MH-5

ISSN 1918-9613

Legislative Assembly
of Ontario

First Session, 39th Parliament

Assemblée législative
de l'Ontario

Première session, 39e législature

Official Report of Debates (Hansard)

Wednesday 22 April 2009

Journal des débats (Hansard)

Mercredi 22 avril 2009

Select Committee on Mental Health and Addictions

Comité spécial de la santé mentale et des dépendances

Mental health
and addictions strategy

Stratégie sur la santé mentale et
les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

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

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

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 22 April 2009

Mercredi 22 avril 2009

The committee met at 1605 in committee room 1.

MENTAL HEALTH AND ADDICTIONS STRATEGY

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen, if we can call to order. We're a few minutes past 4 o'clock.

I just want to draw the committee members' attention to a very nice thank-you letter from the Parents for Children's Mental Health, whom we heard from at our last meeting, and some information that's also before you. It's background on mental wellness initiatives that has been prepared by our research folks for your consideration. When we get to 6 o'clock, we'll be dealing with a letter that has come to us from the Auditor General to get some opinions from the committee.

MINISTRY OF THE ATTORNEY GENERAL

The Chair (Mr. Kevin Daniel Flynn): Right now, we're going to hear from our first delegation, the Ministry of the Attorney General. We've got Curt Flanagan with us today, director of mental health, criminal law division.

Curt, please come forward. Make yourself comfortable. You've got 30 minutes. You can use that time as you choose, and at the end of it all, if there's any time left we'll split that amongst the members who are present here today.

Mr. Curt Flanagan: Thank you very much for inviting the Ministry of the Attorney General to present to this Select Committee on Mental Health and Addictions.

Today, as director of mental health within the criminal law division, I'm happy to provide an overview of existing services and supports that the Ministry of the Attorney General provides. I should indicate to you that when I talk about some of the initiatives, these are initiatives from the Ministry of the Attorney General, but also initiatives with co-partners from other ministries, two of which you will hear from today.

I'm going to talk to you about four areas: the mental health directorate; the mental health and addiction courts and court programs; collaboration with ministry and community partners—additional services and specific services; and also education and training.

In order to put it into context, I've provided a bio in relation to me, and I thought it might be a good idea for members of the committee if I could just explain very briefly, from a criminal law point of view, some of the juncture points that we deal with in court.

There are really three areas that come to be with respect to mental disorder and developmentally disabled. There are the alternatives to prosecution, which may be referred to as diversion, which is a protocol within the criminal law division of the Attorney General; there is the verdict of unfit to stand trial; and there is the verdict of not criminally responsible on account of mental disorder.

1610

The first area that I've mentioned, and that is alternatives to prosecution, is a protocol from the Ministry of the Attorney General that recognizes that mentally disordered or developmentally disabled offenders may warrant special consideration, with an emphasis on restorative and remedial measures as an alternative. Diversion refers to alternatives to prosecution that apply to low-end offences. Key with respect to making a decision on diversion—and I should indicate to you that the decision to divert or to use alternative means of prosecution, i.e., to take it out of formal prosecution, is solely at the discretion of the crown attorney or assistant crown attorney. As I indicated, public protection is paramount. The offences that relate to this protocol are low-end offences.

When you look at unfit to stand trial, that's a verdict of unfit to stand trial that provides a special verdict for an accused person who appears before the court. Let's say, for example, you have an individual in downtown Toronto who is suffering from schizophrenia and is off his medication, he's in a public establishment and he may be breaking glasses, he may be yelling; and as a result of that he may be charged with mischief and damage to property and causing a disturbance. That person would appear before the court in the criminal justice system. One of the issues may be whether or not the person is fit to stand trial. The person is unfit if he's unable, on account of a mental disorder, to understand the nature and object of the proceedings, to understand the consequences of the proceedings, or to communicate with counsel.

Let me tell you that the fitness test in criminal court is a low threshold. It's been referred to as the limited cognitive capacity test. In practice what usually happens,

and there are derivatives, is that a psychiatrist—because it has to be a medical practitioner under the Criminal Code, which would include a psychiatrist, unless they are designated by the different provinces, which is new legislation that I can get into later if you like. It's an examination by the psychiatrist, and it usually takes between 15 minutes and half an hour. This is not an elaborate examination to determine fitness.

If the person is unfit as a result of that examination, what happens? What happens is the court will then decide whether or not a treatment order is applicable. By that I mean the court will decide, based on psychiatric evidence, whether this person can go to a hospital, can be treated, can be made fit within a 60-day period, which is the time period in the Criminal Code, on consent of the hospital. So what happens in practice is you have a fitness hearing, you have a psychiatrist testify, then after the finding of unfit, you get into the treatment order proceeding and then the court may order a treatment order.

Let's suppose that a treatment order is not appropriate because the prognosis of becoming fit within a 60-day period doesn't exist. Then what happens is really two things. The court can give an initial disposition, in which case the person will then be referred to the Ontario Review Board and receive a hearing within a 90-day period. If the court refuses to give a disposition—and I can tell you, on occasion they might, because the review board is an experienced panel of individuals who have the background of hospital reports—then what happens is the person will get a hearing before the review board within a 45-day period because they didn't have the initial one.

Finally, the last juncture—I said there were three. Alternatives to prosecution was the first one, unfit is the second one, and then there's what has been commonly referred to as NCR, which is not criminally responsible. Of course, that is a specialized verdict under section 16 of the Criminal Code. If you are found not criminally responsible, you are then transferred to the jurisdiction of the Ontario Review Board. You'll receive a hearing within 45 or 90 days and an annual hearing each year after that to determine whether or not you present a significant risk to the safety of the public. If I'm at a hearing at the Ontario Review Board—and I can tell you the Ontario Review Board consists of five persons: a chair, a psychiatrist, maybe another psychiatrist or psychologist, a layperson, and a legal member—evidence will be presented by the hospital and may be presented by parties. At the end of the hearing, there has to be a determination whether the person presents a significant risk. If they do, they will stay under the review board system and a particular disposition is fashioned, depending on the risk level. If they don't, they are absolutely discharged and they leave the system.

Those, in effect, are the three juncture points in relation to mental health.

I said I'd talk about the mental health directorate. The mental health directorate is a new initiative by the Ministry of the Attorney General in October 2008. I'm proud to say I am the director of the mental health directorate. Our goal is really three goals: to enhance the delivery of service for individuals with mental health issues and the developmentally disabled in the system; to assist in the integration of a seamless transition—and by that I mean to look at every juncture point, from arrest until release into the community, and see if we can improve upon those particular junction points; and finally, to provide informed assistance to and collaborate with other justice partners. It's clear that collaboration with other justice partners is a very important aspect when dealing with individuals with mental health issues before the court.

The mental health directorate has set up a specific committee which is made up of specialized crown attorneys. These are crown attorneys across the province. There are six judicial regions. For example, in the west region, we will have two representatives, two crowns from that region, so there are 12 crowns on this committee. In addition to that, there are other individuals with special expertise. They may have expertise in the review board, they may have expertise in youth, they may have expertise in policy, and they may have expertise in various other things related to mental health. So it's a very functional and practical committee and I'm actually quite excited about it. That committee has formed working groups, and one of the advantages of that committee is, because of the representatives in the province, they form working groups to deal with practical challenges in each jurisdiction and also to bring to the table, if you like, things that are going on across the province. So that is the first area.

The second area is the mental health and addiction court and court programs. In relation to that, I can indicate—I told you a little bit about alternatives to prosecution. I just want to be very clear that when a crown attorney or assistant crown attorney is looking at alternatives to prosecution, they are really looking at—the present protocol calls for three classifications of offences: class 1, class 2 and class 3. Class 3 contains offences such as murder, firearms and sexual assault. These are prohibited and not allowed to be diverted from the justice system. Class 1 is presumptively eligible, i.e., joyriding, shoplifting, mischief. These are presumptively eligible to be diverted from the criminal justice system. And then there's a larger category of a number of other offences that is in the discretionary category. Crowns will look at the circumstances of the offence, the circumstances of the offender, and decide whether or not they will consent to a particular diversion of the individual, keeping in mind—I repeat—risk to the community, which is paramount.

When I told you about court programs, this is where we share an initiative in relation to my partner ministries; that is, there are what is referred to as mental health court workers. Mental health court workers are present in the court. They are invaluable. They are a tremendous asset. Why is that? Why would you think that they might be a

tremendous asset to us, for example, as prosecutors? Well, if you take into consideration that most courts are very busy, that there is a number of cases, we welcome individuals who specialize, individuals who link to particular services, individuals who have the ability to work up a background in relation to the offender so that I, as a crown, can make an informed decision in relation to risk and as to what is the best program, for example, to use as an alternative to prosecution. I can't say enough about mental health court workers. They liaise with a number of individuals and, quite succinctly, are worth their weight in gold.

You also have mental health court programs and mental health courts. Let me tell you that, first of all, when I refer to a mental health court, that is a court that is sitting either on a full-time basis or a regularly scheduled part-time basis for the exclusive purpose of dealing with disposition of cases involving mentally disordered or developmentally disabled offenders. So that is a court that sits for the exclusive purpose of that population, if you like. That court has a number of persons attached to it. The more persons attached, the more specialized the persons attached, the better and seamless the service is in relation to that particular court. They may deal with not-criminally-responsible issues, fitness issues, disposition hearing, diversion issues or various other things affecting the person before the court.

1620

The largest one is right here in Toronto, and that is 102 court, which was established in 1998. It is the largest mental health court in Canada, and I can tell you that the number of cases that go through that court in an average year lately is approximately 2,000 to 2,500. That is a very busy court. As a result of that, that court has extensive resources, from dedicated judges, dedicated crown, dedicated duty counsel, dedicated bail workers, dedicated mental health workers, two court clerks and various other individuals who specialize in that particular program.

