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Select Committee on Mental Health and Addictions

Comité spécial de la santé mentale et des dépendances

Mental health
and addictions strategy

Stratégie sur la santé mentale et
les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 6 May 2009

Mercredi 6 mai 2009

The committee met at 1604 in committee room 1.

The Chair (Mr. Kevin Daniel Flynn): If we can call this meeting to order, ladies and gentlemen. Thank you for your attention, and excuse my being a little tardy.

MENTAL HEALTH AND ADDICTIONS STRATEGY

MINISTRY OF ABORIGINAL AFFAIRS

The Chair (Mr. Kevin Daniel Flynn): The first delegation today is from the Ministry of Aboriginal Affairs, and we've got Lori Sterling and Alison Pilla with us. The floor is yours. We've allocated 30 minutes to each of the ministries that have come forward. You can use that time any way you see fit. It would be nice if you would leave a little bit of that time near the end for some questions, though.

Ms. Lori Sterling: Absolutely. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): And if you would introduce yourself for Hansard as well.

Ms. Lori Sterling: Yes. My name is Lori Sterling, and I'm the deputy minister at the Ministry of Aboriginal Affairs. I have with me my assistant deputy minister for strategic policy and planning, Alison Pilla.

I'd like to begin by thanking the select committee for the opportunity to make the presentation today and acknowledge the effort that the committee is putting into the question of mental health. As I hope you'll see when I go through my slide deck presentation today, which I hope you all have in front of you, the question of mental health and addiction is an extremely pressing problem for aboriginal people in Ontario.

Before I actually take you through the statistics and the programs, I'd just like to spend one moment telling you a bit about our ministry and what our mandate is.

The ministry is very new, created only in June 2007, and was the result of a recommendation of the Ipperwash report, headed up by Justice Linden. The intention of this ministry is to create bridges and build relationships and trust with aboriginal people in Ontario and the government itself. We remain a very small ministry, under a couple of hundred people. I think I heard the secretary call us small but mighty, because our mandate is very broad; that is, to reduce the socio-economic gap, ultimately, between aboriginal people and non-aboriginal people in this province. We don't do that by actually having a range of programs in the ministry itself; we do that by collaborating and coordinating across all ministries in the government. We also set priorities and we track the progress of aboriginal people in the province.

We also have a mandate to enhance awareness about aboriginal culture and aboriginal people, and to promote best practices by the province on consultation and accommodation of aboriginal rights.

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We also act as "one window" for aboriginal people when they seek to access government services. That's not to say that we close down pre-existing relationships, but for many aboriginal people there are a variety of ministries that may have programs relevant to them, and our job is basically to help them navigate the system.

Then, finally, we work extensively with the aboriginal leadership by, first of all, responding to their immediate needs, and also by ensuring that they become part of the process within government, including most recently the introduction of new legislation.

So that's the mandate of the ministry.

What I'd like to now do is turn to the deck itself and very quickly take you through some of the highlights of the deck. I appreciate that you may want to ask questions, and so I will skip lightly through the pages of the deck. As well, I won't go anywhere near the appendix, which provides far more detailed information about the topics in the deck.

If I could ask you to please turn to page 4, what I'd like to do is start by briefly describing aboriginal people in this province demographically and then describe them from a socio-economic perspective. I think the statistics tell a very sad and sorry tale about the socio-economic plight and the mental health situation, in particular, of aboriginal people.

In Ontario, we have the largest aboriginal population by province in the entire country: 21% of the entire aboriginal population is in Ontario. They are a small part of the overall population, only 2%, but you'll see from the data that their needs far outstrip their actual percentage of the population in Ontario. What is a growing trend is the fact that aboriginal people are increasingly leaving the reserve. Now, 60% of all aboriginal people live off-reserve, and most of them are in large urban centres or small towns.

What is most conspicuous about the demographic population is that it's extremely young and growing very quickly; just under a third of the population is actually 14

years old or younger. So we like to say in the ministry that this is the workforce of the future, given these demographics.

