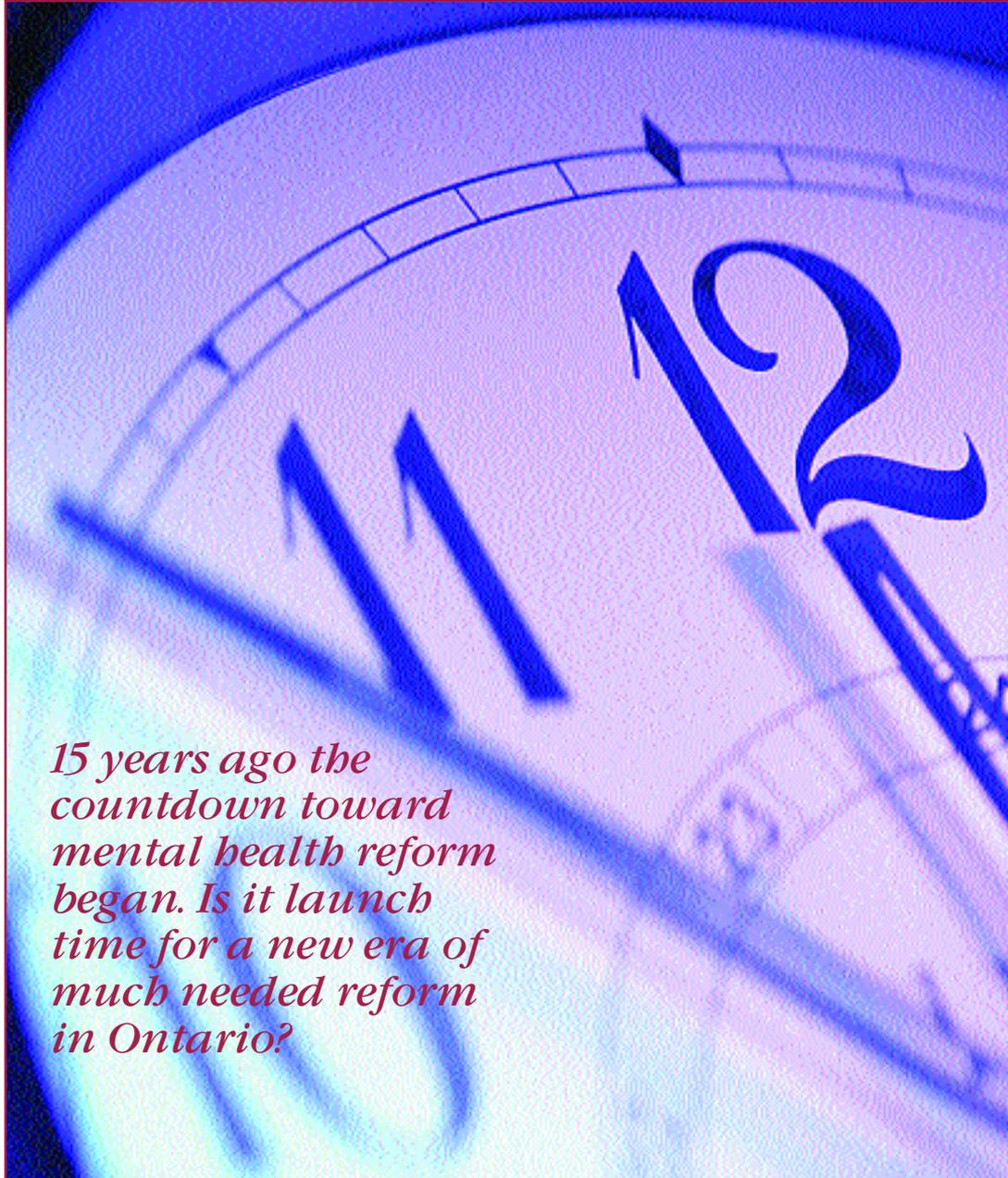


Network

VOL 15 NO. 2

SUMMER 1999



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much needed reform
in Ontario?*



CANADIAN MENTAL
HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE

Ontario Division/Division de l'Ontario

IN THIS ISSUE:

Looking Back – Moving Forward, Mental Health Reform

Mental Health Legislative Review

Who are the Drivers of Mental Health Reform?

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OUR MISSION:

To advocate with and provide programs and services for people with mental disorders, and to enhance, maintain and promote the mental health of all individuals and communities in Ontario.

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CONTENTS

Editorial	3
Looking Back – Moving Forward	4
<i>People have been talking about reform for 15 years – where have we come from and where are we headed?</i>	
An Incomplete Framework	6
<i>The current legislative framework for services for people with serious mental disorders is fragmented and incomplete. Public consultations are being conducted to see whether changes to legislation are recommended to support the mental health reform Implementation Plan.</i>	
Taking the Next Step	9
<i>Making it Happen is the implementation plan for the reformed mental health system. The CMHA, Ontario Division responds to this document produced by the Integrated Policy and Planning Division of the Ministry of Health.</i>	
Who is in the Driver's Seat?	13
<i>Glenn Thompson, Executive Director, CMHA, Ontario Division looks at the forces which are driving mental health reform.</i>	
Clearing Away the Cobwebs	14
<i>Mr. Michael Bay, Chair and Executive officer of the Consent and Capacity Board has said that "without education, mental health law is a cruel joke and a horrible waste of time and money." On what he terms "the road show", he is taking education on mental health law to towns and communities across Ontario speaking to health professionals, family and consumer groups, and police personnel.</i>	
Social Policy	18
Calendar	19

Dear Premier....

As we finalize this issue of *Network* to go to press, we are only three weeks away from an election here in Ontario. What party will take power will soon be known. Whatever the peoples' choice may be, the problem of serious mental illness, as well as less serious but debilitating mental health problems which affect large numbers of Ontarians and their families, will be one of the public policy priorities still waiting to be addressed in earnest. This editorial, and in some measure this whole issue of *Network*, can therefore be seen as an open letter to the Premier of Ontario, whichever party he may represent.

Mental health reform. It's been on the discussion table for fifteen years now. The NDP, the Liberal and the Conservative Party have each brought something significant and positive to the table. We have had the Heseltine Report, the Graham Report, *Putting People First* and now *Making It Happen*—albeit a draft only. We've had input from people in the field, and a current excellent education program being carried out by Mr. Michael Bay about best use of our mental health legislation. In spite of this extensive planning, the mental health aircraft is still on the runway. Perhaps the load of reports are too heavy to allow it to become airborne! Although each of the governments over that fifteen year period have been quite supportive of mental health reform, none of them have moved to put that desirable set of changes into action accompanied with substantial transitional and ongoing funding.

