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# **Submission to the Select Committee on Mental Health and Addictions**

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## ***Executive Summary***

The Centre for Addiction and Mental Health (CAMH) has prepared this submission to provide advice to the Ontario Legislature's Select Committee on Mental Health and Addictions. CAMH supports the decision of the Legislature to establish the committee, and is available to provide any further information the Committee requires.

Mental health and addiction issues have achieved considerable public profile in recent years. The Government of Canada has established the *Mental Health Commission of Canada*, which is currently developing a national strategy. In Ontario, significant new investments have been made in community mental health over the past five years, and capacity in community mental health has been expanded. (At both national and provincial levels significantly less attention has been paid to addiction treatment.)

The progress that has been made in recognizing the rights and capacities of people with mental health and addictions problems – and in improving access to treatments – remains compromised by stigma, funding levels, and the capacity of treatment services to act as a system.

Stigma prevents people from seeking help, and prevents society from taking responsibility for providing services and supports. One way to address stigma is to support the role that primary care plays in helping people with mental health and addictions. Primary care is the most widely used setting for mental health and addiction care, and represents a non-stigmatising environment for delivering treatments and supports. Primary care will be instrumental in addressing the need for better access to care.

Funding support for mental health and addictions remains low. While mental health and addictions account for roughly 13% of death, disability and illness, it receives only 5% of Canadian public health care expenditure. Relative to other OECD countries, Canadian proportion of health care spending in this area is low and relative to other Canadian provinces, Ontario's spending is low. Most importantly, there are many

examples of the inability of services to meet demand. When the call for help is made, the response from health care should be supportive and swift. The Select Committee should recommend a long-term strategy to increase funding, while carefully evaluating the effect of new funding on access to care and clinical outcomes.

Mental health and addictions care must also work better as a continuum of services that can respond effectively to the needs of clients. There is no single way to provide treatment for mental illness and substance abuse -- investments must support a broad system of care. Given the number of people who experience both a mental health problem and a substance use disorder, these services must be better integrated. Services must also be encouraged to provide programs that are accessible to Ontario's diverse population.

Finally, many of the most important supports for people with mental health and addiction problems are not health programs – they are investments in affordable housing, income assistance and employment that promote full inclusion in our society. These investments are critical for those whose lives are most seriously affected by their mental illness or addiction, and are a critical part of the support offered to some of the most marginalized people in Ontario.

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## ***Introduction***

### **The Centre for Addiction and Mental Health (CAMH)**

The Centre for Addiction and Mental Health (CAMH) is the largest mental health and addictions facility in Canada. CAMH is a teaching hospital fully affiliated with the University of Toronto and has been recognized internationally as a Pan-American Health Organization and World Health Organization Collaborating Centre.

CAMH seeks to improve the lives of those affected by addiction and mental health problems and promote health. We operate central clinical and research facilities in Toronto, as well as 27 satellite offices across the province that work with partners to improve the quality and accessibility of services within the addiction and mental health system. While CAMH's work focuses on the needs of Ontario communities, our impact extends across the country and internationally.

CAMH has begun a physical transformation at its primary site on Queen Street West in Toronto. The site was developed as an asylum, and the patient spaces promote isolation and dependence. Our current physical environment emphasizes the separateness of mental health and addiction problems from the mainstream of community life. Yet dramatic advances in treatment and a growing appreciation for the prevalence of these conditions tell us that supporting people with mental health and addiction problems must take place in our schools, our workplaces, our families and our communities as well as in health care institutions. That is why our physical redevelopment will emphasize the connection of the person to the community, and the central role the individual plays in leading his or her recovery.

### **Mental Health and Addictions – Out of the Shadows**

Mental health and addiction problems have attracted significant attention in recent years. More than any other factor, the individual narratives of recognizing mental health and addiction problems, seeking help from others and finding hope have been instrumental in gaining greater public acceptance. At the national level, on the recommendation of the Senate Committee Report *Out of the Shadows at Last*, the

government has created the *Mental Health Commission of Canada*. The Commission has a mandate to develop a national mental health plan, launch a campaign against stigma, and promote knowledge exchange. In Ontario, significant new investments have been made in community mental health over the past five years, and capacity in community mental health has been expanded. The current Minister of Health and Long-Term Care has begun a ministerial process to develop a provincial mental health and addictions strategy. The creation of the Select Committee on Mental Health and Addictions by the Legislative Assembly of Ontario is further evidence of a growing interest in mental health and addiction problems, and is welcomed by all who seek greater attention paid to these issues.

Yet enthusiasm is tempered by experience. The progress that has been made in recognizing the rights and capacities of people with mental health and addictions – and in improving the available treatments – remains compromised by three significant factors:

- The **stigma** against persons with mental illness and addictions remains a barrier to care.
- **Funding** for mental health and addictions treatments are simply inadequate relative to the burden of illness.
- The capacity of mental health and addiction services to act as a **system** – built around the particular needs of individual clients – needs to improve.

Ontario's mental health and addiction strategy must address stigma, offer the hope of enriched funding, and support improved systems of care. The recommendations CAMH makes in this document address these three fundamental challenges to improved care for people with mental health and addiction problems.

## ***Foundations of a Mental Health Strategy***

### **Mental health and addictions – the need for investment**

Ontario should establish a long-term goal of bringing mental health and addiction spending in line with OECD benchmarks, and in closer alignment with the burden of disease.

International analysis of the total public investments in mental health and addictions show that Canada lags behind other countries. Total mental health care spending in Canada was most recently estimated to comprise about 5% of total health care spending (IHE Report, 2008). This is a rate below most comparable countries, and significantly below the percentage of spending on mental health in the United Kingdom, Germany, the United States and Australia. If Canada were to establish a benchmark of the average of countries with similar income levels and epidemiological profiles, Canada would spend an addition \$800 million on mental health care annually. Relative to the burden of disease – a World Health Organization methodology for quantifying the effects of different diseases – the record is worse; the global burden of disease for neuropsychiatric conditions was 13% in 2002, and is estimated to increase to 15% by 2020 spending (IHE Report, 2008).

