CENTRE FOR INNOVATION IN PEER SUPPORT

The History of Mental Health & Addiction Peer Support:

A Canadian Context

Version 1.1

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About the Centre

The Centre for Innovation in Peer Support provides both direct service and system focused supports across Ontario. The Centre for Innovation in Peer Support team has a robust expertise in the application of the *Guiding Standards of Peer Support.*

The Centre has been recognized as a "benchmark of excellence" in peer support, and meaningful co-design and engagement of people with lived/living experience and family & caregivers.

The Centre's Focus: Professional Peer Support

The Centre focuses on providing, and supporting the practice of *professional peer support*.

The practice of professional peer support is emotional, social and/or practical support delivered by mutual agreement by persons who self-identify as having lived/living with similar circumstances and/or challenges. Professional peer support workers have engaged in training and skill development to enhance their ability to support empowering and empathetic relationships with others in their pursuit of self-determined wellness and/or change (Hopkins & Gremmen, 2022).

Professional peer support is when those with personal lived/living experiences work or volunteer in designated roles in mainstream/traditional services while ensuring that the critical aspects of hopefulness, recovery-orientation, empowerment, non-judgmental acceptance, and trust are promoted within the peer support relationship. Professional peer support is an intentional service provided where there is an identifiable 'giver' and 'receiver' of care. Professional peer support workers uphold the fidelity of peer support, while also honouring the responsibilities of their workplace (Hopkins & Gremmen, 2022).

For more information on professional peer support, we invite you to read *Understanding Peer Support: A Proposed Core Service in Ontario* on our Resource Hub

Supporting Provincial Systems & Partners

The **Centre's Provincial, Systems & Partner** stream works within the mental health and substance use/addictions system to support peer staff, supervisors, and organizations from the approach of the *Guiding Standards of Peer Support* with a focus on professional peer support. The Centre also supports organisations to empower people with lived experience and/or family/caregiver experience through meaningful engagement and co-design.

Our full programing is offered through our **Virtual Learning Centre & Resource Hub** which supports the most current, best practices in Peer Support. Through our **Virtual Learning Centre**, we offer trainings, consultation, our peer professional development webinars, and provincial communities of practice. Our **Resource Hub** is home to our toolkits, models, and resources. All of these offerings support the implementation and practice of peer support within Ontario.

We continue to evolve, listening to input from our stakeholders across the province to identify gaps and needs within the system, and using quality improvement processes to pivot, pilot, evaluate and then scale and spread new innovations in peer support.

Supporting People Engaging in Services

The **Centre's Peer Programming** stream began as a consumer survivor initiative under the name TEACH (Teach, Empower, Advocate for Community Health) in 1999. TEACH later came to be housed at Support & Housing Halton (now Support House) and continued to evolve in order to meet the needs of our community, eventually amalgamating with Support House's peer support provincial systems & partner support program, the Centre for Innovation in Peer Support.

Today, the Centre's Peer Programming utilizes its expertise from having provided peer support services for over 23 years in the Halton-Mississauga region to offer quality programs that are designed, developed, implemented, and evaluated by people with lived experience. This stream is focused on peer-led psychosocial and rehabilitative programming. Together, we build community and connection through creating safe spaces to heal and grow for people navigating mental health and substance use/addiction challenges, as well as supporters/families.

Our History

In 2014, the Mississauga Halton LHIN Mental Health & Addictions Leadership Table began discussing future funding priorities. Peer support was identified as the main priority. After consultations and research, the Mississauga Halton LHIN created the Enhancing and Sustaining Peer Support Initiative in 2015. This initiative created peer support positions, supported service coordination, and supported the training and development of these positions across the region.

Support & Housing Halton (now Support House) became the lead agency that hired and housed the Peer Support Systems Lead and the Substance Use & Provincial Systems Lead in a program that would become the Centre for Innovation in Peer Support (Centre). This team worked to sustain the new peer support positions that had been funded, build infrastructure, and bridge the many stakeholders impacted by this initiative.

In January of 2020, the Centre amalgamated with Support House's direct-service-facing peer support program, TEACH. The Centre now has a direct service stream of peer support programming as well as a system and partners stream, which has grown beyond the Mississauga/Halton area to include the entire province of Ontario.

About Support House:

Support House is directed by our core values. They guide our agency's decisions and actions, unite our staff, define our brand, and inspire our culture. We put people first – our supports are **person directed**. We **connect and engage** and start conversations to build and maintain relationships. We focus on **health and wellness** practices to inspire our culture. All employees are required to adhere to our values-based Oath of conduct.

The History of Mental Health and Addiction Peer Support: A Canadian Context

Please be aware the following content may be upsetting to some of us, we encourage you to seek support if this content affects you.