As well, from a socio-economic perspective, they are consistently at the bottom even amongst disadvantaged groups in our society. The unemployment rates are triple those of non-aboriginal people, the income rates are less than two thirds, and one statistic that really is something that has to be remedied is the education rate. At this point, almost 40% of all aboriginal people in this province do not graduate high school.

If I could ask you to turn to page 5, you'll see there's a map of the province. The map has got print which is probably too small for most of us to read right now, but what I can tell you is that it's colour-coded by political-territorial group. There are four political-territorial groups in the province, and then a fifth group called independents. As you can see, these are the First Nation communities and they are literally all over the province, including the far north.

Thirty-three communities in the far north are what we call "remote," meaning there is absolutely no road access at all. To get to those communities, you have to fly in, or sometimes there's some access through ice roads in winter. The ice-road season is generally from early January/beginning of February through to March, depending on the winter. This winter, in fact, I was on one at the end of November, but that was unusual.

The First Nations in Ontario have very sophisticated what they call "political-territorial organizations," and all First Nations belong to the Chiefs of Ontario. I tell you this because when you go out and do your consultation, we would highly recommend that you engage with the Chiefs of Ontario and with the provincial/territorial organizations because they have given a lot of thought to questions of mental addiction amongst their own population.

I'll turn now to the next page. These are some statistics related to mental health amongst the aboriginal population. We've got suicide, depression, emotional disorders and FASD, fetal alcohol syndrome. I'm only going to mention two. The first is the suicide rate, especially amongst aboriginal children and youth. The community of Pikangikum has the world's highest youth suicide rate. It is part of the Nishnawbe Aski Nation, which is the group that runs along the northern part of this province and which itself has, in various communities, high youth suicide rates.

The rates are astounding, especially when you think that the communities themselves range in size from 250 to 2,000. So Pikangikum, which is a large community of 2,000, has had 175 youth suicides in the last five years. I went this year into another community, called Wabasseemoong, which is close to the Manitoba border, and it turned out my timing was the day after a youth suicide of a crown ward who had just returned. The kids go off the reserve. They get flown into towns for grades 10, 11 and 12, and they often come back, and sometimes they come back as crown wards. There was a youth suicide the day before, and the one thing that struck me was that the entire community, given its size, feels the death. The visitation is in the community centre, so even people who didn't know the young girl were all in a communal bereavement mode. So it's a really significant mental health issue amongst the aboriginal population.

The other social indicator that I just wanted to mention is addictions and the related fetal alcohol spectrum disorder, which of course also has implications for their graduation rates, which I mentioned earlier. Addiction within the aboriginal community is not just an alcohol kind of addiction, but especially amongst the youth now—although I don't have hard data, you'll hear it all the time from the chiefs—there's extensive use of prescription drugs. There's a big sign when you enter one community that says, "No lacquer." To be honest, when I went to it, I thought it might be a typo, but in fact it's paint lacquer, which is used as part of substance abuse. Then, in the far north, when you go into those communities, they always have locks on their diesel fuel that's used for energy transmission to prevent theft because there's also substance abuse associated with diesel fuel. This kind of abuse is also found in even the remote communities where these substances actually have to be flown in and there's no sort of road access or entry.

When you chat with the social work experts in this area, they will always tell you that when it comes to mental health issues in the aboriginal community, the priority should be children and youth, and it should be both the suicide and the addiction aspects of mental health.

I'm going to quickly move on to some of the current challenges. They feed into our suggestions for areas in which you might want to do further research.

I can't, on page 8, talk about current challenges without talking about the fact that the responsibility is shared between the federal government and the provincial government. This leaves gaps. The federal government largely funds on-reserve health care, and there's a commonly held view that they fund it at a lower rate per person than the rest of the province. You will see, however, that there are provincial programs which are on-reserve, but the primary responsibility on-reserve is with the federal government.