In addition to Toronto, there is a mental health court in Ottawa, which was set up in 2007; there was one in Peel, in 2002; there was one in London, in June 2007. There was one in Walkerton, and I say Walkerton because—don't get the impression that because you are a large jurisdiction that will necessarily give you a mental health court. Walkerton is a smaller jurisdiction, and they fashioned it—they may not sit as often; they sit maybe once every two weeks—to address their particular jurisdiction. Kitchener-Waterloo is another one, and Windsor is another one.

In addition to these mental health courts across the province—and we're quite proud of them. I should say, and I indicated at the outset, that I share the initiatives with partner ministries, the Ministry of Health obviously being one of the major players in relation to that.

In addition to the dedicated mental health courts, there are mental health court programs. What I mean by that is that if you don't have a dedicated mental health court, you might have a program. Let's take an example: Before I was the director—I'm seconded as the director—I was a crown attorney in Brockville. What we do in Brockville is, we have a psychiatrist come to our remand court, which is once a week, every Friday. So we attach a psychiatrist, which is a mental health program. We also have a mental health worker in the court.

These various programs will vary. Barrie, for example, has two psychiatric nurses attached to the court. An innovative program, and I would invite you to see this, is in Ottawa, because, in addition to the mental health court, what Ottawa has is a mental health clinic, and there is a psychiatrist right in the courthouse. That psychiatrist sits there once a week, will diagnose individuals and send them on for treatment. That ensures, in my respectful view, the person goes for treatment. It's a monitoring system so that the person makes sure that they attend for treatment, and it tends to catch and identify the large population that might be missed had it not been right in the courthouse.

Then we deal with court-ordered assessments. Court-ordered assessments are very important. Why is that? Court-ordered assessments are important because they tend to go to risk as well as fitness and NCR. When you're looking at court-ordered fitness assessments, what are the innovations? Mental health court programs are doing them, like Brockville, for example, or Sudbury, bringing a psychiatrist to the court. There are also on-site assessment clinics at specific correctional institutions. Why is that important? That's important because if I'm in court, I don't have to necessarily find a hospital bed or get a hospital bed for this individual if the person is in custody in a correctional facility and they have a fitness clinic. So that is a very good initiative, obviously in partnership with Corrections and Health.

Then there's also hospital-based assessment, which is going to the hospital to retain a bed. There was an initiative between a number of partners—Health, ourselves and other partners—where there is an Ontario bed registry. If I'm looking for a bed and there's not a bed, for example, at CAMH in Toronto, there may be a bed opened in Brockville Mental Health Centre or in Ottawa Mental Health Centre. So that is a very useful tool in that regard.

Then we move to the youth. There have been a number of initiatives in relation to youth. Both London and Ottawa presently have a mental health court. What that is, is that their adult mental health court is now accommodating mental health court for youth. They are dealing, however, with transitional-age youth, and that is 16- and 17-year-olds who go to court. London is very innovative. Again, if there are site visits, I would invite you to go to London's youth court. They actually are having a conference on Friday—I'm not suggesting you go Friday. But in any event, they have specialized persons at the court. They have clinicians, and they take a long time with the youth. They'll have a clinician assess. They'll have case conferences. They may bring in the school board to address it. These are youths who are very troubled and have particular mental health issues that are complex and significant, so that's a very good initiative in London, and as I indicated, Ottawa also has it.

Then we move to the addictions. In the province of Ontario, there are presently two drug treatment courts formally funded by the federal justice department. They are in the Toronto area and also in the Ottawa area. In relation to that, they have a whole program that brings people to stop the revolving door, to address addictions, to make sure that the person doesn't come back into court and to get them hooked up to appropriate services. Again, the appropriate services brought to the court and linked by a network are extremely important because you specifically have to address the individual.

There is also an innovative initiative in Durham, for example. They don't have a federally funded court, but they do have a drug court. Durham's drug treatment and community restoration court has two components. It's unique because it addresses the adults in relation to addictions, but it also addresses the youth. Although an adult tends not to be able to get into the drug court if he has a problem with cannabis, the youth in that jurisdiction do get into that restoration court with a cannabis problem. I should indicate as I speak a brand-new initiative in Hamilton called SURCH, Substance Use Related to Crime in Hamilton. That is a similar way to fashion it.

The aboriginals, with respect to the addiction support programs for aboriginals, also supply an aboriginal court worker program. These are invaluable persons. Why are they invaluable? Because they know their community. They know how to link the persons up to particular programs that I may not have any knowledge of as a crown, that the judge may not have any knowledge of it. But these particular court workers, aboriginal court workers, are extremely important. And I hate to keep coming back to it, but it's the specialized service that is really advantageous in the court. Again, we have what are referred to as Gladue case workers providing Gladue reports, which are like pre-sentence reports, but frankly focus on, specifically, background in relation to aboriginal offenders. It's a very helpful program.

In addition to that, there are the aboriginal community justice programs. The Ministry of the Attorney General, in partnership with the Department of Justice, funds 11 aboriginal community justice programs. The range of services is for pre- and post-charge diversion, Gladue report service, pre-sentences and various other things assisting the court. For example, the Rama First Nation has direct access to a range of mental health services delivered by professional staff using a blend of western and traditional approaches, where both a psychologist and a community elder respond to the community's mental health needs. An aboriginal community justice program in Mohawk Council, for example, has direct access to fetal alcohol spectrum disorder assessments and diagnoses within their territory. Why are they valuable? Again, because they specialize.

The third component that I said was important in relation to the mental health directorate was collaboration with ministry and community partners. No time is better than the present to continue our collaboration in relation to various ministry partners to look at persons with mental health and addiction issues. In this regard, one of the community partners that I find quite valuable that you may have heard about—I'm not sure whether you did or not—is the Human Services and Justice Coordinating Committee. To explain it very briefly to you, the Human Services and Justice Coordinating Committee is a committee that sits in most, if not every, jurisdiction across the province, made up of various players including crown, defence, probation, medical services and various other mental health workers to look at challenges and to look at practical solutions in relation to how to deal with the mentally disordered as they pass through the court. It's very valuable. What they do is, in relation to these specific jurisdictional committees, they lump them into regional committees, and then there is a provincial committee. So you can see it's a very effective structure that alert—there's a lot of talking. To put it quite bluntly, it's fine to know what the other person is doing, but you have to share information and you have to talk. If you do that, you're able to recognize and come up with innovative solutions, both from a practical point of view and ones that may not take up a lot of time or money.

1630

In relation to the Attorney General: The Attorney General, the Honourable Chris Bentley, has established a round table to address existing challenges in mental health and addictions within the criminal justice system. The round table is made up of multidisciplined individuals with expertise in mental health and addictions. It is a wide range of individuals. It includes seven human services regional chairs, forensic psychologists, forensic psychiatrists, police, defence lawyers, members of the schizophrenia society and various other members who are very informative in looking at challenges. That is an excellent committee.

Then we have interministerial committees. You may hear from my friends from Health that there is a 10-year strategy for the mental health and addictions committee. But in addition to that, I think it's important, for the Ministry of the Attorney General and clearly I as director, that I may sit with other individuals from Health or children's services to look at particular practical issues.

I didn't want to leave out the Ministry of Children and Youth Services, because one thing that they provide—albeit there's a limited number—are mental health youth workers. Think of that as the adult mental health worker, but in youth court. Those, again, are invaluable. There are a certain number of them, they're not in every jurisdiction, but the information they provide goes a long way to help individuals, particularly youth, before the court.

Often, as a prosecutor, you might have a parent come to you and say, "I'm dealing with my 16-year-old or my 17-year-old and I can't get him into any service. Thank God"—and this is a sad comment, in my respectful view—"he's charged with a criminal offence, because maybe now I can direct him. Maybe now he'll get the services that he needs." I say that for two reasons: One,

that shows how effective these systems are that are being put in place across the province; and two, there is a certain amount of comfort zone in relation to individuals—albeit, it may be in the wrong place—a comfort zone to look after the youth.

I don't want to give short shrift to other divisions in the Ministry of the Attorney General. If I'm mindful of the time, I think I have three minutes.

Let me tell you that the Office of the Public Guardian and Trustee delivers a unique and diverse range of services that safeguard the legal, personal and financial interests of mentally incapable persons: for example, in the past year, 5,282 decisions for 4,011 individuals who were incapable of making these decisions. They produce valuable work. Their work is continuing and they are an extensive service to those individuals who are mentally incapable and who, for example, need lawyers, which this particular office is able to facilitate.

Lastly, there is victim services. Victim services also has a number of initiatives within the Ministry of the Attorney General. Victim services, for example, has specialized staff in their particular secretariat—specialized in the sense that they know to refer individuals with mental health challenges to the particular services that they need. In addition to that, the secretariat has funded 10 grants relating to mental health or addictions, including, for example, Bridging the Service Gap for Sexual Assault and Mental Illness Survivors and rural strategies for victims of abuse and mental health and addictions.

I did say lastly, but I will end with education, because education is very important. From the Ministry of the Attorney General, there are a number of education initiatives. We run a specific mental health course every year for one week. That is an all-comprehensive course that brings in experts—psychiatrists, legal experts, members of the board, mental health professionals. We go from A to Z. We don't just look at the Criminal Code, we look at the particular disorders, so I know as a crown counsel: What are the indicia of risk for a person with mood disorder? What are the indicia of risk for a pedophile when I deal with him at the Ontario Review Board?

We also have an introductory course for new crowns that covers the Criminal Code in relation to mental health. I should say that there is an aboriginal justice course, and in addition to that, the office of the public guardian has training, as does Ontario victim services. Finally, the court services division, in relation to their accessibility plan, has specialized training and resources for court staff and justice sector partners who serve persons with mental health and other disabilities. That is an ongoing training process that'll take place within the next year.

