Legislative Assembly of Ontario

Assemblée législative de l'Ontario

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

Final Report

Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians

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LETTER FROM THE MEMBERS OF THE SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

Ontario needs a comprehensive mental health and addictions plan. Many families have been touched by mental illness and addictions; it is clear that no one is immune. The Select Committee on Mental Health and Addictions is pleased to present its final report and recommendations. We trust that our work over the last 18 months, summarized in this report, will lead to the development of this much needed plan and spark a public dialogue.

Each of the province's three political parties was represented on the Committee by Members who volunteered to serve because of our personal commitment to people living with a mental illness or addiction. Regardless of our political convictions, we recognized that we must do better. All Ontarians must get the mental health and addictions care they deserve. We worked cooperatively throughout our entire mandate, and we hope that this spirit of collegiality will influence those who must now implement our recommendations.

We would like to thank the Committee's Clerk and staff from the Legislative Research Service. Their hard work and dedication were impressive. The Committee was given an extremely broad mandate—to consider the mental health and addictions needs of the entire province—and it was with their help that we were able to focus on recommendations that we believe will affect the entire system.

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Finally, but most importantly, we would like to thank those who shared their personal stories and experiences with us. The Committee held public hearings on 30 dates during which we heard testimony from over 230 presenters from all regions of Ontario. More than 300 submissions were received, including written briefs, journal articles, and DVDs. We also went beyond traditional hearings venues and were graciously allowed to make site visits to mental health and addictions facilities as well as several First Nations communities. The stories and experiences greatly affected each Member of the Committee and laid the foundation for our recommendations.

Sincerely,

KEVIN DANIEL FLYNN
Chair

CHRISTINE ELLIOTT
Vice-Chair

BAS BALKISSOON

FRANCE GÉLINAS

HELENA JACZEK

SYLVIA JONES

JEFF LEAL

LIZ SANDALS

MARIA VAN BOMMEL

Legislative Assembly of Ontario

Assemblée législative de l'Ontario

The Honourable Steve Peters, MPP
Speaker of the Legislative Assembly

Sir,

Your Select Committee on Mental Health and Addictions has the honour to present its Final Report entitled "Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians" and commends it to the House.

Kevin Daniel Flynn, MPP
Chair

Queen's Park
August 2010

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

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INTRODUCTION

The Select Committee on Mental Health and Addictions is pleased to present its final report. We began our investigation of mental health and addictions care in Ontario more than 18 months ago, when the Select Committee was created in February 2009.[1] Since then, we have been privileged to share the stories of Ontarians living and often struggling with mental health and addictions issues. It is an understatement to say that we have been moved by what we have heard. Rather, we have been changed by what we have heard, and are now convinced that a radical transformation of mental health and addictions care is necessary if Ontarians are to get the care they need and deserve.

From the parents sleeping by their front door to prevent their son from slipping out to buy drugs, to the daughter who dealt with more than 20 health care providers and social service agencies on her mother's behalf, to the husband who was in the room when his wife committed suicide, we have listened to your stories. These were extremely difficult moments for families to share with the Select Committee.

There were uplifting moments as well. The Select Committee was delighted to meet the woman who could finally speak publicly about her anxiety disorder, the young man confronting his addictions and working to prevent others from taking the same path, and the mother whose son finally managed his schizophrenia, got a job, made new friends, and thanked her for all she had done.

But it is fair to say that these positive stories were in the minority. In general, Ontarians wait too long for treatment. Youth are caught in the gap between programs for children and adults, repeating their case histories to a series of unconnected service providers. First Nations people struggle with above-average rates of mental illness, addictions, and youth suicide owing in part to a history of poverty and the consequences of residential schooling. Francophones are misdiagnosed because they are not treated in their first language. Linguistic and cultural barriers may also affect newcomers and refugees. Seniors unnecessarily languish with depression, often undiagnosed, while society as a whole must face what has been called the coming tsunami of Alzheimer disease.

Similarly, individuals with autism, eating disorders, Fetal Alcohol Spectrum Disorder, or a dual diagnosis are orphaned by a system that seemingly has no place for them.[2] Seriously ill people are often turned away from emergency departments, or released from hospital before their condition has stabilized or without a discharge plan. Those with a concurrent disorder are told to deal with

[1] The Committee's mandate and other information about its history, public hearings, and site visits are presented in Appendix A. Its schedule of public hearings, and a list of witnesses and submissions are found in Appendix B.

[2] Fetal Alcohol Spectrum Disorder is the spectrum of disabilities that may affect individuals whose mothers drank alcohol during pregnancy, while dual diagnosis refers to people who have both an intellectual disability and mental health needs.

their addictions first.[3] Approximately one in ten people suffer from highly treatable, yet overlooked, conditions such as anxiety disorders. Finally, "community support" often means that an individual is cared for by a stressed, over-burdened family struggling along without assistance.

In sum, the Select Committee heard so many stories of distress that we unanimously agreed that we must do better. Furthermore, because the Select Committee was given an extremely broad mandate—considering the mental health and addictions needs of the entire province—we have decided to focus on recommendations that we believe will affect the entire system.

To ensure that we address as many concerns as possible, the Select Committee is recommending the creation of a new organization responsible for overseeing the entire mental health and addictions system. We are also recommending that a core basket of services be made available in all regions of Ontario. We believe that these recommendations, along with several key proposals in the areas of justice programs and mental health legislation, have the best chance of producing the greatest improvement in care for the greatest number of people.

The Select Committee held a frank discussion about the fact that it often takes a crisis to accomplish a major social or political change. We are convinced that this crisis has arrived. However, it is one suffered silently, as those experiencing a mental illness or addiction are ignored, stigmatized, and lack the social power to demand change. These individuals are expecting us to finally take action. We, in turn, expect our recommendations to be adopted. We strongly encourage the Legislature to endorse our recommendations and advocate for their implementation.[4]

[3] A concurrent disorder is one in which a person has both a mental illness and a substance abuse issue.

[4] The Minister's Advisory Group on Mental Health and Addictions is reporting to the Ministry of Health and Long-Term Care and is receiving more expert opinion on a narrower range of concerns. We thank the Minister's Advisory Group for its efforts, and trust that the work of our two groups will be complementary.

MENTAL HEALTH AND ADDICTIONS ONTARIO

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

The Select Committee was struck by the observation that no one person or organization is responsible for connecting these various parts, or "breaking down the silos" as we so often heard. There is also no single organization responsible for ensuring that mental health and addictions services and supports are delivered consistently and comprehensively across Ontario.

The Select Committee therefore recommends

> **1.** A new umbrella organization—Mental Health and Addictions Ontario (MHAO), responsible to the Ministry of Health and Long-Term Care—should be created to ensure that a single body is responsible for designing, managing, and coordinating the mental health and addictions system, and that programs and services are delivered consistently and comprehensively across Ontario.
>
> and
>
> All mental health and addictions programs and services—for all regions of the province and for all ages, including children and youth—should be consolidated in the Ministry of Health and Long-Term Care.

The integration of the mental health system must start at the top, and it is our belief that this recommendation has the best chance of addressing the most serious problems affecting our current mental health and addictions system, and helping the most people. Cancer Care Ontario provides one successful model of the kind of leadership, authority, and integration that the Select Committee is envisioning.

