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Mercredi 18 février 2009

Standing Committee on Public Accounts

2008 Annual Report, Auditor General: Ministry of Health and Long-Term Care

Comité permanent des comptes publics

Rapport annuel 2008, Vérificateur général : ministère de la Santé et des Soins de longue durée

Chair: Norman W. Sterling
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 18 February 2009

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The committee met at 1230 in committee room 1 following a closed session.

2008 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.06, Community Mental Health.

The Chair (Mr. Norman W. Sterling): I'll call the meeting to order. My name is Norman Sterling; I'm the Chair of the public accounts committee of Ontario.

We are today dealing with section 3.06 of the auditor's report of December 8, 2008. The subject matter is community mental health.

I indicate to the witnesses who are here before us—and I welcome them—that we had a report prepared by our research assistant, Lorraine Luski. This morning, we had a meeting, attended by the Auditor General, for approximately an hour and went over that information to brief members of the committee on this matter.

I would also like to note that there is going to be a select committee on this particular matter. I believe that, very recently, the terms of reference were decided by the Legislature of Ontario, by various parties etc. I presume that their work will be beginning in the not-too-far-distant future. Some of the information given today no doubt will be passed along to members of that committee.

I'd like to also indicate that because of the limited number of spaces we have at the front table, if any of those people sitting at the table or someone who is here helping our committee has something to say and wants to step forward, just raise your hand and we'll play a little bit of musical chairs and get that person or those persons to a microphone as well.

I'd like to welcome Mr. Sapsford, the deputy minister. I understand we have, from WOTCH Community Mental Health Services, Diehl Elkin. We have, from the Central LHIN, Hy Eliasoph, and Dr. Robert Cushman from the LHIN in eastern Ontario. From South West LHIN, we have Michael Barrett, and from the Canadian Mental Health Association, Marion Wright.

Dr. Sapsford, I understand you have some opening remarks. If you would proceed.

Mr. Ron Sapsford: Thank you, Chair. Before I start my remarks, if I could introduce to the committee Carrie Hayward, who is the director of the LHIN liaison branch in the Ministry of Health.

I'd like to express my thanks to the Standing Committee on Public Accounts for this opportunity to address the Office of the Auditor General's report on community mental health services in Ontario.

Let me state at the outset that the ministry supports and appreciates the work of the Auditor General to complete this report.

I'd like to start by outlining the health system's structure and the roles and responsibilities of the various players in the context of the report we're addressing today.

Under Ontario legislation, accountability for each entity is clearly set out. The Ministry of Health and Long-Term Care Act establishes the duties and functions of the minister and, through him, the ministry to oversee and promote the health and the physical and mental well-being of the people of Ontario and to be responsible for the development, coordination and maintenance of comprehensive health services. This includes a balanced and integrated system of public hospitals, long-term-care homes, laboratories, ambulances, community-based services, and other health providers in Ontario engaged in providing timely and equitable access to health services to all residents of Ontario.

I'm pleased as well that the local health integration networks have been invited by the standing committee to participate in this session, recognizing their significant role in the province's health system. The Local Health System Integration Act established 14 local health integration networks across Ontario. They are an important part of the government's plan to transform the health system and to make it more patient-centred, efficient and accountable based on local planning for local needs. The LHINs are responsible for planning, funding and integrating local health service providers, including the oversight of their community mental health service providers.

With the introduction of LHINs, the Ministry of Health and Long-Term Care has assumed a stewardship role, focusing more on providing overall direction and system oversight, which includes setting provincial policy and program standards for the province's health system. The ministry works in close partnership with the

province's LHINs to identify and address areas where any service gaps exist.

The boards of directors of community mental health organizations, under relevant corporate legislation and the common law, are responsible for the leadership and direction of their organizations. This includes ensuring that they carry out their mandates, as well as all aspects of their organizations' operations. The boards are responsible for developing strategic plans, financial stability and evaluating their agencies' performance.

Public hospitals also manage some community mental health programs in the province, in which case the Public Hospitals Act is the governing legislation. Under that statute, the hospital's board is responsible and accountable for the quality of patient care.

Before turning to the specifics of the ministry's response to the audit findings, I think it's important to clarify how the mental health system worked before the implementation of local health integration networks and how it will work in the future. Prior to April 2007, the ministry's regional offices were responsible for the oversight of community mental health agencies but did not have the authority to allocate funding directly. Today, community mental health agencies report through the LHINs. The LHINs have established accountability agreements with the agencies and are responsible for allocating funding within their allocations. In turn, the ministry has an accountability agreement with the local health integration network that sets out the government's expectations.

Since their inception, the LHINs have all identified the need to address mental health as one of their priorities. As part of the local planning process, the LHINs will determine the needs of people with mental illness in their own areas and, working within provincial standards, ensure that service reflects local need.

The Auditor General's review happened during this period of transition, and many of the positive changes over the past four years took place under the auspices of the ministry. Going forward, the future mental health system will reflect the change in accountability from the ministry to the local health integration networks. The completed template the ministry provided earlier to the committee outlines our response to the audit recommendations in detail. So for this presentation, I would like to address first the current availability of services and, secondly, the future of mental health services in the province.

Over the course of a few years, the ministry has been improving and expanding the community mental health system to benefit more people in need of mental health services. The ministry is working toward a system that will provide the right kind of service to help people live the best possible quality of life in their community.

Today there are over 300 community mental health programs that offer a range of services across the province. These services allow people to live full lives in the community with the supports they need to be independent. The community mental health budget rose by over $200 million, or 54%, between 2004-05 and 2008-09. These investments have resulted in more people being able to access services like eating disorder treatment, supports for aboriginal mental health, and consumer and survivor initiatives.

In more specific terms, funding has been provided from the $117-million health care accord, which has funded 20 more assertive community treatment teams, bringing Ontario's total to 80, or a 33% increase; more early intervention in psychosis programs—they went from five to 52 over that period of time; and there has been a strengthening and expanded capacity in crisis and case management services. Finally, $50 million was invested in a service enhancement initiative to keep people with mental illness out of the criminal justice system.

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Through crisis response and outreach, there are now better linkages between mental health and police services; short-term residential crisis support beds; supportive housing; 60 new court support workers; and intensive case management services, including those that assist people leaving custody who require community-based mental health services. Almost 20,000 more clients are now being served each year.

This initiative also supports what are called diversion networks; that means various ministries and service providers working together to help divert people who got into trouble with the law to appropriate community services. And that relieves pressures on the criminal justice and correctional systems.

The ministry provided $29.1 million for stabilization and improvements to the community mental health system itself, a 7% increase in base funding since 2004-05, and over the past four years, the province also added a total of 2,250 new supportive housing units, with a budget of approximately $36.5 million.

In addition to the formal system of community mental health agencies, a person with mental health concerns still needs primary care. That's why the ministry has strengthened the ability of doctors and nurse practitioners to ensure that people get the care they need. The ministry has added mental health counsellors into multidisciplinary teams, like family health teams and nurse practitioner-led clinics.

Family doctors also provide mental health care and referral for their patients. In fact, the recent agreement with the Ontario Medical Association provides enhanced payments to physicians for meeting minimum targets across a core of office-based services, which includes mental health services. Family physician groups that demonstrate a focus on priority areas, including mental health, will receive salary support for an additional 500 registered nurses; of these, 150 nurses are already in place under this program.

Finally, this level of investment demands evaluation, and the ministry has commissioned an evaluation of the accord and service enhancement initiative funding to determine its impact on clients and services. The preliminary findings are that Ontario's investments in

community mental health are in fact resulting in new and enhanced programs, additional new staff and more clients who have received services. The study confirms that the new funding has strengthened the community mental health field, and the report acknowledges that it takes time and many complex steps to get new funding into the system and to make programs fully operational.

I'd like to provide you a few examples. In 2006, the province started to fund ConnexOntario to provide information on mental health agencies through the Mental Health Service Information Ontario agency, or MHSIO, the province-wide information and referral service for mental health services. These information and referral services are available on a 24-hour, seven-days-a-week basis in over 140 languages for consumers, families, service providers and others.

Between January 2006 and December 2008, the MHSIO website had almost 107,000 visits, with the vast majority being new visitors. This means that the service is, in fact, reaching more people than ever. An evaluation of the contacts for a 20-month period shows that between 81% to 91% of the respondents found that the service was helpful to them.

Starting last year, MHSIO has been piloting live Web chats via a link on their Website. To date, the staff of the agency have done 200 web chats; 113 of these were in January alone. This is an example of how the system is using modern technology to deliver services to more consumers.

To summarize, the community mental health system of today is more integrated, expanded and accessible than it was in the past. I do, however, appreciate that the Auditor General has highlighted data and accountability issues to look for future improvements. These issues were set out in the template you received prior to today's session.

To summarize, the ministry is committed to collecting information about services and clients, and over the last five years has put resources and funding to implement the management information system and the common data set for mental health.

The ministry has successfully piloted, and is considering implementing across the province, the community mental health common assessment tool, which will help providers understand and act on the needs and progress of individual clients. Using this tool, both providers and consumers completed the inventory of need, and people appreciated being asked what they felt they needed, rather than simply being told, based on a provider's assessment only.

I'd like to share with you some of the consumers' remarks about the effectiveness of this tool: "At first I thought there were a lot of questions but when the assessment was finished, I felt differently. I now see that the agency wanted to make sure they did not miss any areas that could affect my mental health."

A follow-up consumer survey revealed that 74% of the respondents felt that the assessment was useful in assessing their needs, and 84% felt that their answers were helping their worker understand them better.

The ministry recognizes that improvements to the quality of the data are needed, and is working with the local health integration networks to determine how best to assist the providers to improve the data submitted. This is a natural evolution in the implementation of a new information system.

The Auditor General noted that there is not, as yet, an adequate community-based support system to support people with mental illness in the community, and I think we all share the view. The government, the minister and the Legislature all share these concerns. At the same time, they want to ensure that there's a clear vision for the future of community mental health services and that existing and new resources are utilized in the most effective and efficient manner.

To that end, improvements to mental health were a key government platform commitment. The minister has noted on many public occasions that mental health and addictions is one of his personal priorities. Last year, to that end, he established a work group for mental health and addictions.

At the same time, as the Chair has mentioned, the Ontario Legislature is in the process of forming a select committee. The work group and the select committee are expected to report on their findings by early 2010. In addition, as I've stated, the local health integration networks have all identified mental health as a key priority.

There has been significant progress, and the future is promising, but we all recognize that we need to enhance mental health services to further develop a comprehensive system that puts the person first, is barrier free, and easier to access and navigate.

The Ministry of Health and Long-Term Care remains committed to enhancing the strength of mental health services in Ontario with strong provincial policy direction. With our partners, the LHINs and front-line service providers and agencies we will work to ensure better access and quality services to the most vulnerable among our population.

Once again, thank you for this opportunity to address the Auditor General's report on community mental health services. I'd be pleased to respond to questions.

The Chair (Mr. Norman W. Sterling): Thank you very much, Mr. Sapsford. France, you can go first if you want. Mr. Hardeman has indicated that he has questions. Which would you prefer?