Let me end by saying this: There are three things that are very important in relation to criminal court. One is a timely and informed assessment. We, as crown counsel, have to be able to make decisions in relation to risk, as does the court.

Second of all, we need informed protocols and networks to make sure the right persons are in the jurisdictions. I used to think, when I came on this position in late October, that there was one shoe that fits all. I don't think that anymore. I think, depending on the jurisdiction and the size of the jurisdiction, you can implement protocols to make sure that everyone is working together, because with respect to mental health and addictions, it's very important that we share information and everybody works together.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Flanagan. That was an information-filled half-hour; lots of information there for the committee to digest. Unfortunately we have no time for questions, but I did want to thank you for making full use of your half-hour. You can take a breath now. Thank you very much for attending.

GERSTEIN CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our next speaker now is from the Gerstein Centre, and it's Paul Quinn, executive director, if Mr. Quinn would like to come forward.

Mr. Paul Quinn: I brought some people who have been working with me for the past few years.

The Chair (Mr. Kevin Daniel Flynn): No problem at all. Take a seat.

I just noticed we've got a Flanagan, a Quinn, and a Flynn in the chair. There's going to be a fight here somewhere, right?

Mr. Paul Quinn: Hopefully so.

The Chair (Mr. Kevin Daniel Flynn): If you'd like to introduce yourself and perhaps introduce your colleagues for Hansard, so we can get that on the record, and you have 30 minutes to use any way you see fit. Welcome to the committee.

Mr. Paul Quinn: Hopefully we can have some questions, some interaction. That would be great.

I'm Paul Quinn, executive director of the Gerstein Centre, which has been around since 1990. It's a Ministry of Health-funded program. With me is Susan Davis, who's the coordinator of our mental health and justice program and partnership program; Nicki Casseres, who's the coordinator of our training and education and volunteer program; and last but definitely not least, Michael Creek, who is co-chair of the board of directors. He runs the Voices from the Street program, which is a consumer survivor group that works with people who have experienced poverty and homelessness.

I thought what we'd do is just go through what the Gerstein Centre does for you, and each of us will do a little bit of a piece of that and then talk about some of what we think are important things for the community to look at.

The Gerstein Centre is a non-medical crisis intervention centre in downtown Toronto. We've been operating since February 1990, and we have three primary pieces to the service in our original site, which is on

Charles Street. That is: phone access 24 hours a day, seven days a week for anyone who's experienced a mental health crisis of some kind, including whether they think it might not be a mental health crisis. We get 50 to 70 phone calls per 24 hours.

The second piece of the service is a mobile team that actually will go out on-site to meet the individual wherever they are to try and help resolve the crisis. They're always looking for practical, concrete kinds of solutions to whatever situation they're in in an attempt to make sure the crisis doesn't get worse, or helping them develop the skills so that it doesn't happen again.

We also have a 10-bed house on Charles Street, a large Victorian house that's in the middle of, now, a bunch of condos, but it's sort of just sitting there all by itself. It's been invaluable in allowing people a short stay of three to seven days where they can sort through how they got into the crisis in the first place, what kinds of things they might be able to do to prevent it from happening again, and for the staff to have an opportunity to make the connections for the individual so that they don't get into crisis again and that they have the supports in the community. It could be case management; it could be financial; it could be looking at housing alternatives.

In downtown Toronto, about 30% of the people we see at the Charles Street site are homeless or living in poor housing, hostels or boarding homes. That's one of the critical issues for people: trying to find them decent housing that they can maintain.

1640

I think I'll get Susan to talk a bit about our new program, the mental health and justice beds on Bloor Street, which she can describe. She's the coordinator of that program and has worked on that for the last two years.

Ms. Susan Davis: First, it's called Gerstein on Bloor, and it actually houses two programs at that one site. One is the female crisis beds which are aimed at women who are experiencing a mental health crisis and are currently homeless. We have five beds on a female-only floor within that house.

We also have the mental health and justice short-term residential crisis beds located at that site. That's for the downtown area; it's part of a larger network of beds. I think there are 34 beds across Toronto, some in Etobicoke, some in North York, Scarborough and then downtown. We have the nine downtown mental health and justice beds located at Gerstein on Bloor.

Those are for individuals who may be dealing with a mental health issue or a mental health crisis and are having current involvement with the criminal justice system. Mr. Flanagan was talking a little bit about the diversion programs through the courts. Many of the folks we would have coming into our site may come through the courts. They may also come from discharge out of a correctional facility. They may be involved with probation, or they may just be in the presence of police.

Again, the beauty of that program is this sort of cross-sector co-operation that's really put in play to try and make sure that when the individuals are coming back to the community , once they've had the experience in the institutional setting—whether it be a courtroom, a correctional facility or even perhaps a hospital, if fitness is an issue—there are in fact supports in the community for them to actually get the resources they need so as not to end up in crisis or back in the hospital or back in the court system.

Those are the 14 beds that exist over at Gerstein on Bloor. We don't have the other aspects; the crisis team we utilize through the original site. What we do is short-term case management with people, connecting them up to resources so that they are supported as they leave us, hopefully within 30 days, although we're finding a really hard time getting people connected up within 30 days because community resources are limited and 30 days is a quick turnaround to try and get somebody housed.

Mr. Paul Quinn: Nicki will speak on the—

Ms. Nicki Casseres: I got lit up, so it's my turn.

The other component, because we are an organization that promotes early intervention, is a lot of outreach. We also do a lot of education in crisis intervention, suicide prevention and mental health awareness. Part of what is important to us is that people who are working with people with mental health issues are aware of our service, because the earlier we can get to that person who is in crisis, the less intrusive the intervention is and the more options that person is going to have.

We do training with the TTC, with the police, with community-based organizations, with hospitals. We've been across the province, across the city to Brampton, working with people with autism, children who have mental health issues, teaching people about not only Gerstein Centre but other crisis services within their community and that it's important that people access those services early on in their crisis, because we feel that is key to our success. People phone us up early on and we can do a lot over the phone with that person.

The other component that we have which is very important is two training positions. We have one training position for someone who is new to this country and has worked in mental health in their country of origin but hasn't been able to gain employment here because we don't recognize their work experience or their educational background. We provide a full salary; we train them, get them familiar with our system and how it works. Most people who have gone through that program are now working in mental health, and some of them were physicians or doctors who are now physicians or doctors doing the things that they were originally doing in their country of origin.

The other training that we have is for someone who has a mental health issue and because of that mental health issue has not been able to obtain employment because of barriers, because of the nature of having a mental health issue. Maybe they have part of a degree or periods of time of unemployment, but they show potential to be able to work in the field of mental health.

Again, it's a year-long training; it's a full salary with holiday and benefits. Everyone who has gone through

that program and has completed that program is now working in the field of mental health. We just hired someone recently. We had over 200 applications; we interviewed 20 people for the one position. Most people who come there come with a lot of hope and dreams that they will be able to then begin to work. I think one of the things we're always looking for is to create opportunities for more training for people who have mental health issues, because one of the things that happens is that you get this illness and people tell you that you can't dream anymore, that you can't have a career, that you're stuck with this illness, and so we always look for those opportunities.

Michael's going to talk about one of those programs that we have worked on that has created opportunities for people, Voices from the Street. The idea of that program is that we get people who have experienced homelessness or mental health issues and we train them to go back to their communities and become leaders, and to come and speak and advocate on behalf of their own selves to change the system. Some of them will do it while coming to speak here today, or some of them will go back to their communities and talk to the people in their community, other people who have mental health issues or doctors or professionals, and try to make changes in that system.

I'm going to pass it over to Mike.

The Chair (Mr. Kevin Daniel Flynn): Okay. Before you start, if you could just introduce yourself again. I'm not sure if they caught it the first time on Hansard.

Mr. Michael Creek: Sure. My name is Michael Creek and I'm the coordinator of Voices from the Street. I'm also a graduate of Voices from the Street, and that is one of the reasons why I'm here today to speak to you.

In 2005, the Gerstein Centre, in partnership with the Ontario Council of Alternative Businesses and the Parkdale Activity-Recreation Centre, developed a pilot project funded by the city of Toronto to train 12 individuals, who Nicki has mentioned, who are either homeless or have experienced mental illness. The project is built on the premise that people who have been homeless or have gone through mental illness are vital members of the community and deserve the opportunity and chances to make changes and to change the public perceptions and attitudes towards those who experience mental illness. Usually I don't speak a lot off the cuff, but I'm going to speak off the cuff and not from written notes today because it's an area that's very near and dear to my heart.

In 2007, I was at the very bottom of the pit, living in poverty and having 30 years of being a psychiatric consumer/survivor, and I came across a poster that talked about Voices from the Street. Often we see or hear about opportunities or chances for people to get back into society, to reintegrate ourselves to become productive again. Often these things are just resumé writing and they often are dead ends, so I didn't pay much attention to it, but I ended up applying and I was accepted. From that day, my life has completely changed around. That initiative that came about for giving people that opportunity has completely changed my life. Two years ago, as I said, I was living in poverty. Last weekend I was out looking at maybe purchasing a condominium. This is the type of programming that is so innovative that I'd like every person to have that opportunity to be where I am today. Those opportunities and chances for people are too far between—people just don't get those opportunities.

One of the things that is important also is that other people I have taken the course with and other people with whom I've been there through their training process—there's a tremendous change in people who have suffered very serious mental illnesses. All of a sudden people are coming in after a couple of weeks and they look healthier; they're taking less medication. People are making less visits to see their psychiatrist, less hospital visits. So Voices from the Street has made a tremendous difference. We have many people who have gone on now either to part-time employment, full-time employment, or on to volunteering to start rebuilding their lives.