We recommend the following mission statement, strategic goals, and responsibilities for the new Mental Health and Addictions Ontario:

Mission Statement for Mental Health and Addictions Ontario

To reduce the burden of mental illness and addictions by ensuring that all Ontario residents have timely and equitable access to an integrated system of excellent, coordinated and efficient promotion, prevention, early intervention, treatment, and community support programs

Strategic Goals	Responsibilities
System Design *To develop the provincial and regional framework for the delivery of mental health and addictions services*	• Establish a structure in which a single entity in each region of the province, accountable to MHAO, is responsible for coordinating the delivery of mental health and addictions services and supports in that region • Conduct an inventory of services and providers • Develop the optimal mix of services and providers by eliminating gaps and duplication in the core basket of services
System Management *To plan, organize, manage, and oversee the delivery of mental health and addictions services*	• Advise the Ministry of Health and Long-Term Care on all matters related to mental health and addictions • Promote interministerial and intergovernmental coordination, including with the Mental Health Commission of Canada • Oversee a comprehensive provincial mental health and addictions strategy • Establish the accountability of all mental health and addictions agencies and ensure that service delivery meets provincial standards • Play an active role in funding decisions for institutional, residential, and community treatment services
Service Delivery *To ensure timely and equitable access to assessment and treatment for all Ontarians*	• Identify the basket of core services to be delivered at the community level, allowing for regional variability and cultural sensitivity (e.g., traditional healing services may be appropriate in some regions) • Develop a wait-time strategy for underserved populations and conditions, specifically, but not limited to, children and those with severe and persistent conditions • Ensure that every region has an access route to specialized services, such as, but not limited to, those pertaining to concurrent disorders • Ensure the appropriate accreditation of service providers and appropriate qualifications of individuals working for service providers • Ensure the provision of system navigation services via appropriate intake processes and ongoing case management
Supportive Care *To ensure seamless navigation to housing, income, employment, peer support, and other social services*	• Ensure cooperation between hospitals, residential care programs, community treatment programs, housing supports, and social service providers • Ensure appropriate transitions between services

Improved Outcomes *To improve client outcomes through research and best practice guidelines*	• Work with mental health and addictions professionals and service providers to fund, conduct and coordinate research, develop program evaluation tools, and identify and disseminate best practices • Develop centres of expertise, similar to the Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario, for First Nations, Francophones, and seniors, and for issues such as workplace mental health and employment • Develop and maintain centralized and standardized mental health and addictions data • Improve centralized collection and provision of information regarding the availability of mental health and addictions services
Promotion, Prevention, Early Identification and Intervention *To reduce the incidence, severity and mortality of mental illness and addictions through promotion, prevention, and early identification and intervention, from early childhood to the senior years*	• Improve knowledge of mental health issues, foster resilience and mental wellness, and increase awareness of how social determinants affect health • Target particular risk factors and high risk populations • Increase knowledge of early signs and symptoms among health care professionals, employers, and educators in particular, but also the general population • Identify and develop common assessment tools • Enable intervention at earliest stage
Reduce Stigma *To reduce stigma and the harm it causes*	• Coordinate with the Mental Health Commission of Canada regarding an anti-stigma campaign • Address stigma demonstrated by health professionals, emergency responders, and educators through the development of mandatory education programs • Address stigma experienced by mental health and addictions professionals by encouraging careers in these fields and examining the issue of compensation • Work with employers and community agencies to reduce workplace stigma and create employment opportunities for individuals with mental illness and addictions issues

ESSENTIAL SERVICES AND SUPPORTS

The Select Committee is confident that our first recommendation will do much to transform our system of mental health and addictions care; however, we feel it necessary to expand on certain aspects of our expectations of Mental Health and Addictions Ontario. Based on what we have heard and read over the course of our deliberations, the discussion below deals with what we see as priorities for the delivery of mental health and addictions services across the province.

Core Basket of Coordinated Services

Regardless of location or circumstance, many presenters spoke or wrote about their inability to obtain age-appropriate services close to home, long waiting lists, and long lapses between getting an assessment and receiving treatment. We also heard of instances where clients were restricted from accessing services provided outside the confines of a specific geographic area.

At the same time, the Auditor General of Ontario spoke to us about the findings of three audits that appeared in his *2008 Annual Report*:

- The Ministry of Health and Long-Term Care provided transfer payments to local health integration networks (LHINs) which funded about 330 community-based mental health service providers.
- The Ministry of Children and Youth Services provided funding to approximately 440 transfer payment recipients under its Child and Youth Mental Health Program, about 370 of which had an ongoing funding relationship with the Ministry.
- The province's LHINs had service agreements with more than 150 addictions service providers.

The Auditor and his staff referred to accountability-related concerns such as a lack of coordination and collaboration, and a lack of information about quality and quantity with respect to child and youth mental health services. His report expressed concern about the lack of consistency in the practices of community mental health providers, and the autonomy with which child and youth mental health providers operate and the resulting patchwork of services. It also referred to the lack of change in the delivery of addictions programs at the local level, 10 years after recognition of the need for changes such as merging smaller treatment agencies.

This troubling situation, in which there are hundreds of services, yet individuals are still unable to access care, has left Ontarians confused and frustrated when beginning their search for help. People continue to have difficulty navigating once in the system, as needs and service providers change over time. The Select Committee believes that several steps must be taken in order to ensure that

Ontarians have access to a full range of connected, coordinated services and system navigators.[5]

The Select Committee therefore recommends

> **2.** Mental Health and Addictions Ontario should ensure that a basket of core institutional, residential and community services is available in every region of the province for clients of all ages, identify gaps, and eliminate duplication. Referral patterns must be put in place for the provision of those specialized services only available outside of a region. Each region must also have sufficient capacity to care for clients with concurrent disorders.
>
> **3.** Clients and their families should have access to system navigators who will connect them with the appropriate treatment and community support services (e.g., housing, income support, employment, peer support, and recreational opportunities). Those with continuing, complex needs should be supported by a plan that will lead them through their journey to recovery and wellness, particularly on discharge from institutional or residential treatment.

The Select Committee would also like to make more specific recommendations about the contents of the core basket of services. We have collected these recommendations under the headings of treatment, and community services and support. The Select Committee believes that focusing on each of the items listed below will play a pivotal role in reducing the incidence and severity of mental illness and addictions.

Treatment

The items below are listed in alphabetical order.

Access to Beds

Despite the decades-long move from institutional to community care, presenters indicated that there continues to be a need for acute inpatient treatment, particularly in Schedule 1 designated psychiatric facilities.[6] We were also told that

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[5] System navigators play a role in the coordination of services. Depending on need, they can include case managers, peer support workers or family members.

[6] Many public hospitals are designated Schedule 1 psychiatric facilities under the *Mental Health Act* and must comply with the *Public Hospitals Act* and its regulations. (See Appendix C for a list of Schedule 1 designated psychiatric facilities.) Most provide inpatient, outpatient, day care, and emergency services, as well as consultative and educational services to local agencies. Other hospitals (and some Schedule 1 facilities) defined as Schedule 2, 3, 4, 5, and 6 facilities are exempt from providing certain of these services (e.g., Schedule 2 facilities are exempt from the requirement to provide inpatient services). Ontario, Ministry of Health and Long-Term Care, "Public Information: Health Services in Your Community – Designated Psychiatric Facilities under the *Mental Health Act*," updated 27 October 2003, last modified 26 April 2010. Internet site at http://www.health.gov.on.ca/english/public/contact/psych/designated.html, accessed 23 July 2010.

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

The Select Committee therefore recommends

> **4.** Mental Health and Addictions Ontario should conduct an assessment of the need for acute care psychiatric beds for both children and adults by region.

Assessment

Presenters identified prevention, early identification and early intervention as critical components of a more effective and efficient children's mental health system. We concur and firmly believe that these are essential components at all stages of an individual's life. We acknowledge that there are assessment and screening tools in use but feel that provincially-applied, evidence-based, age-appropriate assessment and screening tools are necessary to ensure consistency.

The Select Committee therefore recommends

> **5.** Mental Health and Addictions Ontario should ensure that primary care providers and relevant staff in all levels of the education and long-term care systems have access to common, age-appropriate, evidence-based assessment and screening tools.

Crisis Response

Presenters believed that hospital wait times could be reduced and the quality of services could be improved by having hospitals and community organizations work together to develop coordinated and standardized non-hospital crisis services. These services could include 24/7 mobile crisis intervention teams (for adults and children), mobile crisis home treatment, and crisis centres. We were intrigued by these possibilities and impressed with some innovative services already in place around the province, such as COAST (Crisis Outreach and Support Team) which partners health and social services personnel with police officers.

We also learned that Telehealth Ontario has specific protocols for mental health symptoms for adults and children, an alternative referral source specific to mental health, and a database containing approximately 290 mental health agencies,[7] but note that this is not widely known.

[7] Information contained in e-mail from staff, Office of the Deputy Minister, Ontario Ministry of Health and Long-Term Care, Toronto, 8 June 2010.

