MH-21

ISSN 1918-9613

Legislative Assembly
of Ontario

First Session, 39th Parliament

Assemblée législative
de l'Ontario

Première session, 39e législature

Official Report of Debates (Hansard)

Wednesday 7 October 2009

Journal des débats (Hansard)

Mercredi 7 octobre 2009

Select Committee on Mental Health and Addictions

Comité spécial de la santé mentale et des dépendances

Mental Health
and Addictions Strategy

Stratégie sur la santé mentale et
les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
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Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 7 October 2009

Mercredi 7 octobre 2009

The committee met at 1601 in committee room 1.

MENTAL HEALTH AND ADDICTIONS STRATEGY

SKY STARR

The Chair (Mr. Kevin Daniel Flynn): If we can call to order. Everybody's just getting settled here, but I'm going to ask Sky Starr, if you would come forward and get yourself nice and comfortable. There's some water, some clean glasses there for you, if you need them.

I'll just explain some of the rules for those in the audience as well. Every delegation gets 15 minutes. You can use that any way you see fit. It would be nice if you would leave some time around the end for some questions that some members may have, but that's entirely up to you. As the other members are just sitting down here, I'm going to turn it over to you. I'll let you know when there's about a minute left, just so you can summarize, if need be. The floor is all yours and thanks for coming today.

Rev. Sky Starr: Good afternoon. I'm very grateful for the opportunity to present this. I am a minister and a therapist. I work and live in the Jane and Finch community. My focus right now today is just to present some of the situations that are happening in Jane and Finch, as in the many other priority neighbourhoods. I'm just raising the awareness of grief and the support that grief needs within the community and that youth and family need in the community.

In one report, Gina Browne says, "The prevalence of mental health problems...occurring among younger cohorts, leads...to search for practical solutions to reduce the burden of suffering on children and their families, and the costs to society both immediate and long-term."

Most of the stuff that happens within the Jane and Finch community happens around loss and around violence. It affects the homes and the families. It affects individuals, churches, and it's everywhere. I'm very grateful that it's not only in the Jane and Finch community, but it's also in the other 13 priority neighbourhoods.

As part of the "eye on community," the lack of mental health supports for children and youth is very evident. Generations of people are not exposed to resources. The life trajectory remains alarming. Accessibility is minimal to nil for a population of over 100,000. There are virtually no clinical services available to youth. Mental health issues are entrenched in youth, families and in the community. I just wanted to raise awareness on that.

There is much empirical data which presents that, which supports that. Part of that you will have in a binder that I provided for you. I wouldn't want to waste time going into it, but everything is in that blue folder that you've got in front of you.

The one thing that I'd like to stress on this is, it is important to decrease the stigma both in those with and without mental health illness, particularly in communities where we're expecting youth to grow up to be responsible adults, responsible people in the community. Most of the stuff that you see happening with youth is depression, anxiety disorders, insomnia, inability to cope, social disorders, decreased productivity, negative behaviour patterns, violence, grief, and the cycle just repeats itself. All of these things that are listed here that are associated with grief and loss should be on the mental health radar, and they are not.

A lot of youth suffer in silence and isolation. I would go to a school, for instance, and a teacher would be motioning me inside because a youth has broken down in the class because they're triggered by a word or something that is said during a lecture or during stuff that is happening in the classroom. A lot of the stuff that's happening to kids is overlooked, especially the youth. They're overlooked, misunderstood and misdiagnosed, and the cycle continues.

The negative outlook that we see within the community—marginalization, stigmatization and all of that—I'm sorry, I've got to go back a little bit here. Excuse me for a second—marginalization, stigmatized. They are isolated. There's degradation. There's a dismal future for them—unrealized dreams—and kids continue to go through the process of that without having the clinical mental health attention that they need.

A lot of the anger and frustration that is felt among youth is felt because some of the attention that they need is not there. They're frustrated and angry and it leads to different things like violence, death, grief and grief-related situations in the community.

Grief, as we know, is a natural part of growth and development, but a lot of people are not comfortable with grief, and so a lot of people stay away, tend to shy away from grief. There is virtually nothing except what we provide in the community. I contacted BFO and the

product that we extend is a mutual peer support model. That relates to the entire community grieving, because no one agency or even 10 agencies are able to provide the support that is necessary there. So the fears and phobias—and grief is not a yes or no process. At some point we are all going to go through that because every living thing dies and the connection to grief is connected to everybody. At the end of the day, whether we want to admit it or not, it is something that affects us and it's not just grief related to death but loss in general on any level.

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Grieving is like a natural process. It is something that we probably need to look at and pay attention to. The goals and challenges that I find working in the community, the preventive measures that we need to support youth, especially youth—I got a call this morning. I'm on the crisis team, and I got a call from the city that there was a stabbing again. There was a young man in the hospital who is in critical condition, and probably by the time I get back, I will hear that this person has died. They're going to need grief support for the family and the community again. This is something that is very prevalent, that is very there and needs to be attached to the mental health radar and it is not, because most of the things that the kids and youth are experiencing are all related to mental health.

Many recommendations have been given. The latest we have is the Alvin Curling report. We have reports like that coming from every direction, but they get shelved. They're just piled there; nothing is being done. I would like to implore you to really look at the situation, not just in the Jane and Finch area but also in the other 13 priority neighbourhoods. This is a serious epidemic that we have. I call it an epidemic because I believe the entire community is grieving.

I'd like to raise the awareness that there's a stigma attached to mental health. There's a stigma attached to grief. Within our communities, our youth are suffering. They cannot function properly at school. Grief is something that is entrenched in the children and youth and the family. It's a cycle, a spiral effect that continues to happen. I think we need some immediate attention to that, starting on a systemic level, starting with people realizing that grief and all the fallout from grief are attached to mental health.

As a therapist, when I go to a school, when I go to a group, everything that relates to mental health relates to grief: insomnia, restlessness, depression, social anxieties. All of these things are there. I really would like to impress on you that we need to implement something that is positive for the community, have the support system set in place so that we are able to service the community and the other 13 priority neighbourhoods that are experiencing grief.

Sam Houston said, "The benefits of education and of useful knowledge generally diffused to a community are essential to self-preservation." My sons are 16 and 17. I have two, and I would love to see them live to be maybe 21, but the consensus in the 13 priority neighbourhoods is that you never know. Youth live in fear and the community is in fear, and we really need to have things set in place to support this.

I thank you for listening to me. Any questions?

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sky. You've left quite a bit of time for questions; thank you for that. Each party has about two minutes, so let's start with either Christine or Sylvia.

Mrs. Christine Elliott: Thank you very much, Reverend Sky, for coming here today. I really do thank you for your presentation because we certainly are aware of the need for more mental health services for children and youth, but you've raised it in an entirely new context that, quite frankly, I hadn't thought of.

Rev. Sky Starr: I'm sure.

Mrs. Christine Elliott: I certainly do appreciate that. I want you to know that we are thinking across ministries, across boundaries. With respect to your recommendations, you have suggested that we should have a lead ministry. Could you give us some suggestions on maybe your top few things that you think would be the most beneficial things that we could put into place in a perfect world?

Rev. Sky Starr: First of all, my concentration is on youth because they are our future. For youth within the community, we only have Dellcrest, which is there, but the connection to the community is minimal to none. I'm not knocking their services, but I'm just saying that within the community, the level of service that the youth need is not there. When a shooting happens, for instance, I get calls. My phone is just going off the hook because I'm virtually the only therapist within the community who's providing grief services. Granted, I do understand that it's a very scary topic, a very painful topic and a lot of us don't want to go there, but we need to go there because it is happening. It is affecting our youth and it is in the community.

So my recommendation would be: First of all, we need to have clinical places and areas where youth can go, where they know that if they're in crisis—grief particularly is not something that you can say, "Today, I'm feeling this; tomorrow, I'm not feeling this." It's an ongoing process. People never get over grief, but they are triggered by different things. If there were something within the community where our youth know, "Okay, that's there. When I'm feeling like that, I know I can go there"—we don't have that.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sky. We're going to move on to France.

M^me^ France Gélinas: Continuing with your train of thought, could you describe to me, "We can go there"? What would "there" look like? What would make it open to youth, who usually run away from anything that has to do with mental illness or mental health services because of many reasons? So, describe to me: What would "there" look like so that it is accessible to youth?

Rev. Sky Starr: A physical space, for instance; a safe space where they feel safe. A space that probably has a snoezelen room, a quiet space; a space where they can go

and just relax, unwind. A space where they know there's somebody there to listen to them, or even sit with them in the process that they're going through. A physical space, which we do not have right now.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. Any questions, Helena?

Ms. Helena Jaczek: Thank you very much for your presentation. I was wondering if you could just elaborate a little bit on your Out of Bounds grief support program. It looks like it's quite new.

Rev. Sky Starr: Yes, it is.

Ms. Helena Jaczek: Could you describe how the peer support works? Do you have any results in terms of outcomes, or is it too early?

Rev. Sky Starr: No, no. You've got some leaflets in there. If you would look through it, there are results in there.

The program started in 2007. I contacted BFO because I saw the need in the community and wanted to help. I felt it was insurmountable for me, so I contacted BFO. I arranged to set up some focus groups in the community. We had over 50 youth attend, and—the myth that we have about, "Men don't cry"—we had young men on the floor crying. For me, that was success. Probably you would think that people crying is not success, but for me it was an outlet to see that happen.

All of those youth wanted to have something in the community, a space or somebody they can go to for help, so Out of Bounds was started. I started Out of Bounds with community people: half youth, half adults. Right now, we have 16 people—eight youth, eight adults—and it is growing.

We have a training program going on right now that I am setting up. It's a 13-week program that just started last week and it will run until December, so that community people are trained in a peer-to-peer support model where a parent can relate to a parent, a youth to a youth and suchlike.