1650

So when we think about how $1 can really make a difference for people when it's outside of the sort of medical block—we often think that all that people who are psychiatric consumers/survivors need is a pill or maybe some counselling. It's much more than that. It's these types of opportunities and chances that really make changes in people's lives. This hasn't just happened to me; the exciting part now is that I get to see this opportunity and chances for many other people. I just can't tell you how much joy that gives me. It should give all of us joy that people are allowed an opportunity, a chance to rebuild and change their lives.

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

Mr. Paul Quinn: In thinking about coming here today, we looked at the services we provide in helping people getting through a crisis. We looked at some of the things that we see as key as a community organization that works with hospitals, hostels, detox centres, ambulance, police—sort of everybody in the system, we get referrals from or we give referrals to. So we see a lot of different things that come through it.

For us in downtown Toronto, one of the things that we really think needs to be focused on is the determinants of health and wellness. I'll just read off what we've done, because several people put the work in on this: Investment in the wider social and economic base will contribute to lifelong health and wellness. For example, an increase in income support programs, investment in safe and affordable housing, primary health care, education supports and job creation are critical in an economically sustainable health system and to individual mental health recovery.

I think the other thing is access to community-based services. Smaller services sometimes can be more accessible and react quicker to changes in the client group than larger ones. Larger ones are good in terms of some of the one-stop shopping kind of look at things where you can get a lot of services in one place. But sometimes specific kinds of services that are geared to one particular kind of population are really good. I think consumer/survivor initiatives are critical to support places like A-Way, Fresh

Start and OCAB, where people who have been through the system themselves, who experienced that themselves, are actually running programs, operating them and providing help and support and a community for people who have been diagnosed with a mental illness.

Ms. Susan Davis: I wonder if I could just add to the point around access to community-based services. We've heard many reports that have said that we need to improve services offered in the community. Mr. Flanagan was talking about a family coming to court and saying, "Thank goodness we're here, because now maybe our son will get some help." I think we really need to consider access points for individuals into the mental health system. They need to be multiple and they need to be accessible. Hospitals are an access point, and unfortunately our criminal justice system is an access point at this stage in terms of how we're set up, but greater resources put into the community with accessible resources could really make a difference for people in their lives in terms of being able to access services.

Another plug in terms of those services being coordinated across sectors and how important that is, because then people can access at one point and recognize that they may have needs in other areas and still be able to flow through the system and get those needs met from that single access point—so instead of thinking about a single access point as a well-coordinated system, thinking about multiple access points that then coordinate together as being a really effective way to improve accessibility across all communities, whether in a large centre like Toronto or other centres which are smaller than that.

Mr. Paul Quinn: I think you can see that in the mental health and justice programs that got funded. A large number of different organizations are working together: CMHA, COTA, Reconnect, Gerstein Centre, CRCT. A number of programs that are funded by the Ministry of Health under the mental health and justice umbrella work together to make sure that an individual can get service all the way through, that once they get out of jail, they have a place to stay; that's through Safe Beds. Once they get through Safe Beds we'll find housing, and there were I think about 500 units that were funded across the city. Those units filled up in about six months. So there's a huge need for housing, decent, affordable housing for people.

That was for a very specific population, not for the whole group of people with mental health issues, but for the people who were coming out of jails or in contact with the justice system; so 500 units filled up quickly. So that needs to happen.

Working on access issues within that network was really valuable to all of us, I think. We got to look at things through a different lens and work together, in spite of some slight differences in philosophy, to make sure that the client got what they needed.

Ms. Susan Davis: And then the other thing that came out of that—

The Chair (Mr. Kevin Daniel Flynn): Susan, could we get your last name again? I'm not sure we got it the first time.

Ms. Susan Davis: Davis.

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

Ms. Susan Davis: The other thing that came out of that, as well, is sort of the recognition of the gaps that emerge. They're cross-sector. Whether you're in the criminal justice system, whether you're dealing with youth, whether you're in the developmental sector or in mental health, a lot of these issues that, through good service coordination, emerge are very common, housing obviously being one of the issues. One of the other issues that's emerged very strongly is access to primary health care, psychiatric assessment and ongoing support in the community, not necessarily through an institutional setting. But both are needed. I think you've probably already heard from a number of sources that that's a major issue for us here in Toronto and, I think, across Ontario.

One of the other things, though, that I think is really important and that hadn't occurred in that particular instance was the opportunity to hear from consumer/survivors, individuals who have lived experience of our systems and as well, lived experiences of mental health issues. Being able to hear their voices in our efforts to doing this service coordination is a really important piece, and I think hearing from Mike today really spoke to that.

Mr. Paul Quinn: We thought we'd leave you some time for questions. We have a couple of minutes.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. That's good; you've left about 10 minutes. Sylvia, do you want to take three minutes, and then Michael?

Ms. Sylvia Jones: First of all, thank you for your presentation and for giving us some time to ask these questions.

Paul, you mentioned that in your Charles Street site, the stays are three to seven days?

Mr. Paul Quinn: Yes.

Ms. Sylvia Jones: That seems incredibly quick. Tell me how you can do that.

Mr. Paul Quinn: It is incredibly quick, depending on the issues that the person has when they come in. If housing is the primary issue, then for sure that's way too short. We do have a partnership with the Salvation Army Maxwell Meighen Centre, funded through the Ministry of Health, for their primary support unit for men, so there's a 30-day stay there. They have 10 beds where people can stay for an initial 30 days after they've stayed with us, in order to make the housing connection.

Often the three to seven days is enough time to get over an immediate crisis and make some plans towards what's going to happen after that. The follow-up on that needs to be done by case management, needs to be done by a number of other services which we don't have connected with us necessarily, but which we'll try to make a connection with in the community. Often a one-day stay is enough for some people. If the situation is really bad, if they can get away from it for a night and then sort through what the next step might be, then they can get through it. Our average length of stay is about four and a half days.

Ms. Sylvia Jones: Okay, thank you. The other question that I had related to funding. You mentioned that it was the Ministry of Health that funded you?

Mr. Paul Quinn: Yes.

Ms. Sylvia Jones: Has that now gone through the LHINs? Are you dealing with the LHINs?

Mr. Paul Quinn: Yes, we're now with the LHINs.

Ms. Sylvia Jones: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sylvia. Michael, any questions?

Mr. Michael Prue: Sure, a couple. You mentioned, and I think with some sadness, that one of the major ways that people get access is through the courts. How many would be able to just walk in off the street and how many are referred by the courts?

Ms. Susan Davis: In terms of the Charles Street site, it's all self-referral. I think that's a really important factor to the service, that people can self-refer. It breaks down the barriers to being able to reach out for service. That's what Nicki was talking about: early intervention and being able to respond early on, because people have a sense that things are going askew earlier than maybe when they're going to take the step of going to a hospital or taking something else. If they can easily access support, then that's going to be really important for them.

The mental health and justice beds specifically are all accessed through criminal justice priority referral sources. In some ways it's a problem, because there are lots of people who do fit the criteria who can't access the service because they're not coming through that resource, but I think the idea being that we knew that the demand for the program was going to be huge, and it was. The minute we opened, we were full—not ongoing, but the beds filled quickly. So we really wanted people were currently involved.

1700

There are other aspects to the network, including crisis prevention, where people can access it if they are not currently involved but at risk for becoming involved. That's largely delivered through a case management model, except for downtown, where there's a drop-in model.

Mr. Michael Prue: About a year ago, I had maybe a dozen or 15 people come to my constituency office, parents of teenagers, 17 or 18 years old, who were contemplating suicide and then doing a number of really bad things to themselves. There was really nowhere for them to go. Some of them had to be sent to the east coast; some were sent to the United States. The parents told me that they sometimes wished that their children had been involved with the law, because they could have easily been dealt with, but they weren't being dealt with. Is that same circumstance still existing?

Ms. Susan Davis: Despite the fact that there are excellent resources in our courtrooms—and I think Mr. Flanagan outlined some really great resources that you heard about—by no means are they all-comprehensive and perfect. There are a lot of gaps that still exist. We had a defence lawyer speaking at our last human services and justice coordinating conference, and he talked about that being a misconception, that going into the court system would then somehow get you the access you need. He talked a lot about working with families who were under that impression and then became very disappointed when that wasn't what happened. The reason I speak about it with disappointment is, it is certainly not an access point that is positive for people, whether or not it's effective, which, many times, it isn't. But on top of that, there is the added stigma, and even just a criminal record that can come with that, when there should have been an access point that didn't involve any of that.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Susan. We're going to move on to the government now. Any questions, Maria?

Mrs. Maria Van Bommel: I guess we'll start by saying that very often we hear things about economy of scale, yet you talk about the fact that because you're a smaller service, you're able to make adjustments quickly. I'm just trying to understand how. I know that in the world now, where we all try to be big and everybody seems to think that that's the way to go, and there are economies of scale and efficiencies, you're saying that because you're smaller, you can make adjustments quicker.

Mr. Paul Quinn: I think that when you get to something that's larger, you have a bigger bureaucracy, you have more rules around access, and you have more things going on that make it difficult to actually just listen to the person, find out what they want and then move them to that. You have to jump through hoops to get there. A smaller organization is able to see the person and make a decision. Look at places, drop-in centres like PARC or Sound Times. They're smaller organizations, and people come in the front door and they can identify really quickly what they might need. The staff have the autonomy to be able to make those decisions around where they need to get them. They don't have to get approval from a supervisor or run things through some kind of a bureaucratic paper trail. They can—

Mrs. Maria Van Bommel: So the decision-making is actually right at the point of contact?

Mr. Paul Quinn: Yes.

Ms. Susan Davis: That's right.

Mr. Paul Quinn: That's where it's critical, especially if it happens to be—I think if it's for a specific population, like for an aboriginal population or for other areas—current disorders—those kinds of things where if you really need to make decisions fairly quickly when you get an individual, it's good to have it small enough that it can react quickly.

Mrs. Maria Van Bommel: Thank you.

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

Ms. Susan Davis: We brought a package that we'll leave with you so that you can have some of that information.