Mme France Gélinas: If I can, I will.

The Chair (Mr. Norman W. Sterling): Okay. It was the NDP which has this selection.

Mme France Gélinas: Okay. Thank you for coming, Mr. Sapsford. I appreciate your presentation.

The first question I have: On page 5 you mentioned, "The LHINs have established accountability agreements." It was my understanding that they were in the process of establishing accountability agreements with

the 330-and-some community mental health—is that all done and signed?

Dr. Robert Cushman: No. I think there's some confusion between the LHIN-ministry accountability agreements.

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Mr. Ron Sapsford: Oh, okay. There are two sets of accountability agreements: the first between the ministry and the 14 LHINs individually, and then a series of agreements which are being implemented over time. The first set of agreements between LHINs at the local level was with hospitals, and then moving on into community care access centres. The LHIN agreement with the ministry specifies a certain level of expenditure transfer to the local health integration network for community mental health services and a certain set of operating guidelines that are included as part of that agreement.

Mme France Gélinas: But just to be clear, the LHINs have not established accountability agreements with the mental health community service providers.

Dr. Robert Cushman: That's right. We're in the process of doing it now. The intent is that they'll be in place for the next fiscal year.

The Chair (Mr. Norman W. Sterling): Are they to be somewhat uniform from LHIN to LHIN? I'm sorry.

Mme France Gélinas: Go ahead.

Dr. Robert Cushman: In fact, we use a common template across all LHINs for our multi-sector accountability agreements, and as Ron indicated, they're intended to all be signed by March 31, to start the next fiscal year.

Mme France Gélinas: That's what I thought.

Mr. Ron Sapsford: When the ministry transferred accountability, the service agreements that existed between the ministry and service providers were transferred to the local health integration networks. The process from there would be that the LHINs then negotiate new agreements with their local providers. So there was continuity in the existing service agreements in the transfer to LHINs, and then a new process for the new accountability agreements.

Mme France Gélinas: So when they got transferred, they had never worked out an accountability agreement with the ministry. They had a service agreement with the ministry?

Mr. Ron Sapsford: That's correct.

Mme France Gélinas: That's what I thought.

My next question has to do—you mentioned it on page 15 of your report, if that's of interest to you. You say the Ontario Legislature is in the process of forming a select committee and a work group for mental health and addiction. Could you tell me the difference between the two and how those two groups will or won't work together?

Mr. Ron Sapsford: "Work group" refers to the group that the Minister of Health and Long-Term Care created last fall—

Mme France Gélinas: Have they met?

Mr. Ron Sapsford: Yes, on many occasions. They have developed a work plan to look at a 10-year horizon around mental health services. The minister and ministry staff have been meeting, I think, on a monthly basis to work through some of those issues, to listen to the community and understand where gaps are, and to take advice directly from the community on future policy directions.

Mme France Gélinas: Am I allowed to know the membership of that work group?

Mr. Ron Sapsford: Certainly. We'll provide that to the committee.

Mme France Gélinas: Thank you. And then the select committee?

Mr. Ron Sapsford: As far as I'm aware, there was an agreement in the House that there would be a committee of the Legislature formed to look at mental health services. I'm not privy to the terms of reference or the details of that.

Mme France Gélinas: Do you know if those two groups will ever connect, work in common? Or will they go their separate ways?

Mr. Ron Sapsford: I don't know the answer to that. I don't have input into the House committee's work. I fully expect, however, that part of the work of the House committee would be to consult with the ministry, certainly in terms of information. I would suspect, as the committee process evolves, we'll understand more clearly what the connections will be. But I'm not aware of that at the moment.

Mme France Gélinas: Coming back to the work group, you said that the minister and the ministry staff have been meeting monthly. They have a 10-year work plan. Are the people on that committee all civil servants?

Mr. Ron Sapsford: No; in fact, there are very few civil servants. These are groups of providers: psychiatrists, the psychiatric survivor community, community mental health providers and formal association representation. This is a group of external providers with support from the ministry.

Mme France Gélinas: Okay. I will save my time.

The Chair (Mr. Norman W. Sterling): Mr. Hardeman.

Mr. Ernie Hardeman: Thank you very much for the presentation. My initial questions are somewhat the same as my colleague's on accountability and transferring the responsibility of the accountability over to the LHINs, transferring the same accountability agreements that the ministry had with the providers of the services, and the LHIN takes over. Was there any intention of having an equitable level of service across the province in that transfer? The service that was being provided in one area, under the previous structure, was totally different than in other areas; different providers provided in a different way, different rates—in fact, totally different services being provided by different organizations. Was there any direction for uniformity in that transfer so that we would get to that level playing field?

Mr. Ron Sapsford: The short answer would be no. We simply took existing agreements with existing agencies and transferred, given that they were the services in

operation at that particular time. The future work of local health integration networks, their planning and the work that they do at the local level would then inform, based on that local community, what gaps or additional need there might be, with a view to funding that in future budget cycles. There was no adjustment made, as you've asked, at the time of the transfer. We simply transferred existing programs, services and contracts to that specific local health integration network.

Mr. Ernie Hardeman: Thank you very much. On page 4, I guess that's where I got a little confused. The third paragraph on the page: "Further, the boards of directors of community mental health organizations, under relevant corporate legislation and common law, are responsible" for their accountability. Who are they responsible to?

Mr. Ron Sapsford: They're responsible to their own corporation. Most of these agencies would be corporations under the Corporations Act, so the membership of the organization would be the members of the corporation. They would have formal corporate responsibilities of electing the board, auditors—those kinds of formal corporate responsibilities. I think that the distinction I'm trying to make here is that there's no separate statute which deals specifically with community mental health organizations, unlike the Public Hospitals Act, which is specifically related to hospitals.

Mr. Ernie Hardeman: I understand that. My question really is, who do my constituents hold accountable for the services provided, rather than the fine operation of the LHIN that's doing a wonderful job and the Canadian Mental Health Association doing a wonderful job, but nobody's getting any service? Who is responsible for that level of service?

Mr. Ron Sapsford: The individual agency, originally through service agreements, would specify the amount of money; I don't know all the details of what was in the service agreement, but volumes and levels of service, the kind of service the ministry expected that agency to provide. So within the terms of the service agreement and, in future, the accountability agreement, that local board is responsible for providing the service as it's defined.

Mr. Ernie Hardeman: In a simpler way, I have a constituent who doesn't believe they're getting the level of service from the Canadian Mental Health Association that they should be getting, and they call my office. Who should I call?

Mr. Ron Sapsford: The first call would be to that agency, and I suppose, secondarily, if there was—

Mr. Ernie Hardeman: Their answer was, "That's all the money we've got."

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Mr. Ron Sapsford: Then I would suggest you're into speaking to the local health integration network.

Mr. Ernie Hardeman: But, presently, there's no system in place to hold somebody accountable for delivery of the service. It's all great for the democracy of it, but the actual service—there's nobody responsible for the level of service?

Mr. Ron Sapsford: Well, as I've said, in my view, if you sign an agreement to provide service, then you're accountable for providing it. Your question is regarding if someone feels it isn't being provided, in which case, I would take the question on to the local health integration network because their role, through the agreements, is to ensure the service is provided. So from my point of view, that's the next place to go.

If it's a concern about the quality of the care or the actual service, that's a more difficult question. In those cases, if it's related to a specific professional service and the quality of that service, then one is looking more at questions of the colleges that are responsible for the standards of care.

Mr. Ernie Hardeman: I'd be more interested in the quantity of the service rather than the quality.

Mr. Ron Sapsford: Well, the quantity—

Mr. Ernie Hardeman: That service just isn't available, there's a waiting list and sorry about your luck.

Mr. Ron Sapsford: The local health integration network would deal with those sorts of questions.

Mr. Ernie Hardeman: They would deal with those?

Mr. Ron Sapsford: Yes.

Mr. Ernie Hardeman: Okay, thank you. There was another one. You mentioned, I think more than once in your presentation, that mental health is also a LHIN priority. They've decided that it's one of their priorities. I guess the question is: Was that an option for them to decide whether that was going to be a priority or was that a direction from the minister when the LHIN was structured or when this responsibility was transferred to the LHIN, that they would make it a priority?

Mr. Ron Sapsford: I'll let some of my colleagues speak to that, but at the beginning, the inception of the LHINs, when they first started working, one of the first things that they did was to go out into their local health care systems to meet with the public. There were town halls; they met with local service providers, a variety of people, to begin to understand their local health care system. I think every single LHIN in that process of consultation, in the formal reports that they did as a result of that, identified mental health as, if not the top priority, one of the top three priorities. That was consistent across the province. So from my point of view, this was really establishing priorities that were based on local discussions, as opposed to the ministry or the minister pre-identifying that.

Mr. Ernie Hardeman: This one is kind of tongue in cheek, I suppose, but on page 11, in 2006 we set up ConnexOntario?

Mr. Ron Sapsford: Yes.

Mr. Ernie Hardeman: Then two paragraphs down, between January 1, 2006, and December 31, 2008, we've had 107,000 visits, the vast majority being new visitors. Since it started that year, how could there be any old visitors? Wouldn't they all be new visitors? The thing never existed before.

Mr. Ron Sapsford: Well, it covers two years, so the point I'm making is that the kind of people who we're looking at are first-time, as opposed to—

Mr. Ernie Hardeman: First-time callers.

Mr. Ron Sapsford: —a lot of repeat—

Mr. Ernie Hardeman: They don't repeat their call. They just get their information and don't call again?

Mr. Ron Sapsford: Yes.

Mr. Ernie Hardeman: So at one point they were all new visitors.

Mr. Ron Sapsford: Yes that would be true.

Mr. Ernie Hardeman: Thank you.

The Chair (Mr. Norman W. Sterling): Ms. Sandals?

Mrs. Liz Sandals: Thank you, everyone, for attending today. I wanted to ask some questions around both accountability and allocation. On page 6, Mr. Sapsford, at the top you mention, when you are talking about turning mental health over to the LHINs, that the LHINs would work within provincial standards. I'm wondering, at the point where mental health was turned over to the LHINs, what sort of provincial standards there would be around mental health that the LHINs would be given as a framework that they would be working within.

Mr. Ron Sapsford: In the first instance, the recognition of existing service levels would be the first piece, and that would have been established in the agreements that, in fact, were transferred. As well, we started a process of establishing within the LHIN accountability agreement a number of measures that the ministry would use to monitor performance, not so much of the LHIN but of the delivery system, over a period of time. Many of these indicators are new; we're still in discussion around a number of them as we begin to sketch through what those standards or those fixed positions are that the ministry wants to ensure are maintained right across the province and then in which parts of the puzzle the LHIN has flexibility based on local need.

That is a work in process as opposed to a finished product. In fact, it was identified in the auditor's report that the data and information that are needed to support that kind of framework in many cases are not complete. It's an ongoing discussion with local health integration networks. I think, apart from financial issues like balanced budgets and tracking actual expenditures and ensuring that current volumes are maintained, most of the rest of them are still in development.