Ms. Helena Jaczek: Did you model it on any other existing programs?

Rev. Sky Starr: Modelled on BFO's existing program, Bereaved Families of Ontario, which has been in operation for 30 years. We are partnering with BFO for three years, and at the end of 2010, hopefully the community is sustained enough—and this could be a pilot program that can be extended to the other 13 priority neighbourhoods. That's my vision.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. One question: Have I heard you on the radio before?

Rev. Sky Starr: Yes, you have.

The Chair (Mr. Kevin Daniel Flynn): I thought so. I thought I recognized you.

Rev. Sky Starr: Well, thank you.

The Chair (Mr. Kevin Daniel Flynn): I thought I heard you giving an interview over some event.

Rev. Sky Starr: Yes. I'm just talking about people listening to youth. They need to listen to the youth. If you're asking for their opinion, you at least need to listen to them. Just don't totally disregard them.

The Chair (Mr. Kevin Daniel Flynn): Perfect. Thank you very much for coming today. I think you got your point across very clearly.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning is somebody everybody will know: Doris Grinspun. If you'd like to make yourself comfortable, Doris; there's some water and some glasses if you need them.

Thanks for coming on behalf of the RNAO. Like everybody else, you get 15 minutes, and you can use that any way you see fit.

Ms. Doris Grinspun: Thank you so much. I'm Doris Grinspun, the executive director of the Registered Nurses' Association of Ontario. We're the professional organization for registered nurses, who practise in all roles and sectors across this province. I'm very proud to be here today with my colleague Pat Nashef, president of RNAO's mental health expert group.

On behalf of Ontario's registered nurses, we would like to commend the Select Committee on Mental Health and Addictions for their work in addressing an issue that is vital for the health of individuals, families and communities. One in five people in Ontario has a mental health challenge at some point in their lives, and it is estimated that at least 60% of individuals diagnosed with mental health illnesses also suffer addictions.

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The committee has heard testimony from the Centre for Addiction and Mental Health that nearly 12% of the burden of disease is comprised of mental health and addictions, but Ontario consistently spends only 5% of the provincial health budget on mental health and addictions.

Our government's own report Every Door is the Right Door points out that, in total, including lost productivity, law enforcement, disability claims, drug costs, employee assistance claims and other factors, mental health and addictions costs Ontario at least $39 billion per year. In fact, every dollar spent in mental health and addictions saves $7 in health costs and $30 in lost productivity and social costs. The importance of strategic investment in mental health and addictions services cannot be overestimated. We simply cannot afford not to invest in this area.

To be healthy and live in dignity, Ontarians need to have access to liveable incomes, safe and affordable housing, nutritious food to combat persistent hunger and food insecurity, work that pays a living wage, high-quality early learning and child care, and a system of client-centred health care and community supports. This health care, whether in hospitals or in the community, must be coordinated, seamless and accessible to all.

Access to these conditions that foster health, including health care, is a fundamental human right.

It is timely that it is today that we speak again to you about the connections between social determinants of health and good health as we welcome Minister Deb Matthews as our new Minister of Health and Long-Term Care, coming from her previous portfolio where we worked closely with her on tackling poverty in Ontario. We are also very honoured to learn that we are appearing before the committee today on the same day that Barbara Hall, chief commissioner of the Ontario Human Rights Commission, will be presenting to you.

As registered nurses, we urge our province to live up to article 25 of the Universal Declaration of Human Rights, which states: "Everyone has the right to a standard of living adequate for the health and well-being of" him or herself and his or her "family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his" or her "control."

Nurses say, "Let's start with the fundamentals if we are to seriously tackle mental health, addictions and overall wellness."

We urge the committee and the McGuinty government to step back, look at the immediate needs of people living with mental health challenges and remember they represent 20% of Ontarians, one in five—in fact, one in five of us in this room. We ask that you review Ontario's mental health and addictions system carefully in the context of the real needs of persons living with mental health challenges and lead with boldness.

We propose that you:

(1) Accelerate the progress of the government's poverty reduction strategy, released in December 2008.

(2) Move urgently with the transformation of the Ontario disability support program and Ontario Works so it alleviates rather than exacerbates poverty and human suffering and treats clients and staff with dignity.

(3) Withdraw the government's appeal of the Ontario Divisional Court ruling that found that, under the Human Rights Code, addictions could be considered when deciding whether an individual is disabled and eligible to access the Ontario disability support program.

(4) Prevent people from being forced to choose between paying for food or paying for shelter. Social assistance rates need to be significantly increased so that they reflect the actual cost of living. In the meantime, there should be a $100-per-month healthy food supplement introduced to address the gap between dangerously low assistance rates and nutritional requirements. People should not need to choose.

(5) Fast-track the provincial housing plan, including: capital subsidies to build new affordable housing or renovate existing housing stock that is substandard; rent supplements to ensure affordable housing for low- and moderate-income households; and supportive community-based housing and services for those with physical, cognitive and/or mental health needs.

(6) Fund professional education in mental health and addictions screening, assessment, determination of early recognition and diagnosis, and immediate intervention across all professions as a basic entry-to-practice requirement. This will increase efficiency in health care and provide the opportunity to clearly address mental health and addictions stigma issues when these professionals are graduates. This can be accomplished by ensuring the development of specialized postgraduate education in mental health and addictions, and continuing education throughout that individual's career span.

(7) Improve access to high-quality primary care across the province. We are well on our path; we need to accelerate that.

(8) Develop a systematic and seamless mental health care system for all Ontarians, with sensitivity to cultural norms, delivered at the individual's preferred location, with special consideration for disadvantaged individuals such as those coming from aboriginal communities, older adults and elders tackling new and ongoing mental health and addictions challenges, people from racialized communities, people with disabilities, and children and youth requiring increased and enhanced mental health and addictions services. Several outstanding models of care exist already in the US, the UK and Australia; we don't need to reinvent them.

I will now ask my colleague to present to you.

Ms. Pat Nashef: Thank you and good afternoon. As many individuals and organizations—

The Chair (Mr. Kevin Daniel Flynn): Pat, if you could just introduce yourself for Hansard so they know that Doris's voice hasn't suddenly changed.

Ms. Pat Nashef: Good afternoon. My name is Pat Nashef. I'm the president of the mental health nursing interest group of the Registered Nurses' Association of Ontario.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Ms. Pat Nashef: As many individuals and organizations have already testified to this committee, it is imperative that people facing mental health and addictions challenges receive respectful, equitable, appropriate and seamless client-centred access to health and social services. We need to address stigma in perceptions, attitudes and actions, including funding that creates the conditions for people with mental health and addictions who experience isolation and neglect.

We need a coordinated, comprehensive approach to mental health and addictions so that there are opportunities for building resiliency throughout the life cycle through prevention, assessment, intervention, treatment and ongoing support that demonstrates our societal commitment to treasure every Ontarian.

I have had the privilege of working in psychiatric mental health nursing for more than 30 years. I know that this is a complex issue. People may not recognize that they have a problem, they may not know what kind of help is available, or they may know what exists but are unable to use the services because of barriers such as cost, language and transportation. They may have

difficulty finding what they need when there is a wide range of services and no single point of access. In some cases, the right services for their specific concerns may not be available nearby.

A radical shift in beliefs and paradigms about persons with mental illness and addictions is required, fostering an open dialogue and a systemic belief in recovery. People need to be able to access mental health and addictions prevention and treatment services through every door, but it is critical that this occurs well before the individual hits the criminal justice portal. Indeed, when persons with mental health challenges arrive at the criminal justice portal, it is highly likely that the Ontario mental health and addictions system has not met all of this person's mental health needs.

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For example, the deinstitutionalization of persons with longer-term mental illness commenced in the 1970s here in the province of Ontario and took place at about the same time as the devolution of housing from federal authorities to provincial authorities, and finally on to municipal governments. In fact, I personally had the professional experience of discharging two patients from the Queen Street Mental Health Centre in 1979 who had been full-time patients since 1924 and 1937, respectively. Regrettably, large numbers of people being deinstitutionalized were not accompanied by sufficient community supports, particularly affordable and supportive housing.

Homelessness, in relation to mental health, is an enormous issue, and the transition from hospital to community is complex. In a compelling research study conducted by Dr. Cheryl Forchuk, a member of RNAO, the mental health nursing interest group, and a noted nurse scholar in London, Ontario, studied individuals who had no prior history of homelessness, but were about to be discharged from psychiatric facilities and in-patient psychiatric units. They were divided into two groups: one that received the intervention and one that received the usual care. Those in the intervention group had help in contacting Ontario Works or the Ontario disability support program to fast-track the community start-up fees that assist with first and last month's rent at a new apartment, as well as help in finding an apartment from a housing advocate before discharge. This meant that they exited the hospital with a secure place to live, first and last month's rent paid and some money in hand to buy essentials, as well as ongoing access to mental health, financial and social supports.

In Dr. Forchuk's study, a strategy was created that involved a direct computer link from the psychiatric facility or unit to the Ontario Works and housing databases. Instead of taking one or two weeks, cheques were in hand the same day. Results were so dramatic that the study was stopped for ethical reasons. It was found that all seven people who received the intervention were still housed six months later, but shockingly, six out of the seven who received the usual care were still homeless six months later. The seventh had joined the sex trade for the first time to avoid homelessness with her small child and, six months later, was still in the sex trade.

In the past year, only 10 people were discharged to homelessness in London, Ontario, compared to almost 200 in 2002. This study also prevented 36 children from becoming homeless this past year. A copy of Dr. Forchuk's study is included in your package.

Another study also conducted by Dr. Forchuk tested a new transitional discharge model—

Interruption.

