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Mercredi 3 juin 2009

Select Committee on Mental Health and Addictions

Mental health and addictions strategy

Comité spécial de la santé mentale et des dépendances

Stratégie sur la santé mentale et les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 3 June 2009

Mercredi 3 juin 2009

The committee met at 1604 in committee room 1.

MENTAL HEALTH AND ADDICTIONS STRATEGY

The Chair (Mr. Kevin Daniel Flynn): Okay, if we can call to order. We've got a few members who are joining us in progress. The House is still proceeding through its routine proceedings, and there are some tributes and speeches being made as we near the end of the session. We are going to get going, as we do have a pretty tough agenda ahead of us. It will have us here until at least 7 o'clock, by the looks of it.

MINISTRY OF EDUCATION

The Chair (Mr. Kevin Daniel Flynn): Let me introduce the first delegation; it's from the Ministry of Education. We've got Grant Clarke, who is the acting assistant deputy minister, and Barry Finlay, who is director of special education, policy and programs branch. Each delegation is being given 30 minutes, and you can use that as you see fit, but the trend has been to leave a little bit of time at the end for some questions and answers, we hope. Having said that, the floor is yours and welcome.

Mr. Grant Clarke: Thank you very much. I'm Grant Clarke, and this is my colleague Barry Finlay. Our plan would be to maybe walk quite quickly through the presentation, about 15 or 20 minutes, and have 10 or 15 minutes at the end for any questions the committee members may have.

I'll lead off. You have a package in front of you which is a synopsis of a number of key initiatives that the Ministry of Education is involved with and also points to some of our collaborative work with our colleagues in the Ministry of Children and Youth Services. We're going to walk through it. I'll start by setting the context for it and then ask Barry to carry through on the substance of the deck. We won't read the deck, but we'll just highlight for you, on each of the pages, the key points. If there is anything you'd like to come back to, by all means, we'll be happy to provide you with additional detail.

The stats slide on page 2 probably is familiar to the committee members at this point. Then there are a couple of slides, 3 and 4, which were just background information on the size and scope of public education in Ontario—over two million students and 5,000 schools, 4,000 of which are elementary, 800 and so on are secondary, a very large system—and some details on recent funding, including the last funding increases for the coming year of 2009-10.

If we could go to slide 5, I think this is where the narrative for us would begin. To set the context, Ontario does have three strategic goals for education, and they're listed on the left-hand side of that slide: higher levels of student achievement—and I might also say student well-being is included within that notion; reduced gaps in student achievement, which includes ensuring outcomes for students who are either English-language learners in the province or students with special needs—in some instances boys, with respect to literacy, as we know, continue to be a pressing concern—that we are able to work successfully with our partners in education to close their achievement gaps, to ensure that the gap between students who are performing at the highest levels in the province and those who are performing at the lowest levels decreases over time.

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The third goal is increased public confidence in publicly funded education in Ontario.

Related to that, our student success agenda can be characterized by those three goals. Certainly, special education programs and services are within the framework of student success, an integral part of it, in fact, and the means by which the ministry, in collaboration with school boards and partner groups, attempts to provide those appropriate supports and services to groups of students.

Improved student outcomes for students receiving special education is parallel, of course, to our goal of higher levels of student achievement and well-being for all students.

Building the capacity of schools to effectively meet the diversity of learner needs: We're doing that through a number of targeted initiatives.

Next is ensuring that students who have individual education plans—that's what IEP stands for—which set out for them the program of studies and supports that they will receive through special education programming and supports, that that's linked to curriculum expectations and to progress of those students through the school system so that they have a very solid chance of achieving their educational goals.

Next is more collaboration and co-operation among schools and sectors, including, of course, families and

their advocates who are facing learning challenges in the system, recognizing that it is a shared responsibility and that better outcomes can be assured by working in a collaborative manner.

Last is focusing on the balance between teaching and learning, including providing the appropriate documentation, but first and foremost providing, in a responsive way, supports, programs and services for those students who have special learning needs.

That's the context within which much of what follows in the deck is positioned. I'm going to ask Barry now to walk you through the remaining portions of the deck.

Mr. Barry Finlay: Thank you, Grant.

I need to start with a story to provide a context for our supports for children with mental health needs. It provides a context, I believe, for what we do in public education in support of building healthy young individuals.

I'll take you back to a field, and a family where the father, who is a subsistence farmer, engages all of his children annually in the growing of his crops, in order for the family to survive. He starts by taking his youngest children out each year, and he has them plant a seed. Then he encourages them to nurture, water and take care of that seed and its growth.

This particular father did this with his three-year-old daughter. He did that, and she went out and planted the seed and did everything he asked her to do.

They went back the second year and in fact there had been no growth. The young girl was very upset, thinking that she hadn't done something properly. And he said, "Be patient, my child. If you continue to water your seed and take care of it and feed it and do everything that you should be doing, it will be fine." And she did this the second year. The little girl once again came back and was more distraught because it had only grown an inch. But because she was a little girl and still listened to what her father had to say, she continued to water it and take care of it.

The third year, the same thing happened. At this point, she became very frustrated.

But in the fourth year, finally, she came back and it had grown 60 feet.

In fact, what they were planting was Chinese bamboo. The first four years of growth for Chinese bamboo is all underground. It builds the huge web of its root system in order to support the rapid growth in future years.

For all intents and purposes, that's what we do in public education and in support of children with mental health needs. Our focus is on that universal support and early programming for kids, to help build well-being.

We'll talk about a continuum of service for our children, but you'll see that many of our actions now in our schools are dedicated to that healthy growth and development of our young children, and then, where necessary, attempting to get additional services in order to support children's mental health needs. I would also say that critical about that is the fact that it's about an individual seed, and we are very much focused now, at a provincial level, on all children and each individual child and moving to support individual children, as you will see.

On page 6, you will see a bit of a summary of an approach that we'll be taking in schools in terms of supporting kids' needs. Once, in fact, individuals identify that there are some challenges—they didn't make referrals—if in fact they can do it internally, then they provide the supports. If they can't, then they will attempt to access supports for children outside the education system.

One of the challenges that you will see as we go forward is that children's mental health is really not an identified exceptionality in terms of special education. We have 12 exceptionalities in special education, within four broad categories, and at any given time, children's mental health needs may affect any or all of the children who fall within those exceptionalities. So it's part of the challenge that we all face, consistent with Senator Kirby's treatise of trying to get this out of the shadows.

On page 8, we have a definition for support for children with emotional and behavioural needs—but it's not really about children's mental health. Once again, it's still part of the challenge that we face, but it is one of the exceptionalities. I will point out to you that presently in Saskatchewan and in British Columbia, they have moved to the identification of children's mental health needs as an exceptionality under special education. We have not moved to that at this point, and continue to support the non-medicalization of our exceptionalities and focus it upon learning.

We presently serve approximately 290,000 students in the province with special education needs. Approximately two thirds of those are identified formally through an identification placement review committee process. Therefore, there is a formal placement and identification that does take place. Approximately one third are not officially identified but still receive special education programs and services.

On page 11, we do have in place, and have had for a few years, care and treatment programs to serve children's mental health needs. The focus for these programs is, in fact, treatment. We provide an educational resource—teachers to the program—but these programs are housed, for the most part, in agencies separate from district school boards, and the education is secondary to the treatment, the whole goal being the transition, to get them back into the school system as soon as we possibly can.

As I indicated, our primary focus is around universal and preventive programming for children. Through our health and physical education programs from grade 1 right through to grade 12, building positive children's mental health is addressed, but also, as you will see, are issues such as substance use and abuse, personal safety, injury prevention, healthy growth and development etc. Even in our social science and humanities curriculum in the senior years, there are programs that do address children's mental health issues.

In addition, I would say, having come from the system for many years, schools and boards have a number of

programs that they offer in support of children's mental health needs and building children's wellness. One that we have facilitated at a ministry level, in co-operation with the Ministry of Health, is the healthy schools recognition program, and that's on page 13.

I already addressed some of the curriculum references, but they are very specific for you there on page 14.

We are working with the Ministry of Children and Youth Services around a mapping process. I know that they are presenting at 5 o'clock today, so they will go into more detail with respect to this process, but the purpose of this is for the mapping of all the children's mental health agencies and supports in the province, in co-operation with education, so that we identify not only the resources that are provided through education, but those that we are doing in a collaborative way between and among agencies in communities. We're just moving to phase 2 of that mapping process, which, in fact, will identify the costs related to all of these programs so that we can ensure that we're optimizing the benefit of those programs.

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A program that has not been very costly but has been quite effective is the student support leadership initiative, which is a joint initiative between the Ministry of Education and the Ministry of Children and Youth Services. It's focused upon building collaborative supports within boards and within communities in support of children's mental health needs. They're moving to the third year of that program, where they will be identifying how they will be sustaining the relationships that they've already established and hopefully perpetuating some of the additional resources for students.

We have also entered into some research work, on page 18, supporting the Provincial Centre of Excellence for Child and Youth Mental Health out of the Children's Hospital of Eastern Ontario. Once again, the focus of that research is not only an extensive literature search, but also identifying effective practices of collaboration between boards and health and social service agencies in support of children's needs. Education itself is working with a consultant to do a similar project with respect to the focus on collaboration.

Within that context, the preliminary findings from our external consultant identified some factors that contribute to successful collaboration, and you'll see those on page 18. Not surprisingly, the building of trusting relationships among everyone involved is critical to us going forward in this initiative. Also, factors that serve as barriers to successful collaboration have also been articulated. Often, if we can go at those barriers, the enablers come forward when we remove the barriers to being successful.

The potential framework that has been identified through this research work is not surprising. It identifies a need for some provincial coordination and some work among our ministries to coordinate, and I would say to go beyond that and continue to collaborate in support of children's mental health needs. But we also need it to be addressed at every level: at the district level, to have planning tables doing the same thing; and then at the local level, even between schools, local agencies and within communities, in order to optimize the supports that we presently have in place for students.

In summary, we've always had students in our boards and in our schools with children's mental health needs. We do have roles in our boards to support this. We have psychologists, we have social workers, we have child and youth workers etc. Having said that, we just completed, over the last year and a half, a fairly comprehensive program and financial reviews of 11 district school boards in the province. That included interviews with parents and with staff members representing all roles—directors etc. Among all of those boards and in all of those discussions, children's mental health always came out within the top two in terms of their challenges.

So the issues that we face are not insignificant and they're being felt everywhere. I would say that at a personal level, I'm very pleased that you're convening these meetings because it's an area where our boards are certainly saying, "We really need some additional support and some help."

Thank you, and I'll be happy to answer any questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. I think our practice in the past has always been to start to my left, so I'm going to alternate today and start to our right for this delegation.

Ms. Sylvia Jones: Why change now?

The Chair (Mr. Kevin Daniel Flynn): Well, I'm just trying to be fair. I know there was a question raised the other time, so I'm sensitive to the questions, but I think we can get through it as a committee. Why don't we start with Jeff and then go to France, and then go to Christine or Sylvia. Jeff?

Mr. Jeff Leal: I'd just like to add a question for Mr. Finlay. Thank you for your presentation. And I'll put my preamble: My wife happens to be a vice-principal in a school in Peterborough.

I remember reading the report from Dr. Fraser Mustard and Margaret McCain. One of the things of this government, as an early initiative, was to reduce class sizes in the primary classes. Do we have data now within the ministry to indicate that the reduction of class sizes in the primary classes—one of the reasons that was suggested was to identify potential problems in children earlier and look for solutions early on in their education experience to provide a better platform as they move into the intermediate and on to the senior grades. Have we looked at that and have we got data to indicate what's transpired since we've implemented the lower class sizes?

Mr. Barry Finlay: I'm not aware of any specific data related to that. What I am aware of are the continuous improvements of our EQAO results as a result of the earlier identification, especially in the area of literacy and the growth that has taken place over the past few years. What I would say is that during this past year we had significant growth for children with special education needs, those who are receiving special education pro-

grams and services, at both grade 3 and grade 6. We attribute much of that growth to earlier intervention and supports. Once again, many of those children in those early years are not yet identified, but they are receiving special education programs and services as we work with them to determine whether in fact they have a specific learning problem.

Mr. Jeff Leal: Mr. Finlay, presumably that would also be of great value if there's a debate around today whether we go to full-time kindergarten or not—even earlier identification.

Mr. Barry Finlay: I would certainly support that, and I think for those of us who have been in the system for a long time, the earlier the better.

Mr. Jeff Leal: Thank you, sir.

The Chair (Mr. Kevin Daniel Flynn): Let's go to France and then Christine or Sylvia and then come back to this side.

M^me^ France Gélinas: Thank you, Mr. Finlay and Mr. Clarke, for coming here. We heard from other deputants the idea that maybe we don't do enough early identification of children with mental health needs. I liked one of your opening comments, that you certainly do not have the skills to identify mental illness; I mean, you do education and not mental health. But has any thought been given at all to some kind of a screening that would happen, let's say, in grade 3 and in grade 7, and we go through all of the kids and screen them for mental health and mental illness or mental health needs? Is this something that has ever been talked about at your board or at the ministry?

Mr. Barry Finlay: Not to my knowledge, with respect to a specific screening at those levels for this particular need. I think one of our challenges, as you indicated, is the level of expertise that we have in terms of identifying mental health needs. Very clearly, in education, we attempt to maintain our own level of expertise. Therefore, our focus is primarily on building positive mental health, and then when we get to a level where we need to engage someone else, we do that. A number of boards have psychologists, and they would employ psychologists for that purpose and identify them through a similar process as the IPRC process, with identified specific need, and then they would do assessments. Right now, it is not universal; it is individual, based upon identifying individual needs.

Mr. Grant Clarke: One of the focuses the ministry does have, and many school boards are involved with, is kind of an early identification of readiness for learning, if you will, using a number of indices. There's one out of the Offord Centre—the EDI, is it?