Consider just how large the mental health problem is in Canada relative to other illnesses. Schizophrenia alone utilizes more hospital bed space each year in Canada than three other major illnesses combined, including cancer and heart and stroke. Renowned epidemiologists tell us that depression will be the second most prevalent illness in the world by 2020. Mental illness can no longer be overlooked by governments. It is now recognized as a major factor in lack of

productivity in the workplace. And as is pointed out on page 13 of this issue of *Network*, the general public have finally become so aware of the problem that they are now the main driver for reform. We can now talk openly about mental illness as an issue in our families and in our personal lives.

In a recent document produced by the CMHA, Ontario Division, we attempted to evaluate the Ministry of Health's commitment to its current reform initiative by analyzing their expenditures for mental health over the past eight fiscal years. The Social Policy Column on page 18 summarizes this analysis. It is a sobering account of time and money lost on one of society's major public policy challenges. The ten year reform process has been in an implementation phase for almost six years. If the Ministry of Health is to achieve the reform goals, it now has less than five years left to do so.

Community Treatment Orders or, put differently, more coercive intervention into the lives of the mentally disordered, has hit the front pages in the current election campaign. Whichever party is in power after June 3 should recognize the desirability of not moving ahead with CTOs without a comprehensive review of mental health and associated legislation. It is worth emphasizing yet again our stance at the CMHA, Ontario Division which is that if you have a full spectrum of services in the community, community treatment orders will not be needed.

Mr. Premier, consumers, family members and service providers are all on board – we need a commitment from your new government to move forward aggressively, and with dollars, to truly “Put People First” and “Make It Happen”.



GLENN R. THOMPSON
Executive Director

Looking Back – Moving Forward

MENTAL HEALTH REFORM

15 years ago the countdown toward mental health reform began. Is it launch time for a new era of much needed reform in Ontario?

I isn't possible to talk about mental health reform in Ontario, or across Canada for that matter, without talking about the history of reform. People have been talking about reform for 15 years now – and not a whole lot has happened as a result of that talk. However, at this moment here in Ontario we are probably on the threshold of a terrific opportunity.

In Canada we do not have any community mental health legislation. There is legislation that involves hospitalization, in an enforced kind of way, if someone is mentally ill and unable to care for themselves, or if they appear to be a danger to others, but no one has yet ventured into the territory of creating legislation for the services that are outside the hospital setting. The hospitals have legislation and there is a Mental Health Act that relates to them. But when it comes to what happens in the

community it is treated as an “and also”, “we sometimes have”, or “we may need”, instead of seeing the community as where we all live and where we all centre our services wherever possible.

The initiative to reform mental health services began when the Provincial Community Mental Health Committee was struck in 1987. Its report, known as the Graham Report, was released in July 1988. *Building Community Support for People: A Plan for Mental Health in Ontario* envisioned the development of a community-focused, integrated mental health system that would have, as its first priority, people with serious mental illness and their families. A mental health system planned by service providers and government, in partnership with individuals with serious mental illness and their families. One which would provide for the eleven essential functions of a comprehensive system delivered as close to the district level as possible, with an emphasis on community-focused rather than institutionally-focused services. The Graham Report also promoted an integrated, collaborative approach to planning and delivery of services by health professionals, community agencies, general hospitals and Provincial Psychiatric Hospitals. The Graham Report directed District Health Councils (DHCs) to develop district plans for a comprehensive mental health system. Following the release of the report, the Ministry of Health struck a steering committee and two sub-committees: the Legislation Sub-Committee and the Implementation Strategy Sub-Committee. The latter was given the task of supporting DHCs in developing district mental health plans. In January 1992, the Mental Health Reform Steering Committee began the task of developing a policy framework for mental health reform. A review of all DHC mental health plans yielded critical policy issues for the Committee's consideration.

In response to another recommendation of the Graham report, the provincial psychiatric hospitals (PPHs) undertook the development of strategic plans. A steering committee was struck to oversee the development of the PPH strategic plans and make recommendations about the role of PPHs in the reformed mental health system.

The Committee's final report was released in the fall of 1993.

In June of 1993 the Ministry of Health's policy framework for the reform of mental health services in Ontario was outlined in their document *Putting People First*. The framework and principles for mental health reform, and for the implementation planning guidelines built on the values and vision of the Graham Report and the Health Goals for Ontario, as well as the advice that arose from the DHC and PPH planning process.

Putting People First set out the following principles to guide mental health reform:

- tailoring services to needs
- providing services that are sensitive to gender, culture and race, and to the special needs of vulnerable groups
- as far as possible, enabling people with mental health problems to remain in the community, using hospitalization when clinically necessary
- providing more community and informal supports, and integrating them with other services
- ensuring equitable access to services.

The Graham Report, the Heseltine Report released in 1983, and the NDP Policy Document, *Putting People First*, all set out a plan to provide services in the community and to provide fully comprehensive, or “wrap-around”, support for individuals.

Putting People First, the NDP document was not acted upon in any significant way because of lack of funding, but this government has begun to put some money into the mental health system.

The current government has built upon the *Putting People First* document in creating its two *Making It Happen* documents, which seem likely to be approved depending upon the outcome of the June 3, 1999 election. The documents set out a strategic implementation framework and the service guidelines to operationalize reform. Another vital leg on the mental health stool is comprehensive legislation covering all aspects of the field including community mental health. The next section in *Network* addresses that need.

The initiative to reform mental health services began when the Provincial Community Mental Health Committee was struck in 1987. Its report, known as the Graham Report, was released in July 1988. Building Community Support for People: A Plan for Mental Health in Ontario envisioned the development of a community-focused, integrated mental health system that would have, as its first priority, people with serious mental illness and their families.

An Incomplete Framework

Mental Health Legislative Review

The current legislative framework for services to people with serious mental disorders is fragmented and incomplete.

Existing statutory and regulatory provisions apply primarily to specific institutions. The limited residential services which are governed by legislation are intended for individuals released from provincial psychiatric hospitals. Other community mental health services and supports are not addressed (although psychiatric clients may have access to income and employment support programs which are generally available to persons with disabilities).