The Select Committee therefore recommends

> **6.** Mental Health and Addictions Ontario should facilitate the creation of more 24/7 mobile crisis intervention teams.
>
> **7.** The Ministry of Health and Long-Term Care should expand and do more to publicize Telehealth Ontario's ability to respond to callers with mental health and addictions issues.

Emergency Departments

Emergency departments are often the first places people with mental illnesses and addictions go for help during a crisis either on their own, with their families or with emergency responders. Presenters agreed that these environments have to change. We can well understand that long wait times, inadequate security and staff expertise, along with stigma and confinement in small, noisy areas can create very stressful situations.

The Select Committee visited the Emergency Mental Health Unit (EMHU) of the Emergency Department of Guelph General Hospital. We were impressed with its immediate triage process and the way the Hospital, the Homewood Health Centre (a Schedule 1 designated psychiatric facility), and Trellis Mental Health and Development Services partnered to create the EMHU, provide it with appropriately trained personnel, and link it with community services and supports. We understand that other hospitals have adopted or are looking at adopting a similar model.

The Select Committee therefore recommends

> **8.** Mental Health and Addictions Ontario should work with the Ministry of Health and Long-Term Care to review emergency department protocols in order to increase their capacity to deal effectively, efficiently and sensitively with people appearing with mental health and addictions issues, and when appropriate, redirect or connect them to community-based services and supports.

Primary Care

Primary care and its provision figured prominently in our hearings. We heard some encouraging stories, but much of what we were told related to the system's inadequacies and the need for change. The Select Committee's comments and recommendations in this area focus on three concerns: education, collaboration, and remuneration.

We heard that family physicians and community nurses are the health care professionals most often consulted by those seeking help for a mental illness or addiction. We also learned that primary care providers receive little in the way of relevant training during their formal academic programs. The Select Committee believes that more knowledge will lead to greater sensitivity and a decrease in the amount of stigma attributed to health care professionals by many presenters.

Presenters strongly supported the promotion of mental health and addictions services in primary care centres, noting their potential to assist in early diagnosis and intervention. We agree that interdisciplinary primary care models (e.g., family health teams, community health centres, and Aboriginal health access centres) with a broad range of professional expertise will do much to ensure more timely access to the right services. The Select Committee is encouraged by the Ministry of Health and Long-Term Care's intent to add mental health counsellors to these models.

The Select Committee also learned that addiction to prescription painkillers is a rapidly growing problem in Ontario. We were deeply saddened to learn from several First Nations and from addiction workers the toll this addiction has taken in many communities. This problem must be addressed immediately.

Individuals with mental illnesses and addictions often have difficulty accessing primary care. Physicians require a lot of time to deal with their concerns. We were told that the current remuneration model could lead to a physician's reluctance to take on new patients or to provide the necessary services to existing patients with these issues. The Select Committee views this as a disincentive to providing quality care. However, we learned that the Ministry of Health and Long-Term Care's 2008 agreement with the Ontario Medical Association offers enhanced payments for individuals meeting minimum targets for the provision of services, including mental health services. We hope that this will be expanded.

The Select Committee therefore recommends

9. Primary care providers should be given the proper tools and support to enable them to develop a greater sensitivity for the mental health and addictions needs of their patients. This can take such forms as part of formal academic programs or continuing education.

10. All interdisciplinary primary care models should include a mental health and addictions treatment component (e.g., social worker, psychiatrist, psychologist or mental health worker).

11. The Ministry of Health and Long-Term Care should immediately address the problem of addiction to prescription painkillers.

12. The Ministry of Health and Long-Term Care should examine further changes to the family physician remuneration model to focus on improving access to and the quality of primary care for people with mental illnesses and addictions.

Community Services and Supports

The Select Committee has premised its choice of essential community services and supports on the frequently used phrase, "a home, a friend and a job." While recreational, social, and cultural activities help to create environments that foster

companionship and social support, we feel that housing, peer support, employment, and support for family caregivers are particularly crucial to the creation of a strong basis of community services.

Housing

Our *Interim Report* noted the significance presenters attributed to housing, particularly for severely and persistently ill people. Its provision can contribute to a reduction in psychiatric symptoms and decrease the need for unnecessary emergency department visits and extended hospitalizations. Having a permanent address can facilitate access to a range of services, including social assistance. An individual's housing and support needs can also change as they make their way through the process of recovery.

We are aware of the roles that domiciliary hostels and homes for special care play in providing accommodation for people with mental illness, and were impressed with the way that providers such as Durham Mental Health Services and Woodview Manor have responded to the changing housing needs of their respective clients.

The Select Committee therefore recommends

> **13.** Mental Health and Addictions Ontario should ensure, coordinate and advocate for the creation of additional affordable and safe housing units, with appropriate levels of support to meet the long-term and transitional needs of people with serious mental illnesses and addictions.

Peer Support

Much was said and written about the immense value of involving people with lived experience in the delivery of services. Presenters told us that the lens of experience, provided by consumer/survivor initiatives and more specifically peer support, can contribute to reductions in hospitalizations, and improve well-being and access to treatment.

The Select Committee therefore recommends

> **14.** Mental Health and Addictions Ontario should ensure that institutional and community-based service providers actively seek to involve peer support workers in all aspects of service delivery and take advantage of the Ontario Peer Development Initiative's Peer Support Toolkit Project that will enable peer support organizations to accredit peer workers.

Employment

Mental health and addictions issues in the workplace are a tremendous direct and indirect cost to the Canadian economy. One source suggests a cost of upwards of

$30 billion annually.[8] We know of employers who are actively engaged in the promotion of good mental health and of the related work of the Centre for Addiction and Mental Health, and organizations such as the Canadian Mental Health Association, but feel much more needs to be done to increase awareness of the importance of a healthy workplace in the creation of a positive and successful work environment.

Employers with an understanding of mental illness and addictions can provide an environment within which employees dealing with those issues are more likely to succeed and thrive. That understanding includes knowing how to hire prospective employees, how to accommodate the needs of both new and existing workers, and how to promote a healthy workplace. There could be an untapped supply of skilled workers waiting for the opportunity to enter or re-enter the job market, with the appropriate supports.

Training and employment supports (e.g., resume writing, job interview techniques and job placements) ease reintegration into society, and help in finding and retaining meaningful work. A job can do much to improve a person's financial situation, lessen their dependence on social assistance and, most importantly, bolster self-esteem at a critical point on the road to recovery.

The Select Committee therefore recommends

> **15.** Mental Health and Addictions Ontario should work with employers and community-based service providers on strategies to increase employment opportunities and supports for people with mental illnesses and addictions.

Support for Families and Caregivers

We heard from a broad range of caregivers, among them elderly parents caring for adult children, aging spouses looking after a partner suffering from dementia, grandparents performing parental duties, and middle-aged adults coping with the demands of their own families and those of a sibling. These individuals put so much of their energies into tending to the needs of loved ones that their own well-being can suffer. We were also told that family support groups, particularly those developed by caregivers themselves, can provide help and insight along with education, respite, and opportunities for discussion.

The Select Committee therefore recommends

> **16.** Mental Health and Addictions Ontario should provide for the increased availability of respite care to allow family members the time and freedom to pursue personal, social and recreational endeavours in order to

[8] Great West Life Centre for Mental Health in the Workplace, "Mental Health Facts & Figures," last updated 21 July 2008. Internet site at http://www.gwlcentreformentalhealth.com/display.asp?l1=2&l2=13&d=13, accessed 23 July 2010.

maintain their own mental health. It should also monitor the progress of the Mental Health Commission of Canada's Mental Health Family Link program's peer support project for family caregivers, and adopt best practices.

JUSTICE ISSUES

The Select Committee believes that the justice issues brought to our attention in the last 18 months are serious enough to merit their own discussion and recommendations.

Courts and Corrections

The Select Committee has learned that far too many Ontarians experience their first contact with the mental health system through the justice system. Furthermore, according to the Ministry of Community Safety and Correctional Services, 36% of individuals in custody in Ontario suffer from some form of mental illness, and 50% of Canadian offenders report substance abuse as a cause of their offence. The Select Committee believes that these are obvious signs that mental health and addictions care needs to be transformed in Ontario.