Mrs. Liz Sandals: So if we're thinking about accountability and performance indicators in mental health, when we're looking at some of the other areas where we've talked about performance indicators—you can count the number of hip surgeries or the number of new MRIs; at least we know what we're supposed to count. When you move to mental health, do you have any examples of the sorts of indicator sets that you're working on for mental health?

Mr. Ron Sapsford: There are two things I'd like to say. First of all, in some aspects of the community mental health system, for instance the ACT teams—what are they called?

Ms. Carrie Hayward: Assertive community treatment teams.

Mr. Ron Sapsford: Thank you. Assertive community treatment teams. In the crisis intervention program, in the case management function, which is a component of community mental health, there are fairly detailed operating standards: the kinds of patients, the kind of care, frequency of visits. They vary from piece to piece, but there are performance standards in different sub-parts of the delivery system. A couple of others: early intervention criteria; safe beds is another component of the system. So for these various programmatic pieces there are standards that we would expect to be across the system and maintained as time goes on.

In terms of the broader functioning of the mental health system, cost per individual served would be an example. Readmission rates from the community into hospital would be another one. Wait times from referral to assessment is one that we're working on, and from assessment to service initiation. We want to start a series of client satisfaction measures as part of the overall standards development as well as avoidable emergency department admissions. So we're beginning to set out what those standards are. Unfortunately, in all cases, we don't have the data systems to immediately produce the kind of results that people are expecting.

I think the other thing that people need to really clearly understand is that the mental health delivery system is not like hips and knees. This isn't about a gall bladder problem: admission for surgery, discharged home, case finished. The mental health delivery system is far more complicated. Needs are far more individual. We have a much broader variation in the choice of treatment and service. We find people needing one form of service in intense acute care or medication management and then, over a period of time, more supportive activities in the community: activities of daily living, helping people find jobs, making sure their housing supports are adequate.

My argument here is that the measurement of the mental health system is more complicated than in some other parts of the health system, where it's a case of, "How many procedures did you do and how many more can we do?", where it's a very defined kind of service.

1310

Mrs. Liz Sandals: Yes, and that's actually partly why I asked the question, because it isn't totally obvious what you would count. One of the things I'm very pleased that we were able to do is increase the number of ACT teams. My community was fortunate enough to get one of the additional ACT teams that we were funded, and while families of people who needed the support were sort of lobbying me to lobby you to get one of those ACT teams funded, we actually worked with one family and were able to trace a brother—and they were reasonably public about this—who had been schizophrenic and in and out of the criminal justice system and also psychiatric hospitals. For that one chap alone, we were able to document, between jail and psych hospital, about $1 million

in care; that was what we could count for just the one individual. So getting that community support is a much more humane and sensible way of managing the person's challenges.

I'm wondering if I might ask the LHIN CEOs, then, stepping down a level—because I'm assuming that somewhere in all your LHINs you would have an ACT team—how you would move from the sort of provincial funding and framework down to monitoring the performance of ACT teams within your jurisdiction. Would you be engaging with them on a formal basis? How does that work out at the local level? You guys sort out whoever wants to deal with it.

Dr. Robert Cushman: Sure. I think, if you really look at "Local Health Integration Network," the two words that stand out clearly—actually, the whole thing: "local," "integration" and "network." So in fact, we have mental health networks in our LHIN. I'm from the Champlain LHIN, where Mr. McNeely and Mr. Sterling are from. The Champlain LHIN, I was thinking the other day, is actually about as big as six Canadian provinces in terms of the population, the resources. So you can see that as we get regional and start to drill down locally, we have the benefit of really seeing and understanding what's going on. These are community resources at the community level, and you have to be there to really understand them.

Our LHIN is almost like a loaf with slices of networks. We have identified a mental health network, and we're looking across our LHIN in terms of—we have a number of ACT teams—just how they fit into, I think the deputy mentioned the term, comprehensive care. He also alluded to the fact of how complex this is in terms of a chronic illness and all the other supports that are necessary, from help with jobs and housing and those types of things. By and large, what we're trying to do is to get the players to come together so we can build a comprehensive system and so that it's patient-centred, and you at a particular time during your illness will have what you need so that these transitions from one place to another are smooth, but also that we actually know who's on our catchment list, who our caseload is, so we can really monitor patient flow. To date, I'm really surprised, actually—we can do a much better job in that area.

So just a short summary to your question: I think, as you drill down to the local, you're really able to see how we can take this sort of patchwork quilt and build it into a comprehensive system that knows who the people are, knows how they're doing at any given time and can move them to the appropriate services. That's what we're trying to do. As was alluded to earlier, there is a stress, obviously, on the resources we have. But, rest assured, to use the resources you have today more efficiently can help you address that.

Mrs. Liz Sandals: Does anyone else wish to comment?

Mr. Hy Eliasoph: Just to share a little story with you, I should make a confession: I love ACT teams. I didn't know about them before I started in my new role, and I've spent time with all the ACT teams in our LHIN on the ground at their case management meetings.

What's fascinating about them is—again, where you stand depends on where you sit. From a community perspective, they're seen as very resource-intensive, and they are. From an acute perspective, they're a huge opportunity to help maintain clients in their home communities without having to go into the really big, expensive hospitals. So again, it depends how you want to look at them. We believe that there's a great opportunity to build more community capacity and put those resources in place and help maintain clients in their home communities through instruments like ACT teams.

The other piece that's really critical is, there's a very large body of literature and evidence—because this is not an Ontario thing; it's an international model that has been adopted here in Ontario—that shows the efficacy and effectiveness of these programs. As Rob said, there's a great opportunity to use those and better integrate them into the fabric of the community that we're trying to build.

Mrs. Liz Sandals: I was certainly converted by the president of the local psychiatric hospital, who said, "Here's all these studies, Liz. Look at this." They certainly seem to be very effective if you can implement them well.

The Chair (Mr. Norman W. Sterling): Could I ask a supplementary on assertive community treatment teams? The auditor pointed out that on some teams, they have two staff for every client; on other ACT teams in Ontario, they have one staff for 14 clients. I guess, if I were the Minister of Health—which I don't pine to be, but if I were—I would be saying to the LHINs which had the heavier loads, "We'll give you more funding to fund more ACT teams in your particular area."

Our concern here is that the funding has been generic and based upon history rather than on the needs of the particular LHINs in the various regions of Ontario. Would a measure like the one the auditor has pointed out be helpful to have in each LHIN area? In other words, what's the average caseload per ACT team in Champlain or southwestern Ontario or whatever? I would advocate that that particular information be public as well so that it would draw attention, for the community, for politicians, for the Minister of Health, as to which areas in the province were lacking in service perhaps, and also would draw to the attention of ACT teams that could perhaps see more patients as a result of the fact that they were not maybe pulling their fair share of the load.

Dr. Robert Cushman: Certainly I agree with you 100%. We as LHINs need these performance indicators, and to develop them 14 times or 14 subtly different ones is not the way to go. We need that help and we look forward to having it. You're right: We need to have those benchmarks so we can compare.

I would only caution you, though, that because of the regional variation in Ontario and why LHINs really make a lot of sense is that in an urban area as opposed to a rural area or an area that happens to have a psychiatric hospital

nearby, those benchmarks have to be taken with a grain of salt depending on what the comprehensive set of resources looks like and also what the total needs of the community are.

So, in a word: Yes, bring it on. We need more and more, but also just a little asterisk as a cautionary note as we look at these.

The Chair (Mr. Norman W. Sterling): Could we—the committee—make recommendations that we immediately move to some measures that would become public so that we have some idea of where the greatest lack of resources is in our province, which LHIN needs the most help or which LHINs need the most help? I really believe that if the numbers are there in some form that the general public can understand, more equity will prevail in the long run. I understand the difficulties. You can provide an asterisk with regard to any kind of statistics that you want, but if you don't have any numbers, then we continue along in the quagmire that we've had, you know, for the last decade. France?

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Mme France Gélinas: I didn't have—

The Chair (Mr. Norman W. Sterling): Did you have any questions?

Mme France Gélinas: No.

The Chair (Mr. Norman W. Sterling): I'm sorry.

Mr. Ron Sapsford: I think, in part, in response, when the auditor takes a snapshot in time, there will be variation across the question of ACT teams and how busy they are. The ministry itself has noticed that as new teams come into place, it takes a certain amount of time to come up to the full caseload—partly because of hiring, partly because of newness.

The guideline that has been established is roughly 80 to 100 clients per team, and I think that's where the notion of 10-to-one staff came from, whereas I think others in the sample that were looked at were probably newer teams that weren't to full strength. Of course there are from time to time teams that in fact could do more but aren't and require some remediation on that front. So the standard, at least for the ACT teams, is relatively clear. Getting the performance, I think, is the question that you've raised, and some reporting on that. Certainly the intention of accountability agreements is to provide that kind of reporting.

The question of the distribution of resources across LHINs is a slightly different question. If we go back in time and remember where ACT teams came from, it was in part in response to discharges from provincial psychiatric hospitals, the movement from in-patient to outpatient care. One will find that the concentration of these teams tends to gravitate around former provincial psychiatric hospitals, and, when you look at, "Well, where are the resources?" you see a disproportionate allocation based on some of these factors.

The new funding model the ministry is looking at—we call it HBAM—is to begin to look at broader population models so that we can begin to balance out some of the concerns that you've reflected.

The Chair (Mr. Norman W. Sterling): Ms. Wright, from the Canadian Mental Health Association from Ottawa.

Ms. Marion Wright: I'd like to add another dimension to the conservation about ACT teams and accountability. I'd like to also draw on some of the research that the Ministry of Health and Long-Term Care, in partnership with some of its community partners, conducted over six years, across the province, called the "community mental health evaluation initiative," which compared outcomes, not outputs—which would be numbers of people—what happened to people and the quality of their lives, and, in some cases, the economics, looking at ACTT comparisons and looking at intensive case management. The results are published; they're excellent; they show full well that intensive case management works extremely well, with the same kinds of outcomes as the ACT team, is substantively less expensive and may be suited to other populations.

One of the criteria for ACT team involvement is that the individual has a certain number of hospitalization bed days etc. One of the problems that we are facing in this province at this time is an increase in homelessness—individuals who are living in shelters, living on the streets, and who, by and large, do not populate to the same extent our in-patient psychiatric units and our acute hospital psychiatric beds.

An intensive case management model with assertive outreach is one of the ways to tap into the needs of that population and provide the same kinds of outcomes for those individuals as an ACT team does. So I just wanted to provide a perspective that ACTT is not a unitary solution; there are others that are working for other populations, work equally effectively, have been examined, have fallen under the same scrutiny that ACT teams have and have standards attached to them as well, so that there can be accountability measures built to look at fidelity to the particular model on behalf of community providers, and provide that information on a public basis.

The Chair (Mr. Norman W. Sterling): Ms. Elkin, from WOTCH Community Mental Health Services in London.

Ms. Diehl Elkin: Yes. I just would reiterate my colleague's sentiments on the ACT teams. I firmly believe that we need all levels of care in the community. When we are referring to the ACT teams, we are basically referring back to a hospital-based service, based on their criteria that they must have a certain number of hospitalization days before they qualify, as well as a bona fide diagnosis.

