Strategic Plan
2009-2012

ENVIRONMENTAL SCAN

May 2009

TABLE OF CONTENTS

INTRODUCTION

The Centre for Addiction and Mental Health is currently renewing its strategic plan for 2009-2012. This environmental scan is intended to provide an overview of changes in the environment since the end of 2005, when the strategic plan was last renewed, and to suggest some ways that CAMH may be affected by these changes.

The environmental scan focuses on the following areas:

- Key demographic shifts and their relation to service need, access issues, and health inequities.
- Changes in the broader health system such as: provincial health system reform; importance of health promotion and the social determinants of health; patient safety; and workforce issues.
- Changes in mental health, addictions, health promotion, and related sectors such as primary care and chronic disease management.

1. KEY DEMOGRAPHIC SHIFTS

MAIN TRENDS

Ontario's population continues to grow. The main trends are:

- Population growth continues to be driven largely by immigration. Ontario, and particularly the GTA, is increasingly diverse, serving as a reception area for many of Canada's new immigrants.
- Ontario's aboriginal population – both urban and on reserve – is growing faster than the population as a whole.
- There is an increase in the polarization of income, driven by an increasing disparity between rich and poor resulting from a loss of middle-income jobs.
- The population is aging; more people are living longer.

Each of these trends has implications for the mental health and addictions sector; in particular, growth in the population of marginalized groups will have implications for access to services.

Special efforts will be needed to ensure that all groups that need mental health and addictions services will have access to them.

IMMIGRATION AND CULTURAL DIVERSITY

Ontario, and particularly the GTA, is increasingly diverse, serving as a reception area for many of Canada's new immigrants. Canada's immigrants are currently almost 60% from Asia and the Middle East, approximately 15% from Europe, and the 3rd largest group from Central American, South American, and Caribbean countries. Many immigrants are coming from very difficult situations in their home countries and may experience after-effects of trauma or lack trust in the medical system. Family separation, social isolation, and other challenges related to immigration or settlement may lead to stress or depression. Stigma related to seeking treatment

may be more severe for people who have to rely on interpreters, particularly within small ethnic communities where privacy might not be ensured.[1]

In addition to these specific challenges related to immigration status, broad cultural competency is increasingly important as the proportion of the population in the GTA, for example, that was born outside the country passes 50%. Cultural competency is especially important in the mental health sector because of the role of culture in determining perceptions and behaviour. Cultural competency goes beyond linguistic competency (for example, the use of interpreters) and may involve mental health and addictions services delivered in community settings or by members of a client's ethnocultural community.

As the health system and the mental health and addictions sector focus more on community-based care, cultural competency becomes more critical. A five-year project of the Community University Research Alliance (CURA), *Taking Culture Seriously in Community Mental Health*, is beginning to evaluate 12 demonstration projects that aim to help understand the role of culture in community mental health projects. Some CAMH researchers are involved in this project that will wrap up in 2010.

Ensuring access to mental health and addictions services for the many communities that have found their homes in Ontario will require a number of strategies including partnering with ethnocultural organizations to: increase awareness about mental health and addictions; reach out to people in need of services; and develop cultural competencies on the part of "mainstream organizations". It will also require delivering mental health and addictions services through primary care or in other community settings.

ABORIGINAL POPULATION GROWTH

Ontario's aboriginal population – both urban and on reserve – is growing much faster than the population as a whole. Between 1996-2006, Ontario's Aboriginal population grew nearly five times faster than the non-Aboriginal population – increasing 28.3% as compared to 6.2%. Aboriginal people in Ontario report health status far lower than the general population, experiencing ill health, inferior health care, lower life expectancy and poverty and have high rates of disease, substance abuse, depression and suicide. In a recent address to the Health Council of Canada, Assembly of First Nations National Chief Phil Fontaine discussed issues impacting the health and wellbeing of First Nations families and communities. In addition to high rates of poverty and limited access to services in many communities, Fontaine discussed the mental health issues related to the legacy of the residential schools and stressed the importance of cultural competency when dealing with First Nations patients.[2]

Because of the unique circumstances of aboriginal people in Canada, special approaches may be required to treat mental health and addictions. Approaches may involve addressing family or community wellness, incorporating traditional aboriginal teachings into the healing process and addressing intergenerational trauma. For example, CAMH's Aboriginal Services combines therapy with cultural and spiritual teaching and partners with aboriginal and non-aboriginal agencies across the

[1] Sarah V. Wayland. *Unsettled: Legal and Policy Barriers for Newcomers to Canada – Literature Review,* 106

[2] http://healthcouncilcanada.ca/docs/speeches/2008/HCC_ChiefFontaine_November2008.pdf

province to build local capacity to address mental health and addictions issues. As Ontario's aboriginal population continues to grow, efforts to address the underlying causes of aboriginal mental health and addictions issues and to provide accessible and culturally-sensitive treatment will need to be continued.

POVERTY AND INCOME POLARIZATION

According to Statistics Canada, national low-income rates remained relatively stable between 2001 and 2006, dropping from 11.6% to 10.5%. According to the 2008 Report Card on Child and Family Poverty in Canada, child and family poverty rates nationally remain stalled at 11.3%, almost what they were in 1989. Statistics Canada also reports that median family earnings also stayed stable between 2000 and 2005.

Despite this overall stability, there has been an increasing disparity in Canada and Ontario in general, and in Toronto in particular, between the rich and poor, driven by the loss of middle-income jobs.[3] Statistics Canada reports that the median earnings for the bottom quintile of families declined by 9.1% between 2000 and 2005, while the median earnings for the top quintile of families increased by 5.1%.[4] The result has been an increase in the numbers of "working poor" and a concentration of poverty in certain neighbourhoods where housing, services, and transit access are inferior relative to the rest of the city.[5] More and more, poverty in Toronto is co-related to race and immigration status, increasing the concentration of disadvantage and the ethnocultural segregation of neighbourhoods. Child poverty is also especially urbanized. Fifty percent of children living in poverty in Ontario are in the GTA; child poverty is most prevalent in the inner suburbs and inner city but growing the fastest in the GTA's suburban regions.[6]

Numerous studies have established links between health and income (or more generally, socio-economic status) as a social determinant of health, including mental health. The Canadian Institute of Health Information's Canadian Population Health Initiative's November 2008 report Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada, found that hospitalization rates for mental health increased with lower socio-economic status. Another national study based on the 2005 cycle of the Canadian Community Health Survey, the Wellesley Institute's December 2008 report, Poverty is making us sick, found that "high income does not guarantee good health, but low income almost inevitably ensures poor health." The Wellesley Institute's findings related to prevalence of mental health problems by income quintile found that:

- Self-rated mental health improves substantially as income rises
- Self-rated and formally measured depression improves significantly as income rises

[3] Hugh Mackenize and Jim Stanford, CCPA paper on "A Living Wage for Toronto" cite a 2008 StatsCan report (René Morissette, "Earnings in the Last Decade") saying that 17.4% of Ontario jobs pay less than $10/hr and that this proportion increased in the last decade despite steady economic growth. Ontario is doing worse in this respect than other provinces.

[4] http://www12.statcan.ca/english/census06/analysis/income/eicopqc18.cfm

[5] David Hulchanski's piece in the Star http://www.thestar.com/article/540066; Toronto: Poor city beside rich city; Nov 20, 2008

[6] http://povertywatchontario.ca/2008/12/03/greater-trouble-in-greater-toronto-child-poverty-in-the-gta/ GTA CAS and SPN's December 2008 report on child poverty in the GTA

- Anxiety and mood disorders show significant drops in incidence as income rises

In all cases, the most significant change occurred between the lowest quintile income and the second quintile income, though consistent change occurred through all quintiles. Thus, the findings do not affect only the very poor. The report found that "every $1000 increase in income leads to substantial increases in health" generally, and that this fine dependence was reflected in self-reported depression rates and mood disorders.

Similarly, Toronto Public Health's October 2008 report The Unequal City, though it did not study mental health or addictions, found that "the relationship between income and health in Toronto is not just about the extremes of wealth and poverty … for most indicators there is a continuous gradient of health in relation to income – health status improves through each income increment." It also warned that "recent trends toward increasing polarization of income distribution in Toronto raise concerns that the health inequalities documented here may lead to a decline in the overall health status of the city's population."[7]

A recent large international study on the social determinants of health from the World Health Organization also argues that reducing socio-economic inequities is a necessary step for health equity and confirmed the existence of a "social gradient" linking income and health within both developed and developing countries. [8]

The Ontario government's Poverty Reduction Strategy is an initial step towards documenting, addressing and reducing poverty in the province, but yet Ontario continues to lack a thorough health equity strategy. This is a serious concern given that strategies aimed at serving the health needs of the lowest-income Ontarians may not be able to rely on family doctors as the point of access to the system. The Wellesley Institute report Poverty is making us sick also found that the bottom quintile income group reported both a significantly higher incidence of having no regular doctor and a significantly higher incidence of believing that they had unmet health care needs. Access to health insurance covering medication and hospital care also increases with income.

AGING

As in other developing countries, the population of Canada continues to age. In 2008, 13% of the population was over 65; by 2021 that proportion will rise to 18%. The "oldest olds", or people over 85, form the fastest growing segment of the population. The increase in life-span has been accompanied by an increase in "health-span," but a gap persists – aging is still associated with declining physical and mental health. In Ontario 10% of older people suffer from serious mental illness and 25% take at least one psychotropic medication. Dementia prevalence increases dramatically for people over 85, in one study affecting up to 35% of the population. Other mental health issues commonly associated with aging include anxiety and depression.