Witnesses told the Select Committee that they were encouraged to have a family member arrested simply to receive badly needed mental health services. In some cases, these individuals were diverted away from the justice system, by either police officers or the courts, and into the mental health system. However, in other cases, they languished in prison, receiving inadequate mental health care. As former Senator Michael Kirby summarized so well, "we have made the streets and prisons the asylums of the 21st century."

The Select Committee trusts that the creation of Mental Health and Addictions Ontario, better mental health promotion and prevention, improved addiction awareness, early intervention, and greater use of system navigators, will help to remedy the situation.

However, the Select Committee also believes that specific courts and corrections programs should be made more widely available. We have heard many positive things about the province's Mental Health, Drug Treatment, and Youth Mental Health Courts. Access to these facilities should be expanded where possible. Diversion services should be accessible across the province, even in the absence of these special courts, for example through the expanded availability of mental health workers in court settings.

The Select Committee also advocates strategies that will help to improve police sensitivity, defuse difficult situations, and further assist with the diversion of individuals out of the justice system. We were very impressed with the collaboration between Durham Regional Police Service, Ontario Shores Centre for Mental Health Sciences, Durham College, and the University of Ontario

Institute of Technology that has created simulations to be used in the training of police officers. Other police services need to be made aware of these programs.

Finally, individuals who are incarcerated need access to the full basket of mental health and addictions services. There should be no distinction between their physical health, mental health, and addictions needs. The Select Committee also believes that prison discharge plans for individuals with a mental illness or addiction should include connection to a system navigator, and from there to appropriate community services, particularly housing.

The Select Committee therefore recommends

> **17.** The services of court mental health workers should be made widely available across all regions of Ontario, in order to divert more individuals with a mental illness or addiction out of the justice system and into appropriate mental health and addictions services and supports.
>
> **18.** Additional Mental Health, Drug Treatment, and Youth Mental Health Courts should be created across all regions of Ontario, to provide more appropriate services for individuals with a mental illness or addiction.
>
> **19.** The Ministry of Community Safety and Correctional Services should direct police forces across the province to provide training for officers who may encounter people suffering from mental illnesses and addictions.
>
> **20.** The core basket of mental health and addictions services should be available to the incarcerated population, and discharge plans for individuals with a mental illness or addiction should be expanded to include the services of a system navigator and appropriate community services.

Legislation

Mental Health Act and Health Care Consent Act, 1996

Ontario's mental health legislation places a high value on individual autonomy. The admission of an individual to a psychiatric facility and the person's subsequent treatment are considered distinct matters. The *Mental Health Act* sets out the criteria of admission for patients to psychiatric facilities, and generally restricts involuntary admission to a narrow range of circumstances. The individual must have behaved violently, be threatening violence, or be showing a lack of competence to care for himself or herself, and must be suffering from a mental disorder likely to result in "serious bodily harm."[9] The *Health Care Consent Act, 1996* governs consent to treatment. A fundamental premise of this

[9] A small number of children are also admitted for secure mental health treatment under the provisions of the *Child and Family Services Act*.

law is that all individuals have the right to refuse treatment, as long as they pass a two-pronged capacity test.[10]

However, as we noted in our *Interim Report*, we are troubled that so many witnesses have experienced difficulty in obtaining care for family members who are clearly very ill, yet refuse treatment or are too quickly discharged from hospital. Many told us about their need to go through the complicated Form 1 or Form 2 process—involving the police or a justice of the peace—several times before their loved one was adequately treated.[11] One family told the Select Committee that their son was not admitted to hospital until he threatened to jump from a four-storey building. Another young man was released from hospital even though he had told his family he could stop moving cars simply by touching them.

We are familiar with these stories from our constituents as well. We know of many cases in which an individual was turned away from hospital because he or she had not behaved violently, or refused much-needed treatment, only to experience a potentially irreversible deterioration in health. We also know of cases in which a son, daughter, wife, or father committed suicide or hurt a loved one after failing to receive care.

Rights advocates cautioned the Select Committee that involuntary admission and treatment are such grave violations of autonomy that society has to accept these risks and dangers. They also warned that psychiatric drugs can have serious side effects to which many people are reluctant to expose themselves.

The Select Committee believes, however, that the right to autonomy must be balanced with the right to be well. The Select Committee also believes that our present laws tie the hands of health professionals and families and have contributed to the criminalization of mental illness, where individuals need to be arrested in order to receive care. While Ontario undoubtedly needs better access to community supports and hospital beds, some people will not avail themselves of such services because it is the nature of their condition to deny that they are ill. Furthermore, there are a number of psychiatric conditions for which a delay in treatment can result in an irreversible deterioration in health. Ontario's current legal framework is not adequately nuanced to address this predicament.

We have received testimony that other jurisdictions have broadened involuntary admission criteria by expanding their definition of harm, without unduly jeopardizing autonomy. For example, these jurisdictions consider the threat of all serious harm, not merely physical harm. They also permit treatment in cases of involuntary admission. The Select Committee was particularly impressed by British Columbia's mental health legislation. Similarly, we understand that countries such as Norway and the Netherlands, generally regarded as societies with an advanced understanding of individual rights and high standards for mental

[10] Appendix D provides more detail about these two Acts.
[11] Appendix D also provides more information about the involuntary admission and treatment process.

health care, have a lower threshold than the risk of serious physical harm for involuntary admission and treatment.

Indeed, we were informed by some medical and legal experts that they regularly "bend" Ontario's laws in order to ensure that their clients receive the treatment that they need. Furthermore, we learned that the Consent and Capacity Board, Ontario's courts, and the Supreme Court of Canada apparently interpret harm broadly enough to include psychological harm. However, the Select Committee is concerned that this interpretation is not widely known or practised. The Select Committee is also reluctant to perpetuate a situation in which provincial laws have to be ignored.

After long and careful consideration, the Select Committee does not believe that it has the legal expertise to propose specific amendments to Ontario's mental health legislation. However, the Select Committee is certain of the outcomes that are necessary to address the excessive and unnecessary suffering permitted under our current legislation:

- Involuntary admission criteria must be interpreted or altered to include serious harms that are not merely physical.
- Involuntary admission must also entail treatment.

The Select Committee has been advised that various legislative or policy changes could produce these desired results.

The Select Committee therefore recommends

> **21.** The Ministry of Health and Long-Term Care should create a task force, incorporating adequate representation from, among others, mental health clients and their caregivers as well as mental health law experts, to investigate and propose changes to Ontario's mental health legislation and policy pertaining to involuntary admission and treatment. The changes should ensure that involuntary admission criteria include serious harms that are not merely physical, and that involuntary admission entails treatment. This task force should report back to the Ministry within one year of the adoption of this report by the Legislative Assembly.

Personal Health Information Protection Act, 2004

Under the terms of Ontario's *Personal Health Information Protection Act, 2004* (*PHIPA*), health information custodians can collect, use and disclose an individual's personal health information only with the express or implied consent of that individual, subject to limited exceptions. As is the case with the *Mental Health Act* and the *Health Care Consent Act, 1996*, respect for individual autonomy is integral. *PHIPA* also uses similar language to the *Mental Health Act*,

permitting the disclosure of personal health information for the purpose of reducing a significant risk of "serious bodily harm."[12]

However, families have often struggled with the consequences of a consent-based system. Many people told the Select Committee of their frustration at being emotionally and financially responsible for their loved ones while not being considered a partner in care by the health care system. One mother was not certain how seriously she should take her son's occasional threats of violence, because he would not allow his psychiatrist to release more information about his condition. Some caregivers did not know that a loved one was in hospital, or about to be released, until he or she showed up at the door, or worse, was later found wandering the streets. Yet others have provided information about symptoms to a psychiatrist, only to have this information immediately passed on to the client, exacerbating paranoia and diminishing trust.

When *PHIPA* was reviewed in 2008 by the Standing Committee on Social Policy, Ontario's Information and Privacy Commissioner recommended that the language of the Act be amended to clarify that health information may be disclosed to reduce the risk of "serious psychological harm," as well as physical harm.[13] The Select Committee believes that this is a reasonable amendment, particularly given the similar testimony that we received pertaining to the *Mental Health Act*.

The Select Committee was also informed that British Columbia's legislation permits the release of personal health information to health care professionals, family members, and others involved in a client's care without the client's consent, for the purposes of "continuity of care" and if it is in the best interests of the client.[14] The Select Committee believes that the B.C. legislation may provide a better balance between the autonomy of the client and a caregiver's need for important health care information.