A Brief History of Injustices People Living with Mental Illness and/or Addiction have Faced in Canada

Throughout the world, in the past and presently, people experiencing mental illness and addiction have faced criminalization, violence, abuse and violation of their human rights. This section will explore some examples of past injustices in Canada and the historical mental health and addiction system institutionalization.

According to research conducted by the Ontario Human Rights Commission:
This section is adapted from: (Ontario Human Rights Commission).

- Until **1967** – people with mental health concerns were seen as undesirable classes of immigrants and barred entry to the country to such people who didn't have family support.
- In Alberta and British Columbia between **1929** and **1972** people with mental illness, mentally disabled or physically disabled may have faced involuntary sterilization, sometimes without their knowledge or the knowledge of their parents.
- Alberta, British Columbia and Prince Edward Island passed marriage acts that prohibited marriage of people experiencing mental illness.
- Canadian Elections Act prohibited people who did not have personal control of their property, or who were detained in institutions from voting – it stated the "assumption that a person suffering from any mental disability is incapacitated for all purposes, including voting."

Institutionalization

Throughout the 1800's many people experiencing mental illness and addiction found themselves in prisons and poor houses (Deadman, 2013).

In **1845** the first asylum of Canada opened in Quebec; Toronto soon followed in **1850** (Ontario Human Rights Commission; Deadman, 2013). Asylums and Sanatoriums continued to be established throughout the 18/1900's. Many people spent the rest of their lives in these institutions once they were admitted. "In the early **1900s**, drug addiction…was considered a form of mental disorder that could lead to admission to an insane asylum" (Ontario Human Rights Commission).

The original intention of Asylums was to provide care, but these institutions were often overcrowded, and care was limited (Ontario Human Rights Commission). People often experienced many forms of abuse and neglect from other patients and staff (Addictions & Mental Health Ontario, 2021). Seclusion, chemical and physical restraints were often used (Ontario Human Rights Commission; Deadman, 2013).

Ontario: In 1911, the names of various institutions changed to "Ontario Hospital." Each Province had government run hospitals as the main mental illness care available to citizens (Deadman, 2013).

Provincial Psychiatric Hospitals were the primary system for receiving Mental Health Care, these were widely "overcrowded, understaffed and underfunded" (Hartford et. al, 2003). Some General Hospitals had small psychiatric units. In the following decades, increasing complaints and varying levels of attention would be paid to the conditions of these institutions. Overcrowding in Provincial Psychiatric Hospitals reached its peak in 1959 (Deadman, 2013), spurring the need for reform.

The aforementioned injustices and poor treatment set the stage for advocacy, the Consumer Survivor/Ex-Patient movement and reforms in the mental health and addiction system in Canada. It also led to the creation of peer support and peer-led initiatives.

A Brief History of Peer led Change and Peer Support

Early Peer Support and Peer-Led Initiatives

It is reasonable to assume that various forms of peer support have existed throughout history, as people turn to others with similar experiences for support.

1700's - One of the first medical recordings of peer support was recorded by Phillipe Pinel. Jean-Baptiste Pussin, a recovered patient at a hospital in Paris, France, became governor of the hospital and made it a policy to hire recovered patients on staff. Phillipe Pinel, the head physician documented the results of this practice and found that peer staff would treat other patients more humanely. This eventually led to Pussin and Pinel pioneering "moral treatment" (Davidson et. al, 2012).

1800's – "Alleged Lunatic Friends Society" established in England (1845) and other peer-run groups formed in Germany, protesting involuntary confinement laws (O'Hagan et.al, 2010).

Through the **1800's and 1900's** a number of biographies and petitions were created by people with lived experience. These works emphasized the poor treatment of individuals with lived experience of mental illness and addiction (O'Hagan et.al, 2010). *The Snake Pit* (1946), written by Mary Jane Ward brought attention to mental health care (Deadman, 2013).

Early 1900's – The origins of the Canadian Mental Health Association (CMHA) can be accredited to a Canadian doctor, Dr. Clarence Hincks, and an American patient, Clifford Beers. Beers was a person with lived experience of "cruel medical treatment for his mental illness". Together, Hincks and Beers established the Canadian National Committee for Mental Hygiene in 1918, based on a similar model Beers created in 1909 in the United States This committee became the Canadian Mental Health Association in 1950. CMHA National went on to provide localized community services and advocacy. CMHA has provided a number of reports to local, provincial and national governments advocating for the support of people experiencing mental illness and addiction (CMHA Ontario -a).

1930's – Alcoholics Anonymous was founded in 1935, and formalized its "12 Steps" in 1946 (Alcoholics Anonymous). In 1937, Abraham Low, an American Psychiatrist created The Association of Nervous and Former Mental Patients, later called Recovery Inc. (now Recovery International). "The mission of Recovery International is to use the cognitive-behavioral, peer-to-peer, self-help training system developed by Abraham Low, MD, to help individuals gain skills to lead more peaceful and productive lives" (Recovery International, 2021).