The Chair (Mr. Kevin Daniel Flynn): That means you have a minute left. Keep going.

Ms. Pat Nashef: —which combined peer support and ongoing professional support. Findings showed that persons receiving the intervention were discharged on average 116 days earlier than those who were not receiving the intervention.

Ms. Doris Grinspun: We thank you for the opportunity to share our expertise and experiences. We ask you to lead with boldness, linking fundamental, basic needs of people with their health, including their mental health needs. Lead upstream, not downstream, is our recommendation to you. Ontario nurses are unwavering in our commitment to improve the health and health care system for all Ontarians and we wish you the best in your deliberations.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Doris. Thank you, Pat. As usual, very clear, very concise, and you used up exactly 15 minutes—very well-planned. Thank you very much for coming today. It's appreciated.

Ms. Doris Grinspun: Thank you for having us.

ONTARIO HUMAN RIGHTS COMMISSION

The Chair (Mr. Kevin Daniel Flynn): The next speaker was previously introduced in glowing terms. Barbara, thank you very much for coming today.

Ms. Barbara Hall: Thank you very much, Mr. Chair. I'm here with Anya Kater, senior policy person from the commission.

I'm really here to offer our support to you in this vital work that you're doing. We're very concerned about the level of discrimination that is faced by people with psychiatric disabilities. Because we've begun to see more cases and learn of more discrimination that exists, we've made mental health one of our strategic priorities moving forward.

We're in the process of talking with a number of people, as you are, and we'll be pleased to share our findings with you as we determine our strategic priorities with respect to mental health. We're hopeful that applying a human rights perspective can help give direction to this issue.

Using a human rights approach, I have four key points to make today. First, as we've heard from others, is the issue of stigma and discrimination. We think that has

impacted the number of people who have come to the commission with complaints about discrimination. The stigma is so great that, if they do know of their rights, it's still coming out to file a complaint that deters many people. The Supreme Court of Canada has noted that mental disabilities often create "fear and stereotypical responses in people." "A person may have no limitations in everyday activities other than those created by prejudice and stereotypes." Individuals and institutions have a legal obligation under the code not to engage in discrimination and can be held accountable for discriminatory acts. Overall, organizations have a positive obligation to take action to prevent and respond to breaches of the code.

Let me give you an example of a complaint that we worked on. Paul Lane was a quality assurance analyst in the technology industry. He was considered hard-working and productive by his employer. But when he changed firms, he didn't reveal that he was bipolar. A previous experience had shown him that the stigma of his illness could trump his record of achievement. When, eight days into his new job, he had to reveal his condition, he was terminated. Last year, the Divisional Court upheld the Ontario Human Rights Tribunal's ruling in the Lane case. The tribunal had declared that Mr. Lane's firing "was a serious violation of [his] right to be free from discrimination by an otherwise sophisticated employer that had every reason to know better." Even though he'd only been on the job for eight days, the settlement he received was well over $100,000. His life fell apart as a result of this discrimination.

How can situations like this be prevented? I think others have said, and we would add our voice to saying this, that massive public education is key, for starters. Every organization, employer, school and service provider needs a plan and a process to ensure the needs of individuals are considered. Stereotypes about people with mental health needs need to be combated in all of these areas.

Meeting those needs is what the Human Rights Code calls the duty to accommodate and must be met right up to the level of undue hardship. The test for undue hardship is very high, with only three considerations: cost, outside sources of funding, and health and safety. In practical terms, that means employers and service providers must work with individuals to look for real solutions. The good news is that when people sit down and listen, accommodation is often quite simple. It's a question of having the conversation, entering the process. Both sides, with goodwill, are often able to find relatively simple solutions.

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Ontario's health care system needs to work that way too. Not only should it be designed inclusively, with the needs of people with mental health issues in mind right from the start, but it should be able to respond to the real needs of individuals through service delivery.

The second point is that we need to get rid of the silos within the health care system. We hear that a lot for a lot of different reasons, and here's another one: Holistic approaches do work. And I know that the developing poverty strategy and the roots of violence initiatives flowing from the Curling and McMurtry report are gaining ground because that holistic approach works.

An integrated health care system is vital. Mental health and addiction services need to be built into all health care services, not seen as separate issues. By streaming people into the mental health system as opposed to the physical health system, we perpetuate the stigma that leads to discrimination and increases the isolation of people with mental health disabilities.

The Supreme Court of Canada again has recognized that discrimination against individuals with mental disabilities is unlawful. In Gibbs versus Battlefords, the court struck down an insurance plan that limited benefits for persons with mental disabilities as compared to the benefits provided under the plan to persons with physical disabilities. It's our position, like the court's, that such distinctions between mental and physical disabilities are discriminatory, and that same approach should be applied to other areas beyond insurance, such as health care.

We often hear that people with mental health disabilities seeking general health care services are turned away because their needs are perceived to be too complex. However, under the code, all health care providers must provide their services to the public in a non-discriminatory way.

Thirdly, we need to ensure that there's coordination across the public service. Integration and holistic approaches may start with better coordination in health care, but it needs to go much further than that. If health care workers need help understanding the issues they face there, what do we think is happening in the jails, in the courts, in policing? I think on Wednesdays there's the mental health court at College Park. People end up there because of a lack of support and services elsewhere.

Community-based programs, whether it's policing and the courts, income support—the whole range of government services—are used by people with mental health issues. There needs to be a more unified approach to delivering services there. Gaps in services create new problems for people who already have difficulty dealing with stress or navigating complex systems.

We know that people with mental health issues who can't access health care services are more likely to end up in court or in jail. Having a criminal record then impedes their ability to access employment, supportive housing or volunteer opportunities. Better coordination across sectors will help prevent these types of situations.

The fourth point I want to make is in relation to acknowledging that there are many other issues that create barriers that are within your broader policy mandate. We heard from RNAO about issues related to homelessness. Yesterday, we launched our policy on human rights in rental housing and we heard so frequently the link between homelessness or discrimination in housing and mental health. We heard a lot in that context about how the rates of social assistance are

inadequate to maintain both housing and healthy living. Income support is a major issue. It has come before us at the commission and there are cases currently before the Human Rights Tribunal dealing with issues in relation to the Ontario disability support program, which doesn't provide for special diet allowances for individuals with mental health disabilities. We're still hearing that people with addictions such as alcoholism are not eligible for ODSP, despite the multiple court decisions that have determined this to be discriminatory. I understand there's a recent appeal by the government, so once again that issue will be in the courts for potentially years.

We're looking at issues like land use planning and the fact that many municipal housing bylaws contribute to discrimination against different groups of people. Housing for people with mental health issues is an ongoing target of NIMBYism and restrictive bylaws.

We've also heard a lot about the need for appropriate supportive housing, and over and over about the unsafe living conditions that many people face. Clearly, poor housing or no housing makes it harder for people to manage their treatment and increases the risk of relapse.

Education is another area where mental health issues come up, as many children are still not having their disabilities, including mental health concerns, fully accommodated within the system. This creates the vicious circle of missed educational opportunities, having a great impact later in life when students who haven't succeeded in education are unlikely to have success in their employment situation. We also found students being disciplined for behaviour related to their disability.

In the few minutes I've had to speak to you today I've raised four points. I guess I could easily have spent the time talking about the needs of children with mental health problems and the need to identify and address those problems earlier and more effectively. I know others have done that.

In spite of all the problems that I've spoken to, I think there is some good news. There are more people addressing the stigma and discrimination. We're moving towards more effective holistic solutions.

At the commission, we are now focusing on systemic discrimination, and getting to the roots of discrimination and the necessity of multi-faceted approaches to discrimination becomes more and more obvious to us every day.

We are delighted that this all-party select committee has taken up the challenge and we look forward, in the months and years ahead, to working with you to contribute our expertise and experience as we look for better ways to deal with the many, many Ontarians who live with mental health issues.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. An excellent presentation, as we knew it would be. You've used up all your time, unfortunately, so there's no time for discussion, but you made your points very clearly. Thank you.

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MARK DUKES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is Mark Dukes. Mark, if you'd like to make yourself comfortable there. Like all the other presenters we've had before us today, you get 15 minutes to use any way you see fit. If you would like to leave some time at the end for some questions and answers, that works well, but if not, how you use your time is entirely up to you. The floor is all yours.

Mr. Mark Dukes: Thank you. Hi, everybody. My name is Mark Leanelle Dukes, and in my 36 years of life I have lived in Toronto, Cobourg, Belleville, Kingston, Trenton, Peterborough, Orillia and, finally, back home to Toronto. To be fair, I've been intoxicated in some fashion or another throughout my life, so dates, addresses and employment are hard to recall, but I'm sure I've got the cities right. Good afternoon, everyone.

I've come here today to discuss my perception of addictions within Ontario, although I have concurrent disorders right now—I suffer from a mental health issue and addiction. I've come here to propose opportunities for change. I propose these changes not as a peer, a consumer of services or a survivor of addiction, but as a current drug user. I base my proposals upon my personal experience with addiction as well as four solid years of working with some of the top addictions stakeholders of not only Toronto but the country. I sit as the drug user representative on the Toronto drug strategy implementation panel for the capital of the province, but I don't represent them here today; I'm just an individual who does drugs.

The Toronto drug strategy addresses issues of addiction in four main categories: law enforcement, treatment, prevention, and last, but certainly not least, harm reduction. In my time spent analysing these four methods for positive addiction intervention, I have come up with opportunities for change within these areas that I would like to share with you now. But before I begin, I want you to all know that throughout my advocacy and my volunteering of time, I've tried to remain non-partisan within the issue of addiction, so I would accept funding from any one of you here to get the job done. I don't discriminate.