As we noted above, the Select Committee does not believe that it has the legal expertise to propose specific amendments to Ontario's mental health legislation, or in this case, personal health information legislation. However, the Committee is convinced that changes to *PHIPA* are necessary to ensure that caregivers are provided with the appropriate personal health information.

The Select Committee therefore recommends

> **22.** The task force created to investigate and propose changes to Ontario's mental health legislation and policy should also investigate and propose changes to the *Personal Health Information Protection Act, 2004.* The changes should ensure that family members and caregivers providing support to, and often living with, an individual with a mental illness or

[12] Appendix D provides further information about the *Personal Health Information Protection Act, 2004*.
[13] Information and Privacy Commissioner, "Recommendations for Amendments to the *Personal Health Information Protection Act, 2004*," 28 August 2008, No. 17.
[14] British Columbia, *Guide to the Mental Health Act*, 2005 ed., 4 April 2005.

addiction have access to the personal health information necessary to provide that support, to prevent the further deterioration in the health of that individual, and to minimize the risk of serious psychological or physical harm.

CONCLUSION AND FOLLOW-UP

In closing, the Select Committee would once again like to thank the many people who have contributed to this project. Even though the subject matter has been at times quite difficult, we feel privileged to have been given this important work.

However, we are aware that many reports regarding Ontario's mental health and addictions system have already been submitted, some of which have made similar recommendations to this document. The necessary changes have yet to be made, and individuals continue to suffer.

The Select Committee therefore recommends

23. The Legislative Assembly of Ontario should review progress on the implementation of the recommendations in this report within two years of its adoption.

As we noted in the introduction, there is public expectation that action will be taken. We share this expectation.

CONSOLIDATED LIST OF RECOMMENDATIONS

1. A new umbrella organization—Mental Health and Addictions Ontario (MHAO), responsible to the Ministry of Health and Long-Term Care—should be created to ensure that a single body is responsible for designing, managing, and coordinating the mental health and addictions system, and that programs and services are delivered consistently and comprehensively across Ontario.

and

All mental health and addictions programs and services—for all regions of the province and for all ages, including children and youth—should be consolidated in the Ministry of Health and Long-Term Care. (See detailed recommendations regarding MHAO's mission statement, strategic goals, and responsibilities in the body of the report.) *(pp. 3-5)*

2. Mental Health and Addictions Ontario should ensure that a basket of core institutional, residential and community services is available in every region of the province for clients of all ages, identify gaps, and eliminate duplication. Referral patterns must be put in place for the provision of those specialized services only available outside of a region. Each region must also have sufficient capacity to care for clients with concurrent disorders. *(pp. 6-7)*

3. Clients and their families should have access to system navigators who will connect them with the appropriate treatment and community support services (e.g., housing, income support, employment, peer support, and recreational opportunities). Those with continuing, complex needs should be supported by a plan that will lead them through their journey to recovery and wellness, particularly on discharge from institutional or residential treatment. *(pp. 6-7)*

4. Mental Health and Addictions Ontario should conduct an assessment of the need for acute care psychiatric beds for both children and adults by region. *(pp. 7-8)*

5. Mental Health and Addictions Ontario should ensure that primary care providers and relevant staff in all levels of the education and long-term care systems have access to common, age-appropriate, evidence-based assessment and screening tools. *(p. 8)*

6. Mental Health and Addictions Ontario should facilitate the creation of more 24/7 mobile crisis intervention teams. *(pp. 8-9)*

7. The Ministry of Health and Long-Term Care should expand and do more to publicize Telehealth Ontario's ability to respond to callers with mental health and addictions issues. *(pp. 8-9)*

8. Mental Health and Addictions Ontario should work with the Ministry of Health and Long-Term Care to review emergency department protocols in order to increase their capacity to deal effectively, efficiently and sensitively with people appearing with mental health and addictions issues, and when appropriate, redirect or connect them to community-based services and supports. *(p. 9)*

9. Primary care providers should be given the proper tools and support to enable them to develop a greater sensitivity for the mental health and addictions needs of their patients. This can take such forms as part of formal academic programs or continuing education. *(pp. 9-10)*

10. All interdisciplinary primary care models should include a mental health and addictions treatment component (e.g., social worker, psychiatrist, psychologist or mental health worker). *(pp. 9-10)*

11. The Ministry of Health and Long-Term Care should immediately address the problem of addiction to prescription painkillers. *(pp. 9-10)*

12. The Ministry of Health and Long-Term Care should examine further changes to the family physician remuneration model to focus on improving access to and the quality of primary care for people with mental illnesses and addictions. *(pp. 9-10)*

13. Mental Health and Addictions Ontario should ensure, coordinate and advocate for the creation of additional affordable and safe housing units, with appropriate levels of support to meet the long-term and transitional needs of people with serious mental illnesses and addictions. *(p. 11)*

14. Mental Health and Addictions Ontario should ensure that institutional and community-based service providers actively seek to involve peer support workers in all aspects of service delivery and take advantage of the Ontario Peer Development Initiative's Peer Support Toolkit Project that will enable peer support organizations to accredit peer workers. *(p. 11)*

15. Mental Health and Addictions Ontario should work with employers and community-based service providers on strategies to increase employment opportunities and supports for people with mental illnesses and addictions. *(pp. 11-12)*

16. Mental Health and Addictions Ontario should provide for the increased availability of respite care to allow family members the time and freedom to pursue personal, social and recreational endeavours in order to maintain their own mental health. It should also monitor the progress of the Mental Health Commission of Canada's Mental Health Family Link program's peer support project for family caregivers, and adopt best practices. *(pp. 12-13)*

17. The services of court mental health workers should be made widely available across all regions of Ontario, in order to divert more individuals with a mental

illness or addiction out of the justice system and into appropriate mental health and addictions services and supports. *(pp. 13-14)*

18. Additional Mental Health, Drug Treatment, and Youth Mental Health Courts should be created across all regions of Ontario, to provide more appropriate services for individuals with a mental illness or addiction. *(pp. 13-14)*

19. The Ministry of Community Safety and Correctional Services should direct police forces across the province to provide training for officers who may encounter people suffering from mental illnesses and addictions. *(pp. 13-14)*

20. The core basket of mental health and addictions services should be available to the incarcerated population, and discharge plans for individuals with a mental illness or addiction should be expanded to include the services of a system navigator and appropriate community services. *(pp. 13-14)*

21. The Ministry of Health and Long-Term Care should create a task force, incorporating adequate representation from, among others, mental health clients and their caregivers as well as mental health law experts, to investigate and propose changes to Ontario's mental health legislation and policy pertaining to involuntary admission and treatment. The changes should ensure that involuntary admission criteria include serious harms that are not merely physical, and that involuntary admission entails treatment. This task force should report back to the Ministry within one year of the adoption of this report by the Legislative Assembly. *(pp. 14-16)*

22. The task force created to investigate and propose changes to Ontario's mental health legislation and policy should also investigate and propose changes to the *Personal Health Information Protection Act, 2004.* The changes should ensure that family members and caregivers providing support to, and often living with, an individual with a mental illness or addiction have access to the personal health information necessary to provide that support, to prevent the further deterioration in the health of that individual, and to minimize the risk of serious psychological or physical harm. *(pp. 16-18)*

23. The Legislative Assembly of Ontario should review progress on the implementation of the recommendations in this report within two years of its adoption. *(p. 18)*

APPENDIX A

Committee Mandate and Processes

COMMITTEE MANDATE

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

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

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

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

[1] Ontario, Legislative Assembly, *Votes and Proceedings*, 1st Sess., 39th Parl. (24 February 2009): 3.