In 1971 the first Canadian peer support service, the Mental Patients Association was established in Vancouver (O'Hagan et.al, 2010). Consumer based groups and programs began emerging across the country.

De-institutionalization and System Reform

Decades of complaints from People with Lived Experience, their loved ones, and allied mental health professionals, lead to varying political pressure throughout the first half of the 1900's. This led to studies and new reports in Canada and the United States (Deadman, 2013).

In 1959 reforms began. Hoch & Schrecker's *The Dymond Report* (2003), called for, among other recommendations, "greater emphasis on services at the community level, establishment of psychiatric units in general hospitals". In 1962, a national Royal Commission on Health Care made similar suggestions (Hartford et. al, 2003).

People with Lived Experience were at the forefront of reports throughout the 60's 70's 80's 90's and 2000's (in Ontario these included the commonly known Heseltine, Newman and Graham Reports.) These reports continued to advocate for reforms and community-based supports. They also identified areas of focus, and concerns regarding the implementation and planning of these supports by governments. Ultimately, people with lived experience have helped, and continue to help shape and strengthen community-based services.

In 1969, based on the recommendations from a national Royal Commission on Health Care, a task force for the Minister of Health in Ontario was formed to focus on the divestment of Provincial Psychiatric Hospitals. The Ontario Council of Health (an appointed advisory body to the Minister) "observed a lack of coordinated long-range planning program for health services and related facilities" (Hartford et. al, 2003) Furthermore, "by the **late 1970's** there was a notable shortage of housing and community-based support systems. De-institutionalization is credited with increased rates of homelessness in the United States and Canada" (Hartford et. al, 2003).

The Consumer, Survivor Ex-patient Movement

Beginning in 1970's - In response to mass de-institutionalization the **Consumer, Survivor Ex-Patient Movement began**, with groups organizing across North America to:

- Bring change to the mental health system
- Educate other ex-patients and the public to challenge stereotypes about mental illness
- Advocate for patient rights
- Create alternatives to psychiatric institutions (including consumer survivor initiatives)
- Provide formal and informal peer support
- Network and connect with other ex-patients, curating magazines and newsletters

(Ontario Human Rights Commission)

The Consumer, Survivor Ex-Patient Movement worked independently of the current mental health system of the time, and had two areas of focus: peer support (to support each other and recover from their experiences), and political action (to change the people and systems affecting their well-being) (O'Hagan et.al, 2010).

This movement played a key role in the future changes to the Mental Health Act, and the establishment of the Psychiatric Patient Advocate Office (Ontario Human Rights Commission; Hartford et. al, 2003). It also was instrumental in the Psychosocial Rehabilitation and Recovery Movements (Piat & Sabetti, 2012; Davidson, 2016), the creation of government funded Consumer Survivor Initiatives, and other mental health and addiction reforms in Ontario and Canada (Ontario Peer Development Initiative; Ontario Human Rights Commission; Hartford et. al, 2003; Piat & Sabetti, 2012).

The Recovery Movement and Psychosocial Rehabilitation

"Mental health recovery in Canada is essentially a consumer driven paradigm with origins in the North American ex-patient liberation movement… Long before recovery became a policy issue, ex patients were promoting recovery as self-determination, and empowerment, while advancing alternative, community-based services that opposed the traditional medical model and lifelong dependency on mental health providers" (Piat & Sabetti, 2012).

As a result of continued advocacy and the lived experience voice, allied health professionals and researchers began to embrace and understand recovery, leading to the **Recovery Movement** (Davidson, 2016). Larry Davidson, professor of psychology in the Department of Psychiatry at Yale Medical School, identifies two core principles of the recovery movement: "that people with mental illness can lead productive lives even while having symptoms, and that many will recover from their illnesses" (Davidson, 2016). By the late **1980's** evidence had emerged that not only demonstrated recovery as possible but also promoted a "vision of recovery" (Davidson, 2016). The Recovery Movement in Canada has grown to include language such as well-being (Piat & Sabetti, 2012).

Psychosocial rehabilitation "emerged as a significant field of practice and study during the **1970s** and **1980s**" (Farkas, 2013). Psychosocial rehabilitation today is evidence-based. It focuses on the strengths of a person, is person directed and collaborative. Psychosocial Rehabilitation "promotes personal recovery, successful community integration and satisfactory quality of life for persons who have a mental illness or a mental health and/or substance use concern. Psychosocial rehabilitation services and supports are collaborative, person directed, and individualized, and an essential element of the human services spectrum. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice and include a wide continuum of services and supports" (PSR/RPS Canada). For more information visit: https://www.psrrpscanada.ca/what-psychosocial-rehabilitation

Recovery and Psychosocial Rehabilitation continue to be areas of focus to this day.