First, I'd like to begin with my recommendations in law enforcement. I see two major opportunities for change that would help not only the drug user, but the community that they live in. I propose that at least a reasonable percentage of all proceeds of crime that are seized from drug crime by both provincial and municipal police services be directly applied to the other areas of positive interventions in addiction; namely, treatment, prevention and especially harm reduction. Simply put, take the supply-side drug money that is seized and use it to fund the demand-side addiction services—it sounds pretty simple. I will be engaging the Senate concerning this issue and hope that with your collective help, we can

increase the funding towards helping the communities dealing with addictions, but most importantly, the user.

Secondly, I will point out to the committee the high percentage of times a call to 911 within Ontario involves an aspect of drug or alcohol use. Considering the economic situation that we all find ourselves in—I know that money doesn't grow on trees, although it's made from them—doesn't it make sense to divert people with addictions to health services instead of jail or overcrowded hospitals? I think you could save money; I really do.

So in that frame of reference—saving money—I propose a new division in labour within police services across the province to be created to address addiction issues specifically. I do not mean drunk driving or meth or crack labs or violence involving drugs or alcohol. What I'm talking about is instituting a new division in labour that is modelled after the already-existing mobile crisis intervention team. We have one of those in Toronto. It's a nurse and a police officer. So I'd like that for addictions as well. I guess that's what I'm really saying to you.

The law surrounding addiction in Canada has just changed. Although Ontario is appealing the decisions surrounding addiction as a disability, I expect that, if and when the appeal is struck down, this proposed division in labour will be instituted in order to reflect the Charter of Rights and Freedoms, specifically the parts concerning discrimination and safety of the person. If people with mental health are handled differently by enforcement, then why not people who are addicts?

Treatment: Once again, no new money means innovation with existing infrastructure. I see treatment in three phases, personally—I'm not a doctor or anything. I see it in three phases: first contact; acute or chronic care; and maintenance or aftercare. The two phases that I would suggest updating would be first contact and aftercare. Regardless of whether you are in urban or rural settings within Ontario, your first contact in dealing with your substance-use issues should not be getting arrested. That would only lead to more criminalization, institutionalization and stigmatization of a person who essentially needs help or support. My proposal of a new division in labour of the police services could actually change the first contact from an arrest to an assist for those suffering from addiction.

As far as the aftercare, I would suggest partnerships between large and well-funded hospitals and health centres and their community counterparts, which are the street-level community services—drop-in centres and the like. These types of partnerships create the kind of continuity an individual experiencing addiction needs to receive consistent health care.

Prevention: In my opinion—and I really stress this this time; this is only my opinion—the biggest opportunity for change that I can see for this area of positive intervention is the funding—not the amount of funding, but the ideology and the process that the organizations applying for the funding have to go through in order to get it.

Let me just define what I mean by that. The fact that the province is funding normally one- or three-year projects only encourages organizations to take the easy road. In order to get the win, they create a pilot project that is going to win, not the one that they should be creating that potentially might not win but helps the people who are most directly involved, like street-level users. Phrases like, "We need to make our pilot project successful and viable and attractive to the government so we can get more funding later"—I hear phrases like that and I just refuse to accept them. This kind of reasoning, which I have witnessed, makes economic sense but, again, encourages organizations to take the easy road and give you what they think you want versus what they should do. I suggest we take the high road and prevent communities and youth already involved in drugs and drug use from further involvement. I would like the province not to look into after-school programs for at-risk youth, but instead call for a proposal for educating youth who are already at risk and preventing them from future use. There again, I see a natural partnership between law enforcement and health services.

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As promised, last but not least, harm reduction: It saved my life, harm reduction. The RIDE program, regular checkups at your doctor's office and handing out clean crack pipes and needles are all a part of this area of positive intervention, and they are all vital services that address harms associated with alcohol and substance use. It is my opinion, though, that discrimination and stigma associated with alcohol and drug use far outweigh all the rest as being the biggest harm and obstacle to stability and recovery of an individual or communities affected by addiction. Isn't that why you're all here together as a committee?

The fact that there is no argument concerning the need to create a strategy to deal with addiction and mental health—I think it's great that you all came together.

Just give me another second. Sorry; it's kind of personal.

The Chair (Mr. Kevin Daniel Flynn): You've got all sorts of time left, so just take the time you need.

Mr. Mark Dukes: All right, thank you.

To continue, if it's your intention to create a strategy to deal with addiction and mental health, I ask you all to directly involve drug users within the solution and not just the problem. I'd like to see drug users involved at every level, from policy creation to policy implementation and then on to the evaluation of that policy.

I have always been accused of being a dreamer, and although my visions are grand in design, I hope you all agree that we can accomplish any of these things I just mentioned if we are inclusive throughout the process. If all of these parties in front of me here today can come together to create a strategy that affects me directly, then I can at least find the courage to step from the safety of the shadows of stigma and reveal myself as someone most directly related to the issues of addiction—a drug user. Thank you. Any questions?

The Chair (Mr. Kevin Daniel Flynn): I'm sure there will be. We'll start with the NDP. We've got about three minutes left.

Mr. Rosario Marchese: Thanks very much, Mark, for your presentation. I agree with a lot of what you said, particularly with issues of prevention and treatment. It's always the case that we spend less money and attention on prevention, and we spend less time and money and attention on treatment as well.

There are many in society who just want to be able to punish someone as soon as something happens rather than finding out what the problem might be and what we could do to help, and what we could have done to prevent it. It's a difficult challenge for many, particularly those like you who are telling us what we should be doing. I agree with your presentation; it makes a lot of sense. I hope we can get to some of the suggestions and recommendations you're making.

Mr. Mark Dukes: Me, too.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Rosario and Mark. Any questions from this side? Bas?

Mr. Bas Balkissoon: Mark, thank you very much for your presentation. The committee had an informal discussion earlier today, and you raised a good point about first contact and criminal charges. How do you see the system working to recognize someone with mental health or an addiction at that first contact point and redirect them out of the justice system?

Mr. Mark Dukes: Not to be smart, but common sense would be the first thing. Your question was, how would you—sorry, once again? How does somebody identify somebody who's experiencing—

Mr. Bas Balkissoon: How does the system identify a person on first contact and redirect them out of the justice system so that they don't get into the justice system and they don't have a criminal record?

Mr. Mark Dukes: Right. My idea on that would be that—I referred earlier to consistency and continuity. Within the health industry, it's kind of scattered in silos, as somebody referred to earlier. The person involved directly—the drug user—has to sign a piece of paper everywhere they go. Pretty soon, you get tired of signing pieces of paper, or certain pieces of paper aren't signed, so therefore organizations can't communicate back and forth.

The continuity of information between those existing systems out there doesn't exist, so that person kind of bounces around, and maybe information catches here and there. You need to organize yourselves accordingly in terms of communication and continuity for an individual case. You have one case file, but in a region or an area, you need somebody who knows where these people are going, what they're doing and what's happening throughout the day. That's the identification.

I would assume that people who are in emergency services, fire, police and ambulance, upon entering a situation, know what's going on. They've seen it a million times before.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mark. We're going to go on to Christine.

Mrs. Christine Elliott: First, I'd like to thank you very much, Mark, for coming today and talking about something that's obviously very difficult for you.

I'd just like to carry on a little bit on the justice side, and I agree with you that some of the diversion teams, where you have a police officer and a mental health or addictions nurse going out, seem to be very effective where they're working in areas of the province, but there are some situations where there may be some charges that are going to be laid that can't be diverted.

I've had an opportunity to attend—we have a drug court where I live, and it seems to be a good way of almost harm reduction for certain people who choose to enter into it in the sense that it helps people along the way and helps them to sort of deal with the addictions issue. Could you just give me your opinion on it? Do you think that it's a useful investment?

Mr. Mark Dukes: Firstly, I will stress again that I'm going to make a distinction between mental health and addiction. I think if you were to create such a thing, you would look at the model that already exists, but addiction is different in many forms. Including some of the charges that you alluded to earlier, concerning the ones you can't—you walk up and you knock somebody out. Regardless of the fact of whether you're drunk or stoned, you're going in the bin, right? I understand that.

What I would like to see and what's already happened—I think we need to create a status here. People have been stigmatized within this issue for years, they've been institutionalized for years, and going through that wringer over and over again, the police run the routine and so do the addicts. There needs to be a break in that habit. The people who are the victims in the war on drugs need to be pulled off the battlefield and the cops and the drug dealers need to go at it. I'm in full support of that.

In answer to your initial question, I would love to see a nurse out on a street talking to somebody with addictions as opposed to somebody with a gun.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Mark—an excellent presentation, very well received.

Mr. Mark Dukes: I hope so. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

PEEL CHILDREN'S CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this afternoon will be from the Peel Children's Centre: Humphrey Mitchell, the executive director. If you'd like to come forward, Humphrey, make yourself comfortable. Any one of the chairs has a live mike. Sit wherever you like. There should be some clean water—well, I'm assuming the water's clean. The glasses should be clean as well.

Mr. Humphrey Mitchell: Thank you. We'll see what we can do.

The Chair (Mr. Kevin Daniel Flynn): Make yourself at home. You've got 15 minutes like everybody else, and you can use that any way you see fit. If you can leave some time at the end for any questions, we'll see if we can split it evenly. Thanks for coming.

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Mr. Humphrey Mitchell: Thank you very much. I appreciate the opportunity to speak to you today.

You've heard many presentations already and covered many different gambits of the issue of addictions and mental health. My focus today is going to be in the area of children's mental health and youth mental health. I've spent the last 30 years of my career working in this field, so that's going to be the area that I will focus on today. I have five different areas that I'd like to speak to you about. I'm going to speak not from a clinical perspective, but more from a systemic perspective, because I think that is one of the issues that I think we struggle with and, at a higher level, is something that recommendations coming out of the committee can probably make a profound difference in in terms of mental health and addiction services throughout our province.

