addictions services be divided into three areas: addictions-only programs, concurrent-disorder capable programs, and concurrent-disorder enhanced programs.

Some witnesses requested that the province give greater consideration to harm reduction, and provide more education about its merits. Others stated that Ontarians need more education about addictions in general. One recovering drug user asked the Committee to include people like himself in the development of an addictions strategy, and to fund programs deterring youth already involved in drugs from further use. He argued that agencies presently apply for grants that they believe will be successful in obtaining funding, rather than for the most needed programs.

---

[4] The Drug and Alcohol Registry of Treatment (DART) is operated by CONNEXOntario and funded by the Ministry of Health and Long-Term Care.

The Committee is deeply concerned about the growing use of highly addictive prescription painkillers such as OxyContin and Percocet, as highlighted in its visit to Sandy Lake First Nation and other rural and northern communities around the province, all of which need assistance in fighting this particularly powerful addiction. One organization recommended that physicians be educated about the need to reduce the prescription of these drugs.

Several witnesses recommended that research and programs pertaining to addiction could be funded by a small tax on alcohol or the proceeds of drug crime.

The Committee is aware that there is a higher incidence of drug and alcohol addiction among individuals with mental illness. The Committee also learned of a little-known connection between addiction and mental illness: almost half of all cigarettes sold are consumed by individuals with a mental illness.[5] Perhaps somewhat surprisingly, the Committee has to date heard little about gambling addiction.

POPULATION GROUPS

While our hearings process was very inclusive and covered the concerns of the general population, the Committee's mandate includes consideration of the mental health and addictions needs of specific population groups: children and young adults; First Nations, Inuit and Métis peoples; seniors; and Francophones and ethnic minorities.

Children and Young Adults

Between 15% and 21% of children have at least one mental health issue; 14% of children and youth suffer from a diagnosed psychiatric disorder; and suicide is the second-leading cause of death for youth 15 to 19.

Ministry of Children and Youth Services

Mental health and addictions services for children and young adults elicited more concerns and recommendations than those for any other population group. The Committee heard from parents and youth who spoke or wrote with passion about the challenges they and their loved ones face on an ongoing basis. We also heard from those who work with children, youth and families, describing their frustrations and hopes.

The Dare to Dream Program reported that onset of mental illness is before the age of 24 for 75% of those diagnosed with mental illness. The Offord Centre for Child Studies conducted the last Ontario Child Health Study 20 years ago; it told the Committee that the province must come up with a new estimate of prevalence and needs. Michael Kirby, chair of the Senate Committee when it released *Out of the Shadows at Last*, called the children's system the worst part of the mental health

[5] The Nickel-a-Drink Research Foundation presented this statistic in the package it submitted to the Committee. We investigated further and discovered that the figure comes from the following study: Karen Lasser, J. Wesley Boyd, Steffie Woodhandler et al., "Smoking and Mental Illness: A Population-based Prevalence Study," *Journal of the American Medical Association* 284 (22 November 2000): 2606-2610.

system, across the country. (*Out of the Shadows at Last* referred to children's mental health as "the orphan's orphan" within the health care system.[6])

The Ministry of Children and Youth Services (MCYS) is the lead ministry for children and youth up to the age of 18 experiencing mental health issues. Unlike child protection services, children's mental health services are not mandated under the *Child and Family Services Act*; they are provided to the extent that resources are available. Most services are community-based. The MCYS released a policy framework, *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health*, in 2006. The first step in implementing the framework is "mapping" it against current service provision. The MCYS continues to hold regional workshops with stakeholders to share what has been learned through the mapping exercise.

Discussion and submissions covered a range of issues, including the difficulties associated with age-related transitions, fetal alcohol spectrum disorder (FASD), and autism, which are discussed later in the report. The three issues presented below were referred to on a routine basis: funding; prevention, early identification and early intervention; and the education system.

Funding

Funding impacts all aspects of mental health and addictions services. When sectors and areas of the province are battling the effects of economic recession and an increased demand for services, the impact is greater than usual. Presenters told us that reliance on short-term funding makes it difficult for programs to fulfill their potential. It is time-consuming for agencies to apply for and to maintain. Budgetary constraints affect community-based agencies' ability to retain and recruit staff, given the higher salaries offered in institutional settings.

The Auditor General briefed the Committee on the audit of child and youth mental health agencies in his *2008 Annual Report*. Agencies are struggling to maintain core services because funding is tied to historical needs and population. Some witnesses called for the application of a population-based funding formula. According to Children's Mental Health Ontario (CMHO), funding is scattered across 440 agencies of varying sizes, 85 of which are accredited members of CMHO.[7] The Auditor General referred to this fragmentation as well, saying children with the same mental health condition have different wait times and treatments depending on where they live.

> **"We need more resources for that 10% of children and youth with chronic and severe mental illness."**
>
> ***Offord Centre for Child Studies***

Cost is a barrier to timely care for many families. Parents for Children's Mental Health referred to funding as "the elephant in the room" and emphasized that

[6] Canada, Parliament, Senate, Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Ottawa: The Committee, May 2006), p. 155.
[7] E-mail from staff, Children's Mental Health Ontario, Toronto, 18 February 2010.

persistence and using their own funds were necessary to enable participation by their children in special programs.

Prevention/Early Identification/Early Intervention

> **"We need to invest, very heavily, in the early years zero to six, and invest when the resilience to all kinds of chronic disorders, especially mental health, can actually prevent them."**
> ***Ontario College of Family Physicians***

Prevention, early identification and early intervention were cited as critical components of a more effective and efficient system. Physicians are most often the first point of contact for those seeking help with a mental health or addictions concern. The Committee heard that they are under-prepared to deal with many of these issues as they receive little training in these areas.

The Canadian Paediatric Society reported that while 40% of visits to paediatricians have a mental health component, only 20% of those children and youth will receive care. It is estimated that about 70% of these conditions could be solved through early interventions.

CMHO spoke of the lack of any systematic program to screen for potential mental health problems. It told the Committee that only 125 children's mental health agencies are using the Brief Child and Family Phone Interview (BCFPI), the common screening tool.

The Auditor General noted that the need for a greater focus on early identification and intervention was the most important conclusion of the audit of child and youth mental health agencies. The agencies visited indicated they would need the assistance of schools to aid in this task. Witnesses spoke of inter-ministerial cooperation and partnerships between school boards and agencies.

Support for families in providing a mentally healthy home will assist in prevention, according to some presenters. Workforces in various sectors will require training in order to identify the early signs of mental health and addictions issues and to intervene appropriately.

Education System

> **"Many of these young children with undiagnosed mental health disorders are so anxious or depressed they can't concentrate, they cannot attend school regularly, they fail and even drop out."**
> ***A paediatrician***

Many suggested how to better incorporate the education system into a mental health strategy. Mental health problems often manifest themselves as behavioural issues in school. A major concern is the need to build staff capacity. The Committee was told that personnel, particularly teachers, require training to recognize a possible mental health or addictions issue, to communicate that knowledge to families and to make appropriate referrals.

Presenters felt that more could be done within the curriculum to educate students about mental health and addictions issues, even though they may have differing opinions about the appropriate time to introduce the topics to students. References

were made to the concept of schools as hubs for the integration of educational, social and health services, and assessments for children and youth.

School boards offer a number of programs in support of children's mental health needs and building wellness. Outside supports are recommended when needs extend beyond a school's ability to respond. The Ministry of Education is collaborating with the MCYS in its mapping exercise and on the Student Support Leadership Initiative, the goal of which is the building/enhancing of partnerships between boards and community agencies.

Increasing numbers of post-secondary students were said to be seeking counselling services. As a population group, they have a high risk for mental illness. The sector is considered an ideal setting for promotion and early intervention strategies, but we heard that partnerships are needed to transform what is called a fragmented and under-funded system.

First Nations, Inuit and Métis Peoples

As noted earlier, the Committee has visited several First Nations communities and organizations delivering health, mental health, and addictions care. Although the mandate of the Committee includes the consideration of the needs of the province's Métis and Inuit peoples, we have not heard testimony or received submissions from these groups.

A history of oppression, the consequences of residential schooling, unemployment, isolation, and other factors contribute to higher rates of trauma, grief, and mental illness and addictions among First Nations people. Clients of First Nations mental health and addictions agencies have multiple and complex needs.

> **"So you may ask, 'What does all this history have to do with mental health anyway?' I think that there's a lot of discussion now ... about the phenomenon—perhaps the intergenerational phenomenon—of historical trauma."**
>
> ***Noojmowin Teg Health Centre***

The Committee also received a number of complaints about the complexity of the federal and provincial funding arrangements for mental health and addictions care for First Nations communities and individuals. Similarly, the possibility was raised that First Nations communities are not adequately connected to their respective local health integration networks (LHINs).

Northern Communities

The Committee witnessed first hand the struggle of community leaders confronting the new menace of prescription painkillers in Sandy Lake, and the distress of health care workers addressing suicide in the communities along James Bay. Aging grandparents are assuming care for children when parents are disabled by their condition and unable to obtain adequate services.

"You have come to Sandy Lake at a very crucial time. As you may know, prescription drug addiction is a big problem in so many First Nation communities and ours is no different."

Sandy Lake First Nation

There is a severe shortage of services to address this situation, particularly in the north. As a result, care is typically crisis-driven. For example, Sandy Lake has started its own drug treatment program, with little funding or professional input. The Committee was profoundly impressed by these efforts, but our goodwill is not enough. Sandy Lake requested funding for this program, and other communities called for assistance for most forms of mental health and addictions programming, including children's services, youth outreach, visiting psychiatrists and psychiatric nurses, senior care, and all stages of addictions treatment.

There is also a need for more general social and economic support in the form of education and literacy programs, employment opportunities, anti-racism campaigns, justice and diversion services, and funding for infrastructure. The Committee can attest to the immediate need for improved housing.

It is hoped that telemedicine will provide greater access to needed services in the future, although witnesses suggested that first contact should be face-to-face. The creation of a pool of fly-in mental health specialists would also assist these northern communities in accessing services.

Southern Communities

First Nations in the south of the province are also struggling with the needs of their communities. Members of Oneida Nation of the Thames spoke openly about the inability of their people to form attachments and their lack of trust of the outside world, both consequences of the trauma of residential schooling. Children are bussed to schools in larger centres, yet they do not have the self-esteem to deal with the urban issues they will encounter there. The Oneida made a special request for early intervention programs for their children and youth, and parenting skills programs for adults that reflect their traditions.

Members of Six Nations at Brantford spoke of their similarly complex situation. Although the community maintains a unique and admirable mental health service, there is concern about a recent increase in crime and violence that they attribute to addictions. The Six Nations made a specific request for peer support training, withdrawal management, after-care, follow-up, and diversion programs tailored to First Nation needs. Providers of mental health services also expressed an interest in improved diagnosis of fetal alcohol spectrum disorder (FASD), a condition which is taking a huge toll on First Nations communities across the country.

Aboriginal youth commit suicide at rates 5 or 6 times greater than non-Aboriginal youth, 20% report solvent use, and 20% to 25% suffer from an emotional disorder. Half of Aboriginal youth offenders have FASD, as do 8% of all Aboriginal children.

Ministry of Aboriginal Affairs

Witnesses appearing in various cities also requested assistance in developing a youth engagement strategy. Youth need positive images of First Nations history and people, and some hope for the future. Long-term treatment centres, relapse

support, peer-led prevention, aftercare, and outreach—particularly to pregnant women and youths—are all required to provide better addictions support to individuals both on- and off-reserve.

Some witnesses made more specific requests, such as funding for mentoring programs or exchanges between care workers in Aboriginal settings, and a conference to initiate a research strategy for Aboriginal mental health and addictions.

First Nations people in the north and south asked that we respect their right to use their own methods, such as traditional healing, to solve problems in their communities. Greater awareness of history and tradition are also seen as ways forward. Witnesses asked that special consideration be given to funding programs that are culturally competent, particularly those run by and for First Nations people. Health care providers need education about First Nations issues, because misdiagnoses are common. Furthermore, the size of many communities means that confidentiality can be a concern, necessitating the availability of outside services. It is also difficult for many locations to retain staff. Finally, First Nations people asked for full representation in the development of the mental health and addictions strategy.