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

Mr. Paul Quinn: You're all invited to come visit the Gerstein Centre any time you want a tour.

The Chair (Mr. Kevin Daniel Flynn): Okay, we might just take you up on that.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today, from the Ministry of Health and Long-Term Care, is Ron Sapsford, deputy minister. If you'd like to come forward, Mr. Sapsford. You've got 30 minutes. Thank you for attending today. If you have any colleagues with you, if you would introduce them in your opening remarks for Hansard, that would be appreciated. The floor is yours.

Mr. Ron Sapsford: Thank you, Mr. Chair and members of the committee. On my right is Susan Paetkau and on my left is Anne Bowlby, both members of the ministry staff who are with me here today.

Thank you for the invitation. I won't take too much of your time talking. I've assumed this may be the first time the ministry is in front of you, so what we've tried to do in preparing for today's presentation is to give you a high-level overview from our perspective of the mental health system—some of the services. In the binders that we've left for the committee, we've tried to give you a bird's-eye view of some of the components and a little more detailed information on different aspects of the health care system. The information you have, of course, is backed up in the ministry with large amounts of detailed information. As you go through your exploration of the topic, if there is additional information, numeric or otherwise, that you might require for your deliberations, the ministry certainly stands ready to help you with that and to provide additional information.

Thank you for this opportunity to outline the province's mental health and addictions system. The binder that you've got will provide information on mental health and addictions reflecting the committee's terms of reference.

I'd like to start by briefly outlining the health system's structure and the roles and responsibilities of the various players in the context of the mental health and addictions system.

The Ministry of Health and Long-Term Care is responsible for the development and coordination of policy and program standards relating to the province's health system. The province's 14 local health integration networks are responsible for planning, funding and integrating local health service providers. The LHINs establish accountability agreements with community mental health and addictions agencies and are responsible for allocating funding to these organizations. The boards of directors of the individual provider organizations—the hospitals, community mental health and addictions agencies—are responsible for the leadership and direction of their own organizations in the provision of service.

We all recognize that mental health and addictions issues have a huge impact on society. One in five Ontarians will experience a mental illness in their lifetime. About 10% of people in Ontario are dependent on substances, including alcohol. About 250,000 people have moderate to severe gambling problems in this province. One in seven hospital days involves people with a diagnosis of mental illness. The economic cost of mental health and addictions for Ontario is estimated to be in the area of $34 billion per year. About half of those with gambling concerns also have issues with substance abuse or psychological functioning.

Mental health and addictions are a serious issue, and there are challenges in meeting the demand and ensuring coordinated care for people with addictions and mental illness, particularly for those with co-occurring mental health and substance abuse disorders at the same time.

In 2008, the Ministry of Health and Long-Term Care spent $2.6 billion on services for people with mental health and addiction problems. This would include community, hospital and physician services, as well as the cost of drugs. This number is broken down by category in the information provided to you to give you a sense of the distribution of expenditures across the full range of mental health and addiction services. But to give you an idea of what some of the funding went for, over 71,000 clients received substance abuse services, almost 5,700 clients received problem gambling service treatment, and over 642,000 clients used community mental health services in the province.

The community mental health budget rose by over $200 million, or 54%, between 2004-05 and 2008-09. The ministry has provided $29.1 million for stabilization and improvements to the community mental health system, a 7% increase in base funding since 2004-05.

1710

Currently, the government provides $679 million to community mental health agencies for a wide variety of services and supportive services, including:

—over 300 community mental health programs. These services allow people to live full lives in the community with the supports that they need to be independent.

—assertive community treatment teams. These are 79 self-contained, multidisciplinary teams providing necessary services to people with serious mental illnesses on an ongoing basis. This has meant a cost avoidance equivalent of about $120 million per year, keeping people with serious mental illnesses out of hospitals.

—crisis intervention, which is offered by telephone or mobile team;

—intensive case management;

—early intervention in psychosis;

—vocational programs;

—consumer/survivor initiatives; and

—supportive housing.

This represents the full range of services provided in community mental health treatment.

Most people with mental illness or addictions use their family doctor as a primary service provider. 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 as needed. In fact, the recent agreement with the Ontario Medical Association provides enhanced payments to physicians for meeting minimum targets across a core set of office-based services which include mental health services. And family physicians groups that demonstrate a focus on priorities, which include mental health, will receive salary support for an additional 500 registered nurses. Of that allocation, 150 are already in place.

In addition to the provision of community and primary care services, people with symptoms of illnesses such as bipolar disorder or schizophrenia usually turn to hospitals for care.

In terms of infrastructure to support the whole mental health system, there have been a number of innovations in the past several years. The ministry funds one such agency, ConnexOntario. In the early 1990s, the ministry began with a Drug and Alcohol Registry of Treatment, which is referred to as DART. This registry was started so that people with problematic substance use issues could find services in the province.

In the late 1990s, we began funding the Ontario problem gambling helpline in recognition that people with gambling problems need a place for information and referral. In 2006, as an extension, we began funding Mental Health Service Information Ontario, which provides referral information to citizens on request.

For addictions specifically, the ministry currently allocates about $123 million for 150 substance abuse treatment programs across the province. Treatment programs in this area include withdrawal management and community counselling, as well as residential treatment and support. Also, an additional $10 million will be allocated to substance abuse programs starting in 2009-10.

In the area of drug and alcohol treatment, the ministry also funds the information system, DATIS, which is a client utilization system that is used for planning purposes. When the province began funding programs for problem gamblers, problem gambling service utilization was included as part of this information system.

In the area of problem gambling, the following resources are also available: 49 community treatment programs across the province, as well as residential treatment services in four communities; extensive training for counsellors and allied professionals; a helpline; and funding of a research centre into problem gambling.

As you're probably aware, problem gambling funding is through gross slot machine revenues at charity casino and racetrack operations. The amount of funding available is based on a 2% levy, or a 2% proportion, of those revenues.

The ministry has also recently increased the capacity of youth residential addictions treatment services through the addition of 20 additional beds, 15 of them English and five French, in Ottawa. We've also started to fund additional beds—16 youth beds—in the Waterloo Wellington LHIN in addition to an existing program. These investments respond to the need for additional capacity for youth who require residential addictions treatment and reduce the need for out-of-country referral to US services.

Finally, I'd like to talk about the minister's decision to form an advisory group for mental health and addictions. This advisory group was started in the past year and is in the process of assisting the ministry in developing a 10-year strategy for mental health and addictions services. The strategy will include a review of specialized community and institutional services, the health care system and broader community services as well as mental health issues in the workplace.

The group has met on a number of occasions and has selected five main topics to frame the discussion: the design of the system, healthy communities, consumer partnerships, early identification and early intervention and, finally, building capacity and competencies in the area of mental health human resources.

The minister's advisory group is providing an opportunity to raise the profile of mental health and addiction issues, to identify opportunities to leverage existing resources and to ensure that the concerns and needs of people and families living with mental illness and addiction are addressed. The first interim report is posted on the ministry's website and is available in the binders we have provided for you today.

As part of the development of the strategy, the Ministry of Health and Long-Term Care is working with other provincial ministries to meet the needs of varied client groups. A list of these ministries that we're working with is included in your binder as well. Ministry representatives are meeting in order to determine policy and program direction so that a comprehensive, government-wide response to mental health and addictions issues can be developed co-operatively among ministries.

We all recognize the need to enhance mental health and addiction services to further develop a comprehensive system that puts the person first, is barrier-free and easier to access and navigate.

Once again, I thank the committee for this invitation, for the opportunity to speak to you today. I'd be pleased to answer any of your questions or to receive any comments or suggestions about further information that you might require. Thank you, Chair.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Mr. Sapsford. You've left quite a bit of time, about 18 minutes, so we'll take six minutes each, starting with Michael.

Mr. Michael Prue: The first question I happened to ask the last group, but I think this is the more appropriate one: You've written on page 10, "These investments respond to need for additional capacity for youth who require residential addictions treatment and reduce the need for out-of-country prior approval for these services." There were a lot of children going out of country and out of province; some went to the east coast. How many are out-of-country today?

Mr. Ron Sapsford: How many are out-of-country today?

Mr. Michael Prue: Yes. How many are we funding?

Mr. Ron Sapsford: I could find that out for you, specifically.

Mr. Michael Prue: Are we still funding out of country or do we have enough here now?

Mr. Ron Sapsford: No. There are still patients who receive care out of country—yes.

Mr. Michael Prue: How many more beds, then, do we need to make sure that all of our children are looked after in their country, in their province, where they live?

Mr. Ron Sapsford: People make choices about going out of country for specific services. We're endeavouring to supplement the capacity for the kind of care that is included as part of our treatment regime in Ontario. There have been some gaps in that capacity, as we indicated. The additional resources have improved the situation overall.

Mr. Michael Prue: What is the waiting time? Part of the complaints I was getting was that the waiting time might be 12, 15, 16 weeks. Parents were apoplectic that their child might be dead by that point and they ran off to the States or wherever. What is the waiting time today?

Mr. Ron Sapsford: I can get that information for you and return it to the committee.

Mr. Michael Prue: Okay. The second set of questions I have relates to supportive housing. You've included that on page 6 as one of the things that needs to be done: "housing and supports for people with serious mental illness and addiction problems."

A number of years ago, there was a need identified, I believe, for some 6,000 such units in Ontario; there may be more identified today. How many have been built?

Mr. Ron Sapsford: Since that date? We'll provide the information. I can't answer you.

1720

Mr. Michael Prue: How many people are living in supportive housing today?

Mr. Ron Sapsford: You can answer that.

The Chair (Mr. Kevin Daniel Flynn): Could you identify yourself?

Ms. Anne Bowlby:I'm Anne Bowlby.

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

Ms. Anne Bowlby: There is a fact sheet at the back on supportive housing, and I believe—thank you. I don't have my glasses on. I'll have to hold this out a little bit.