[7] Toronto Public Health, The Unequal City, Executive Summary, p.1
[8] Closing the Gap in a Generation: Health equity through action on the social determinants of health (WHO, August 2008)

Because of these trends, Canada's health care system will soon experience an unprecedented influx of older adults with mental health, substance use, or gambling problems. Because of the gap between life-span and health-span, most of the older adults with one of these problems will also have various other age-related illnesses complicating treatment. Though mental health, substance use and gambling problems in older adults often go unrecognized, and stigma may prevent older people from seeking help, research has shown that older persons do as well or better than their younger counterparts when treated for depression or substance use problems and that treatment can help slow down general "functional decline" associated with aging.[9] It will be important over the coming years for the health care system and CAMH to develop and enhance ways to recognize, treat, prevent, and raise awareness about mental health, substance use, and gambling issues among older adults.

[9] *Improving our Response to Older Adults with Substance Use, Mental Health and Gambling Problems: A Guide for Supervisors, Managers and Clinical Staff*, CAMH, 2008

2. The Broader Health System

Over the past 20 years there have been a series of initiatives at both federal and provincial levels to reform health care. For the most part, addictions and mental health have not been at the centre of public discourse on Canadian health care. It has been a challenge for CAMH and other mental health and addiction service providers to orient themselves in the changing health care landscape, to ensure that the needs of our clients are reflected in reform efforts, and to ensure that funding remains available for clinical care, research, and health promotion. This section of the report reviews some of these broad changes in the health system; specific changes and initiatives focused on mental health and addictions are reviewed in section 3 of this report.

Progress on Canada's 10-Year Plan to Strengthen Health Care

Five years after the 2003 federal-provincial-territorial Accord on Health Care Renewal and the follow-up 2004 10-Year Plan to Strengthen Health Care, the Health Council of Canada (HCC) in June 2008 released a report studying the progress made. The report, *Rekindling Reform: Health Care Renewal in Canada, 2003-2008*, found that progress had been made by major purchases of medical equipment and information technology, improved waiting list management, access to health information and advice through telephone help lines, and better access to publically insured drugs and some health care services. However, progress was uneven across the country and slow in some areas. The HCC was particularly concerned about the following areas of stalled, slow, or uneven progress:

- Catastrophic drug coverage, planned to be available to all Canadians by the end of 2006, is still unavailable. The National Pharmaceuticals Strategy which was meant to address this and other issues is in limbo.
- Publicly funded short-term home care is available everywhere, but only for two weeks. This is inadequate for many needs and disparities in the availability and cost of home care persist across the country.
- Progress on Aboriginal health has been on a much smaller scale than envisioned and the prevalence of preventable health problems in many Aboriginal communities continues to be a serious concern.
- Progress in primary health care is uneven nationwide and care is often not coordinated, comprehensive, or available when needed.
- Progress implementing electronic health records is too slow.

More national initiatives specifically related to mental health and addictions are described in section 3.

Changes Provincially

The Creation of Local Health Integration Networks

The most significant health policy change in Ontario over the past three years has been the development of 14 Local Health Integration Networks (LHINs). LHINs are the foundation of the government's plan to better integrate health services and strengthen access to services while ensuring the sustainability of health care costs.

The principle underlying the transition to LHINs is that decisions regarding the administration of health care should be made at the local level.

In the spring of 2006, the government of Ontario released draft strategic directions, intended to assist LHINs in their planning activities. The draft strategic directions focused on 5 areas:

- Renewing community engagement and partnerships concerning health care
- Improving the health status of Ontarians
- Ensuring equitable access to health care
- Improving the quality of health outcomes
- Establishing a framework for a sustainable health system.

In the fall of 2006, the LHINs published their first Integrated Health Service Plans (IHSPs). Mental health and addictions were prominent in 13 of the 14 plans. The IHSP of CAMH's LHIN, Toronto Central, listed mental health and addictions as one of four areas of focus.

On April 1st, 2007, the LHINs took on responsibility for planning, funding, and integrating health services in their local areas. Of the total provincial health budget of about $37 billion, $20 billion is administered by LHINs. Of this total, $4 billion is administered by the Toronto Central LHIN, CAMH's primary funder. In the first year of their administrative authority, LHINs negotiated accountability agreements with Ontario's hospitals. In 2008-9, LHINs are developing similar agreements to govern the funding relationship with Community Care Access Centres and community health providers, including community mental health and addiction agencies.

A provincial review of the effectiveness of the transition and the devolution of authority found that it was effective and an overall success, but did identify some outstanding issues related to relationships and trust, clarity of communications, and effectiveness of processes and structures related to transfer of authority between MOHLTC and the LHINs (KPMG, 2008).

The 2008 Provincial Auditor's annual report identified some concerns about the capacity of LHINs to monitor expenditures and track outcomes, particularly the desire to better track waiting times. The report also noted a concern that per capita spending varies significantly across the LHINs.

Some LHIN priorities and initiatives related to mental health and addictions are reviewed in section 3 of this report.

IMPACT OF CHANGE ON THE MINISTRY OF HEALTH AND LONG-TERM CARE (MOHLTC)

The development of the LHINs and their increased operational authority has had a profound effect on the Ministry of Health and Long-Term Care. The Ministry has been restructured to focus less on the delivery of health care and more on the provision of overall direction and leadership for the system. The Ministry describes its new role as ***stewardship***. Regional Ministry offices were closed and new branches of the Ministry were established to support broader strategic functions: Performance Improvement and Compliance, LHIN Liaison, Financial Management, and Reform Implementation.

Overall the sector has supported the transformation despite concerns (based on experience in other jurisdictions) that mental health and addictions services could be overlooked, and has strongly advocated for clear provincial standards and expectations regarding mental health and addictions. Reinforcing these concerns, and as mentioned above, the provincial auditor has expressed doubt as to whether LHINs have the capacity to monitor service quality and capacity.

Since the development of the LHINs, MOHLTC has been working to define and implement its stewardship role. The mental health and addictions sector has been working with them to develop strategy maps articulating general goals for mental health and addictions services and to identify the indicators that will be used to assess them. In addition, as part of its election strategy, in 2007 the government promised to establish a strong mental health and addictions policy direction and is proceeding with the creation of a mental health and addictions strategy.

PROVINCIAL HEALTH PRIORITIES

The Government of Ontario has made improving access to primary care and reducing wait times, especially in emergency rooms, priorities of its plan to improve access to health care. In a November 2008 speech, David Caplan the new Minister of Health identified three related areas of focus:

- chronic disease management, starting with a four-year $741-million investment in prevention, treatment, and management of diabetes;
- e-Health, setting a target of electronic health records for every Ontarian by 2015; and
- mental health and addictions.

All three areas of focus are intended to reduce wait times and inappropriate use of hospitals and rely on or enhance improved access to primary care combined with a broader range of community supports.

In the 2008 Budget the government included some initiatives furthering these priorities:

- expanding the scope of Ontario's Wait Time Strategy to include emergency departments and general surgeries;
- the $1.1 billion four-year Aging at Home strategy launched in 2007, designed to help seniors to live in their homes; and
- the chronic disease prevention and management (CDPM) framework which is in the initial stages of implementation and is discussed more in the next section.

Provincial primary care initiatives include a significant expansion of the community health centres and the creation of 150 Family Health Teams (FHTs). FHTs are intended to provide comprehensive care 24 hours a day and typically consist of a multi-disciplinary team where doctors work alongside nurse practitioners, nurses, and other health professionals. In many cases, this includes mental health and addictions workers.

The connections between these priorities and mental health and addictions services have not yet been fully explored. For example, the 2008 budget included a $180 million commitment to address emergency department overcrowding. The first investments made from this fund made it clear that the funding would not necessarily be directed at emergency departments themselves, but could include a range programs and initiatives intended to provide alternatives to care in emergency

departments. Some of the funding has been allocated to enhance home care and to develop local alternatives to hospital care, intended to let Ontarians, particularly seniors, be cared for at home, consistent with the government's Aging at Home strategy.

In response to a request from MOHLTC, in May 2008 the Partnership of six provincial mental health and addictions organizations including CAMH submitted advice on reducing emergency department wait times. The submission included five recommendations involving alternate crisis response, prevention, discharge, and diversion:

- to develop a comprehensive 24-hour crisis response system in communities throughout Ontario to better respond to mental health and addiction needs;
- to invest in non-medical programs for alcohol and drug crisis management;
- to invest in peer support warm lines;
- to support peer support workers' involvement in discharge planning, to offer support and facilitate transitions from institutional to community care; and
- to invest in community mental health and addiction services that connect directly with hospitals, to facilitate appropriate diversion from emergency rooms and support access to the most appropriate community-based services and supports.

The Ministry has maintained its commitment to constrain hospital budget increases while making investments in community and primary health care. Given the strategic shift away from hospital-based care and the increasing reliance on alternate points of access to the health-care system it is more important than ever for CAMH to continue its efforts to work effectively as part of a broader system to avoid service gaps and ensure quality of care in mental health and addictions. Continuing medical education and mental health and addictions training targeting primary care and community mental health services is one way to do this. Last year, 7600 health professionals participated in CAMH training targeted to build capacity for working with people with mental health and addictions problems.