Within Canada, Ontario's record is not very good. Only the Saskatchewan and Newfoundland and Labrador governments spend less per capita on mental health services. Ontario's per capita investments in community mental health are strikingly lower than in British Columbia and Quebec, and well below the national average spending (IHE Report, 2008). (While this study was published last year, the data come from 2003-04; given Ontario's recent investments in community mental health, Ontario's relative position has likely improved.)

The inability to adequately fund mental health and addiction services is deeply rooted in our collective shame and discomfort about confronting these problems. Governments' manifestly inadequate response to the burden represented by mental health and addiction problems perpetuates this attitude. Using population based studies, researchers have estimated there are 1.6 million Canadians with an undiagnosed mental

illness (Lim, Jacobs, Ohinmaa, Schopflocher & Dewa, 2008). Although it is shame and stigma that often prevent the call for help, many can't get the help they require even if that call is made. The mental health and addictions system continues to lack capacity in many areas. As an example, recent research in court support programs pointed out that although one program can serve up to 120 individuals per year, the number of individuals that go through that particular court is in the thousands (Aubrey, 2009). Similarly, access to psychiatrists is still not adequate; for example, only 40% of Assertive Community Treatment Teams (ACTT) in Ontario have the required psychiatrist FTE (George, 2009), despite the fact that this particular program is a critical community mental health service for individuals with severe mental illness.

## **Social Determinants of Health - Poverty Reduction**

<p>Ontario's anti-poverty initiatives must include strategies to support people with mental health and addictions problems -- particularly programs that strengthen the connection to educational and employment opportunities.</p>
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The Government of Ontario has committed itself by statute to the development of poverty reduction planning, target setting and reporting. CAMH is encouraged by this development. The legislation recognizes that not all people share the same level of risk of poverty. People with serious mental health and addiction problems often experience significant barriers to securing adequate employment and education, and therefore live in chronic poverty. CAMH has a strong interest in increasing the capacity of our clients to live full lives in the community; poverty and exclusion from the workforce are barriers to meeting this objective.

No comprehensive poverty reduction strategy is complete unless it recognizes the need to reduce poverty among those with mental health and addiction problems. Over half of the caseload of the Ontario Disability Support Program (ODSP) are people with a mental health disability (Roch, Hansard, 2009). Like all persons on ODSP, they deserve respectful treatment and humane support. The real value of ODSP allowances has declined over the past 10 years; for most of this time, economic growth was strong. CAMH would be extremely troubled to see any further erosion of this support, and

advocates that – at a minimum – ODSP rates be automatically increased by the consumer price index. This would ensure that those excluded from workforce participation because of a disability are not placed in more dire circumstances.

Much more work is required to promote the workforce participation of persons with a mental health and addiction problem. Participating in the workforce is the key to reducing poverty. For persons with a mental health or addiction problem, work is also proven to improve social and cognitive abilities, enhance quality of life, reduce hospital admissions and health care costs, and improve self-esteem. Yet it has been estimated that between 70 and 90% of people with a serious mental health problem are unemployed (Standing Senate Committee on Social Affairs, Science and Technology; CMHA Ontario, 2009).

Many people with mental health problems who wish to work are not gaining access to any vocational assistance. Excellent programs are required to support individuals to gain better access to employment, and support them in employment. Some of these programs – such as CAMH’s Out of this World Café – are businesses operated by people with mental health and addiction problems. Supported education and augmented education (for people with difficulty meeting the demands of regular college programs) are examples of initiatives that target education and post-education support, in order to improve workforce participation. Unfortunately, there is virtually no sustained funding for these programs, which ought to be a critical tool for addressing poverty among people with mental health and addiction problems.

## **Housing**

**Ontario needs to invest in supported housing with an appropriate mix of housing types and levels of support.**

Safe, secure and affordable housing is a key component to anyone’s mental health. For those who have more severe mental illness or addictions and who are struggling with crisis and treatment regimens, it is even more critical. Despite this need however, Ontario government spending on housing is low relative to other provinces. When

municipal housing spending is included in the mix, Ontario just makes the provincial average (Wellesley Institute, 2008). The lack of affordable housing is even more problematic for particular groups such as Aboriginals, women, and racialized communities who experience greater health inequalities (United Nations, 2007).

In Ontario there are three general types of housing that target individuals with mental illness and addictions: custodial housing, supportive housing and supported housing.<sup>1</sup> The need for housing and related supports exceeds the available supply and a significant amount of housing in Ontario does not follow best practices in housing for individuals with mental health or addictions. Not only is the supply inadequate, the type of housing that exists does not match the needs of individuals. Research has shown that there is an inappropriate balance of the housing available to meet the needs of individuals with mental health and addictions. For example, there are more congregate units than people require and there are too few independent housing units, such as apartments with related supports, to meet the need (CAMH, 2002; Sylvestre, George, Aubry, Durbin, Nelson, & Trainor, 2007).

The importance of housing to individuals with mental health and addictions cannot be overestimated. Research has shown the benefits that stable housing has on clients' quality of life, treatment outcomes and service utilization. Previous research on supportive housing has shown that hospitalization rates among those in the program were significantly reduced (McCarthy & Nelson, 1991). More recently, research on 'housing first' models have shown reduced health care costs and reduced alcohol use among chronically homeless individuals with severe alcohol problems (Larimer et al., 2009). As well, stable housing has an impact on the success of other mental health programs. One review found several studies that demonstrated better outcomes when housing was combined with case management programs than just the case management on its own (Nelson, Aubry & Lafrance, 2007).

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<sup>1</sup> Custodial housing is generally for profit 'room and board' settings with little or no rehabilitation support. Supportive housing is congregate settings which include rehabilitation support. Supported housing is a strengths-based approach aimed at helping consumers get and keep independent housing in the community.