PRECEDING DEVELOPMENTS

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

Two Ontario developments are particularly noteworthy: creation of the Minister's Advisory Group and passage of a Private Member's motion. The former Minister of Health and Long-Term Care established the Minister's Advisory Group on Mental Health and Addictions in October 2008. The membership of the Minister's Advisory Group will help to develop a new 10-year strategy for mental health and addictions services. As a first step, it released a consultation paper, *Every Door is the Right Door*, in July 2009.[2]

On December 4, 2008, Christine Elliott (PC – Whitby-Oshawa) moved the following:

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

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

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

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

The mental health issues of children;

The increase in suicide among young people;

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

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

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

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

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

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

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

The motion carried unanimously. [3]

COMMITTEE MEETINGS

The Committee met for the purpose of organization and to discuss business matters in March and early April 2009. Public hearings were held in Toronto and various other locations, beginning in mid-April 2009 and ending in early May 2010. The spring 2009 hearings involved presentations by government ministries which play a role in the delivery of mental health and addictions services. The Auditor General of Ontario spoke about relevant audits which were reported in his *2008 Annual Report*. Also appearing during this period were invited guests who attended as individuals or representatives of stakeholder groups (for example, former Senator Michael Kirby on behalf of the Mental Health Commission of Canada).

In the weeks following, the Committee heard from individual consumers/survivors, family members, health care and social service professionals, and related organizations. The Committee also met with the Minister's Advisory Group on Mental Health and Addictions twice, and the Minister of Health and Long-Term Care.

All told, the Committee held public hearings on 30 dates during which it received the testimony of more than 230 individuals and organizations. It received more than 300 submissions, including written briefs, memoranda, journal and magazine articles, pamphlets, newspaper articles, and DVDs. The Committee's schedule of public hearings, and a list of witnesses and submissions are found in Appendix B.

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

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[3] Ontario, Legislative Assembly, *Votes and Proceedings*, 1st Sess., 39th Parl. (4 December 2008): 5 and 6.

SITE VISITS

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

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

APPENDIX B

Schedule of Public Hearings
List of Witnesses and Submissions

SCHEDULE OF PUBLIC HEARINGS

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

Toronto	April 8 and 22; May 6, 13 and 27; June 3; September 8, 16, 23, and 30; October 7, 21 and 28; November 4, 18 and 25; December 2 and 9, 2009; March 24; April 14, 21, and 28; May 5; June 2 and 7, 2010[1]
Windsor	June 15, 2009
St. Thomas	June 16, 2009
Hamilton	June 17, 2009
Kingston	June 18, 2009
Ottawa	September 9, 2009
Sudbury	September 10, 2009
Thunder Bay	September 11, 2009

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

LIST OF WITNESSES AND SUBMISSIONS[2]

(as of July 21, 2010)

Organization/Individual	Date of Appearance	Submission(s)
Addictions and Mental Health Network of Champlain		✓
Addictions Ontario; Canadian Mental Health Association, Ontario Division; Centre for Addiction and Mental Health; Ontario Association of Patient Councils; Ontario Federation of Community Mental Health and Addiction Programs; Ontario Peer Development Initiative		✓
Advisory Committee for Mental Health and Addiction Services	September 11, 2009	✓
Advocacy Centre for the Elderly		✓
Alliance of Psychotherapy Training Institutions	September 8, 2009	✓

[1] The 2 and 7 June 2010 hearings were in-camera.
[2] Submissions include written briefs, memoranda, letters, journal and magazine articles, pamphlets, newspaper articles, and DVDs.

Organization/Individual	Date of Appearance	Submission(s)
Alzheimer Society of North Bay and District	September 10, 2009	✓
Alzheimer Society of Thunder Bay	September 11, 2009	✓
Andruski, Peter	September 23, 2009	
Associated Youth Services of Peel	December 2, 2009	
Association for Better Care of Children		✓
Atwood, Brenda, Karen Miller and Linda Kachur	September 11, 2009	
Aubert, Annick		✓
Auditor General of Ontario	May 13, 2009	✓
Baker, Eleanor	October 21, 2009	✓
Baker, Kathy and Ann Tassonyi	November 18, 2009	✓
Bélanger, Maryse	November 25, 2009	✓
Bell, Lorie	September 10, 2009	✓
Bethany Residential Care Program	December 2, 2009	✓
Blais, Aimé		✓
Bowering, Donna	June 16, 2009	✓
Brain Injury Services of Northern Ontario	September 11, 2009	
Brown, Dr. Alan	November 4, 2009	✓
Brown, Chris		✓
Brown, Rev. Glenn	September 8, 2009	✓
Buchanan, Lembi		✓
Buchholz, Andreas	September 11, 2009	
Bulimia Anorexia Nervosa Association	June 15, 2009	✓
Burge, Dr. Philip	June 18, 2009	✓
Burlington Counselling and Family Services	June 17, 2009	✓
Canadian Association for Pastoral Practice and Education, Ontario	June 17, 2009	
Canadian Counselling Association	June 18, 2009	✓
Canadian Hearing Society	June 16, 2009	✓
Canadian Mental Health Association, Champlain East Branch	September 9, 2009	✓
Canadian Mental Health Association, Elgin Branch	June 16, 2009	✓
Canadian Mental Health Association, Nipissing Regional Branch	September 10, 2009	
Canadian Mental Health Association, Ontario Division	May 27, 2009	✓

Organization/Individual	Date of Appearance	Submission(s)
Canadian Mental Health Association, Ontario Division, Ontario Consumer and Family Advisory Council	November 18, 2009	✓
Canadian Mental Health Association, Ottawa Branch	September 9, 2009	✓
Canadian Mental Health Association, Sudbury-Manitoulin Branch	September 10, 2009	✓
Canadian Mental Health Association, Thunder Bay Branch	September 11, 2009	✓
Canadian Mental Health Association, Toronto Branch	October 7, 2009	✓
Canadian Mental Health Association, Windsor Essex County Branch, Consumer Council	June 15, 2009	✓
Canadian Paediatric Society	September 9, 2009	✓
Canadian Pensioners Concerned, Ontario	September 8, 2009	✓
Caritas Project	October 21, 2009	✓
Carla	June 17, 2009	✓
Casola, Dr. Paul and Adrianne Sequeira	September 8, 2009	✓
Centre for Addiction and Mental Health	June 3, 2009	✓
Centre for Addiction and Mental Health, Centre for Prevention Science	June 16, 2009	✓
Centre for Addiction and Mental Health, Problem Gambling Institute of Ontario	March 24, 2010	✓
Champlain Addiction Coordinating Body	September 9, 2009	✓
Champlain Mental Health Network	September 9, 2009	✓
Chatham-Kent Consumer and Family Network	June 15, 2009	✓
Child Development Institute	October 28, 2009	
Children's Centre Thunder Bay	September 11, 2009	✓
Children's Mental Health Ontario	June 3 and December 2, 2009	✓
Chittaro, Eddie	June 15, 2009	
Citizens Commission on Human Rights Canada		✓
Clark-Wittenberg, Sue	September 9, 2009	
Coalition Against Psychiatric Assault	September 23, 2009	✓
Community Counselling Centre of Nipissing	September 10, 2009	
Community Criminal Justice Organizations		✓
Community Networks of Specialized Care	December 2, 2009	✓

Organization/Individual	Date of Appearance	Submission(s)
Concerned Friends of Ontario Citizens in Care Facilities	November 25, 2009	✓
Connex*Ontario*[3]	March 24, 2010	✓
Cortese, Dr. Leonardo	June 15, 2009	
Csiernik, Dr. Richard	June 16, 2009	✓
Cunningham, Mary K.		✓
Dandy, Cathy	September 8, 2009	✓
Dare to Dream Program	September 9, 2009	
de Camps Meschino, Dr. Diane	September 16, 2009	✓
de Mercedes-Angelssen, Vincent	September 23, 2009	✓
Dealberto, Dr. Marie-José	September 9, 2009	✓
District of Thunder Bay Social Services Administration Board	September 11, 2009	✓
Downtown Guelph Fetal Alcohol Spectrum Disorder Support Group	September 8, 2009	✓
Drug Awareness Committee of Thunder Bay	September 11, 2009	
Drummond, Heather	September 23, 2009	✓
Dubois, Catherine and Germain Dubois	September 9, 2009	
Dufresne, Dr. Annette	June 15, 2009	✓
Dukes, Mark	October 7, 2009	
Duncan, Heather A.		✓
Durham Mental Health Services	June 3, 2009	✓
Durham Regional Police Service; University of Ontario Institute of Technology; Ontario Shores Centre for Mental Health Sciences; Durham College	April 21, 2010	✓
Echo: Improving Women's Health in Ontario		✓
Elgin Respite Network	June 16, 2009	✓
Elgin St. Thomas RAISE Coalition (Reducing Addictions – Increasing Safe Environments)	June 16, 2009	✓
Elson, Steve	June 16, 2009	✓
Eshesh, Gamal		✓
Eva's Initiatives	October 21, 2009	✓
Fair Share Task Force	September 8, 2009	✓
Family Advocates for Mental Health and Addictions		✓

[3] This presentation was in-camera for technical reasons.

