

January 4, 2011

Hello everyone,

Included here is the 2011 proposed resolution for Ontario Council prepared by CFUW Oakville concerning a Mental Health Strategy for Ontario.

Please read it carefully, prepare amendments if you wish. We will be voting on this resolution at the 2011 Ontario Council Annual General Meeting to be held in Oakville May 13-14, 2011.

Included in this package is:

The important dates

Ontario Council 2011 Proposed Resolution, Background and Bibliography:

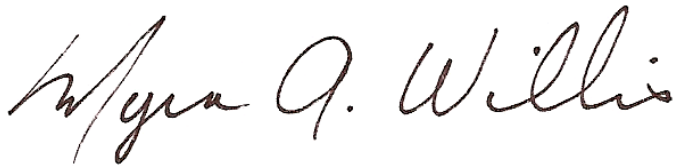
**Mental Health Strategy for Ontario, proposed by CFUW Oakville**

Ontario Council Resolution Amendment Process

Ontario Council Resolution Amendment Sheet

We would like to thank Luba Pudolsky and the Resolutions Committee of CFUW Oakville for this resolution.

Sincerely,



Myra Willis  
President

Each Ontario Council Club is urged to make arrangements to circulate the Ontario Council Proposed Resolution among the members and to discuss it.

### **Important Dates**

<b>March 31, 2011</b>	Amendments due
<b>April 14, 2011</b>	Final amended version to clubs.
<b>May 14, 2011</b>	Vote at the Ontario Council AGM

Amendments to be e-mailed to:

Jane Sagar, Chair, OC Committee on Resolutions

[legislation@cfuwontcouncil.ca](mailto:legislation@cfuwontcouncil.ca)

## **MENTAL HEALTH STRATEGY FOR ONTARIO**

Proposed by CFUW Oakville

RESOLVED that the Ontario Council of the Canadian Federation of University Women (CFUW) request the Government of Ontario to create, and adequately fund, an umbrella organization responsible to the Ministry of Health and Long Term Care (MOHLTC), or its successor, with the mandate to design, manage, and coordinate the mental health and addictions system, and to ensure that all mental health and addictions programs and services are delivered consistently and comprehensively across the province.

RESOLVED that the Ontario Council of CFUW urge the Government of Ontario to provide, and fund appropriately, mental health and addictions programs and services, including, but not limited to, the following:

1. improved public education about mental illness and addictions
2. system navigators to connect those requiring care with the appropriate providers
3. a core basket of institutional, residential and community mental health and addictions services
4. standardized assessment tools
5. support services for families dealing with mental health and addiction problems
6. community programs that include age-appropriate early intervention and treatment services for mental illness and addictions
7. supportive housing and treatment for the homeless with mental illness and addictions
8. research into brain function and mental illness
9. regular monitoring of program outcomes by the umbrella organization.

## **BACKGROUND**

### **i) The scope of the problem**

The Select Committee on Mental Health and Addictions was established in February 2009 by the Legislative Assembly of Ontario, with Kevin Flynn MPP as its chair. This all-party committee worked collaboratively to produce a final unanimous report that was released in August 2010 (K. Flynn MPP, personal communication). According to this report:

“One of the main problems in Ontario’s mental health and addictions system is that there is, in fact, no system. Mental health and addictions services are funded or provided by at least 10 different ministries. Community care is delivered by 440 children’s mental health agencies, 330 community mental health agencies, 150 substance abuse treatment agencies, and approximately 50 problem gambling centres. Many people simply fall through the cracks, or give up in frustration because of the complexity of the system.” (Flynn, 2010, p.3).

According to the 2010 Mental Health and Addiction Statistics prepared by the Centre for Addiction and Mental Health (CAMH) in Toronto, one in 5 Canadians will experience a mental illness in their lifetime. Schizophrenia affects 1% of all Canadians, major depression affects 8%, and anxiety disorder is a problem for 12% (CAMH Statistics 2010).

The Ontario Government strategy paper “Every Door is the Right Door” (commissioned by former Health Minister David Caplan) reported in July 2009 that the

following ministries were involved in providing mental health and addictions programs and services:

*Aboriginal Affairs; Attorney General; Children and Youth Services; Citizenship and Immigration; Community and Social Services; Community Safety and Correctional Services; Culture; Education; Finance; Health and Long-Term Care; Health Promotion; Labour; Municipal Affairs; Training, Colleges and Universities.*

The need to establish a coherent system is also supported by the accounts of those needing help being bounced from place to place, often with no resolution to their problems. One recent horrifying example was described in a column by Christie Blatchford (*Globe and Mail*, Sept. 22/10). A man who had been trying for months to get help pushed two teenaged boys into the path of a Toronto subway train. In another instance, a 28 year old man who had stopped taking his medication and had become agitated was shot dead by police. The inquest into his death recommended that one agency be established for all mental health services (Morrow, Adrian, *Globe and Mail*, Oct. 9/10). These are just two of the more sensational cases that get into the news. In the Select Committee Report, there are many more examples of the need for consolidation, including the case of a daughter who dealt with more than 20 health care providers and social service agencies on her mother's behalf (Flynn, p.1). The report also acknowledges that youth are caught in the gap between programs for children and adults, and that individuals with autism, eating disorders, Fetal Alcohol Spectrum Disorder, or a dual diagnosis are orphaned by a system that seemingly has no place for them (ibid). According to CAMH, only one-third of those who need mental health services in Canada actually receive them, and wait times for treatment are frequently unacceptable (CAMH Statistics 2010).