Independent housing with appropriate supports is what most consumers have identified as their preference (Forchuk, Nelson & Hall, 2006; CAMH, 2002). Having this level of choice over housing and professional supports has been shown to improve clients' quality of life and community functioning (Nelson et al, 2007). Experts agree that not only does Ontario need more housing for individuals with mental health and addictions, but that it matters what kind of housing. Evidence-based models of housing are central to improving clients' quality of life and wellness. Increasing the availability of independent housing *and* the required support services is a critical element in a provincial mental health and addictions strategy (Sylvestre, George, Aubry, Durbin, Nelson & Trainor, 2007; CAMH, 2002).

## **Cultural competence and health equity**

Ontario needs much greater research on the mental health status of immigrant and racial minority communities. Cultural competence training should be available to all mental health and addiction professionals. Minority ethnic communities should be engaged in planning and designing mental health and addiction services.

An important driver of health care reform has been the need to increase access to health care services. Increasing access is not limited to expanding capacity within the system; it is also about creating services that are culturally accessible to diverse groups. In mental health this is particularly important, since ethnicity, culture or religion can affect the understanding and interpretation of symptoms, illness and treatment.

In Ontario, we have very little research or data on the experiences of minority ethnic groups in our mental health system. Research does exist on inequalities of mental health care for some ethnic minority groups. For example, in Canada it has been shown that those from a higher socio-economic status have better access to psychiatrists (Steele, Glazier & Lin, 2006). We also know that suicide and depression rates for the Aboriginal population are much higher than the Canadian average (CMHA, 2009). Finally a few studies exist that examine the experience of specific sub populations; for example the barriers to mental health care for Ethiopians in the city of Toronto (Noh, Hyman & Fenta, 2001). In order to assess how well ethnic minorities are faring in our mental

health and addictions system, we need to collect data on their participation in services and the outcomes of their treatment. Currently Ontario does not collect this data based on ethnicity. Establishing consistent, reliable data should be a first priority. Similarly, conducting research using this data is essential to determine the specific areas of need for improvement in services and treatments.

In the United Kingdom, data from a national survey of ethnic minorities was used to examine the disparities between various ethnic groups, including the majority white population. They found that ethnic minorities appeared to be at increased risk of hospital admission and coercive care within mental health services. It was also found that patients from minority ethnic groups were more likely than the white majority to be misunderstood and misdiagnosed and more likely to be prescribed drugs than given psychotherapy or counselling. Among black and minority ethnic groups re-admission rates were higher and they spent longer periods of time in hospital. The report acknowledges that some of these experiences, particularly for African Caribbean peoples may be attributed to treatment delay. The report also suggests that general practitioners have more difficulty recognizing psychiatric disorders in black and ethnic minority patients and that minority ethnic groups face barriers when seeking help, such as language, lack of knowledge of services and differences between the interpretation of symptoms between patient and physician (National Institute for Mental Health in England, 2003).

Research in the USA has reported similar disparities in the experience of the mental health system of ethnic minority populations. Examples include less access to psychiatric services; more difficulty getting into and staying in treatment; the over diagnosis of schizophrenia in African Americans and depression in Latinos; as well as the high rates of suicide among American Indians. Specific practices have been identified that may lead to such disparities. These include the underidentification of psychiatric problems by general practitioners and the subsequent underreferral to specialist services; the lack of language translation and cultural interpretation services; the cultural bias of psychiatric assessments; and the inadequate research and knowledge

of the effects of various medications on different races (Atdijian & Vega, 2005; US Department of Health and Human Services, 2001).

Improving the accessibility of our mental health and addiction services to minority ethnic groups requires improving the cultural competency of our services. Efforts should be made to increase the ethnic minority representation in the mental health and addictions workforce including supporting individuals from under-represented communities through training and professional development; and providing cultural competence training to all mental health and addictions agencies, and within professional practices training and continuing education. Including cultural information and needs in assessments and treatment plans will help identify clinical and other supports required (such as language translation), appropriate levels of care, and the role of family and community in a patient's recovery. Finally, improving the services available to individuals from ethnic minority groups will be ineffectual if individuals in these communities are unaware of such services or too fearful to utilize them.

Communities themselves have a role to play in preventing mental health and addictions, addressing the stigma of mental health and addictions and providing information about how to access services and supports. All mental health and addiction providers need to reach out to the ethnic minority communities in their area to develop partnerships that will reduce these barriers (see also Mental Health Commission of Canada, 2009).

## ***Key Components of an Integrated System***

### **Health promotion and prevention**

Ontario needs to provide targeted, evidence-based prevention and health promotion efforts, such as those described by the government's *Roots of Youth Violence* report.

The *Roots of Youth Violence* report contained a stirring call for improved action to prevent youth violence. Justice McMurtry and Dr. Curling concluded that the government's focus is "on interventions once the roots had taken hold rather than on actions to prevent that happening" (p. 1). The commissioners were passionate in their descriptions of the need to "enhance prevention through programs that promote health, engagement

and activity for youth” (McMurtry & Curling, 2008, p. 37). This message of health promotion and prevention must also play a central role in a provincial mental health and addiction strategy.

Prevention and health promotion in the area of mental health and addictions may seem like a daunting challenge for governments. Mental health status is affected by income inequality and poverty, lack of affordable housing, and weak labour force attachment. Positive mental health is promoted through vibrant, healthy communities. These are big problems, not easily addressed programmatically or without enormous public investment. Yet we have sufficient empirical evidence to describe the type of programs and initiatives that work to promote mental health and prevent substance use problems. The provincial mental health and addiction strategy can suggest an approach to mental health and addictions prevention and health promotion that is grounded in evidence in what works, and build from success.