Organization/Individual	Date of Appearance	Submission(s)
Family Service Ontario	November 18, 2009	✓
Ferguson, Kerry	June 16, 2009	
Fetal Alcohol Spectrum Disorder Coalition of Ottawa	September 9, 2009	✓
Fetal Alcohol Spectrum Disorder Stakeholders for Ontario	October 21, 2009	✓
Fine, Randi	November 18, 2009	✓
Fink, Judith	June 17, 2009	✓
Finn, Paul and Denise Finn	June 18, 2009	✓
Forsdyke, Patricia	June 18, 2009	✓
Frederick, Mary Ellen	June 17, 2009	
Frontline Partners with Youth Network	October 21, 2009	✓
Fuller, Moira E.		✓
General Practice Psychotherapy Association		✓
Gerstein Centre	April 22, 2009	
Gestalt Institute of Toronto	November 18, 2009	✓
Gillies, Catherine	September 11, 2009	
Goering, Dr. Paula	May 27, 2009	✓
Gorski Centre for Applied Sciences	September 8, 2009	✓
Gray, Dr. John	December 9, 2009	✓
Griffin Centre	September 8, 2009	✓
Group of Families from the Ottawa Area		✓
Guelph General Hospital, Emergency Mental Health Unit		✓
Gunn, Margareth		✓
H.M., Mrs.	September 30, 2009	✓
Hacio, Lois		✓
Hadida, Donna		✓
Haldimand-Norfolk Resource Centre	June 17, 2009	✓
Halton Region Our Kids Network	October 28, 2009	✓
Hamilton Addiction and Mental Health Collaborative	June 17, 2009	✓
Hartman, Joy A.		✓
Heath, Dr. David	September 8, 2009	✓
Home Suite Hope Shared Living Corp.		✓

Organization/Individual	Date of Appearance	Submission(s)
Hope Place Centres	September 8, 2009	✓
Hôpital Général de Hawkesbury and District General Hospital; Centre Royal-Comtois Center; Dr. Suzanne Filion		✓
Hôtel Dieu Hospital/Kingston General Hospital Mental Health Program	November 4, 2009	✓
House of Sophrosyne	June 15, 2009	✓
Hudson, Barry	September 23, 2009	
Huron Perth Healthcare Alliance	June 16, 2009	✓
Hussman, Jack		✓
Jabalee, Christina, Jennifer Takacs and Carol Farkas	October 28, 2009	
John Howard Society of Canada	June 18, 2009	✓
John Howard Society of Hamilton, Burlington and Area		✓
John Howard Society of Ontario	April 21, 2010	✓
John Howard Society of Sault Ste. Marie		✓
John Howard Society of Sudbury		✓
John Howard Society of Thunder Bay and District	September 11, 2009	✓
John Howard Society of Toronto		✓
John Howard Society of Waterloo-Wellington		✓
Johnson Purden, Sherri	September 10, 2009	
Kairow, Iris	September 30, 2009	✓
Kinark Child and Family Services	September 8, 2009	✓
Kinna-aweya Legal Clinic	September 11, 2009	✓
Kirby, Michael	May 27, 2009	
Koka, Dr. Rayudu	September 10, 2009	✓
Lavallée, Diane	April 14, 2010	✓
Layton, John		✓
Legacy of Hope Foundation		✓
Lester, Dr. Bob	December 2, 2009	✓
LHIN (Local Health Integration Network) Collaborative	April 28, 2010	✓
Lindsey, Heather	June 15, 2009	✓
LOFT Community Services	September 8, 2009	✓

Organization/Individual	Date of Appearance	Submission(s)
London Health Sciences Centre; St. Joseph's Health Care	June 16, 2009	✓
Long, Victoria	September 23, 2009	✓
Lurie, Steve (see also Canadian Mental Health Association, Toronto Branch)		✓
MacLean, Sandra	September 11, 2009	✓
Magpie Publishing		✓
Mainstay Housing		✓
Marcil, André (see also Hearst, Kapuskasing and Smooth Rock Falls Counselling Services)	April 14, 2010	✓
Margaret Frazer House	September 8, 2009	
Martin, Neasa	September 8, 2009	✓
McCaffrey, C.J.	September 9, 2009	✓
McGrattan, Lorraine and Paul Hamel	June 17, 2009	✓
McLelland, Maureen; Hôpital régional de Sudbury Regional Hospital	September 10. 2009	✓
McNeely, Joyce	September 9, 2009	✓
Mederak, Jane	September 30, 2009	✓
Mental Health Commission of Canada		✓
Mental Health Legal Committee	September 23, 2009	
Mental Health Rights Coalition	June 17, 2009	✓
Ministry of Aboriginal Affairs	May 6, 2009	✓
Ministry of the Attorney General	April 22, 2009	✓
Ministry of Children and Youth Services	June 3, 2009	✓
Ministry of Citizenship and Immigration	May 6, 2009	✓
Ministry of Community and Social Services	May 6, 2009	✓
Ministry of Community Safety and Correctional Services	May 6, 2009	✓
Ministry of Education	June 3, 2009	✓
Ministry of Health and Long-Term Care	April 22 and December 9, 2009	✓
Ministry of Health Promotion	April 22, 2009	✓
Minwaashin Lodge, Aboriginal Women's Support Centre	September 9, 2009	✓
Modi, Rakesh	November 25, 2009	✓
National Association for the Dually Diagnosed	October 28, 2009	✓

Organization/Individual	Date of Appearance	Submission(s)
Nickel-a-Drink for Addictions and Mental Health Research Foundation	October 28, 2009	✓
Noojmowin Teg Health Centre	September 10, 2009	✓
North of Superior Counselling Programs	September 11, 2009	✓
Northumberland Poverty Reduction Action Committee	November 18, 2009	✓
O'Hara, Frank (Family Council/Secret Handshake)	September 23, 2009	✓
O'Reilly, Dr. Richard	April 14, 2010	✓
Oborne, Dr. David W.		✓
Offord Centre for Child Studies	June 17, 2009	✓
Oneida Nation of the Thames		✓
Ontario Art Therapy Association	June 16, 2009	✓
Ontario Association for Suicide Prevention	November 18, 2009	✓
Ontario Association of Consultants, Counsellors, Psychometrists, and Psychotherapists	June 18, 2009	✓
Ontario Association of Non-Profit Homes and Services for Seniors	November 25, 2009	✓
Ontario Association of Non-Profit Homes and Services for Seniors, Region 7	September 9, 2009	
Ontario Association of Psychological Associates	September 30, 2009	✓
Ontario Association of Social Workers		✓
Ontario Coalition of Mental Health Professionals	September 30, 2009	
Ontario College Counsellors	September 9, 2009	✓
Ontario College Health Association		✓
Ontario College of Family Physicians	September 16, 2009	✓
Ontario Community Outreach Program for Eating Disorders	November 25, 2009	✓
Ontario Federation of Community Mental Health and Addiction Programs	November 25, 2009	✓
Ontario Federation of Indian Friendship Centres		✓
Ontario Hospital Association	October 7, 2009	✓
Ontario Human Rights Commission	October 7, 2009	✓
Ontario Long Term Care Association	November 4, 2009	✓
Ontario Peer Development Initiative		✓
Ontario Problem Gambling Research Centre	March 24, 2010	
Ontario Psychiatric Association	September 11, 2009	✓