Concerns about the fragmented delivery of mental health/addictions programs in Ontario are not new. The 2008 Annual Report of the Auditor General of Ontario expressed concern about the lack of consistency in the practices of community health providers and the autonomy with which child and youth mental health providers operate (Co-ordination of Access to Services, 2008 Auditor General's Report). The resulting patchwork of services has greatly compromised care of the mentally ill and addicted in Ontario.

#### ii) **The need to include addiction**

A key issue is the need to integrate addiction treatment with mental illness care. The "Every Door is the Right Door" report stated that, because mental illness and addictions are so closely linked, the services addressing these disorders must be integrated (page5). CAMH reports that 20% of people with mental disorders have a co-occurring (concurrent) substance use problem, while 1 in 10 Canadians 15 years of age and over report symptoms consistent with alcohol or illicit drug dependence. (CAMH Statistics 2010.)

CAMH is Canada's largest mental health and addiction teaching hospital, integrating specialized clinical care with innovative research, education health promotion and policy development. It is fully integrated with the University of Toronto and has 32 community locations throughout the province. The following is the conclusion of its submission to the Select Committee on Mental Health and Addictions (2010.05.18, p.7-8):

"In the past, the treatment of mental illness and addiction has often been relegated to distinct systems of care, particularly for those with the most severe and persistent problems. Yet we have painfully learned that separating these problems from each other –

and distinguishing these services from the rest of health care – works against the interest of building a strong system of care. More importantly, it works against the interests of those with mental health and addiction problems, who have demonstrated a capacity for recovery and community participation that would have been difficult to imagine a generation ago.”

“Collaboration amongst sectors can facilitate delivery of the ‘right services’ by the ‘right people’ at the ‘right time’, and thus reduce the risks and impacts of the many other health conditions associated with addictions and mental illness...”

“Methodical and deliberate service integration must be focused on the experience of clients, and its most successful champions must be clients and service providers at the local level.”

### iii) **Other jurisdictions**

The Canadian Mental Health Association (Ontario) conducted a survey of strategies for mental health reform in Australia, England, Scotland and New Brunswick (CMHA Ontario, 2010.03). Among the similarities in the core elements of these strategies were the need for system reform and involvement of people with lived experience; that is, who had been mentally ill and/or addicted themselves, or had cared for a mentally ill and/or addicted individual. All these jurisdictions also noted a common need for prevention via cultivation of healthy families, a good start in early childhood, establishing mentally healthy workplaces, and reducing risk factors. Early identification and early intervention were seen to be clinically beneficial and cost-effective. In addition, all jurisdictions proposed to broaden their system’s focus to reach beyond the delivery system and the client and include the client’s informal networks of family, peer groups and other supporters.

### iv) **Research needs**

The deficits in the field of mental illness/addiction are not restricted to diagnosis and treatment. Dr. Zul Merali, President and CEO of the University of Ottawa Institute of Mental Health Research, has pointed out that only 5% of all health research dollars go into studies of mental health (Adam, Ottawa Citizen, 2010.09.26). Such research will become ever more important as the Ontario population ages demographically. Today’s longer lifespans bring with them a higher incidence of degenerative diseases, many of them affecting mental health. More research into how the brain functions, its plasticity, and the reasons for its deterioration will be needed to determine the causes of disorders such as Alzheimer’s dementia (Report of the Alzheimer Society, 2010). At present, there is no known cure for this devastating disease, although a variety of treatments are being tested (Globe and Mail series on dementia, 2010.09).

### v) **Potential solutions**

In 2001, the final report of the Commission on Medicare to the Government of Saskatchewan (the Fyke Report) highlighted the fact that the real problem underlying difficulties in the Saskatchewan health care system was poor organization. (Fyke, “Caring for Medicare”, 2001). This was also the conclusion of “Crossing the Chasm”, a 2001 report of the US Institute of Medicine, which stated that it was not health care providers such as nurses and doctors that prevented the delivery of good quality health care services, but rather the dysfunctional organization of the health care system itself (reported in “Prescription for Excellence” by Dr. Michael Rachlis, pp.23-24).