The following is an edited transcript of a presentation made by the Ministry of Health staff to the Provincial Advisory Committee on Mental Health on February 16-17, 1999. As the government examines the current Mental Health Act and related legislation it will assess how well current legislation achieves its mental health policies. A mental health legislation educational project is being conducted by Michael Bay and includes information gathering on proposed legislative change. These public consultations will be summarized to present an analysis of issues and opportunities, and to determine what changes to legislation are recommended to support the mental health reform Implementation Plan and enhance public safety. If a decision is made to support legislative changes, draft legislation is planned for the end of this year, with the new legislation to be in place by the summer of the year 2000.

What legislation is to be reviewed?

The Mental Health Act; Mental Hospitals Act; Homes for Special Care Act; Community Psychiatric Hospitals Act. Related legislation is the Health Care Consent Act and Substitute Decisions Act. The issues/barriers in associated statutes are the Public Hospitals Act and the Ministry of Health Act.

What are the purposes of the Review?

To ensure mental health and related legislation:

- ▶ builds a strong foundation for mental health reform through a single comprehensive statute
- ▶ supports an integrated, coordinated mental health system and continuum of service and supports
- ▶ allows consumers access to services where and when needed
- ▶ provides for public safety

What is the scope of the Review?

Legislation will focus on:

- the seriously mentally ill
- adults only (to be harmonized with the Child and Family Services Act)
- comprehensive legislation to include services, civil committal, and other current Mental Health Act matters.

What are the themes of the Review?

How well does current legislation achieve the objectives of mental health reform, i.e.

- mental health system is integrated, coordinated, and responsive
- range/continuum of services from prevention to community and hospital treatment, based on changing client needs
- improved access to services where and when needed
- reduced risks to client and public safety through appropriate service interventions, access, and coordination mechanisms
- clear accountability for system management and service delivery.

How should legislation be developed to meet these objectives?

What are some of the broad policy questions that are being addressed?

- In relation to the purpose statements for the mental health legislative review, does legislation need to be improved to meet these objectives? How?
- What outcomes are expected through the development of new legislation?
- What value statements should frame the development of new legislation?
- What principles should be articulated to guide the development, delivery and evaluation of mental health services and supports?
- What powers does the Minister need to fund and organize mental health services?
- What structures and processes need to exist in communities to support the development of an integrated, coordinated mental health service delivery system and support the ministry's Implementation Plan for Mental Health Reform?

- What role should be identified in legislation for general hospitals, specialty psychiatric hospitals, community agencies, physicians and other service providers, health science centres, universities and other training facilities? Should the specific services each provider is expected to deliver be defined?
- What should be included in the new legislation?
- When an effective and coordinated mental health service system is in place as outlined in the Implementation Plan and supported by legislation, is there a need for more assertive legislative provisions (for example, priority service expectations, community treatment provisions, extended leaves of absence)?
- Should criteria for civil committal based on "substantial mental or physical deterioration" be included in Ontario legislation? Should other civil committal approaches be considered?
- Are there areas or provisions within guardianship, substitute decisions, and consent to treatment legislation which require further clarification to be effectively applied?

"The whole issue of dangerousness needs to be brought out into the open so that we don't go off into cul-de-sacs thinking that community treatment orders are the solution to everything. Even if you were a believer in community treatment orders, the research in the U.S. says that if you don't have wrap-around treatment, if you don't have the full spectrum of services in the community, it doesn't work. And our opinion is that if you have a full spectrum of services community treatment orders would not be needed in any case."

Glenn R. Thompson

EXECUTIVE DIRECTOR, CMHA, ONTARIO DIVISION

Mental Health Legislative Review

An Incomplete Framework

Continued from page 7

The Legislation Being Reviewed:

The Mental Health Act

applies to psychiatric facilities designated under it, and not to mental health services in other settings. Provisions in the Act allow the ministry to plan, implement, and supervise the delivery of mental health services provided through designated psychiatric facilities. A regulation under the Act indicates that a psychiatric facility should provide the following essential services: inpatient services; outpatient services; daycare services; emergency services; and consultative and educational services to local agencies. Specific facilities may be exempted from some of these requirements by the regulation.

The Mental Hospitals Act

sets out broad powers of the government to regulate the care, treatment and maintenance of patients, financial and business affairs, and the inspection, superintendence, government, management, conduct, operation, maintenance, care and use of institutions and equipment. In practical terms however, the Act applies to the provincial psychiatric hospitals. It has also been used to establish a limited number of "approved homes" to assist inpatients of designated psychiatric facilities in making the transition back to community living.

The Community Psychiatric Hospitals Act

allows the government to establish community psychiatric hospitals for the care and treatment of persons suffering from emotional or psychiatric disorders. However, few, if any, programs are designated under this Act.

The Homes for Special Care Act

sets out licensing, payment and other regulatory requirements for homes for the care of psychiatric

patients who have been discharged from provincial psychiatric hospitals and who require long term supervision in the community. The administration of the program is complex, and requires a high degree of monitoring by the Ministry.

The Public Hospitals Act

governs public hospitals. The Act provides for the management and administration of these facilities. Both the Public Hospitals Act and the Mental Health Act apply to general hospitals with psychiatric units designated under the Mental Health Act.

The Health Care Consent Act 1995

clearly establishes the right of all people in Ontario to make informed decisions about health treatment. The Act codifies the elements of consent to health services in one piece of legislation and applies to treatment provided in all settings by health practitioners specified in the Act. The Act also provides a mechanism to obtain a treatment decision from a substitute decision-maker for those who, at the time health treatment is required, are not mentally capable of consenting on their own behalf.

The Substitute Decisions Act

sets out various duties of guardians and powers and obligations of the Public Guardian and Trustee, as well as various rules related to capacity assessments, statutory guardianship of property, etc. This Act may be applicable when someone is not mentally capable on an on-going basis of making decisions about their property and personal care.

The legislation being reviewed is the Mental Health Act; Mental Hospitals Act; Homes for Special Care Act; Community Psychiatric Hospitals Act. Related legislation is the Health Care Consent Act and Substitute Decisions Act.

Taking the Next Step

MAKING IT HAPPEN

Implementation Plan for the Reformed Mental Health System

INTEGRATED POLICY AND PLANNING DIVISION,
MINISTRY OF HEALTH, FEBRUARY 8, 1999

The Canadian Mental Health Association, Ontario Division, recognizes that Making It Happen is intended to be a guide for the reform of the mental health system in Ontario, and as such the guiding principles for reform are directly connected to “systems outcomes”. We believe that systems outcomes have validity only when consumers of the mental health services actually experience outcomes that are of importance to them. Consumers have identified these outcomes in the following terms: “a home, a job, and a friend.” In past mental health reform documents, the Ministry of Health has outlined the desired consumer outcomes of a reformed mental health system. We encourage the Ministry to reiterate these consumer-related outcomes in order to ensure that systems development is not achieved at the expense of consumer outcomes.