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The second is that there is a current challenge in that there are very few aboriginal people trained to deal with mental health care. I think what the communities will tell you is that the people who stay locally are people who are born there. It's no different than, for example, what you hear about doctors in some of the communities. In the mental health area, the people who come in to help out are there on locums or on apprenticeships. In one community, they didn't have any psychiatric assistants on reserve, so they were doing psychiatric interviews by telephone once a month. Kids would line up in a waiting room to get access to that kind of care. So it's really important that there be skills training that would enable local people to be trained on mental health issues.

The third is the cultural aspect of whatever mental health care training does take place. Aboriginal people tell you that you have to recognize the uniqueness of their culture, their desire for a more holistic approach and always community involvement in the actual program.

Other problems related to aboriginal people you might find among other groups in society as well, and those relate to poverty; for example, inadequate housing and absence of money to pay for certain kinds of treatment are also endemic to the aboriginal community. Even food-related things, which might impact on mental health, are particularly problematic. When I was up in the north, it cost $10 for six apples at any point in time because of the cost of transportation.

Finally, you can't leave the question of current challenges without for a second mentioning the residential school experience. What we are learning is that it in fact has an intergenerational impact on these communities and any mental health care has to take that into account.

Turning to what we currently have in Ontario—appreciating that I'd like to leave some time for questions, I'm not going to take you through the funded programs that we have—you will notice that there are a few Ontario programs, but they are largely run by individual ministries. What you don't see in our deck is a government-wide, comprehensive mental health strategy for aboriginal people. Then the other point to be made is that when you combine what's available from Ontario with what's available from the federal government, there doesn't seem to be a lot of coordination between the two.

Could I ask you now to turn to "Other Jurisdictions"? The sitting of this committee is very timely because, in fact, many of the other provinces have had internal research and committees looking at this issue, and in particular with respect to aboriginal people, what you see on the page dealing with the jurisdictional analysis is that Alberta, Manitoba, British Columbia, Saskatchewan and Nunavut have all recently looked at the question of what should be the component parts of an aboriginal mental health strategy. We would encourage this committee, when it engages again outside, to have discussions with some of the other jurisdictions. In the appendix you'll see some more details about what those other jurisdictions have decided to do about the issue.

That brings me to the question of what we've called gaps and opportunities. I think it's fair to say that the gap that comes to mind first and foremost is the absence of an aboriginal-specific mental health strategy that runs across the government, through all the various ministries that have a role. You'll be hearing from many of them in the course of these hearings and have a forum to come together to deal with aboriginal mental health issues.

The second one that we've noticed as a gap is programs to enhance the training for aboriginal people, and I mentioned that earlier. I also mentioned earlier the need for coordination with the federal government.

Finally, one issue in the gap, which I'm sure you will hear from various ministries, is the need for collection of information and data and greater sharing of that information amongst the various agencies.

That brings me to the conclusion.

What I'd like to suggest is that this ministry is not really the main repository of expertise on aboriginal mental health issues. You will find that expertise within aboriginal communities themselves. In particular, the Chiefs of Ontario have indicated that they would like to meet with you, outside government, within government. Of course, you're meeting with the Ministries of Health and Children and Youth Services.

While we may not have the main expertise on mental health, we can speak on behalf of aboriginal people with respect to what they see as their priorities. What we have learned is that they would like a specific program that takes into account their unique circumstances. That program would include:

—questions of funding: Are they getting adequate or equitable funding?

—the training point;

—the need for recognition of their linguistic and cultural differences. When you go into the north in particular, you will see that a large segment of the community still does not speak English; and finally,

—the ability to track data and monitor the progress that's made.

I understand that you're also interested in going into a community. We would recommend that you take a trip up to the northwest part of this province for an example of a community that is more remote but nevertheless has significant mental health issues, and then visit another community, in the south, that's closer to an urban area, which has access to more mainstream resources but which has nevertheless chosen to develop more aboriginal-specific programming within their own community.

Those would be my opening remarks. I'm open to any questions you may have.