First, ensure equitable access to mental health services for all children, youth and adults throughout the province of Ontario. It sounds simple, but it's a very complicated and challenging issue. I come from the Peel community. We've had dramatic growth, as many of the 905 areas have had, and historic funding patterns have not kept pace with the growth. If you look at rural communities in the north where you have people who live great distances, access to mental health services, whether it's children or adult mental health services, is wildly different. I strongly believe that what we need is a formula that's predominantly based on population, that takes into consideration key proven social indicators that we know contribute to mental health challenges, and also, for our colleagues in rural communities and northern communities, something that takes into consideration the distance factor. But to have truly accessible mental health services for children, youth and families in this community, what we need is a formula that in fact will be equally distributed, with certain variations, across the entire province. For a child living in Peel to receive $1 for every child living in Toronto receiving $6, simply by division of the Etobicoke Creek, really doesn't make sense in terms of mental health differences. The poverty situation, the diversity situation, in the Peel community is very, very similar to that in Toronto and the differences just don't justify that kind of difference in terms of funding.

Secondly, integrate the child and adult mental health systems. The David Peterson government, in the late 1980s and early 1990s, just before Mr. Rae took over, was on the cusp of taking a strong stand and moving forward in integrating the adult and children's systems. It's unfortunate it didn't happen, in my opinion. What we have right now is what I would call a conveyor belt. Children's mental health provides services up to the child's 18th birthday. At that point in time, the child goes into a free fall. A lot of the children we work with are going to need mental health services for the balance of their lives, so to have them change systems from the Ministry of Children and Youth Services to a Ministry of Health and Long-Term Care structure, in my mind, really causes—the more seams you have, the more chance to fall through the seams. Thistletown Regional Centre, which is directly operated by the province of Ontario, has, I think, 10 or 12 adults between the ages of 28 and 38 who are currently being served in its triad program simply because there's nowhere in the adult system for them to go. Whether it's a formal ministerial approval or a linkage, or whether it's some kind of formal linkages approved throughout the province on a consistent basis, we need to link these two systems so that we don't have children and youth fall through the cracks on their 18th birthday.

Thirdly, create a universally available province-wide continuum of mental health services. I know it sounds complex—and one of the speakers I heard earlier today was saying there are models in Australia, there are models in the States, there are models in Europe. There are models available that we can learn from. They may not be perfectly applicable to our Ontario situation, but there are models that will tell you what kind of services should be available, all the way from the prevention side to the most intensive intervention side and everything in between. We know from years and years of studies and research that if you don't provide every level of service along that continuum, you'll either over-serve at a higher cost a particular child or youth, or you'll underserve at a much greater risk for that child or youth in terms of their mental health needs.

Fourthly—and the last two areas I'm going to talk about are really around what I would call efficiency and economic savings. We always talk about wanting more money, and I know it's probably a mantra you hear often. I think there's a way our systems can be better operated, even with existing dollars. I'm not saying we don't want more money in the system, but I think they can be better operated.

Realign geographic catchment and planning areas, both across and within ministries and ministry-funded service providers. As a service provider, we're being asked to sit on multiple LHINs that are available now, new catchment areas that have been created. In the Ministry of Children and Youth Services, we have a central west region. Even within that same ministry, the youth justice portfolios, the children's mental health portfolios and the child welfare portfolios have different catchment areas. Our school boards have different catchment areas. I realize that we will probably never have one that's perfect, but if I look at the amount of time—recently I was talking to a senior vice-president in one of the Halton hospitals, saying that their senior staff are spending upwards of two days a week representing the various LHINs. You look at the amount of time that's going into the planning, and there are different planning cycles for different groups. We need something that's cohesive and, I think, can be much more effective and much more efficient in terms of delivery of service.

Lastly: Rationalize the number of providers with mental health services throughout the province. This would not be popular amongst some of my colleagues. In children's mental health, there are over 400 providers of children's mental health services funded through the Ministry of Children and Youth Services. I would say to you, in my not so humble opinion, it's far too many. I know the recent consultation, Every Door is the Right Door; I would say, in this province, we have too many doors. I think it's convoluted; it's confusing for consumers. The consumers, at a point in time of need, don't know where to turn, and we need to simplify this in the community. I would also say to you, by virtue of having fewer providers, you're going to have a greater level of expertise in a whole host of areas, all the way from your administrative infrastructure to your clinical areas. Multiple small agencies can fit niche markets and they can continue to be niche, but you need some way of linking them so that in fact they can have the benefits of a larger system.

I would be glad to answer any questions you would have, but those were the five points that I wanted to make. I just wanted to thank you again for the opportunity to speak with you today.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you. You've left about two and a half minutes for each of the sides. Liz?

Mrs. Liz Sandals: You've raised a number of interesting issues. One of the issues that we've talked about—interestingly, not just from a mental health point of view and the confusion around what service is provided by whom but also from the public accounts point of view—is, is the money being spent effectively? Have we actually got the province covered? So there has been a lot of conversation about rationalizing the number of agencies. Practically speaking, what would you see as key steps in going about that?

Mr. Humphrey Mitchell: I think there's a good opportunity for government to create some incentives for organizations to come together. I remember Minister Chambers saying she was shocked at the children's mental health conference—I'm not here to talk about amalgamation and mergers. I don't think amalgamation and mergers are bad, as long as they are done for the right reason. I think there are opportunities, in terms of strategic directions. We have a strategic direction with Nexus Youth Services that allowed Nexus Youth Services to continue to have its own identity, but it gets the benefit of a larger infrastructure that we can provide. So they have access to psychiatry, psychology, human resources and information technology, which they just never would have access to as a small agency of four or five people.

I think there are opportunities to create this that will really bring people forward. Not everyone will want to play, to be honest, and at some point in time, I think some decisions have to be made. But I do think there is a critical mass, that there is a level of efficiency to be gained, and without that, I would question whether in fact it's viable to continue, to be honest.

Mrs. Liz Sandals: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: I wanted to delve a little deeper into your fourth point about realigning geographical catchment and planning areas. I've heard the LHIN issue before, in children's mental health, of course. You've added that other component of the schools etc. What do you envision in terms of how you would look at that realignment?

Mr. Humphrey Mitchell: That's your job.

Ms. Sylvia Jones: That's why I'm asking you.

Mr. Humphrey Mitchell: No, it's a huge task, and I don't have a cookie cutter, but I think, within the province, it's not unreasonable to think that you have a provincial level, you then have perhaps what I would call regional levels and then you have local area levels, and they should be consistent across, as much as you can, school boards, hospitals, for all our planning so that when we come together, we come together once with a focus on a particular geographic area—the same population. We can talk about the demographics for our community and we're all talking the same language. Right now, it's highly fractured. I didn't mean to be glib. I don't have a magic formula for what those structures should be, but I really think it's critical and I think there are huge, potential efficiencies if this can be done.

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Ms. Sylvia Jones: I can see why you would be frustrated because even within the LHIN systems, they have different priorities; they have different areas that they want to focus on in terms of for their catchment area, for lack of a better word. Looking at your organization, where you're dealing—do you have three LHINs?

Mr. Humphrey Mitchell: Two.

Ms. Sylvia Jones: Two—that you would have very different wants and needs coming from the LHIN system.

Mr. Humphrey Mitchell: Please, I'm not being critical of the LHINs in any way, shape or form; I just use them as examples of different structures and different geographic boundaries.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Humphrey. France?

M^me^ France Gélinas: Your second point, "integrate the child and adult mental health system": Do you see it as high as having a ministry for mental health, or do you see this more as integration at service delivery or anywhere else in between?

Mr. Humphrey Mitchell: I think it can be done in different ways, but I think it has to be done. In 1979, children's mental health services moved from the Ministry of Health to the Ministry of Community and Social Services. I think there are benefits both ways. I think the creation of the Ministry of Children and Youth Services has had some benefits with it. I would be one to say that maybe it hasn't gone far enough. But even if children's mental health continues to be funded from that ministry, we need some formal linkages that are province-wide—

it's not just left to local areas to figure it out—that are given, are confirmed and you can really count on.

We have children going from one part of this province to another part of the province, and the ability to access those services is dramatically different. The same thing happens as people go from—if you think of people, often at age 18 they're going to community colleges. They maybe go to universities. And what they're being exposed to, again, is dramatically different in different communities throughout our province. Just to have an alignment that is consistent everywhere throughout the province, or as much as you can, I think would be wildly beneficial for people in this province.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France, and thank you for coming today, Humphrey. It certainly was appreciated.

Mr. Humphrey Mitchell: Thank you very much for your time. Good luck in your deliberations.

SHERBOURNE HEALTH CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is from the Sherbourne Health Centre, Suzanne Boggild?

Ms. Suzanne Boggild: Boggild, yes, thanks.

The Chair (Mr. Kevin Daniel Flynn): Close. Please make yourself at home there; introduce your colleague. You get 15 minutes like everybody else, and you can use that in any way you see fit. If there's any time at the end, we'll do what we just did and see if we can split it amongst the three groups.

Ms. Suzanne Boggild: Great. Thank you very much. Good afternoon. As I said, my name is Suzanne Boggild. I'm the CEO of Sherbourne Health Centre. With me here today is Jothi Ramesh, one of our mental health counsellors who has helped build our mental health program at Sherbourne. I want to thank you very much for giving us this opportunity to provide you with some of the background on the important work we do every day at Sherbourne Health Centre to help those with mental health and addiction issues.

You'll see from our report that I've organized our recommendations under three broad strategies. I'll go over these, and then Jothi will highlight a case study based on our actual experiences at Sherbourne. We hope this case study will actually bring to life for you how our recommended strategies, we believe, really improve client and system outcomes.