Seniors

Seniors make up a growing segment of Ontario's population. The fastest component of that growth is people over the age of 85. Figures provided by the Seniors' Secretariat show that the prevalence of seniors with depressive symptoms in Canada may be 10% to 15%.

> **"Older adults take up to 40% of all medications prescribed in Canada and most older adults take several types of medication at a time."**
>
> ***Seniors' Secretariat***

The Committee heard that addressing the shortage of geriatric specialists, and educating and training health professionals, service providers and informal caregivers will enhance our understanding of the complexity and diversity of seniors' mental health and addictions issues. This will in turn lead to earlier diagnosis and better treatment. Presenters said enhanced community services will reach more seniors and provide alternatives to long-term care.

Witnesses identified a greater number of concerns about Alzheimer disease and related dementias, and long-term care homes than any other issues related to seniors.

Alzheimer Disease and Related Dementia

The risk of developing dementias increases with age. While there are different forms, Alzheimer disease is the most common among seniors, affecting 66% of those with dementia. According to the Alzheimer Society of Ontario, more than 180,000 Ontarians have dementia; in less than 25 years, that number will double. The Alzheimer Society of Canada released *Rising Tide: The Impact of Dementia on Canadian Society*, in January 2010. Without intervention, the report expects

that 2.8% of the Canadian population will have dementia by 2038, compared to 1.5% in 2008.[8]

> **"Dementia is more than just an important health concern. It has the potential to overwhelm our health care system if fundamental changes are not made in research, funding and care delivery."**
>
> ***A family caregiver***

According to presenters, a coordinated, integrated response will enable service capacity to keep pace with growing numbers of persons with dementia and their caregivers, and assist them through the continuum of their condition. Additional specialized geriatric services, training for staff, assessment, diagnosis and early intervention, and consideration of the effects on the acute, community and long-term care systems would be part of the response. We also heard a call for respite for caregivers who put so much of their energies into tending to the needs of loved ones that their own well-being can suffer.

Long-Term Care Homes

The care, treatment and safety of those with mental health and addictions issues are concerns for those who work in Ontario's long-term care sector, and for the family and friends of residents of long-term care homes. According to the Ontario Long Term Care Association, increased acuity in mental health conditions has been noted upon and following admission. It cited recent data showing that 26% of residents reported signs of worsening depression over a three-month period, and 2% had previously been in a psychiatric hospital.

Presenters spoke of the need to increase and strengthen collaborative partnerships between homes and resources such as community care access centres (CCACs), family councils, and dedicated mental health resources. They called for appropriate funding to accommodate seniors with mental health issues, including more and/or increasingly specialized units, and ongoing education and training for staff. Reference was made to a need for a comprehensive and effective assessment tool to be used by CCACs to help determine the potential for aggressive behaviour, prior to admission. This will help in determining those homes most appropriate for placement recommendations. Another suggestion was revising policies related to readmission to a home following discharge or a period of absence, in order to allow for sufficient time to complete behavioural assessments.

> **"Long-term care facilities must be funded appropriately to accommodate seniors with mental health issues."**
>
> ***Advisory Committee for Mental Health and Addiction Services***

Francophones

Even though consideration of the mental health and addictions needs of Francophones is part of the Committee's mandate, presentations said very little

[8] Dementia is expected to cost over $872 billion in direct health costs, unpaid caregiver opportunity costs and indirect costs associated with unpaid care over the next 30 years. See Alzheimer Society of Canada, *Rising Tide: The Impact of Dementia on Canadian Society – Executive Summary* (Toronto: The Society, January 2010), pp. 7 and 10.

about those needs. Some asked for more funding and consideration. While in Sudbury, we heard of the difficulty that community had in getting Francophone psychiatrists to establish practices there.

Newcomers and Refugees

The Ministry of Citizenship and Immigration spoke to the challenges which make immigrants and refugees more vulnerable to mental illness and addictions (e.g., unemployment and underemployment, and the absence of family and a social network). Immigrants also encounter barriers in terms of access, among them language difficulties, lack of awareness of services, and differing cross-cultural interpretations of mental illness.

Several witnesses stressed that unaddressed trauma is one of the most important causes of mental illness and addictions, particularly in the case of women, immigrants and refugees, and communities that are relatively deprived and suffer from high rates of violence.

> **"We're seeing a number of people coming from war-torn countries who are victims of trauma, women and children who are victims of domestic violence, and abuse in young people."**
>
> ***Hamilton Addiction and Mental Health Collaborative Services***

Presenters saw translators as valuable additions to the health and social services systems. They believed more funding and research will help in understanding the needs of immigrants and visible/racial minority communities. The development of cultural competency and awareness within programs was described as crucial to positive outcomes.

COMMUNITY SUPPORT SERVICES

In the spring of 2009, the Ministry of Health and Long-Term Care (MOHLTC) reported that the government provided funding to community mental health agencies for services that included the following: over 300 community mental health programs; 79 assertive community treatment (ACT) teams;[9] crisis intervention; intensive case management (ICM); early intervention in psychosis; vocational programs; consumer/survivor initiatives; and supportive housing. It also supports services specifically aimed at drug and alcohol treatment, and problem gambling.

An audit of community mental health in the Auditor General's *2008 Annual Report* found that the MOHLTC had met its deinstitutionalization target of 35 beds per 100,000 and that some good local coordination practices were in place. However, funding has not followed people from institutions to communities. In order to maintain the deinstitutionalization target, the MOHLTC determined that 60% of funding would have to be

> **"We found that there still wasn't an adequate level of community-based support."**
>
> ***Auditor General of Ontario***

[9] Assertive Community Treatment (ACT) teams are multidisciplinary units providing services to individuals with serious mental illness.

community-based. According to the audit report, it spent about $39 on community-based services for every $61 spent on institutional services in 2006/07.[10] Timely access is a principal barrier to effective community care, as the LHINs indicated that wait times can be up to 180 days.

As discussed earlier, the Auditor General noted that historical-based funding has created significant regional disparities. At the time of the audit, average per capita funding for community services ranged from $19 to $115. (The 2008 audit of addictions programs cited an MOHLTC analysis which indicated that per capita funding for those programs ranged from about $3 to more than $40, across the 14 LHINs.[11]) Witnesses called for a new funding model recognizing relative needs.

Many witnesses and submissions called for increased funding for a range of community support services. They spoke of the need to create environments that foster companionship and social support, making frequent use of the phrase "a home, a friend, and a job." Recreational, nutritional, and cultural activities could be provided through community centres, libraries and adult education centres. References were also made to the needs of those with complex needs who are hard to serve. (See also the "Integration" and "Treatment Issues" sections of the report.)

"I would like to have more fun activities on the weekend so I don't feel so alone."

A consumer/survivor

Those service areas which generated the greatest amount of comment are discussed below: education and employment; financial assistance; housing; legal advocacy; peer support; and support for families/caregivers.

Education and Employment

Education, training and employment supports ease reintegration into society and help in finding meaningful work. A job can do much to improve a person's financial situation and, perhaps just as important, bolster self-esteem. Presenters thought that eligibility criteria for these services could be made more flexible as access difficulties have been identified. Employers with a sensitivity to mental illness and addictions will provide a more reassuring and accepting environment within which people are more likely to thrive.

Financial Assistance

Data provided by the MCSS clearly indicate that a high proportion of clients accessing social assistance and employment supports have or are at risk of developing mental health and addictions issues. For example, 72% of domiciliary hostel tenants reported being diagnosed with at least one mental health issue. Over 50% of Ontario Disability Support Program (ODSP) recipients have a mental health disability. A survey conducted by the City of Toronto found that

[10] Ontario, Office of the Auditor General, *2008 Annual Report* (Toronto: The Office, 2008), p. 178.

[11] Ibid., p. 52.

86% of homeless people had a lifetime diagnosis of mental illness or substance abuse.

Social assistance rates were considered inadequate by presenters, with the ODSP being singled out for particular attention. They asserted that ODSP rates should cover the real cost of living and be raised in tandem with the rate of inflation or the consumer price index.

> **"I want the government to provide money to those of us with mental illness so we will have a better standard of living beyond subsistence."**
>
> ***A consumer/survivor***

The Committee was informed of research suggesting that individuals discharged from hospital are less likely to become homeless if they are given assistance in connecting to ODSP or OW.[12] Another study showed that individuals receiving ODSP are considerably more likely to leave the social assistance system if they receive mental health care and other community services.[13]

We heard that a review of social assistance should go beyond minor changes. Of particular concern are the disincentives to work built into the ODSP and the clawbacks that prevent recipients from getting ahead. These include the loss of drug benefits, reduced payments with earnings, and complications associated with the fear of relapse and getting back into the assistance system.

Housing

The Committee heard repeatedly about the significance attributed to housing. According to presenters, its provision can contribute to a reduction in psychiatric symptoms and decrease the need for unnecessary emergency room visits and extended hospitalizations. They regularly used the terms affordable, safe, supported, and supportive to describe the characteristics of the types of housing they wished to see.[14]

> **"There is no mental health without a home."**
>
> ***The Dream Team***

The audit of community mental health services reported by the Auditor General found that most areas reported a critical shortage of supportive housing, although there are vacancies across the province. LHINs indicated to audit staff that affordable supportive housing is the cornerstone of cost-effective community

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[12] C. Forchuk, S.K. Macclure, M. van Beers et al., "Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and 'No Fixed Address'," *Journal of Psychiatric and Mental Health Nursing* 15 (2008): 569-75.

[13] Canadian Institute for Health Information, "Hospital Length of Stay and Readmission for Individuals Diagnosed with Schizophrenia: Are They Related?" *Analysis in Brief*, 17 April 2008.

[14] The brief tabled by the Centre for Addiction and Mental Health referred to three general types of housing that target individuals with mental illness and addictions: custodial, supportive and supported. "Custodial housing is general for profit 'room and board' settings with little or no rehabilitation support. Supportive housing is congregate settings which include rehabilitation support. Supported housing is a strengths-based approach aimed at helping consumers get and keep independent housing in the community."

care. According to MOHLTC staff, current government policy emphasizes rent supplements so that individuals may live in the community.

One organization recommended the appointment of a lead agency in its jurisdiction for application and waiting list management for all supportive housing. Centralization would bring about consistency in application, improve customer service, offer sound waiting list statistics for strategic planning, and improve services for individuals requiring mental health and addictions support.

Other presenters suggested that the Ministry of Municipal Affairs and Housing's Long-Term Affordable Housing Strategy, and the mental health and addictions strategy could offer a coordinated and collaborative approach to providing housing supports to those with mental illness and addictions.[15] Housing strategies from the past can serve as models. We were also reminded of the needs of shelters and the costs they incur in providing services to those homeless with complex mental health and addictions issues.

Legal Advocacy

The Committee heard that legal advocacy services should be made more readily available. The services provided by the Psychiatric Patient Advocate Office (PPAO) are only offered at former psychiatric hospitals; they have not followed the migration of services to the community. It was suggested that the establishment of a provincial treatment advocate would help to balance the role played by the PPAO in protecting legal rights.

Peer Support

> **". . . I believe that a peer support network of one kind or another is ideal."**
>
> ***A consumer/survivor***

Much was said and written about the value to be gained from involving those with lived experience in the delivery of services. Presenters told us that the lens of experience, provided by consumer/survivor initiatives and more specifically peer support, can contribute to reductions in wait times and hospitalization, and improved access.

The Committee learned that peer support can be made available informally or formally through speakers' bureaus, public education, research, assessment, hospital emergency rooms, and "warm" (pre-crisis) telephone lines, and as system navigators and advocates. The Ontario Peer Development Initiative's Peer Support Toolkit Project will enable peer support organizations to accredit peer workers by September 2010.