Mr. Barry Finlay: Yes.

Mr. Grant Clarke: It's looking at, as young people come into the system, what their capacity is to really learn within the classroom. It's not the same as an assessment for a specific purpose—mental health and other—but often there is an overlap or collaboration where one set of indicators may alert you to the need for further assessment.

We also had a multi-year study—and perhaps Barry can tell you a little bit more about that—with the Ontario Psychological Association looking at early assessment from the standpoint of reducing the amount of time or lag between a problem with a child and a referral, if that was needed, or some other remedy that was within the scope of what teachers in the classrooms could actually do to mitigate the need for subsequent referrals. So we're operating on a number of fronts. I think you could probably anticipate that we will, with the release of Dr. Pascal's report and the minister's and the government's response to that, be looking at ways for more effective assessments in the kinds of programs that would occur in full-day learning.

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

Mrs. Christine Elliott: Thank you very much for your presentation today. You did speak briefly about the categories of exceptionalities and why mental health needs haven't been identified as a separate exceptionality, and I was wondering if that might have an effect on the ability to collect data and information. Could you just elaborate on that a little bit further, please?

Mr. Barry Finlay: Yes, I can. It is an area where we receive significant requests from a number of groups, not only children's mental health groups, but other groups, primarily with a medical focus. Our challenge is, very specifically, do we wish to medicalize learning exceptionalities? If we begin to move in that direction, then it is almost infinitely related to the number of diseases and disorders that are available. Simply because they're not identified doesn't prevent a student who has a children's mental health need from getting additional special education supports. So they can still have an individual education plan that identifies their learning needs, but they haven't gone through that official process. The issue for us, really, is around the medicalization and, I would say, the further deficit focus on our children and their learning, as opposed to focusing upon their strengths. You can see that other provinces have moved in that direction, and we continue to look at this all the time.

Mrs. Christine Elliott: Just one other brief question, if I might?

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

Mrs. Christine Elliott: It was just a question about whether you could name two or three things that you think could be done to improve our system of delivering children's mental health services vis-à-vis educational issues. Can you give us some idea of what they would be?

Mr. Grant Clarke: It's clear that school board and agency collaboration is really key to this. There are supports and services; often, they're fragmented. Really, because we're attempting to map the degree to which these relationships exist across the province, it means that we don't actually have a good database of how those supports or—if you will, a map of how those agency and school board partnerships occur. What we're hearing from the school boards is that they sometimes don't

know who to turn to in their communities, and sometimes there are issues which seem beyond the capacity of school boards to deal with and there isn't an appropriate agency referral that can be made. So, at the very least, I think step one is to maximize those relationships where we can, through the support of finding out the extent of them and where they are; secondly, identifying some better practices that are in place in a number of communities in the province and looking at them from the standpoint of: What can we learn about these models that might help other communities fashion their own better relationships to ensure that services both within the school and from whatever community supports are available are made available to students in a timely way?

Mr. Barry Finlay: If I may add a third, that is two things—focus on transitions for these children. Frequently, these children move in and out of programs, in care and out of care, and we really need to focus—and we're attempting to do that now—on ensuring that these transitions for these children are as seamless as possible. The second thing is that our children with special needs really need a team around them. It's part of the collaboration. They need to have a group of people—an interdisciplinary team—who understand them and can provide all of the different supports that are required to enable them to be successful.

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

Mrs. Liz Sandals: This may be as much a comment as a question, but feel free to comment. One of the things that I think is a little bit confusing is that when we talk about special education, we're really focusing on issues that a child may have which interfere with their education. So if you have a child with a mental health issue who exhibits some sort of behaviour that interferes with their learning, then they might be categorized as having a behavioural exceptionality, even though that's really some sort of a mental health issue, and get support. But if, on the other hand, you had a young woman, for example, with bulimia, that may not interfere with learning because she may be a very high-achieving student. That young woman, who also has a mental health issue, wouldn't be identified because it isn't interfering with education. We have this confusion between special education, which has one focus, and children's mental health, which has a different focus. They often intersect, but it's actually two different clusters. Is that fair?

Mr. Barry Finlay: Fair.

The Chair (Mr. Kevin Daniel Flynn): We've got time for one brief question, if anybody has one. You both put your hands up.

M^me^ France Gélinas: Is it okay if I go with my brief one?

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

M^me^ France Gélinas: I have no idea if you know the answer to this. We all know that mental illness carries an awful stigma. I was wondering: When you deal with young learners, young people, do you find that also, or at what age does it start?

Mr. Barry Finlay: I'm aware, because I come from the system, that it starts as early as six years of age. There are children who are in children's mental health treatment centres at the age of six who have been removed from their homes and are still in in-school programs. It's one area where we're really focusing our attention about this seamless transition for these children so that they feel a part of the school at all times and are not removed from the school at all times in order to get their treatment supports. It does start very early.

M^me^ France Gélinas: So children as young as six would be stigmatized by their peers because they have a mental illness?

Mr. Barry Finlay: Children are quite resilient; even their peers are quite resilient, but mental illness, still, and mental health issues are stigmatizing at all levels, including for young children.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Finlay. Thank you, Mr. Clarke, for being here today.

DURHAM MENTAL HEALTH SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is David Clarke from Durham Mental Health Services.

David, if you'd come forward. Make yourself comfortable. There's some water there if you need it. Like all other delegations, you have 30 minutes, and you can use that any way you like. If you would leave some time at the end for questions, as the previous folks did, that would be appreciated.

Mr. David Clarke: Great. I have a prepared speech, and then afterwards, I'd be happy to answer questions.

Good afternoon. My name is David Clarke and I'm coordinator of communication and training with Durham Mental Health Services, which is a community mental health agency that serves the Durham and Central East regions. I'm speaking today on behalf of Rob Adams, our executive director.

I appreciate this opportunity to speak to the Select Committee on Mental Health and Addictions about what has made Durham Mental Health Services successful and about some of the challenges involved in meeting the complex and diverse mental health needs of our communities. I thank you for your invitation to speak and for your attention to the needs of one of Ontario's most vulnerable and underserviced populations: individuals with mental health and/or addiction problems.

Just as I begin, I would also like to recognize Christine Elliott, MPP for Whitby–Oshawa, for her dedicated service on behalf of mental health issues generally and of Durham Mental Health Services in particular. Ms. Elliott's strong advocacy for the establishment of this all-party Select Committee on Mental Health and Addictions is just one recent example of her tireless efforts on behalf of individuals in need.

You may know that in 2005 Ms. Elliott received the Peter Perry Award, an award for Whitby's outstanding citizen of the year, in recognition of her exceptional contributions to the community. She has long been a supporter of Durham Mental Health Services, joining our

board in August 1989. She was board president from September 1993 to September 1997. In 2002, we recognized her service to the agency by naming one of our new residential locations Elliott House. We are so grateful for her call to action on behalf of individuals with mental health and/or addiction problems, and we've been delighted and gratified by the unanimous support that that call has received.

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There is a lot of research out there about what makes mental health and addictions services successful. Ontario governments have disseminated this knowledge in reports, including, Making it Happen: Implementation Plan for Mental Health Reform, from 1999; and The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario, from 2002. For this knowledge to be effective, it has to take hold within local communities—and I mean the community, broadly speaking, and also political communities, communities within health care and human service organizations, communities of care providers. Local communities must recognize need, respond collaboratively, and be guided by best practices in doing so.

Durham Mental Health Services was created out of just such a grassroots response to need. For 22 years, we have been an example of what can happen when knowledge about mental health problems and service practices encounters a compassionate community prepared to take action.

Back in 1987, action was needed in Whitby on behalf of individuals who had been discharged from what was then Whitby Psychiatric Hospital; individuals who lacked adequate community support. At that time, boarding homes were one of the few affordable housing options in Whitby. People who lived there would be offered accommodations and meals. The conditions in some of these boarding homes were deplorable; at times, they were ghastly. Parishioners at Whitby All Saints' Anglican Church recognized that there was a need for decent, supportive housing and established Whitby All Saints' Residence Corp.

Our founders had modest ambitions. David Sims, a Whitby lawyer and an All Saints' parishioner who served as the agency's first board president, reports, "We simply wanted to provide clean, decent accommodation with good nutrition for a few people with mental health problems forced to live in substandard conditions.... To tell the truth, we didn't even know what supportive housing was or what was involved in providing it." In fact, he says if they had known at that time the kind of challenges they would encounter, they might not even have started with the project. Ultimately, guided by their recognition of the community's need and striving to adhere to the highest values, the foundation of Durham Mental Health Services was put in place.

Our first major expansions—we added case management services and also a crisis support team—followed this same organic process. Of course, we knew that these services were an integral part of the continuum of care. More than that, we knew people—graduates of our housing program—who were living independently and who needed a helping hand. We also knew that our services at that time did not come close to meeting the community's needs. Therefore, we sought and obtained funding for Helping Partners, our case management program, and for a four-bed crisis location with a 24-hour telephone support line.

Mr. Sims has described how values impacted the delivery of services in these early days. He says that while Whitby All Saints' Church, which established this nonprofit corporation, imposed no rules or restrictions, it did have two expectations. Those expectations were, first, that what the organization did would be excellent, and the second was that it would be done caringly. Those expectations—caring response and a standard of excellence—have guided the agency from its inception, with one program, one location, eight service recipients, nine or 10 total staff; to its current position, with six housing locations supporting about 40 individuals, 400 clients living in the community who receive support from 20 case managers, a crisis program that has thousands of contacts with the Durham community each year, and deep connections within the Durham community and with the whole gamut of regional services and supports.

I was fortunate enough in 1989 to be hired as a summer student at Durham Mental Health Services, which was then two years old, and I've been able to participate and to watch as the agency has grown into what it is now, and it has been an exciting story.

Time and again, our grassroots origins and guiding philosophy have enabled us to learn from best practices while adapting these practices to local conditions, resources and needs. But sometimes the process has been reversed: first of all, identifying local needs and then saying, "How are we going to meet these local needs so that we actually come across best practices?" Just as we established supportive housing before we knew exactly what supportive housing entailed, so too we were promoting recovery before recovery had a name.

An example of this is when, in the early 1990s, we expanded our supportive housing program. At that time, we established three levels of support so that as clients learned skills, connected to supports, and established routines, they had the opportunity to move to greater levels of independence. Our ultimate role in any of our programs is to work ourselves out of a role.

Recently, this model of congregate and transitional housing support has been supplemented by the development of other housing models for individuals with serious mental illness. For example, one emergent model is called "supported housing," or "independent living with intermittent or on-call staff support." At DMHS, we believe strongly that congregate, transitional housing is an integral component of the whole broad range of community mental health supports. No one model of housing support can meet the broad and divergent needs of all individuals with mental health problems.

For example, independent living with intermittent or on-call staff support does not meet the needs of many

individuals who are transitioning from a structured, 24-hour hospital setting or from a home where family members have been heavily involved in providing care.

When we consider the continuum of services that are available in an ideal mental health system, there has to be a range of options available to meet the needs of individuals at any stage of recovery. Congregate, transitional housing is not a solution for every person, but it is a needed support for many. We have seen this in the experience of those who have benefited from this service, and we have also heard it in the grateful testimony of family members who are seeing their loved ones thrive in independent living, in many cases for the first time in their lives.

One of the pressing issues in mental health service delivery today is the need for collaboration across services and sectors to meet complex needs. This is so whether we're considering the needs of individuals who have concurrent mental health and addiction issues, the needs of families in crisis or the needs of individuals with mental health issues who languish without adequate treatment in provincial jails.

The complexity of presenting problems that community mental agencies are encountering seems to be increasing. Problems are growing more complex. Individuals who are seeking support do not care at all about which service provides support. The only question that matters is, do they receive support that is compassionate, efficient and effective? This matters particularly when it comes to mental health services, given the pervasive stigma associated with reaching out for help, the paucity of information generally known about mental illness and the frustration of navigating a system that, as is well known, at times can seem more like a maze.

I would like to briefly highlight two of Durham Mental Health Services' cross-sector partnerships which are helping to create solutions to complex problems. The first is our partnership with Durham region's child and youth service providers to offer integrated crisis response. The complex needs of families in crisis are best served through such partnerships.

Traditionally, child/youth and adult services have operated in isolation. Families have not experienced the system as seamless and integrated. By integrating a crisis service response, each sector can contribute its resources and its expertise, and families are receiving a holistic and humane response.

When child/youth and adult services integrate in this way, it also helps to facilitate a seamless transition for a young person who has mental health problems from child and youth supports to the adult mental health system, which will be providing service to the individual as soon as they hit 16 or 18.

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Another example of these cross-sector collaborations which are so vital is Durham region's drug and mental health treatment court and the associated youth community restoration court. When I think about these courts, I think of how judges and prosecutors want to be catching bad guys, criminals, not people who are ill. These courts constitute a cross-sector collaborative approach to the problem of addiction. Durham Mental Health Services partners with addiction services and with justice system resources to provide a humane, rehabilitative alternative to the punitive approach to addictions. Durham's drug and mental health treatment court promotes recovery, reduces pressure on the justice system and reduces recidivism. Individual outcomes and public safety are both enhanced through this collaborative and evidence-based approach. In both of these examples of service integration and in many others, differences in philosophies, policies and service delivery models need to be creatively addressed. But the effort is worth it when it results in closer partnership and enhanced capacity to respond to complex community needs.

What Durham Mental Health Services contributes to these partnerships is our expertise on community mental health. From the beginning, we have closely adhered to our mandate and to our guiding vision. As we've recognized needs, we've responded to those needs creatively. For example, as our housing program grew, we recognized the need for more local day programming options, and so we applied for Trillium funding and started our own day program and our own pre-vocational program. Working with families, we recognized the critical role that they play in recovery, and also their desire for information, linkage to resources, and connection to others who share similar life experiences. So we started our family support program. At the same time, we recognize that we have a core group of functions on which to focus, thereby avoiding the temptation to do so many different things that we cannot achieve excellence in any.