Promoting mental health and preventing mental illness depends on initiatives to strengthen the resilience of individuals, families, and communities. These efforts should be focused and subject to rigorous evaluation. Children and youth are a logical starting point. As Justice McMurtry and Dr. Curling point out in their report, there is strong evidence that locally available mental health services that provide early identification of problems for children and youth are effective interventions. They point out that the best programs are integrated with local communities, rather than a time-limited ‘fix’ to a problem. This is consistent with empirical evidence on the effectiveness of prevention initiatives (Wolfe, Jaffe & Crooks, 2006). The most effective youth health promotion interventions “emphasize the development of specific skills, and have a focus on building positive capacity in youth” (Wolfe, Jaffe & Crooks, 2006, p. 150). The least effective youth health promotion efforts “are often oversimplified, with an implicit assumption that a particular negative behaviour is caused by a single determinant” (Wolfe, Jaffe & Crooks, 2006, p.150).

While there are elements of mental health promotion that are universal, prevention activities can be effectively targeted. There are different methodologies for targeting prevention efforts where they can make the greatest impact. The *Roots of Youth Violence* recommends using an approach that identifies areas using five indicators of disadvantage. CAMH has been working with the City of Toronto and community partners to deliver one award-winning prevention initiative in targeted neighbourhoods. *Strengthening Families for the Future* targets children aged 7 to 11, and their families, and works to reduce risk factors, build individual resilience, and enhance family protective factors. It is one example of an effective, community-based prevention campaign built on what we know about effective practice.

In addressing and preventing addiction problems, it should be noted that the provincial government plays an enormous policy, enforcement, regulatory, and operational role in the area of tobacco, drugs, alcohol, and gambling. While the committee is likely focused on prevention and treatment within a health context, the most effective prevention efforts use all government's policy levers to promote health and prevent health problems. This is particularly important in areas with the greatest impact on health: tobacco and alcohol. Tobacco remains Ontario's single most harmful addiction, and significant work remains to be done to address rates of smoking and the effects of second hand smoke. Yet tobacco is also an example of what can be achieved by a coordinated government response that involves targeted prevention efforts with legal and regulatory initiatives. The Smoke Free Ontario program has been successful in addressing rates of smoking, and this work must continue.

This kind of comprehensive approach has been taken in addressing alcohol at the national level. CAMH participated in the development of a National Alcohol Strategy, *Building a Culture of Moderation*. Recognizing the enormous health burden that alcohol represents, a national strategy was developed by a broad cross section of stakeholders, including the organizations representing alcohol producers. They recommended a range of interventions to reduce the health burden of alcohol, such as the development of minimum retail social-reference pricing, a commitment to maintaining existing systems

of control over alcohol sales, and creating incentives for lower-alcohol drinks. CAMH would be pleased to provide a more extensive briefing on alcohol policies that can better promote health and prevent problematic and dangerous use.

Similarly, CAMH has recommended that Ontario develop a comprehensive drug strategy. International evidence suggests that the most effective approaches to reducing drug-related harm are grounded in a coordination of the state's role in prevention, treatment, enforcement and harm reduction efforts. One urgent priority for drug policy work is the alarming increase in the use and misuse of prescription opioid drugs, such as oxycodone or morphine. This increase has highlighted the uneven access of methadone maintenance treatment across Ontario; a proven, effective treatment for opiate addiction that has helped thousands of Ontarians reclaim their lives.

## Peer Support

**Ontario should provide targeted funding to LHINs for peer and family initiatives. These programs should be evaluated and their effects on treatment costs documented.**

Over the last ten years the role of consumer survivor initiatives (CSI) and family support initiatives has been promoted in policy and research efforts in Ontario. In *Making it Happen*, consumer survivor self-help, consumer initiatives and family self-help were identified as key ingredients in a reformed mental health system. In the last 10 years, new research has shown the importance of these programs to the mental health and addictions system.

A recent review of research shows that CSIs reduce hospital use, lead to improvements in the health system, and provide employment. In one study, participants in the study went from an average of nine hospital days (in previous nine months) to only two hospital days after participating in a CSI for 18 months. The same study reported that participants in CSIs experienced greater reductions in symptom distress, improvements in social support and quality of life. Another study reported that the role of CSIs in assisting clients' transition from hospital to the community saved the health care system more than \$12 million because of shorter hospital stays (Canadian Mental Health

Association, Ontario, Centre for Addiction and Mental Health, Ontario Federation of Community Mental Health and Addiction Programs, Ontario Peer Development Initiative (hereafter CMHA/CAMH/OFCMHAP/ODPI), 2009; Standing Senate Committee on Social Affairs, Science and Technology, 2006).

CSIs serve primarily those with serious and persistent mental illness: in one study 64% of CSI participants had a mood disorder, 33% had schizophrenia and 90% were taking psychotropic medication (CMHA/CAMH/OFCMHAP/ODPI, 2009). They have an important role in reducing the stigma attached to living with a mental illness and have become an important element in system planning regionally and provincially. CSIs have addressed stigma in part by employing individuals with serious mental illnesses. Alternative businesses alone employ over 800 individuals across Ontario. Many of these individuals were out of the workforce for many years and were told that they were permanently unemployable (CMHA/CAMH/OFCMHAP/ODPI, 2009).

The effectiveness of consumer survivor initiatives warrants their inclusion in a provincial strategy and the allocation of stable, permanent funding. These critical partners in the mental health and addictions system need to be accessible across Ontario and involved in system planning and design at a regional level. Adequate and comparable funding as compared to other community mental health and addictions programs will provide the resources for CSIs to stabilize and mature.

Families who care for relatives who have mental health or substance abuse problems contribute significantly to the care and recovery of individuals. The majority of individuals who have been hospitalized for a mental illness are discharged to the care of their family. Research in Ontario has shown that families are regularly involved in the lives of individuals with mental illness; many live together and those that don't have daily or weekly contact. This care and support can take the form of crisis intervention, system navigation, treatment monitoring, and assistance with daily living (Family Mental Health Alliance, 2006). In some cases this care costs families money, approximately 58% of families report paying out-of-pocket expenses to care for someone

with a mental illness. Family require better education and support in their role of caregiver, consistent availability of peer support and recognition of their role in the treatment and recovery of their loved one (Family Mental Health Alliance, 2006).