[15] The Ministry of Municipal Affairs and Housing completed consultations on its Long-Term Affordable Housing Strategy in December 2009. A report may be released by late spring 2010. Telephone interview with staff, Office of the Deputy Minister, Ontario Ministry of Municipal Affairs and Housing, Toronto, 19 February 2010.

Support for Families and Caregivers

Families and caregivers serve as major support systems for individuals suffering from mental illness and addictions but can experience burnout and financial difficulties in response to caregiving demands. The results of a 2009 survey of 200 families caring for someone with a mental illness found that 80% felt overwhelmed or severely stressed.

We were told that family support groups can provide help along with education, respite and opportunities for discussion. Those developed by consumers/survivors and caregivers themselves would give families invaluable insights. We also heard that structured family support can be incorporated into an individual's recovery plan, when they wish to have their family involved. (See also the discussion of privacy in the "Treatment Issues" section of the report.)

Presenters said difficulties with system navigation are a major barrier to accessing treatment. The creation of navigator positions would help families face the challenges inherent in recognizing symptoms, getting a diagnosis, understanding legal issues (e.g., confidentiality of health care information), and making their way through the maze of services. (See also the section on "Integration".)

Family members spoke of the need for educational resources, particularly with respect to their role as caregivers. Internet links to reliable sources of current information would be a good first step. Respite care allows caregivers the time and freedom to pursue personal, social and recreational endeavours. Financial assistance in the form of a caregiver allowance would be of benefit to those without sufficient income to take advantage of tax relief measures. One presenter told us that such an allowance was announced by the government of Nova Scotia in August 2009.[16]

> **"Our family has been very frustrated in trying to find someone who will see us; frustrated with the time frame we got for the initial appointment, frustrated with the time between appointments, and frustrated with the lack of available resources."**
>
> ***A family member***

HEALTH CARE PROFESSIONALS

While the door of a family physician's office is referred to as the main door to mental health and addictions services, a range of health care, social service and mental health professionals participate in their provision. The benefits of multidisciplinary teams and greater collaboration among professions were widely acknowledged.

Primary Care

Presenters strongly supported the promotion of mental health and addictions services in primary care centres, noting their potential to assist in early diagnosis

[16] Nova Scotia, Department of Health, "Allowance to Aid Caregivers," *News Release*, 11 August 2009.

and intervention, particularly in the north. The Centre for Addiction and Mental Health drew our attention to the fact that family physicians and community nurses are the health care professionals most often consulted by those seeking help for a mental illness or addiction, providing about 80% of the work in the sector.

We heard that mental health professionals can and should be more actively involved in primary health care delivery or shared care settings. Possible models include colocation (i.e., a community mental health agency sharing facilities/staff with primary care services), links between physicians and psychiatrists, the supervision of staff in family health teams (FHTs) by a community mental health provider, and bringing psychiatrists and social workers into family practices.

Access to primary care was frequently described as difficult for people with lived experience of mental illness and addictions, particularly those with complex needs. Without a family physician or other forms of primary care, they cannot enter treatment programs, see specialists or receive medication. The failure to address physical health problems can accentuate mental health issues. Incentives to take on such patients may prove worthwhile. In Sudbury, for example, the Committee was told that the Sudbury Regional Hospital pays a stipend to a family physician to provide a mental health primary care clinic in one of its facilities.[17]

"I phoned his family doctor, who said, 'I don't do psychiatry'."

A family member

Rural and remote areas are particularly affected by wait times, travel costs, and the attraction and retention of health care professionals. Individuals may receive treatment in larger centres, only to relapse when they return to their underserved community.

Telemedicine and e-health innovations could serve to fill some access gaps, particularly in isolated areas. A fly-in mental health resource pool could also be created, and incentives provided to attract and retain mental health professionals. While some proposed that a central hospital or other agency should provide a full range of services, others were concerned that access is limited when distances become too great to these hubs. The Champlain East Branch of the Canadian Mental Health Association (CMHA) recommended the use of generally-trained intensive case managers, supplemented with ACT teams and crisis services, because it is unrealistic to think that specialized services could be provided in a rural setting.

Related to access is the matter of education and training. Between 30% and 70% of a family physician's normal caseload consists of individuals whose ailments are either of a psychological origin or significantly related to psychological factors. A survey of family physicians found that respondents had almost no instruction in mental health at medical school. The Committee was told that there is a need for more relevant training for primary care providers during their formal academic programs and in-service (e.g., with respect to concurrent disorders). More knowledge can also lead to greater sensitivity, as people with lived

[17] At the time of writing, the Sudbury Regional Hospital was in the process of moving to one site.

experience have encountered prejudice or stigma on the part of professionals in primary and emergency care.

Presenters spoke of the time physicians require to deal with the mental health and addictions needs of their patients. The current fee schedule fails to adequately compensate them for that time and serves as a disincentive to take on more patients. The government was urged to work with the Ontario Medical Association (OMA) on new remuneration models.

In the spring of 2009, the MOHLTC talked about its intent to add mental health counsellors to units like FHTs and nurse-practitioner-led clinics. As of January 2010, 122 of the 170 FHTs had mental health or social workers approved as part of their teams. As of February 2010, 11 nurse-practitioner-led clinics were under various stages of development. The original submissions of five of these clinics indicated that mental health would be one of their proposed services. However, no mental health workers had been hired as these clinics had yet to request staff funding.

The MOHLTC also advised that its 2008 agreement with the OMA offers enhanced payments for individuals meeting minimum targets for the provision of services, including mental health services. The reference is to section 5.2 of that agreement, "In Office Service Bonus".[18]

> **5.2** The PSC [Physician Services Committee] will develop a payment to PEM [patient enrollment model] physician and physician groups who provide a broad range of in-office services. A recommendation will be made to the parties for implementation by April 1, 2010. A fund of $5 million will be set aside in the first year of the program and $10 million will be set aside on an annual basis thereafter.[19]

Psychiatrists

Across the province, the Committee was told of the need for more psychiatrists and the long waits to see them. In one community, it heard of the large number of psychiatrists who are university-appointed staff and not providing care to clients in clinical practice. With respect to children and young adults, a paediatrician reported that there are fewer than 500 child and youth psychiatrists in the entire country.

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[18] E-mail from staff, Office of the Deputy Minister, Ontario Ministry of Health and Long-Term Care, Toronto, 24 February 2010.

[19] "Memorandum of Agreement Between the Ontario Medical Association and Her Majesty the Queen in Right of Ontario as Represented by the Minister of Health and Long-Term Care," 1 April 2008 to 31 March 2012. Internet site at http://www.health.gov.on.ca/english/providers/physiciansa/docs/oma_agreement.pdf, accessed 25 February 2010.

We heard that the need for more psychiatrists could be met in part by the promotion of psychiatry as an attractive option for young physicians; however, that may be difficult. The president of the Ontario Psychiatric Association agreed with many other presenters that stigma is a barrier to access and care for his members' clients, but also pointed out that psychiatrists themselves experience stigma as care providers, a critical issue for recruitment and retention.

The Committee pursued the matter of the supply of psychiatrists with the MOHLTC. We learned that the ratio of practising psychiatrists for every 10,000 people in Ontario decreased by 2.4% between 2002 and 2007. In recognition of the shortages of qualified practitioners, the number of first-year psychiatry residency training positions offered in the province increased by 52.6% (from 38 to 58) between 2002 and 2008.[20]

Other Professions

> **"Medicare pays for doctors and hospitals, full stop. The reality is that the vast majority of mental health services aren't provided by doctors. They're provided by all kinds of other health care workers."**
>
> ***Michael Kirby, Former Chair***
> ***Standing Senate Committee on Social Affairs, Science and Technology***

Representatives of other self-regulated, or soon to be self-regulated, professions made the case for their members becoming more actively involved in the provision of mental health and addictions services. These presenters said greater participation on the part of psychologists and psychological associates, psychotherapists and mental health therapists, and social workers will enable more people to be assessed and treated in a cost-effective, timely manner. As the Committee was reminded, the medical model of care is neither sought nor needed by all mental health clients.

Many expressed support for extending public funding to psychologists and psychological associates, psychotherapists and social workers who provide mental health services.

INSTITUTIONAL CARE

Many public hospitals, which must comply with the *Public Hospitals Act* and its regulations, are designated Schedule 1 psychiatric facilities under the *Mental Health Act*. They provide inpatient, outpatient, day care, and emergency services, as well as consultative and educational services to local agencies. (A list of these facilities is found in Appendix C.)[21] Since April 1, 2007, LHINs have been responsible for the planning, funding and managing of health services, including hospitals, in their respective jurisdictions.

Hospitals referred to the challenges faced by the institutional sector. These have included implementation of the Health Services Restructuring Commission's directives and changes brought about with the introduction of LHINs. In St.

[20] E-mail from staff, Office of the Deputy Minister, Ontario Ministry of Health and Long-Term Care, Toronto, 25 September 2009.
[21] Facilities defined as Schedules 2, 3, 4, 5, and 6 are exempt from providing certain services.

Thomas and Ottawa, we met with representatives from the London Health Sciences Centre and the Royal Ottawa Health Care Group. They spoke of their mandates to provide acute care services and their missions as academic health sciences centres. Reference was also made to the importance of community partnerships and the building of community capacity.

Two topics related to institutional care mentioned by a number of witnesses, access to beds and emergency rooms, are discussed below.

Access to Beds

Deinstitutionalization was deemed a noble goal, but some presenters expressed a need for more psychiatric beds. Specific reference was made to Schedule 1 facilities, whose acute care beds should be increased in number, and the subject of a review which would include the development of benchmarks. Another recommendation was the creation of Form 1 capacity in local hospitals, a Form 1 being the application completed by a physician for the purposes of detention in a psychiatric facility for a psychiatric assessment. (See Appendix D for greater detail about the Form 1 and other steps in the admission and treatment process.)

As well, the Committee heard that criteria used to assess whether or not someone is admitted to hospital, how long they stay and when they get discharged need to be reassessed. Some presenters were convinced that discharge and admission decisions are based on bed availability as opposed to need.

> **"While the new 'model of care' in a community setting may serve the majority of patients well, I speak on behalf of many who are greatly concerned that adequate funding will NOT be received by the facilities treating 'complex' and 'difficult to treat' patients."**
>
> ***A parent***

Emergency Rooms

The treatment available in hospital emergency rooms (ERs) for those with mental illness and addictions elicited comments from both organizations and individuals. All agreed that something has to change in these environments. The Committee can well understand that long wait times and confinement in small, noisy areas can create very stressful situations.

We were told that health professionals and other front-line staff working in ERs need to have a greater understanding of mental illness. This could come in the form of mandatory anti-stigma training for all staff, training in mental health de-escalation techniques and the implementation of mental health patient safety guidelines for ERs. Crisis, community-based discharge or peer support workers placed in hospitals/ERs could provide comfort and referrals to appropriate case management, housing and other longer-term resources.

> **"Emergency service care for mentally ill individuals is miserable; they require almost immediate assistance, but are typically left waiting for hours in an environment that can be very threatening for them."**
>
> ***A sibling***

Presenters believed that wait times could be reduced by having hospitals and community organizations work together to develop coordinated, standardized and

measurable non-emergency services. These services could include 24-hour community-based crisis response systems with direct links to hospitals, 24/7 mobile crisis intervention teams and crisis centres. The Committee also heard about mobile crisis home treatment, which is short-term intensive treatment in the individual's home or other types of residences (e.g., shelters).

Among the changes that presenters think could be made within institutions themselves are 24/7 emergency room access for those in crisis, drop-in clinics with professional health care staff, diversion/community mental health liaison programs in high-volume ERs, and crisis safe bed programs.