There have been a number of reports on the mental health system in Ontario which have informed mental health reform. Each report has built on the recommendations of the previous reports. The Heseltine Report: *Towards a Blueprint for Change: A Mental Health Policy and Program Perspective* (Ontario Ministry of Health), was released in 1983. Major recommendations or goals were “a balanced and comprehensive mental health care system” and “a separation of treatment and accommodation”. In 1988 the Graham Report: *Building Community Support for People* (Provincial Mental Health Committee Report) was released, proposing a long range plan for the development and implementation of an organized, comprehensive, community-focused mental health system. The priority population for mental health services was identified as those persons with serious mental illness or disability. Province wide principles and objectives were established to guide the District Health Council planning process, with consumers and family involvement being encouraged. A ten year mental health reform strategy was set out in the 1993 document: *Putting People First: The Reform of Mental Health Services in Ontario* (Ontario Ministry of Health). Building on the Graham Report recommendations, *Putting People*

First put forward a common vision and values, reform strategies, identified the seriously mentally ill as the priority population and established measurable targets and timelines such as fiscal shifts from institution to community, bed ratios, hospitalization rates, and key service ratios. In early 1998, half way through the ten year plan, the Honourable Elizabeth Witmer, Minister of Health, determined that it was time to review the progress to date. Mr. Dan Newman, Parliamentary Assistant to the Minister of Health, led a consultative review of progress on mental health reform in Ontario. The overwhelming response was that while the principles and direction of mental health reform were sound, the government needed to take the next steps in implementing reform through the development of a clearly designed implementation strategy. *Making it Happen*, incorporates and builds on previous reform initiatives. It puts into action the recommendations in Mr. Newman’s report, focusing specifically on how the service delivery system can be more effectively integrated and coordinated, and also based on best practices and within a comprehensive continuum of services. Mental health services in Ontario cover the continuum of health care from highly specialized inpatient care and physician services, to home care

Taking the Next Step

Continued from page 9

and informal community supports. Some of the challenges related to reforming such a complex system are:

- individuals with severe and complex mental health needs tend to require more than one mental health service provider as they address their treatment, service and support needs;
- treatment and support needs cannot be easily predicted and planned
- service users may move back and forth between community and inpatient care during alternating periods of clinical instability and wellness.

The purpose of this implementation plan is to increase the capacity of the system to provide comprehensive and integrated treatment, rehabilitative and support services, focusing on community alternatives wherever possible. This plan will also guide strategic reinvestments to support the restructuring of the mental health system over the next three years to support much needed changes in the mental health delivery system.

PRINCIPLES

The Ministry remains committed to the vision and principles outlined in previous reform documents. The specific principles which will guide *Making It Happen: Implementation Plan for the Reformed Mental Health System* are:

- the client is at the centre of the mental health system;
- services will be tailored to client needs with a view to increased quality of life;
- client choice will be improved while access to services will be streamlined;
- services will be linked and coordinated so the client will move easily from one part of the system to another;
- services will be based on best practices;
- mental health funding will continue to be protected;
- there will be continued investments/reinvestments in mental health services to support mental health reform and increase the overall capacity of the mental health system.

THE CMHA's RESPONSE

While the CMHA, Ontario Division supports the principles that will guide the implementation plan for Mental Health Reform, we are concerned that certain principles which were key in earlier reform documents have not been reiterated in *Making It Happen*. Specifically, both the Graham Report and *Putting People First* stressed the importance of creating healthy community environments for people with serious mental illness. Through these healthy community environments, community and informal supports would be provided, and such supports would be integrated with more formal supports. The CMHA, Ontario Division believes that a truly integrated mental health system is not only integrated within itself and within the overall health care system as well as with other social service sectors, but will also be integrated with the efforts of volunteer and natural supports. While the CMHA, Ontario Division recognizes that many consumers will require ongoing intensive and specialized services, focusing on community inclusion and building on personal and community strengths

GOALS

The goals for *Making It Happen: Implementation Plan for the Reformed Mental Health System* are to ensure that core mental health services and supports:

- are provided within a comprehensive service continuum developed to meet client needs and based on best practices;
- are part of the broader health and social services service continuum;
- are organized and coordinated based on a levels of need structure to ensure that clients have access to the services that best meet their needs;
- are appropriately linked to other services and supports within geographic areas;
- facilitate a shared service approach to serving the needs of individuals with serious mental illness who have multiple service needs;
- achieve clear system service responsibility and accountability through the development of explicit operational goals and performance indicators;
- are simplified and streamlined according to the client's needs.

will assist in promoting personal recovery and diminish unnecessary dependence on the formal mental health system. Equally important principles, stressed in both the Graham Report and in *Putting People First*, are those of prevention and early identification/intervention. Without a commitment to public education, health promotion and disease prevention strategies in a reformed mental health system in Ontario, there will be an increasing need to focus on high cost, “downstream-focused” mental health services.

BEST PRACTICES IN MENTAL HEALTH SERVICE DELIVERY

The CMHA, Ontario Division would like to add some caution to the use of “Best Practices” as a basis for describing a service framework for the reformed mental health system in Ontario. It is important to make a distinction between the creation of an overall framework and the use of best practices to fully describe each service function that would be considered essential in such a framework. It is also important to distinguish between “Best Practices” as these are described in the literature, and the actual implementation of Best Practices. “Best Practices” must be evidence-based to deserve that title, and their success is highly dependent on the specific community in which they have been implemented, together with the available resources, commitment and other social factors that impact upon the implementation.

While current best practices provide direction for what services and supports should be available within a reformed mental health system, it is important to note that best practices evolve and will continue to be refined and added to based on new evidence and research. The Ministry of Health will continue to consider innovative approaches to service delivery based on evolving best practice evidence. Existing and evolving best practices will also be considered at the regional and local level through system development.

INTEGRATION OF MENTAL HEALTH REFORM WITH OTHER HEALTH CARE REFORM INITIATIVES

The CMHA, Ontario Division would strongly urge the Ministry to immediately consider and

implement the necessary mechanisms that would effectively connect mental health care networks with primary health care services. In order to have a truly effective mental health care system, Mental Health Reform and Primary Care Reform must be closely linked.

