Response to *Human Rights Mental Health Strategy for Ontario: Public Consultation Paper*

Submitted by the Centre for Addiction and Mental Health (CAMH)

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Introduction

The Centre for Addiction and Mental Health (CAMH) commends the Ontario Human Rights Commission for its work in developing a Human Rights Mental Health Strategy for Ontario. We are pleased to submit this response to the Commission's consultation paper, and we look forward to further discussions of how we might work together to strengthen human rights protection for people who live with mental illness and addiction.

CAMH is a teaching hospital, and the largest mental health and addictions facility in Canada. We operate central clinical and research facilities in Toronto, as well as 26 satellite offices across the province that work with partners to promote health and improve the quality and accessibility of services within the addiction and mental health system.

CAMH has begun a physical transformation at its primary site on Queen Street West. The site was developed as an asylum, and our physical environment has historically emphasized the separateness of mental health and addiction problems from the mainstream of community life. Yet preventing mental health and addiction problems – and mitigating the impact of these problems – depends on the full social inclusion of those who live with these conditions. This is an imperative for health care organizations and providers; but it is also a task for schools, workplaces and communities. That is why the participation of the Commission is so important.

The Role of the Ontario Human Rights Commission

There is greater awareness of mental health and addiction issues than ever before, and increased recognition of the enormous impact of these conditions. One of the key drivers of greater recognition has been individuals who speak of their experience recognizing mental health and addiction problems, seeking help from others and finding hope. Individuals also describe instances of discrimination on the basis of their mental illness and addiction. One example that has been repeatedly documented is the use of the criminal record check to inappropriately exclude people with histories of mental illness from

some jobs and volunteer opportunities. Legal protections against discrimination such as this must be strong and effective.

The legislative change to the human rights regime in Ontario presents an opportunity to go further. As noted in the Commission's Public Consultation Paper,[1] the Commission's mandate now includes such functions as "developing and conducting programs of public information and education" and "reporting on the state of human rights in Ontario." The Commission has a key role to play in documenting the extent to which our society excludes people with mental illness and addiction, and using this information to propose public policy measures that promote social inclusion.

CAMH proposes that the Commission develop a series of indicators that document the social exclusion of Ontarians with mental illness and addiction. CAMH would be pleased to work with the Commission and others – most importantly, people with mental health and addiction problems – in developing these indicators. Although there are many other areas of social exclusion that affect people's lives, we propose two areas where exclusion has particularly serious consequences.

1. Labour Market Participation

There are two dimensions to the issue of labour market participation.

a) Stigma and discrimination in workplaces plays a role in intensifying social exclusion and isolation. The Commission's consultation paper notes that "most people alleging discrimination based on a mental health disability complained about actions taken by their employers." Labour market participation has been consistently proven to reduce the impact of mental illness, across a range of measures. Access to work improves social and cognitive abilities, enhances quality of life, reduces hospital admissions and health care costs, and improves self-esteem.[2] Most importantly, participating in the workforce is key to reducing poverty. Yet the vast majority of people with serious mental health problems are unemployed.[3]

b) Disability pensions that foster exclusion are the second dimension of workplace exclusion. In Ontario, most people with serious mental illness rely on Ontario Disability Support Program and/or Canada Pension Plan - Disability. While these programs have made efforts to be more facilitative of return to work their structure and administration often keep people out of work. These problems range from a lack of coordination between the programs (many consumers are on split pensions) to administrative practices that make working a risky venture.

The Commission can play a key role in documenting the social exclusion of Ontario's workplaces. Such data can also be used to inspire change that might include greater education and information of employers, increased awareness about the nature of workplace accommodation, greater access to education and employment supports, and policy changes regarding the treatment of earned income by social assistance programs. Increasing the workforce participation rate of those with mental health and addiction problems must be a critical element of the Poverty Reduction Strategy, and the Commission can play a role in documenting the problem and providing data to be used to evaluate interventions.

2. Access to primary care

For many years the poor physical health of people with serious mental illness and chronic addictions has been a significant concern. Poor physical health is rooted in poor housing and nutrition, high rates of smoking, and the effect of some psychiatric medication. But there is also evidence that patients with severe mental health and addiction issues who have existing co-morbid diseases and physical conditions are not adequately cared for. Inadequate access to primary care – and to specialized care requiring referral from primary care – is a big part of this problem.

According to a 2007 study, patients with severe mental illness who experience a heart attack are significantly less likely than the general population to receive drug therapies of proven benefit, are less likely to undergo cardiac catheterizations and receive emergency angioplasties or coronary artery bypass graft surgery.[4] Additionally, it is estimated that 35% of individuals with serious mental disorders have at least one undiagnosed medical disorder,[5] and the cancer death rate is 65% higher among the mentally ill.[6]

In its public consultation draft the Commission noted the reluctance of some physicians to provide service to those with mental illness and addictions. The Commission could report on the percentage of Ontarians living with a serious mental illness or addiction who do not have access to primary care. This information could be used to develop strategies that might promote models of care that would improve the care delivered to these patients, and make significant improvement to their physical health.

Conclusion

We have identified two areas of critical importance to people with mental health and addictions issues. In both cases we see the value of systematic and public reporting on these two issues. The Commission

could lead in the documentation of these patterns of social exclusion and ensure that the information is put in the right hands to generate positive public policy changes.

The two issues above are certainly not meant to be an exhaustive list. There are many other areas where the Commission could play this role. We agree that analysis of the intersection of mental health with other Ontario Human Rights Code grounds for discrimination is critical. In 2004, CAMH presented the Commission with a paper on racial discrimination on mental health. The paper documented both the contribution of racial discrimination to poor mental health, as well as the impact of race on a person's treatment by mental health providers, and the mental health system. The paper noted the startling lack of Canadian research on these issues relative to other jurisdictions– an area that the Commission may wish to consider in the context of its new role.

CAMH would be pleased to work with the Commission in developing a comprehensive set of social inclusion indicators that might act as a catalyst for public policy and other changes to strengthen efforts to promote the full participation of those with mental illness and addiction in all sectors and settings.

For more information on this submission and on CAMH's work on the social determinants of health, please contact:

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[1] Ontario Human Rights Commission (2009). Human Rights Mental Health Strategy: Public Consultation Paper ISBN: 978-1-4435-1677-8

[2] Centre for Addiction and Mental Health (CAMH), Canadian Mental Health Association (CMHA), Ontario (2010). Employment and Education for People with Mental Illness: Discussion paper

[3] Ibid.

[4] Newcomer, J. and Hennekens, C. (2007). Severe Mental Illness and Risk of Cardiac Disease. JAMA 298(15), p. 1794-1796

[5] Bazelon Centre for Mental Health Law (2004). Get it Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders

[6] Picard, André (2009, April 9). Cancer death rate 65% higher among the mentally ill. The Globe & Mail. Retrieved http://www.theglobeandmail.com/life/article965397.ece