While in Thunder Bay, the Committee heard from a psychiatric nurse who spoke of her dream of an integrated psychiatric emergency service attached to the ER at Thunder Bay Regional Health Sciences Centre. It would be staffed by psychiatrists and mental health nurses. Confidentiality would be maintained. The attending staff would initiate treatment, and provide limited follow-up and referral to community providers. The service would address individuals with co-morbid mental illness. Timely intervention and response to those with addictions issues would be addressed with community agencies invited to participate in the discharge planning process.[22]

INTEGRATION

"We don't ask those with broken legs to run marathons, or those with heart failure to lift tonnes, but I feel we often ask so much of individuals with mental illness and their caregivers."

A family member

Almost every witness appearing before the Committee has made a plea for some form of service integration. Presenters had strong, sometimes diverging, opinions on this topic. Regardless, words like "silos" and "navigation" have become part of our vocabulary. The CMHA, Ontario Division noted that Ontario has one of the most comprehensive baskets of services in the country. However, there are quite literally hundreds of organizations offering mental health and addictions programs, and at least 10 ministries addressing at least some aspect of the system. Ontarians may not know where to turn when they are facing a mental illness or addiction.

The Committee has been particularly saddened to hear of the many children and youths who fall through the cracks as they transition to the adult system. Families spoke of their frustration at having to repeat their stories over and over again to a multitude of service providers when they do obtain treatment. Many people simply drop out of the system because it is too complex and exhausting to manage.

[22] The Committee received a petition signed by 196 people from the Thunder Bay area supporting the creation of a psychiatric emergency service in the ER at Thunder Bay Regional Health Sciences Centre.

> **"Mental health needs don't fit into life stages or lifestyle activities."**
> ***Griffin Centre***

While a shortage of services is responsible for some of the system's shortcomings, the coordination of our existing services appears to be fundamental to reform. The current system is organized around specific needs or age groups, but mental health does not fit into life stages or activities. More specifically, witnesses suggested that the following aspects of the mental health and addictions system would benefit from closer integration:

- children, youth and adult services;
- adult and senior services;
- addiction and mental health services;
- developmental disability and mental health services;
- justice system and mental health services;
- maternal and infant/child services;
- college/university counselling and community mental health services;
- the transition from hospital to community care;
- geographic catchments and planning areas (particularly as these affect LHIN funding);
- mental health and addictions services and the health system in general;
- ministries addressing mental health and addictions; and
- provincial and federal strategies.

Witnesses made a number of recommendations to facilitate integration. Many proposed that case managers or system navigators be used to guide individuals to the appropriate services, advocate on their behalf, and transfer health care information more effectively, thereby ensuring continuity of care. The CMHA, Ontario Division commended the province for providing greater access to case managers in the last few years.

Some also suggested that if funding were to follow clients, rather than be attached to agencies, fewer people would fall through the cracks. One expert argued that "continuity of caregiver," where one psychiatrist is responsible for an individual in an institution and in the community, was an overlooked concept, and just as important as continuity of care.

Another common recommendation was for the "every door is the right door" approach, where individuals are hooked into the network of services regardless of their entry point or type of need. Multiple services could be provided at one location or "hub," or a lead agency could assume responsibility for connecting clients to other parts of the system. There are already examples of successfully integrated services operating in Ontario that could serve as a model to other organizations, such as the Halton Our Kids Network and the CMHA, Grand River Branch.

Others proposed a centralized list of health and community care organizations to assist care providers in making referrals to appropriate services. Greater use of outreach may also be necessary, both to inform individuals of available services, and to monitor their condition and participation.

There was debate about the wisdom of merging some of the province's many community services. Some witnesses suggested that it would reduce confusion and duplication. The CMHA, Toronto Branch argued that there is no evidence that mergers work, and considerable evidence that they do not work. It might be more important to support collaborative planning and service delivery in communities.

Witnesses were also adamant that the "silos" separating ministries must be broken down through stronger formal links. Proposals included assigning one official overall responsibility for the system, creating a secretariat, or establishing an agency like Cancer Care Ontario to oversee the mental health and addictions system.

Witnesses asked that the Committee pay attention to the many documents, policies, and strategies already in place, and partly align its agenda with that of the national government. Finally, the CMHA, Ontario Division cautioned the Committee that mental illness is a complex subject and that reform strategies must be integrated and focus on the entire system.

JUSTICE SYSTEM

> **"To this day my son has never understood why I charged him . . . he refers to me as 'the woman who claims to be my mother'."**
> ***A mother***

One of the concerns voiced most frequently to the Committee is that far too many people have their first contact with the mental health system through the justice system. Some witnesses revealed that they were encouraged to have a family member arrested simply to receive badly needed mental health services. Youth are particularly affected by this predicament.

Ontario has a number of innovative justice programs serving the needs of people with mental illnesses and addictions. For example, the province's mental health courts sit on a full- or part-time basis for the exclusive purpose of disposing of cases involving individuals with mental illness or developmental disabilities.[23] Individuals with a mental illness or developmental disability may also be diverted from the justice system entirely and referred to a person, service or hospital to

[23] According to the website of the Toronto Mental Health Court, the largest such court in the province, these courts address pre-trial fitness issues. They also hear guilty pleas, and hold bail hearings, certain NCR (not criminally responsible) trials, and disposition hearings upon a verdict of Unfit (to Stand Trial) or NCR. The Ministry of the Attorney General indicates that other Mental Health Courts currently operate in Kitchener/Waterloo, London, Windsor, Owen Sound, Newmarket, Peel, Walkerton, Sault Ste. Marie, Sarnia Lambton, and Ottawa. Youth Mental Health Courts operate in Newmarket, Ottawa and London.

obtain treatment. Other services include crisis response, emergency services, safe beds, housing, case management, peer support, and links to social, education and employment supports. However, witnesses argued that there are not enough of these services, and that they should be made available before a situation deteriorates to the point of arrest.

Furthermore, individuals who are arrested do not always receive the care they need. Families related moving stories about loved ones who had been abused or even died within the criminal justice system when they should have instead been receiving mental health or addictions treatment. Michael Kirby suggested that the shortage of community services is one cause of this problem; the deinstitutionalization process has yet to be matched with adequate community support. Witnesses argued that more mental health and addictions services need to be provided in correctional facilities, and to prevent people from being criminalized in the first place.

> **"We have made the streets and prisons the asylums of the 21st century."**
>
> ***Michael Kirby, Former Chair Standing Senate Committee on Social Affairs, Science and Technology***

Witnesses argued that greater efforts should be made to divert individuals away from the justice system. For example, crisis intervention teams consisting of a nurse and police officer could help move vulnerable people, including those with addictions, into the health care system. Furthermore, as noted elsewhere, greater efforts must be made to inform people of the programs that are already available, and to integrate these programs into a seamless whole. New and existing programs may need additional funding. Ontario's court support programs that are able to connect people to appropriate community services received considerable praise from several witnesses.

Witnesses advocated greater use of addiction courts modelled on Ontario's successful mental health courts.[24] The Ministry of Community Safety and Correctional Services informed the Committee that more than half of Canadian offenders report that substance use was directly related to their offences. Justice programs have a responsibility to explore the connections between social issues such as poverty and homelessness, on the one hand, and mental health, addictions, and criminal behaviour on the other. One witness commented that there is too much emphasis on behaviour modification, and inadequate attention to exploring these underlying issues.

Those that have committed more serious offences may need access to the diversion programs that are available to those committing relatively minor offences. While there appear to be a large number of offences that are eligible for diversion, witnesses suggested that many offenders are not diverted.[25] Better

[24] There are presently two federally funded drug treatment courts, one in Toronto and the other in Ottawa. There is also a drug treatment court in Durham that is not federally funded.

[25] Criminal offences are divided into three classes for the purpose of determining which are eligible for diversion. Persons accused of Class I offences, which include minor crimes such as theft and possession under $5,000, joyriding, and causing a disturbance, are presumptively eligible for diversion. Diversion is not available to persons accused of Class III offences, which include serious crimes such as murder, manslaughter, offences causing serious bodily harm, kidnapping,

assessment, discharge planning, and follow-up upon release from an institution are also required.

Community criminal justice organizations, such as the John Howard Society, requested recognition during the development of the mental health and addictions strategy.

MENTAL HEALTH PROMOTION AND EDUCATION

Witnesses were virtually unanimous in the opinion that the province must engage in various forms of mental health promotion and education, including an anti-stigma strategy.

One of the most important types of education pertains to the signs and symptoms of mental illness and addictions. As stated throughout this report, family physicians, health professionals, police, paramedics, policy makers, teachers, employers, the partners of pre- and post-natal women, seniors' drop-in centres, parents, children—everyone—should have this knowledge so that early intervention becomes a reality. Similarly, everyone, but particularly children and youth, would benefit from consistent, ongoing communications about the risks of drug and alcohol use. Those working directly in the health care field also require more formal training in methods of assessment, early diagnosis, and treatment.

> **"There isn't a cure yet, but one day there will be, and if our leaders get behind a significant public education program, they'll have fired the first shots in the war to defeat mental illness."**
>
> ***A consumer/survivor***

Other witnesses recommended that the 211 system (the Ontario directory of social, health, and government services) be implemented across the province, or that a complete directory of mental health and addictions services be created on a centralized website. Clearer guides to Ontario's mental health legislation could provide clients, physicians, family members, and others with better information about treatment options and other aspects of the system. Although the Committee heard little about workplace mental health, educating employers about—and making them responsible for—healthy workplaces, could increase early diagnosis and reduce the impact of mental illness and addictions.

> **"Resiliency is the ability to overcome a crisis quickly and move past it. Resiliency also refers to your ability to be connected to the community and feel supported."**
>
> ***Parents for Children's Mental Health***

The promotion of positive mental health throughout the lifespan is considered to be one of the most promising directions in mental health and addictions policy, although the Committee has received little testimony pertaining to specific programs or strategies.

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child abuse, offences against a spouse/partner, and sexual offences. Persons accused of Class II offences (all other offences, including threats, forgery, obstructing justice, dangerous driving, and some assaults) may be eligible for diversion, at the discretion of Crown counsel. See Ontario, Ministry of the Attorney General, *Practice Memorandum on Mentally Disordered/ Developmentally Disabled Offenders*, reprinted in Richard D. Schneider, ed., *Annotated Ontario Mental Health Statutes*, 4th ed. (Toronto: Irwin Law, 2007), p. 678 (Appendix G).

However, the Ministry of Health Promotion highlighted a number of their successful sports and recreation programs. Such programs can improve family and community bonds, empower participants, and increase their sense of self-worth. There is also evidence that they give children resilience to deal with life stresses and potential mental health and addictions issues. Several witnesses also mentioned the Triple P-Positive Parenting Program, developed at Australia's University of Queensland, which aims to prevent behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents.

A number of witnesses asserted that greater attention must be paid to all of the social determinants of health—for example, income, social exclusion, housing, education, and employment—as there is growing evidence that these factors play a major role in mental health and addictions. The Committee heard many times about the fundamental role that "a home, a friend, and a job" play in both prevention of, and recovery from, mental illness and addictions.

> **"Housing, adequate income supports, and access to the labour force are fundamental to the well-being of individuals and fundamental to our system—for every single one of us."**
>
> ***Centre for Addiction and Mental Health***

Anti-Stigma Strategy

People dealing with mental illness and addictions spoke candidly about the painful impact of stigma. Many said that it was the worst aspect of their condition. Stigma is experienced in the housing and employment markets, in the media, and from family and friends. Some people spoke of "self stigma," their own feelings of shame and low self-worth as a consequence of their condition. Tragically, health care workers too often treat individuals with mental illnesses or addictions poorly. As noted earlier, these same workers also experience stigma, working in a devalued sector of the health care system.

Witnesses proposed many ways to tackle stigma. A comprehensive anti-stigma campaign should send a message of optimism, conveying the possibility of recovery and the fact that mental health and mental illness exist on a continuum. Positive images of individuals with a mental illness or addiction, and the health care workers and programs serving them, could reduce stigma and attract more people to the mental health field. Witnesses praised the humour in recent cancer ads, something typically lacking in mental health campaigns. Peer support could also help people to feel better about themselves.