MENTAL HEALTH AGENCIES

The CMHA, Ontario Division believes that capitation funded, managed care approaches must be tied into policy initiatives that guarantee access to primary health care for consumers of mental health services. Our experience indicates that it is often the case that certain general practitioners deny such access, either to particular individuals who experience mental health problems or to any person who has been diagnosed as having a mental health problem.

This situation reaches critical proportions when it becomes impossible for certain consumers to find a general practitioner who will provide them with primary health care.

RESTRUCTURING OF THE PROVINCIAL PSYCHIATRIC HOSPITALS

The CMHA, Ontario Division is concerned that bed number calculations made by the Health Services Restructuring Commission (HSRC) may result in an inadequate number of mental health beds across the province, depending upon the assumptions on which the calculations are based. The CMHA, Ontario Division is also hopeful that the Ministry of Health, in setting targets for bed ratios in a reformed mental health system in Ontario, will distinguish between chronic beds and acute beds. This information is vitally important in that *Making It Happen* is largely silent on the matter of consumers who experience mental illnesses and who also have long term care needs.

STREAMLINED ACCESS

The CMHA, Ontario Division encourages the Ministry of Health to consider a multi-window streamlined (or coordinated) access model, as

Taking the Next Step

Continued from page 11

opposed to a single point of access model. Recently the Ministry of Municipal Affairs and Housing mandated coordinated access models and processes to be developed and implemented in each region throughout the province. This allows for multiple ways to access social housing while ensuring coordination and timely access to service. Our organization encourages the Ministry of Health to mandate the development of similar coordinated access processes for mental health services in local areas.

SHARED SERVICE MODELS OF CARE

The CMHA, Ontario Division believes that shared service models have the potential to be both extremely effective and frustratingly challenging. While we eagerly support shared service models of care, our organization encourages the Ministry to ensure that the models that are adopted are ones which provide the consumer and family members/key supports an integral role in describing the needs and in determining how services will be coordinated to meet those needs.

INFORMATION SYSTEMS

The CMHA, Ontario Division believes that a consumer-centered information system is the linchpin to a successfully integrated mental health system in Ontario. Many of the mechanisms for integration identified in *Making it Happen*, such as shared service agreements, streamlined intake, etc., cannot occur without such an information system to tie them together. We encourage the Ministry not to endorse information systems/evaluation tools that require large amounts of administrative time and resources, without allowing for such administrative supports in program and systems budgets.

POLICY FRAMEWORK FOR SCHEDULE 1 GENERAL HOSPITALS AND PHYSICIAN SERVICES

We look forward to further details on the policy framework for Schedule 1 Facilities and Physician Services, and encourage the Ministry of Health to ensure that such a policy would be applicable in all Schedule 1 facilities, including those located within specialty hospitals.

POLICY ON HOUSING

Our organization urges the Ministry to include guidelines regarding Boarding Homes, Homes for Special Care, and Domiciliary Hostels within its housing policy framework. We feel that it is essential for fixed points of responsibility to be identified for these types of housing. As well, it is imperative that individuals who reside in such settings be linked to the overall mental health system.

LEGISLATIVE REVIEW

We have enthusiastically supported the Ministry's recent education strategy regarding the *Mental Health Act* and related legislation and encourage the Ministry to continue to work collaboratively with this education initiative. We are pleased to note that the legislative review will ensure that mental health legislation supports the creation of an integrated and coordinated mental health system, capable of providing a continuum of care from prevention to in-hospital and community based treatment. The CMHA, Ontario Division is hopeful that this legislated continuum includes rehabilitative and support services.

We are aware that the Ministry of Health has received intense and competing pressures to examine the *Mental Health Act* from the point of view of "community treatment orders". We would like to reiterate our position regarding Community Treatment Orders: that no client of a community agency should be coerced into accepting services from that agency against their will. This position is in keeping with the views of many groups, including the Mental Health Legal Committee. Many groups, including the media, have demanded legislative changes based on perceptions that public safety is at risk. Often, advocates for change to the *Mental Health Act* base their concerns on a less than clear understanding of the Act. It is for this reason that the CMHA, Ontario Division strongly supports the Ministry of Health initiative to provide education regarding the content and appropriate use of the Mental Health Act, an initiative that is currently underway in Ontario through the leadership of Mr. Michael Bay.

Who is in the Driver's Seat?

In an interview with Glenn Thompson, Executive Director, CMHA, Ontario Division, he talks about the convergence of things outside of people who are in the system, outside of consumers and their families and caregivers, that are driving the engine to make change in Ontario's mental health laws.

Who are the drivers who are making mental health reform come to the top of the agenda?

GLENN THOMPSON: I think you have to look back and recognize that the Heseltine Report, the Graham Report, and certainly the NDP with its courage to put forward a policy document and adopt it as policy, have all brought us to where we are today in our push for reform. I think Elizabeth Witmer, the Minister of Health, is very concerned about mental health and its tremendous burden. All of the reports and reviews that have been conducted over the years by people in the field have had an impact. I believe though that now, more than anything else, the general public have become the main driver. Not only are the public now aware, but perhaps more importantly, are ready to talk about mental health as a social concern and as an issue in their family and their personal lives.

Why do you think that is?

GLENN THOMPSON: Some of it is because of the random acts of violence that have occurred, but a lot of it comes from people realizing that a close friend or family member has a serious mental illness and they don't want to see them taken away to hospital for the rest of their lives. They want to talk about it and do something about it. I think the media are doing a tremendous job in exposing us to more mental health debate. So I think the driver at the moment is the public readiness that has been created by all of these factors. One of the other things that is bound to have a big impact is the growing awareness of

the cost in the workplace of people who are not functioning well emotionally, because they are under tremendous stresses. I think of young women who are looking after families and having to travel long distances back and forth to work - all of that is creating tremendous stress in the workplace and people are now beginning to recognize that it creates a major productivity problem. The cost in the U.S. is estimated in the billions of dollars lost each year because of people feeling stressed out. So I believe there is a convergence of things here outside of people who are in the system, outside of the consumers and their families and their caregivers. These have been the people who have been talking to one another for the past 15 years, but now the rest of the world is starting to talk. It's becoming mainstream opinion and that's what drives really significant change.

Is the topic of mental health starting to have less stigma attached to it because it has become a mainstream topic?