The Harm Reduction Movement

Prior to the 1900's a variety of psychoactive substances were widely available and prescribed. Views shifted in the 1800's and early 1900's when the temperance movement with an "emphasis on moral purity, and sobriety, [and] an increased uneasiness in the medical community around unregulated medicine" (Canadian Drug Policy Coalition), colonization and racism all come together to create prohibition and criminalization. In the **1960's and 70's** increased substance use resulted in increased criminalization (Cavalieri & Riley, 2012).

"Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws" (Harm Reduction International).

"Harm Reduction minimizes harms related to substance use and sexual activity. Harm reduction services help prevent HIV, hepatitis C, illness, infection and overdose" (BC Centre for Disease Control).

People with Lived Experience, have been, and continue to be at the heart of reducing stigma, and increasing compassionate care and policy reforms related to substance use. People with lived experience have throughout Canada's history organized and brought awareness to the harms they have experienced, and continue to experience within their communities and beyond.

Taking off in the **1980's** people with lived experience of drug use, along with their allies have implemented and shaped Canada's harm reduction policies and practices (Cavalieri & Riley, 2012). This grew to include needle exchange programs, opioid agonist programs (also known as heroin-assisted programs), Naloxone distribution programs, supervised injection facilities and overdose prevention sites. With their voices and actions as the driving force, Canada and its provinces/territories have seen increased adoption of harm reduction philosophy and interventions, saving countless lives, but this work still continues.

For more information related to the Harm Reduction Movement see Appendix B.

Peer Support: 1990 to Present (Canada and Ontario)

1990's During the 1990's funding for consumer run programs and organizations in Ontario became available. In **1991** the Consumer Survivor Development Initiative (CSDI) was created to support Consumer Survivor Initiatives and build a consumer survivor sector. Its existence provided key support to the reform process underway at the Ontario Ministry of Health and Long-Term Care. In **2001** the CSDI became the **Ontario Peer Development Initiative (OPDI)**. OPDI's current mission is to acquire, understand and amplify the unique and distinct voice of consumer survivor organizations across Ontario. OPDI provides training and resources for Peer Supporters (Ontario Peer Development Initiative).

In 2003, from the advocacy of people who use drugs and allies, **Insite**, North America's first ever legal supervised injection site opened. Canada's Conservative government attempted to shut down Insite in the 2000's, and the Portland Hotel Society; and two people with lived experience of drug use fought the Canadian government all the way to the Supreme Court of Canada, where it was ruled that Insite could continue to operate, stating: "Insite has been proven to save lives with no discernable negative impact on the public safety and health objectives of Canada" (Kerr et al., 2017). Insite remains open and supervised injection facilities have expanded across Canada. For more information visit: https://www.phs.ca/program/insite/

In 2006 *Out of the Shadows at last: Transforming Mental Health, Mental Illness and Addiction services in Canada* was the first national government report on the state of Canada's Mental Health system (Piat & Sabetti, 2012). In this report Kirby & Keon, identified "recovery to be the primary goal around which the mental health delivery system should be organized" (Piat & Sabetti, 2012). The report further identified two recovery models "the first an empowerment model emanating from the consumer advocacy movement; the other a psychosocial rehabilitation model representing the perspective of mental health professionals." (Piat & Sabetti, 2012). This report led to the creation of the Mental Health Commission of Canada.

In 2007 the **Mental Health Commission of Canada (MHCC)** was created. In **2010** they launched their Peer Project and published *Making the Case for Peer Support* based on an international literature review, surveys of peer support workers and focus groups with over 600 Canadians. This led to the creation of the *Guidelines for the Practice and Training of Peer Support* (2013), which identified seven key **Values of Peer Support, Principles of Practice** as well as essential skills, knowledge and training for Peer Supporters. In 2016 *Making the Case for Peer Support* was published in its second edition.

In 2010 Peer Support Canada – Formerly known as Peer Support Accreditation and Certification Canada was created with the aim of continuing the work of the MHCC in peer support and promoting the growth, recognition and accessibility of peer support (Peer Support Canada). Peer Support Canada developed a comprehensive **certification process** and auditing tools for training adapted from the MHCC's *Guidelines for the Practice and Training of Peer Support*. They further enhanced the **Principles of Practice** for Peer Supporters, and the **Core Competencies** of Peer Workers. Peer Support Canada also created a **Code of Conduct** for Peer Support.

Also in **2010**, the Select Committee on Mental Health and Addictions, made up of provincial MPPs from Ontario's three political parties published their final report, "Navigating the Journey to Wellness: The Comprehensive Mental Health and Addiction

Plan for Ontarians." In this report the Select Committee recommended that **"**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**"** (Ontario Select Committee on Mental Health and Addictions, 2010).