## **Primary care, mental health and addictions: the promise and the challenge**

Ontario needs to continue building multi-disciplinary primary care environments with greater mental health and addictions capacity. We need to provide primary care clinicians greater tools and incentives to identify and treat the most pervasive problems: depression, anxiety, and the misuse of alcohol.

For many people in Ontario with mental health and addiction problems, the fundamental challenge is not inadequate care, or uncoordinated care – it is gaining access to *any care at all*. In our society we tolerate abysmally poor access to care for conditions affecting our minds, psyches and brains: if only half of Canadians with cancer, hypertension or diabetes received care, this would constitute *de facto* evidence of a health care crisis. According to the *Primary Care in Ontario Atlas* produced by the Institute of Clinical Evaluative Sciences (ICES) in 2006, a total of 428,827 Ontarians reported having major depression. However, less than half (47%) reported a contact with a health professional for mental health care (ICES, 2006). Other studies indicate although nearly 20% of Ontario residents are affected by mental health conditions, as few as one-third seek treatment (CAMH, 2003).

Change is coming, as Canadians increasingly accept the legitimacy of mental health problems and seek medical and professional assistance to help them. There is evidence that young people are increasingly likely to seek help for their mental health and addiction problems (Adlaf & Paglia-Boak, 2007). When Canadians seek mental health and addiction help, they typically choose the most accessible, non-stigmatized health care setting – their family doctor. For this reason, Ontario’s mental health and addiction strategy must assess the capacity of primary care providers to adequately screen for and identify mental health and addiction problems, provide appropriate and effective treatment, and connect their patients and clients to more specialized services.

For those of us concerned about access to primary care for persons with mental health and addiction problems, there are two key problems to address:

- How can we improve the mental health and addictions care delivered in primary care settings by ensuring high fidelity to best practices?
- How can we improve the overall health of persons with serious mental health and addiction problems?

According to the World Health Organization, “[i]ntegrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the care they need” (WHO, 2008).

### ***Delivering high quality mental health and addictions care in primary care settings***

There is strong evidence that many primary health providers lack the knowledge and tools to adequately assess patients for potential issues related to mental health and addictions. This is a significant barrier to proper diagnosis and treatment of mental health and addiction problems. A key role of the family physician is the identification and early diagnosis of problems; inadequate access to mental health and addiction services often result from the absence of early identification, and lack of support for this function. The four principles developed by the College of Family Physicians of Canada speak to the key role of the family physician and to the high level of skill needed to deliver comprehensive care; however, the current healthcare system does not provide incentives or any support for family physicians to practice according to these principles (Rosser & Kasperski, 1999).

Studies recognize that physicians in the primary healthcare setting lack the tools and other screening instruments required to adequately assess mental health and addiction problems in their patients. The Solberg, Maciosek and Edwards study (2008) found that screening in primary care settings can accurately identify patients whose levels or patterns of alcohol consumption do not meet criteria for dependence but do place patients at risk for morbidity and mortality. Furthermore, they found that behavioral

counselling interventions with follow-up can produce small-to-moderate reductions in alcohol consumption, sustained over a period of 6 to 12 months.

In terms of follow-up, Simon, VonKorff, Rutter and Wagner (2000) conducted a study using two inexpensive programs to improve the treatment of depression in primary care. The authors believe that despite the high prevalence of depression among patients in primary care, management often falls short of expert recommendations and only a few patients receive the proper levels of pharmacotherapy. Therefore, one inexpensive program was feedback only, wherein the patient would return to the doctor and the pharmacotherapy discussed and the other program was feedback plus care management, which incorporated the first two strategies in addition to follow-up by telephone. The latter program resulted in improved care and the incremental cost was \$80.00 per patient.

The general lack of a comprehensive strategy of care contributes to the misdiagnosis and under-treatment of mental health and addiction issues. Improving the access to specialized mental health and addictions care (e.g., psychiatrists) by primary care physicians can address these issues. To further support the need for a comprehensive strategy of care, patients with severe mental health and addiction issues who also have existing co-morbid diseases and physical conditions are not adequately cared for.

For example, individuals with serious mental illnesses living in the community have age-related mortality rates 2.4 times the rate for the general population. Additionally, it is estimated that 35% of individuals with serious mental disorders have at least one undiagnosed medical disorder (Bazelon Centre for Mental Health, 2004). A recent Canadian study found that the cancer death rate is 65% higher among the mentally ill. As one physician said, stigma often interferes with the doctor-patient relationship because this population doesn't complain much about their physical ailments (Picard, 2009).

A comprehensive strategy would also contain community resources and other support necessary for those patients who can self-manage. Similar to other chronic conditions, there are opportunities for patients to self-manage mental health and addiction issues; however, systems must be in place to support these patients.

### ***Tiered models of care***

Tiered models of care seek to match intensity and acuity of the problem to the intensity and acuity of the treatment; primary care plays a key role in these models.

There are examples of other jurisdictions that have more explicitly articulated a tiered approach to care. Tiered models typically provide better definition of the role that primary care clinicians play relative to other system players. They also shape the information and other needs that must be met in order for primary care to play this key role.

The New Zealand Guidelines Group (2008), for example, presents a tiered model or a 'stepped care' approach for the treatment of depression, which is grounded in a few guiding principles. First, most people with depression can be managed within primary care and a good outcome depends on partnerships between the patient and practitioner and on provision of active treatment and support for a sufficient length of time. Second, the use of self-management strategies for depression is encouraged and supported by primary care physicians. Finally, brief psychological interventions such as structured problem-solving therapy should be available in the primary care setting. Progression through levels of care is determined on the basis of patient response with support for self-management a major feature.

In order to support such a tiered model of stepped care in Ontario, structural change to the organization of care should be made. As Kates and Mach (2007) summarize, the prevalence of depression in primary care is high; however, the detection, treatment and referral rates are low and if treatment is initiated, most patients do not receive adequate follow-up. This is not so much due to oversights by individuals or ineffective treatments as it is due to problems in the way systems of care are organized. Kates and Mach (2007) stress that central to all models of improved systems of care for individuals with

depression in primary care is a redesign of the way services are organized and delivered. This includes the incorporation of mental health care managers or coordinators, visits by psychiatrists in stepped care model and changes in treatment protocols to include screening and follow-up for patients.