Finally, before offering some practical suggestions that are based on our experience—our experience, I think, is one that is representative of community mental health agencies, at least ones in the GTA—I would like to draw attention to a potential shadow side of what has been an increasing emphasis on quantitative outcomes. We recognize, absolutely, that service providers need to demonstrate objectively that their services are providing value. At the same time, an exclusive or disproportionate emphasis on quantitative outcomes can compromise quality. When service volumes and outcome measures are the primary focus, there is a temptation among service providers to offer quick, in-and-out service and maximize the number of people receiving services. We become service brokers rather than relationship builders. Relationship building is right at the heart of recovery and of community mental health work. We feel strongly that it must also be central to the vision of a transformed mental health system.

On the basis of our experience at Durham Mental Health Services, I offer the following suggestions on how governments might help address the burden of mental health and addiction problems.

First and foremost, the foundation of everything is to raise awareness of mental health problems and help to eradicate stigma. As long as people are feeling that

mental health problems are something that is never going to affect them—something strange and aberrant—the motivation to collaborate as a community and to address mental health needs won't be there. So governments can support communities throughout Ontario, in homes, schools, workplaces, faith associations and health care sites, to recognize, first of all, the commonality of mental health problems, and secondly, their burden, but also our capacity, individually and collectively, to alleviate that burden.

Secondly, governments can help to facilitate communication and co-operation between diverse sectors, from the health care system to the justice system to the child and youth system, and, particularly, work to reduce the barriers between mental health and addiction services, which have long worked in isolation despite the body of evidence showing that an integrated response to mental health and addictions is the only effective response.

Thirdly, provide adequate resources to individuals and communities, not only in terms of providing funding for evidence-based services but also in terms of providing affordable housing, sustainable income rates for individuals with disabilities and supported employment programs that can help individuals with chronic mental health problems get off disability.

Fourthly, promote knowledge exchange, set service standards and ensure accountability to those standards so that what is known to be effective is actually being implemented by mental health services, large and small, across Ontario.

Finally, focus on enhancing and mobilizing a local capacity so that communities can respond to the burden of mental health problems in ways that respect local conditions and leverage local resources.

I thank you for this opportunity to speak to you today. I speak for everyone at Durham Mental Health Services when I say that we've been energized by the growing media attention to mental health and addiction issues, by the work of the Mental Health Commission of Canada and by the establishment of this provincial committee. We look forward to working in partnership as we all, together, address the aching burden of mental health problems in Durham region and across Ontario.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David. Thank you for that presentation. We've got time for about three questions. Let's start with Christine.

Mrs. Christine Elliott: Thank you very much, David, for your presentation. Certainly I'm very proud of the work that Durham Mental Health Services has done, and you really do tremendous work in our community. I think some of the issues that you've raised certainly move across Ontario. I think the range of supportive housing that you provide is really important in terms of the work that you do. I wonder if you could just elaborate a little bit more on the differentiation in the types of housing options that you have allowed for.

Mr. David Clarke: Certainly. We've got a supportive housing program that provides transitional housing. There are three types of housing: First of all, people who are first leaving a psychiatric hospital or who are moving out from a family home for the first time go first to a house called McKay House, which is double-staffed 24 hours a day. It's where people are first connected to community resources. They work one on one with a dedicated individual, who will help them to set goals and to progress toward those goals.

When individuals are doing well at that level of support, the next level of support is offered at a house called Sims House, and that is still staffed 24 hours, but it often is single-staffed, and there are times when staff will go out of the building. There's more of an expectation that individuals living there will be taking ownership of their routines and of the upkeep of the house and of staying in touch with their health support networks, with their day programs, that kind of thing.

Finally, when individuals are doing well at that level, there are four houses that we offer that offer a range from 20 hours of support a week to 40 hours of support a week. So it's really, in a way, independent living at that time, but there is this safety net there so that if individuals are moving out to this low-support housing, they still are supported by Durham Mental Health Services; they still have on-call access and scheduled contact with staff support.

From there, individuals can move to the community, but still be connected to our case management program. They always are supported throughout every stage. As well, we've got our 24-hour crisis support so that individuals not only in the community, but also DMHS service recipients, can access that program if they do have mental health needs and they need some support attending to those needs.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David, for that answer. France and then Helena.

M^me^ France Gélinas: I, too, was really impressed, and I thank you, Mr. Clarke, for coming. It's nice to see that sometimes, it does work. I'm really proud that in Durham, you got it together. The more I learn about mental health and recovery, the more I see that in order for recovery to be successful, you need housing, you need support and you need an income. It seems like you were able to put all of that together.

Of course, as I listen to you, I'm thinking, "Jeez, I would like to have that in my community." So the next question is, where do you get your funding for your double-staffed 24/7 supportive housing?

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Mr. David Clarke: Primarily, the funding for our services now is routed through the Central East local Health Integration Network and stems from the Ministry of Health and Long-Term Care. We also receive funding through some Trillium proposals. There is funding through the region of Durham for domiciliary shelters—that's some of our low-support housing. We also get some funding for our human service and justice coordinated programs, like our court support services or our release-from-custody workers; some of that does come

from the Ministry of the Attorney General. So it's a combination of governmental resources.

M^me^ France Gélinas: Wow; very impressive. As I say, I'm starting to understand, they need housing, they need support and they need income. Where do the people you treat and work with—what are their sources of income?

Mr. David Clarke: Primarily, when people are beginning with our programs, they're receiving ODSP for the most part. Sometimes, in fact, getting a person connected to the Ontario disability support program income support is a goal that we set from the start with clients. But ODSP has the flexibility that people can earn $170 a month, first of all, free and clear without having any of that clawed back, which is an incentive for people to explore vocational opportunities. Then, as people are getting more comfortable with vocational opportunities, they can continue to have an outside income; it's just that as they earn more and more, a more significant portion of their ODSP is taken back. But, an individual, even if they're earning a decent income on their own, can still be supported by ODSP for—and I can't remember the length of time right now, but in order to, for example, still receive health coverage, dental coverage and those needed coverages. So often the employment that they're going into will not have that kind of benefit plan.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Clarke, for that answer. Next is Helena.

Ms. Helena Jaczek: Thank you, Mr. Clarke, and congratulations to Christine for having had such an important role in this organization, because it sounds really exemplary.

Since some of my questions have been answered already, I would like to just concentrate on the case manager role. You mentioned 20 case managers for a client load of 400. So the ratio is essentially one to 20, on average. Knowing that everybody always wants more staff, is that reasonable? Is that manageable in terms of a ratio?

Mr. David Clarke: Yes. That standard is the standard that's set out in the Ministry of Health documents around intensive case management. It's very individual because you could have a client who has very high and complex needs and is in crisis at that time and is taking up a good deal of time, but then you may also have clients who have set goals and achieved goals and who are transitioning off of case management to be independent, but know that we're there as a support as needed and there's always an open door to return. So it does tend to balance out. The only way at all that it can work is if our case manager is working in close co-operation with the variety of health, human services and naturally occurring resources—libraries, gyms and faith associations—that are there in our community.

Ms. Helena Jaczek: Do you try and keep the same case manager for that client throughout the process?

Mr. David Clarke: Yes, unless problems develop in terms of a person seeing an individual as the only person that can support them. Those kinds of dependency relationships can develop and they can interfere with recovery, but generally speaking, it's best to establish one trusting relationship, and that also helps case managers, because so often it might not be that they're seeing results immediately with every client that they provide service to, but when they stay connected to the clientele over a period of time, they can be gratified as they see progress, and it revitalizes them as well.

Ms. Helena Jaczek: Just one final question: What sort of qualifications do your case managers have?

Mr. David Clarke: Most of our staff are coming out of college programs. Specifically, human services counselling programs are, I would say, probably the most frequent educational credential for the staff of Durham Mental Health Services. One thing that we've been gratified by is that colleges are recognizing the need for people to have not only experience with and knowledge of mental health problems but also addiction problems. For example, the local college offers a postgraduate program that combines knowledge of addiction and mental health. I feel strongly that it's people who are coming from those integrated programs who are really going to be the leaders as they enter the field. That is the future, for sure.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Clarke, for coming today. Thanks to the committee for their questions.

MINISTRY OF CHILDREN AND YOUTH SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our next speakers today are from the Ministry of Children and Youth Services, if they would come forward. We've got Judith Wright, Aryeh Gitterman, Gilbert Tayles and Marian Mlakar.

Thank you very much for coming today. As with the other delegations, you have 30 minutes. You can use that any way you like, but we would appreciate it if you would leave some time at the end for some questions from the committee. The floor is all yours.

Ms. Judith Wright: I understand the purpose is discussion. I believe we've handed out a slide package.

The Chair (Mr. Kevin Daniel Flynn): Perhaps you can introduce yourself, as you speak, for Hansard.

Ms. Judith Wright: Okay. I'm Judith Wright, deputy minister at children and youth services. It is a pleasure to be here to talk about services for children and youth who are experiencing mental health issues. Let me introduce the people I have with me. To my right is Gilbert Tayles. Gilbert is the assistant deputy minister for the youth justice division, which looks after children who are in conflict with the law. To my right is Aryeh Gitterman, assistant deputy minister at the program and policy development division, which is responsible for the policy framework for children and youth services. Beside me is Marian Mlakar, who is the director of the children and youth at risk branch, which is also responsible for policy related to children's mental health.

I think we distributed a slide presentation. I'm going to walk you through it at a very high level to leave a chance for discussion and to help frame that discussion.

Let me begin, first of all, just on page 2. In 2006, the ministry released a policy framework on children's mental health which was called A Shared Responsibility, and I believe we've provided you with a copy of that. The purpose of this was to set a framework for children and youth mental health services, and part of what it did was actually provide a definition of what children and youth mental health is and to give that definition on a continuum from prevention and promotion right through to the more serious mental illnesses with clinical conditions that children and youth experience. On page 3, we've outlined what the continuum looks like.

On page 4 is a reminder that in addition to the services that are provided by children and youth services, we also are linked with addiction services, which are funded by MOHLTC, and eating disorders, also funded by MOHLTC. The Ministry of Children and Youth Services also provides funding for complex special needs. These are children and youth who have one or more disabilities, in most cases, an incredibly complex set of needs, some of which are mental health and some of which are physical disabilities. We also provide funding for that.

Page 5 has some prevalence data which I think will probably be familiar to you by now at this point in your hearings. Just to go over them: Between 15% and 21% of children have at least one mental health issue; 25% of youth aged 15 to 24 have reported a mental health issue; 14% of children and youth suffer from a diagnosed psychiatric disorder; 5% of children and youth have experienced depression before the age of 19; and suicide is the second-leading cause of death for youth 15 to 19.

Page 6 talks a little bit about the responsibilities of the ministry itself. We are the lead ministry for children and youth who are experiencing mental health issues. It is important to note that within our ministry, mental health services are not a mandated or entitlement program, so the services are provided to the extent that the resources are available to support them. We are responsible for children up to the age of 18. The services are primarily delivered through a range of community services.

Children and youth mental health services, as a number of us have discussed before at public accounts, have grown up from the community, so there's a full range of services that can go from a $200,000 agency to a $55-million agency. There's a broad range of service agencies that we support. The services that they can provide include counselling, identification of issues, individual and group therapy, parental education, supports for families and crisis intervention, so it is a full range of services that are provided by the community organizations.

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In addition to the community organizations, we also provide mental health services for youth who are in conflict with the law or at risk of being in conflict with the law. The ministry directly runs two facilities, Thistletown Regional Centre and the Child and Parent Resource Institute, which provide very specialized services for special needs children and youth, including mental health issues. We support a telepsychiatry program, specialized programs for aboriginal children and support for outpatient services in 17 hospitals, and finally, we provide funding to the Centre of Excellence for Child and Youth Mental Health. The purpose of that funding is to reinforce the importance of evidence-based research and to have evidence-based research disseminated to the agencies that are providing the service.

On page 8, we just touch a little bit more on telepsychiatry and aboriginal programs.

Page 9: I'd like to talk a little bit about the assessment tools that are used. I think, as you probably know, one of the challenges around children and youth mental health services is the standardization of both intake and assessment. As part of the framework and in recognition of that, the ministry does support three common assessment tools. One is the brief child and family phone interview, which is an assessment of the child's needs on intake and which is supported through funding that we give to CMHO. The second is the child and adolescent functional assessment scale, or CAFAS, which is a clinical assessment for determining the functional impairment of children and youth and which is supported through the Hospital for Sick Children. The third is the risk-needs assessment, or the RNA, which is used to assess youth in conflict with the law and their risk of re-offending. I think as we've mentioned at public accounts, we are currently reviewing the first two of these, BCFPI and CAFAS, both to just confirm that they're still current with the latest evidence and also to take a look at their doability and usability.

As you're aware, children and youth mental health services—when you look at the full spectrum, we aren't the only ministry that's involved in them. On page 10, we talk about the role that MOHLTC plays, the role that education plays—I believe you spoke with them this afternoon—and health promotion.

One of the reasons that we actually did the framework was to reinforce the importance of all of the players involved in mental health working together to have a common, coordinated and collaborative approach to children's mental health. We have a bit of distance to go on that, but the framework provides a basis from that discussion. On page 11, we just set out some of the objectives of the framework.

I'd like to talk a little bit now about the mapping activities that the ministry has undertaken. As a first step in the implementation of the shared responsibility framework, the ministry made a decision to work with the sector to identify all of the services that are currently being given under the children and youth mental health label in the communities and to look at those services that are currently being provided against the framework to identify what's on the ground, what are the gaps and can we develop a consensus on what we shouldn't be investing in, in terms of children and youth mental?