In 2011 Ontario released *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy.* "It articulated six principles, including that of "person-directed services". "People with lived experience of a mental illness or addictions, and their families, bring their strengths, wisdom, and resilience to their care. They must have a voice as essential partners in system design, policy development, and program and service provision, and the opportunity to make informed decisions about their personal care and support" (Cramp et. al, 2017). In the pursuit of timely, high-quality, integrated, and person-directed service developing and implementing best practices and standards across sectors to support peer and family support was identified as a key strategy (Ontario Ministry of Health and Long-Term Care, 2011).

In 2012 the Mental Health Commission of Canada released *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, based an earlier proposed framework: *Towards Recovery & Well-Being: A Framework for Mental Health Strategy for Canada.* This 2012 strategy outlines recommendations for action to create the mental health system envisioned by the framework produced in 2009 (CMHA Ontario -b). Recognizing peer support as an essential component of mental health services was identified as a priority (Mental Health Commission of Canada, 2012).

2014 & 2017 Addictions and Mental Health Ontario (AMHO) published two final reports of their *Best Practices in Peer Support Project.* "This project's goal was to identify best practices for active engagement with mutual aid/self-help and peer support resources and provide direct service providers and their governors with the necessary information and resources to ensure that peer support services are provided in the best way possible and are appropriately incorporated into the addictions and mental health treatment system" (Cramp et. al, 2017). This body of work included literature and network reviews, and recommendations for 3 priority areas: capacity building, public speaking and training, informed by Peer Supporters, organizations providing Peer Support and other expertise.

2015 – **Support House's Centre for Innovation in Peer Support** grew out of the Enhancing and Sustaining Peer Support Initiative of the Mississauga and Halton LHIN and the local CSI Teach, Empower, Advocate for Community Health (TEACH).

The Centre undertook a quality improvement and research process to better understand and develop role clarity for Peer Supporters. This led to the development of the **Peer Support Values in Action**, 17 tangible action statements that were validity and reliability tested. The integrity of peer support services can be measured by assessing their alignment to these actions.

Through this body of work, the Centre also finalized the **Peer Support Integrity, Quality and Impact (PSIQI) survey** which measures integrity of peer support services, perception of quality of service and the impact peer support, from the self reporting of people engaging with peer support services. Support House's Centre for Innovation in Peer Support supports the most current, best practices in Peer Support through their **Virtual Learning Centre & Resource Hub.**

2015-2018 Peer Engagement and Evaluation Project (PEEP) Project in British Columbia – "Peer Engagement in harm reduction: development, implementation and evaluation of best practice guidelines for BC" (Toward the Heart, 2018).

In 2020, in Ontario, the *Roadmap to Wellness: a Plan to Build Ontario's Mental Health and Addictions System* identifies peer support as a proposed core service (Government of Ontario, 2020).

Would you like to add further knowledge to this Document?
Send us your resources to CentreInfo@supporthouse.ca with the subject line "History of Peer Support Resource for Consideration"

Appendix A:

A Brief History of Key Reports and Calls for Mental Health Reform

In 1959, **reforms begin**. According to Hoch & Schrecker (2003) the Dymond Report "called for greater emphasis on services at the community level, establishment of psychiatric units in general hospitals" and more. In 1962, a national Royal Commission on Health Care made similar recommendations (Hartford et. al, 2003).

In 1963, the Canadian Mental health Association publishes **More for the Mind**, calling for reforms (Deadman, 2013).

In 1967, **Ontario's Mental Health Act** is introduced. In the coming decades changes would be made based on lived experience advocacy (Hartford et. al, 2003).

In 1983, Towards a Blueprint for Change: A Mental Health Policy and Program Perspective (**Heseltine Report**) – a review, advocated for "a mental health care system...which directs energy and resources toward providing services outside the hospital so that hospitalizations occurs only when dictated by treatment and care in the least restrictive and disruptive settings which are as close to a patient's or client's home as practical" (Hartford et al., 2003).

In 1987, the **Graham Report** – identified decreased funding for Mental Health care compared to other areas of government spending. It also identified a lack of clear policy, continuity of care and a lack of a systems approach, planning, and coordination. A disparity between availability in services between urban and rural areas. It recommended that plans be made by Provincial Psychiatric Hospitals and District Health Councils (Hartford et. al, 2003). This report also defined "seriously mentally ill" patients and recommended that priority be given to services for people living with serious mental illness (Hartford et al., 2003; CMHA Ontario -b). This report also introduced the words consumer and partnership into the mental health system dialogue of the time, driven largely by the Consumer, Survivor Ex-patient Movement and earlier work by Canadian Mental Health Association (Hartford et. al, 2003).