Some cautioned that not all anti-stigma programs are effective. Programs that challenge the myths of what a person with mental illness looks like, ideally through personal contact, are the most consistently effective. It was suggested that Ontario participate in the Mental Health Commission of Canada's anti-stigma campaign. New media popular amongst young people could be particularly effective tools. A number of people suggested

> **"We need to find a champion for mental illness. The champion needs to be supported by all political parties and have the authority to make the changes that are required."**
>
> ***A family member***

that a "champion" for mental health and addictions needs to come forward to promote awareness.

> **"The policy neglect of government plays a critical role in contributing to stigma and discrimination."**
>
> ***A consumer/survivor***

Experts stressed that treatment itself is essential to fighting stigma. The presence of so many individuals who are clearly not receiving treatment sends a negative message about mental illness and addiction. The disparity between mental health and addictions funding, and funding for the rest of the health care system also sends a negative message. The full integration of mental health into the health care system could help to normalize mental illness and reduce stigma.

Finally, the Ontario Human Rights Commission and several other witnesses stressed that stigma is more properly viewed as a rights or discrimination issue. Under the Ontario *Human Rights Code*, there is a legal obligation not to engage in discrimination against individuals with a mental illness, and a positive obligation to prevent and respond to such discrimination where it occurs.

RESEARCH

Research is essential to the better understanding of most mental illnesses and addictions, and the overall functioning of the system. Surprisingly little is known about many conditions. In particular, experts advocated for more research into the causes of mental illness and addictions, and the effectiveness of various treatments. Similarly, there is inadequate sharing of information about proven techniques. Some treatments are introduced based on anecdotal evidence, while others that have proven effective in controlled studies take years to disseminate into clinical practice.

Data collection on mental health indicators would set a baseline that could then allow for the monitoring of treatment effectiveness. Money for academic and practice-based research could also fill some of the knowledge gaps, but appropriate evaluation and assessment tools also need to be developed.

> **"There should be evaluation of every step of every development, so that we can be clear that funding is appropriately being used, that people who need funding and need new treatments are getting them."**
>
> ***Centre for Addiction and Mental Health***

Some witnesses praised the MOHLTC for its forthcoming uniform assessment process for consumers entering the community mental health system (the Ontario Common Assessment of Need, OCAN).[26] The Service Enhancement Evaluation Initiative (SEEI), which has assessed the results of MOHLTC's large investment in community mental health services, has also been well received in the mental health and addictions community. Experts would like similar tools and program or system evaluations

[26] The OCAN is presently being piloted in the North East LHIN and some organizations in the Central West LHIN. Further implementations are forthcoming in the Toronto Central LHIN and South East LHIN. E-mail from staff, Office of the Deputy Minister, Ontario Ministry of Health and Long-Term Care, Toronto, 24 February 2010.

to be developed in the future. In particular, the progress of the new mental health and addictions strategy will need to be monitored.

SPECIFIC ILLNESSES

The Committee has received a considerable amount of testimony pertaining to specific illnesses and conditions.

Anxiety, Depression and Other Mood Disorders

The Committee has received relatively little testimony pertaining to anxiety and mood disorders, including depression, which is perhaps surprising given their incidence and social and economic toll. In particular, CAMH informed the Committee of the vast numbers of Ontarians who suffer from depression, yet either fail to seek treatment or receive inadequate care for this "eminently treatable" disease. Several witnesses spoke of the difficulty they experienced in overcoming specific conditions, and the need for greater awareness. The Committee commends these individuals for speaking publicly.

> **"The population of older persons with depression experiences a suicide rate which is five times higher than that of any other age group."**
>
> ***Canadian Pensioners Concerned***

Autism Spectrum Disorders

The Committee was touched by the stories of families and caregivers struggling with the needs of children and adults with an autism spectrum disorder (ASD). Although ASD services are typically provided by the Ministry of Children and Youth Services (MCYS), there is a sizeable interface with mental health. ASDs are increasing in prevalence, leading to long wait-times for treatment and a heavier burden on families.

Witnesses requested public funding for treatments, research into the full range of possible causes, individualized client-focussed care, social skills and vocational training, expanded funding for intensive behaviour intervention, access to a broader range of health and mental health professionals, and access to a broader range of care (e.g., outpatient, inpatient, day, residential, and respite). Woodview Manor, a not-for-profit mental health centre, was highlighted as one of the few locations offering a broad range of services and supports in one location.

Some witnesses asserted that the MOHLTC should reassume its leadership position for ASDs, arguing that MCYS lacks the necessary funding and medical expertise. There was also criticism of the benchmark criteria employed in Ontario, and concern about adults with an ASD falling through the cracks.

Dual Diagnosis (Developmental Disabilities and Mental Illness)

> **"I'm sure you'll understand how rejection, teasing, loneliness and isolation for someone with an intellectual disability can lead to depression and anxiety, emotional outbursts, anger and aggression."**
>
> ***National Association for the Dually Diagnosed***

Witnesses informed the Committee that a high number of individuals with developmental disabilities—an estimated 38%, or 100,000 people in Ontario—also experience mental health issues. Sadly, these mental health issues can be the consequence of the bullying and sexual abuse that people with developmental disabilities often experience.

Families spoke of their concern for the future of their children with a dual diagnosis. There is a severe shortage of professionals and services capable of treating these clients, who are often excluded from existing services because of their dual condition. These families asked that their children be fully integrated into the mental health and addictions strategy.

Witnesses appealed for many of the things that others have requested: appropriate assessments, case management, more care options in a community setting, supportive housing, mobile crisis services, better integration with mental health and addictions services (perhaps through "specialized care networks"), better coordination between ministries, and strategies aimed at reducing stigma. However, these individuals also have unique needs necessitating access to appropriately trained professionals and new, accredited services that can address the complexities of a dual diagnosis.

Several witnesses asked for assurance that the 2008 MOHLTC and MCSS "Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis" would be implemented.

Eating Disorders

Witnesses asked the Committee to help eating disorders achieve recognition as a serious mental illness, one leading to high rates of death and disability. The condition requires complex treatment that is best provided in a hub or multi-disciplinary setting. However, there are very few dedicated inpatient beds or services in Ontario. Furthermore, there are no residential programs, and no services for those suffering from a concurrent addiction. Youth transitioning to adult services are also inadequately served.

In order to improve the situation, it was proposed that a standardized assessment be developed, and evidence-based treatment disseminated. Some suggested that public education plans promoting general wellness and healthy eating would be more effective than messages emphasizing illness. Anti-bullying strategies could target harassment linked to body type (e.g., being called fat or skinny). Finally, physicians (particularly those in emergency rooms) need to be better educated about eating disorders.

Fetal Alcohol Spectrum Disorder

The Committee received testimony from witnesses across the province about fetal alcohol spectrum disorder (FASD), which affects at least 1% of live births in Canada. Children with FASD generally have mental health and addictions issues and require complex care through their lifespan. Untreated, they suffer considerably and are at increased risk of conflict with the law and suicide. FASD is particularly devastating for First Nations, as discussed above.

Witnesses noted that early diagnosis is key, as is the case with most conditions. However, FASD diagnoses are complex and typically require a multi-disciplinary team. Thus, FASD is frequently misdiagnosed as attention deficit hyperactivity disorder (ADHD) or autism, and treated incorrectly, if at all, or simply dismissed as bad behaviour.

Witnesses advocated for proper diagnostic services, case management, special education and developmental programs, addictions counselling, assisted living options, skills training, the provision of structured environments, and respite care for families.

It was also recommended that a single ministry take the lead for this condition and provide a targeted pool of resources. At present, FASD has "orphan" status, as no ministry assumes responsibility for it, and it lacks an OHIP billing code. Finally, care for individuals with FASD should be incorporated into a strategy for those with concurrent disorders, and a prevention campaign sensitive to the needs of particular communities should be developed.

Perinatal Mood Disorders

Perinatal mood disorders such as postpartum depression are frequently overlooked conditions until a particularly grave case catches the public's attention. When left untreated, these disorders increase the risk of more severe maternal depression and morbidity, and can have a permanent impact on a child's development. In extreme cases, they can lead to suicide and infanticide.

> **"Mental illness is the most common complication of pregnancy and the most common complication of postpartum, bar none."**
>
> ***A physician***

Witnesses appealed for the development of a policy, database, assessment and treatment standards, and a culturally-sensitive screening program. There is also a need for preventative and educational messages targeted at pregnant women, their partners, and obstetricians, paediatricians, and other health care professionals. Witnesses stressed that these efforts require a coordinated effort encompassing experts from outside of primary care.

Good treatment results have been achieved by teams including a counsellor and a psychiatrist. However, some mothers may require a fuller range of services in special homes, and isolated mothers may need follow-up support. Witnesses also suggested that Best Start hubs could be provided with funding to organize peer support meetings for mothers.

Schizophrenia and Other Forms of Psychosis

> **"The oft-quoted statistic that 1 in 5 citizens suffer from a mental illness obscures the fact that a small percentage of individuals, numbering about 2 to 4%, suffer from psychotic disorders which rob them of the ability to lead a normal life."**
>
> ***A psychiatrist***

Many of the recommendations appearing elsewhere in this report relate to schizophrenia and other forms of psychosis in one way or another. However, witnesses also made several more specific recommendations. One expert argued that these conditions merit special consideration in the provincial strategy, owing to their severity. Research and funding should be much higher considering the incidence and toll of these conditions.

Other witnesses noted that early intervention is particularly important for forms of psychosis, as it is believed that the possibility of recovery lessens with each episode.

Witnesses were also adamant that Ontario needs faster and better access to new antipsychotic medications, such as paliperidone and ziprasidone. These so-called third generation antipsychotics do not have as many side effects as older drugs and may lead to greater willingness to take medication, at not much extra cost to the system. Some proposed that psychiatrists and people with lived experience of mental health and addictions should have more input into the drug approval process. Many witnesses seemed particularly optimistic about the use of various forms of peer support for this population of individuals.

Suicide

Families and caregivers highlighted the tragic link between mental illness and addictions, on the one hand, and suicide on the other as they told the Committee about the deaths of their loved ones. The Committee has been deeply saddened by these stories.

Experts confirmed that suicide is often caused by underlying depression or other mental health and addictions issues. Suicide is the tenth leading cause of death in the province—and the second leading cause for youth—resulting in the deaths of 1,100 Ontarians each year. Ontario was advised to follow the lead of other provinces by developing a suicide prevention strategy simultaneously with the strategy for mental health and addictions.

Witnesses stressed that suicide is preventable, and must not be taken for granted. It is essential for community-based prevention and early intervention programs to convey this message. Short-term strategies could include limiting access to lethal means such as firearms, establishing a medication registry showing the quantities individuals have received, and ensuring that the media portrayal of suicidal behaviour, mental illness, and substance abuse is more realistic. Finally, funding for suicide research and improved surveillance is necessary, as it is widely believed that suicide is underestimated as a cause of death.

TREATMENT ISSUES

Care Models

Several witnesses proposed a dramatic change in the way that mental illness and addictions are treated in Ontario. Our current system treats mental illness as an acute disease, one requiring intense hospitalization and minimal support afterwards. It results in frequent relapse, and unnecessary deterioration in many individuals.

Some presenters proposed that mental illness and addictions should instead be treated like manageable chronic conditions such as diabetes or heart disease. Others advocated the recovery model, which emphasizes that individuals with mental illness and addictions can and do recover. Although the chronic disease model and the recovery model are not the same, they share the belief that individuals with mental illness and addictions can live full lives even if they may not be fully cured.

> **"By recovery, we're talking about maximizing the opportunities for each individual experiencing a mental illness to live as full and productive a life as possible. In the mental health field, we often speak of three cornerstones of recovery: a home, a friend and a job."**
>
> ***Canadian Mental Health Association, Ontario Division***

Presenters argued that the use of these alternative models of treatment would entail that individuals be provided with preventative care, education, easily-accessible community support, and life-skills and employment. Clients should never be abandoned upon discharge from hospital, with little attention paid to follow-up or making connections with community services, as is often the case now. They must also be provided with hope and the tools to help themselves. Discharge plans should be replaced with collaborative recovery or wellness plans that incorporate well-defined care paths and opportunities for audits. These plans could be made available electronically to encourage client self-management and family participation.