This has been a very significant exercise. Over 370 agencies participated. We have 1,500 survey instruments that were developed. We are working with MOHLTC and education in order to incorporate some of their data into this mapping exercise, and we've also looked at other research.

We are currently taking that data and developing it into what I'd call regional maps that we will then go out and talk to the community and the community agencies about. "What does the data tell us about what services are in your community and what they do, and what do we want to do with this data now that we have it?" We do have some very preliminary data results on page 13 from the mapping. We know that an estimated 255,000 children and youth were served through these agencies in 2007-08, and that youth between the ages of 14 and 16 were the largest users of the service.

We also identified the services that were being provided against the four levels that are in the framework. So you can see from page 13 that 21% were at level one, which is a child or a youth not at risk or not experiencing mental health problems. Twenty-eight per cent of the services were for children at risk of experiencing some mental problems or illnesses. Levels three and four are the more serious levels: 33% and 18%. We also know from this data that there was an average wait for services of 38 days from the time that the assessment was made. Approximately 75% of children experienced improved functioning as a result of the intervention.

We outline a little bit on page 14 some additional work we're doing on mental health and some of the additional findings. I did want to close with just talking a little bit about the findings that are more at a policy level that we have on page 16, as I think they're probably the ones of most interest to the select committee. I think what we're seeing already in this data, none of which I think will be a surprise to you, is that first and foremost there really is a need to have better coordination between the services being provided through children and youth mental health education and health, and that part of that is actually a greater sharing of information about not only what the services are but what the client is receiving. Part of that is actually the need to look at a more standardized assessment process, possibly even a single common assessment process, and that information about the assessment process should also be shared better between the agencies.

We're also finding, I think, as we indicate here, a need to talk more and develop better alignment around addiction services, particularly for youth at conflict with the law or at risk of being in conflict with the law.

Two additional findings: One is the need to ensure that there's a better, stronger, perhaps, voice for parents and clients in the way the services are designed and delivered; and finally, and this is the point the auditor has made to us in the past, the need to have stronger data on wait times.

That's a very brief run-through of the slide package. I hope it wasn't too brief.

The Chair (Mr. Kevin Daniel Flynn): No, that was just right, and you've left quite some time for questions. This time we're going to start with France and then Helena.

M^me^ France Gélinas: My first question is not that important, but we'll put it aside quickly. You've said that you had 373 agencies that participated. You fund 440. What happened to the other 67?

Ms. Judith Wright: When we started out—actually I'll let Aryeh talk about this in more detail since he led the mapping exercise—we started with some rigorous definitions about what mental health is and what agencies were in and out of that according to that definition, so that narrowed it down from the number that are funded. In addition, some of the agencies funded under that number are complex special needs agencies that don't necessarily meet the mental health definition. That line funds both complex special needs and mental health. I don't know if you want to add to that.

M^me^ France Gélinas: So the 373 are all of the transfer payment agencies that provide mental health to children.

Ms. Judith Wright: And met the definition that we were looking at in mapping.

Mr. Aryeh Gitterman: I would just add, not a qualification, but just for clarification, the mapping was a point in time, so periodically there are time-limited, one-time funds available for certain things, so that can have the number fluctuate a little bit over time.

M^me^ France Gélinas: Okay. Something we've talked about here is that there are some great things happening in Ontario. There are also some areas, as you said, because those programs grew from the ground up, that are not getting as many resources through the mapping or any other thing that your ministry's doing. Are you looking at equity of access?

Ms. Judith Wright: Can you just clarify what you mean by equity of access? That's a vague term.

M^me^ France Gélinas: We just had a gentleman from Durham explain to us everything that is available there. Mind you, it was for adults. Do we know, or is there a way of knowing, if a service is available in Sudbury, if the service is also available in North Bay?

Ms. Judith Wright: What the mapping data will tell us is what services are available where, and it will tell us, I think within a certain degree of rigour, whether that service is comparable. As you know, because we're not a mandated funding—that's a bit why I was going with the equity of access—the services are those which have developed according to the community need and that we have been funding. I think the mapping exercise for the very first time will enable us to talk to communities about, "Is this the kind of service that you think you still need?" and is it representative of what we think the appropriate use of our resources should be.

1720

M^me^ France Gélinas: I understand the mapping gives you a point in time as to services, who are the beneficiaries, how much they cost etc. The part that is assessment

of the community needs will be done through community forums, using the mapping as—

Ms. Judith Wright: Right.

M^me^ France Gélinas: Okay.

Mr. Aryeh Gitterman: And, I would just say, adding information also collected through our exercise with the Ministries of Health and Education, because that gives a more complete picture of what the current provision is in a community, which connects to the point the deputy made earlier about the alignment between the different methods of delivering children and youth mental health services. One could be offset a bit by the other, so the complete picture is required first.

M^me^ France Gélinas: I realize that you are preliminary, and I'm really happy to see some of the findings from the mapping have already come out. Are there already directions to follow as to best practices that are developing or ideas for making the children's mental health system better for everybody?

Mr. Aryeh Gitterman: Do we have some ideas already? Yes, of course we have some ideas.

M^me^ France Gélinas: Could you share them with us?

Mr. Aryeh Gitterman: That's a different question. I think the page on findings is a hint as to the ideas we're developing further, if I can say it that way. We haven't tested all of these ideas out through the appropriate channels.

One of the forms we will be using to test out these ideas are the workshops we'll be conducting back with the agencies who provided the information. We're going to feed back the information and layer that information with our findings and assumptions about the things that have to be done now. So that last page gives a hint.

For example, we do think the question of access that you raised is a very important question. Are the right children finding their way into the right services, programs and agencies? I'll just use this by way of example: Because children are in schools a lot of the time, do schools and personnel in schools have the right tools at the right level to help make some of the right recommendations about that route to the right programs and services? We've started those discussions with our colleagues in education, but again, that's an idea we have at this point; it's not a direction. We have to test that out to see if it conforms with the notions that the people in the field, in the agencies and in the schools have. But it's an example of one of the directions.

The Chair (Mr. Kevin Daniel Flynn): Thank you. It's time to move on. First from this side is Helena, and then Bas.

Ms. Helena Jaczek: Well, thank you for your presentation and going into some detail around the mapping. I've certainly heard from the agencies in my riding and, in York region as a whole, from the providers. I must say, they are distraught in terms of the waiting lists that they're trying to manage in York region, given the growth in York region. They come to me in my constituency office, they come at every opportunity to express their absolute dismay around the funding provided to the agencies within York region. They see the mapping exercise, they understand the reasoning and so on, but they want to be assured of some sort of progress.

We've heard in this committee about early recognition and early access to a treatment plan, and when you have such a very large number of children on waiting lists, those in that community, the providers, obviously, are very anxious to somehow provide sooner. What is your time frame for the mapping exercise and for solutions and, hopefully, for some sort of equity in terms or service across the province?

Ms. Judith Wright: I can appreciate, actually, that the providers are a little anxious. I think that we underestimated the amount of information we would need to manage when we got the 1,500 survey results—plus it's been a combination of managing data and doing a qualitative analysis of what the agencies told us. So we've taken longer than we had wanted to to get back to them. As I said, we're forming them into the community maps and the provincial maps. I think we're targeting to take those out in the fall—

Mr. Aryeh Gitterman: We're starting our first discussions, just to make sure we have information that makes sense back to the agencies, in June or July, just to make sure we have the right presentation—and then rolling out from them through all of our nine regions, and many of those regions will have more than one workshop. So they'll start immediately after that.

Ms. Judith Wright: And just to recognize that we understand that wait lists and wait times are a very difficult situation for parents, children and youth, and the providers. In light of this not being a mandated service, we are optimistic that the data in the mapping will enable us to have a better understanding of whether the child or youth is on the right waiting list for the right service. It still won't end waiting lists, for sure, but at least will help bring a little bit more understanding to that situation. York has many special challenges by virtue of, as you just said, the extraordinary growth that's happening in that area.

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

Mr. Bas Balkissoon: Thank you for your input. It's nice to know you're doing some work—you say you're not mandated to look after mental health but you're doing some work there. The previous group said they received funding from the Ministry of Health, through the LHINs. They received funding from the AG's office, and they're handling ODSP clients, which is the Ministry of Community and Social Services. I suppose the Ministry of Health Promotion is going to get into the ball game in the future, because when they were here they were really at the preliminary stage of doing anything seriously. Which ministry is mandated to take total control of mental health?

Ms. Judith Wright: Just to be clear in what I mean by "mandated," the Ministry of Children and Youth Services has the mandate and is responsible for funding agencies that provide services for children and youth mental health that are community-based. The Ministry of Health has

responsibility for the medical-based services, and education has responsibility for services in schools—although we work with both of those service providers.

Mr. Bas Balkissoon: But who is in total control, who can say, "We're doing a good job and we're succeeding"?

Ms. Judith Wright: From a policy perspective, it is the Ministry of Children and Youth Services that says, "Here's the policy framework." When I was saying we don't have it mandated, I mean our programs are not entitlement programs, but we do have a mandate to take responsibility for it. I think I said in my remarks that we recognize that there is a real need for better coordination, both at the community level and at our level, of what services are being delivered by the three big service delivery areas: health, the Ministry of Children and Youth Services, and education.

Mr. Bas Balkissoon: But if you recognize that there needs to be better coordination, where would you put that coordination—in which ministry's hand?—and give somebody responsibility; that they're accountable, and that services are accessible, and we're meeting the needs of the public and it's measurable? Where do you see that resting?

Ms. Judith Wright: Good question. I think from the perspective of the community-based services—so not necessarily those that are covered by the LHINs and health—the best place to put that responsibility would be with the Ministry of Children and Youth Services. Having said that, the best place would be to put it in some kind of community capacity, because really what you need in children's mental health is that community governance model that enables those services to work together in a way that's responsive to the community they have.

Mr. Bas Balkissoon: If I go back to the work we did on the poverty committee, at the end of the day we recognized that we were not serving the client, truly, because we had all of these people doing different things, and the client was not the centre of that whole service model, and we needed to change. We're moving toward making that change. I'm sitting here asking, in mental health, who is the prime person who requires the help so that they live a fuller life? Again, it's the client. If we fund agency A and agency B, but we're not sure the client is getting all the services they need, we're not improving the system, are we?

1730

Ms. Judith Wright: No. Agreed.

Mr. Bas Balkissoon: So I want to know who's best to coordinate that—

The Chair (Mr. Kevin Daniel Flynn): It's time to move on, on that note. Thank you, Bas. And thank you for your answer.

Who's up next? Sylvia?

Ms. Sylvia Jones: Thank you, Ms. Wright. I also want to talk about the mapping that ties into what Helena was referencing. On page 13, the average wait for service is 38 days. I've got to tell you, that jumps out at me, because in my experience in my community, when a staff member highlights the need for an assessment within the school system, the assessment can be a year and a half to two years. So my question for you is, that average wait of 38 days for services: Is that after assessment? So assessment to service?

Mr. Aryeh Gitterman: Just to be clear, the information on wait times on this page refers to community-based agencies, not wait times in the school system.

Ms. Sylvia Jones: Yes, I understand that. But what happens is, the school staff say, "I think you should get your child assessed." It goes to a community-based service, and that's where the wait time is.

Mr. Aryeh Gitterman: Yes. So the wait time referred to here is from referral to beginning of service. So I phone or I'm referred to and I have the initial intake conversation. Before service begins, it's an average wait time of 39 days. But that's an average. What we have realized in the mapping exercise—and this had never been done before—is that there are 1,500 different programs being delivered by our agencies. Each of those programs may have slightly—and again, this is a description; whether it's good or bad is a whole separate discussion. Each of those programs may have a separate wait time associated with it.

When we refer later in the package to one of the steps or avenues of work that we believe has to be done, it is in fact landing on clarity on what the wait time is, clarity on how we will collect that information, and then a determination, which is a separate exercise, as to whether we find that wait time acceptable or not and whether we wish to set any different targets for lowering that wait time. But that's an average across very many different programs.

Ms. Sylvia Jones: I understand. So can you provide the committee with where those numbers are coming from? Because again, it comes back to—if I'm hearing from parents that it's a year and a half, then somewhere in Ontario someone's waiting an hour.

Interjection.

Ms. Sylvia Jones: Exactly my point. So can you provide that to the committee?

Mr. Aryeh Gitterman: It's not in a presentable package yet, but we will be able to provide information on wait times by program, by region of the province. And you are right: There is quite a lot of variability, which is what led us to the conclusion that we've already talked about.

Ms. Sylvia Jones: So when you say "by region," are you doing it by LHIN? What is the breakdown by community?

Mr. Aryeh Gitterman: We're doing our agencies by our regions.

Ms. Judith Wright: We have nine regions.

Ms. Sylvia Jones: Okay.

Mr. Aryeh Gitterman: But we're also collecting information from the Ministry of Health through their hospital-based programs, so that'll be a different organizational structure.

Ms. Judith Wright: We've had this discussion in other forums, but wait times—there will be duplications of kids who are on more than one wait list. So this average wait time data also has to be taken into account with the fact that—it has to be looked at within the fact that we don't have a unique way of having a wait time for each kid.

Ms. Marian Mlakar: It also takes into consideration all the levels across the continuum. Some children would be at level 4 and they'd be requiring fairly urgent service, and others would be at the more prevention level. So the community dialogue, we hope, will also talk about what we can tolerate around a wait list. Maybe we're more comfortable with having a longer wait list for a child who's not in dire need and less of a timeline for children who really urgently need mental health care.

Ms. Sylvia Jones: Right, which the CCAC currently does.

Ms. Judith Wright: A version of it, yes.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation today. It certainly is appreciated. You raised some very interesting issues and generated some good discussion. Thank you for coming.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): We certainly will.