In 1993, **Putting People First** – Followed the lead of the Graham report, this 10-year strategy, priority to serious mental illness was a priority. It "outlined Provincial Psychiatric Hospitals, general hospitals, community mental health programs and services by family practitioners and psychiatrists … as the four solitudes of mental health" (Hartford et. al, 2003). Key principles of mental health reform identified in this report include: "enabling people with mental illness to remain in the community and only using hospitals when clinically necessary, providing more community and informal supports and integrating mental health with other services" (Hartford et. al, 2003). It also stated that by 2003, psychiatric beds in hospitals would decline by 30 percent, and spending would be allocated as 40% to hospital care, and 60% to community-based services (Hartford et. al, 2003).

1990's – Health Services Restructuring Commission – proposed a reduction in psychiatric beds and divestment of Provincial Psychiatric Hospitals.

In 1998, The **Newman Report**, based on consultations, called for a review of the Mental Health Act provisions (responding to Consumer led activism) and later revisions were made. This report endorsed the Graham report and Putting People First, calling for further mental health reform (Hartford et al., 2003).

In 1999, **Making it Happen Report** - the government “committed to increasing community care and divestment of Provincial Psychiatric Hospitals” (CMHA Ontario -b).

Appendix B:

Harm Reduction Movement: A Brief Overview

According to the Canadian Drug Policy Coalitions Summary of Busted, written by Dr Susan Boyd; **prior to the 1900's** a wide variety of psychoactive substances were widely available and prescribed. Views shifted in the **1800's and early 1900's** when the temperance movement with an "emphasis on moral purity, and sobriety, [and] an increased uneasiness in the medical community around unregulated medicine," colonization and racism all come together to create prohibition and criminalization (Canadian Drug Policy Coalition). In the 1960's and 70's increased substance use resulted in increased criminalization (Cavalieri et. al, 2012).

1950's – In **1952** "Dr. Lawrence Ranta and others published a report in Vancouver, this report argued that drug use and addiction are a health issue rather than a criminal justice issue" (Canadian Drug Policy Coalition). In **1955** Politician Earnest Winch, a member of the Legislative Assembly in BC argued that medical clinics for treatment and medical–drug assisted programs were necessary. He also highlighted that poor and working classes were disproportionately at risk for criminalization (Canadian Drug Policy Coalition).

In 1964, the first Methadone Treatment program officially begins in Canada, run by the Addictions Research Foundation in Ontario. Soon programs were established across Canada including BC (Toward the Heart, 2018).

In 1969, the Commission of Inquiry in the Non-Medical Use of Drugs, also known as Le Dain Commission "described and analysed the social costs and individual consequences of the criminalization policy" (Cavalieri et al., 2012.) It recommended reduced criminalization, increased medical treatment and the development of less costly alternatives for criminalization (Canadian Drug Policy Coalition; Cavalieri et. al, 2012).

1980's – Harm reduction efforts begin around the world, in the UK, Australia, Netherlands and Canada (Canadian Drug Policy Coalition; Hyshka et. al, 2017). In Toronto the first form of harm reduction programs opened in the early **1980's,** "in the form of controlled drinking programs." Due to increasing HIV rates, peer-driven bleaching programs for injection drug use began and evolved into needle exchange programs (Cavalieri et. al, 2012; Hyshka et. Al, 2017). Vancouver, Montreal and other communities also began operating needle exchange programs in the late 1980's (Canadian Drug Policy Coalition; Cavalieri et. al, 2012). Many provinces today have needle exchange programs operating (Hyshka et. al, 2017). In the late **1980's and early 1990's** methadone programs increased across Canada.

In 1995, A peer led group, IV Feed, opened and operated an unsanctioned drug user-run supervised injection facility known as back alley (Kerr et al., 2017). Other unsanctioned supervised injection sites would open in the following years.

In 1997, **Vancouver Area Network of Drug Users (VANDU)** was created, Canada's first drug-user union, their efforts led to a health emergency being declared by the local Health Board (Canadian Drug Policy Coalition; Cavalieri et. al, 2012). Calls for supervised injection facilities and medically assisted heroin programs intensified (Canadian Drug Policy Coalition). According to the Canadian Drug Policy Coalition, "VANDU was instrumental in advocating for the rights, health and safety of people who use drugs and residents of the Downtown Eastside. Its members mobilized community and organized

protests drawing attention to the drug poisoning and HIV crisis…" VANDU continues to address gaps in services shaping practices for assistance with injection drug use at supervised injection facilities and even piloted a safer smoking room for people who smoked substances (Kerr et al., 2017).

In 2001, a report, *A Four Pillar Approach to Drug Problems in Vancouver* included city-wide consultation, and recognized "a four pillar approach", which includes harm reduction alongside treatment, enforcement and prevention as key areas in a drug strategy. This has been adopted in many jurisdictions across Canada (Canadian Drug Policy Coalition). This report also recommended supervised injection facilities and heroin-assisted treatment.