> **"My story, though unique, is testament to other unsung heroes alike who have faced tremendous obstacles and barriers, adversity and strife, yet still have risen up to re-create and recover."**
>
> ***A consumer/survivor***

Some witnesses expressed concern, however, that the recovery or chronic disease model of mental illness and addictions might lead to a further reduction in acute care services. The transition from institutional-based care to community care has led to a shortage of inpatient beds. It is feared that the recovery model, with its emphasis on empowerment and managing symptoms outside of a hospital setting, could lead to further reductions in service, particularly for seriously ill individuals.

Involuntary Admission and Treatment

> **"We walked and drove the streets looking for our brother to finally have the police bring him to hospital. To our horror, the hospital did not contain him for the 72-hour observation. We were deflated. Why would the family seek help through the justice of the peace and why would he grant a Form 2 if there is no just cause? Again, this cog in the wheel is just another opportunity for the patient to fall through the cracks."**
>
> ***A brother and a sister***

The Committee is particularly concerned about the many witnesses who have experienced difficulty in obtaining care for family members who are clearly ill, yet refuse treatment or are too quickly released from hospital.

The typical story is that a son, daughter, uncle, or friend—often after a crisis or lengthy period of illness—is brought into the hospital on a Form 1 or Form 2. (These forms, and other steps in the admission and treatment process, are explained in Appendix D.) The police are also involved in taking individuals to the hospital, a process that is particularly painful for families. Once in the emergency room, all parties may be forced to wait for hours, causing further stress and often wasting valuable law-enforcement resources. Yet parties wait in the hope that the individual will finally receive the mental health treatment that he or she clearly needs.

Instead, the Committee was told that far too many individuals are being released without receiving adequate treatment. Sometimes, families are not notified that the person is being discharged. When the individual's condition deteriorates some time later, the entire process is repeated again, in a "revolving door" scenario that can continue for years.

The failure to treat very sick individuals often results in prolonged and possibly unnecessary disability, devastating stress for families, and even suicide, homicide, and other acts of violence. Families are also troubled when they have to be the instigator to committing their loved one. Some individuals refusing treatment are nonetheless detained in hospital for extremely long periods. The Committee was moved by the sheer number of these tragic stories, and heartened by those cases where a family member was finally treated after a series of arrests, admissions, and releases.

> **"If you have a broader harm criterion, or a deterioration criterion that doesn't require a previous admission, you can say, 'Look, if you're not treated, you're going to deteriorate, and I'm pretty sure you're going to be back here in a couple or three weeks. Therefore, I can keep you'."**
>
> ***A mental health policy expert***

Ontario's *Mental Health Act (MHA)* sets out the criteria of admission for voluntary and involuntary patients to psychiatric facilities. The *Health Care Consent Act (HCCA)* governs consent to treatment and capacity to give that consent. Several experts recommended that Ontario examine the legislation in other jurisdictions with an eye to increasing the likelihood of successful treatment at the earliest possible point. Other witnesses spoke highly of the province's ACT teams, which have significantly reduced hospitalization time, and recommended that their use be extended to avoid hospitalization altogether, as is the case in Australia and New Zealand, or expanded to include other individuals (e.g., those with a dual diagnosis).

At the same time, rights advocates reminded the Committee that psychiatric patients have been subjected to severe violations of their rights over history. These witnesses argued passionately that involuntary hospital admission and treatment, including Community Treatment Orders,[27] are a continuation of this dark history, and that an individual's autonomy should never be violated, except on the rarest of occasions.

> **"The ability to make decisions about the things which most affect us is fundamental to our rights as human beings and our membership in a democratic society."**
>
> ***Psychiatric Patient Advocate Office***

Privacy

Health information privacy is another extremely sensitive issue raised by many witnesses. Under the terms of Ontario's *Personal Health Information Protection Act, 2004* health information custodians can collect, use and disclose an individual's personal health information only with the express or implied consent of that individual, subject to limited exceptions. Consent and respect for individual autonomy are viewed as integral to our patient-centred health system.

However, family members have sometimes struggled with the consequences of a consent-based system. One mother wrote that she was not sure how seriously to take her son's occasional threats of violence, because he would not allow his psychiatrist to release more information about his condition. Others spoke of not knowing that a loved one was in hospital, or about to be released, until he or she showed up at the door. Yet others have provided information about symptoms to a psychiatrist, only to have this information immediately passed on to the client, exacerbating paranoia and diminishing trust.

> **"Due to very strict interpretation of the privacy laws, any information that we provided to [our brother's] treatment team was communicated directly to [him]. . . . This pattern made it impossible for us to communicate our concerns about his mental state without worsening his paranoia and causing him to mistrust us."**
>
> ***A sibling***

In general, families spoke about their frustration at being emotionally and financially responsible for their loved ones while not being considered a partner by the health care system. Many families asked for a role in the development of a treatment plan.

Some expert witnesses have recommended that Ontario amend its personal health information legislation to allow information to be disclosed to individuals involved in a client's "circle of care." However, patient rights advocates cautioned that treating individuals with a mental illness differently from everyone

[27] The Psychiatric Patient Advocate Office explains Community Treatment Orders as follows: A Community Treatment Order ("CTO") is a doctor's order for a person to receive treatment or care and supervision in the community. A person can only be placed on a CTO if very specific rules or conditions are met, including that he or she must have a serious mental illness and have been a patient in a psychiatric facility two or more times, or for a total of 30 days or more, in the last three years. See, Psychiatric Patient Advocate Office, "Community Treatment Orders." Internet site at http://www.ppao.gov.on.ca/inf-com.html, accessed 23 February 2010.

else would only exacerbate stigma, and contributes to feelings of diminished self-worth.

FUNDING

While some of the problems affecting the mental health and addictions system could be resolved through better system integration and the provision of case management and navigation services, other access problems appear to stem from a shortage of services.

> **"We're confronted in this country and this province with an enormous gap between the size of the problem and the health care response."**
>
> ***Centre for Addiction and Mental Health***

The Centre for Addiction and Mental Health reports that mental health and addictions issues account for 13% of death, disability and illness, yet receive only 5% of total health funding in Ontario and Canada. This funding is low relative to other Organisation for Economic Co-operation and Development (OECD) countries, and Ontario's per capita spending is ranked ninth among Canadian provinces. However, the province also provides funding for mental health services through other ministries, such as Children and Youth Services, and Community and Social Services.

Experts recommended that the mental health and addictions share of total health funding be gradually increased to 10%. Wait lists could be established for certain services, to create a focus for system improvement. Others argued that some services should be mandated in legislation. A number of witnesses suggested that young people should be actively recruited into mental health and addictions careers to address the shortage of professional services.

> **"To be clear, there needs to be more funding for specialized services such as mental health and addictions, including guaranteed core funding for children's mental health services."**
>
> ***OPSEU***

CLOSING COMMENTS

Now that we have reported observations from our hearings across the province, we move on to the next stage of our work: developing recommendations for a final report. The Committee has been very heartened by the constructive discussion generated by and in response to our hearings process. We applaud the courage demonstrated by so many individual presenters and submission writers. We also commend the dedication of those professionals who work in Ontario's mental health and addictions system.

APPENDIX A

Private Member's Motion
Re Select Committee to Develop Mental Health and Addictions Strategy
Carried December 4, 2008

Mrs. Elliott then moved:

That, in the opinion of this House, a Select Committee should be established immediately to develop a comprehensive Ontario mental health and addictions strategy;

That, in developing its strategy and recommendations, the Committee shall focus on the following issues:

The urgent need for a comprehensive mental health strategy in Ontario to work in cooperation with the Mental Health Commission of Canada and to coordinate the delivery of mental health programs and services in Ontario;

The lack of coordination in Ontario for the delivery of mental health programs and services across many provincial ministries;

The mental health issues of children;

The increase in suicide among young people;

The mental health and/or addiction problems of homeless people;

The mental health needs of residents of long term care facilities;

The lack of access to even basic mental health services for aboriginal Canadians in many parts of Ontario; and

The issues facing courts and police across Ontario in dealing with increasing numbers of alleged offenders with significant mental health and/or addiction problems;

That the Committee shall have authority to conduct hearings and undertake research, and generally shall have such powers and duties as are required to develop recommendations on a comprehensive Ontario mental health and addictions strategy; and

That the Committee shall present an interim report to the House no later than the end of 2009, and a final report no later than June 30, 2010.[1]

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[1] Ontario, Legislative Assembly, *Votes and Proceedings*, 1st Sess., 39th Parl. (4 December 2008): 6. Internet site at http://www.ontla.on.ca/house-proceedings/votes-and-proceedings/files_pdf/December_04_2008.pdf, accessed 4 March 2010.

APPENDIX B

Schedule of Public Hearings
List of Witnesses and Written Submissions

SCHEDULE OF PUBLIC HEARINGS

Public hearings were held in Toronto and various other locations on the dates listed below.

Toronto	April 8 and 22; May 6, 13 and 26; June 3; September 8, 16, 23, and 30; October 7, 21 and 28; November 4, 18 and 25; December 2 and 9
Windsor	June 15
St. Thomas	June 16
Hamilton	June 17
Kingston	June 18
Ottawa	September 9
Sudbury	September 10
Thunder Bay	September 11

The proceedings for each Committee meeting can be accessed via http://www.ontla.on.ca/web/committee-proceedings/committee_transcripts_current.do?ParlCommID=8915&locale=en.

LIST OF WITNESSES AND WRITTEN SUBMISSIONS

Organization/Individual	Date of Appearance
Advisory Committee for Mental Health and Addiction Services	September 11, 2009
Alliance of Psychotherapy Training Institutions	September 8, 2009
Alzheimer Society, North Bay and District	September 10, 2009
Alzheimer Society, Thunder Bay	September 11, 2009
Alzheimer Society of Ontario	June 16, 2009
Peter Andruski	September 23, 2009
Associated Youth Services of Peel	December 2, 2009
Brenda Atwood, Karen Miller and Linda Kachar	September 11, 2009
Auditor General of Ontario	May 13, 2009
Eleanor Baker	October 21, 2009
Kathy Baker and Ann Tassonyi	November 18, 2009
Maryse Bélanger	November 25, 2009
Lorie Bell	September 10, 2009
Bethany Residence	December 2, 2009
Donna Bowering	June 16, 2009

Organization/Individual	Date of Appearance
Brain Injury Services of Northern Ontario	September 11, 2009
Dr. Alan Brown	November 4, 2009
Chris Brown	Written submission
Glenn Brown	September 8, 2009
Lembi Buchanan	Written submission
Andreas Buchholz	September 11, 2009
Bulimia Anorexia Nervosa Association	June 15, 2009
Dr. Philip Burge	June 18, 2009
Burlington Counselling & Family Services	June 17, 2009
Canadian Association for Pastoral Practice and Education, Ontario	June 17, 2009
Canadian Counselling Association	June 18, 2009
Canadian Hearing Society	June 16, 2009
Canadian Mental Health Association, Champlain East Branch	September 9, 2009
Canadian Mental Health Association, Elgin Branch	June 16, 2009
Canadian Mental Health Association, Nipissing Regional Branch	September 10, 2009
Canadian Mental Health Association, Ontario Division	May 27, 2009
Canadian Mental Health Association, Ottawa Branch	September 9, 2009
Canadian Mental Health Association, Sudbury-Manitoulin Branch	September 10, 2009
Canadian Mental Health Association, Thunder Bay Branch	September 11, 2009
Canadian Mental Health Association, Toronto Branch	October 7, 2009 and written submissions
Canadian Mental Health Association, Windsor Essex County Branch, Consumer Council	June 15, 2009
Canadian Paediatric Society	September 9, 2009 and written submission
Canadian Pensioners Concerned	September 8, 2009
Caritas Project Therapeutic Community	October 21, 2009
Carla	June 17, 2009
Paul Caseola and Adrianne Sequeira	September 8, 2009
Centre for Addiction and Mental Health	June 3, 2009
Centre for Addiction and Mental Health, Centre for Prevention Science	June 16, 2009
Champlain Addiction Coordinating Body	September 9, 2009
Champlain Mental Health Network	September 9, 2009
Chatham-Kent Consumer and Family Network	June 15, 2009
Child Development Institute	October 28, 2009
Children's Centre Thunder Bay	September 11, 2009