ONTARIO SENIORS' SECRETARIAT

The Chair (Mr. Kevin Daniel Flynn): Continuing right along the age continuum, we go from children and youth services right to the Ontario Seniors' Secretariat. We've got Diane McArthur, assistant deputy minister, and if you'd introduce your staff, Diane, that would be appreciated.

Ms. Diane McArthur: I certainly will.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else, you've got 30 minutes. You can use that any way you see fit. If you would leave some time at the end, we'll share that as appropriately as we can.

Ms. Diane McArthur: Absolutely. I am Diane McArthur. I'm with the seniors' secretariat. This is Katherine Mortimer and Elizabeth Esteves. I'd also just like to note that we have a student with us, Ana Talag, who has done some work on the presentation and who is with us from McMaster University.

I'd like to start today by thanking the committee for the opportunity to present and for including the mental health needs of seniors within your work, and for recognizing that mental health is a broad issue beyond the scope of any single service, sector or organization.

Many of the things you'll hear me say I think you've heard already. The thing that is unique, I think, is the dynamic that happens between aging and mental health.

My presentation today will cover the seniors' secretariat mandate and highlight some relevant demographic and social trends. It will provide you with a quick overview of mental health and addictions among seniors; some key initiatives that the secretariat was involved in; some of the barriers that exist for seniors with mental health and addictions; and finally, some opportunities on how to better meet the needs for seniors with mental health and addictions.

Seniors face some unique challenges that increase the complexity of their physical and mental health needs. Seniors with mental health and addictions face both the stigma of mental illness and ageist attitudes. Population aging means that these challenges are only going to intensify.

Good mental health is the result of many factors. There is no single way to promote it, and there's still a lot we don't know about seniors' mental health and addictions in particular. We definitely need more research and a better understanding of the current and future needs of seniors with mental health and addictions issues if we're going to help to create a basket of services that are required to respond to those needs. Ideally, this response would be provided within an integrated and coordinated system of services, ministries and organizations.

On slide 3, you'll see a quick overview of the seniors' secretariat mandate. Unlike many of the presentations that you've heard today, we do not directly deliver services. We are focused mainly on leading policy initiatives for seniors, working across ministries and jurisdictions to make sure that the views and the needs of seniors are taken into account as policies and programs are developed.

We also work with public education and awareness both for seniors and for the general public about aging, the contributions that seniors make to society and about the availability of programs and services that seniors can have access to.

We work closely with many seniors' organizations to do this, and through the seniors' secretariat liaison committee, the advisory committee on seniors' housing, and the advisory committee on long-term care, the 11 largest seniors' organizations in the province have direct access to ministry staff from a variety of ministry program areas. We also arrange for key interest organizations, like the securities commission, to come and meet with the organizations so that they have an opportunity to discuss and have input on the development of a variety of programs and initiatives that affect seniors' day-to-day lives.

We've provided you with a list of the 11 organizations in the materials. I know that a number of them would be very pleased to meet with the committee during your consultation process.

On slide 4, I'll just speak quickly to some of the demographic and social trends that I'm sure we're all well aware of.

Ontario is home to 1.7 million seniors. That's about 13% of Ontario's total population and 38% of the nation's seniors population. That is a fast-growing demographic. The numbers will more than double to 3.5 million by 2031.

The fastest component of that growth is going to happen with people over 85 years of age. Older women will continue to outstrip the number of older men—that perhaps was an odd figure of speech.

Chronic disease is increasing the complexity of their health needs. And as with the rest of Ontario's population, seniors are becoming increasingly diverse.

Currently, over 70% of informal caregiving is done by family, friends and others, and mainly, that is by women.

Changing fertility patterns, reduction in household size and increasing geographic distance between family members are going to challenge our ability to provide intergenerational care.

There is a growing expectation among seniors that we'll be able to age in place and remain in our own homes as long as possible.

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All of these trends will affect both the demand for and our capacity to meet future health and social service needs, including those for seniors with mental health and addiction issues.

In the appendices in the handout provided, we outline some of the mental health and addictions issues faced by seniors, including statistics on prevalence. While I won't cover these statistics in detail, it is important to keep in mind that seniors are a heterogeneous population. Their needs and circumstances differ according to their mental health condition, life experience, gender and country of origin.

I'll speak to these needs along two dimensions: first, the aging of people with mental health and addictions issues and then, those who develop a mental health or addiction issue as they age.

Some conditions like psychosis are more likely to develop in early adulthood and may be marked by a cyclical pattern of recovery and relapse. In the most extreme cases, these conditions can limit employment, income and housing at various points throughout their lives. They can be extremely isolating; stigma, as well as behavioural, cognitive and affective symptoms, may make it difficult to establish and maintain long-term relationships and can contribute to the loss of social networks over the life course. As a result, care and support systems can't depend on informal caregiving to take the lead role, to advocate for these seniors or to help them navigate the system.

Finally, as people with mental illness get older, additional needs and complexities are likely to arise as part of the aging process. These can include mobility restrictions, memory impairment, difficulty with self care, chronic physical illness or cognitive and behavioural difficulties due to dementia. Mental health and addiction service providers need to be prepared to anticipate and deal with these complexities.

For the general seniors population, the most commonly discussed mental health issues continue to be depression, alcohol addiction and the impact of dementias. Risk factors for developing a mental health issue or an addiction later in life include social or emotional isolation, particularly as they relate to critical transition points: the loss of a spouse, unemployment or retirement, disability, illness, loss of independence, and caring for a spouse with dementia. The literature tells us that diagnosis for these seniors is particularly problematic as symptoms are sometimes overlooked as being part of the "normal aging process."

It's important, therefore, that health service providers and informal caregivers be educated about how to recognize these issues, because early intervention may mitigate loss of function and independence, delaying cognitive decline and reducing the health service use and emergency room visits.

On slide 6, I'll give you a quick overview of some of the initiatives that the Seniors' Secretariat has been involved in. It's important, though, to stress that seniors' mental health requires a variety of direct and indirect responses. As I said, we're not directly involved in direct service delivery, though we have led several initiatives that do relate to the general area.

I'll begin on slide 7 with Ontario's strategy for Alzheimer disease and related dementias. In addition to mental illness, seniors suffer from a variety of behavioural and cognitive disorders associated with brain diseases such as Alzheimer's disease and related dementias, or ADRDs. ADRDs are the most frequent cause of challenging behaviours in older adults. They also affect the health and well-being of the caregivers, many of whom are seniors themselves, resulting in burnout and depression from lack of support and respite. We know that caregiving is disproportionately provided by women and that depression is two times more common among senior women than senior men. These realities certainly underscore the mental health impacts of dementia.

Ontario's strategy for Alzheimer disease and related dementias was the first of its kind in Canada. Our secretariat led the development of this strategy with advice from a broad range of stakeholders and we worked closely with the Ministry of Health on its implementation.

Beginning with a five-year investment of $68.4 million and 10 initiatives, the strategy has resulted in $13 million in ongoing funding for respite programs, psychogeriatric resource consultants and public education coordinators. The strategy has also supported the development of two education programs for front-line staff.

Next, let me mention our work on elder abuse. Elder abuse takes many forms: physical, emotional, financial, and it can also be neglect. It is often perpetrated by those who are closest to the senior. Mental health and addictions problems can increase the vulnerability of seniors to abuse. It affects their ability to judge their own risk and vulnerability to exploitation by strangers or by someone they trust. Mental health and addictions can also be experienced by the people who are closest to seniors, increasing the risk of abuse.

Ontario's strategy to combat elder abuse has been implemented through a partnership with the Ontario Network for the Prevention of Elder Abuse. Through the strategy, regional consultants work with 52 local networks and service providers to improve local service coordination, help train front-line staff who serve seniors, and increase public education about elder abuse and

where seniors can go for help if they're experiencing abuse. These networks include members from the mental health and addictions sector, as well as partners such as CCACs, long-term-care homes, community support agencies and police. As abused or at-risk seniors have a multiplicity of needs that can't be served by any one of these services, it's important that service providers work together to improve the local response to cases of elder abuse and fill those service gaps.

Lastly, I'd like to talk about our safe medication use seminars. Older adults take up to 40% of all medications prescribed in Canada, and most older adults take several types of medications at a time. When combined with alcohol, some medications can cause harmful interactions. This is of particular significance, given the fact that alcohol is the substance most commonly abused by seniors with substance abuse problems. To date, over 100 educational safe medication use seminars have been delivered across Ontario through a partnership between the secretariat, the Ontario Pharmacists' Association and the United Senior Citizens of Ontario. Through those seminars, we specifically address the interactions and the problems of alcohol abuse.

While these initiatives make a contribution, we know that seniors who struggle with mental health and addictions face a number of challenges that can prevent them from getting the care and support they need. Some of these barriers are unique to seniors, and other barriers are shared by people of all ages. Let me mention a few specifically.

Lack of connection to primary care: Primary care is significant, especially for seniors, because of the complexity of needs that arise with aging. Primary care providers are essential as part of the early identification and intervention process because they're able to form lasting relationships with patients and can observe the changes that occur over time, some of which are very uncharacteristic or very subtle.

In addition, public knowledge and attitudes about mental health and addictions problems have changed rapidly, aided by the expansion of scientific research. This has been a good thing. But we can't assume that older generations have had the same exposure to this change. For generations that pride themselves on their ability to survive hard times through sheer will, mental health and addictions can be seen as personal failures. Lack of knowledge about what mental health and addictions are, or stigma about people who have mental health and addictions problems, can prevent some seniors from seeing their own symptoms clearly and seeking help.

Communication barriers and cultural differences can also affect the ability of a senior to communicate their experience and make them less willing to report symptoms, and may combine with other barriers to prevent diagnosis or cut them off from community supports.

Identifying mental health and addictions problems among seniors is complicated. Seniors' symptoms can be overlooked, and stereotypes about seniors and aging can contribute to under-diagnosis of mental health and addictions problems.

Social isolation can contribute to poor mental health and addictive behaviours, as well as prevent intervention. It cuts seniors off from the people who can identify their issues and trigger a response.

Seniors can face mobility limitations that make them unable to travel independently to places where care and support are provided. They may also live in communities where care and supports are not readily available. These barriers underscore the importance of making services available to seniors where they live.

Due to loss of capacity related to dementia or other illness, combined with the loss of social connections, seniors with mental health and addictions may need additional help to find, organize and access the services they require. For these people, the complexity of the support system itself is a barrier to care.

Elder abuse: Seniors with mental health and addictions problems are more vulnerable to abuse and may be living in situations where they are prevented from seeking help due to physical abuse, threats or intimidation.

Probably the largest barrier is the lack of appropriate housing options. Physical, functional and cognitive impairments related to aging may make seniors a poor fit for residential options developed for the adult population, or they may be functionally well and not require the level of care provided in a long-term-care home. Challenging behaviours like aggression, substance abuse and smoking can contribute to difficulty in accessing adequate and appropriate housing and community services particularly for seniors.

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Beginning on slide 11, we outline some of the specific opportunities to meet seniors' needs. There's no one way to promote seniors' mental health, but there are several key ways that services for seniors can be improved.

First, the use of community-based mental health outreach services and multidisciplinary teams: Seniors benefit from models that facilitate understanding and partnerships among the health care professionals needed to address mental health and the complexity of needs arising from aging. These partnerships include physicians, geriatricians, psychiatrists, nurses, personal support workers, case managers, mental health workers and occupational therapists. These models can also facilitate access to health care services that deal with the whole person, preventing a revolving door between emergency rooms, mental health services or difficulty finding services at all. Services designed to improve community living and coping skills can also be linked up to help support independence.

A focus on early diagnosis and treatment can make a difference for seniors. Training, not just for health professionals but also for the range of front-line community support workers and family members who have direct contact with seniors, would help them better recognize the mental health and addictions problems early. Training and education would also help improve approaches that address cultural differences. Use of specialized assessment tools for seniors would aid in early

diagnosis and help professionals and front-line workers to better distinguish between physical and mental health symptoms.

Affordable and appropriate housing options linked to community services: For seniors with mental health and addictions problems, appropriate and affordable housing is a key to independence and to aging at home. Supportive housing can help seniors have access to the level of physical and psychological care they require so that they're eating healthfully, even if they're not able to organize their own meal preparation, and they have help with the activities of daily living, which often become a challenge later in life. Supportive housing can also link seniors to transportation services that help them maintain good health by ensuring they're able to travel to medical appointments and to the support services they need.

For people who are aging with mental health and addictions issues, particularly those who have had insecure housing in the past, affordable and accessible supportive housing options are of the utmost importance to health and well-being. We also have to ensure that existing services for seniors like Meals on Wheels, many of which are powered by seniors as volunteers, are able to respond to people with mental health and addictions issues.

Finally, research on how to meet the diverse needs of seniors: To ensure we're prepared for the future needs of seniors, we need to know more about how seniors with mental health and addictions problems are being served by the current care and support system. We know there are creative and innovative options out there in our communities; for example, the inner-city access and support pilot program, which is an 18-month pilot program serving homeless and marginalized seniors in the Toronto area. This partnership between the Toronto Central community care access centre, the Homes First Society and others has just begun to improve the care and supports for a vulnerable and marginalized population of shelter users, many of whom experience mental health and addictions problems. The partners recognized that the health and well-being of this group can be improved through more thoughtful and holistic approaches than have been traditionally available. It will be very interesting to see what lessons are learned through this program and what new knowledge can be shared to improve service to these groups.

That brings me to the end of my presentation. I'd like to thank you again for the opportunity to speak with you and will answer any questions.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you, Diane. Maybe I can start with a brief question, and that is that I seem to be hearing from people in my own community about the increasing problem of seniors developing behavioural issues that may include violence and the inability of the long-term-care facilities to cope with that behavioural issue, and then not knowing where to turn next. Are you seeing that as well?