Mr. Michael Prue: You could borrow mine, if you need them.

Ms. Anne Bowlby: Actually, they're in my purse.

We do have 8,500 units of supportive housing for people with serious mental illness across the province. That's a mix of dedicated as well as the rent supplement.

What we've been doing in the last few years, actually—I can't even tell you how many years it is—instead of building, we've been offering rent supplements. It allows people to live in a number of different community places. The mental health agencies are the ones that provide the supports, whether it's case management, connection with an ACT team, or whatever the supports are that the person needs in order to live independently,

Mr. Michael Prue: Okay. So the person would live in an apartment, in somebody's house somewhere, and the team would come to them.

Ms. Anne Bowlby: Yes.

Mr. Michael Prue: Is that as efficient as having a unit of, say, 12 or 15 people living in a building with the support on-site?

Ms. Anne Bowlby: I think that for people with mental health, that's probably the most independent way that we could offer it. I don't know if you're going to be hearing from the Dream Team here, but certainly, they have some pretty strong views on how housing should be offered, and that there should be choices for people.

Mr. Michael Prue: That's fair enough. I listen to them a lot—a great group.

Ms. Anne Bowlby: They are.

Mr. Michael Prue: In terms of the supportive housing, has there been any money identified in this year's budget for the purchase of additional supportive housing? Or are you going to continue to rely on supplement?

Ms. Anne Bowlby: Not for mental health. There is some money identified for supportive housing for people with problematic substance use issues, and hopefully, that will be starting this year.

Mr. Michael Prue: In terms of the services that are given to survivors or people with mental health issues, is it still the goal of the health team to provide job counselling and help people to get a job? It seems to me that once you put a roof over their head and provide an opportunity to get a job, many of the difficulties seem to disappear. We had Mr. Creek give a very moving story earlier today. Is that the experience? And what success have you had with that?

Ms. Anne Bowlby: There are a number of alternative businesses that we have funded, and that's something that we can get you some more information on. There are also vocational counsellors within ACT teams, within a number of the agencies, who help people get regular jobs.

One of the challenges for people with serious mental illness is that they often can't work a 40-hour week. The alternative businesses are a fabulous alternative for them, because they can work the number of hours that they're able to, and continue to collect their disability pensions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Anne. Thank you, Michael. From the government—Jeff?

Mr. Jeff Leal: I have a question for the deputy minister. If I could just go back, Mr. Sapsford, to your presentation, on page 7, I want to ask a couple of questions about family health teams. There were about 150 of them implemented, I think, across the province of Ontario during the last mandate of the government. How many of those now would have mental health counsellors attached to them? Secondly, as we go through fiscal 2009-10, what additional resources have been identified in your ministry's budget to add additional staff into family health teams, particularly mental health counsellors?

Mr. Ron Sapsford: As to how many current teams have them, I'll find that out for you. Each of the teams, as

they're created, is put forward on the basis of the needs in a specific community—

Mr. Jeff Leal: Right.

Mr. Ron Sapsford: And so, depending on where the family health team is located, mental health counselling may not have been part of their original request, but where that was identified as a need in a particular community, then the resources were put forward. But we can find out the specifics of how many numbers.

I mentioned in the OMA agreement, particularly, one of the things we've been trying to do, in return for increasing fees and giving economic consideration to the agreement, is begin to identify more clearly what the expectations for service provision are. The ministry views mental health as one of those core primary care services that should be widely available so that access to mental health services at the primary level is provided in many places. We have put some premiums forward in that agreement where physicians, either solo or in group, wherever they practise, are prepared to include primary mental health counselling as part of their general service delivery.

As well, in the family health teams specifically, we're making available, I think I said, about another 500 nurses, where those groups of physicians agree to provide these basic core services to supplement the team. So with an additional nurse, of course, they can provide more clinical time doing the kind of counselling that we want to see.

As far as the net number of family health teams themselves, the plan over the next two years is for an additional 50 to be found and funded.

Mr. Jeff Leal: Okay. I'd appreciate if you could get back to me with that. Thanks.

The Chair (Mr. Kevin Daniel Flynn): Helena.

Ms. Helena Jaczek: Mr. Sapsford, you've been able to tell us how many clients in various categories receive service. Does the ministry have any way of following these particular clients? I'm thinking in terms of health outcomes. I'm thinking of potential success, potential recidivism; in other words, people perhaps accessing a particular service and how many are able to lead mentally well lives subsequently. Do you have any figures in terms of progress through the system and health outcomes?

Mr. Ron Sapsford: Not in the kind of systematic way your question implies. There is isolated information. When you say the "outcome of care," in the area of mental health services, particularly as you get into the serious mental illnesses, what is a positive outcome is a matter of debate in many cases. So it's quite unlike what we do for public hospitals, for general hospital care: How many people went through for an appendicitis, had an appendectomy and came out basically cured of that particular acute care incident? It's relatively easy to keep track of it, and we do.

In many acute care services, the outcome measures are much more easily defined and results are easily collected. It's not the same thing in mental health. In fact, some of the research that we're funding right now is on these very points: How do you measure successful outcome, and how do you track people through the course of a disease which sometimes can last 10 or 15 years but not be constant? There are times when the disease flares and then stabilizes and is managed, and someone can then go on for two or three years with reasonable support, and then the disease, in an acute sense, flares again—

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Sapsford. We're going to have to move on to Sylvia now.

Ms. Sylvia Jones: Just a follow-up question, actually. You talk about the clients you have been able to serve. I am quite interested in whether you are keeping stats on the waiting lists and the length of the waiting lists. Those are the people that, obviously, I have to deal with. Do you keep those stats?

1730

Mr. Ron Sapsford: No; in the kind of consistent, provincial way, service by service, we don't have the information systems to do that. In some, we would have waiting information for things like acute hospital admission in certain categories—

Ms. Sylvia Jones: Would the LHINs have any of that?

Mr. Ron Sapsford: No. If we don't have it, they don't have it. Maybe Anne can help to clarify some of it.

Ms. Anne Bowlby: One of the things we do have, through ConnexOntario—they actually do keep the availability, so we know the wait time for various services for substance abuse and problem gambling.

Ms. Sylvia Jones: By area?

Ms. Anne Bowlby: By area—by individual agency, actually. What we don't have are wait lists. We've talked about that for a number of years, and it's just too complicated because people sign up for four and five agencies, so we don't know what that actually means. But the wait time has given us some idea in terms of access and availability. We can get you those two numbers.

Ms. Sylvia Jones: Yes, I think the committee would find that helpful, actually. Thank you.

It sort of ties into the availability/access again, and it references what Jeff was raising with family health networks and family health teams. There are a number that I've spoken to that have it as part of their agreement but have been unable to access the staff. If you're providing that information, I would be interested in seeing just how many agreements are out there where they have been unable to find the health care professionals.

Mr. Ron Sapsford: In terms of their ability to actually find people?

Ms. Sylvia Jones: Yes.

Mr. Ron Sapsford: The hiring piece.

Ms. Sylvia Jones: Because they all see the value in having it in their agreement and having it as part of their network or their team, and then they post the job and there's no one available.

Mr. Ron Sapsford: Fair enough.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your attendance today. The information that's been requested, you'll be forwarding on to the committee clerk?

Mr. Ron Sapsford: To the clerk, yes.

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

MINISTRY OF HEALTH PROMOTION

The Chair (Mr. Kevin Daniel Flynn): Our next and final presenters for the afternoon are from the Ministry of Health Promotion. We've got Mary Beth Valentine, Cynthia Morton and Jean Lam, if you'd like to all come forward.

Ms. Cynthia Morton: Good afternoon. How are you?

The Chair (Mr. Kevin Daniel Flynn): Very good, thank you. If you'd like to introduce yourself and the people you have with you, and you've got 30 minutes, like everybody else. You can use that any way you like. If you would leave some time at the end for questions, the committee appears to enjoy that.

Ms. Cynthia Morton: Absolutely. My name is Cynthia Morton. I'm the Deputy Minister of Health Promotion. I have with me today my two assistant deputy ministers: Jean Lam, to my left, and Mary Beth Valentine, to my right. Jean will assist with any questions around programs and the substance of programs and what we're achieving there. Mary Beth focuses on strategic policy. So I'm surrounded by lots of good information sources for you here.

I do have prepared remarks, which I will go through quickly, and I believe we've provided you with a deck. Hopefully my remarks will reflect what you're also reviewing in the deck as we go along.

I first just want to thank and acknowledge the work of this committee and the effort of all political parties who are represented on this committee that has led, I think, to significant changes in mental health care and treatment over the last 25 years in this province. As a small ministry focused on health promotion, I think we're also looking forward to what could be a very exciting opportunity for renewed effort and focus on the mental health agenda in this province, and we're glad to be here today to share with you our work.

If I can, I'd like to take a few moments to describe to you the mandate of the ministry. We're a new ministry, a small ministry, and a relatively innovative ministry within government. We reflect, perhaps, what we could call a shift in the perspectives of the health care community and the caring community generally that started in the World Health Organization's meetings in 1986 in Ottawa and culminated in what was called the Ottawa Charter for Health Promotion. The Ottawa charter set out a vision for achieving an individual and community's physical, mental and social well-being. The charter emphasized that to really ensure and to achieve that well-being of a community and an individual, it required an intersectoral approach to the definition of what health meant; that it went well beyond a health system to provide the kind of services and supports to a community and an individual that they would need to achieve that real state of wellness and well-being.