Within Canada, a National Treatment Strategy entitled *A Systems Approach to Substance Use in Canada, 2008*, has been developed which utilizes a tiered model. This approach recommends different levels of services and supports corresponding to the acuity, chronicity and complexity of risks and harms associated with substance use. Services and supports in the lower tiers are open to all and are intended to meet the needs of many, while those in the upper tiers are designed to meet the needs of smaller numbers of people and in many cases, are specialized for people with more severe substance use problems. This model matches the level and kind of services and supports to the specific nature of a person's substance use problem as well as promoting efficient use of resources.

The National Treatment Strategy is based on common principles; most importantly, people must be able to access the continuum of services and supports at any tier and at any time, and be linked to the appropriate services and supports that they need. Such a continuum requires an integrated system in which services and supports are linked, both within and between tiers, and in which different jurisdictions and systems must be able to easily share information to coordinate services and supports. Primary care is one of the foundations of any tiered system of care, since primary care plays a role in identifying problems and navigating systems of care.

### ***What can Ontario do? Multi-disciplinary care teams***

The Province of Ontario has identified reducing emergency room wait times as a priority for health care reform. In order to achieve this goal the provincial government has invested in two related areas: chronic disease prevention and management and

access to primary care. Services and care for those with mental illness and addictions need to be front and centre in these initiatives.

It has long been argued that addictions and mental illness are chronic diseases, and more closely resemble other chronic diseases such as diabetes and heart disease, in that they are often lifelong, chronic diseases with periods of relapse (McLellan, Lewis, O'Brien & Kleber, 2000). Addressing the management and prevention of chronic diseases is a priority for the new primary care services being established throughout Ontario. Family Health Teams (FHT) have a specific mandate to focus on health promotion and disease prevention in particular in the context of chronic diseases. As a result, FHTs, along with community health centres, represent an emerging infrastructure for potential coordination of services and a higher degree of collaboration between primary health and specialty centres like CAMH.

The Ontario College of Family Physicians has two initiatives currently in place to help address integrating primary care with mental health and addictions. The *Collaborative Mental Health Care Network* links family physicians from across the province with a Psychotherapist and Psychiatrist mentor in a collaborative relationship to support easy access to case-by-case support and ongoing continuing professional development regarding mental health care. The *Medical Monitoring for Addictions and Pain* initiative is intended to support physicians with expertise in pain management and addictions, including methadone prescribers, to mentor family physicians interested in chronic pain and or addictions.

## **Getting the most from investments in specialized health care**

Ontario's provincial mental health strategy should support efforts by institutions to build community capacity and innovative mechanisms to support people in the community.

Teaching hospitals such as CAMH play an essential role in delivering a range of health services to Canadians. They are where our most complex cases are treated; they play a critical role in training the next generation of health providers; and they conduct the

majority of health research in Canada. They are also expensive institutions to operate. In the area of mental health and addictions, the gaps in available, accessible treatments are so significant that it can be challenging to offer highly specialized clinical services. That is why CAMH is determined to help build an integrated system of care.

CAMH has a strong interest in improving the capacity of lower intensity treatments offered by others. Simply put, the intensity and acuity of the problem should be matched by the intensity and acuity of the treatment. CAMH devotes considerable resources to supporting community-based health promotion and prevention initiatives, and providing education and training to both primary care clinicians and community providers. This is consistent with stepped models of care that would expand the reach of screening and brief treatment tools in primary care (see above). This type of support – with appropriate resources from government – allows community providers to play a larger role in providing specialized care. This is consistent with the objective from *Making It Happen* that “People with serious mental illness will achieve greater independence; that is, the ability to live in the community with the least intervention from formal service...” (Ministry of Health and Long-Term Care, 1999, p. 4).

*Making It Happen* recognized the need to invest in specialized community providers, as part of its commitment to the least restrictive and the least intrusive interventions. At the time, CAMH was the only provincial psychiatric hospital that had been divested to the community. Since that time all of provincial psychiatric hospitals have been divested (the last one only last year), and the province has made significant new investments in community mental health. These investments have been successful, in that they have served many more clients, and significantly re-energized parts of the system. CAMH has collaborated with community providers in advocating for increased community resources for mental health and addiction treatments.

Yet the need for care continues to exceed available treatments. In an efficiently run system, teaching hospitals such as CAMH will focus on providing care to the most complex cases. Community providers would have greater capacity – and greater access

to affordable accommodation – so that those with chronic problems were better served in a community, rather than a hospital. CAMH is committed to this model. We have begun working with community partners to develop joint arrangements that combine the specialized care of a hospital with a setting more conducive to recovery and community participation.

For example, CAMH’s Geriatric Mental Health Program had entered into a partnership with LOFT Community Services. LOFT is providing high support housing to geriatric clients who have been long-stay CAMH patients. CAMH continues to assume responsibility for medical and nursing care of the clients, within a community setting. CAMH also will provide a hospital bed for any clients in the event that they return to a state of illness significant enough to warrant hospitalization. This initiative received funding from the Toronto Central LHIN in 2008-09.

CAMH believes that the work of focusing specialized clinical resources on patients with the most complex needs is critical to building a system of care. But it is not more important than improving the reach of mental health and addiction treatment in primary care, or providing community-based specialized treatment for people with mental health and addiction problems. Specialized hospital care depends on a system of care that is responsive to the needs individuals, and constitutes an active partnership between providers and the person receiving the care. Too often, barriers have been placed by parts of the system that prevent client-centred care. All of us must work more diligently to build a system of care.