Ms. Diane McArthur: We are certainly hearing about it. We're working closely with some of the information providers to understand in more detail what the prevalence rate is. Anecdotally, with the increasing rate of dementias you would expect to see those kinds of problems show up. I think the strain is on the system to find the innovative approaches.

The traditional historical approach to somebody with a dementia was 24-hour, locked-ward care. I think the challenge in the system now is to find more innovative approaches and support systems that allow for care in the community as long as possible.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any other questions from this side before I move on? Okay. Christine or Sylvia?

Mrs. Christine Elliott: I just have one quick question. One of the things that I encountered in my past life as a practising lawyer was some of the issues relating to people who are maybe in early stages of dementia who are preparing wills and, more particularly, powers of attorney for finances and for health care, but primarily financial. There seems to be a real growing problem. Do you have any particular studies that are under way on that, any collaboration maybe with the Ministry of the Attorney General? Or is that something that's sort of high on your radar screen as well?

Ms. Elizabeth Esteves: We do. We're quite engaged with the Ministry of the Attorney General, in particular, the public guardian and trustee, and also the Ministry of Health and many community organizations like, for example, the Advocacy Centre for the Elderly. The secretariat has actually produced educational materials, our Guide to Advance Care Planning, to assist families and seniors before they lose mental capacity to understand that they can prepare an advance care plan that sets out their wishes for a time when they're no longer capable. Those kinds of educational programs actually have been weaved into our seniors' seminar series, so along with the medication management seminars we do have seminars that talk about those kinds of issues. But you're right; more needs to be done to reach more seniors and families.

Mrs. Christine Elliott: If I could just say, I think also there's a greater need for more legal education on that subject too, because it's very difficult often when you have someone who comes in to see you and you're not really sure whether they're mentally capable of making their own decisions or not but you can certainly see that there may be some influence that's being exerted by family members. So I think it's something that maybe the law society could be helpful with as well.

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

M^me^ France Gélinas: Just a general question. I appreciate your presentation and certainly see that you do cut across a lot of ministries and have a positive influence for the seniors of Ontario through the work that you do. Through the work that you do and the partnerships that you share, do you see any shining lights out there, as in groups of people or research under way that could really make a difference as to the growing number of seniors struggling with mental illness?

Ms. Diane McArthur: We tried to highlight one in the presentation. We've been working with some of our partners to try and identify others, particularly the seniors' organizations themselves. There are some very innovative programs; for example, the francophone community has a very informal program that they're working on now, which is Good Neighbours, Bons voisins, which helps people understand and recognize when someone in their immediate community might be at risk and how to help work with a senior in their local community, to provide some of the supports. When it's connected with the rest of the system, it's the early identification and making sure that people know if you think you have someone in your community who's developing a mental illness, who you speak to and how you connect. Those sorts of examples are out there. We haven't really pulled them together in any way; I think they're relatively informal. We are trying to work with the Ministry of Health as well through some of the work that they're doing on a mental health strategy to try and encapsulate some of those.

M^me^ France Gélinas: So there is nobody right now working on best practice for either early identification or treatment or support specifically for seniors—

Interruption.

M^me^ France Gélinas: He'll turn it on for you.

Ms. Elizabeth Esteves: I'm having a problem turning it on.

At a national level there is considerable work under way by the Canadian mental health coalition. There are guidelines on dementia, on delirium. There are lots of wonderful resources. For example, the National Initiative for the Care of the Elderly has also developed guidelines on assessment of particular conditions among seniors. So there are wonderful coalitions of experts.

For example, in Ontario, and I believe that he's on the minister's advisory committee, Dr. Ken Le Clair and many others are involved in this and many physicians that we've developed relationships actually through the Alzheimer's strategy. Dr. Marie-France Rivard is also working at a national level with the working group that is supporting the Mental Health Commission of Canada. There is some work going on at the national level. They'd like to develop a knowledge exchange, a centre of excellence for data and research on mental health, seniors' mental health, and they're also committed to developing a 10-year anti-stigma campaign. There is this wonderful work going on and that will yield lots of new research, so there are key experts working in this field.

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The Chair (Mr. Kevin Daniel Flynn): There's time for one more question. Liz?

Mrs. Liz Sandals: Yes, it just occurs to me that there's a lot of work going on in the area of dementia and Alzheimer's, which makes sense because they're newly acquired diseases for seniors, if you can put it that way. Is there really any work that goes on looking at what happens to somebody who has a mental illness, schizophrenia or bipolar or something like that, and they've had it for a long time and then they will inevitably age. Has anybody looked at that issue?

Ms. Diane McArthur: There was very little that we could find about that and that's why we think the need for research is so important in this area. The aging of people with mental illness is a relatively recent phenomenon, not unlike the aging of people with special needs, because you used to develop a number of complex other problems in your life course. It's particularly as they get to their much older years and you start to layer on the additional complexities of aging that it's going to become much more difficult, because those people who could self-manage will have additional challenges.

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

CENTRE FOR ADDICTION AND MENTAL HEALTH

The Chair (Mr. Kevin Daniel Flynn): Our previous host now becomes the guest. Dr. Garfinkel, if you'd come forward. Thank you very much for the tour the other day. I'm sure it was appreciated by all the members who are seated here. Very interesting, very valuable. Like everybody else, you have 30 minutes. You can use that any way you choose. If you could leave some time at the end for questions, that would be wonderful. The floor is yours. Welcome.

Dr. Paul Garfinkel: Thank you for the opportunity to present my views to this group and thank you for the work that you do on this committee. I've brought with me copies of my submission, the submission that CAMH is making, to assist you in your work. I'll be making a few remarks, I hope few enough to leave you with plenty of time for questions and answers.

I'd like to begin by reflecting on the mandate of this committee. I don't need to tell you that many people are wondering how this committee will intersect with the group that the minister has put together with regard to the mental health and addictions strategy, and we believe there are great opportunities at this time for alignment of these two processes. I, of course, want to focus on the opportunities that this committee has at this time.

Your mandate is appropriately brought. You can look outside the traditional silos of mental health and addiction and how they're funded and you can actively explore all the areas of government, including how well main street government services meet the needs of people who live with a mental illness or a substance abuse problem.

For example, the government has launched an anti-poverty strategy. We welcome these efforts. One key objective of an anti-poverty strategy should be much higher rates of workforce attachment for those with serious mental illness or an addiction.

Another example is the physical health of many of our patients. As you know, as we talked about last week, this can be rather poor. There is about a 65% higher mortality rate from cancer for our patient group than for the Canadian average. Access to primary care is a significant

challenge for many people with mental illness or an addiction, and there are many reasons for this.

The answer to a number of these issues does not lie within traditional mental health and addictions budgets and programs. It relies on ensuring that mainstream health practitioners and programs are sensitive to the needs of people with mental health and addiction problems. Your committee has the breadth in its mandate to explore these issues.

Simply put, this committee's task is very important because mental health and addictions are common, serious and neglected problems. The prevalence of mental illness and addiction, I'm sure you've heard many times, is that at least 20% of us will need some help for these problems at some point in our lives.

In economic terms, mental illness and substance abuse cost Ontario about $34 billion a year, mostly due to productivity losses but also going through the full spectrum of costs that we experience. Of course, millions of families in Ontario know that the biggest cost can't be measured in dollars and cents. Individuals with these problems know of the shame, loss of control, broken relationships and exclusion. Tragically, these problems are often ignored. Just last year we learned that 65% of Canadians experiencing multiple episodes of psychological distress never did consult a health professional about the problem.

What makes people less likely to seek help for a mental illness or an addiction? Why do I hear patients speak about "entering the mental health and addictions system"? I never hear of anybody entering the "arthritis system" or the "diabetes system"—it doesn't happen. Mental health and addictions are like any other type of human illness, and deserve appropriate attention and appropriate care. The scientific base is strong and the suffering is real.

I believe that the breadth of your mandate and the non-partisan nature of your commitment to improving mental health and addictions care provides you with the scope to address three critical issues.

First, you should acknowledge that many of the key investments that governments make in health don't come from any health budget. Housing, adequate income supports, and access to the labour force are fundamental to the well-being of individuals and fundamental to our system—for every single one of us. Housing is extremely critical for the mental health treatment system, and lack of appropriate housing is one of the greatest impediments chronically ill people face to a full, rich and satisfying life.

We want our hospital beds to be occupied by people who need to be in hospital—people who have complex, specialized needs—for a period of time of the illness. Most people who have an illness don't have to be in hospital for most of the time. Hospital beds can be used well for people who are living in the community, and people have to come back to us for relatively short periods when their illness has flared up. Not only is that better economics—it's cheaper—people have better quality of lives when they're in the community. There's less loss of identity; there's less dependency; all the problems that hospitals cause can be prevented in the community and you can get just as good care—better care. So that's my first point.

My second point for you to consider is the issue of funding. I'm not here to play a victim and say how poorly we've been treated. We've been treated very well in the last half-dozen or so years, and I also know that this is probably the worst time ever to talk about money in Ontario. Nevertheless, you have to know that for a variety of reasons related to what we've just been talking about, the serious mental illnesses account for about 12% of human distress and suffering. This is data from the World Health Organization. It's true in Canada, it's true in Brazil and it's true in Australia. It uses a global burden of disease to measure disability; it looks at early death or lack of productivity and the burden that you experience. So five out of the 10 top causes of disability are in our sector, whether it's depression, schizophrenia, OCD, alcohol—five out of the top 10. They account for 12% of disability. Our funding is always about 5% to 5.5% of the provincial health budget. Even with the gains that we've made in recent years, we're about 5.4%.

1810

Most OECD countries devote a considerably greater percentage of health care dollars to mental health, including the UK, the USA, Germany and Australia. We're way back. Within Canada, Ontario's spending for mental health trails the national average: On total per capita spending across the provinces, we are ninth. Clearly, we're confronted in this country and this province with an enormous gap between the size of the problem and the health care response.

There are no magic solutions to addressing this gap. Government has made important investments in community mental health care in the last six, seven years that I think are amazing. I never would have thought I would see the kinds of investments made and how they're used so well. You heard last week from my colleague Paula Goering that these investments are being rigorously evaluated to ensure they're building a better system. The government is to be congratulated both for the investment and for assessing the impact of these new developments, yet the gaps in treatment remain significant.

This committee represents a non-partisan commitment to addressing mental health and addictions care in Ontario, and ought to be establishing long-term objectives to building a stronger system of care. We would all be greatly enhanced if there were goals that were clearly defined over the coming decade.

The committee should also consider establishing an objective of systematically increasing investments in mental health and addictions care, particularly in the community sector. So you'll have a hospital coming to you saying, "Invest in the community," particularly community supports, social supports and housing.

In keeping with these new investments, there should be evaluation of every step of every development, so that

we can be clear that the funding is appropriately being used, that people who need the funding and need the new treatments are getting them. This has not always been the case in our province.

The third thing I wanted to just comment on is that I'd ask you to look at the issue of primary care. Family doctors, community nurses—these are the people who are most often consulted by people seeking help for a mental illness or an addiction, and that's the way it should be. Some 80% of the work in our sector will continue to be done by the primary care. We want that.

We must remember that the health needs of people with mental health and addictions problems are the same as the health needs of people throughout Ontario. Early recognition is important; identification of emerging problems is important; prompt and respectful referral to more specialized services, without stigma or embarrassment; and ongoing support to assist the person to take greater control of their health and their lives. We can do an awful lot more in this arena.

Unfortunately, there is evidence that the ability of primary care to provide mental health and addictions treatment that conforms to guidelines and best practices is often limited. I think last week I gave you the data from Ontario that said for an eminently treatable disease, depression, half of people in Ontario won't get treatment. They won't come for treatment, or it won't be recognized as a problem of depression. Even as alarming is that of the half who come forward, one half of those won't get the best practice, will be inadequately treated—and that's as true for urban Ontario as it is for rural Ontario.

Research points to many solutions here. It emphasizes the multidisciplinary team and better patient follow-up, which haven't always been optimal in our province. The Ministry of Health and Long-Term Care is headed in the right direction with the expansion of community health centres and community health teams. We should be assessing whether these investments have been successful in improving mental health and addictions care and outcomes. We should also be assessing whether these mental health and addictions problems are getting better access throughout our primary care system.

We have to learn how better to help our primary practitioners. This is a responsibility that CAMH takes very seriously. We are connected to many family practices across the province, and we provide continuing updates in a highly valued way so that people can learn about health promotion, and prevention, early identification and treatment of common mental illnesses.

I'd like to just end with a note about CAMH and its role in the system. Eleven and a half years ago, we were created when the HSRC amalgamated four institutions: the Donwood, the Addiction Research Foundation, the Clark Institute of Psychiatry, and the Queen Street Mental Health Centre. I've had the privilege of serving as president and CEO of CAMH throughout it's history, and I'll be leaving this post in a number of months. I'm very, very proud of what we've accomplished at CAMH, and I think Ontario can also be proud. We've successfully brought together the treatment of mental health problems and addictions problems, and we've improved services for large numbers of our patients who have both a mental illness and an addiction. CAMH is the largest mental health and addictions hospital in the country, one of the very large ones in the world. We can make a huge difference in the lives of people throughout the province, whether it's by fly-in service, teaching, building capacity, or telemedicine.

Depression is one example where we make a very significant difference. Just a few blocks away from here, you'll find the most sophisticated brain imaging centre in the country and the best in the world. The researchers in our PET centre have had significant impact on best practices, new medications in treating depression, and in fact understanding the role of psychotherapy as it plays on the brain. Our basic science has provided a whole new understanding of how the brain works, leading to new and innovative treatments. A lot of this has occurred just in the last three years, and it's quite thrilling to us. At the same time, our health promotion specialists are looking at how you can prevent the fall in self-esteem that occurs in adolescence, how you can prevent depression, how you can recognize it earlier, and, if someone is troubled by depression, how you can live a full life in Canada in all aspects.