There are a lot of people that fall through those cracks, and those cracks are seen in the homelessness population. When you have a homeless population that you're trying to work with, who do not have a formal diagnosis of a serious mental illness, they're lost to the system; they are lost to the community. There are no services available to them other than shelters and outreach street workers.

I would just reiterate: Please refer back to my colleague's comments on the research that the Ministry

of Health did a few years back on community mental health. Please, I would reiterate that you look at the broad picture. Even though hospitalizations are necessary in some cases, they're not necessary in all cases.

The Chair (Mr. Norman W. Sterling): Thank you very much. Mr. McNeely. I'm sorry. Mr. Balkissoon.

Mrs. Liz Sandals: No. There's Phil and then Bas.

The Chair (Mr. Norman W. Sterling): I'm sorry. Phil, you go—

Mrs. Liz Sandals: I was giving you a whole list.

Interjections.

Mr. Bas Balkissoon: Phil's going to come in later.

Actually, the last questions and answers could segue into my question, because on page 7 of your comments, Mr. Sapsford, it says: "The ministry is working toward a system that will provide the right kind of services to help people live the best possible quality of life in their communities." On page 3, it says: "The LHINs are responsible for planning, funding and integrating local health service providers, including the oversight of their community mental health service providers."

In the case of a homeless person or a person living in a shelter or a group home, can you, or anybody on the panel, I guess, tell me about the oversight by the LHIN and what services are provided to a person living in a group home, as an example—how that is done? I really want to understand that, because to me, that's where we get the highest possibility of complaints from the local communities.

Dr. Robert Cushman: I'll take a stab at that. I think the real issue here is case management: knowing who the client is and where they are at a point in time.

The other thing is, there are other agencies and other ministries involved here. In our community, certainly, for homelessness, we've had discussions with the shelters, which we don't fund; we've had discussions with the municipality, discussions with the United Way, discussions with the police. By and large, at the grassroots level, I would argue that you're able to bring key players together quicker than you are from the provincial level. So that helps us.

Also, looking to pool resources: It's been talked about—housing and homelessness. There's an initiative going on in Ottawa now where we have a number of players—again, some of the ones I mentioned earlier—coming together. Just to have that closer to where the decisions are made and to know the players—my thesis is that that helps deliver a better service.

I would also say that, historically, the health care business has been from the bottom up in terms of observations about new diseases, observations about clinical interventions that are effective. I think that, because we're now at the local level and we're able to get involved at the community level, we can make a difference with respect to that, again, as I said earlier, by bringing the players together but also having a better handle on who the clients are.

We have an inner-city health program in Ottawa, and by and large, we know who those people are; there's a roster, effectively. But what we have to do is extend that roster to a number of other illnesses in this particular domain.

Mr. Bas Balkissoon: So how do you see the oversight in a group home situation, and the accountability, and what are the things you're going to measure when you're dealing with clients in a group home setting?

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Dr. Robert Cushman: I think the deputy minister touched on it, as did Ms. Sandals. There's a lot of what I call other evidence from other domains: ambulance use, emergency room use, police encounters, all these types of things. What we know, for example, from the city of Ottawa is that we have a certain number of people who use an inordinate amount of these resources. We can have them on a roster, we can see that we're dealing with their needs upfront and we can actually compare what they used last year to this year. That was actually done in a paper that was published in the Canadian Medical Association Journal a few years ago with respect to an Ottawa population. What we need is more of that.

Mr. Bas Balkissoon: Just one last question on accountability because I've had situations, working with group home administrators, the local police and some of the local street workers. In a lot of cases, most of the people actually say that the mental health person—when they're in their shelter they're responsible for them, but the minute they walk out the front door they're on their own. That's where the community comes in and is quite reluctant to see some of these homes in their particular setting. How do you see us changing in the future to take some responsibility and accountability to that particular client when they walk out of that group home onto the public sidewalk?

Dr. Robert Cushman: You've just touched on probably the weakness of the health care system in Ontario today, and that is the transitions. Transitions of patients: It doesn't matter whether it's diabetes or schizophrenia; we have a 400-highway series with poor bridges, basically. We do very poorly with the transitions. This gets back to the point about case management: People have to have a caseload and they have to be the case manager and the navigator for these folks regardless of where they are. By bringing the various agencies together, this is the type of system we're building.

Marion, do you want to comment a little more on this? Certainly you know much more about it than I do.

Ms. Marion Wright: Thank you. I think from a "how do you fix the system"—seeing as we're into infrastructure and building bridges and repairing roads—significant investment, as Dr. Cushman has said, into two levels of support. One would be intensive case management service to ensure that when those folks do go out the door of the shelter or the group home, there's someone who is assisting them, managing them—the term doesn't sound very good, but navigating them through a myriad of services and resources.

The other thing that we need, and we desperately need from a health perspective, is housing. We need afford-

able, safe housing with supports. That's the long-term way we're able to really address issues of homelessness and severe and persistent mental illness. Most of those individuals are residing in our shelter system, in our jails, in our acute hospitals for long lengths of stay. If we are really going to look at fixing the system from any perspective—from a humanity perspective, from an economic perspective, from any way you want to look at it—those are two very key investments that would go a long way.

Although the Ministry of Health has been very good about providing investments in this area, the under-resourcing at the community level is by more than 100%. So the investments have been excellent, they've been good, but they haven't been anywhere near adequate to address the emergent needs, the current needs or even the needs we had in 2003, when some benchmarking was done.

Dr. Robert Cushman: Just to pick up on that, what we've heard, for example, from some of these programs is that when the treatment is finished, they have trouble placing their patients because, again, affordable housing and housing with supports—it's not just the programs but it's the affordable housing and the supports. I've been in this business a fairly long time and with public health, emergency rooms, pretty much there's a good spectrum of health care. If you ask me what health care in Ontario needs today, I would tell you that the answer is affordable and supportive housing, not MRIs in hospitals. That's from the mental health perspective, that's from the seniors' perspective—this ALC crisis we're having, which is really a symptom of the fact that we don't have enough affordable and supportive housing.

Also, very early in my career, I did a lot of work with young children. Many of our young children are nomads. They go to four or five different schools during the year, and the reason is that they don't have affordable housing in safe neighbourhoods. Getting back to Marion's point, with this infrastructure investment we're talking about, if I could just leave a message with you, I would hope there will be some investment in affordable housing as well as bridges and 400-series highways.

The Chair (Mr. Norman W. Sterling): Could I ask a supplementary on that? Is there a measurable number, LHIN by LHIN, so that we could get a picture, LHIN by LHIN, of the need for this kind of housing? Is it a number that can be produced and understood?

Mr. Ron Sapsford: We certainly have information, LHIN by LHIN, for existing and/or planned expansions to the supportive housing from the Ministry of Health. Certainly we can provide that. As to the details of every LHIN's plan, I don't think we've got that collated.

Dr. Robert Cushman: Mr. Chair, we're working with the various municipalities in our LHIN to look at what their housing stock is; for instance, the vacancy rate tells you quite a bit. But through the Ministry of Health's information in terms of what they're investing—also, there's a round table in Ottawa, for example—we can come up with a fairly solid portrait of what the needs are.

The Chair (Mr. Norman W. Sterling): Thank you. Mr. McNeely?

Mr. Phil McNeely: A question for Dr. Cushman, whom I worked with for many years in Ottawa on Smoke-Free Ottawa, pesticide problems and things like that; I'm very pleased that he's here today.

On page 8, the deputy minister mentioned that $50 million was invested in service enhancement and initiative expansions to keep people with mental illness out of the criminal justice system. My question for Dr. Cushman is, how is this going with the youth interface with drug addition, mental health and the criminal justice system? How is this working out? Our youth are, of course, very important, and I know that Alex Munter, with Youth Services Bureau, is in that business as well. I'd just like to know how it's going in our LHIN in Ottawa.

Dr. Robert Cushman: First of all, I think there are some key points here. What we're hearing from the psychiatric community is that the facilities available for children and youth are actually poorer than they are for adults. This is very interesting, because it gets back to the whole "ounce of prevention" piece. If you talk to the experts, they will tell you that if you really want to help someone who has a chronic mental illness, $1 invested before the age of 25 is probably better than $10 invested after the age of 25. So there's a real imperative to do something.

Our community has really come to the fore on this, and by and large identified this problem and talked about the need for more resources. We have been the beneficiaries of some funding for a new youth treatment centre for some involvement in the schools, and there's been a pooling of resources—we're very grateful for the ministry funding, but also United Way funding, and the school boards have come on board—just in terms of getting these interventions into the schools so that we can again build a comprehensive program for youth in our community.

I would add too, though, that while I'm a big fan of the auditor's report—really, this is a terrific report—the one blind spot I thought there was, Jim, was that the interface with mental health and addictions was not clearly identified, and that's probably because you were looking at a funded sector. But what people are telling me—and we all know it when we think about it, especially for youth—is that there's an enormous interface, basically because of the self-medication. This is the problem you see very much for youth. Again, there is a little bit of tension—there is tension—between the mental health sector and the addictions sector, and somehow we have to get some confluence on this if we're really going to deal with these problems. There is a tendency for one sector to say, "Oh well, if it's an addictions problem, it's over to you" or if there's a history of schizophrenia, "It's over to you," even though there is a substance abuse issue. This has to stop. We have to be more effective and to really meet the needs of the client and our community. We have to do some work in this area.

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The Chair (Mr. Norman W. Sterling): Ms. Elkin, did you have a comment?

Ms. Diehl Elkin: Yes. I wanted to back up just a little bit. When we were talking about the responsibility of the Ministry of Health with individuals in shelter situations, I believe the comment was made that once they leave the shelter, they're somebody else's problem. I think that's an indicator of the need for not just the Ministry of Health to be responsible, but for all ministries to be responsible. That way, we could work through ways, at the bureaucratic level, of interacting to downplay these issues around uses of emergency rooms, uses of the criminal justice system.

I would like to now comment on the housing situation. In London, specifically, we have 157 apartment units for the homeless population, and this has been highly successful, because they are supported through intensive case management. We have 72 beds in 33 homes that are supported through intensive case management. I would like to reiterate the importance of the supports with the housing. I think that housing is not successful unless there are ongoing mental health supports, and that includes addiction knowledge and supports in addiction.

The Chair (Mr. Norman W. Sterling): Mr. Ouellette.

Mr. Jerry J. Ouellette: We'll go to the London issue. When you talk about the success of the 157 units, according to the London, Ontario, police, they have doubled the time they spend dealing with clients like this, as a result.

We talk about the $50 million that Mr. McNeely brought up. Is there any tracking of the information, as to the number of increased costs on the policing community for the deinstitutionalization of individuals, or other aspects, such as the 157 units that were just mentioned in London?