I think earlier today there was a reference made to the social determinants of health. Within the World Health Organization and, in fact, the mandate of the Ministry of Health Promotion, the social determinants of health are sort of our cornerstone of how we describe our mandate and establish our goals. When the World Health Organization described social determinants of health in the Ottawa charter—which we have a copy of, if you'd like it; it's a very interesting, innovative document. When they described what those social determinants of a community or an individual's health would be, they included fundamental outcomes like peace, shelter, education, food, income, a stable economic system, sustainable resources and both social justice and equity. Only when a community committed to achieving all of those things in an integrated fashion would the well-being and wellness of a community and an individual within it be guaranteed. To the extent that we have a mandate—a modest mandate, as a small ministry—we too have adopted those same goals. We approach our work and our mandate as an innovator and an incubator, and as the entity within government that is here, really, to try and promote that intersectoral integration across ministries and across communities in the province.

We have adopted a population health focus in achieving our work as well, which means that we direct our actions and our resources to those communities where the health status is the poorest, and as a result, the need for innovation and interventions is the greatest. As we adopt new strategies and we build new partnerships, we are paying the greatest attention to the poorest communities in Ontario: to the aboriginal communities on and off reserve, to children and youth in particular, working with our schools and our public health units and, increasingly, within the large ethnic populations where chronic diseases are rampant.

In the context of mental health, we see our responsibility as working across government and across communities to focus on the prevention of the illness and the promotion of healthy activities that make people more resilient, better able and better equipped to deal with issues of isolation, depression and addiction that can often lead to mental illness. We have worked, continue to work and will work more in the future with systems of public health, education, parks and recreation, children and youth services and so on. Our partners are First Nations leaders and community leaders, and we work with many of the NGOs who will probably appear before you during your deliberations. We've adopted the principle that mental wellness, self-esteem and social inclusion must be outcomes of almost every initiative that we fund within the ministry and every relationship that we have.

I'm going to give you some examples of how we reach the most at-risk communities, for want of a better word, in the context of three particular parts of our mandate.

One is the sports and recreation portfolio; another is our work in addictions prevention; the third is the area of supports we provide to the public health system, to families, to young parents and to infants through the public health programs.

In the context of sports and recreation, I think the evidence is pretty clear—and we can certainly provide you with some interesting articles to this effect—that children or youth who may not traditionally excel in school or, say, be members of a family where they live in a supportive home, are the children who we know, if they are allowed an opportunity to participate in sports and physical activity in their communities, can acquire resiliency, leadership and notions of success that other ways of engagement in their community don't allow them. So we have, within our sports and recreation programs, really focused on the inclusion of children who would otherwise be excluded from these opportunities.

1740

In this way, we do know that we are enhancing the connection between physical wellness and mental wellness, and we're trying to ingrain in children as young as possible the connection between the two and the skills that that connection will provide them for a lifelong ability to see themselves as valued and successful, in perhaps non-traditional ways. It also provides them with notions of team, discipline and success that they may not otherwise have.

When we solicit funding proposals for sports and recreation initiatives across the province, we do so with a requirement that children in poverty, children with special needs or disabilities, aboriginal children and newcomers to Canada will receive priority inclusion in this programming for these very reasons.

When these organizations that we fund report back to us on the year-end results, they must advise us on how well they have achieved these goals and what their plans are in the years ahead to continue to reduce those barriers for children, to give them opportunities for physical and mental wellness.

An example of one of those programs is a partnership between York University, the YMCA and the Canadian Mental Health Association that we fund called Minding our Bodies, that you may or may not have heard about. It was recently discussed in the media. It was an opportunity for people with mental illness who are traditionally excluded from team sports to come together and not only enjoy themselves but to acquire physical wellness as well as opportunities for bonding and success that they would otherwise not have.

I want to talk a bit about the services and the relationships that we have with the aboriginal communities on and off reserve.

We know that suicide rates for aboriginal youth, nationally in Canada, are five to seven times higher than for non-aboriginal youth, and for Inuit youth they're 11 times the suicide rate of the non-aboriginal youth.

The ministry is increasing its focus and its relationships with aboriginal communities both on and off reserve, with a clear focus on services to children and youth in terms of the sports and recreation portfolio. We have other services I'll tell you about shortly with respect to addiction and gambling, starting with teens. But for sports and recreation, we adopted a philosophy that we had to approach serving these communities and these children and youth in a way that would be welcomed and would be play.

We have across this province now a program called activators, that is in excess of $2 million both on and off reserve, that provides to children and youth an opportunity to play safely in a well-supported environment. In one community we have an example of an activators program that began as a program for children and youth and now has been expanded to include their parents.

Parents are now coming to participate in a program with their children, as opposed to other nighttime activities they could have chosen. Parents are now realizing that their own physical wellness is something they can improve, as well as their children's, and they have quite explicitly said they would prefer to be there playing baseball with their kids than "perhaps going to the casino"; that's a quote from one of the parents in the community.

It is through these small, innovative, incubative opportunities for change that you can actually start creating best practices for a much more systemic change across communities. One of our goals is to champion best practice, not by telling communities what to do but by funding partnerships so that one community can demonstrate to another community what can make a positive difference. So while we are a small ministry, we very much believe that that incubation and promotion of innovation and best practice can make a very palpable and powerful difference in the highest-risk communities in our province.

I'd like to tell you now a bit about addictions and the work that we're doing in addictions.

I don't think I have to share with any of the members here today the work that the ministry has done on the smoke-free Ontario portfolio. It is, I think, for Ontario as a whole a very good success story. It has its challenges, one of them being young males who continue to just defy us in terms of how to reach them meaningfully. But we are undaunted, and we continue to work with the experts in the field of smoking cessation to try and reach into the area of addictions with young males in particular, but youth generally, in terms of the smoke portfolio. We are very community-focused on that initiative and we work with youth right across this province in very innovative ways to find new ways to reach youth.

Our hope and our intention is that the successes that we're having in the smoke-free agenda with youth are going to be our entree into a larger conversation with youth addictions generally. We're using our youth leaders and our youth experience of the last five years to have now a larger conversation with them around addictions and self-esteem.

We are also tackling the issue of mental health and addictions by integrating the work we're doing in one

portfolio with another. For example, while CAMH has clients walk through the door for one need to be met—a mental health need—we're also funding and partnering with CAMH so that they will offer those same clients an opportunity to start a smoking cessation program under the direct supervision of a physician; and that when those clients go back into the community, they can take with them the supports both of CAMH and access to, for example, our smoker's quit line, so that people will stay in touch with those patients, those clients, as they return to the community. We have those same supports offered in other hospitals across Ontario.

We also, for purposes of addictions and dealing with the consequences of people with addictions—whether that's other chronic diseases or injury prevention—fund these programs in 22 communities across Ontario, called Focus, which again some of you may know about because they're in your communities, or you have written to us very lately hoping that we would continue their funding, which we have. The intent of these community programs is really, one, that they have to at least focus one third of their activities on addiction outreach and prevention for youth, but also that they are, in the year ahead, going to be used as an opportunity to become integrated into a larger mental health strategy. They exist in 22 communities today; we're hoping we could replicate some of their strengths and successes across the province.

I want to give you an example of one of the successes that I think has great potential. It's located in Regent Park and is called the Regent Park Focus Youth Media Arts program. It's using young people's interest in that community in media to promote both healthy lifestyles and give them alternatives to street and gang activities. The Regent Park program provides these youth with opportunities to work either on a newspaper, which is online or in print, or to participate and host a weekly radio talk and music show. The youth themselves have described this program as something they consider as—I know it's hard when you hear an old person say it—a really cool alternative to being part of a gang or the street activities that they see around them.

The Focus program also links these same youths back into the education system through Pathways, which is sort of an alternative program for kids who have left that system. Many of the graduates from this program have returned, and they themselves now are mentoring others in the program. So for a small investment of less than $100,000, we've made a huge difference—I think this program has—in the lives of many kids in a very high-risk neighbourhood. It's an example of one of the successes we want to incubate and share across the province. Without giving you the entire list of the awards that program has won, they've been recognized with an award from the mayor, from the CBC, from Now magazine and from many others for engaging youth in a very innovative model that addresses both violence and addictions in the community.

We are working, as well, in conjunction with the work that Deputy Sapsford has shared with you in terms of the gambling prevention initiatives under way in this province. We do have some provincial initiatives that are based for population access overall, but our primary work, again, is in aboriginal communities, and we have many on- and off-reserve partnerships that we could share with you in more detail if you would like. But for the most part those kinds of activities, including access to community information centres, are training for front-line staff or funding the First Nations to train staff. We fund support groups and we provide educational materials for those support groups.

1750

Finally, I would like to just talk a bit about the work with the public health units that we do. The responsibility and mandate of the ministry is to oversee four mandated programs of public health units in this province. We share that responsibility with the Ministry of Health and Long-Term Care. The ones that we have responsibility for are focused on maternal and early childhood health, for the most part, and we very much believe that it is very important, even as a women is pregnant, that she start to get access to services that can allow her to be screened and assessed for addictions and mental health issues that will face both her and, eventually, her child in their lives ahead. We then know that as a child grows, they are often exhibiting behaviour that may warrant a special examination of their physical and mental needs and, in fact, the health of their family. Such interventions can and should occur in a doctor's office, a preschool, through a public health visit or at a kindergarten. As a child becomes a young adolescent, we often see addictions, isolation and self-esteem become critical risk factors for those children, which must be understood and addressed by adults across many child-serving systems.

I would just like to offer a brief personal note. One of my former roles was children's commissioner in British Columbia, where I examined the lives and deaths of children at risk, and then I became a member of the federal parole board. So I met many young offenders who had not received services as children or youth, and whose needs were not fully understood nor identified in communities. I think that one of the opportunities this ministry has is to bring together all of the players across those communities and afford them the opportunity to share best practices and do more integrated planning, so that a child's and a family's needs can be put at the centre of everyone's focus.

I think I'll end it there. Thank you.

The Chair (Mr. Kevin Daniel Flynn): That was a really cool presentation. You've left us each about four minutes. Let's start with the government—or we can come back to the government. Do you have a question?