The work of this committee can also be an important milestone in building a healthier Ontario. With a focus on long-term funding commitments and social investments that support health and primary care, you can bring a pan-government perspective that is needed to make a sustainable difference in the lives of so many people who have mental illnesses and addictions. We welcome any opportunity to support you in your work. Please don't hesitate to call us if you have any questions or need for anything from our point of view to help.

1820

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. Let's start with this side this time, either Christine or Sylvia.

Ms. Sylvia Jones: Just very briefly, I wanted to get you to expand more on the role of the primary care physician. You mentioned 80% of the work will be done by primary care providers. If you had a number one wish list, what would be the best way to either educate, inform—get buy-in, basically?

Dr. Paul Garfinkel: Could I have three number ones?

Ms. Sylvia Jones: Absolutely. You're leaving.

Dr. Paul Garfinkel: I think our universities, our medical schools and our health disciplines training have very recently gone into inter-professional education. I see that as hugely important. The way physicians have been trained—sometimes selected and trained—works against building effective teams, and I can't tell you how important teamwork is in everything we do in health care. It's true in much of life these days. But you can't do in health care or in health care research without effective teams, and you can't make the doctor the prima donna and expect an effective team. That's the first thing I'd say.

The second thing is that physicians need, in the primary care setting, an awful lot of education support, but not in the traditional way where you go to a conference and you come back. Those are very good for motivation; they make you want to know more and read more, but what you need is ongoing help when you have a clinical problem. We need to evolve shared care models. Say, a family health team has access to our depression specialists on Fridays, and you connect by the phone, by web, by TV, as the person's in their office—or we're out there every Friday.

Those two are critically important. I would add a reconsideration of OHIP funding models. As I understand it, the family health teams are really addressing that. A good primary care doctor can spend six or seven minutes with a patient, and how can you do good care in that time allotment? That has a lot to do with how OHIP reimburses primary docs. I do think there's a lot the multidisciplinary team does, but I think you want physicians to be well funded for sitting and being with people. As you all know, it's very important to be able to sit with somebody who is very ill or disturbed and just be with them, not sitting and staring at, "Is it six minutes or seven minutes?"

So those are my three.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Speaking of six minutes, France, it's your turn.

M^me^ France Gélinas: I'm pleased to see you again. I was most interested by some of your solutions for primary care and certainly support them wholeheartedly. I was also intrigued by—you gave that 50% of the people with depression won't get recognized and therefore, won't get treatment, and of that 50% who comes, they won't get the right treatment. Could you expand on this? Let's start with the first 50% who will never come. How come, and what can we do to change this? And then the next question will be, for the 50% who do come, how come they get the wrong treatment?

Dr. Paul Garfinkel: The 50% who don't come, don't come for a variety of reasons. They can be embarrassed. They can feel it's a moral problem: "I should pull up my socks and solve it myself." They can feel, "It'll hurt my career." They can be from some groupings in our society who feel hugely embarrassed related to the marriageability of others in the family: "If I have a serious illness, what does that mean for my brothers and sisters and who's going to want to marry them?" So, many people don't come.

If they do come for treatment, it may not be recognized. The primary doc may see it as a physical problem. Many people in our society present with depression with physical symptoms: "I can't sleep. My gut hurts, I can't move my bowels. I'm twitchy"—and you could go on to a very lengthy series of investigations rather than the right treatment. Or sometimes, a family doctor or a primary care worker is not comfortable in this arena and won't ask the right questions, or will ask the questions in a distorted way. Your family doctor says to you, "You're a moderate drinker, right?" It's very hard to say, "No, I'm a heavy drinker." It has a moralistic tone. In spite of that, 80% of people who go to the primary care person for help respond to say, "This is a very positive experience."

When you come for help for depression in Ontario—before, I was talking about any kind of primary care; now I'm talking about a family doctor—chances are very heavy that they'll put you on an antidepressant, and because of perhaps worries about side effects or a lack of familiarity, they will put you on a very tiny dose, not enough to have the proper benefit. The antidepressant drugs we use are effective in about 80% of people when they're used with counselling and when they're used in the right dose.

We have a very busy clinic for mood disorders that does consults. There are many consults a week. The most common response is just to increase the treatments. So it makes you wonder, "Why do our specialists have to do this? Is there not another way to connect to the family doctor?"

In addition, there are some newer forms of psychological treatment. They're focal treatments; they're not the long, extended treatments that may last 20 weeks. They're really effective for depression and anxiety. Here the issue is, how do you teach people them when they've been out in practice and how do you have practitioners spend the time that's necessary to do so? Again, we do teaching for thousands of people a year in primary care. They rate it highly; they love it. Sometimes, outside of family health teams, it's hard for them to be able to do what they have to do and earn a living.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dr. Garfinkel. We've got Helena and then Liz.

Ms. Helena Jaczek: Very much on the same theme about the 80% who have that primary contact with the primary care physician—we did talk a little bit about this when we were visiting your facility. What is CAMH doing in terms of helping family physicians to make the diagnosis—this whole issue of early recognition—given that, clearly, there may be physical symptoms that distract you and you have a broad differential diagnosis and so on.

It seems to me that the average family physician with the six minutes needs some sort of tool that they can use as soon as they have a suspicion that perhaps there's an ill mental health component to this presenting situation, that they have an easy way, somehow, of being able to recognize—so that's my first question: What are you doing in terms of helping, given the research you've done? And second, there will always be many family physicians who will not feel able to spend the time and explore in more depth and really have the ability to know what's out there in terms of supportive housing and so on. So could you give us a recommendation, if that physician is not on a family health team and is in solo practice, for where they go from that diagnosis to making an effective referral?

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Dr. Paul Garfinkel: Good points, and they cover the two ends of the spectrum. The housing is, by and large,

for chronic, serious illness, and I don't expect any regular doctors—and maybe many community psychiatrists—to know the details of different types of housing. This is an area that has a real science to it now. When we went to school, everybody went from the hospital, if they were lucky, to a crummy rooming house. Now there is supportive housing, which makes a huge difference in readmission to hospital. So I would expect them to connect with specialists in the area of chronic illness, who, by and large, are in the specialty hospitals in Ontario.

The other part of your question about the front end relates to many of the things I mentioned in the previous question. We have to see that the medical schools, the nursing schools and the social work schools give adequate time and information, that people feel comfortable with these. We have a real obligation when teaching people in undergrad, teaching the residents. We have a set-up with about 82 primary care docs right now as a base to get into this more. We have to do a better job of getting people access when the doc is worried. I might see somebody in consult—it might take me two or three weeks. I say, "Let's try this and this, and then send them back." If the person is really having trouble, I should be able to take them back very quickly. Otherwise, the family doctor feels burned. We have some work to do on that.

In my own area of, say, anorexia nervosa, when people are improved and stable, I do find the primary care docs very accommodating. But things can go bad very quickly, and if you can't see the person in 24 hours, they won't take the next person. And they're right not to.

The Chair (Mr. Kevin Daniel Flynn): There's time for one very short question and one very short answer—or maybe one long question and no answer.

Liz.

Mrs. Liz Sandals: You've noted in the materials that you gave us that there's often an overlap, a dual diagnosis, between people with particularly serious personality disorders and addiction, but we tend to organize the mental health system around, "Here's mental health and here's addiction." Do you have any particular recommendations on how we can break down those silos and integrate the treatment.

Dr. Paul Garfinkel: Yes. In 1989, I was at Toronto General and we had about 40 psychiatrists on staff—this is going to be a long answer; sorry. We had 40 psychiatrists on staff, 25% of our referrals were for an addiction-related problem, and we had nobody with a clinical ability in addictions and nobody who could teach the students about it. So for the last 12 years, we've been working hard to break down those silos. Twenty per cent of the people at CAMH now have cross-program connections. The figure should be 40%.

Mrs. Liz Sandals: But what you're really saying is that that's a deliberate hiring and training strategy as opposed to—it isn't so much that the government said, "Thou shalt integrate," it's actually, at the local agency level, deliberate hiring and training.

Dr. Paul Garfinkel: This is clinical idealism that turned poorly about 40 or 50 years ago, in which there was a split, particularly in North America. The addictions community did not have a common view. They hated the pathologizing and the moralizing of the mental health community, and the self-help movement was very successful, so they just split off. It had nothing to do with patients. Patients readily get—you need to help them both.

The Chair (Mr. Kevin Daniel Flynn): Thank you for being here today.

Dr. Paul Garfinkel: My pleasure.

The Chair (Mr. Kevin Daniel Flynn): I'm not sure if I should thank you for the news that you'll be leaving us soon. That was a bit of a surprise.

Dr. Paul Garfinkel: It's time.

The Chair (Mr. Kevin Daniel Flynn): My first thought is, if we can't quit, you can't quit.

Laughter.

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

CHILDREN'S MENTAL HEALTH ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next presenter, our final presenter of the day, has arrived with perfect timing: Gordon Floyd, executive director of Children's Mental Health Ontario. If you'd like to come forward, Mr. Floyd, the floor is all yours. As with the previous delegations, you've got 30 minutes. You can use that any way you see fit, but if you could leave a little bit of time at the end for some questions, I know that the members would appreciate that.

Mr. Gordon Floyd: I will certainly try to do that. Thanks, Mr. Chair.

I really do appreciate this opportunity. I know you have had a long day. My guess is, everybody wants to get away to dinner. I'll try not to hold you up too much. I will try to keep my opening remarks reasonably brief so that I can deal with your questions and talk about the things you want to talk about.

I am the executive director of Children's Mental Health Ontario. We're an association that was established in 1972. Our mission is to champion the right of every child and youth in Ontario to mental health and well-being.

Our core membership consists of about 85 accredited children's mental health centres. They are spread across the province. There are about 32 of them in the GTA. In most parts of the province, in most counties, in most districts, in most regions, there is only one accredited children's mental health centre.

Most of those agencies are multi-service agencies. I know that you have heard a fair bit, and you will hear more from me, about the need to integrate services in many ways. One of the interesting things that I have learned is that at the community level, there is a very great degree of service integration already going on. Approximately 70% of our accredited members are multi-service agencies. Some of them combine with youth justice agencies; some of them combine with children's aid societies;

some of them combine with adult mental health services; some of them combine with women's shelters—it's quite an array of services.

We also have, in our membership, a range of other child and youth mental health service providers, not accredited—that's a smaller number—and we include as well in our membership a number of individuals, parents and clinicians.

Our key activities, besides being an accrediting body, include work in the areas of public education about children's mental health—anti-stigma work. We also provide significant support to service providers in the implementation of evidence-based practice and the improvement of their services in that way.

On behalf of the Ministry of Children and Youth Services, we provide training and management related to the mandated intake tool, screening tool, that's used across the system. It's called the brief child and family phone interview, BCFPI. We have also worked very closely with the ministry on policy development initiatives. We played a very strong partnering role with the ministry in the development of the policy framework for children's mental health that appeared about a year and a half ago, called A Shared Responsibility.

Some of you will know us in our other role, which is as advocates, and advocates in particular in relation to the funding of services and the capacity of the children's mental health system.

In our public education work, we focus most of our messages on three themes. The first is one that I expect many of you are familiar with, and that is that one in five children in Ontario has a diagnosable mental illness. We use this theme, and hit on this one first, in large measure to help de-stigmatize children's mental health problems. The significance of one in five children being affected is that essentially every family in the province has some direct connection to a child with a mental health problem. Certainly every classroom is affected; in a typical classroom, there will be four or five children who are struggling with some type of a mental health difficulty, and most certainly every community is dealing with these problems.

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In our public education work, we also emphasize that children's mental health problems are serious. They're not to be dismissed. Many people of my generation have the attitude that a kid who's having a bad day probably just needs a kick in the butt and all will be right. We make the point repeatedly that children's mental health problems are extremely serious and, when untreated, far too often lead to very serious consequences such as suicide. I know that Senator Kirby last week was talking to you about some of the suicide statistics, and I won't go into those again.

The third message that we emphasize is that treatment works. The mythology that is still prevalent, that mental health problems are not treatable, is just that: It's mythology—particularly when you're dealing with children and particularly when you're able to intervene early. The wonderful thing about working in the children's mental health field is the realization that you're still dealing with developing brains, you're still dealing with problems that are in their infancy, that haven't taken deep root, and it is most often possible to overcome those problems by intervening early with effective, evidence-based treatments.

The messages that you may have heard from us more often are some of our advocacy messages. I'm not going to go into those in detail, but I'm going to touch on them lightly because they are critical, I believe. The first of those is that our existing system of services for children and youth with mental health problems and their families is inadequate to meet the needs. It is unable to meet the needs of children and families in this province, and the gap in that regard is getting wider and wider.

I have provided you—yes, the clerk has had a chance to get this to you—with a two-page paper that summarizes what's happening in 10 children's mental health agencies around the province. I didn't pick the 10 worst; I picked 10 typical agencies in all parts of the province to put into this document. What you will see there is that agencies are chronically running deficits. Agencies are systematically, year after year, cutting back services, laying off staff. They are, year after year, raising the bar for admission to their services so that they're increasingly becoming crisis-based services and they are, in many respects, falling further and further behind.

I know that all of you are aware of the crisis that emerged a few weeks ago at the Roberts/Smart Centre in Ottawa, where the board began the process of heading to bankruptcy. You may not be as aware that earlier this year in Hamilton, the Community Adolescent Network folded its doors due to insolvency. What you definitely will not be aware of, but must be aware of, is that these two agencies are the canaries in the coal mine.