### ***Bringing it together***

#### **Improved integration of mental health and addiction services**

Ontario needs to target its program planning and funding allocations so that mental health and addiction programs are integrated where prevalence data indicates the highest need, e.g., young adults and those with personality disorders.
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There is a wide range of clinical, sociological and cultural factors that bring the fields of mental health and addictions together. From a medical perspective, substance use

disorders are a distinct category within the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental health and addictions are both rooted in a complex and variable combination of biology, genetics, and life experience – particularly exposure to stress and trauma. This means that many of the clinical skills used to treat mental health problems and addictions are similar. But the single most compelling reason for promoting greater integration of mental health and addiction services is the significant number of people who experience both a mental health problem and a substance use disorder.

Prevalence rates for concurrent disorders vary by methodology, but all estimates are high enough to warrant significant attention. Data from Statistics Canada's Canadian Community Health Survey (CCHS) (2002) suggests that those with a substance use disorder are twice as likely to have a mood or anxiety problem (Rush et al., 2008). It is also true that persons diagnosed with a mood and anxiety disorder are twice as likely to suffer from a drug use disorder. In another study, 43% of individuals with a 12-month substance use disorder have a diagnosable mental health problem (Kessler et al., 1996). National epidemiological data from the US shows that 55% of individuals with a lifetime alcohol use problem and who have sought help for their addiction had a lifetime mental disorder (Regier et al., 1990). The likelihood of having a substance use disorder was four times higher for those with schizophrenia than for the population at large, and those with bipolar disorder were five times more likely to develop these problems.

More significant than the number of people with concurrent disorders is the *experience* of persons with concurrent disorders. These stories provide an impression of inadequate care, dissatisfaction with the care received, and difficulty in navigating a system of supports. Canadians with concurrent disorders are more likely than any other category of substance users to seek care (Ross, Lin & Cunningham, 1999), yet are four to seven times more likely to report unmet need than those who have one of a mental health or substance use problem (Urbanoski et al. 2007). Statistically, they also report low satisfaction with care (Urbanoski et al. 2007).

The acuteness and severity of concurrent disorders should also be recognized. In this area, as well, empirical data and the experiences of individuals and their families are mutually reinforcing. In terms of economic cost, there is strong evidence that the cost of care for one person with a concurrent disorder is greater than the cost of care for two people that each have one of mental health or addiction problem. One study that tracked health and social costs found that per person hospital costs for the individual with mental disorder were \$390; for a person with substance use disorder were \$344; for the person with concurrent disorders were \$1485 (Somers, Carter & Russo, 2007). The welfare costs per person for those with a mental disorder alone were \$480; for a substance disorder alone, \$1246; and for a co-occurring disorder, \$3348 (Somers, Carter & Russo, 2007)). In both health care and social service settings, having a co-occurring disorder was strongly associated with antisocial and challenging behaviour, legal involvement and risk of suicide or self-harm (Rush & Koegl, 2008). The complexity in providing care and support is likely related to the fact that rates of substance use disorders are particularly high among particular subpopulations of those with mental health problems, including young adults with personality disorders (Rush & Koegl, 2008; Grant, et al., 2004), the homeless (Farrell, Howes, Taylor et al., 1998), those involved with the criminal justice system (Abram & Teplin, 1991), and people with a history of sexual or physical abuse (Kendler, et al., 2000; Malinosky-Rummell & Hansen, 1993). The existence of a mental health problem significantly reduces the efficacy of substance use treatment, as these clients have rates of relapse far higher than the average.

Across North America, the fields of addiction and mental health developed in ways that have been surprisingly distinct from each other, given the overlapping and related nature of the diagnoses. The success of the self-help movement (particularly Alcoholics Anonymous) contributed to the rejection of addiction as a medical/psychiatric problem, since AA typically embraced mutual support and eschewed physicians and the pharmacological treatment of addictions. As a result, those who care for persons with both mental health and addictions problems were left with this dilemma: while rates of concurrent disorders are high – and as scientific literature increasingly points to the

related etiology of mental health and addiction problems – the cultures of mental health care providers and addiction care providers were historically distinct, if not hostile. From a health care perspective, this presents an example of care that is focused on the person providing the service, and not on the person whom the services are designed to assist.

This has been slowly changing over the past two decades. The evidence is clear that integrated support for people with co-occurring mental and substance use disorders are more effective than non-integrated treatment and support. The plea for greater coordination of care has been made by the Substance Abuse and Mental Health Services Administration in the US, and by Health Canada. The creation of the Centre for Addiction and Mental Health is both a result of this change, and a contributor to it. Since its inception, CAMH has made concurrent disorders one of its priorities. We have significant experience in addressing the system integration and system capacity needs with respect to concurrent disorders.

The experience of CAMH and other integrated services provides important case studies of the mechanisms of integration, and the priorities. Administrative integration can be successful, but even the smoothest administrative collaboration is no guarantee of improved services. The tools for improving services are predominantly practical ones relating to assessment tools and service system collaboration. The success of integration should be assessed based on the experience of clients, not planners.

No service system can encompass all the needs of people with either mental health or addiction problems, or both. But we know that – across all areas and types of services – we require a targeted and strategic approach to integration that focuses on particular subpopulations. The prevalence and the consequences of concurrent disorders – the health system and beyond – requires us to focus on the severity and complexity of the problems faced by people needing assistance. Epidemiological data should be strengthened, and used to plan integration activities. Areas of acute need for integrated services include young adults (particularly those with personality disorders), people

who are homeless, people with a history of sexual or physical abuse, and those with criminal justice histories.

In the last few years, as the Local Health Integration Networks (LHINs) have become operational, there has been much attention paid to service integration. The mental health and addictions system is under increasing pressure to coordinate and integrate services through partnerships and networks. Given what we know about the experiences of those with concurrent disorders, it is crucial that these efforts are targeted to populations with the greatest need, and that the underlying objective is to improve access to and the quality of services for those with both mental illness and addictions.