Organization/Individual	Date of Appearance
Children's Mental Health Ontario	June 3 and December 2, 2009
Eddi Chittaro	June 15, 2009
Sue Clark-Wittenberg	September 9, 2009
Coalition Against Psychiatric Assault	September 23, 2009
Community Counselling Centre of Nipissing	September 10, 2009
Community Networks of Specialized Care	December 2, 2009
Concerned Friends of Ontario Citizens in Care Facilities	November 25, 2009
Dr. Leonardo Cortese	June 15, 2009
Dr. Richard Csiernik	June 16, 2009
Cathy Dandy	September 8, 2009
Dare to Dream Program	September 9, 2009
Dr. Marie-José Dealberto	September 9, 2009
District of Thunder Bay Social Services Administration Board	September 11, 2009
Downtown Guelph FASD Support Group	September 8, 2009
Drug Awareness Committee of Thunder Bay	September 11, 2009
Heather Drummond	September 23, 2009
Catherine and Germaine Dubois	September 9, 2009
Dr. Annette Dufresne	June 15, 2009
Mark Dukes	October 7, 2009
Heather A. Duncan	Written submission
Durham Mental Health Services	June 3, 2009
Echo: Improving Women's Health in Ontario	Written submission
Elgin Respite Network	June 16, 2009
Elgin St. Thomas RAISE Coalition (Reducing Addictions – Increasing Safe Environments)	June 16, 2009
Steve Elson	June 16, 2009
Gamal Eshesh	Written submission
Eva's Initiatives	October 21, 2009
Fair Share Task Force	September 8, 2009
Family Advocates for Mental Health and Addictions	Written submission
Family Service Ontario	November 18, 2009
Kerry Ferguson	June 16, 2009
Fetal Alcohol Spectrum Disorder Coalition of Ottawa	September 9, 2009
Fetal Alcohol Spectrum Disorder Stakeholders for Ontario	October 21, 2009
Randi Fine	November 18, 2009
Judith Fink	June 17, 2009

Organization/Individual	Date of Appearance
Paul and Denise Finn	June 18, 2009
Patricia Forsdyke	June 18, 2009
Mary Ellen Frederick	June 17, 2009
Frontline Partners W/Youth Network	October 21, 2009
Gerstein Centre	April 22, 2009
Gestalt Institute of Toronto	November 18, 2009
Catherine Gillies	September 11, 2009
Dr. Paula Goering	May 27, 2009
Gorski Centre for Applied Sciences	September 8, 2009
Dr. John Gray	December 9, 2009 and written submission
Griffin Centre	September 8, 2009
Margaret Gunn	Written submission
Mrs. H.M.	September 30, 2009
Lois Hacio	Written submission
Donna Hadida	Written submission
Haldimand-Norfolk Resource Centre	June 17, 2009
Hamilton Addiction and Mental Health Collaborative	June 17, 2009
Joy A. Hartman	Written submission
David Heath	September 8, 2009
Home Suite Hope Shared Living Corp.	Written submission
Hope Place Centres	September 8, 2009
Hôtel Dieu Hospital/Kingston General Hospital Mental Health Program	November 4, 2009
House of Sophrosyne	June 15, 2009
Barry Hudson	September 23, 2009
Huron Perth Healthcare Alliance	June 16, 2009
Jack Hussman	Written submission
Christina Jabalee, Jennifer Takacs and Carol Farkas	October 28, 2009
John Howard Society of Canada	June 18, 2009
John Howard Society of Hamilton, Burlington and Area	Written submission
John Howard Society of Ontario	Written submission
John Howard Society of Sault Ste. Marie	Written submission
John Howard Society of Sudbury	Written submission
John Howard Society of Thunder Bay and District	September 11, 2009
John Howard Society of Toronto	Written submission
John Howard Society of Waterloo-Wellington	Written submission

Organization/Individual	Date of Appearance
Sheri Johnson-Purden	September 10, 2009
Iris Kairow	September 30, 2009
Kinark Child and Family Services	September 8, 2009
Kinna-aweya Legal Clinic	September 11, 2009
Michael Kirby	May 27, 2009
Dr. H. Rayudu Koka	September 10, 2009
John Layton	Written submission
Dr. Bob Lester	December 2, 2009
Heather Lindsey	June 15, 2009
Loft Community Services	September 8, 2009
London Health Sciences Centre/St. Joseph's Health Care	June 16, 2009
Victoria Long	September 23, 2009
Steve Lurie (see Canadian Mental Health Association, Toronto Branch)	Written submission
Sandra MacLean	September 11, 2009
Magpie Publishing	Written submission
Mainstay Housing	Written submission
Margaret Frazer House	September 8, 2009
Neasa Martin	September 8, 2009
C.J. McCaffrey	September 9, 2009
Lorraine McGrattan and Paul Hamel	June 17, 2009 and written submission
Maureen McLelland	September 10. 2009
Joyce McNeely	September 9, 2009
Jane Mederak	September 30. 2009
Mental Health Legal Committee	September 23, 2009
Mental Health Rights Coalition	June 17, 2009
Vincent De Mercedes-Angelssen	September 23, 2009
Dr. Diane de Camps Meschino	September 16, 2009
Ministry of Aboriginal Affairs	May 6, 2009
Ministry of the Attorney General	April 22, 2009
Ministry of Children and Youth Services	June 3, 2009
Ministry of Citizenship and Immigration	May 6, 2009
Ministry of Community and Social Services	May 6, 2009
Ministry of Community Safety and Correctional Services	May 6, 2009
Ministry of Education	June 3, 2009

Organization/Individual	Date of Appearance
Ministry of Health and Long-Term Care	April 22 and December 9, 2009
Ministry of Health Promotion	April 22, 2009
Minwaashin Lodge – Aboriginal Women's Support Centre	September 9, 2009
Rakesh Modi	November 25, 2009
National Association for the Dually Diagnosed	October 28, 2009
Nickel-a-Drink for Addictions and Mental Health Research Foundation	October 28, 2009
Noojmowin Teg Health Centre	September 10, 2009
North of Superior Counselling Programs	September 11, 2009
Northumberland Poverty Reduction Action Committee	November 18, 2009
Offord Centre for Child Studies	June 17, 2009
Frank O'Hara (Family Council/Secret Handshake)	September 23, 2009
Dr. Richard O'Reilly	Written submission
Ontario Art Therapy Association	June 16, 2009
Ontario Association for Suicide Prevention	November 18, 2009
Ontario Association of Consultants, Counsellors, Psychometrists, and Psychotherapists	June 18, 2009
Ontario Association of Non-Profit Homes and Services for Seniors	November 25, 2009
Ontario Association of Non-Profit Homes and Services for Seniors, Region 7	September 9, 2009
Ontario Association of Psychological Associates	September 30, 2009
Ontario Association of Social Workers	Written submission
Ontario Coalition of Mental Health Professionals	September 30, 2009
Ontario College Health Association	Written submission
Ontario College of Family Physicians	September 16, 2009 and written submission
Ontario Colleges Counsellors	September 9, 2009
Ontario Community Outreach Program for Eating Disorders	November 25, 2009
Ontario Consumer and Family Advisory Council (Canadian Mental Health Association, Toronto)	November 18, 2009
Ontario Federation of Community Mental Health and Addiction Programs	November 25, 2009
Ontario Federation of Indian Friendship Centres	Written submission
Ontario Hospital Association	October 7, 2009
Ontario Human Rights Commission	October 7, 2009
Ontario Long Term Care Association	November 4, 2009
Ontario Peer Development Initiative	Written submission
Ontario Psychiatric Association	September 11, 2009

Organization/Individual	Date of Appearance
Ontario Public Service Employees Union	September 9 and December 2, 2009
Ontario Public Service Employees Union, Child Treatment Sector	December 2, 2009 and written submission
Ontario Seniors' Secretariat	June 3, 2009
Ontario Shores Centre for Mental Health Sciences	June 18, 2009
Ontario Society of Psychotherapists	September 30, 2009
Ontario Telemedicine Network	June 18, 2009
Open Access to Antipsychotic Medications	Written submission
Our Kids Network (Halton Region)	October 28, 2009
Parents for Children's Mental Health	April 8, 2009
Peel's Children Centre	October 7, 2009
Penny Paterson and John Paterson	June 18, 2009
Petition re Psychiatric Emergency Service at Thunder Bay Regional Health Sciences Centre	Written submission
Colette Pilon	September 10, 2009
Terrie Pitfield	September 10, 2009
Provincial Centre of Excellence for Children and Youth Mental Health	September 9, 2009
Psychiatric Patient Advocate Office	September 8, 2009 and written follow-up
Psychiatric Survivors of Ottawa	September 9, 2009
Joanne Purdon	November 4, 2009
Raising Our Children's Kids (Canada)	June 17, 2009
Madhuri and Kris Ramakrishnan	June 17, 2009
Registered Nurses Association of Ontario	October 7, 2009
Renascent	Written submission
Rideauwood Addiction and Family Services	September 9, 2009
Cindy Robin	September 10. 2009
Gary Robinson	September 8, 2009
Marvin Ross	September 8, 2009
Royal Ottawa Health Care Group	September 9, 2009
Jane Russell	September 9, 2009
St. Jude Community Homes	December 2, 2009
Diane Sacks	October 28, 2009
Schizophrenia Society of Ontario	September 16, 2009
Schizophrenia Society of Ontario, Thunder Bay Chapter	September 11, 2009
Self Help Alliance	June 16, 2009

Organization/Individual	Date of Appearance
Seniors Health Research Transfer Network	November 4, 2009
Victoria Shearon	June 15, 2009
Sherbourne Health Centre	October 7, 2009
Rena Sherring	Written submission
David Simpson	June 16, 2009
Sioux Lookout Community Action Partnership for Fetal Alcohol Spectrum Disorder	September 11, 2009
Social Planning Council of Sudbury	September 10, 2009
Société Alzheimer Society, Ottawa and Renfrew County	September 9, 2009
Société Alzheimer Society, Sudbury-Manitoulin	September 10, 2009
Southern Network of Specialized Care	Written submission
Sky Starr	October 7, 2009
Dr. Cameron Stevenson	June 18, 2009
Jordan Stone and Bowen McConnie (Secret Handshake)	September 30, 2009
Success By 6	September 9, 2009
Sudbury Action Centre for Youth	September 10, 2009
Thames Valley District School Board Mental Health and Wellness Committee	June 16, 2009
Patricia Teskey	September 8, 2009
The Dream Team	Written submission
The Men's Project	September 9, 2009
The New Mentality	November 4, 2009
City of Toronto, Shelter, Support and Housing Administration	October 21, 2009
Kevin Tregunno	September 8, 2009
Judy Tyson	June 17, 2009
United Way/Centraide Ottawa	September 9, 2009
Simone Usselman-Tod	October 21, 2009
Vicky Voukelatos	Written submission
Gaby Wass	June 16, 2009
Waterford Family Council	November 18, 2009
James Weber	September 8, 2009
Marlene Westfall	June 17, 2009
Wesway	Written submission
Jean Wiebe	June 17, 2009
Windsor Essex County Drug Strategy Implementation Group	June 15, 2009
Woodview Manor Parents' Council	November 4, 2009
Mrs. X	September 8, 2009

Organization/Individual	Date of Appearance
York Centre for Children, Youth and Families, Blue Hills Child and Family Centre, Kinark Child and Family Services	December 2, 2009
Youthlink	December 2, 2009
Ewa Zakrzewska	September 30, 2009
416 Community Support for Women	September 8, 2009