Mr. Michael Barrett: I can respond on behalf of the London question. We've had numerous discussions with the police services board, as well as with the deputy police chief, around this issue. They do track that information. I don't have it here today with me, but we could get it for the committee's review. They have significant concerns about the number of clients they're dealing with that they end up picking up at the emergency department—because they're not there for health services. They need supports from the community mental health agencies. So we're in discussions now to look at initiatives that would help divert those clients away from the emergency departments and get them to a place where they're more appropriately served. As opposed to having them be dealt with from a criminal perspective, get them dealt with from a health care perspective.

Mr. Jerry J. Ouellette: It's not just the London area. I know that where Christine and I are from, in the region of Durham, I get a number of inquiries regarding mental health and the policing component and their ability or lack of ability to deal with that issue.

Is there a province-wide initiative that you're aware of to inform—I know the police have in-service training, where they have automatic training on an annual basis that would update the skills of the on-the-street officer to be able to address these issues, immediately identify and know where to go. I don't know if that's in place now or if there are any initiatives like that.

Mr. Michael Barrett: I'm not sure, but Diehl may have that information.

Ms. Diehl Elkin: Yes, there is ongoing training. The issue is not whether the police are trained or not; it's partly one of a police officer's time, and having to guard an individual in an emergency situation at a hospital. It also has to do with the dignity of the client, and having to have the police officer sit beside them until the busy emergency room triage can see that person.

The other thing is that the London city police respond to twice as many mental-health-related calls as they do to car accidents with injuries. That is a tremendous amount of dollars and cents, if you want to take it back down to that, and time across the board—of hospital staff, of mental health workers, of police. It's just the process that is difficult. It is not people not wanting to help the individual.

Mr. Jerry J. Ouellette: Maybe that's something, Chair, that we could possibly have some recommendations on trying to move forward.

Some of the other areas to discuss: I think it was Mr. Sapsford who mentioned, although I'm not quite sure, the reaction to medications. Is there any linking of mental illness to medications that would be improperly—that cause depression or those aspects? I've watched TV commercials or know individuals who have depression reactions to medications. Is there any tracking of that sort of information to ensure that proper medications are not causing the reactions that are sometimes taking place?

Mr. Ron Sapsford: Certainly the ministry doesn't track that, in terms of clinical treatment. Drug reactions, in the clinical side, would happen all the time. As to how broad a problem that is, I'm not exactly sure. Perhaps one of our providers would be able to answer that. Unless there's an issue with the drug—it's often in terms of an adverse event—in which case there is federal reporting of that, about the action of the drug itself, but not in ongoing practice.

Mr. Jerry J. Ouellette: Recently—it was on the weekend—I saw a television commercial—it's the first time I saw it—where one of the reactions to the drug was severe depression. I know that's US-based advertising, and we don't have that here, but I wondered if there was anything equivalent that we would have in Canada to monitor those sort of things.

Mr. Ron Sapsford: No. My view of that would be that that's part of the clinical decision-making of the physician. So the monitoring of the patient with that kind of medication, when there's a common side effect that's well understood, would be the responsibility of the physician to do that kind of monitoring—or the institution, if it's a medication dispensed as part of a course of hospital care.

Dr. Robert Cushman: Just to add to that briefly, as the deputy said, that's really a clinical issue, and a very important clinical issue.

Now, if there are side effects that have been documented, there is a reporting mechanism with the federal government. How well it's used is another issue, but this is why sometimes we see these reports coming out about these medications where further restrictions are urged.

One thing you're touching on that is very important, which you're implying maybe, is the abuse of prescription drugs when we talk about addictions. The abuse of prescription drugs sold on the black market is right up there now rivalling cannabis and cocaine and other drugs, and this is a serious problem.

Mr. Jerry J. Ouellette: The deputy mentioned the website had 107,000 visits. Was that website in 140 languages? It doesn't specifically say; it just mentions that there was service in 140 languages.

The other aspect of that is, is there any data tracking as to common information that could be provided through advertisements of some sort from those 107,000 visits? So if it's a common thing like, how do you react to this? It could be done through television advertising or commercials, as we're seeing with a number of service providers, whether it's Canadian Mental Health providing in this situation. Are we seeing any information or is there any data tracking from that?

Mr. Ron Sapsford: The website is not in 140 languages; it's the phone lines. Remember, Connex is about the addiction treatment network, it's about community mental health services, it's also about forensic bed directories; there are a number of functions of that service. The 107,000 is directly related to the website, but when people call in, there are translation services available to help people understand.

The kinds of requests, though—well, in some cases, they've dealt with crisis calls on the phone; a small minority of the calls are based on that. But it's more about providing information to callers about where they can get access to service at their particular community. So it's more of an information and access point than it is about trying to provide more direct service on the phone.

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Mr. Jerry J. Ouellette: Okay. Also you mentioned the aboriginal component in mental health. Doesn't the federal government have an agreement to cover some of the costing for aboriginally-related mental health?

Mr. Ron Sapsford: Well, for services on First Nation reserves, yes, we look to the federal government, but there's a very large aboriginal population in Ontario that lives off-reserve. So the ministry works very closely with the aboriginal health association and different groups to provide culturally sensitive services off-reserve. So it's a combination of federal and provincial funding, depending upon the status of the reserve and where the population lives.

Mr. Jerry J. Ouellette: Lastly, Deputy, you had mentioned the distribution of resources. We had heard earlier on during our briefing that on a per capita, per patient basis it ranges anywhere from $115 to $20, yet we have about 320 service providers. Is there any breakdown as to the number of service providers and how the funding would apply? So, for example, in the LHIN that we're in, we may have five service providers where another one, just to use figures, may have one. In that one, they may receive $115 whereas in the five providers, they may receive $20 each. Is there some sort of breakdown for the resources and the funding aspect that way?

Mr. Ron Sapsford: Yes. We can provide information, annual funding, by provider, by LHIN. So we have it segregated or distributed that way.

I think the issue when you get into per capita is not straightforward in the sense that just because a service is located geographically in this position doesn't mean that it doesn't serve the population from a neighbouring LHIN, particularly in some of our city centres where there's a concentration of service. Particularly here in Toronto, the residents of Halton and/or Durham and/or York may receive service in Toronto proper, but the way we publish the number on a per capita basis would show a higher per capita expenditure in Toronto versus Halton, for instance, simply by virtue of the referral patterns.

The newer mechanisms that we're talking about—in our response to the committee, we referred to a mechanism called HBAM, which doesn't focus on geographically where the service is located but looks at the referral population so that we can in fact understand who's being served by a particular provider and allocating that back to the LHIN of residence, if you will. That will help in terms of future allocations as well as long as we understand that the LHIN borders are not closed. In other words, where someone gets service isn't directly dependent upon the LHIN in which the service provider is located. I think you have to bear that in mind when you start to look at per capita expenditures.

What's more important from the ministry's point of view in allocations is around some of the factors that go into allocation: the age of the population; the socio-demography of a particular part of the province; we've heard about homelessness, so factoring homelessness into allocation questions. These are more important factors to determine the level of funding that we provide, as is the geography of a specific service provider. For instance, in northwest Ontario, geography is important. I think the per capita is about $175, but given the size of the population, the size of the geography, we're not going to take resources away from the northwest because the per capita calculation is at the high end. So the newer approaches to funding allocation look at the characteristics of the population: Who are we trying to serve, and what are the better ways to allocate resources to satisfy that particular population's need?

The Chair (Mr. Norman W. Sterling): Could I ask a supplementary on that, Mr. Deputy? The auditor pointed out this particular problem of allocation of resources first in 1997, then in 2002, now in 2008—11 years later. You have indicated in your interim report to us, on page 4, that you have developed a health-based allocation model, HBAM, which I understand you're referring to. You're saying that "it is expected that the community mental health module will be ready within 24 months."

My first question is, why does it take 24 months? My second question is, will the module be ready at that point in time or will it be implemented at that time? And if it won't be implemented at that time, when will it be implemented, so that we can get a fair allocation of these resources across all of Ontario?

Mr. Ron Sapsford: The methodology requires that we have a certain amount of data and information on the population that we're trying to serve. I think, as the auditor also reported, the ministry's data sets—in other words, the information that we have reported on clients served in agencies, and the kind of information that we need to make those allocations—aren't complete. In some cases it's not reliable, because the reporting mechanisms need to be strengthened, and I think the auditor indicated that as well.

Part of our response has been to strengthen the reporting requirements from community mental health agencies to make sure that we can fill in the information sets that we need in order to proceed with that kind of allocation, and then to actually run the methodology and go through the normal testing that we would go through to make sure that it's a fair and accurate method of doing the allocation. That's part of the reason it takes time.

When we started this data collection—you have to remember that in some cases, many community mental health agencies didn't even have computers to report; this was a paper-and-pencil exercise. We've had to do a fair amount of investing in the infrastructure in order to create the system that would allow us to move forward. That's principally the reason that we've estimated, I think, 2011, which would be the point at which we would look to make allocations based on this newer methodology.

The Chair (Mr. Norman W. Sterling): How are the LHINs going to be involved in that? Are they going to be the collectors of information?

Mr. Ron Sapsford: They don't collect it directly. In all of our reporting since LHINs were put in place, we've tried not to duplicate reporting systems. So where there was provincial reporting and continues to be, or new information requirements, we continue to rely on the reporting from the agents through the normal ministry channels. Then the ministry presents the information back to local health integration networks, as opposed to creating double reporting processes.

The normal reporting that agents would have, the LHINs have an influence on what is reported, so if there are new reporting requirements, then we work that through, to make those requirements, in either accountability agreements or new regulatory reporting requirements.

The Chair (Mr. Norman W. Sterling): Do the LHINs have access to that information, that raw information that you get?

Mr. Ron Sapsford: Yes. We've set up electronic mechanisms to communicate.

Mme France Gélinas: Continuing on with data collection, are you telling us today that you feel confident that 24 months from now, we will have robust—for lack of a better word—data coming from all 330 community mental health agencies?

Mr. Ron Sapsford: Yes, that's the plan. I think we've all been impressed, as the Chair has indicated—there has been audit after audit that speaks to this issue, so we've made a concerted effort to try to plan this out.

My only concern about it is that there are 330 agents, and if you throw public hospitals into it and a couple of agents, there are a great number of disparate agents that we have to rely on for accurate reporting and then, subsequent to that, making sure that the funding formula itself works and that we can account for variations in our existing services and what population is that serving and where do we need new services based on some of the analysis that LHINs are doing in their local planning.

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The notion here is that we would be using it to allocate money to the LHIN. Then, according to their local plan, the allocations to individual service providers would take place. So this isn't about the ministry figuring a way to give agency X more money; it's a method to fairly allocate resources across population need, LHIN by LHIN, and then relying on the LHIN and their mandate to actually work with local agencies and local providers to do the detailed allocations.

Mme France Gélinas: We've heard this afternoon statements like—and I think we all believe the mental health delivery system is complicated; it has more variation than a lot of other parts of the health care system, whether it be in treatments or services or even the type of medication that will be used. We've also heard statements such as, "There is a stress on the resources," with a parenthesis saying that there could be some efficiencies to be used in there. But comments such as, "They didn't have computers," lead one to believe that we're dealing with an area of the health care system that may not have been very well resourced. Then I hear, "Twenty-four months before we have data that will allow us to allocate money to the LHINs that will then allocate it." If I knit all of this together, are we looking at an area of the health care system that is poorly resourced to meet the needs, which are very complex, and that hasn't got a whole lot of a chance of getting any more resources for the next 24 months because we don't have robust data available to help us do this in an accountable way?