I am not one to use the word "crisis" lightly. I don't like the word because it is so overused. I'm not one to sound alarmist, but I will tell you that there is absolutely no doubt that what we have seen with the Community Adolescent Network and the Roberts/Smart network is going to be repeated many times over in the next couple of years. Across the province, agencies truly are hitting the wall. Today, I heard from one agency where again this year, after they did their union negotiations, they've had to lay off another couple of staff and cut services by that much more. I heard from an executive director who was almost in tears this morning. She has only been in her agency for eight months and she realizes that her budget is heading for a $500,000 deficit this year. She has absolutely no money in her budget to train her staff about the implementation of evidence-based practices. She really does not know whether her agency is going to be able to survive. That's an agency here in Toronto. There are other examples in the material that I've provided you with.

The reason for this lack of capacity is quite simple: In 12 of the last 15 years, there were no funding increases of any kind for children's mental health services. During that period, the system lost, just by inflation alone, about

25% of its capacity. What has been happening at the same time as the system has been losing its capacity is that the demand for children's mental health services has been steadily rising. That's for a whole lot of logical reasons that we all know. We know about the changes that have happened in family life, in the structure of families, in the last 20 or 30 years. We know about the increased pressures that young people are feeling through the media, through the need to excel at school, through the need to keep up with their peers. We also know that, fortunately, we're doing a better job of recognizing behaviour and emotional problems for what they are, so more children are being referred for service at the same time as we have less and less capacity to meet their needs.

As I mentioned earlier, services are remarkably well coordinated at the local level. The coordination in most instances is pretty informal. If you go to a place like Lanark county, there's one children's mental health centre, there's one children's aid society, there's one family service organization, there's one developmental disabilities organization, and they all talk—they case-manage situations on a weekly basis and the coordination at the community level happens all the time.

Where there is no coordination or very little coordination is across ministries and at the policy level. In particular, here in Ontario we have, in truth, three different children's mental health systems that don't connect very well. We have the community-based system, which is the one that I'm most involved with. That's a system where services are delivered through transfer payment agencies. We have a school-based mental health system, which is pretty anemic, but it's important. The psychological services and the support services that are available through the schools are geared to help children who have learning problems, and rightly so. But the link between those services and the community-based services is very ad hoc and very, very weak; truly inadequate. Then we have a whole other set of services that exist in the health system. Some of those are hospital-based services such as the crisis stabilization that happens when a child's having a psychotic episode, or the eating disorder clinic, which is essential to providing the intensive care that children with those problems need.

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We also have within the health system what is probably the most used and least equipped part of our children's mental health system, which is the part that happens in family physicians' offices. Family physicians in this province get no training at all in children's mental health. We have been told by the Canadian Paedriatic Society that half of all visits to pediatricians in this province are for mental health problems. We know that family physicians are constantly dealing with these issues. They don't have the training. They don't have the time. They certainly are not compensated in a way that they can spend an hour doing cognitive behavioural therapy with a child who needs that, so they pull out their prescription pad and write a prescription, usually for drugs that have never even been tested on children.

The only drugs in the field of mental health that have been tested on children are those for ADHD, and yet on a constant basis we are writing prescriptions for anti-depressants, anti-psychotics and a whole host of other pharmaceuticals without having any understanding of what the long-term effect is going to be on the brains of the children that are processing them. Everything that happens in those physicians' offices is disconnected from what's happening in the schools and from what's happening in the community-based agencies.

We have a very serious problem, and I think that there is a serious issue to be addressed about the organization of children's mental health services in Ontario. There are probably many ways to look at this, but the question that keeps popping into my mind is whether it makes sense for us to have a single children's mental health system, a set of services, if you like, that moves in and out of various systems, or whether we want to maintain three separate systems and try to figure out ways to connect them better. I think that that's a fundamental decision that needs to be made and that I hope your committee will wrestle with.

I guess what's implicit in much of what I'm saying is that system reform is urgently needed in the child and youth mental health services area. We are fortunate in Ontario that we, for the last year and a half, have had a really good map for what the system reform should look like, and that map is set out in the policy framework, A Shared Responsibility, that was produced by the Ministry of Children and Youth Services a year and a half ago, in November 2007.

Unfortunately, in the time since that policy framework was issued, there has been no visible movement on its implementation. If you haven't already heard from the ministry, I'm sure you will that they have a mapping exercise under way and that they're trying to get a sense of where services exist, and that's great. In the meantime, we're trying to run agencies and we've got kids coming to our door and nothing has changed in the 18 months since that policy framework appeared.

The recommendations in that report, the way forward that's set out in that policy framework, really make good sense. The contents were developed after extensive consultation with people in all of those systems that I talked about a moment ago, and there is strong buy-in to the direction that's laid out in A Shared Responsibility.

The key points there, as we understand them, are quite closely related to the five points that are laid out on that page you've got in front of you, the five things that kids and their families need. We need a front end to our children's mental health system. We need a system that does something other than or more than deal with crisis situations. We need a front end that includes health promotion, illness prevention and early identification. We don't have any of those pieces in places in a comprehensive way in Ontario today.

We don't engage public health. We don't engage the Ministry of Health Promotion. We don't engage our schools, our Best Start agencies or our other early

childhood facilities in any systematic program to screen for potential mental health problems. We screen newborns for 26 different physical health problems. We have nine—I believe it's six or nine—mandatory vaccinations, yet we don't have any universal programs for either prevention or identification in the mental health sphere.

A second key plank or part of the policy framework speaks about the need for more timeliness in terms of services. I'm sure that you have all heard at various times about the long wait-lists and the long wait-times for children's mental health services. In 2008, the average wait-time to start service in a children's mental health centre in Ontario was 69 days. There were 1,716 children who waited longer than six months to get into service in 2008. That's 10% of all the kids who got into service waiting longer than six months. In any other field of health, that would be readily recognized as completely unacceptable.

A third piece in the policy framework which we, again, strongly support—I guess what I will say about the timeliness, before I leave that, is that there's no way that we're going to achieve greater timeliness, easier access to services without putting more resources into the system. This is the burning platform at the moment, and I want to make it very clear that we strongly support the medium-term and longer-term initiatives that need to be taken to reform and fix the system. We are not talking about maintaining the system as it is and just putting more money in to keep doing the things that are being done now.

At the same time, I cannot emphasize strongly enough that it is not good enough to say that we have a 10-year implementation plan under way for a policy framework and to continue to freeze funding while that 10 years is playing out. We are not able to meet the needs of children today. Agencies have reorganized their services; they've gone from single counselling to group counselling; they have merged across the province—most of our member agencies are mergers—and they have stripped out all of their management capacity, to a point that is dangerous, as the Auditor General noted in his report. Agencies have truly cut to the bone, and it simply is not good enough to say, "Hey, we've got a mapping exercise under way. We've got a policy framework that we're going to implement, and once we've got a better case in place for funding services, then there will be more funding." By then, we won't have very many agencies left.

I will move on, very quickly. I've just a couple of more quick points.

Again, linking back to the policy framework, the framework calls for more collaboration across systems. I have already said to you that there is some good collaboration happening at the community level, but the real place where collaboration is needed is at the ministry and policy level.

The framework talks about eliminating gaps, the need to eliminate gaps in services, particularly in rural areas and northern parts of the province. We certainly see that those gaps exist and strongly support that aspect of the framework.

And finally, the framework talks about the need for more use of research-based practices and outcomes evaluation; in other words, better services, more effective services. I'm very proud of the work that goes on in child and youth mental health agencies, but there's no question that the science in this field has gotten far ahead of the practice. There have been very, very exciting discoveries, innovations and research findings over the last 15 years, and very few of them have been implemented in our system in Ontario. There simply is no capacity to do that implementation. Nobody has the time or the room to send their staff off for training, like that agency that I referred to earlier, where I got the call from the ED today.

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In some ways, the slow movement in the implementation of evidence-based practice in Ontario is one of the things that frustrates me the most. We have, at Children's Mental Health Ontario, frankly decided to stop waiting for the government and the ministry to get on with the implementation of evidence-based practices, and we have now launched several communities of practice for knowledge exchange around implementation of various kinds of evidence-based practices, because the ministry's not doing anything in this regard. It is showing no particular interest, to date, in doing anything in this regard.

The one piece that the ministry has been supporting that is very valuable, that relates to evidence-based practices, is through the provincial centre of excellence at CHEO, which is very strongly supporting agencies in their work to evaluate their outcomes. Of course, if we're to have an evidence-based system, it has to be a system where we have the kinds of feedback loops that will allow agencies to know how well their services are doing when they're delivered, so evaluation is a very important part.

I don't want to overlook the important work that is being supported by the ministry in terms of outcomes evaluation, but in terms of enabling agencies to develop the systems and protocols and to train their staff and the rest of it, to actually be able to deliver evidence-based practices, it's not going on there. So we have, together with others, been taking our own initiative in that area.

So I guess I will leave it at that. I think I've made my key point for the opening, and I hope I've left a little bit of time for your questions.

The Chair (Mr. Kevin Daniel Flynn): Unfortunately you haven't, but we could each take a minute. I mean, the gentleman's come here. It's entirely up to the committee.

Mr. Bas Balkissoon: One question each.

The Chair (Mr. Kevin Daniel Flynn): One very brief question from each, perhaps starting with France?

M^me^ France Gélinas: I can sense the urgency in your field of children's mental health. Things are not doing well, and the demand for your services keeps escalating. Just a quick question from me: The ministry presented today, and they talked about 373 transfer payment agencies providing children's mental health services, yet your agency talks more about 100 and some. Where's the disconnect here?

Mr. Gordon Floyd: Most of the difference is made up by small agencies that are being funded to deliver one or two programs. So there are only about 90 to 100 full-blown, if you like, children's mental health centres in the province. Dollars are flowing to many more agencies to deliver a specific program to a specific population.

The big concern with that is that there are only 125 agencies in the province that are using BCFPI—the brief child and family phone interview—which is the common screening tool, and the same 125 agencies are the only ones that are using the CAFAS tool, the child and adolescent functional assessment scale, which is the outcomes measurement tool. Since the other agencies aren't using it, we really don't know who they're taking into service and we don't know what the outcomes of their services are.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Floyd. Helena?

Ms. Helena Jaczek: No, I will defer to Liz.

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

Mrs. Liz Sandals: This is actually a follow-up on what you just said because—we've got some public accounts training here that is coming through. It's our understanding that many of the agencies, as you said, that are being funded are not actually accredited. I wonder if you could talk to us about, what does an accredited children's mental health agency look like and what are the qualifications that agency has to get accredited, as distinct from some of the other agencies?

Mr. Gordon Floyd: Sure. The accreditation program, which was developed initially about 20 years ago, requires agencies to be measured against over 300 different standards. A number of those standards are about general agency management, so they're about governance, financial management and the like, but most of the standards and the ones that are most relevant in this context are what we call program standards. Those cover everything from the way in which you put together and maintain a client's file to the way in which you involve various types of professionals in assessing the child and meeting the child's needs, and it goes on.

The children's mental health accreditation standards are really the only place where good practice in the delivery of children's mental health services is laid out. The ministry's regulation is limited to the provision of residential services and it mostly relates to the size of the window, the safety of the accommodation and the staffing ratio. Over 90% of the children who are seen in our children's mental health system are seen on an outpatient basis, or a day treatment basis, so those residential regulations are not relevant to them.

I would be happy to provide the committee with the full book of standards, if it would be helpful.

Mrs. Liz Sandals: It would actually perhaps be—at least the executive summary, or whatever is easy for us all to have, so if you were to submit that to the clerk, because I think this will become relevant to our discussion, thinking about accreditation and evidence-based programming and those sorts of things. I think that would be helpful information.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Liz. The last word to you, Sylvia.

Ms. Sylvia Jones: It's going to be hard to pick one. I appreciate your candour this afternoon. I'm trying to square the circle with, we had children and youth services in and they were talking about some of the preliminary results that have come from their mapping exercise. They made reference to an average wait of 38 days for children and youth, and yet you made reference to 69 days and upwards to six months. Where's that disconnect coming from? Because quite frankly, your numbers are closer to what I experience in my communities.

Mr. Gordon Floyd: Yes. The 38 days is the average wait time for those who were admitted. That 38-day figure—

Ms. Sylvia Jones: So it's almost a crisis.

Mr. Gordon Floyd: —does not include the children who came looking for service and were still waiting for service at the end of the year. The 69-day figure includes all the children.

Ms. Sylvia Jones: Which, as you pointed out, because most services are not provided in a residential setting, would be the majority.

Mr. Gordon Floyd: Yes. That would be a majority.

Ms. Sylvia Jones: Your 69 would be the majority of people seeking services.

Mr. Gordon Floyd: Absolutely, yes.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Perhaps I can ask one question. A lot of your presentation was about funding. Just so I understand this: You said that out of the last 15 years, in 12 of those years the agencies have not received any increase at all. That would stress, I think , any organization.

Mr. Gordon Floyd: Yes.

The Chair (Mr. Kevin Daniel Flynn): We can understand that would stress them. How long has that been going on? Presumably in three years they did receive increases.

Mr. Gordon Floyd: Yes.

The Chair (Mr. Kevin Daniel Flynn): Do you know which years they were?

Mr. Gordon Floyd: Yes. They were 2004—some of that increase was bumped up, so I'm counting 2005 as being a year of increase, and 2007. The three increases have all happened in the life of the current government, but there were no increases in 2006, 2008 or 2009.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you very much. That is some interesting information. Like Sylvia, thank you for your frankness.

Mr. Gordon Floyd: Sorry to have gone on for so long.

The Chair (Mr. Kevin Daniel Flynn): No, you didn't go on at all. It's your 30 minutes. I think you generated a lot of questions. We've got some time to work on this.

Mr. Gordon Floyd: Thank you.

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

We're adjourned.

The committee adjourned at 1907.

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