Organization/Individual	Date of Appearance	Submission(s)
Ontario Public Service Employees Union	September 9 and December 2, 2009	✓
Ontario Seniors' Secretariat	June 3, 2009	✓
Ontario Shores Centre for Mental Health Sciences	June 18, 2009	✓
Ontario Society of Psychotherapists	September 30, 2009	
Ontario Telemedicine Network	June 18, 2009	✓
Ormston, Hon. Mr. Justice Edward F.	June 7, 2010	
Parents for Children's Mental Health	April 8, 2009	✓
Paterson, Penny and John Paterson	June 18, 2009	
Peel Children's Centre	October 7, 2009	✓
Pilon, Colette	September 10, 2009	✓
Pitfield, Terrie	September 10, 2009	
Provincial Centre of Excellence for Child and Youth Mental Health at Children's Hospital of Eastern Ontario	September 9, 2009	✓
Psychiatric Patient Advocate Office	September 8, 2009	✓
Psychiatric Survivors of Ottawa	September 9, 2009	✓
Purdon, Joanne	November 4, 2009	✓
Raising Our Children's Kids (Canada)	June 17, 2009	
Ramakrishnan, Madhuri and Kris Ramakrishnan	June 17, 2009	✓
Regional Municipality of Halton, Office of the Chair		✓
Regional Municipality of Peel, Office of the Chair		✓
Registered Nurses' Association of Ontario	October 7, 2009	✓
Renascent		✓
Réseau des services de santé en français de l'Est de l'Ontario		✓
Rideauwood Addiction and Family Services	September 9, 2009	✓
Robin, Cindy	September 10. 2009	✓
Robinson, Gary	September 8, 2009	
Ross, Marvin	September 8, 2009	✓
Royal Ottawa Health Care Group	September 9, 2009	✓
Russell, Jane	September 9, 2009	
St. Jude Community Homes (See Children's Mental Health Ontario)	December 2, 2009	
Sacks, Dr. Diane	October 28, 2009	

Organization/Individual	Date of Appearance	Submission(s)
Sandy Lake First Nation		✓
Schizophrenia Society of Ontario	September 16, 2009 and April 21, 2010	✓
Schizophrenia Society of Ontario, Thunder Bay Chapter	September 11, 2009	✓
Self Help Alliance	June 16, 2009	✓
Seniors Health Research Transfer Network	November 4, 2009	✓
Services de Counselling Hearst, Kapuskasing et Smooth Rock Falls Counselling Services (see also André Marcil)		✓
Shearon, Victoria	June 15, 2009	
Sherbourne Health Centre	October 7, 2009	✓
Sherring, Rena		✓
Simpson, David	June 16, 2009	
Sioux Lookout Community Action Partnership for Fetal Alcohol Spectrum Disorder	September 11, 2009	✓
Sioux Lookout First Nations Health Authority		✓
Social Planning Council of Sudbury	September 10, 2009	
Société Alzheimer Society of Ottawa and Renfrew County	September 9, 2009	✓
Société Alzheimer Society of Sudbury-Manitoulin	September 10, 2009	✓
Société Alzheimer Society of Ontario	June 16, 2009	✓
Southern Network of Specialized Care		✓
Starr, Rev. Sky	October 7, 2009	✓
Stevenson, Dr. Cameron	June 18, 2009	✓
Stone, Jordan and Bowen McConnie (Secret Handshake)	September 30, 2009	✓
Stress Reduction Program		✓
Success By 6 Ottawa	September 9, 2009	
Sudbury Action Centre for Youth	September 10, 2009	✓
Sullivan, Dr. Terrence	June 2, 2010	✓
Teskey, Patricia	September 8, 2009	
Thames Valley District School Board Mental Health and Wellness Committee	June 16, 2009	✓
The Dream Team		✓
The Men's Project	September 9, 2009	✓

Organization/Individual	Date of Appearance	Submission(s)
The New Mentality	November 4, 2009	✓
Thomas, Lynn		✓
Tides Centre/Social Venture Network		✓
Toronto, City of, Shelter, Support and Housing Administration	October 21, 2009	✓
Tregunno, Kevin	September 8, 2009	
Tyson, Judy	June 17, 2009	
United Way/Centraide Ottawa	September 9, 2009	✓
Usselman-Tod, Simone	October 21, 2009	✓
Voukelatos, Vicky		✓
Wass, Gaby	June 16, 2009	
Waterford Family Council	November 18, 2009	
Weber, James	September 8, 2009	✓
Weeneebayko Area Health Authority Traditional Healing Program		✓
Weeneebayko General Hospital		✓
Westfall, Marlene	June 17, 2009	
Wesway		✓
Whitney, Diane		✓
Wiebe, Jean	June 17, 2009	✓
Windsor-Essex County Drug Strategy Implementation Group	June 15, 2009	✓
Woodview Children's Mental Health and Autism Services		✓
Woodview Manor Parents' Council	November 4, 2009	
X, Mrs.	September 8, 2009	
York Centre for Children, Youth and Families; Blue Hills Child and Family Centre; Kinark Child and Family Services	December 2, 2009	✓
Youthdale Treatment Centres	May 5, 2010	✓
YouthLink	December 2, 2009	✓
Zakrzewska, Eva	September 30, 2009	✓
416 Community Support for Women	September 8, 2009	

APPENDIX C

Schedule 1 Designated Psychiatric Facilities

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

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

[1] Ontario, Ministry of Health and Long-Term Care, "Public Information: Health Services in Your Community - Designated Psychiatric Facilities under the *Mental Health Act*," updated 27 October 2003, last modified 26 April 2010. Internet site at http://www.health.gov.on.ca/english/public/contact/psych/designated.html, accessed 23 July 2010.

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

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

[2] Formerly Welland County General Hospital.

APPENDIX D

Ontario's *Mental Health Act*, *Health Care Consent Act, 1996* and *Personal Health Information Protection Act, 2004*

Introduction

This appendix provides a brief summary of Ontario's *Mental Health Act* as it relates to voluntary and involuntary admission to psychiatric facilities, the *Health Care Consent Act, 1996* as it relates to consent to treatment and the capacity to give that consent, and the *Personal Health Information Protection Act, 2004*.

The *Mental Health Act*

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

Form 1 – Application by Physician for Psychiatric Assessment

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

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

[1] R.S.O. 1990, c. M.7. E-laws Internet site at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm, accessed 29 July 2010.

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

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

Form 2 – Order for Examination

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

Form 3 – Certificate of Involuntary Admission

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

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

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

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

The *Health Care Consent Act, 1996*

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

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

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

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

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

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[10] Byrick and Walker-Renshaw, *A Practical Guide to Mental Health and the Law in Ontario*, p. 40.
[11] S.O. 1996, c. 2. E-laws Internet site at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm, accessed 29 July 2010.
[12] Byrick and Walker-Renshaw, *A Practical Guide to Mental Health and the Law in Ontario*, p. 7.
[13] Ibid. There are exceptions in the case of an emergency and if a person has been accused of a criminal offence (and the treatment is required in order to stand trial). These requirements are outlined in s. 25(3) of the *HCCA, 1996*, and s. 672.59(1) of the *Criminal Code*, R.S.C. 1985, c. C-46.
[14] *Health Care Consent Act*, s. 4(1).
[15] Ibid., s. 18(3) and (4).

The *Personal Health Information Protection Act, 2004*

Ontario's *Personal Health Information Protection Act, 2004* (*PHIPA*) governs the collection, use, and disclosure of personal health information by health information custodians, which include hospitals and health care practitioners (s. 3(1)).[16]

PHIPA is a consent-based statute. For example, the Act requires the express consent of an individual for the release of his or her personal health information to someone who is not a health information custodian (s. 18(3)(a)). Individuals may also withhold or withdraw their consent to the collection, use or disclosure of their personal health information to a health information custodian, even if the purpose is to provide or assist in providing health care (s. 20(2)). As explained in a *Fact Sheet* published by the Office of the Information and Privacy Commissioner/Ontario,

> [*PHIPA*] gives Ontarians control over the collection, use, and disclosure of their personal health information by stipulating that health information custodians can only collect, use and disclose an individual's personal health information with the express or implied consent of that individual, subject to limited exceptions.[17]

One of these limited exceptions may occur "if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons" (s. 40(1)).

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[16] S.O. 2004, c. 3. Internet site at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm, accessed 21 July 2010.

[17] Office of the Information and Privacy Commissioner/Ontario, *Lock-box Fact Sheet*, July 2005, IPC Internet site at http://www.ipc.on.ca/images/Resources/fact-08-e.pdf, accessed 21 July 2010.