Mrs. Maria Van Bommel: At this point, nothing. No questions at this point.

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

Ms. Sylvia Jones: I wanted to go back to your smoking cessation programs. Would you be able to provide us

with some stats on your success rates, depending on which program they're tied into?

Ms. Cynthia Morton: We certainly can.

Ms. Sylvia Jones: Thank you. Sorry, I have another question.

The Chair (Mr. Kevin Daniel Flynn): Go ahead. We've got time.

Ms. Sylvia Jones: I am not familiar with the Focus program that you referenced—22, you said, across Ontario?

Ms. Cynthia Morton: Yes, 22. That's correct.

Ms. Sylvia Jones: So if you could give the committee a list of where those 22 are.

Ms. Cynthia Morton: Sure.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Sylvia. France, any questions?

M^me^ France Gélinas: Yes. Nice to see you. I haven't seen you in awhile.

Ms. Cynthia Morton: Yes.

M^me^ France Gélinas: The Ministry of Health Promotion—I mean, the name implies you're there for health promotion. Do you see a unique role for your ministry in funding promotion, prevention and early intervention in mental health? Is this something, as this committee works, that we should encourage to be located at your ministry? Or do you see it being a little bit everywhere?

Ms. Cynthia Morton: Health promotion is in a continuum of services that are being provided. I don't think any jurisdiction has quite sorted out where the lines are that you draw between one system and another, so they're grey. Where you move from prevention to intervention, for example, is a continuum, and from a community's perspective, it should be seamless. It shouldn't matter which ministry it's in.

From our perspective, we see our mandate as working across whatever ministry is our partner. So whether it's in this ministry or another, we still consider it a government-wide mandate to do health promotion. If it's in health or in children and youth or wherever the program is, we see it as an opportunity for us to leverage relationships across government and bring all of those players to the table to do that kind of holistic and integrated planning.

We're not looking to become a major service delivery kind of ministry. We're hoping we can continue to be the ministry that can incubate and promote innovation, evaluate best practices and share outcomes, with that kind of a focus. So it's not critical, for us to do our work, I guess would be the answer.

M^me^ France Gélinas: I appreciate the answer. I'm hoping once our work is done, we can put forward a strategy, and a component of that will certainly be promotion, prevention and early intervention. If I focus on promotion and prevention, is it reasonable to expect that your ministry would have the lead on that part of the strategy and, through the leverage of those relationships that you have with the other ministries, make sure that it gets implemented? I guess I'm trying to know—

Ms. Cynthia Morton: Yes, we definitely see that as our role. It's a role that we're playing now—not in mental health, because that framework is unfolding and that strategy is unfolding at this and other tables. But yes, it's absolutely the role that we want to play.

M^me^ France Gélinas: Unfortunately, my colleague hasn't had a chance to brief me on the Ministry of Health presentation that came before you, but is your ministry right now, or in collaboration with other ministries, working on a promotion/prevention mental health strategy? Is there work going on right now that we should know about?

Ms. Cynthia Morton: We're working with the Ministry of Health, the Ministry of Children and Youth Services and, to some extent, the Ministry of Education on these very issues around the integration of a holistic approach to mental health. I think Deputy Minister Sapsford spoke about that before we joined the table today.

M^me^ France Gélinas: Is this through the committee that exists, or is this through other tables, other relationships that you have?

Ms. Cynthia Morton: It is work that we've always been engaged with, because we all have the responsibility at a service delivery level to do better with the mandates that we've been given. I think what is lacking is the overall strategy for the future, and that's what we're hoping this table and others will provide. In the interim, we really do believe that mental wellness is a fundamental part of almost everything that we do, and that's what we expect of the programs and the partners that we fund.

M^me^ France Gélinas: I certainly support your strategy, where you put the resources with the communities with the highest needs—newcomers, First Nations. I was just surprised that francophones were never mentioned. Is there a reason for this?

Ms. Cynthia Morton: We're basing our interventions on health status, so we're going to those parts of the province where health status is the poorest. To the extent francophone communities are fitting within that definition, they will definitely be part of our target communities.

M^me^ France Gélinas: The way that you do your assessment to identify the communities—is this something you can share with the committee? I would be interested in knowing what those communities are, but I would also be interested in knowing the process for the evaluation so that you know one community is needier over another.

Ms. Cynthia Morton: Sure, we can give you that. It's essentially a cross-mapping of a number of indicators that we've put together. Knowing we can't be everywhere, we have to prioritize the ones that we go to, depending on that mapping.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. We're going to go back to the government. Jeff and then Liz, I think.

Mr. Jeff Leal: Ms. Morton, you finished your presentation touching upon young offenders. Could I just explore that a minute with you? There are some people who share the philosophy that dealing with young offenders through extensive jail sentences is the be-all and end-all to try to address their problems. I think others have different views, because many of them have suffered from various forms of mental illness. Based on your experience, if you could shed a little bit of light on this one for the committee, I'd really appreciate it.

Ms. Cynthia Morton: I think the greatest indication of a community's failure is when a young offender graduates to the federal system, where they do even more time, spend even longer in jail and are even harder to reach in terms of rehabilitation. The evidence is clear—it's not my personal opinion—that if you want to ensure that young offenders do not become older offenders, you must intervene early through a supportive and rehabilitative framework. I can give you all kinds of studies that have shown over time the consequences of adopting one approach over the other and the success rates of both.

Often, though, you will see young offenders, especially with mental illness—they were living in the community, self-medicating mental illness through addiction. Often, sadly, they are receiving their first treatment in a correctional facility. So to some extent, it may be the very best place they can be until they're stabilized and allowed to return to the community, with a new sense of how to manage their illness with supports in place—because a lot of these kids live underground. They're very hard to find. They're homeless, they're transient, they're high-risk, and they may be living in crime. They are the hardest to reach. Sometimes, the first time a community will interact with those kids is in a criminal court. So their first opportunity to get treatment could be in a correctional facility.

I think the best thing you can do for those kids is get them plugged in to their community and give them an opportunity to be successful, because that's what's going to keep them out of jail: success in their community. I've seen too many examples of failure, and I've seen very good examples of success—and they never come back. They never want to come back.

The Chair (Mr. Kevin Daniel Flynn): Thank you. To Liz for the final question today.

Mrs. Liz Sandals: Yes. In the deck that you gave us on page 10, there's a comprehensive framework for a mental health and addiction strategy that you've included. I wonder if you could tell us a little bit about where that particular framework came from, how it was developed—because there isn't anything to sort of place it, in terms of where did it come from. Is that from your ministry or from some other source?

Ms. Cynthia Morton: It's just our advice.

Mrs. Liz Sandals: It's your advice. Okay.

Ms. Cynthia Morton: It is a reflection of a population-health, social-determinants-of-health approach to identifying the context for mental illness in the larger context of a community's role and of wellness.

Mrs. Liz Sandals: So it would be your recommendation, then, from the point of view of your ministry, looking at health promotion, that as we are looking at a mental health and addictions strategy, as we're doing report writing, this might be a bit of a checklist to see if we've included the elements that are framed here on this slide.

Ms. Cynthia Morton: It is our advice, and it's essentially a model of how the ministry approaches the same issues.

Mrs. Liz Sandals: Okay, thank you. That's helpful. I just wondered where that came from.

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

COMMITTEE BUSINESS

The Chair (Mr. Kevin Daniel Flynn): That's the final delegation, but I would like to draw the committee's attention to a letter and some information we received from the Office of the Auditor General of Ontario. The last paragraph of that says—he provides a lot of information, a lot of background, but he also asks if we would be interested in an overview of the findings and observations. He'd be pleased to provide a short briefing.

I'm assuming the answer to that would be yes, but I just wanted to make sure that the committee agreed with that. Okay.

Ms. Sylvia Jones: Chair, for future presentations that come forward, particularly, I guess, related to the ministries, can we ask that they not use their 30 minutes so that we have an opportunity for a bit of discussion?

The Chair (Mr. Kevin Daniel Flynn): We can suggest that, perhaps.

Ms. Sylvia Jones: Thank you. Strongly?

The Chair (Mr. Kevin Daniel Flynn): Strongly—as strong as I get.

Mr. Bas Balkissoon: Can we get the reading material ahead of time so we could craft some questions?

The Chair (Mr. Kevin Daniel Flynn): That's a good idea. We'll try to accommodate that.

Mr. Bas Balkissoon: Because I think the Auditor General sending us his stuff will prepare us, and when he comes here, we would have a better discussion.

Ms. Helena Jaczek: If it's here, yes.

Mr. Bas Balkissoon: Yes, but when he arrives here, we'll have a better discussion.

The Chair (Mr. Kevin Daniel Flynn): Oh, I see. Okay. He didn't send the stuff, actually. Susan was being modest. She provided the stuff—which probably isn't a good thing to say at an addictions subcommittee, but—

Mr. Bas Balkissoon: That's a good idea. It's a very good idea for the future.

The Chair (Mr. Kevin Daniel Flynn): Okay, we will work to ask them to see if they can leave some time for questions.

We're adjourned. Thanks for your attention this afternoon.

The committee adjourned at 1801.

CONTENTS

Wednesday 22 April 2009

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

Chair / Président
Mr. Kevin Daniel Flynn (Oakville L)

Vice-Chair / Vice-Présidente
Mrs. Christine Elliott (Whitby–Oshawa PC)

Mr. Bas Balkissoon (Scarborough–Rouge River L)
Mrs. Christine Elliott (Whitby–Oshawa PC)
Mr. Kevin Daniel Flynn (Oakville L)
M^{me} France Gélinas (Nickel Belt ND)
Ms. Helena Jaczek (Oak Ridges–Markham L)
Ms. Sylvia Jones (Dufferin–Caledon PC)
Mr. Jeff Leal (Peterborough L)
Mrs. Liz Sandals (Guelph L)
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