GLENN THOMPSON: I think the stigma associated with mental illness is still the biggest impediment. Not so long ago cancer had the same stigma attached to it. It was a dreaded word. If a family member had cancer it was not something that was talked about. Now that has all changed. If a friend or relative has cancer the support is there for them. People are still fearful, unfortunately, of mental illness. It still has a stigma that makes it difficult for people to talk about it and receive support. To many people mental illness

equals dangerousness. That equation has to be broken down and we have to do a better job with people when they are dangerous, because this does happen. Aggressive behaviour though is almost always directed towards family and friends. I remember my elderly grandmother who lived to be 99 and lived with us for many years after her husband died. As her mental health declined in her later years, this loving little lady who loved no one more than my mother, her daughter, began to think that she wasn't being well cared for and began to get quite aggressive and angry towards my mother, her caregiver. I think that kind of thing happens a lot at intermittent intervals with seriously mentally ill people. One day they are delighted with their family and helpers and the next day they are angry for no apparent reason. Some of it is almost like the adolescent behaviour where young people want to be independent one day and a child the next.

Is it this concern about the danger that is making community treatment orders appear to be an attractive option in the eyes of the general public?

GLENN THOMPSON: The whole issue of dangerousness needs to be brought out into the open so that we don't go off into cul-de-sacs such as community treatment orders imagining that they are the solution to homelessness and dangerousness. Even if you were a believer in community treatment orders, the research in the U.S. says that if you don't have wrap-around treatment, if you don't have the full spectrum of services in the community, they don't work. And our opinion is that if you have a full spectrum of services community treatment orders will not be necessary.

Clearing Away the Cobwebs

AN INTERVIEW WITH MICHAEL BAY

CHAIR AND CHIEF EXECUTIVE OFFICER, CONSENT AND CAPACITY BOARD

The CMHA, Ontario Division strongly supports the Ministry of Health initiative to provide education regarding the content and appropriate use of the Mental Health Act, an initiative that is currently underway in Ontario through the leadership of Mr. Michael Bay, Chair and Chief Executive Officer, Consent and Capacity Board.

One of the things that has been touched on with respect to this whole issue of mental health reform is the initiative that you currently have underway as far as providing education on mental health law. What is taking place?

MICHAEL BAY: We are educating people about three pieces of legislation - the *Mental Health Act* which covers, among other things, the rules for holding people in hospital, the *Health Care Consent Act* which sets out the rules with regard to treatment, and the *Substitute Decisions Act* which is the legislation that covers things like guardianship and powers of attorney. The project has a number of parts to it. We have redrafted a government publication that was put out years ago called *Rights and Responsibilities: Mental Health and the Law*. It's written in plain English and covers everything from the tools for maintaining people in communities, how to get them into hospital, the rules for keeping them there, the rules for treatment, etc. We hope it will be a guide for the public, consumers and families, and also will be used by professionals. We've also been working with the police community and have helped to compose the legal sections for two publications being published by

the Toronto police and the Ontario Police College on mental health matters. The project has also circulated an eight-page simplified booklet on the rules for consent to treatment.

I know that you've been travelling across the province since November of last year speaking to many different groups of people. What takes place in those sessions?

MICHAEL BAY: We have made educational presentations to many groups and conferences. We also have what we call our road show which has been visiting many communities across the province. We usually visit the emergency unit at the hospital to review with staff the legal provisions that effect them. We also do a presentation for the in-patient psychiatry department and other professionals. And we've been holding public sessions which have attracted between 50 to 300 people from a whole variety of backgrounds and disciplines. We've had a tremendous response from various health professionals who deal with vulnerable people. We've also seen attendance by a good number of family physicians and psychiatrists, although I would certainly like to see more. I should point out that when we talk about law and

mental health, we are not just talking about the law as it relates to those suffering from conditions such as schizophrenia and bi-polar effective disorder. We are also talking about the vulnerable elderly grappling with things like dementia or delirium, as well as individuals facing intellectual impairment, brain injuries and numerous other challenges. That's why we have been gratified to see significant attendance by professionals dealing with these populations. We have also seen good attendance from the police around the province and to some extent fire and ambulance. And I'm gratified to tell you that we've had good participation from both family groups and consumer groups. During our presentations we have tried to take advantage of the fact that we have all of these different sectors present in our lectures. We invite people to bring their own literature which is then displayed so that the various groups can network. Our community sessions take about four hours. It is a kind of crash course on the tools for keeping people in the community, tools for getting them to hospital and rules for keeping them there and giving them treatment.

What are the really hot topics - the hot buttons - that people keep coming back to in these sessions?

MICHAEL BAY: There has been a tremendous amount of interest in the whole issue of leaves of absence under the *Mental Health Act*. The Act has always contained a very flexible provision for leaves of absence but, for some reason, they are rarely used. Most psychiatrists and other professionals seem to be unaware of them. We originally thought we were just mentioning them as one of the various tools in the law but, for some reason, people have really locked onto this one. People are also interested in the Ulysses Contract concept. This is something that I often refer to as a '12-cylinder power of attorney'. It's a power of attorney for personal care that an individual can make in a very special way. A Ulysses Contract allows me to empower the person named in my power of attorney for personal care, to do things like have me forcibly admitted to hospital. For example, a gentleman suffering from bi-polar disorder may decide that the last time he was

manic he did things that have troubled him ever since. He wants to make sure that he is brought to hospital and treated next time he is sick, even if he is objecting at the time. He can arrange with his psychiatrist for a note to be given to his attorney saying that he is desperately in need of treatment and his attorney can then make the necessary arrangements. The need for treatment, not dangerousness, is the key to hospitalization under these provisions. There is a lot of protection to ensure that a Ulysses Contract is only signed by a person who is capable of signing and really wants to set this up.

As you might expect, the audience is most interested in hearing about the Mental Health Act tools for apprehending people in the community and getting them to the hospital. The major interest in our sessions is in how the *Mental Health Act* works. We talk about the way justices of the peace can sign a Form 2, the authority of police officers and the authority of physicians. The number one hot button is when I dispel the common mythology in Ontario that you have to be imminently dangerous to yourself or others to be held under the Act. Many people are astonished to find out that the supposed requirement that one pose an imminent or immediate danger to self or others is the product of the overactive imaginations of some ill-informed journalists. People are also surprised when we go through the depth and breadth of the authority that exists in our current *Mental Health Act*.

Is this a deep rooted mythology?

MICHAEL BAY: Yes, it is. First of all the danger to self or others doesn't have a requirement of imminence: it only exists in a section about people who can't take care of themselves. But this isn't just a common misunderstanding. My belief is that it has formed a fundamental part of the belief system, not just of the health care establishment, but of the population of Ontario. We in Ontario firmly believe that we have a law that says that you have to be imminently

"...the legislation must be clear and understandable in concept and language. It must be brought to the attention of those to whom it applies and to those who must apply it. Without education, mental health law is a cruel joke and a horrible waste of time and money."