Harm Reduction Action Society (made up of local PWUD and, "activists, health professionals, researchers and families" of PWUD) created a proposal for supervised injection sites (Kerr et al., 2017).

In 2003, the advocacy of people who use drugs and allies leads to the opening of **Insite**, North America's first ever legal supervised injection site. It was rigorously evaluated and originally opened as a pilot (Kerr et al., 2017). Canada's Conservative government attempted to shut down Insite in the 2000's, and the Portland Hotel Society and two people with lived experience of drug use fought the Canadian government all the way to the Supreme Court of Canada, where it was ruled that Insite could continue to operate stating" Insite has been proven to save lives with no discernable negative impact on the public safety and health objectives of Canada" (Kerr & Kennedy, 2018). Insite remains open and Supervised Injection Facilities have expanded across Canada.

In 2005, Heroin-Assisted treatment (Opioid Agonist Treatment) trial began in Vancouver and Montreal, the treatment proved successful (Canadian Drug Policy Coalition). Opioid Agonist Programs are spreading.

Also in 2005, Naloxone distribution begins at *Streetworks*, a Harm Reduction and needle exchange program in Edmonton (Buxton et. al, 2019).

2010's – Increases in overdose deaths related to the opioid pandemic led to increased demands for Naloxone access. Throughout the 2010's the provinces and territories began take-home Naloxone programs (Buxton et. al, 2019). Overdose Prevention Sites, were piloted where sterile equipment is provided and overdose responses can be responded to when needed. These were piloted by activists and people with lived experience in Vancouver and have spread across Canada. Opioid Agonist Treatment Pilot Programs expand across Canada.

Here is a video featuring people with lived experience advocating for Naloxone Access in **2013**: https://www.youtube.com/watch?v=nYnTzI6sfs8

In 2017, the Good Samaritan Drug Overdose Act was made law in Canada (Toward the Heart, 2018), people with lived experience and family/caregivers advocated for this law.

In 2015-2018, the Peer Engagement and Evaluation Project (PEEP) Project in British Columbia operates. This included "Peer Engagement in harm reduction: development, implementation and evaluation of best practice guidelines for BC" (Toward the Heart, 2018).

2020's – Opioid Agonist research and consultation continues throughout Canada. Addictions and Mental Health Ontario (AMHO), published results from their work around Injection Opioid Agonist Pilot Programs: This work aims "to assist governments and health authorities in determining whether supervised injectable opioid agonist treatment programs should be expanded in Ontario … [and] to support the implementation of programs" (Addictions & Mental Health Ontario, 2021).

Here is a summary of the AMHO iOAT project and a video sharing about Ontario's first IOAT program https://amho.ca/our-work/ioat/

ADDITIONAL RESOURCES TO EXPLORE

Centre for Innovation in Peer Support's

Provincial Systems Virtual Learning Centre & Resource Hub

for Peer Supporters & Organizations

Support House's Centre for Innovation in Peer Support's full programming is offered through our Virtual Learning Centre & Resource Hub which supports the most current, best practices in Peer Support.

Through our Virtual Learning Centre, we offer trainings, consultation, our Peer Professional Development Webinar Series, and provincial communities of practice. Our Resource Hub is home to our educational toolkits, documents and videos. These offerings support the practice and implementation of Peer Support within Ontario.

Products on our Resource Hub:

- ***Guiding Standards of Peer Support*** (from Mental Health Commission of Canada, Peer Support Canada & Centre for Innovation in Peer Support)

CLICK HERE TO VISIT OUR VIRTUAL LEARNING CENTRE & RESOURCE HUB

CLICK HERE TO VISIT OUR YOUTUBE CHANNEL

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References

Addictions & Mental Health Ontario. (2021, June 15). *Injectable opioid Agonist treatment in Ontario*. AMH Ontario. https://amho.ca/our-work/ioat/.

Alcoholics Anonymous. Historical Data: The Birth of A.A. and Its Growth in the U.S./Canada.

BC Centre for Disease Control. (n.d.). *Harm reduction services*. BC Centre for Disease Control. http://www.bccdc.ca/our-services/programs/harm-reduction.

Buxton, J. et al., Environmental Scan: Naloxone Access and Distribution in Canada. Vancouver: Canadian Research Initiative on Substance Misuse (CRISM); 2019 Jun. Available from: https://open.library.ubc.ca/media/stream/pdf/52383/1.0379400/5

CMHA Ontario -a. History of CMHA. https://ontario.cmha.ca/about-cmha/history-of-cmha/

CMHA Ontario -b. History of Mental Health Reform. CMHA Ontario. https://ontario.cmha.ca/provincial-policy/health-systems-transformation/history-of-mental-health-reform/.

Canadian Drug Policy Coalition. (2021, July 14). *History of Drug Policy in Canada*. Canadian Drug Policy Coalition. https://drugpolicy.ca/about/history/.