HEALTH PROMOTION

In 2005 the Government of Ontario created the Ministry of Health Promotion (MHP), with a mandate to "help Ontarians lead healthier lives by delivering programs that promote healthy choices and healthy lifestyles." The Ministry has led the government's anti-tobacco efforts, which have included collaboration with CAMH in research and health promotion in the area of smoking cessation. Working with system partners, CAMH has also urged the Ministry to assume leadership for a comprehensive Ontario drug strategy, but this has not yet emerged as a priority for the government.

Increasingly, for both the Ministries of Health and Health Promotion, the prevention and management of chronic disease is a framework for focusing the government's health promotion activities. Chronic disease is a significant driver of health care costs, and the management and prevention of chronic disease is a priority for the government. The province's chronic disease prevention and management (CDPM) framework developed by MOHLTC and the MHP is in the initial stages of implementation across the province. A major early initiative under the framework

was the July 2008 announcement of a four-year, $741 million diabetes strategy that includes improved online resources for self-care and increased access to diabetes supplies and equipment.

There is some indication that the province intends to address some mental health issues in a chronic disease framework: in its research developing the CDPM it included depression as one of the top 10 chronic conditions in terms of burden of disease costs in Ontario. This is not without controversy, as some in the mental health system , contend that treating mental illnesses in the same way as chronic diseases is problematic. In a discussion paper prepared in August 2008, CMHA Ontario stated: "Serious mental illnesses are not preventable in the same way as chronic physical conditions, but there are strategies known to promote mental health and reduce the risk of mental illnesses. It is possible that serious mental illnesses may benefit from a CDPM approach, but there is little available research and writing on this topic. Consideration must also be given to whether the recovery approach, as well as the services and supports that are already in place to support people with serious mental illnesses, fit within a CDPM framework." Ultimately, the paper did suggest that a CDPM approach may be useful in integrating physical care and mental health care by improving the physical health of people with serious mental illnesses, and screening and managing depression in people with chronic physical conditions.[10]

CAMH believes that health promotion efforts should be integrated into hospital care. One concept that combines health services and health promotion and has been gaining traction recently in Ontario is the Health Promoting Hospital (HPH) model. The model was developed by the World Health Organization (WHO) and has become a global movement with over 660 hospitals in the international HPH network. The Ontario Hospital Association (OHA) has embraced the concept with the support of Accreditation Canada and plans to connect with the LHINs later this year.

In March 2008, the Toronto Central Health Promoting Hospital Network became the first official HPH network in Ontario and the second in Canada. It followed lessons learned from the Montreal HPH Network and evolved out of the Ontario Hospital Health Promotion Network. The HPH approach fits very well with the traditional mandates and strengths of CAMH in moving beyond diagnosis and care to health promotion within the hospital and in the community. Though adopting the concept does not involve significant change for CAMH, its wider adoption is an opportunity for CAMH to take on a leadership role in the province. CAMH is a member of both the international HPH network and the Toronto Central HPH network.

Social Determinants of Health and Ontario's Poverty Reduction Strategy

Ontario's Poverty Reduction Strategy

Adequate income is widely recognized as one of the most important social determinants of health. The Government of Ontario released a comprehensive plan to reduce the rate of family poverty, *Breaking the Cycle – Ontario's Poverty Reduction Strategy*, in December 2008. A cabinet committee has been established to

[10] *What is the Fit Between Mental Health, Mental Illness and Ontario's Approach to Chronic Disease Prevention and Management?* CMHA, August 2008.
http://www.ontario.cmha.ca/backgrounders.asp?cID=25745

develop poverty indicators and targets, with a focused strategy for reducing child poverty and lifting more families out of poverty over the course of the government's four-year mandate. A target of reducing the number of children living in poverty by 25 percent over 5 years has been set. Legislation requiring the government to report on key indicators, such as income levels, school success, health care and housing, is expected in spring 2009.

One of the government's tangible steps toward poverty reduction was implemented in July 2008, with the first Ontario Child Benefit payments to low-income families. Families with an annual income of $20,000 or less will receive the full benefit for each child, while families earning more may also be eligible based on the number of children under 18 and the family net income. These payments are not linked to social assistance payments, so that parents may move from social assistance to the workforce without losing the benefit. In 2008, the government also announced a new program to provide basic dental services to children in low income families.

The initial stages of the poverty reduction strategy, described in December 2008, are likely to have a positive effect on low income people with mental health and addictions problems. But the poverty reduction strategy itself may not include extra support for mental health and addictions initiatives. For example, the strategy's report *Breaking the Cycle* said: "Under the Poverty Reduction Strategy, some funding from the government's Mental Health and Addictions Strategy will be re-profiled to provide a direct component for low-income youth and adults with severe mental illness and/or substance addictions." The strategy has also been criticized by some for its initial exclusive focus on children and families with children, at the expense of low income singles and couples without children.

Social Assistance

As part of the anti-poverty strategy, the government indicated that it will be undertaking "a review of social assistance with the goal of removing barriers and increasing opportunity – with a particular focus on people trying to move into employment from social assistance." In the years preceding the adoption of this new anti-poverty strategy, some enhancements were made to the ODSP provisions for employment supports. In addition, the mechanisms for funding employment support agencies was changed - from funding agencies based on their activities to funding based on outcomes. Some people with mental illnesses and addictions may need extra supports or extended timelines to move successfully into employment. There is concern that the new method of funding agencies only on the basis of their successful placements may not always accommodate reasonable timelines for people who have experienced severe mental health and addictions problems.

In 1997, regulatory changes were made to exclude addictions from constituting a disability, for the purposes of assessing eligibility for ODSP. (People with an addiction and another disabling condition, such as mental illness, may be eligible.) This exclusion has been the subject of a legal challenge. In the April 2006 *Webeski and Tranchemontagne vs ODSP* ruling, the Supreme Court of Canada found that the Ontario Social Benefits Tribunal must consider human rights regulations. The effect of this ruling could be to nullify the exclusion of addiction as a potential cause for disability although the provincial government is currently appealing the Social Assistance Tribunal decision. (The Supreme Court ruled only on the question of jurisdiction.) This is an important issue because many CAMH clients rely on the

ODSP, and more than 30% of the provincial caseload are people whose primary disability is mental illness.

Since CAMH's last strategic plan was adopted, ODSP rates increased by 2% in 2007 and an additional 2% in 2008, but these increases are considered inadequate by many, especially in regions like the GTA where the cost of living and housing is high.

ECONOMIC OUTLOOK

Health care costs continue to escalate; in 2008-9, the health sector accounted for $40.5 billion or 46% of government program spending in Ontario. Increasing costs for physicians, nurses and drugs, to name a few, continue to negatively impact on hospital budgets, with approved funding consistently inadequate to cover inflation on basic costs. In November 2008, MOHLTC officials notified the TC LHIN about a substantial Stabilization Grant for CAMH, to be added to the funding base and intended to cover the costs of "better planning for the delivery of services". No additional information about this grant has yet been confirmed, but it appears that this funding is being targeted to specialty mental health and addictions facilities.

As a means of maintaining, if not reducing health care costs, the government is trying to reorient the ways in which health care services are delivered and used. There is a greater emphasis on building the capacity of the primary care sector, as an entry point to the system, and on reducing the use of hospitals, expect for those services that cannot reasonably be provided elsewhere.

Despite this shifting emphasis towards care in the community, there is some concern that community health and social service spending in some regions has not kept pace with needs. Annual studies conducted by the Strong Communities Coalition since 2006 have shown a widening and substantial per capita funding gap between high growth communities, the GTA/905 region in particular, and the rest of Ontario. This creates pressures for CAMH, in two ways: as a hospital with a constrained budget and as an agency in a high growth community, with a mandate to build capacity and enhance services.

Meanwhile, Ontario has been hit hard by the global economic downturn. The government's economic outlook statement released in October forecasted a new $500 million deficit for 2008-9 and committed to delaying some health expenditures including the opening of 50 new Family Health Teams and expected nurse hirings. The government also indicated that transfer payments would not increase in 2009-10 to the extent predicted in the 2008 Budget.

The broad social effects of the economic downturn are likely to lead to an increased demand for heath and social services, including mental health and addiction services. Recent research conducted at CAMH on behalf of the WHO has established a strong link between poor mental health and precarious employment. Such precarious employment as temporary contracts or part-time work has been increasing faster than full-time work[11].

[11]http://www.camh.net/News_events/News_releases_and_media_advisories_and_backgrounders/WHO_work_report_muntaner.html]

ACCOUNTABILITY AND TRANSPARENCY

Over the past ten years, increased public funding for health care has been accompanied by demands for increased accountability. Facilitated in part by the Internet, governments and citizens have established higher expectations for reporting on quality of care and health outcomes.

ACCOUNTABILITY AGREEMENTS

Accountability has been implemented through service accountability agreements, contracts that identify the responsibilities of different parties and set out specific performance indicators and targets related to finances, organization, and quality of care. The first such agreements appeared in 2005 and currently exist between the MOHLTC and LHINs, and between LHINs and hospitals. The Ontario Joint Policy and Planning Committee, a partnership between the MOHLTC, the OHA, and the 14 LHINs, finalized the 2008-2010 Hospital Service Accountability Agreements in January 2008.[12]

New agreements are being developed between LHINs and other organizations, such as community care access centres, community health centres, long-term care and other community service providers. These agreements are currently being negotiated, and are expected to be in place by March 31, 2009.