First, I'd like to give you a little bit of an idea about Sherbourne Health Centre. We're an urban primary care centre. We've been serving southeast Toronto—just really down the street from here—since 2002. We focus on three distinct populations: homeless and underhoused individuals, newcomers and immigrants, and members of lesbian, gay, bi and trans communities. You'll see from the chart in our presentation that since our inception in 2002, our client visits have grown dramatically. We've found that approximately 50% of our clients raise mental health concerns while receiving primary care. We believe that this rapid growth and success with our mental health service within a primary care setting gives us credible experience on which to base our recommendations.

Our first recommendation is that you enhance mental health services within primary care. We certainly understand that governments cannot ignore the needs of other parts of the mental health and addictions care continuum, but we believe that improving the way government approaches and funds primary mental health services must be a cornerstone of your report and recommendations. When mental health services are embedded within primary care, we believe there is less negative stigma attached to mental health care, thus leading to earlier interventions and more voluntary care. We also believe that primary mental health care increases the likelihood of client commitment to their care regime and it normalizes mental health issues within a health promotion and chronic disease management framework. So we believe this improves both physical and mental health, which we believe have been somewhat artificially segregated for too long.

We certainly support a continuum of care and we know that should clients need more specialized care, the primary care team needs to serve as a system navigator, case coordinator and often, a knowledge translator.

The good news is that Ontario already has a good network of primary care providers. There's a growing number of family health teams, as you know, across the province, and community health centres are growing as well. We believe that incremental investments within these existing structures have the potential to leverage big gains for the people of Ontario and the health system. That's our first recommendation.

Our second recommendation, and one which Jothi's case study will highlight, is the need to recognize the particular importance of health promotion strategies and illness prevention initiatives in newcomer and immigrant communities. Our experience with many different newcomer communities convinces us that there are multiple and particular barriers to receiving care for individuals within these communities. We believe that at the primary care level, one needs specific community engagement strategies and targeted health promotion activities, especially if they're integrated with physical health, in order to lead to earlier intervention and acceptance of mental health care within newcomer and immigrant communities.

We're certainly happy to talk about how we serve our other populations from a mental health point of view, but today we wanted to highlight the challenges within newcomer and immigrant communities. You'll see that our paper gives a couple of examples of what we think are low-cost and high-value initiatives with immigrant youth and newcomer moms that have led to very positive mental health results. That is our second recommendation.

Our third recommendation is that the select committee support more mental health training and development of primary care teams. Again, the good news is that there is

already a platform for this within Ontario, and we believe HealthForceOntario is that platform. We believe it could be the tool the government uses to meet this recommendation. One of the goals of HealthForceOntario is to build on the skills of those already in the system.

How to build on those skills? We believe that primary care teams need the skills to engage clients in mental health promotion, to undertake mental health assessments and ongoing treatment, to refer to specialized mental health resources, and very importantly, to partner with communities and other organizations to improve mental health promotion at the population level.

In order to succeed, we believe that primary care needs: access to psychiatrists and psychotherapists for case consultation; funding formulas that support case-conferencing by a group of interdisciplinary professionals; opportunities for individual clinical supervision; and opportunities for multidisciplinary team development.

That is our final recommendation. Now I'll ask Jothi Ramesh if she'll paint a picture of how these recommendations can work on the ground. I want to emphasize that the case study is, of course, an amalgam of our experiences at Sherbourne Health Centre and it in no way identifies a real client.

Ms. Jothi Ramesh: Thank you, Suzanne. The following case study illustrates the importance of the three strategies we are advocating. The case demonstrates the importance of the integration of primary health care and mental health care, supports the value of care developed for newcomer/immigrant populations and illustrates the positive outcomes available to clients of well-trained and clinically supported teams.

The outcome for this client was positive, as the treatment approach helped to keep the client out of the emergency department and in-patient units. The facts of this case have been altered to ensure this client could not be identified.

Mr. S is a 50-year-old man who emigrated from Eritrea 10 years ago. He was living in a market-rent apartment and working part-time as a security guard. He's married and lives with his wife and son. Mr. S was educated as an engineer in Eritrea but had been unable to find work in his field.

Mr. S was referred to the Sherbourne Health Centre through a settlement worker who had made contact with a counsellor at the Sherbourne Health Centre who spoke Arabic. The counsellor at the Sherbourne Health Centre, Ms. R, met with Mr. S and was able to communicate with him in Arabic. It became clear that Mr. S had been in crisis for some time.

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Mr. S had been under severe financial stress for many years. Due to his difficulties finding employment, Mr. S had to rely on money from his brother to pay his monthly expenses.

In the six months prior to being seen at the Sherbourne Health Centre, Mr. S began feeling suspicious of people. This increased to feeling like people on the street were laughing at him and he was hearing voices. These symptoms made it extremely difficult for Mr. S to sleep. He began to drink alcohol in order to get some sleep. Mr. S's situation escalated to the point where one evening, after consuming some alcohol, he had a verbal and physical altercation with his wife, and the police were called. Mr. S was charged with assault and the court appearance was pending.

At the time of initial contact with Mr. S, the counsellor at the Sherbourne Health Centre was able to ascertain that Mr. S had a serious mental health issue. The health centre had a psychiatric consultant employed for case consultation. This psychiatrist was able to see Mr. S within a week, and this was very important because the counsellor acted as an interpreter during the assessment.

Mr. S was then referred to the family health team for follow-up. He received prescription medication to help him with his paranoia and sleep. This was prescribed by the family doctor after he had consulted with the psychiatrist, so it was a team working with him. Mr. S also benefited from ongoing supporting and counselling from Ms. R, who was able to speak with him in Arabic.

As time went on, Mr. S gained some weight—this being a side effect of the medication—and he was referred to the nurse and the dietitian at the family health team to offer him some education around his diet and overall well-being.

Mr. S was able to have his court matter diverted through the mental health diversion program. He returned to work part-time, and he reunited with his wife after receiving couples therapy.

He's still on medication and his symptoms have improved greatly. He still takes alcohol on and off, but it has been a great positive outcome because it reduced costs—going to emergency departments all the time or getting in-patient care. This was possible only because we had a team working together and we intervened right at the very beginning.

Ms. Suzanne Boggild: Thank you very much for your attention. I hope our presentation demonstrates how Ontario can use existing platforms, namely our primary care system and HealthForceOntario, to give the people of Ontario better local access to mental health care and how small investments in primary care team training and development can lead to more accessible, culturally competent and ultimately more affordable mental health care.

Again, I thank you for this opportunity to make our recommendations, and we welcome your questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Suzanne. You've left about three minutes, so about a minute for each party. Christine or Sylvia?

Mrs. Christine Elliott: Thank you very much for your presentation and for highlighting particularly some of the issues that you face with newcomer clients. In the particular case example that you gave us, the counsellor happened to speak Arabic, so it worked out. Do you often encounter situations where you have translation issues and problems in communicating with your clients?

Ms. Jothi Ramesh: Yes, but we do have some counsellors who speak some of the languages that represent

our population that we're serving in the catchment area. But we do run into situations where the client does not speak English and we don't have a counsellor who speaks that language.

If you look at counselling, it's a one-hour appointment every week. Our funding does not allow us to provide translation services—it's quite expensive—so we'll have to refer them out if they can't speak. We have phone translation to do intake to provide some support to help them with the referrals, but to carry it on—because we have open-ended counselling, too, so it's—

The Chair (Mr. Kevin Daniel Flynn): Thank you. We're going to move on to France.

M^me^ France Gélinas: It sounds like a wonderful model. Where does your funding come from for the Sherbourne Health Centre?

Ms. Suzanne Boggild: We're funded both through the Toronto Central LHIN and through the Ministry of Health through our family health team, and then we have funding through other aspects of the Ministry of Health. We receive a little bit of private funding and have had one-time grants from the federal government and from the city as well, but our core funding comes through the Ministry of Health and the Toronto Central LHIN.

M^me^ France Gélinas: Do you charge for any of your services?

Ms. Suzanne Boggild: No, we don't.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. Jeff?

Mr. Jeff Leal: Thank you very much for your detailed presentation. Do you see the family health teams as being one of the principal platforms to extend both services and assessment in the province of Ontario? We have about 150 that are functioning today and functioning very well. Additional investments on that side of it to address things that you've identified, you believe, is one of the ways we should go.

Ms. Suzanne Boggild: Absolutely. I've really had the pleasure of developing, with other folks, the family health team at Sherbourne and being engaged in the family health team initiative across the province, and I think it's an excellent platform to build in more primary mental health. I think we underestimate how stigmatizing mental health can be. I think it's a very positive way within local communities for people to engage around their mental health, both prevention, promotion and treatment.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. It really is appreciated.

Ms. Suzanne Boggild: Thank you very much for your time.

CANADIAN MENTAL HEALTH ASSOCIATION, TORONTO BRANCH

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is the Canadian Mental Health Association, Toronto branch. Steve, if you'd like to come forward—Steve Lurie, executive director. Make yourself comfortable. Like everybody else, you have 15 minutes. Use that any way you see fit.

Mr. Steve Lurie: Thank you very much for inviting me. I started out my career in mental health working in Christine Elliott's riding at Mental Health Durham in 1975. For the last 30 years, I've been here in Toronto providing services in part to Scarborough, where Bas Balkissoon, as you know, works and lives. During that period, I've had a great opportunity to also work on some of the policy initiatives in this province and also some of the Canadian ones, so my presentation today is going to focus on those. I was involved in developing the first mental health strategy for Ontario, Building Community Support for People, by Bob Graham in 1988. As a result of that—or as penance—I became the Ministry of Health's coordinator for mental health and addictions and contributed to what was then Putting People First. Then I was on the provincial advisory committee on mental health that contributed to the Conservative government's strategy, Making it Happen. In 2005, I provided some assistance to Senator Kirby with his committee. Since then, I've been chairing the service systems advisory committee for the Mental Health Commission of Canada. In my spare time I also teach health and mental health policy, so what I'm going to try and offer you is actually evidence-based, to some extent.