Following the May 2006 report of the Standing Senate Committee on Social Affairs Science and Technology entitled "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada", the Federal government created the Mental Health Commission of Canada (MHCC), with Senator Michael Kirby as its chair. Work towards a national strategy is in progress, but to date Canada remains alone among G8 countries without one (National Council of Women of Canada policy on-line ). Recommendations of the Select Committee to the Ontario Legislative Assembly appear consistent with the thinking of the MHCC.

A demonstration project (At Home/Chez Soi) of the MHCC is now in progress in Toronto, Moncton, Montreal, Winnipeg and Vancouver (MHCC, Aug. 2010). Homeless people with a mental illness are given a place to live, and are offered services to assist them. A control group receives the regular services currently available in their cities. The participants have to pay a portion of their rent and are visited at least weekly by program staff. The results of this study should provide much valuable information on how and which services should be delivered to the homeless, information that can be broadly applied across Ontario.

Innovative services such as COAST (Crisis Outreach And Support Team) are available in some regions of Ontario. A COAST team is comprised of health care workers and police officers trained in mental health and crisis intervention. Referral services such as Telehealth Ontario exist, but are not widely known.

#### vi) **Implementation**

A valid concern with calling for the integration of multiple agencies is the cost associated with what appears to be another layer of bureaucracy. CAMH puts the existing annual cost of mental illness and addictions at \$34 billion in terms of direct health care costs and loss of productivity (CAMH Statistics 2010). Implementing an umbrella organization at the provincial level need not require additional bureaucracy at the local level. In 2006, the MOHLTC divided Ontario into 14 regions and established Local Health Integration Networks (LHINs), one per region. Each LHIN was mandated to plan, fund and integrate health services locally. Consolidating all mental health and addictions services within the MOHLTC would allow the mandate of the LHINs to be amended to handle these additional local responsibilities.

The North East LHIN in Ontario has already implemented the pilot phase of a tool to make data collection and sharing of information consistent and more accessible for mental health organizations in Ontario. The tool is called the Ontario Common Assessment of Need (OCAN), and is part of a project led by the CMHA (CMHA, Ontario. 2010.09.16).

**NOTE:** On December 30, 2010 the Minister's Advisory Group on the 10-year Mental Health and Addictions Strategy published " *Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy Report to the Minister of Health and Long-Term Care,* " (Respect, Dec.2010) its comprehensive 45 page report to the Minister of Health and Long Term Care. The Advisory Group consists of 21 members (p. 5) drawn from, among others, service providers, medical and mental health associations, social services and family health teams across Ontario.

The report highlights the need for a coordinated provincial system and proposes a ten-year plan, implemented in stages, to achieve it. An umbrella organization called the Mental Health and Addiction Council, composed of leaders from agencies and organizations involved in mental health and addictions and reporting to the MOHLTC, would develop and oversee the plan. Each regional level of the province would form a network to implement the plan as adjusted to local needs (pp38-42).

The report documents the need to enhance community-based services, strengthen social supports, promote family and peer involvement, improve the training of medical, educational and caregiver personnel, increase public education and decrease stigmatization. Our resolution is in line with the main thesis of this report.

### **Conclusion**

**Changes to the organization and management of mental illness and addictions in Ontario are imminent. If CFUW is to have any input into these changes, we need a resolution to give us policy. We urge you to support our resolution.**

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### **Amendments to Proposed Resolutions**

- Amendments are meant to strengthen, clarify and support the original resolution.
- An amendment must always be germane – that is, closely related to, or having bearing on, the subject of the motion to be amended. This means no new subject can be introduced under the pretext of being an amendment. “Roberts Rules of Order”, Newly Revised. 10<sup>th</sup> edition
- Hostile amendments, which change the meaning or direction of the resolution, are unacceptable.
- The Resolution Proposers may accept or reject your amendment. If it is accepted, it will be incorporated into the amended Resolution to be presented at the AGM.

### **Amendment Procedure**

- Study the Resolution carefully. After reviewing it, if you consider making an amendment, follow the procedure below.
- To be considered, amendments must be received by March 31<sup>st</sup>.
- **Please** submit amendments in the requested **Resolution Amendment format**. Due to the number of amendments received by the Chair of Resolutions, we also request that you send these by email..
- Simply **copy and paste** from ‘Resolution number and title’ to ‘Rationale for amendment(s)’ into your word processor and fill it out the document from there.

**CFUW Ontario Council  
Resolution Amendments  
2011**

**Proposed amendments must be received  
by the Chair of Resolutions  
via e-mail ([legislation@cfuwontcouncil.ca](mailto:legislation@cfuwontcouncil.ca))  
by March 31, 2011**

Name of Club:

Contact Person: (Name, address, telephone, e-mail)

Amend clause number ... by:  
Striking out the word or words,  
or  
By inserting the word or words

The amended clause to read:  
RESOLVED, That

Rationale for amendment (s):