Mr. Ron Sapsford: That would be an emphatic no. We will continue to allocate resources to community mental health services according to our budgetary allocations. In the last year there were additional allocations made, and those decisions will continue to be made. Please don't make the mistake of assuming that we won't allocate any more until there's a new funding formula. We will have to rely on the advice of local health integration networks, and some of the perspectives that the ministry staff bring to bear on relative need, and continue allocating new resources where resources are made available by the government. One does not stop the other.

The adequacy of resources: There is need in the system; no one is going to debate that, least of all me. The question is, what are the gaps, where should the money be allocated and at what pace can it be absorbed by the system? There you will get a variation of views on that; some say faster than others. I would simply point out that in the past four years there has been a $200-million increase which the system has absorbed. The research is ongoing right now as to its effectiveness. We've tried to not just do a general analysis but to look very specifically and to fund research in questions around the ACT teams, the crisis intervention system, the relative use of resources of hospitalization versus community treatment, and to actually measure some of the outcomes of those investments so that we have better information on where we make the next set of investments over the next four or five years.

From my point of view, this is a longer-term issue. It cannot be resolved in two years. There needs to be a sustained look at this system over a longer period of time, initially based on improving our data, our information, so that our decision-making can be better, and to invest based on local planning and advice from providers in those parts of the system that show the best results.

I think some of the examples you've heard today about assertive treatment teams, about the importance of very strong case management, the importance of not just drugs and hospitals but supportive services to people who live with mental health issues for long periods of time—it's not episodic; it's over months and years in many cases. The needs of people change as their condition changes. So we need to do this, from my point of view, in a more measured and long-range perspective.

Mme France Gélinas: When I hear you talk about gaps, would that also include such things as—in order to provide quality care, let's say, in case management, we know that consistency is important. When agencies have a hard time recruiting and retaining staff—because in my community their salary grids are way lower than any other parts of the health care system, and I will include the CHC that I was from. I was always arguing for more funding, but when I looked at my cousins in the mental health system, their pay scales were even lower and certainly their benefits were even worse, which meant that recruitment and retention were an issue, which meant that continuity of care was an issue, which meant quality affected outcomes etc.

So when you look at gaps—I'm trying to use the language that you've used—are those the types of gaps that would be on the radar or are we—I will leave it at that.

Mr. Ron Sapsford: I have to say to you that when I'm talking about gaps, it's really more in the service systems themselves, or particular functions. Wages obviously have an impact on employment. I don't have any specific position on that point alone. I know that when new money did go into the system, though, there was a fair amount of turnover in some community mental health agencies as a result of that. The salary question, from my point of view, is more of a local question. But to the degree you can't find staff to provide the service, that would certainly be an indicator you'd have to take into consideration.

Mme France Gélinas: Could I ask Ms. Wright a little bit as to—she's from the Canadian Mental Health Association—

Mr. Ron Sapsford: Sure. That's better.

Mme France Gélinas: —how she deals with it at the local level.

Ms. Marion Wright: Thank you for your question. Also, another issue that bears looking at with respect to this is unionized staff and collective bargaining responsibilities that many of the community agencies have. We have found that recruitment and retention are very challenging in the community mental health sector, especially compared to our hospital colleagues. We would employ nurses, psychologists, psychiatrists and social workers, and what they are paid relative to working in the community—what they could get elsewhere is a measure of their dedication to working in the community because there certainly are disparities there.

I do think that the increases that have come across the board from the ministry in the last several years have not kept pace with the bargained, unionized environments that many of us find ourselves in, and as a result we need to reduce our number of staff—and therefore our ability to provide services—to maintain a balanced budget. So it is a challenge for us. Thank you for your question.

Mme France Gélinas: So if I understand it well, there is a gap between what you are paying your employees who hold the same degrees as the hospital—I'm hearing you say that you pay your nurses less than what a nurse is getting in a hospital, plus I'm hearing you say that you actually have to cut services in order to meet those lower pay scales.

Ms. Marion Wright: The first part of that I would certainly agree with. The second part was really related to unionized environments where, for example—and I'll speak from my own agency's perspective. We received a 1.5% increase this past year and our unionized environment and our collective agreement had us providing 3.25%—so that difference. Appreciating that these are very difficult issues to deal with on a provincial level and certainly looking at how services are provided in the community, it's different than it is in the hospital. There are many people, many of my staff, who would say, "I would far rather work in the community, because I'm closer to people"—or for a variety of reasons—"than work in the hospital." For them, even though there is a salary difference, they choose to work in the community. So I don't think it's as clear and straightforward an issue as one might think when you first look at it.

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Mme France Gélinas: Just to give me an example, if we take a nurse in your own community, what would be the difference between what you pay and what the hospital pays? Just give me an example. Are we talking a dollar an hour or $10?

Ms. Marion Wright: We're talking about 10% to 15% less, with respect to wages. If you look at benefit packages, I think you're looking at substantively more.

Mme France Gélinas: So you offer better benefits?

Ms. Marion Wright: No, we don't. We offer less good—whatever that word is. No, we don't offer benefits that are better than those for the hospital-based nurses, for example.

Mme France Gélinas: Do you offer a pension plan?

Ms. Marion Wright: The Canadian Mental Health Association has a very small pension plan, yes.

Mme France Gélinas: Thank you.

The Chair (Mr. Norman W. Sterling): Mrs. Albanese.

Mrs. Laura Albanese: We've heard that the community mental health programs are delivered by different ministries at times. I wanted to ask, is there any coordination between the services that could be offered under different ministries? Has any effort been made to break these silos, for example, with the Ministry of Municipal Affairs and Housing—we heard that housing is one of the main issues—or the Attorney General for the courts?

Mr. Ron Sapsford: Yes, there is a great deal of interministerial co-operation, at the level of the province but also at local levels where there's work with municipalities, and between LHINs and municipalities, on issues related to housing. There are a number of them.

In the criminal justice side of it, the ministry and the Attorney General and the Ministry of Community Safety have worked for a number of years on issues around forensic mental health—which isn't the topic here—but also, as I talked about earlier, the court diversion programs, where we can intervene at much earlier levels. There's been a formal committee that's been struck for a number of years on that particular front.

The Ministry of Community and Social Services would be the other example I'd use, where we share a population. We refer to it as the dual-diagnosis population: developmentally handicapped people who also have a mental health problem. There, the ministries work quite extensively together. In fact, I think there's been a new guideline that's just been published in the last month or so between the two ministries to clarify responsibilities and how we manage this population between health and community and social services. In this particular case, MCSS has the lead responsibility for this group of clients, supported actively by the Ministry of Health through LHINs and local providers. That would be another example.

In the housing area, I know we've had extensive discussions; in fact, the Ministry of Health's housing stock, if I can use that expression, really was inherited from other ministries over the years. So our supportive housing stock—I think there are about 8,500 beds now related to mental health clients—came from municipal affairs and housing over time.

There are different forms of housing options for people. You heard some of the discussion today about how that works, or in some cases has difficulty working, because the Ministry of Health has housing stock related to certain populations—municipal housing, domiciliary care. All of these different forms of housing programs serve clients with mental health issues. So there's a fair amount of discussion among the ministries around questions of housing stock as well.

Mrs. Laura Albanese: So if we talk about the need, determining the need, how do we know, let's say, how many beds dedicated to clients with mental health problems are being allocated from the Ministry of Health, the Ministry of Housing? Is there somebody keeping track of that or—

Ms. Carrie Hayward: It's a combination. We've talked earlier about not always having a "need" sense of information, but working with the resources that we have. We certainly work very closely with other ministries. For example, in terms of supportive housing the Ministry of Health invested in 2,200 new units of supportive housing. Also, municipal affairs and housing was developing an affordable housing program. We negotiated with them to actually enhance and ensure that a portion of their allocation was actually going to build affordable housing for people with mental illness. So another 600 to 700 units of housing were put in place through that avenue as well.

When we were working on the service enhancements to keep people with mental illness out of the criminal justice system, we were working very closely with children and youth, with MCSS and corrections. One of the things that we did do was look at the very specific needs of those ministries. Dr. Cushman mentioned issues around youth mental health; we actually transferred some of the resources associated with that initiative to MCYS to build onto their children's treatment system.

With respect to developmental disability and dual diagnosis, the Ministry of Community and Social Services was creating a set of specialized networks, if I recall, to provide some very specific supports to those clients. Again, as part of that initiative, we actually transferred some resources to that ministry to deal with some very specific need that they had that tied in with our overall strategy and initiative.

With corrections—we talked to corrections—their concern was when people are actually released from jail. They were very worried that they may have provided care to people in the jail but when they got out of jail there was a potential for recidivism. So that ministry actually identified where they needed more case managers in the system, based on where the jails were located. About 36 FTEs were identified to line up where those jails were, so that when people actually left jail their probation officer would be able to work very closely with a case manager to ensure that they had continued support and could be linked up with appropriate community service.

One of the things that brings all of that together is something called the provincial human service and justice coordinating committee. It's a provincial committee but it's comprised of regional committees and

people who work at a regional level, and then also subsequently at a local level, where you have very extensive partnerships between police and corrections, justice, the attorney general and our community mental health agencies, who are all trying to work together to try to meet the needs of those particular clients and ensure that there's a lot of cross-ministerial coordination.

Mrs. Laura Albanese: So are there any future investments planned by the Ministry of Health and Long-Term Care in this sector? I guess the other question that remains for me is, how do you identify where to make those investments? Is it, for example, through these groups that you just mentioned or through the LHINs?

Mr. Ron Sapsford: From the last budget cycle, there was a commitment for community mental health of an additional $80 million. This would be an additional expenditure over the next three years. Of that allocation, there was a plan for a thousand additional supportive housing beds over that period of time. So we're right in the process now to start implementation during fiscal 2009-10 for the first part of the bed stock. The monies will be allocated through local health integration networks, who will then look at where their relative need for investment is in programming and make those decisions.

Mrs. Laura Albanese: Thank you very much.

Dr. Robert Cushman: I was just going to add—sorry, one piece, just in terms of what Carrie Hayward was saying—that in eastern Ontario, the children's hospital, which is mostly Ministry of Health, and the treatment centre, which is the Ministry of Children and Youth Services, and the CCAC have gotten together and identified 170 patients who are very needy and cross the boundaries between the various ministries. While it's not really an effort to look for more funding, it's an effort to pool resources to do case management in a better way, to meet the needs of these families. To me that is another example of, in terms of really knowing what our caseload is and really knowing what their needs are, having patient- and family-centred care.

These are some of the initiatives that are currently going on which I think are very positive.

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Mrs. Laura Albanese: I appreciate that. Actually, that was the intent of my question, to see if there is coordination between the different ministries, not only for funding but also to share, let's say, what's available there, and best practices, models that could be used across the province, if that's suitable.