What I've decided to try and focus on is the need for a 10-year investment in a mental health and addictions strategy. I know that with what's going on today, there are a lot of discussions about value for money, but I honestly believe that a focused investment plan on the right things will actually provide value for money, especially for those people and their families who live with mental illness or addictions. I might say that mental health and addiction live in my family, so I can tell you that had good care been available, in many cases, tragedies could have been avoided.

What I've tried to do is divide my presentation into the why, what and how.

Why should we do this? You've heard eloquent testimony since you've been set up as a committee that mental illness and addiction affects 20% of Ontarians each year—that's the people directly affected. If you estimate families and friends, it's a far higher number. Regrettably, only three in 10 get any services at all, and of those that do, 50% don't get what they need. People with mental illness die 25 years earlier than the general population. According to the material prepared for the minister's mental health and addiction strategy, mental illness has overtaken cardiovascular disease in terms of the leading cause of disability, and it has huge costs in law enforcement. Also, mental illness accounts for one third of the hospital days across Canada and likely in this province, and we could reduce that significantly by putting in place more of the programs that are already working. As the Every Door Is the Right Door document said, for every $1 invested in mental health and addictions, there's a $7 reduction in health costs and a $30 reduction in social costs.

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Also, in what used to be one of the most prosperous provinces in the country and is what is supposed to be the fourth-best place in the world to live, we have the lowest proportion of mental health spending of any of the OECD countries, and that includes Ontario—5%. The goal should be 10% to 12%. As I actually uncovered for the Graham committee 20 years ago, the mental health share of spending in Ontario is still declining, as it was 20 years ago. To make that apparent, in the last mandate, the Ontario government added $8 billion in spending to its health care budget; of that, $200 million went into mental health; so, far less than the actual need. That's not to say that the services weren't welcome and needed, but proportionately, mental health didn't get the bulk or anywhere near its share of mental health spending.

If you look at the costing for Out of the Shadows at Last, where they proposed a $5.3-billion investment in mental health services across the country, Ontario's share of that would be $800 million over 10 years, and a commitment by the government to implement an $80-million funding increase over a 10-year period each year would actually increase only 1.5% of health spending. That is just over one tenth of 1%. So the question is, I think as Doris Grinspun said, "How can you afford not to?"

The other evidence-based finding in this—and I'm sure you've been given the service enhancement evaluation research project that was done—is that the $200 million that was spent actually paid off in terms of better outcomes for people, families and communities, but it was insufficient to leverage system change. For example, we know that court support programs and crisis intervention teams work. I just had a look at the court database—we provide court support services in Scarborough and in Finch West—and only a third of the people coming through those services had ever been connected with a case management program, whereas over 65% of them had previously been in hospital and over 60% had been on psychiatric medication. So people are just moving in and out of the institutions but not getting connected with the community services.

So, what should you be investing in? Well, I've given you a pretty extensive list: peer support—culturally and linguistically; responsive services, as you heard in the previous presentation; case management; and assertive community treatment. We already know that for each ACT team you put out there, you can dramatically reduce hospitalization. Last year in this province, out of about 4,300 people, there were 65% who spent no days in hospital when previously they would have spent 50 days a year in hospital.

We need 23,000 more supportive housing units, and that's just taking the estimates from the Senate committee report and looking at Ontario's proportionate share—and that was developed by CMHC, not CMHA. They looked at the number of people who are housing-deprived relative to the population in Canada and came to the conclusion that people with mental illness were more housing-deprived than the rest of the population. So 57,000 units would at least get them to the level of the rest of the population. Ontario's share would be 23,000. Putting that in perspective, in 1999, we estimated that 14,000 supportive housing units were required. Today, in Toronto, we just completed a study on supportive housing, and, if you apply for supportive housing in Toronto, there are 4,300 units, approximately, that have taken over 30 years to develop, but you have a two in three chance of not getting in, simply because they're full.

We run a safe bed program, and regrettably, we now have to discharge people from the safe beds, where they come through the justice system, out of jail. They get 24-hour support; they can stay for up to 30 days. We have to discharge many people to the hostels, which isn't the way it should be working. We need more supportive housing.

We need more systems research and technical support. There has been a good initiative: The service enhancement research project actually cost less than 1% of the money that was spent, and it provided really useful information for clinicians, community planners, the LHINs and the ministry.

As Suzanne said previously, improving access to primary care and chronic disease management would be a very important thing to do, and you can do it two ways: by increasing the capacity of the primary care system to provide mental health services, but also—and there are some wonderful examples here in this province. I'm assuming that when you were in Windsor you heard about the work that's going there at CMHA Windsor, with one nurse practitioner and now a community health centre embedded in the community mental health service. You can get tremendous results. So it's not one size fits all; it's a both/and support.

I want to remind us that poverty is a huge issue for people living with mental illness. Our ODSP payments are 43% of the low-income cut-off. You have to do something about that. A 2% raise a year leaves most people in poverty. An apartment in St. Catharines, your own apartment, costs $700 to $800 a month and the ODSP allowance is $900, so it doesn't leave much room. Think of how much of a problem that is in Toronto.

How would we do this? I want to take issue with my friend Humphrey Mitchell. I think it's more important to support collaborative planning and service delivery that focuses on connection at the front line in local communities than to unleash a 10-year initiative to merge organizations. You should look at the evidence of the Health Services Restructuring Commission as to whether that really improved hospital services. I'll send an article along to your clerk that I did and was just published and shows that actually, in the private sector, 80% of mergers fail. Even strategic alliances have a failure rate of 60% to 70%. There are ways to make these things work, but the evidence is not there that administrative restructuring improves clinical care systems. If you don't believe me, I would quote Henry Mintzberg, who is Canada's leading expert on strategy.

I think it's really important that we enhance capacity for peer-led services; that may be the game-changer.

There's a lot of that going on in our LHIN: programs like Wellness Recovery Action Plan. Plans run by consumers, pulling them together, really have a potential to both empower people to learn how to manage their own illness symptoms as well as keep them out of hospital emergency departments.

It's important to have a whole-government focus: one ministry alone can't do this. I was impressed to see that the minister's strategy involved other government departments, and that needs to be a recommendation of your committee. One department alone can't do this.

There does need to be a focus on the justice system, not only from a cost perspective but also because of the benefits of working together. I actually have been chairing the Toronto Human Services and Justice Coordinating Committee for the last 12 years. It's a lot of work that my colleagues and I do across the province, but we really are beginning to build partnerships with the justice system. The SEEI reports that I've mentioned previously point to some of the good work that has been done and some of the learnings.

It's important to establish benchmarks based on evidence and encourage service quality, not only at the system level or the LHIN level but within organizations, because organizations and programs are what can make a difference in how a service is delivered. Let me give you an example of this: If you were to go on to the health indicator tool from the Ministry of Health and look at what the average cost of case management services is, you'd see a figure of about $1,750. If the LHINs were to use that as a benchmark, we would have real problems, because there was a study done by Tim Aubry from the University of Ottawa that showed that the service range to keep homeless people housed, out of the justice system and out of emergency units actually cost an average of $6,000 a year. So that's where you have a research-established benchmark, and that's why things like the systems enhancement evaluation initiative are so important: because they can actually give you those benchmarks that you're not going to get out of a data system.

There also needs to be a mechanism to monitor progress for 10 years at least, in co-operation with service users, families, LHINs and health service providers. This is so critical, because if you don't have something like that, there is no way of keeping governments' or LHINs' or service providers' feet to the fire.

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As experience shows, in Italy, for example, it has been 30 years since they passed a law to close down their large institutions and build a community-focused system. They've had uneven progress across the country, but there have been parts of the country where stakeholders were really focused on making sure the reform happened, like Trieste. There, you have 94% of the money being spent in the community and the lowest rate of involuntary hospitalization in the country. They send very few people into the forensic system. So this can be done, but you do need a mechanism to keep people's feet to the fire.

There also have to be strategies focused on mental health promotion and well-being and, as I said before, strategies to reduce poverty among people living with mental illness. That includes dealing with ODSP and OW rates, and it also includes helping people with employment.

Also, I think Ontario has a tremendous opportunity to use the work of Canada's mental health commission. At the end of this month, there'll be a new set of goals enunciated by the commission that are the result of a year of consultation. I think you can also contribute to the work.

As a policy initiative, I would suggest that the mental health share of health spending must be at least 10% by 2019, but there are10 years to get there and hopefully the recession won't last that long.

The final thing is: Believe that we can actually make some progress.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Steve. You've left about 30 seconds for questions, so I'm going to steal that.

We've had a number of presentations, and some of them would be termed as "qualitative presentations," where it's the right thing to do, to get better at this. Yours had a lot of quantitative analysis, where it's not just the right thing to do; it's the smart thing to do. You're saying, "If you invest in mental health"—I think the ratio is $1 to $7 in your presentation.

From a cold, clinical, business perspective, what is the payback period of a sizable investment in mental health? When would you start to see your jail costs come down? When would you start to see the justice costs, the hospital stays and the other things outlined come down? Has anyone done any work in that regard?

Mr. Steve Lurie: In fact, I can cite two pieces of evidence that already exist. For example, with the assertive community treatment team initiative, what we were able to show is, within one year for people who access ACT teams—it took a year or so to get them set up, but there was a 23% reduction in hospital days. At the end of six years, there's an 82% reduction. So if you think of two to five years, you would begin to see those payoffs.