The Chair (Mr. Kevin Daniel Flynn): That's great. You've left about nine minutes, so we'll start with Christine.

Mrs. Christine Elliott: Thank you very much for your presentation. I'm sorry I wasn't able to be here for the beginning. It's very informative, and it's very helpful to know that the chiefs would like to meet with us, because we would very much like to discuss with them the problems in their specific communities. I would hope that you might be able to help us facilitate that and perhaps offer us some suggestions on specific communities that you think it might be helpful for us to visit.

I really just had one question, and you may have covered it already; I'm not sure. Is the ODSP operational in aboriginal communities? I just don't know.

Ms. Alison Pilla: The disability plan or the drug plan?

Mrs. Christine Elliott: Disability, ODSP.

Ms. Alison Pilla: Oh, yes. Under the 1965 welfare agreement, the province delivers all social welfare programs on-reserve, and that would be both the general welfare assistance program and the disability program.

Mrs. Christine Elliott: In your experience, is it as easy to receive ODSP benefits in the south as it is in the north, in some of the communities? Do people have greater difficulty accessing ODSP?

Ms. Lori Sterling: I'm not sure if the Ministry of Community and Social Services, which actually delivers the program, is appearing before you. The concerns that we generally hear about ODSP relate less to the delivery to the individuals on-reserve and more to the question of cost-sharing between federal and provincial for the delivery. But again, I'd have to defer to the Ministry of Community and Social Services.

The Chair (Mr. Kevin Daniel Flynn): I think they're up next, so that would be timely.

France, you've got about three minutes.

M^me^ France Gélinas: I was just curious to know: In the work of your ministry, do you ever do any kind of inventory or mapping of the services that exist that would include the mental health and support services that exist in the different First Nations communities?

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Ms. Alison Pilla: It really depends on the particular policy that we're looking at at the time. For instance, on the mental health and addictions piece, it hadn't been a focus for us at this point, being a new ministry. We obviously did some work for this presentation, but we haven't undertaken a full analysis of all the programs. Ministries have done their own work as to what programs are in place and where they are. That's a good question, and maybe some work needs to be done.

M^me^ France Gélinas: Through your ministry, do you know, and can we have access to, a little bit of the demographics of the different First Nations communities, as in how many residents—

Ms. Lori Sterling: Yes. We can absolutely provide you with the demographic information for every First Nation community in Ontario.

M^me^ France Gélinas: I'm not sure if we have finished our selection; we will be going to First Nations communities for sure. Once we've made that selection, if we share that with you, you would share all of the social demographics that you have?

Ms. Lori Sterling: Yes, and we can help facilitate the actual trip, if you'd like.

M^me^ France Gélinas: Very good. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. We've got two speakers from the government: first Maria, then Jeff.

Mrs. Maria Van Bommel: Thank you very much for this information. I'm just looking at the information you gave us on page 4, and the map, of course. The information you gave us is sort of province-wide, but my gut tells me that there are differences between the northern part of the province and the southern part, and also a difference between on-reserve and off-reserve. Is there any way of getting some stats from you to give us some ideas? Like I said, these numbers are province-wide, so when you talk about who completes high school and that sort of thing, I'm just wondering if there's greater opportunity for completing an education in southern Ontario than in northern Ontario, or whether being on-reserve or off-reserve gives advantage in any way at all to some of these things.

Ms. Lori Sterling: The Ministry of Education is in the process of collecting data that would be of assistance to you. What is interesting is that, in the north, all the reserve students actually go off-reserve to finish high school. Just capturing who completes high school in a town is not going to give you the on-reserve/off-reserve—

Mrs. Maria Van Bommel: In my own riding, we have situations where the elementary school is on-reserve and the secondary is off-reserve.

Ms. Lori Sterling: Yes. I think that we can look into the issue and get back to you.

Mrs. Maria Van Bommel: Okay. Thank you.

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

Mr. Jeff Leal: Deputy, thank so much for your comprehensive presentation today.