HEALTH BASED ALLOCATION MODEL (HBAM)

As part of the transition to LHINs, the MOHLTC is developing the Health Based Allocation Model (HBAM) to allocate funding to LHINs. The HBAM is meant to ensure equitable access and equitable funding across the province by tying funding levels to service utilization within each health sector (for example, hospital, long-term care, community care access centres, community supports, community mental health.)

Because it is primarily based on utilization, HBAM may not adequately deal with unmet need and may create disincentives to reducing inappropriate utilization of institutions. HBAM has also been criticized for its use of only one socio-economic indicator, income quintile, which may not adequately represent the reality of service costs for certain populations.[13] A mental-health and addictions sector response to HBAM prepared by the Partnership in January 2008 raised the following concerns: [14]

- HBAM must be aligned with Ministry directions for mental health reform and addiction services. For example, HBAM did not explicitly identify addiction treatment services, peer support, nor consumer/survivor initiatives; these important services are subsumed under the umbrella of mental health.
- HBAM's proposed approach for constructing electronic health profiles and assigning clinical groups is not a valid indicator of utilization of mental health and addiction services. Mental health and addictions issues are less likely to

[12] *Accountability Agreements in Ontario's Health System: How can they accelerate quality improvement and enhance public reporting?* JPPC, OHQC, July 2008

[13] *Health Equity and Ontario's Health Based Allocation Model,* Michael M. Rachlis, Wellesley Institute, February 2008

[14] *Brief to the Ministry of Health and Long-Term Care on the proposed Health Based Allocation Model (HBAM) Funding Formula for LHINs with respect to the Mental Health & Addictions Sector,* "The Partnership", January 2008

be disclosed by patients, and recognized and recorded by health providers. People with mental health and addictions needs are often unable to access OHIP-based services and people using community health centres and other capitation models may not be counted.

- HBAM may not adequately address issues of equity or recognize the needs the most disadvantaged who may experience barriers to accessing health care. HBAM must adequately fund community-based mental health and addictions services, which are designed to reach out to these populations.
- HBAM must incorporate existing utilization data from community mental health and addictions services and supports, which use unique client classifications not based on medical model diagnoses. The community mental health sector uses the 'Common Data Set – Mental Health' and Management Information System reporting (CDS / MIS). Similarly, addiction services submit data to the Drug and Alcohol Treatment Information System (DATIS).
- HBAM may need to make allowances for increased funding for community-based services.
- HBAM's focus on utilization does not address unmet need. That the current funding for LHINs for community mental health varies widely per capita suggests that unmet need is widespread.

PATIENT SAFETY

The past three years have seen an increasing and major emphasis on patient safety and maintaining a patient safety culture:

- In 2008 renewed funding of up to $8 million a year over the next five years was announced for the Canadian Patient Safety Institute to support its programs and services.

- Between September 2008 and April 2009, MOHLTC's Ontario Patient Safety Initiative is instituting mandatory reporting on 8 indicators of patient safety in hospitals including several types of infectious diseases.

- Greater attention is being paid to pandemic planning since the 2003 SARS outbreak. The Canadian Pandemic Influenza Plan for the Health Sector was last updated in 2006 and the Ontario Health Plan for an Influenza Pandemic continues to be updated annually.

- Accreditation Canada (formerly the Canadian Council on Health Services Accreditation, CCHSA) is moving to a new system of stringent requirements for all hospitals. The new requirements involve continuous quality improvement and accreditation will be dependent on having "required organizational practices" (ROPs) in place designed to promote patient safety. 25 ROPs were required in January 2008 and another 6 will be required starting January 2009. The ROPs cover the areas of culture, communication, medication use, worklife, workforce, infection control, falls prevention, and risk assessment.

This increased focus on patient safety has resulted in considerable activity at CAMH as the organization proactively addresses patient safety.

EXPECTATIONS OF CLIENTS AND FAMILIES

CLIENT AND FAMILY-CENTRED CARE

Hospital care continues to place an emphasis on client choice, empowerment, and client and family-centered care, which views patients and families as partners in the care process. Principles in client and family-centred care include: treating clients and families with dignity and respect, sharing information with clients and families, enabling client and family participation and collaboration in care decisions. The CAMH Empowerment Council (Client Council) and the CAMH Family Council ensure that there is a structured voice for clients and family members at CAMH. The CAMH Bill of Client Rights was developed by the councils and staff in 2004 to assert and promote the dignity and worth of all of the people who use the services of CAMH.

These broader trends are especially relevant in the mental health and addictions sector. For example, "Out of the Shadows at Last", the final report prepared by the Kirby Commission, it was recommended that "family-based treatment of mental illness be integrated into the curriculum of mental health professionals and primary care physicians" and that "evidence-based family therapies be employed so that all family members are provided the assistance they need."

CAMH's Family-Centered Care Initiative aims to improve the care and support that CAMH provides to family members and to work with families to improve the quality of life of clients by involving families in client care, developing and enhancing professional services for families, and supporting families in helping each other.

HEALTH LITERACY, SELF-HELP, AND CONSUMER ADVOCACY

High expectations of clients and families have been accompanied by increasing health literacy in the population. There has been an increasing interest in online self-diagnosis tools in both the broader health field and the mental health and addictions fields. CAMH has been involved in the development of some of these tools allowing self-assessment of substance use and addictive behaviour. More broadly, consumer initiatives including self-help, peer support, and consumer advocacy are becoming more common. In the mental health and addictions fields, they are viewed as playing a role in enabling people's transition from formal mental health services back into the community. It is important that mechanisms for consumer decision-making, choice and participation are protected.

RESEARCH FUNDING

Hospitals account for more than 80 per cent of the publically funded healthcare research in Canada. CAMH is the leading mental health and addiction research facility in the country with clinical, neuroscience, and social prevention and health policy research departments, as well as a PET research centre. CAMH remains focused on research with a human impact. Some projects showing the breadth of CAMH since 2006 include:

- Genetic research to minimize the side-effects of antidepressant and antipsychotic drugs

- The discovery of epigenetic changes in people with mental illness
- Several studies of smoking treatment, including nicotine replacement, genetic variation, and the role of family physicians
- Understanding the links between stress, mental illness, physical conditions, and the ability to work
- Canada's longest-running school survey of youth substance abuse, the Ontario Student Drug Use and Health Survey
- PET studies of postpartum depression
- Understanding the context of bisexual mental health
- Evaluating the effects of recent changes in the community mental health system

In addition to research, CAMH plays an important role in research training for graduate students and fellows, and CAMH's Technology Transfer Office enables discoveries to be translated into real-world applications that benefit the public.

In 2007-8, 50% of CAMH's total $38.7 million research funding came from federal sources, 19% from provincial sources, 23% from US sources, and 7% from industry. Currently, the top 5 granting agencies in order of contribution levels are:

- Canada Foundation for Innovation (CFI)
- Canadian Institutes of Health Research (CIHR)
- National Institutes of Health (NIH)
- Ontario Mental Health Foundation (OMHF)
- Ontario Problem Gambling Research Centre (OPGRC)

CIHR-INMHA

The Canadian Institutes of Health Research's (CIHR) is one of CAMH's major funders. The agency's budget has increased by 18% to $963M in the three years since 2005/6, including increases both to grant budgets (80% of the budget) and to Canada Research Chairs (11% of the budget).[15] Mental health and addictions research funding comes through CIHR's Institute of Neurosciences, Mental Health, and Addictions (INMHA). In 2005-2006, approximately 90% of INMHA funding went to open (investigator-initiated) funding through the operating grant competitions, with 10% allocated to strategic initiatives.[16]

INMHA's 2007-2011 Strategic Plan includes a commitment to continue to support the four strategic research initiatives established in the first strategic plan: Addiction and Cross-Addiction; Regenerative Medicine and Nanomedicine; Early Life Events and First Episodes in Brain Disorders; Co-morbidity and Co-occurrence of Brain Disorders with other Health Problems, each receiving 10% of future strategic budgets. In addition to these strategic research initiatives, INMHA pledged to allocate 25% of future strategic budgets to Strategic Training in Health Research (STIHR) projects designed to help train and develop Canada's health research community. Bridging funding for promising research projects that fail to win competitions will represent 10% of strategic budgets. The other strategic priorities of the plan are to promote effective knowledge translation of research findings (10% of strategic budgets); to pursue creative partnerships with NGOs, VHOs, and government agencies; and to encourage international collaboration and training (7-10% of strategic budgets). The

[15] Current Budget – CIHR – March 2008. http://www.cihr-irsc.gc.ca/e/22953.html
[16] INMHA 2007-11 Strategic Plan. http://www.cihr-irsc.gc.ca/e/34306.html

strategic plan also identified several emerging topics for strategic research, most prominently mental health in the workplace, psychiatric epigenomics, and sensory disorders.

CANADA FOUNDATION FOR INNOVATION

The Canada Foundation for Innovation, unlike the CIHR, funds research infrastructure. In August 2008 CAMH received a grant of $15 million from the Canada Foundation for Innovation, the largest single grant in CAMH's history. As part of a $38 million project, the grant will be spread among six research themes: Schizophrenia, Mood Disorders, Addictions, Community Health & Knowledge Exchange, Neuroimaging, Pharmacogenetics and Neuroscience. With the additional financial support coming from donors through the CAMH Foundation, the project will address key issues such as:

- Optimizing treatment across mental illness and substance use disorders, including the development of individualized treatment based on molecular genetics
- Translating discoveries into improved clinical practice, prevention and intervention strategies
- Reaching out to underserved and understudied communities such as First Nations, remote populations, the workplace, women, the elderly, and children.