APPENDIX C

Schedule 1 Designated Psychiatric Facilities

SCHEDULE 1 DESIGNATED PSYCHIATRIC FACILITIES
Under Ontario *Mental Health Act*[1]

LOCATION	NAME
Ajax	Rouge Valley Health System - Ajax and Pickering Health Centre Site
Barrie	Royal Victoria Hospital
Belleville	Quinte Healthcare Corporation - Belleville General Hospital
Brampton	William Osler Health Centre - Brampton Civic Hospital, Brampton Hospital Campus
Brantford	Brantford General Hospital
Brockville	Royal Ottawa Health Care Group – Brockville Mental Health Centre, including Forensic Treatment Unit
	St. Lawrence Valley Correctional and Treatment Centre, Secure Treatment Unit
Burlington	Joseph Brant Memorial Hospital
Chatham	Public General Hospital Society of Chatham
Cornwall	Cornwall General Hospital
Goderich	Alexandra Marine and General Hospital
Guelph	Homewood Health Centre Inc.
Hamilton	Hamilton Health Sciences Corporation - Hamilton General Hospital Site, Chedoke Hospital Site, McMaster University Medical Centre Site, Henderson General Hospital Site
	St. Joseph's Health Care System - Centre for Mountain Health Services Site, St. Joseph's Hospital Site
Kenora	Lake of the Woods District Hospital
Kingston	Hôpital Hôtel-Dieu des Religieuses Hospitalières de St.-Joseph à Kingston/ Hôtel-Dieu Hospital
	Kingston General Hospital
	Kingston Penitentiary, Regional Treatment Centre
	Providence Continuing Care Centre, Mental Health Services (former Kingston Psychiatric Hospital)
Kitchener	Grand River Hospital Corporation - Kitchener-Waterloo Health Centre
Lindsay	Ross Memorial Hospital
London	Regional Mental Health Care, London - St. Joseph's Health Care London

[1] Ontario, Ministry of Health and Long-Term Care, "Public Information: Health Services in Your Community - Designated Psychiatric Facilities under the *Mental Health Act*," updated 27 October 2003. Internet site at http://www.health.gov.on.ca/english/public/contact/psych/designated.html, accessed 4 March 2010.

	St. Joseph's Health Care, London
	London Health Sciences Centre - University Campus, Victoria Campus
Markham	Markham Stouffville Hospital
Mississauga	Credit Valley Hospital
	Trillium Health Centre-Mississauga Site
Newmarket	Southlake Regional Health Centre
Niagara Falls	Niagara Health System - Greater Niagara General Hospital
North Bay	North Bay General Hospital
	Northeast Mental Health Centre - North Bay Campus
Oakville	Halton Healthcare Services Corporation - Oakville-Trafalgar Memorial Hospital Site
Orillia	Orillia Soldiers' Memorial Hospital
Oshawa	Lakeridge Health Corporation - Oshawa Site
Ottawa	Children's Hospital of Eastern Ontario
	Hôpital Montfort
	Queensway Carleton Hospital
	Royal Ottawa Mental Health Centre - Royal Ottawa Health Care Group
	Regional Children's Centre, Royal Ottawa Hospital - Royal Ottawa Health Care Group
	The Ottawa Hospital - Civic Campus, General Campus
Owen Sound	Grey Bruce Health Services - Owen Sound Site
Penetanguishene	Mental Health Centre Penetanguishene
Peterborough	Peterborough Regional Health Centre - Hospital Drive Site
Richmond Hill	York Central Hospital
St. Catharines	Niagara Health System - St. Catharines General Site
St. Thomas	Regional Mental Health Care, St. Thomas - St. Joseph's Health Care, London
Sarnia	Sarnia General Hospital
Sault Ste. Marie	Plummer Memorial Hospital
Stratford	Stratford General Hospital
Sudbury	Northeast Mental Health Centre - Sudbury Campus
	Northeast Mental Health Centre - Regional Children's Psychiatric Centre
	Hôpital régional de Sudbury Regional Hospital
Thunder Bay	St. Joseph's Care Group - Lakehead Psychiatric Hospital Site
	Thunder Bay Regional Hospital

Timmins	Timmins and District Hospital/L'Hôpital de Timmins et du district
Toronto	Rouge Valley Health System - Centenary Health Centre Site
	Scarborough Hospital - General Division Site, Grace Division Site
	North York General Hospital - General Division Site
	Humber River Regional Hospital - Finch Avenue Site, Church Street Site, Keele Street Site
	Centre for Addiction and Mental Health
	Baycrest Hospital
	William Osler Health Centre - Etobicoke Hospital Campus
	Mount Sinai Hospital
	Trillium Health Centre - Queensway Site
	St. Joseph's Health Centre
	St. Michael's Hospital - Bond Street Site, Wellesley Central Site
	Sunnybrook Health Sciences Centre
	Toronto East General and Orthopaedic Hospital Inc.
	University Health Network - Toronto General Hospital Site, Toronto Western Hospital Site, Ontario Cancer Institute/Princess Margaret Hospital Site
Welland	Niagara Health System - Welland Hospital site[2]
Whitby	Whitby Mental Health Centre
Windsor	Hôtel-Dieu Grace Hospital - Hôtel-Dieu of St. Joseph's Site
	Windsor Regional Hospital
Woodstock	Woodstock General Hospital

[2] Formerly Welland County General Hospital.

APPENDIX D

Ontario's *Mental Health Act* and *Health Care Consent Act, 1996*

Introduction

This appendix provides a brief summary of Ontario's *Mental Health Act* as it relates to voluntary and involuntary admission to psychiatric facilities, and the *Health Care Consent Act, 1996* as it relates to consent to treatment and the capacity to give that consent.

Ontario's *Mental Health Act*

One purpose of Ontario's *Mental Health Act* (*MHA*) is to set out the criteria of admission for voluntary and involuntary patients to psychiatric facilities.[1]

Form 1 – Application by Physician for Psychiatric Assessment

Under the terms of the *MHA*, if a family member or caregiver is able to persuade an person to see a physician, the physician can assess the patient according to a list of criteria that has been described as a "serious harm test:"

> **15.**(1) Where a physician examines a person and has reasonable cause to believe that the person,
>
> > (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
> >
> > (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
> >
> > (c) has shown or is showing a lack of competence to care for himself or herself,
>
> and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
>
> > (d) serious bodily harm to the person;
> >
> > (e) serious bodily harm to another person; or
> >
> > (f) serious physical impairment of the person,
>
> the physician may make application in the prescribed form for a psychiatric assessment of the person.

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[1] *Mental Health Act*, R.S.O. 1990, c. M.7. E-laws Internet site at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm, accessed 24 February 2010.

It is important to note that not all of the criteria set out in paragraphs (a), (b) and (c) must be met. Instead, the physician is required to establish the existence of only one of the behaviors described. However, the physician must also establish that the disorder will likely result in one of the harms in paragraphs (d), (e) and (f).[2] It is also possible for a police officer to conduct a similar assessment, and to take an individual into custody for examination by a physician in an appropriate place (generally, a hospital).[3]

The document to be completed by the physician is known as a "Form 1," or an "Application by Physician for Psychiatric Assessment." Once completed, it allows any person to take the individual who is the subject of the application to a psychiatric facility for detention of up to 72 hours for the purposes of psychiatric assessment.[4] There is no right to apply to the Consent and Capacity Board (CCB) for a review of the criteria for the issuance of a Form 1. The CCB is the administrative tribunal with the authority to adjudicate matters of capacity, consent, civil committal, and substitute decision making.[5]

Form 2 – Order for Examination

An alternative method available to family members and others in this situation is to appear before a justice of the peace to provide sworn information that a person is suffering from a mental disorder.[6] The "Form 2" order, or an "Order for Examination under Section 16," is directed to the police and provides them with authority to take the person into custody and to detain them for the purpose of examination by a physician.[7]

Form 3 – Certificate of Involuntary Admission

Once a person has been taken to hospital and has remained there for 72 hours for assessment, the person can be admitted against his or her will for a longer period only if the conditions in s. 20(5) of the *MHA* are met. This section requires that the symptoms of the mental disorder be such that there is a likelihood of serious bodily harm either to the patient or to another person, or that the patient will experience serious physical impairment unless detained in a psychiatric facility.[8] Alternative grounds for involuntary hospital admission were added to the *MHA* in 2000 to address persons with recurrent mental illness.[9]

There are various safeguards in the law of involuntary admission. The physician who completes a Form 3, the "Certificate of Involuntary Admission," cannot be the same as

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[2] Katharine Byrick and Barbara Walker-Renshaw, *A Practical Guide to Mental Health and the Law in Ontario* (Toronto: Ontario Hospital Association, March 2009), p. 31.
[3] *Mental Health Act*, s. 17.
[4] Ibid., s. 15(5).
[5] According to the CCB's website, over 80% of its applications involve a review of a person's involuntary status in a psychiatric facility under the *Mental Health Act*, or a review under the *Health Care Consent Act* of a person's capacity to consent to or refuse treatment.
[6] Byrick and Walker-Renshaw, *A Practical Guide to Mental Health and the Law in Ontario*, p. 33.
[7] *Mental Health Act*, s. 16.
[8] Byrick and Walker-Renshaw, *A Practical Guide to Mental Health and the Law in Ontario*, p. 36.
[9] These provisions are set out in s. 20(1.1) of the *MHA*.

the person who completed the Form 1, building a second medical opinion into the process. Further, the first certificate of involuntary admission expires after two weeks and the first certificate of renewal lasts for one month. There are time limitations with respect to subsequent certificates of renewal. The patient has the right to apply to the CCB for a review of whether the criteria for issuing or renewing a certificate of involuntary admission are met. Even if the patient chooses not to apply to the CCB, the *MHA* provides that the fourth certificate of renewal must be reviewed by the Board.[10]

Ontario's Health Care Consent Act, 1996

Ontario's *Health Care Consent Act, 1996* (*HCCA*) governs consent to treatment and capacity to give that consent.[11] The admission of an individual to a psychiatric facility and the individual's subsequent treatment in that facility are considered distinct matters in Ontario.

A fundamental principle of health care in Ontario is that treatment shall not be administered without the consent of the individual in question.[12] Health lawyers Katherine Byrick and Barbara Walker-Renshaw summarize the situation as follows:

> If a patient is capable, then that patient will decide whether to consent to, or refuse, the proposed treatment. If a patient is not capable, then a Substitute Decision-Maker will be asked to make the decision on their behalf.[13]

There is a two-pronged capacity test under the *HCCA*. A person is capable with respect to treatment if they are able (1) to understand the information that is relevant to making a decision and (2) to appreciate the reasonably foreseeable consequences of a decision or a lack of decision.[14]

No treatment can be initiated if a patient indicates that he or she intends to apply or has applied to the CCB for a review of a finding of incapacity, except in an emergency.[15] Unless the parties agree to a postponement, the CCB must meet to hear the application within seven days and must provide a copy of its decision to the parties the following day. If the CCB upholds the practitioner's finding of incapacity, treatment cannot be initiated if the patient appeals the Board's decision to the courts.

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[10] Byrick and Walker-Renshaw, *A Practical Guide to Mental Health and the Law in Ontario*, p. 40.
[11] *Health Care Consent Act*, S.O. 1996, c. 2. E-laws Internet site at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm, accessed 24 February 2010.
[12] Byrick and Walker-Renshaw, *A Practical Guide to Mental Health and the Law in Ontario*, p. 7.
[13] Ibid. There are exceptions in the case of an emergency and if a person has been accused of a criminal offence (and the treatment is required in order to stand trial). These requirements are outlined in s. 25(3) of the *HCCA, 1996*, and s. 672.59(1) of the *Criminal Code*, R.S.C. 1985, c. C-46.
[14] *Health Care Consent Act*, s. 4(1).
[15] Ibid., ss. 18(3) and (4).