Cavalieri, W., & Riley, D. (2012). *Harm Reduction in Canada: The Many Faces of Regression*. http://www.eelgroundhealthcentre.com/wp-content/uploads/2012/10/Harm-Reduction-in-Canada.pdf.

Cramp, J., Indrakumar, A., & Sani, B. (2017). *Best Practices in Peer Support.* https://amho.ca/wp-content/uploads/Best-Practices-in-Peer-Support-Final-Report-2017.pdf

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012, June). Peer support among persons with severe mental illnesses: a review of evidence and experience. World psychiatry : official journal of the World Psychiatric Association (WPA). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363389/.

Davidson, L., JS, S., CM, H., L, D., L, C., WT, C., … M, O. (2016, June 1). The Recovery Movement: Implications For Mental Health Care And Enabling People To Participate Fully In Life: Health Affairs Journal. Health Affairs. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0153.

Deadman, J. (2013). The Ontario Psychiatric Association's 90 Years of History. Dialogue Ontario Psychiatric Association, (SPECIAL ISSUE). https://www.eopa.ca/sites/default/uploads/files/OPA-HistoryBook-Dec2013.pdf.

Farkas, M. (2013). Introduction to Psychiatric/Psychosocial Rehabilitation (PSR): History and Foundations. Current Psychiatry Reviews, 9(3), 177–187. https://doi.org/10.2174/1573400511309030003

Government of Ontario. (2020, March 3). Roadmap to wellness: a plan to build Ontario's mental health and addictions system. Ontario.ca. https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system.

Hagan, M., Priest, R., & McKee, H. (2009). (rep.). Consumer Survivor Initiatives in Ontario: Building for an Equitable Future.

Harm Reduction International. (n.d.). *What is harm reduction?* Harm Reduction International. https://www.hri.global/what-is-harm-reduction.

Hartford, K., Schrecker, T., Wiktorowicz, M., Hoch, J., & Sharp, C. (2003). Report: Four Decades of Mental Health Policy in Ontario, Canada. Administration and policy in mental health. 31. 65-73. 10.1023/A:1026000423918.

Hyshka, E., Anderson-Baron, J., Karekezi, K. et al. Harm reduction in name, but not substance: a comparative analysis of current Canadian provincial and territorial policy frameworks. *Harm Reduct J* 14**,** 50 (2017). https://doi.org/10.1186/s12954-017-0177-7

Portland Hotel Society. Insite: PHS Community Services Society. PHS. (2020, September 23). https://www.phs.ca/program/insite/.

Kerr, T., Mitra, S., Kennedy, M. C., & McNeil, R. (2017). Supervised injection facilities in Canada: Past, present, and future. *Harm Reduction Journal*, *14*(1). https://doi.org/10.1186/s12954-017-0154-1

Mental Health Commission of Canada. Peer Support. https://www.mentalhealthcommission.ca/English/what-we-do/recovery/peer-support.

Mental Health Commission of Canada. (2012). Changing directions, changing lives: The mental health strategy for Canada. Calgary, AB: Author https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf

O'Hagan Mary, Cyr Céline, McKee Heather and Priest Robyn, for the Mental Health Commission of Canada (2010). Making the Case for Peer Support: Report to the Peer Support Project Committee of the Mental Health Commission of Canada

Ontario Human Rights Commission. Policy on preventing discrimination based on mental health disabilities and addictions: Appendix A: Historical context. Ontario Human Rights Commission. http://www.ohrc.on.ca/en/policy-preventing-discrimination-based-mental-health-disabilities-and-addictions/appendix-historical-context.

Ontario Ministry of Health and Long-Term Care. (2011, June). *Open minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. Ontario Ministry of Health and Long-Term Care. Retrieved March 30, 2022, from https://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth.aspx

Ontario Peer Development Initiative. About OPDI. https://www.opdi.org/about/opdi.

Ontario Select Committee on Mental Health and Addictions (2010) Final Report Navigating the Journey to Wellness. The Comprehensive Mental Health and Addictions Action Plan for Ontarians. Legislative Assembly of Ontario.

Peer Support Canada. https://peersupportcanada.ca/.

Piat, M., & Sabetti, J. (2012). Recovery in Canada: Toward social equality. International Review of Psychiatry, 24(1), 19–28. https://doi.org/10.3109/09540261.2012.655712

PSR/RPS Canada. What is Psychosocial Rehabilitation? PSR/RPS Canada. https://www.psrrpscanada.ca/what-psychosocial-rehabilitation.

Recovery International. (2021, June 22). *About*. Recovery International. https://recoveryinternational.org/about/.

Toward the Heart. (2018, December 4). *The History of Harm Reduction: International & Provincial (BC) Perspectives*. BC Centre for Disease Control.