FUNDING ENVIRONMENT TRENDS

CAMH remains successful at attracting funding for research but is operating in a constrained funding environment. Despite the CFI success and the Canada Research Chairs program, it remains difficult in general to attract core funding for research. In recent years there has been a recognition that CAMH can look for international funding sources that provide core funding with grants. CAMH has been successful in recruiting staff from the US, Britain, and Europe who have brought grants with core funding with them. If attracting core funding from Canadian sources remains challenging, CAMH should expect to increase dependence on international funding sources. In addition, as US funding for science increases, Canadian researchers may be attracted by opportunities south of the border.

The federal government developed a new Science and Technology Strategy in 2007. This strategy has identified four research priorities for Canada one of which is health and related life sciences. The sub-priorities for this area include regenerative medicine; neuroscience; health in an aging population; biomedical engineering and medical technologies. CAMH researchers are working in a number of these key areas.

Another change in the funding environment has been the increasing emphasis on knowledge translation (KT) as a central aspect of research. Knowledge translation involves the active exchange of information between researches and those that benefit from their research, for example translating research findings into strategies or guidelines for treatment. Partnerships are a central vehicle for integrating KT into research. Funders such as CIHR have expanded programs that involve partnerships in research and the incorporation of decision-makers into research endeavours.

WORKFORCE PLANNING

The healthcare workforce continues to age overall. Physicians had an average age of 49.6 in 2007 compared to 48.3 in 2003; regulated nurses had an average age of 46.2 in 2007 compared to 44.5 in 2003. Over 55% of nurses are between 43 and 61. The proportion of women physicians is increasing; 56% of female family physicians are younger than 40 compared to 16% over 60. Registered nurses and licensed practical nurses are 94% and 93% women, a proportion which has remained relatively unchanged since 2003. Women who are regulated nurses are more likely to work part time than men; 32% of women reported part-time status compared to 19% of men. Only 57% of registered nurses work full-time; 34% are part-time and 11% are casually employed. In 2007, 22% of physicians and 7% of regulated nurses in Canada were internationally trained.

The number of physicians in Canada has increased by 7.1% between 2003 and 2007, faster than overall population growth; the ratio of physicians to 100,000 Canadians increased from 187 to 192. This national increase has not been reflected in Ontario. Over the same period the physician-to-population ratio in Ontario remained below the national average, unchanged at 176 per 100,000; the ratio for family medicine physicians increased slightly from 84 to 85 and the ratio for specialists declined slightly from 92 to 91. The number of working registered nurses (RNs) in Canada has increased since 2002 but stayed relatively steady since 2005 at about 782 RNs per 100,000 Canadians. The number of working licensed practical nurses (LPNs) has increased nearly 10% since 2003 to about 211 LPNs per 100,000 Canadians.

Research from November 2008 confirms that 4.6 million Canadians still do not have a family doctor. The College of Family Physicians of Canada (CFPC) has been calling since 2007 for collaborative efforts to ensure that 95% of residents in each community have a family doctor by 2012. The CFPC issued a report card in November 2008 that criticized the lack of a pan-Canadian health human resources plan in Canada, but acknowledged progress in supporting medical students and residents to receive family medicine training and an increase in spots for medical students. Challenges identified in the report card include: the growing demand for family doctors to provide more complex care for an ageing population; the changing patterns of practice in all specialties resulting in a demand for family doctors to focus a greater amount of time on patients whose needs were previously met by other specialists; increasing student debt load combined with a growing gap in incomes between family doctors and other specialists; and, increased urbanization luring family doctors away from rural Canada.

The difficulty many Canadians face finding a family physician is a challenge for approaches to addictions and mental health care that rely on family physicians for early intervention and to provide broader access to mental health and addictions services. Above and beyond the workforce challenges in the broader health field, mental health and addictions services faces challenges attracting staff due, perhaps, to the stigma that has so long been associated with this field. Programs aimed at building the capacity of medical professionals, particularly family physicians and nurses, to deal with mental health and addictions issues may be one important way of dealing with expected staffing shortages.

3. MENTAL HEALTH AND ADDICTIONS

Comprehensive and current data on mental health and addictions prevalence is not readily available and there are many information gaps. The most recent large-scale national survey on general mental health was the 2003 Canadian Community Health Survey (CCHS): Mental Health and Well-being Supplement.

Despite a lack of data, general public awareness of mental health and addictions continues to increase, accompanied by a continued focus on mental health and addictions issues in the media. In addition, public awareness campaigns like CAMH's own successful Transforming Lives campaign generate increased interest and attention.

National changes since the last environmental scan include the establishment of the Mental Health Commission of Canada, a significant re-orientation of the National Anti-Drug Strategy and continuing progress on the National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada. There is a general sense that the increased discussion related to these national initiatives is increasing awareness of mental health and addictions issues and has been leading more people to seek treatment.

Provincially, of great potential significance is the government's commitment to developing a comprehensive mental health and addictions strategy. The largest structural change in the provincial health landscape over the past three years has been the regionalization of the provincial health system through the development of LHINs; some of their early activities managing mental health and addictions will be reviewed in this section. Other structural changes have been the completion of divestment, changes to the forensic system, and the ongoing shift in emphasis to community mental health and addictions treatment. Children and youth mental health is receiving more attention, particularly in the area of youth violence, and a framework on child and youth mental health has been developed.

PREVALENCE, COSTS, AND SERVICE STATISTICS

MENTAL HEALTH

One in five Canadians will experience a mental illness in their lifetime and the remaining four will have a friend, family member or colleague who will - 12% suffer mild to severe impairment from anxiety disorder, 8% are affected by major depression, and 1% are affected by schizophrenia. A 1993 study by Health Canada estimated the annual economic impact of mental health problems as $7.3 billion. A 1996/7 study estimated the cost at $14.4 billion. Estimating costs is difficult but both authors believed their figures to be underestimates due to data limitations.[17] According to a study released by the Centre for Addiction and Mental Health in 2006, the estimated total economic cost attributable to mental illness and substance abuse was about $33.9 billion per year in Ontario; approximately 85% ($28.7 billion) is due to productivity losses and the remaining ($5.1 billion) is related to direct costs, such as hospitalization, community mental health and substance use programs, law

[17] *A Report on Mental Illness in Canada,* Health Canada, 2002

enforcement, research and education.[18] Of this $5.1 billion, the direct costs of mental disorders was $2.1 billion, while that of substance abuse was higher at $3 billion, with higher costs of law enforcement for substance abuse accounting for the substantial difference. The direct cost of alcohol abuse was the highest of any diagnostic group at $1.5 billion. For mental disorders, the highest direct cost was for severe mental disorders at $641 million.

With the Ontario population aging rapidly, the impact of dementia (includes Alzheimers) on health and economy has also been studied[19]. Current socio-economic costs of dementia to Ontario are $7 billion per year. Dementia is the leading cause of disability in Ontario's over 60 population and results in more years living with disability than stroke, cardiovascular disorders and all forms of cancer. There are currently more than 160,000 people living with dementia in the province and this figure is projected to more than double by 2031.

Hospitalization rates for mental illness have stayed roughly the same between 2000-2001 and 2005-2006 but length of stay has decreased to a historic low. In 2005–2006 patients diagnosed with mental illness represented 6% of all general hospitalizations in Canada, but 13% of all inpatient days. The average length of stay for patients diagnosed with mental illness in general hospitals decreased in 2005 to 16 from 36 days in 2000-2001 and in psychiatric hospitals from 160 to 100 days. [20]

GAMING AND GAMBLING

About 83% of adults in Ontario participate in some form of legalized gambling; the most common form being lotteries (64%).[21] Prevalence studies suggest that between 2% and 4.8% of adults in Ontario are moderate to severe problem gamblers, though some have suggested that only 0.8% have serious problems and 3.9% are at moderate to high risk of becoming problem gamblers.[22]

DRUG USE

Alcohol and tobacco remain the most commonly used drugs with the highest overall impact. Ontario adult drug use data from 2005 shows that 80% had used alcohol in the past year; 20% had used tobacco; 14% had used cannabis, and 2% had used cocaine. Risk-level alcohol consumption among adults in 2003-2005 was significantly higher for men than for women. Substance dependence among Ontario adults for alcohol was 6% according to a CAMH study in 2005; for Cannabis it was 1.2% according to an ARF study in 1994 but has probably increased. Adult tobacco

[18] The Economic Costs of Mental Disorders and Alcohol, Tobacco, and Illicit Drug Abuse in Ontario, 2000: A Cost of Illness Study, W. Gnam, A. Sarnocinska-Hart, C. Mustard, B. Rush, E. Lin, October 2006

[19] It's Time to Act, Ontario's Dementia Imperative

[20] Canadian Institute for Health Information: Hospital Mental Health Services in Canada, 2005–2006, 2008 and 2004-2005, 2007. Also http://www.cbc.ca/health/story/2008/08/19/mental-hospital.html.