The Chair (Mr. Norman W. Sterling): Mrs. Elliott.

Mrs. Christine Elliott: Good afternoon. I'm sorry I wasn't able to be here for your entire presentation, but I was certainly very interested in the comments that you made about the correlation between the mental health and addictions piece. That is something that I've just heard about recently in my riding. Of course, we have a large mental health centre there and have some very willing local agencies that are working together. Recognizing that, they have come up with a very innovative court program. We already have a drug treatment court that was put together voluntarily by the judges, defence counsel, crown attorneys and the addictions services in the area, but now they're looking at developing that into a mental health and drug court, recognizing that you can't really deal with one component without dealing with the other component. The idea behind it, of course, is to make sure that people get well, that you can treat both sides of the problem. What we also want to do is make sure that people stay on their meds and stay off drugs, and can then live in the community.

That sort of leads to the next part of it, which to me is one of the major problems hindering community access and the success of community programs, and that is, what do you do with people who don't realize that they're ill, who don't have that insight? You might be able to have all the best community services in the world, you might have social housing that's going to be able to serve them, but—we can see that this is happening on a daily basis. Just two news articles today: One gentleman, who died alone in his own apartment, didn't have access to services because, I suspect, he didn't realize that he needed them and was living a very isolated life; the other one, with respect to the person who's alleged to have pushed those boys off the subway platform. To me, they're all evidence of the same sort of thing, that we need to have some sort of change in our mental health legislation, recognizing the need to balance civil liberties with society's right to be protected, and also the right of the person to be treated like a human being too, because we're not doing them any service by allowing people to live on the streets, by not having any access.

I can tell you—and I'm sure all the other members here would agree that they have people coming into their offices on a daily basis, family members, saying, "I have a very ill family member and I can't get any treatment for them." I'd just like to get your comments on that. Do you think that we need to have some changes to our mental health laws?

Mr. Ron Sapsford: The Legislature has looked at this question a couple of times before, in the Mental Health Act. I think you're quite right. The balancing of an individual's rights to freedom and liberty against questions of danger to the public or to themselves is, I believe, the way it's cast. From my point of view on those questions, I think the current legislation seems to be stable. We've not received huge pressure from the public or from the treatment community that that balance needs to be relooked at.

The other adjustment that was made to legislation was around the issue of community treatment orders, that treatment under the legislation did not need to be confined to a treatment facility but could be extended into, if I can say, the outpatient side of it. I think that was the last major innovation that allowed treatment to proceed in cases where otherwise it may not have been followed by a particular client.

That would be my summary of it. As I've said, we've not had, as far as I'm aware, strong pressure for amendments to that particular part of the legislation. I don't know whether Carrie has any comments.

Ms. Carrie Hayward: No. The only other thing I would add to that is of the investments that were made in the last four years, a significant amount did go to crisis service. One of the main purposes of a crisis service is to identify a client in need, and it might be the very first time that they're in need of service and then can be referred appropriately to other community services and hooked up to get the support they need. Many of those crisis services are also connected with the police and their mobile teams who actually go out and travel with the police to provide that. So that's one of the ways we've approached that particular aspect of service. That doesn't help those people who don't necessarily know they're ill, but if they have an event then certainly they're connected.

Also, we talked about ConnexOntario. As the deputy mentioned, a number of people reach out to Connex to actually get help. For some of them it's a family member, sometimes it's an individual, and Connex will keep that person on a phone line until they can connect them with the police or an ambulance, depending on the nature and severity of the crisis they're experiencing.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Norman W. Sterling): Can I ask sort of a supplementary question on this? I've been involved in terms of some of the changes to the Mental Health Act in the early 1990s; I worked with Frances Lankin, who was then the Minister of Health, in dealing with some of the changes at that time. I was a great proponent of things like the enduring power of attorney and those kinds of instruments to help people who are mentally ill. I've also represented Smiths Fall, which had Rideau Regional Centre, which either is closed or close to being closed at this time. My concern always was when, as I would put it, the ministry evicts a resident from their home of 40 years at Rideau Regional. My understanding from the Ministry of Community and Social Services was that after a short period of time, they lose all responsibility for that individual and that individual is essentially—hopefully they have parents, friends or someone in the community who cares to look out for or advocate for that particular individual. Who bears the responsibility as the guardian of these particular individuals who are on the street? Who's looking out for them? I ask this because I know in that institution they would try to track people who had left and could not find a trace of them. They still had friends in Rideau Regional, but somebody would just disappear.

Mr. Ron Sapsford: For the developmentally handicapped population, I'm not exactly sure myself of how that works. I think if there are questions, though, of competence, there is a process of law where if someone isn't competent to manage their care there are alternate mechanisms provided for them or a form of guardianship if it's restricted to financial management. But in terms of the details around the developmentally handicapped centres, I'm not exactly sure. I know that a large proportion of the populations were discharged to group homes, where there is a protected environment. But I know certainly not all were removed from those facilities in that fashion.

The Chair (Mr. Norman W. Sterling): I don't believe the official guardian, who's under the Attorney General, either has the staff or the ability to really be looking after the individual care of people who are there. That's why I'm interested in the LHINs and putting case workers forward and that kind of thing. I would surely love to give some kind of legal responsibility or make somebody legally responsible to ensure that that person is getting proper medical care and those kinds of things, because particularly the last 100 who have been discharged are people who have complex mental and physical disabilities. That concerns me very greatly, and I still think that a lot of these people who suffer from mental illness are on the street on their own.

I think we'll probably be able to finish this by 3 o'clock for people who were kind enough to come here today. We have a few more questions. Mrs. Sandals.

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Mrs. Liz Sandals: Just one more question. I want to comment, first of all, on Mrs. Elliott's question about the act. While it would certainly be true that I've never had any requests from the medical community about changing the Mental Health Act, I've certainly had very strong representations from families of people with mental health issues who have been trying to access mental health services for family members, including one family of a young mom who committed suicide and another from a family—the mom was eventually murdered by the son; she had been trying to get assistance for her son.

What I wanted to ask you about was one area that I don't think we've touched on today. I'm finding that we're talking about the LHIN having the capacity to build community links, and one of the links that I see being very productive in my community is the community mental health sector working with the long-term-care sector and some formal partnerships there, with the community mental health provider going into long-term-care homes to work with the staff there on how to manage mental health issues in that older population. I wonder if what I'm seeing is a trend around the province that we are building that linkage which, while it's within the same ministry and within the same LHIN, is crossing that boundary between medical and mental health that is not always crossed.

Dr. Robert Cushman: You touch on a very important point. My simple analysis of the ALC problem is that there are two very important factors there. The real problem is supportive and affordable housing, but in terms of the people who are stuck, there seem to me to be two major criteria. One is ability to pay, and the second is dementia. Then you move over to the long-term-care sector, and what you see is that the foundation for most of the funding formula—I think it's changing, and Carrie can probably help me with this—is really for physical illness and physical disability, but what they're seeing is more and more dementia—

Mrs. Liz Sandals: That's certainly what I hear from my long-term-care operator.

Dr. Robert Cushman: —and it's very interesting, because at the age of 88, how much of a heart do you need to function and how much of your lungs do you need to function and how much of your kidneys do you need to function? The answer is, probably, not that much. But in terms of your brain, I suspect it's quite a lot. This is why we're seeing this dementia piece.

The long-term-care homes are not really funded for the dementia piece, which is a big problem. In terms of the skills and in terms of dealing with these folks, there are some challenges. We're very fortunate in Champlain, because we have a women named Marie-France Rivard, a psychiatrist who is well known internationally, who has actually worked with the local psychiatric hospital to get out into the long-term-care homes and educate them about the needs of folks with dementia on top of the standard physical ailments.

Your point is right on: If that is really what the primary problem of the residents is, we've got to address the problem. What we're trying to do in our area, and what they did successfully long before I arrived but we're now trying to generalize, is to get those resources out so we can improve the skills in these long-term-care homes. For example, you've probably been in a long-term-care home where you've seen the door camouflaged with a beautiful mural of a country setting because people are always looking for a way to get out, but if they see this beautiful mural, they feel more comfortable staying in—just things like that.

To your point: This is a major issue, and we have to do a better job. There is some new funding for more nursing services in long-term-care homes and, relying on some of the resources and talents we have, I think we can do a better job in addressing this problem.

Mr. Ron Sapsford: If I could comment on the long-term-care piece: The question is on the linkage with community mental health and long-term care. I think Dr. Cushman has started the answer. I think it's more important to focus on long-term care and provide the service that's needed for that group of people than it will be to try to create an active link with community mental health agencies, partly because, yes, there are some commonalities, but the focus for our mental health system, particularly the community, is on the severely mentally compromised who are in the community. In long-term-care homes, yes, there's a need for service and for training and education. In fact, the ministry has started a number of training programs for staff in long-term-care homes related to behavioural issues. Creating the referral mechanisms with the psychiatric community to support the care in the home requires staff, training, resources and knowledge and establishing some standards around behavioural care in homes, and as well, with the new regulations that are coming under the new long-term-care act, specific standards of care and the use of measurement tools similar to what we're talking about in community mental health, so that we've got a much clearer sense of the needs for the elderly population in those facilities, and to begin to develop that expertise in the home as opposed to trying to import it on a coordination basis from the community system.

Mrs. Liz Sandals: I think what I saw was training as opposed to treatment.

Mr. Ron Sapsford: That's been identified as a key need, yes.

Mr. Michael Barrett: I'll just add that in the South West LHIN, we have 139 people who are waiting for placement in a long-term-care home and are sitting in a hospital right now. Forty of those can't be placed because of behavioural or mental health issues. We have an example, which the deputy referred to, in one of our long-term-care homes, where it's a psychogeriatric unit. It's one wing of a long-term-care home, but they're provided with additional supports, additional funding for more staffing and access to psychiatrists and staff from the regional mental health care centre in London to ensure that those additional supports are provided within the long-term-care-home setting. That's the type of unit that will help get those 40 people out of the hospital and into a more appropriate setting where they belong.

Mrs. Liz Sandals: Thank you.

The Chair (Mr. Norman W. Sterling): France?

Mme France Gélinas: I don't know if anybody has a good enough memory to answer this, but we'll give it a shot and see where it goes. Not so long ago, most severely mentally ill people lived in psychiatric hospitals. Then, I fully supported the move toward community living for people with severe mental illness. Out of the psychiatric hospital and into our communities they went, with trials and tribulations at that. Was there any cost analysis as to how much it cost us before, when a client was in a psychiatric hospital, versus how much is being spent now? I understand that the value of money has shifted over the years in all of this, but do we have any data, evidence or study on that?

Mr. Ron Sapsford: Not that I'm aware of, in terms of that direct comparison. The kinds of questions that we're now trying to answer are, given the investments in community mental health—we have a more articulated community health system than we did then—as a result of that, are we using less hospital resources to care and manage people's treatment course, given that we have community health? Those are the kinds of active research questions that are in place now, and we're hopeful that understanding the answer to that question will help guide future investment into the community mental health system.