The SEEI that I spoke of earlier showed that on the one hand, while more people were brought to emergency, which would seem to be a problem, the hospitalization rate actually went down because the right services were in place in the community.

I would certainly suggest that with housing, if you can provide stable housing for people, you'll see huge benefits immediately.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): Our final presenter of the day is the Ontario Hospital Association. We've got Tom Closson and Glenna Raymond. If you'd like to come forward. Make yourselves comfortable. You have 15 minutes to use any way you see fit. If there's any

time at the end, I promise not to steal it. I'll try to share it amongst the group this time.

Mr. Tom Closson: You'll share it. Good afternoon. My name is Tom Closson. I'm the president and chief executive officer of the Ontario Hospital Association. With me today is Glenna Raymond. Glenna is the president and CEO of Ontario Shores Centre for Mental Health Sciences in Whitby.

The Ontario Hospital Association is a voluntary organization representing approximately 155 public hospital corporations throughout Ontario. Over 70 of our hospital corporations have in-patient units for people with mental illness, and all of our hospitals, all 155 of them, serve people with mental health and addiction needs in some way or another.

Recently, the Ontario Hospital Association provided input to the Minister of Health and Long-Term Care's draft 10-year mental health and addictions strategy. Today we're really pleased to have an opportunity to present to you, the members of this committee.

At the outset, I would like to stress one key thing: We're not here to request additional resources for hospitals. Rather, we're here to talk about the great potential for success in concentrating existing resources throughout the Ontario health care system on a high number of high-impact areas. Rather than taking a broad approach to mental health, which is a complex issue, we believe it's important to use an evidence-based, targeted approach to try and have impact on what can be achieved for people with mental health and addiction problems. Our recommendations today align with the Ministry of Health priorities that have already been stated by the ministry in terms of trying to transform the health care system, their two key priorities being reducing emergency room wait times and improving access to care.

It's our goal to work closely with legislators to identify and deliver practical solutions for improving the broader health care system. So with this view, these are our recommendations. I'm going to start this off with the first two and then pass this on to Glenna for the others.

The first recommendation is to reduce emergency room wait times by enhancing mental health and addictions service delivery. Achieving this would require acute care hospitals and community organizations to work together to develop non-emergency services that are coordinated, standardized and measurable. Many people experiencing mental health and addiction issues don't seek treatment at all, while others seek care in emergency rooms only at times of crisis. It is often because there are few or no alternatives available in the community. Recognizing that not one solution fits all communities, expanding the range and availability of alternative services would help ensure that emergency care is available for patients who truly need it, the goal being to minimize the number of people who actually go to emergency departments in crisis.

There are two possible solutions that we're suggesting in a concrete sense. One is developing a 24-hour, seven-day-a-week, community-based crisis response system. With direct links to hospitals, this model would be able to meet an individual's need for crisis stabilization outside of the hospital.

The other is placing a community-based discharge worker in a hospital with links to case management, housing etc. This would help ensure continuity of care while diverting patients away from the emergency room and facilitating earlier discharge to the community if a patient ends up being admitted.

The second recommendation is to improve access to care by strengthening mental health care and addiction clinical capacity in the community. Strengthening mental health clinical capacity within the community ensures that individuals seeking mental health and addiction care receive the most appropriate care where and when they need it. Two possible initiatives are suggested here.

The first is expanding family health teams, nurse practitioner clinics and community mental health centres in an organized way in order to increase access to primary care services for people with mental health and addiction needs.

The other is improving the mental health care and addiction knowledge and expertise of the multidisciplinary health care professionals who work in these primary care clinics. Ensuring that appropriate training and supports are in place for these practitioners will assist in early intervention and screening and create safe and supportive environments for people seeking treatment.

So far, I've outlined two of the five recommendations we're presenting to you today. I'm now going to pass it over to Glenna, as I said. At the Ontario Hospital Association we have a mental health and addiction provincial leadership council which advises me, as the CEO. Glenna is the chair of that council and she's also a great ambassador for mental health and addiction patients throughout Ontario; so Glenna will address the remaining recommendations.

Ms. Glenna Raymond: Good afternoon, everyone.

Our third recommendation is that a central leadership structure and accountability framework be created to support mental health and addiction issues. We're all quite familiar in Ontario with Cancer Care Ontario and the tremendously positive impact that it has had as a provincial agency, improving direct cancer services across the province. Similarly, a second example: A provincial approach is being utilized in support of the diabetes strategy. These are great examples of how we should be treating mental health and addiction care, and as such, we strongly endorse a similar province-wide approach to the delivery of mental health and addiction services. This approach would promote equitable access, accountability, standardization of care, delivery of evidence-based practices, quality measures and provincial coordination of resources.

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Our fourth recommendation is to focus more strongly on interministerial collaboration. Within the mental health and addictions sector, there are subspecialty populations such as children's needs, seniors, forensic clients,

the homeless, and those individuals living in rural and remote communities, among others, whose care and treatment are the responsibility of a number of different ministries. Interministerial collaboration would ensure that services are planned and delivered in a coherent and equitable fashion, and ensure that individuals have the range of services that is really essential for recovery, whether that's housing, employment, education or community services.

Currently, some clients in rural and remote communities face real difficulties in accessing specialized inpatient mental health and addiction services, as well as the community supports. These patients not only require improved access to care, but transportation options, such as the use of the northern health travel grant program; they require affordable housing; and also for our professionals working in the field, workplace strategies to ensure recruitment and retention. Strengthening interministerial collaboration will help ensure that these subspecialty populations receive the most appropriate care required.

Our fifth and final recommendation we want to focus on today is related to research and development. Many do not consider the economic imperative of investing in mental health and addictions. In 2007-08, the government of Canada, through the Canadian Institutes of Health Research, invested $65.9 million in mental health and addictions, although it's estimated that mental health problems cost the economy $33 billion per year in lost productivity. Furthermore, the presence of co-morbid conditions and high mortality rates among the mental health population has been very well-documented. As such, we believe that investments in mental health research and related biomedical research are greatly needed.

While we strongly support the work of the Mental Health Commission at the national level for their endorsement of a broad vision of mental health research, they too have expressed concern that adequate resources are not being devoted to mental illness and addiction, especially given the social and economic burden on Canadian society.

We encourage government to support academic and specialty mental health hospitals in leading the creation of research capacity in developing and then disseminating best practices.

In closing, I'd like to reiterate our enthusiasm for the commitment that government has shown in helping those Ontarians and their families who cope with mental health and addictions every day. Thank you for the opportunity to speak with you. We welcome any questions that you may have.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Glenna. Thank you, Tom. I think we've got time for one question each, starting with France.

M^me^ France Gélinas: Thank you so much for coming to present. I'm most interested in your recommendation number three, which is creating a central leadership structure to support mental health and addiction. The field of addiction is very different from cancer, which is mainly with oncologists in hospitals; with mental health, you're talking about over 400 children's mental health agencies and over 330 community mental health agencies, not to mention hospitals, doctors' offices and everything else. Did you think it through and can you talk about this a bit more?

Mr. Tom Closson: Maybe I'll start. The point we're trying to make here is, even though regionalization makes a lot of sense in terms of trying to integrate service at the ground level, you need central leadership on: What are the best practices that we're going to implement? What are the, say, six key things that we want to implement over the next few years that are really going to make a difference? Somebody needs to be driving this from the centre, based on evidence.

Right now, we have nothing in terms of central leadership around mental health in the province. Cancer Care Ontario was just used as an example where we've had very strong central leadership over quite a few years. I used to work in British Columbia; British Columbia used to have a much better cancer system than Ontario, and that was because they had strong central leadership on the full range of services. Ontario, in my opinion, based on the data, has caught up. That's because, over the past particularly five to seven years, there has been a much stronger central focus across the continuum of cancer care.

So we're not saying how to actually organize this, but we do think the concept of central leadership is essential.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Any questions? Liz?

Mrs. Liz Sandals: I find the concept intriguing because one of the things that Cancer Care Ontario did, I think, was establish what needed to be available in tertiary care and what needed to be available in secondary acute-care hospitals around each region.

Do you see that same sort of thing, then, in mental health, where somebody would be saying, "These are the services that need to be available in each community or each LHIN," and then having a focused way of looking at: "Are those services available and, if not, how do we make sure they're there"?

Ms. Glenna Raymond: There's very much an approach to define where the best setting is or the most appropriate setting for various communities, knowing, of course, that each community might be slightly different: the standards of care, the roles of various providers, the measurement tools, the accountability framework to report back on those and setting that in motion.

The central authority or central coordination that we're suggesting would not be, by any stretch, the provider of all services. It's quite different than providing the service.

Mrs. Liz Sandals: But it's identifying what the service is, what the benchmarks are and what the standard of care is so you've got a consistent vision across the province.

Ms. Glenna Raymond: And how they are connected.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Glenna. Christine?

Mrs. Christine Elliott: Thank you very much for your presentation. I just have a quick question regarding the research piece. Generally speaking, I think the research issue has been seen to be more at a federal level than at a provincial level. But if I could just clarify, are you speaking more about working on best practices in hospitals and funding some of the projects more locally in local settings? Is that your vision? Maybe you could speak a bit about that.

Ms. Glenna Raymond: Sure. There's room for two directions in research: one, which you suggested, is best practices—the dissemination of that—and the research of treatment modalities. More applied research at a local level is definitely needed. As well, though, the role that we see of academic health providers in other diseases—we need to see more of that in mental health, from the academic mental health science centres and the specialty areas, whether it's biomedical research, cures or treatments. That's a second focus or a second direction for research that's needed, and we lag way behind other illnesses. In that way, we're discriminating against those with mental illness.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Thank you very much for your presentation.

To the members of the committee, thanks for your attendance today. We're adjourned.

The committee adjourned at 1805.

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