[21] *Review Of The Problem-Gambling And Responsible-Gaming Strategy Of The Government Of Ontario*, Stanley Sadinsky, for the MOHLTC and Ministry of Economic Development and Trade, March 2005

[22] Sadinsky 2005; 2008 Provincial Auditor's report, Chapter 3.01 – Addictions Programs

dependence is probably between 7.2 and 16.9%.[23] The 2003 CCHS survey noted above found that one out of every 10 Canadians aged 15 and over – about 2.6 million people – reported symptoms consistent with alcohol or illicit drug dependence, and 8% of youth between the ages of 15 and 24 reported being affected by an alcohol or illicit drug dependency.

The 2006 study of the economic costs of drug abuse in Ontario in 2002 found that tobacco and alcohol combined accounted for almost 80% of the $14.3 billion cost in 2002, with the cost split roughly evenly between them. The total economic cost of tobacco use in Ontario was nearly $6.1-billion, including $1.6-billion in direct health care costs.[24] In the same year, 1.3 million or 17.8% percent of all hospital days were related to alcohol, tobacco, and illegal drugs. Smoking and alcohol again dominate; 58.8% of the days were related to smoking, 33.1% to alcohol, and 8.1% to illegal drugs. Of 407,500 alcohol and drug offences in Ontario in 2002, forming 53% of all offences, 58.1% were related to alcohol and 41.9% were related to illegal drugs. 15,253 or 19% of all deaths in Ontario in 2002, were drug-related. Of them 87% were related to tobacco, 9% were related to alcohol, and 4% were related to illegal drugs.[25]

SERVICE UTILIZATION STATISTICS

According to the 2003 Canadian Community Health Survey referenced above, only one third of Canadians experiencing feelings and symptoms consistent with a surveyed mental disorder or substance dependence sought help from a health care professional. About 21% of individuals with any of the surveyed mental disorders or substance dependencies reported feeling they needed help for their emotions, mental health or use of alcohol or drugs, but did not receive it during the 12 months prior to the interview. Thus, service utilization statistics are not a reliable indicator of prevalence of mental health or addictions problems, but they may be an important tool to track the disparity between prevalence and treatment.

At present, provincial service statistics for community mental health and addictions services are unreliable, but the Ministry is working with LHINs to improve data collection and reporting. According to the 2008 auditor's report, the Ministry plans to collaborate with ConnexOntario to establish provincial wait-time statistics for community mental health services.

The Ministry requires addiction services to report to ConnexOntario on service availability, but the auditor's report found that more than three-quarters failed to do so. The Ministry also funds and maintains other information systems to capture different types of data relating to addictions in Ontario, including the Management Information System (MIS) and the Drug and Alcohol Treatment Information System (DATIS), operated by CAMH. The provincial auditor's report identified inconsistencies and inaccuracies in the data reported by addictions service providers using these systems.

The Ministry estimates suggest that treatment rates are especially low for substance abuse problems (7%) and problem-gambling (3%). For example, the Ministry of Health estimated that in 2006/7 about 193,000 people were in need of problem-

[23] Powerpoint stuff
[24] Cancer Care Ontario Tobacco Facts
[25] Rhem et. al. *The Costs of Substance Abuse in Canada in 2002,* Canadian Centre on Substance Abuse

gambling treatment. However, in 2006/7 Ontario's addiction service providers treated only an estimated 5,900 problem gamblers, and the number of calls made to the province's help-line was very low. The Ministry is continuing to work with ConnexOntario and the Ministry of Health Promotion on strategies to improve awareness of problem-gambling treatment programs, to refer callers to these programs, and to provide resource materials to callers that may assist a person in making a decision to seek help. [26]

STUDENTS AND YOUTH

Good data is available for students in Ontario, more so than for the population as a whole. This is due to CAMH's Ontario Student Drug Use and Health Survey (OSDUHS). The survey studies Ontario students in grades 7 to 12 and is the longest-running study of its kind in Canada.

The 2007 OSDUHS found that more youth are seeking treatment for mental health and addictions issues, reflecting an increased awareness of these issues and the available services. The survey found that 21% of all students reported at least one visit to a mental health professional during the 12 months before the survey; between 1999 and 2005 the rate remained steady at about 12%.

Other indicators are new or remained stable overall. About 11% of students reported poor mental health; females are more likely to report poor mental health than males. Elevated psychological distress is reported by 31% of students; females are significantly more likely to report these symptoms and have reported a significant short-term increase since 1999. About 10% of students reported that they had seriously considered suicide during the past year and 3% of students reported attempting suicide. Females are more likely to report contemplating and attempting suicide than males. 29% of students reported gambling money on cards in the past year and about 2% of students may have a gambling problem.

The 2007 OSDUHS found that despite overall use of drugs remaining stable or decreasing, the misuse of prescription opioids and the increasing prevalence of binge drinking are causes for concern. Alcohol was the most used drug by students with 61% reporting use in the past year. Binge drinking was reported by 26% of students. Cannabis was the second highest drug used, with 26% reporting past year use. Significantly, opioid pain relievers were used by 21% of students; 72% of them obtained their opioids from home. (2007 was the first year that non-medicinal use of opioids was studied by the survey.) Tobacco was used by only 12% of students. 4.9% of students in 2007 reported having at least one alcohol-related problem with the police and 2.6% reported an illegal drug-related problem. 1.7% reported a problem requiring medical care related to alcohol and 0.8% reported one related to illegal drugs.

[26] 2008 Provincial Auditor's report, Chapter 3.01 – Addictions Programs

NATIONAL MENTAL HEALTH AND ADDICTIONS INITIATIVES

MENTAL HEALTH COMMISSION OF CANADA

A major leap forward in national mental health research and advocacy was the August 2007 announcement by Prime Minister Harper of the new Mental Health Commission of Canada (MHCC). The Commission is led by former Senator and mental health champion Michael Kirby, with David Goldbloom of CAMH serving as deputy chair. Three priorities were identified for urgent attention by the Commission:

- the development of a mental health strategy for Canada,
- a multi-year plan to address the stigma and discrimination directed at those with mental health problems, and
- a mental health knowledge exchange network.

The Commission currently has eight advisory committees (Child and Youth; Mental Health and the Law; Seniors; First Nations, Inuit and Métis; Workforce; Family Caregivers; Service Systems; Science) working on 24 projects.

In the federal budget the Commission was given responsibility for directing a multi-site five-year $110 million homelessness research demonstration project. In Toronto, the project will also pay particular attention to address the needs of homeless people from immigrant and ethno-racial minority communities.

In November 2008, the Canadian Psychiatric Research Foundation joined forces with the Mental Health Partnerships of Canada (MHPC) to create a new national mental health charity. MHPC will support the goals of the MHCC by expanding fundraising activities and developing leading research and demonstration projects in the field of mental health, mental illness and brain injury.

NATIONAL ANTI-DRUG STRATEGY

The federal government has developed a drug strategy that is distinct in several respects from the approach of previous governments. The leadership role of Health Canada has been diminished, with increased funding and responsibility given to the Ministries of Justice and Public Safety Canada. The government's National Anti-Drug Strategy focuses exclusively on illicit drugs, rather than on the range of substances (i.e. alcohol) responsible for drug-related harms. As a result, the government's drug policy has included changes to criminal law that increase the penalties associated with drug possession and trafficking.

The federal government has also adopted a *three*-pillar approach that includes prevention, treatment, and enforcement. Harm reduction is no longer a pillar of the strategy, and the federal government has expressed its opposition to the continued operation of Insite, the supervised injection site in Vancouver. The expected closing of Insite was disrupted by a judicial ruling in May 2008 that nullified sections of the *Controlled Drugs and Substances Act*; the Government of Canada is currently appealing this ruling.

The new federal strategy offers little for projects aimed at reducing the harmful impact of legal drugs such as alcohol or legal – but misused – prescription drugs. It is also contrary to CAMH's support of harm reduction as a pillar of strategies for

dealing with illicit drugs, a strategy that is supported by public health research in a broad range of jurisdictions.

National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada

Health Canada (HC) and the Canadian Centre on Substance Abuse (CCSA) has provided leadership in the development of a National Framework for Action on Substance Use and Abuse in Canada, the first edition of which was released in 2006 after cross-Canada consultations in 2004-2005. Partners in the development of the framework include: the federal government, provincial and territorial departments and agencies, municipalities, non-governmental organizations, Aboriginal communities, communities of interest, and the private sector and it has been endorsed by 44 partners. The second National Framework Forum was held in May 2008. Forum participants reaffirmed the importance of the framework for framing the context and responses to problematic substance use in Canada and for defining vision, principles, goals and priorities related to reducing the harms associated with alcohol and other drugs and substances. Forum participants also reviewed progress, identified next steps and continuing and emerging priorities.

Two working groups supported by the National Framework have released strategies: the National Alcohol Strategy (NAS) developed by the National Alcohol Strategy Working Group (April 2007) and the National Treatment Strategy (NTS) developed by the National Treatment Strategy Working Group (November 2008).