Clearing Away the Cobwebs

Continued from page 15

dangerous to self or others. For the truth of my statement look at any newspaper article, listen to any interview with a psychiatrist on the television or radio, listen to any public debate – it's become culturally embedded in the belief system of Ontario, and it has absolutely no basis in fact whatsoever. Moreover, based on what we have heard at past inquests I think it is pretty clear that it's one of the causes of serious problems in the province. People die because of this mythology.

The other thing that strikes a chord in the audience, is when I say that there is an enormous number of physicians who refuse to exercise any authority under the *Mental Health Act* because of a false belief that somehow they are going to get sued if they exercise their authority. I have to remind them that, in fact, their authority to sign a form to have somebody brought in for an assessment is so broad and allows so much judgement that there is no real legal exposure for doing it. Legal exposure is in negligently refusing to do your job. There's this kind of nod of recognition from other professionals in the audience expressing a great deal of pent up frustration. The challenge is to bring this home to the family physicians, and that's exacerbated by the fact that the project has not, in my estimation, yet reached a large enough number of family physicians. That's something we hope to deal with in the future.

So you are saying that before we can have mental health reform it's imperative that we have a true understanding of what our current mental health law says and does?

MICHAEL BAY: The debate about the future of our mental health legislation must be grounded in an understanding of the existing law. It's absolutely essential that we dust the cobwebs off. We must not allow mythology to cloud our understanding of the status quo. If we blame the legislation for problems that have other causes, it will not be possible to find workable solutions. Blaming scapegoats usually means that you ignore the real causes of a problem. Besides, you can never reach your desired destination if you miscalculate your starting point. It isn't enough to give me a goal, a

map and a compass; I have to know where I am starting from.

We have to know where we are, in order to know what changes are needed or we end up with a

“We seem to have two Mental Health Acts in Ontario. The first Mental Health Act is the one passed by the legislature. The second one has different versions depending on who you speak to. It's the one often referred to in the press, cited at conferences and sadly, frequently, but certainly not always, the one applied by mental health professionals. This second version is the one that says the involuntary committal provisions only apply to a person who has a macheté in one hand and an Uzi in the other and is about to commit murder that very minute...I am one of those who believes that its widespread misapplication causes much suffering and sometimes even death in this province, not to mention much confusion. When criticizing the Act or considering change, one must be sure which Act is presenting the problem. If it is the real Mental Health Act, then consider legislative change. If it is the mythological but very powerful Mental Health Act, then consider education, enforcement or cultural change since legislative change can't and won't have any effect.”

situation like the Brian Smith inquest in Ottawa. Many people appeared before that inquest who were supposedly experts but who had no idea what the law actually says. The jury made many thoughtful recommendations. Sadly, however, this misinformation misled the jury and resulted in some recommendations to change the law so that it would say what it already says and do what it already does.

The whole issue of dangerousness - is this something that is addressed in your debates?

MICHAEL BAY: Well, that's not an issue that this project is touching on, but I think that a few things have converged in an interesting way over the last year or so. They include some horrible tragedies in Ontario, and the subsequent public

outry, and great deal of almost public panic about a year ago which corresponded to a perception that mental health law should be about locking up the mentally ill who were perceived to be an intensely dangerous group. I think our project has contributed to the understanding that public safety is certainly an important issue but so is the safety, treatment and rights of the vulnerable population. There now seems to be an appreciation that the issue is exceedingly complex, and that it is about a search for balance: a balance between an individual's right to self-determination and that same individual's right to treatment, care and safety, as well as society's right to safety. Striking that balance is not a matter of sloganeering or finding simple answers. I think that a number of things have come together and I think that we have seen a profound change in the debate. The work of the CMHA has been important. The work of groups like the Schizophrenia Society and consumer groups has been essential in explaining to the public that these are real flesh and blood fellow citizens suffering from these problems. In addition, enormous work was done through two series published in the *Toronto Star* last year. All of these efforts, together with our project, have caused a substantial change in the debate in Ontario. I think the population has moved from a search for simple draconian answers, which is what we look for when we are frightened, to an understanding that these are profoundly difficult issues needing to be addressed with courage, compassion and wisdom.

“We need to learn to write our laws in English.....we need a true revolution in legal drafting if we are going to expect people to read, understand and obey our laws.”

Over the past six months Michael Bay has addressed many groups including the Ontario Hospital Association, the College of Physicians and Surgeons of Ontario, groups of nurses, family physicians, social workers, community care access centres, various provider groups, and the Ontario Psychiatric Association. Public forums have been, and continue to be, held in over 40 towns and communities across Ontario. This first phase of the project ends in June of this year. Minister of Health Elizabeth Witmer has recently informed Mr. Bay that she has directed that the project be continued at least until the end of the current fiscal year, extending its lifespan to the end of March 2000. The direction the second phase will take has yet to be decided but some of the issues are those of reaching more family doctors, the training curriculum for new professionals and even more intensive outreach to families and consumers.

In designing and managing the project Mr. Bay recognizes the outstanding support, cooperation and enthusiasm received from the Schizophrenia Society, the Canadian Mental Health Association, various consumer advocacy groups including the Advocacy Centre for the Elderly, and the Psychiatric Patient Advocate Office, as well as the Ontario Psychiatric Association, the College of Physicians and Surgeons of Ontario, the Ontario Hospital Association, the Ontario Medical Association, the police community, the Office of the Chief Coroner and the Office of the Public Guardian and Trustee. The District Health Councils across the province have been invaluable partners.

Trends in Mental Health Expenditures

Evaluating the Ministry of Health's commitment to mental health services and supports. An edited version of a report produced by the CMHA, Ontario Division dated May 7, 1999.

Mental illness is a serious problem in Ontario, affecting large numbers of people and their families. The cost of meeting the mental health needs of Ontarians continues to grow as the demand for services increases.

Mental Health Reform is a new way of looking at the provision of mental health services in Ontario. It is a way of reallocating dollars spent on mental health care in order to achieve a more efficient and effective system. Additionally, it is a coordinated effort between mental health institutions and agencies in the community, where joint participation in the decision-making process is required by all parties to achieve a more comprehensive, integrated and accessible system of care (Health Systems Research Unit of the Clarke Institute of Psychiatry, 1997.) Simply put, the not so new emphasis is on people, and not institutions. And so, decisions to redistribute resources cannot be fairly justified without the answers to: who needs what, where, when and how much?