### **Continuum of care**

**Ontario has learned that targeted investments improve specific areas of the system, but may increase pressures in other areas. Investments based on a *whole system* strategy are more likely to improve coordination and continuity of care.**

In 1998 the Province released *Making it Happen*. This framework served as a vision for the future of the mental health system in Ontario. This vision provided the direction for investments in mental health funding over the last 10 years. One of the main elements of *Making it Happen* was to shift the focus of mental health services from hospital-based services to community-based services. As a result, significant investments were made between 2004 and 2008 in community mental health programs. These investments almost doubled the funding envelope of community mental health in Ontario. As part of this change, the province funded a large multisite evaluation of the impact of the new investments, the System Enhancement Evaluation Initiative (SEEI) (*Moving in the Right Direction*, 2009).

SEEI has taught us several important lessons on improving the continuum of care. One of the most important of these is that system change requires coordinated large-scale investments which must be driven by a comprehensive vision for the entire system. The mental health system in Ontario is, and has been, under resourced. Even a doubling of community mental health funding has not satiated demand. Rather it has resulted in increased demand in other parts of the system. In order to improve the continuum of

care, the system as a whole must be examined and the impact on other parts of the system must be taken into account in individual funding decisions.

When the investments in community mental health programs were announced it was anticipated that they would have certain effects on the mental health system. It was expected that the access to services would increase and that client outcomes would improve in affected program areas. It was also expected that the use of emergency department and inpatient services would be reduced because increased community services would prevent the use of these two resource heavy services. Similarly it was assumed that the pressure on jails, courts and forensic mental health services would be reduced and that the system overall would be better integrated.

In looking at overall system performance in one region of the province it was found that there were some improvements in the match of the needs of clients to the level of care received, particularly for those clients who require intermittent services and supports (Stuart, Krupa & Koller, 2009). However, this study also found that there continued to be high levels of unmet need in the areas of social and vocational services and that a significant amount of clients who need daily intensive support (71%) are still receiving a level of care that is less than recommended (Moving in the Right Direction, 2009).

The new funds were rolled out over four years. Over the course of this time period an increase in program capacity was noted. For example, in the Early Intervention (EI) and Court Support (CS) programs studied, enrolment more than doubled; from 161 to 370 for EI and 350 to 842 for CS (Moving in the Right Direction, 2009). These programs also saw improvements in reaching and serving their specific target population. As the EI programs studied implemented the new funding they saw that the average age of their clients was getting lower and they were serving a more appropriate target group. Court Support programs were found to be serving clients with very challenging life circumstances, over and above their criminal justice involvement. Clients reported very low incomes and educational attainment, the majority of clients reported a minimum of

five years of positive untreated psychotic symptoms, and more program participants had class 2 or 3 charges (Dewa, 2008).

Improvements were seen in the continuity of care for individuals in EI over the three years of the study. Indicators of continuity of care, including service match, referrals, travel time and waiting time for referred services showed improvements for this program area. It was found, however, that continuity of care for Court Support program participants was more challenging. Many clients had difficulty accessing care and referrals were less successful. This may be due to the lack of capacity in the system and the hesitancy of other providers to serve clients who have legal involvement (Dewa, 2008).

It was found through the SEEI that as more people accessed the enhanced programs and services, the demand for other services in the system also increased. Contrary to what was expected, emergency department and inpatient use did not decrease. Rather there were slight increases in volume of emergency department visits and inpatient admissions. This finding was not consistent across all user groups, however. New users of the system actually saw a decrease in use. As well, early return rates to emergency (within 30 days) also saw a decrease (Moving in the Right Direction, 2009). The system is complex and it is not well understood how one service impacts on other resources in the system. The investments targeted certain programs, but some studies in SEEI showed that the corresponding, and necessary support programs were not enhanced. There continues to be a lack of services for housing and vocational training for court support clients (Aubrey, 2009). ACT teams have had difficulty implementing the concurrent disorders model and peer support, partly because of a lack of appropriate human resources in the system (George, 2009).

The results of the SEEI study illustrate the need for a comprehensive provincial mental health and addiction strategy to provide a vision for the system and guide funding and research decisions. A vision for the *whole* system is critical in improving the continuum of care and the integration of services.

## ***Conclusion***

Mental illness and addictions are enormous problems in Ontario. The most recent analysis tells us that the economic impact of these problems is \$34 billion each year. The human cost to individuals and families cannot be quantified, but is real. Mental health and addiction problems can affect people of all income levels, ages, and ethnicities, although it must be noted that there are patterns of suffering that point to the correlation of mental illness and addiction with trauma, poverty, racism and social disadvantage. Virtually all who suffer from these problems – regardless of their severity – have experienced the sting of stigma and discrimination. For these reasons, the government’s response to these problems is a reflection on our collective values as a society.

In the past, the treatment of mental illness and addiction has often been relegated to distinct systems of care, particularly for those with the most severe and persistent problems. Yet we have painfully learned that separating these problems from the mainstream – and distinguishing these services from the rest of health care – works against the interest of building a strong system of care. More importantly, it works against the interests of those with mental health and addiction problems, who have demonstrated a capacity for recovery and community participation that would have been difficult to imagine a generation ago.

The Government of Ontario has invested significantly in community mental health, and these investments are working. Yet we must continue building a broader continuum of care. The range of organizations and settings that provide support for those with mental health and addiction problems needs to be broadened. Schools and workplaces, for example, are key settings of support, particularly as problems are emerging. When people seek the assistance of their family doctor or local health centre, primary care must have the tools, information and expertise to respond appropriately, and refer for more specialized care as appropriate. The increasingly multi-disciplinary nature of primary care strengthens its capacity to be the setting of choice to address the mental and physical health needs of the majority of people with mental illness and addictions.

The Select Committee on Mental Health and Addictions has a mandate to report to the Legislature on its “observations and recommendations with respect to a comprehensive mental health and addictions strategy.” In doing its work, the Committee should seek opportunities for alignment with the development of a national mental health strategy by the Mental Health Commission of Canada, and the development of a provincial strategy by the Ministry of Health and Long-Term Care. The Committee’s work can be significant milestone in the effort to improve the treatment and support offered to people who live with mental health and addictions, and to bringing these issues out of the shadows.

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