National Treatment Strategy (NTS)

Work on the NTS was initiated and supported by CAMH, the British Columbia Mental Health and Addiction Services (BCMHAS), and the Canadian Centre on Substance Abuse (CCSA). Its November 2008 report, *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy*, proposed a system based on a flexible, tiered model of services and supports that matches intensity of treatment to the intensity of the addiction problem. Lower-tier services, such as out-patient programs, are broadly available at the community level, while higher-tiered and more costly services, such as intensive residential programs, would come from more specialized groups. The report emphasized the key role of primary care providers in identifying and providing initial interventions for people with substance use problems. It also pointed to the importance of early identification and intervention as a key to better outcomes. To facilitate cooperation between organizations the report recommends the development of a knowledge exchange system to support communication and adoption of best practices. The report also recommends the development of national treatment indicators to provide overviews of the availability of services, effectiveness of treatment, and cost-effectiveness. Finally, the report recommends efforts to address stigma and discrimination and increased support for research on addiction issues.

National Alcohol Strategy (NAS)

The NAS was initiated and supported by the Health Canada, the CCSA, and the

Alberta Alcohol and Drug Abuse Commission. The NAS identified four strategic areas for action:

- *Health promotion prevention and education* aims to raise public awareness about responsible alcohol use and create a culture of moderation, including the development of national alcohol use guidelines.
- *Health impacts and treatment* aims to reduce the negative health impacts of alcohol consumption including injury and chronic disease by expanding early intervention and specialist treatment options and services.
- *Availability of alcohol* aims to implement and enforce measures to control alcohol availability, including expanding mandates of liquor control boards, reinforcing regulations, and considering taxation, pricing, and advertising policies.
- *Safer Communities* aims to minimize harms related to intoxication by fostering a culture of moderation and looking at the social contexts in which harmful drinking occurs.

The NAS was endorsed by the CAMH Board in 2007.

POPULATION MENTAL HEALTH RESEARCH

The Canadian Institute for Health Information (CIHI) has identified population mental health as one of its research priorities. CIHI's Canadian Population Health Initiative (CPHI) has identified "Mental Health and Resilience" as one of its four areas of focus for 2007-2010. Recent CIHI/CPHI reports on "Improving the Health of Canadians" have studied mental health among people who are homeless, youth and adults involved in the criminal justice system, and the links between youth delinquency and mental health. The third and final report on "Improving the Health of Canadians" is scheduled for release by the CPHI in February 2009, and will look at the concept of positive mental health. In parallel to these studies, CPHI has commissioned a collection of papers on "mentally healthy communities" focusing on mental health promotion in community settings.

PROVINCIAL MENTAL HEALTH AND ADDICTIONS INITIATIVES

LHIN MENTAL HEALTH AND ADDICTIONS PRIORITIES

In their initial Integration Priority Reports (2005), 13 of 14 LHINs identified addiction and mental health as priorities. In April 2007, CAMH and the Partnership reviewed the LHIN integrated health service plans (IHSPs) to see if the initial priorities had translated into action plans (*A Focus on Addictions and Mental Health: Review of LHIN Integrated Health Service Plans*). Encouragingly, the review found that addiction and mental health were a priority in 7 of the 14 LHINs and a sub-priority in 5 others.

However, the review was critical of the way some of the LHINS were addressing mental health and addictions:

- Some LHINs underestimated the importance of access issues, especially those related to marginalized groups,
- Service gaps related to chronic underfunding were rarely addressed

- Few LHINs recognized the importance of housing, income, employment and social supports for people with addictions and mental health or addressed them as determinants of health.
- Most LHINs did not acknowledge the importance of peer support programs or make a significant commitment to culturally competent service.

There has also been some concern that the broad recognition of mental health and addictions as priorities by LHINs has not been matched by investment, though it should be noted that some investment has occurred, but not under the banner of addictions and mental health.

More than $700 million was provided to LHINs to fund initiatives in support of an Aging at Home strategy. As of June 30, 2008, 7 LHINs have given Aging at Home funding to mental health and/or addiction agencies, or other agencies that were primarily focusing their Aging at Home initiatives on serving people with mental health and/or addictions problems.

The percentage of LHIN Aging at Home funding going to mental health and addictions initiatives varied from just 1% to over 38% in the Toronto Central LHIN. In addition, the Toronto Central LHIN started working on adapting the existing Long-Term Care Home Mental Health Framework to create a Community Mental Health Framework for seniors, to coordinate services for seniors who live in private homes, retirement homes and supportive housing.

The 2009-2010 Toronto Central LHIN's call for Aging at Home proposals continued to focus on diverting seniors from long-term care homes and emergency departments to care in the community and targeted seniors with mental illness, dementia, and/or addictions. It included requests for supportive housing services for seniors with dementia or mental illness, increased access to specialized geriatric assessments in the community, crisis intervention for seniors with mental illness, and development of a transitional unit for seniors.

Other LHIN movement on addictions and mental health has taken place under the banner of health equity and chronic disease management. Driven by the Toronto Central LHIN's new requirement for hospital health equity plans and the collaborative outline presented by the Hospital Collaborative on Marginalized Populations in 2008, the LHIN plans a 2-year equity focus on chronic diseases adversely affecting marginalized populations and has identified diabetes and addictions and mental health as two key priorities.[27]

ALL-PARTY COMMITTEE ON A PROVINCIAL MENTAL HEALTH AND ADDICTIONS STRATEGY

The 2008 Ontario Budget included a commitment to developing "a comprehensive mental health and addictions strategy." Later in the year, Minister Caplan established an advisory panel to assist him in developing the strategy. On December 4, 2008 the legislature voted unanimously to establish an all-party committee to advise the government on a mental health and addictions strategy for Ontario. The resolution calling for the committee was introduced in by an opposition MPP.

[27] Toronto Central LHIN newsletter, Nov/Dec 2008

A Focus on Recovery

In mental health and addiction treatment, there is an increasing recognition of the importance of recovery goals that focus on wellness, health, and hope, and that are consistent with the strategies of health promotion. "Out of the Shadows at Last," the Kirby Commission's final report, said that "recovery must be at the centre of mental health reform." In Ontario, the Provincial Forum of Mental Health Implementation Task Forces said "the philosophy that recovery — as defined by the individual, not by service providers — is possible for all people living with mental illness is central to the Provincial Forum's vision for reform." Recovery has also been recognized as an essential principle by the Ontario CMHA and by CAMH, which has proposed that "a person begins recovery when he or she has hope for a full life, defines him or herself as an individual, not an illness, feels empowered to make decisions in his or her own best interest, takes responsibility for self management, and finds personal meaning."[28]

CAMH is dedicated to promoting full recovery and community participation for people with serious mental illness and/or substance use problems. The Clinical Programs work in the areas of housing, income, employment and social support. An important trend in recovery programs is an emphasis on employment; CAMH's Employment Initiative aims to develop employment and training opportunities for people with addiction and mental health issues both within CAMH and in the community. CAMH's new Alternative Milieu units aim to create a natural transition toward community reintegration by creating a home-like supportive therapeutic community, empowering clients to regain independence and assert control over their recovery plan.

Community Mental Health

The Ministry of Health and Long Term Care has increased funding for community mental health services by more than 50% since 2003 to a total of approximately $647 million in 2007/8. Though the Ministry has almost met its target for reductions in psychiatric beds of 35 per 100,000, in 2006/7 the Provincial Auditor contended that the Ministry has failed to meet its commitment to community health care contained in the 1999 provincial policy document *Making It Happen*. In *Making it Happen*, the Ministry established the objective of shifting its funding portfolio in mental health from "60% hospital/40% community" to "60% community/40% hospital".

The 2008 Provincial Auditor's report voiced concerns that this discrepancy may mean that a breadth and depth of community-based supports are not available to people being discharged from hospital. This may lead to a higher risk of re-hospitalization, emergency room visits and/or police intervention, or delay discharges from institutions. Supporting this analysis, the auditor's report found that wait times for community-based services are on average 180 days, and range between eight weeks and more than a year. For supportive housing, the wait times can be up to six years in some areas of the province, while other areas may report vacancies.

[28] *Making Recovery Come Alive at CAMH* (draft - June 2005),

The audit also found considerable discrepancies in funding for community mental health services across the province, which it attributed to historical funding patterns. The auditor noted that significant work had to be done by MOHLTC and LHINs in the assessment, oversight, and coordination of community-based care.

In response to some of the issues raised by the auditor's report, the MOHLTC noted that it has allocated $20 million in 2009/10 to support community mental health initiatives that can impact on emergency department wait times as part of the provincial wait time strategy. As discussed in section 2 of this scan, the Partnership and CAMH have made recommendations related to mental health and addictions services that could alleviate pressure on emergency departments, including investments in upstream community services and supports and the development of a comprehensive 24-hour crisis response system.

The 2008 Ontario budget also committed an additional $80 million over three years to community mental health and addiction services. At the MOHLTC's request, the Partnership's submission on emergency department wait times also included two recommendations to improve access to community mental health and addiction services and supports:

- to expand and strengthen case management services, including the development of addiction-specific intensive case management teams and a role for peer support; and
- to provide provincial funding to support integration strategies being organized in communities throughout Ontario, to facilitate access and coordination of community services for individuals with mental health and addiction needs.

To guide the further development and funding of community mental health and addictions services and identify service gaps, the province has started to map out mental health and addictions services.

The continuing provincial emphasis on expanding community care affects both CAMH's role as a specialized hospital and as a resource for community services. CAMH needs to continue to support, primary care practitioners, community mental health and addictions service providers and provide mental health services that other hospitals are unable to provide given the changing allocation of funding. CAMH and other hospitals will likely be pressured to continue developing better integration and partnerships with community mental health services.