Part of the Ministry of Health's commitment to the reform process is a "redistribution package" of health care dollars. The pledge to reallocate mental health spending from institutional to community care is the thrust of the reform agenda. With the increased flow of health care dollars into the community, stronger and more stable community supports will be established. The expected end result will be a greater capacity for the reintegration of people with mental health problems into the community, thereby fostering a higher quality of life.

Should the reform plan be achieved, we will witness a growth in overall expenditures allocated to community-based services (in general) and specifically to community mental health programs. Such an increase in spending would allow the necessary support systems to be developed in the community and enable the government to reach its targeted goal. Thus, the critical component of the Mental Health Reform initiative is the Ministry of Health's stated goal to

revise current spending patterns by having 60% of mental health spending directed toward community services by 2003, with the remaining 40% to go to institutional care.

Since 1993, various government constraint processes have affected the progress of Mental Health Reform. As a result of the Social Contract of 1993, health services found their budgets cut by 4.36%. In addition, sessional fees for psychiatrists were reduced 25% from April 1, 1993. The Expenditure Control Plan, announced April 23, 1993, required that \$6 million also be recovered from community mental health programs. In response, hospitals began closing psychiatric beds in order to meet savings targets required under the Social Contract, and many community mental health agencies were forced to cut services.

On October 28, 1994 the then Minister of Health, the Honourable Ruth Grier, announced that the government would be investing \$20 million in community mental health services. At the same time, it was announced that Provincial Psychiatric Hospital constraints would be suspended "...until programs are available in the community."

Regional allocations for this so called Community Investment Fund (CIF) funding were announced December 15, 1994. With the election of a new government in June 1995, the Social Contract was ended, although pre-Social Contract funding levels were not restored. In 1996 the Ministry of Health issued a directive that no further general hospital psychiatric beds were to be closed. Beginning in 1996 the government imposed funding cuts on hospitals and community health agencies. The Health Services Restructuring Commission (HSRC) has also made various final and interim recommendations concerning savings to be obtained from closures and mergers of hospitals. Recommendations for reinvestment of closure savings into community services have been made by the HSRC, and the CMHA, Ontario Division has urged that community services be in place prior to the closure of further beds.

Although we are currently at the half way point of the Ministry of Health's reform initiative, the Ministry is still far behind the pace of change required to meet its objective of 60% spending in the community and 40% spending in hospitals.

Although we are currently at the halfway point of the Ministry of Health's reform initiative, the Ministry is still far behind in meeting its objective of 60% spending in the community and 40% spending in hospitals.

Even with the exclusion of OHIP expenditures, the Ministry of Health still has a long way to go before reaching its objective regarding the redistribution of health care dollars into the community. Community supports will require greater governmental subsidies if they are to be fully in place by the year 2003.

At present, the Ministry of Health is distributing mental health care dollars in favour of hospital based services at the ratio of approximately 4 to 1. Many Provincial Psychiatric Hospitals (PPHs) have been closed, and yet this ratio is unchanged since the start of the reform initiative in 1993.

Community mental health spending, on the other hand, has not increased proportionately and significant investment in community mental health is yet to take place. For the Ministry of Health, time is running short.

Merely reallocating funds after the closures of institutions will not provide community services for persons with mental illness who are discharged during the period of institutional downsizing prior to closures. Even though the proportion of health care spending for mental health services has remained relatively constant as a percentage of provincial health care expenditures (between 7.3% and 8.8% over 1994/95 to 1997/98), this amount is insufficient given the prevalence rates of mental illness in Ontario and the government's stated policy to address the needs of this population. Transitional funds for the creation and expansion of community-based mental health services must be provided to avoid another deinstitutionalization crisis.

The Ministry of Health in 1998 announced expenditures of \$713 million as part of "...a five-year, \$2 billion commitment made by the provincial government in the 1997 budget to support hospital restructuring". Any of the announced funding allocated to mental health services was for renovation/construction of inpatient beds in accordance with HSRC directives which concerned hospital restructuring.

The Ministry of Health also made various specific mental health funding announcements in 1998. Of the \$66 million announced, \$39.6 million was transitional funding, leaving \$26.4 million in annualized funding, an amount very similar to the CIF, which was to be annualized. Even with this announced funding, which has begun to be distributed in April 1999, the total expenditures on

community mental health services are still not close to those for institutions.

Mental illness cannot simply be overlooked any longer. It is a growing concern in Ontario, as it permeates through all media forms to reach most of Ontario's citizenry. The CMHA, Ontario Division recognizes this growing concern as the organization continues to advocate on behalf of persons with mental health problems. The recognition that appropriately treating mental illness demands adequate resources is only the first step. Funding must increase commensurate to need. If hospital cutbacks are going to continue, the Ministry of Health must commit to community supports in order to counterbalance the negative effects of this decreased funding. While it is expected that community mental health funding will increase dramatically over the next few years, the Ministry of Health may be hampered in its ability to reach its ultimate objective in view of the reduced time now available and the complex staff training and program development involved.

CALENDAR

July 11 - 15th, 1999

40th Annual Institute on Addiction Studies "Celebrating the Journey", Kempfenfelt Conference Centre, Barrie, Ontario.
Contact: Concerns Canada (416) 293-3400.

August 18 - 21, 1999

Reaching for the Sun. The CMHA National Conference: Vancouver, British Columbia. For more information contact the Conference Coordinator, Heather Ross at (604) 688-3234, or fax (604) 688-3236, or e-mail: hross@cmha-bc.org.

October 20 - 22, 1999

Take the Next Step with PSR 5th Bi-Annual Conference. Sheraton Fallsview Hotel, Niagara Falls, Ontario. Choose from Six Streams: Recovery and Consumer/Survivor Empowerment; Wellness and Health Promotion; Partnerships with Communities and Families; Multiculturalism; Research, Evaluation and Accountability; and Recovering the Excitement of PSR. Keynote speakers include: Julie Flatt, from the Consumer/Survivor Development Initiative, Ontario and Judi Chamberlin, from the Center for Psychiatric Rehabilitation, Boston. For more information call Sheila Bristo at (905) 641-5222.

Beethoven. We would have been music to his ears.

Beethoven, whose music still calms
the restless soul, was known to experience
severe depression.

Famous or not, anybody can suffer the effects of mental
illness. That's why we are here – to help you help yourself
and those you know and love.

Mental health – it's music to the mind.



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