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But as to the question of whether chronic schizophrenic populations living in institutions are less or more costly than what it currently takes to care for them, either in homes or special care or supportive housing, I'm not aware of any formal studies. Carrie, I don't know if—

Ms. Carrie Hayward: Not from a study perspective, but we were talking earlier about supportive housing. Maybe just as a general comparison, 1,000 units of supportive housing in the rent supplement model, including case support—the case manager who helps that person

maintain that housing—costs about $16 million. If you take that 1,000 units, or 1,000 people, and a hospital bed can be $700 a day, that's $7 million a day to maintain that same person in hospital. That's a very rudimentary comparison, but I think there is a strong belief, and it's been proven, that community services are a more cost-effective way to support people, and it's certainly a more normalized way for people to live, in the community with the supports.

Some people need quite a bit more support, as with the example earlier with the assertive community treatment teams, where you've got this sort of 1-to-10 ratio. Other people with mental illness may simply need a case manager, some peer support and a place to live.

It's hard to do that kind of comparison because each person's illness, and the way their illness progresses, is very different. But there's a very quick comparison for you.

Mme France Gélinas: Thank you.

Dr. Robert Cushman: Just on page 177 of the report, there are some figures comparing hospital to jail to community. Again, as Carrie Hayward has said, there's a differential between who these people are.

When I started my medical training, I spent some of my time at the psychiatric hospital—some of my time as a student, not as a patient—at the Hamilton Psychiatric Hospital. Just recently, I served on a board of the Foyers Partage, which, as Norm would know, is one of the community settings as a result of Rideauwood closing down. One particular member had to go to the Supreme Court because his family actually didn't support his willingness, his want, to move to the community. But just to see the difference from these large institutional settings, as you move to the community setting, it makes a lot of sense.

One of the problems we have with places like Rideauwood is that we're dealing with such a history; people have been there for so long. But if you could make that choice, sort of an A or B choice, for your child or a family member, I think you'd make it very quickly.

Mme France Gélinas: I have no problem supporting—I think people with severe mental illness should be in our community. They make our community richer and they certainly have a better quality of life. I've always supported it and I always will.

I was just curious to see, because while it was happening, it's certainly an argument that would pop up every now and again, that it would be a whole lot cheaper. I was just wondering if there was ever any follow-up to this. I've never found one, but you guys seem pretty knowledgeable so I thought I would ask.

The Chair (Mr. Norman W. Sterling): Could I just ask a question on that? My concern is that, notwithstanding that there have been increases in budgets for mental health, there have been some savings with regard to people who were in other settings, with regard to costs. For instance, while Rideau Regional, which I'm most aware of, wasn't under the Ministry of Health, probably the Ministry of Community and Social Services is going to save maybe $50 million a year because of the closure of that. It will have some additional costs in terms of the placement of those individuals, but it won't be anywhere near $50 million out of their budget.

I guess my question is, what are the pluses and minuses in this equation so that we can ensure that what's gone to mental health has in fact been $200 million or whatever it is? Or is it something much less than that? Perhaps the deputy could collect those figures and provide them to the committee in terms of the closure of the institutions.

I noticed that when the psychiatric hospitals were closed—pardon?

Mr. Ron Sapsford: I don't know which psychiatric—I mean, we're going back over 20 years for an outright closure, Chair.

The Chair (Mr. Norman W. Sterling): Well, we could go back—

Mr. Ron Sapsford: We've divested all of the psychiatric hospitals, but they've not been closed, nor has there been significant bed contraction. So I'm not sure what I'm going to report to you.

The Chair (Mr. Norman W. Sterling): Perhaps you could report to us what fewer costs the ministry—

Mr. Jim McCarter: I think we've said that since 1998 the ministry has divested itself of or transferred nine of 10 provincial psychiatric hospitals to public hospitals and community-based service providers.

Mr. Ron Sapsford: That's correct. But they're all currently in operation.

The Chair (Mr. Norman W. Sterling): They're currently in operation as psychiatric—

Mr. Ron Sapsford: Absolutely; every last one of them.

The Chair (Mr. Norman W. Sterling): We had one member here this morning who indicated that he wasn't certain that the money transferred to his hospital was in fact being used for mental health. Mr. Hardeman?

Mr. Ron Sapsford: Well, I'd love to hear about that.

Mr. Ernie Hardeman: I think my comment this morning was different; it was about whether a fair amount of dollars for mental health was coming into my community. When you look at the Oxford Child and Youth Centre as the only youth facility in Oxford that was providing mental health for youth and you compare that to my surrounding counties, you'll find that we're much lower than Perth is and Middlesex is. When we inquired—this is a few years ago—the answer was that we were funding a bunch of money to the Woodstock General Hospital for youth mental health, only it's not earmarked for that; it can be used anywhere within the hospital budget. So the need for mental health services is all in one place and the dollars are going somewhere else. It becomes an uneven playing field.

Mr. Ron Sapsford: Well, children's services are an additional, in a sense, complication because children's community mental health is managed through the Ministry of Children and Youth Services, not the Ministry of Health. For a number of years, though, I know for certain

as it comes to allocations of mental health dollars to general hospitals, there were always strict rules in place that the hospital had to maintain service expenditures at the level for mental health unless there was a very specific approval to do otherwise. As far as I'm aware, that general principle remains in effect.

But in cases where the ministry has divested psych hospitals, quite honestly, by and large, the budgets are adjusted upwards in divestment, not downwards. So I'm quite confident, at least on the divestment of the psychiatric hospitals side of the question, that all of them have been more than fairly funded for the service they've provided. On the general hospital side, service agreements and accountability agreements between the ministry and hospitals over the years have always specified that for any change in expenditure on the mental health portion of their global budget, specific approval was needed to reduce.

Mr. Ernie Hardeman: I think that's true, and I'm not implying that the hospital wasn't providing mental health service to the youth, except—and it comes back to my original accountability question. If your benchmarking is quite broad, shall we say, as to what you're expecting for the money you're giving, on the size of a hospital budget, it's not hard to show we're providing mental health services to the youth and find out that the waiting line there is much longer than the other place, so chances are they are not providing near as much. There's never a clawback for that money, so there's not as clear an accountability if it's being provided within a larger budget at a general hospital.

Mr. Ron Sapsford: I accept that.

Mr. Ernie Hardeman: That was really the concern I was bringing.

The question, though, as I've been sitting here—and I'm sorry I wasn't able to be here for all of it. The issue of housing and mental health: Is the provision of that a health issue? I think it was expressed here that there's a great connection between them, and not having housing being a big problem in mental health. But should the Ministry of Health be providing that? Should they be in the housing business? Should they be providing housing the same as we provide it to other people who need assistance in getting housing? How did that get put together? I really have a concern that we're putting an awful lot of dollars—when we look at a 7% increase in spending in the last five years, that's not a very high increase. But are people with mental health problems getting 7% better service, or are we providing more services and in fact the quality, the service to the individuals, is less than it used to be?

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Mr. Ron Sapsford: A lot of ministries are involved in housing questions. The Ministry of Health share of that is about 12,500 beds. As I said in an earlier question, many of those were inherited from other ministries, where programs were transferred through the years, many of them from municipal affairs and housing. We also operate nearly 1,000 homes with special care beds. But of the supportive housing, those 12,500 beds, about 8,500 are occupied by people with mental health problems. So a significant part of our supportive housing stock is related to mental health patients and their support in the community.

MCSS also has domiciliary housing. Municipalities have started, in co-operation with the Ministry of Health, offsets for their homeless population, many of whom are mental health patients. I think, as we've heard from some of our service providers who are here today, that the issues of homelessness linked with mental health and the lack of housing is a huge instability to beginning the process of treatment and restabilization. So I think you've hit an issue.

I will say that the ministry is adding an additional 1,000 supportive housing beds over the next couple of years. I suspect that in the minister's work and perhaps in the select committee we may hear more advice on the issues related to housing, because it does seem to be a common theme that comes up across the piece. But to say that they're all health, I would share some of your concern about that. It's an important adjunct to make sure that people are able to get better, but I think there's room to debate whether it's operated as a health program or provided at a different level in the system. Certainly the mental health support, the clinical support that comes from community mental health agencies or hospitals for people, irrespective of what their housing is, is the important focus for the Ministry of Health. I think some agencies find that it's more an integrated approach if you can provide housing and treatment service as one package as opposed to dealing with different groups for different components. I think that's why we have, at the present day in Ontario, a mixed system of how housing needs are met.

Mr. Ernie Hardeman: First of all, I totally agree with special-care housing where we have a small hospital; we have a group of people who are being cared for in a facility or in a housing setting. I think that's part of the needs of the mental health issue. I was dealing with one not too long ago; it's just a normal house within the community. The reason I was involved had to do with the neighbour complaining about the house being there—I think we've kind of quieted him down.

The argument was that there was nothing different about that house because it's owned by the Canadian Mental Health Association. It's no different from any other person living in that community. I personally agree with that, but because it was part of the Canadian Mental Health Association, the neighbour was making an argument that it was different from just a private residence for a family to live in. The fact that they had health needs beyond the neighbour is irrelevant. It would seem to me that if that was just public housing or a supportive housing setting as opposed to a unit to provide health care, as opposed to a unit for somebody who has health care needs to live in, it would solve some of our community problems.

Mr. Ron Sapsford: As I've learned, it's very difficult to generalize about the population needing mental health

services. For some people, yes, institutionalization; for others, more of these protected environments, where you've got a group of people together. For some patients, that's not the appropriate approach. They need some form of housing with supports: living in what you've described as more generic housing but making sure they've got supports for the activities of daily living more integrated with the community as opposed to an institutional setting.

I think it's important that there isn't one answer you can apply everywhere in a consistent way. We need different components of care and different levels of housing with support in order to satisfy the needs of this particular population. I think we sometimes run the risk of saying, "If only we had more of these, we could put everybody there and the problem would end." But that isn't going to help either.

I think we've got to listen far more carefully to the needs of people. When you do that, what we hear constantly from providers is that you need a range of services, and you need to be sensitive and flexible about how you provide the care and not simply create one setting you force everybody into. I think that's our history.

Mr. Ernie Hardeman: The only reason I mentioned it is that I think what we need to do is make sure that as many people as possible live just like everybody else. They just have a health problem.

Mr. Ron Sapsford: Yes, absolutely.

Mr. Ernie Hardeman: By creating that type of housing, if it was just another rental unit, in my mind there would be less stigma attached to it.

The Chair (Mr. Norman W. Sterling): Thank you very much.

I'd like to thank you, Deputy, and I'd like to thank our special visitors from outside Toronto: Ms. Elkin; Nancy Annett, who was with her; Mr. Eliasoph, from the Central LHIN; Dr. Cushman, from Champlain LHIN; Michael Barrett, from the South West LHIN; and Marion Wright, who is the executive director of the Canadian Mental Health Association. I think your knowledge given to our committee members today will not only be used to help us write a report, but will also be helpful to the select committee, which is probably going to be embarking on a deeper study with regard to some of the matters we discussed today. Thank you very much and have a safe trip home.

The committee adjourned at 1457.

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