FORENSIC MENTAL HEALTH SERVICES

With the establishment of LHINs, responsibility for health care operations has largely been transferred to them from the Ministry of Health and Long-Term Care. However, the accountability agreements between the Ministry and the LHINs have established a number of services that remain areas of provincial interest; one such area is the forensic mental health system. The Ministry has maintained the right to "determine and advise the LHIN of the number and type of forensic mental health beds" (Toronto Central LHIN agreement, page 17).

Over the past few years the provincial government has made significant investments in the area of mental health and justice services, most notably in community-based diversion services. CAMH's Law and Mental Health Program (LAMH) received funding to augment its capacity. These new investments in LAMH – along with efforts to

improve efficiency and reduce lengths of stay – have made the overall capacity pressure on CAMH's forensic program less acute than it was three years ago. Nonetheless, the ability of LAMH to meet the demands of the court system in Toronto remains an ongoing challenge; occupancy rates on all LAMH units consistently exceed 100%.

LAMH clients generally fall into two categories: those on remand awaiting trial, often undergoing psychiatric assessment, and those whom the courts have concluded cannot be found criminally responsible – or are unfit to stand trial – by virtue of their mental illness. Those in the latter category fall under the jurisdiction of the Ontario Review Board (ORB). The number of clients across Ontario under ORB jurisdiction has increased dramatically since 1992, but has been relatively stable over the past three years (although regional pressure in the GTA is challenging). There is ongoing pressure on the remand side, where client numbers continue to increase. This reflects a broader pattern of increasing numbers of incarcerated persons awaiting trial

ADDICTION TREATMENT PROGRAMS

Substance abuse and gambling treatment services are offered by over 150 providers across the province, funded through their local LHINs. In 2006/7 the Ministry, through the LHINs, provided $129 million in transfer payments to these providers or to sector organizations. Since 1999, funding for substance abuse programs has increased by only $7 million, while funding for problem-gambling programs has increased by $24 million, or 700%.[29]

The 2008 Provincial Auditor's report found that "the vast majority of Ontario's population needing addiction treatment services" did not receive services (though some may have received services from sources not tracked by the Ministry) noting that only about 7% of people with substance abuse problems and 3% of people with gambling problems received treatment.

Service providers contacted by the auditor reported wide variations in wait times for both substance abuse and problem-gambling services, in many cases resulting in inacceptable service gaps. The audit found that funding for substance-abuse treatment had not kept up to inflationary increases. The audit identified an urgent and persistent need for youth residential services related to addictions, including services for youth with concurrent disorders.

Despite their service agreements with LHINs, the audit found that more than three quarters of substance abuse and problem-gambling service providers did not report service availability to ConnexOntario. Data collection and review procedures to identify unreasonable service gaps were often lacking and per-capita funding was uneven across the province and based on historical levels rather than need. Finally, while most service providers were using the provincial substance-abuse assessment tools, they did not consistently apply the admission and discharge criteria and some indicated a desire for more training on applying the criteria. All service providers had concerns with the problem-gambling assessment tool and half of them used other tools.

[29] 2008 Provincial Auditor's Report, Chapter 3.01 Addiction Programs

In response to the report the Ministry has stated that it plans to:

- use the new HBAM funding model to support LHINs in their plans to develop addictions treatment strategies by allocating funds more equitably across the province;
- work with ConnexOntario in increasing awareness of treatment options;
- work with LHINs to improve reporting techniques;
- "encourage addiction agencies throughout Ontario to access and take advantage of the training currently offered by CAMH" in using provincial assessment tools; and
- develop new guidelines with LHINs for agency oversight.

PROBLEM GAMBLING STRATEGY

In response to a 2005 provincial review of its problem gambling and responsible-gaming strategy, the Cabinet approved a modified provincial problem-gambling strategy that included prevention, treatment, research, and responsible gaming, to be implemented by the MOHLTC with the Ministries of Health Promotion, Public Infrastructure Renewal, and Government Services. A quarter of the 2% of annual gross slot machine-revenue ($36.6 million) was to go to the Ministry of Health Promotion and the rest of the 2% was to go to local gambling prevention, awareness, research, and treatment activities. The 2008 Auditor's Report found that there had been no assessment or coordination of the local activities by the ministries and no reconciliation that the money was being spent on problem-gambling activities. At the time of the report's authoring, the problem gambling strategy had not been released to the public.

CHILDREN AND YOUTH

Provincial Framework on Child and Youth Mental Health

In 2006, the Ministry of Children and Youth Services (MCYS) released a provincial Child and Youth Mental Health Policy Framework, *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health*. The Framework's goals include:

- increased consistency in service provision across the province;
- increased collaboration across the child and youth sectors and with the adult sector;
- increased emphasis on health promotion, prevention, and early identification;
- timely and appropriate service within client's own cultural and community context;
- evidence-based treatment; and increased accountability.

The framework identified several priority areas for action and is intended to guide future research and investment in the sector. The Ministry has started to collect and disseminate waiting-time information and initiated a mapping of children's mental health programs and services.

MCYS increased funding for children and youth mental health services by $24.5 million in 2007 for a total increase of $80 million since 2003/4/ The funding represents a five per cent increase in base annual funding to child and youth mental

health agencies across the province to reduce wait times and help address cost pressures ($18.5 million); $4.5 million in regional annual allocations to address community priorities based on the ministry's new Policy Framework for Child and Youth Mental Health; and $2 million annually that would enable agencies to provide immediate children's mental health support when a local community is faced with an extraordinary crisis or circumstance.[30]

Despite these increases, the 2008 Auditor's report found that there had been erosion of core funding for service agencies over the past decade that had lead to reduced services, in particular in prevention and early-intervention programs. The report also found that services existed in a patchwork of inconsistent service availability and standards across the province.

Youth Violence

Youth violence is increasingly being seen as a mental health issue; this was the theme of the February 2008 George Brown College and CAMH Mental Health Conference, *Youth Violence "Mental Health Issue or Criminal Behavior?" - A Public Health Discussion for Prevention*.

The landmark "Roots of Youth Violence" study by Roy McMurtry and Alvin Curling released in November 2008 found that "mental health and substance abuse can be viewed as direct roots of the immediate risk factors for violence involving youth, particularly alienation, impulsivity, and no sense of belonging." The report cited concerns that the large majority of children and youth with mental health or behavioral disorders do not receive mental health services or support and emphasized the importance of preschool and younger school-age children with mental illnesses receiving early intervention. The report included recommendations to "bring youth mental health out of the shadows" through prevention and locally available, culturally appropriate, and integrated early identification and treatment programs; and to develop a plan for universal, community-based access to mental health services for children and youth.

4. CONCLUSIONS

Since CAMH last conducted a scan of the environment, Ontario's population, and Toronto's in particular, has continued to age, is more culturally diverse, and is more polarized by income. Health care services in general - and specifically, mental health and addictions services – must continue to deliver responsive services to meet new and emerging needs. Special outreach to marginalized communities will be necessary to ensure access to mental health and addictions services for everyone who needs them. Increased reliance on primary and community care as gateways to mental health and addiction services must be designed with these challenges in mind and must address the ongoing difficulties many people experience in accessing primary care.

[30] http://www.gov.on.ca/children/english/news/releases/STEL02_186787.html, April 3, 2007

Recent research illustrates that the prevalence, cost and impact of mental illness and addictions is significant and we are perhaps just beginning to understand the true economic, societal and personal costs of these illnesses.

Proactive media attention and awareness building efforts, such as CAMH's own *Transforming Lives* campaign, have succeeded in decreasing some of the longstanding stigma associated with mental illness and addictions. This has been a much welcomed shift by consumers, families and service providers alike, but also presents the sector with a challenge as well – meeting increased demands for services during a period of economic downturn.

Both the federal and provincial governments continue to maintain a strong focus on health issues. However, health is no longer their primary priority, as economic and environmental concerns become more critical. At the federal level we have seen the establishment of the Mental Health Commission of Canada, a national organization that will provide leadership on mental health and addiction issues for Canada. We have also seen considerable federal government activity related to drug policies and strategies, with a shift towards more enforcement oriented responses to drug problems and a move away from harm reduction. Provincially, work is in progress on a mental health strategy, and the new Minister of Health has identified mental health and addictions as a key priority. Government and the newly created LHINs will be challenged by the economic downturn and will maintain their focus on accountability and performance measurement to ensure that resources are efficiently and effectively used.

There have been reductions in federal funding for research, a significant concern for the Canadian research community. This decrease, coupled with significant investment in US based research and development, may lead many Canadian researchers to consider relocating south of the border. Increased emphasis on knowledge exchange is a trend that continues to gain momentum.

We continue to experience human resource shortages in the health sector. The challenges posed by these shortages are compounded for mental health and addictions. Services in our sector have been chronically underfunded and we experience additional barriers to recruitment caused by stigma and perceptions of increased risk. CAMH must offset these challenges by developing and sustaining a healthy workplace, and by building the capacity of other healthcare providers, particularly at the primary care level, to address the mental health and addiction needs of the population.

The LHINs continue to emphasize the importance of integration and partnerships. It is becoming increasingly important to build strategic alliances with other healthcare providers such as general hospitals, community service providers, and primary care, to ensure a comprehensive continuum of mental health and addictions services exists. It will be important for CAMH to play a central role in this kind of system planning, as it is within the scope of these discussions that we can refine our role as an academic specialty hospital and ensure client needs are addressed.