Jurisdictional wrangles, I think, have had some real repercussions for First Nations communities in Ontario. Attawapiskat and Kashechewan are two good examples. Has there been any move for INAC to provide funding instead, getting out of the way of delivery of services and giving the province those dollars? Because the province is in the best position to deliver dollars, whether it's health care, education or financial resources to develop mental health programs. Secondly, the need to incorporate—for example, our First Nations communities use healing circles as a way to address individuals or communities that have mental problems and associated difficulties, so to bring that sort of tradition into the way that we approach providing mental health services to our brothers and sisters in our First Nations communities.

Ms. Lori Sterling: First, on the question of the federal-provincial divide: At this point, the federal government provides education, for example, on-reserve, and I don't know that there has been any indicated willingness for either the provincial or federal government to actually have the province take over delivery. With respect to social assistance, I think I mentioned earlier, it's actually delivered by the province. And in the area of health care, as I say, it's largely delivered federally on-reserve, but there are some supplemental provincial programs. I'm not aware at this point of an initiative that would allow the province to do all the delivery.

The second question was about holistic approaches to healing. There have been efforts to try to become more holistic, more in tune with the community needs. I think this is an area where the First Nations would like to see more work done.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation today. It was a pleasure having you.

Ms. Lori Sterling: Thank you very much.

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our next speakers this afternoon come from the Ministry of Community and Social Services: Lucille and David.

Thank you for attending today. Make yourselves comfortable. You've got 30 minutes, like everybody else. If you would leave some time at the end, I know the committee would appreciate that for any questions they may have. If you would introduce yourselves for Hansard, that would be helpful, and the floor is all yours.

Ms. Lucille Roch: Great, thank you very much. My name is Lucille Roch. I'm the Deputy Minister of Community and Social Services accessibility in the Office of Francophone Affairs. I'm accompanied here today by David Carter-Whitney, who's the assistant deputy minister, policy, in the Ministry of Community and Social Services. Thank you very much for giving us the opportunity to appear before you today.

From our perspective, it's really great that you're taking a kind of whole-government approach to this issue, because it's obviously one that requires such an approach. I'm assuming you all have a copy of our slide deck. You'll see from the outline on slide 1 that we're going to provide you with a pretty high-level overview of the intersections between our programs in social services and supports and people with mental health and addiction issues. Obviously, if you want more information, we'll make ourselves available to you or provide you with additional information after we leave here today.

As you can see from slide 1, I'll give you a bit of an overview and then we'll address more specifically three issues that we think need to be looked at. We'll make some references to some case studies that we have attached as part of the addendum to the slide deck.

Slide 2 gives you an overview of the ministry's vision and mission. As indicated here, we try and help people build resilience and remove some of the obstacles they're facing as they're attempting to participate in community life.

I'd just like to say that the Ministry of Community and Social Services focuses on vulnerable adults. Some of you may recall that at some point this ministry included all children and family community support services. In 2003, the Ministry of Children and Youth Services was created, so we've focused on adults' programs and services.

Slide 3 of the deck gives you an overview of our services and supports. We provide income and employment supports through the Ontario disability support program and the Ontario Works program. Those are the two programs that people refer to when they talk about social assistance or welfare.

If you look at the Ontario Works description, there's a reference here to the addiction services initiative, which is a program that's provided in about 15 communities and three First Nations in the province. It's provided to recipients of Ontario Works and ODSP. Through that program, we provide some intensive supports to people who are barriered, in the sense of being able to access employment because of their mental health issues and addiction issues. We've implemented it, as I referenced, in about 15 municipalities and three First Nations.

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As you can see from that slide as well, we provide services for adults with developmental disabilities, and we also provide other community services such as programs for women who are fleeing domestic abuse, homelessness and interpreter and intervener services. We also have a unique partnership with other ministries and about 14 aboriginal organizations and First Nations as we oversee the aboriginal healing and wellness strategy, which focuses on reducing family violence and improving the health and healing of aboriginal people.

I'd just like to mention as well that the ministry is responsible for the accessibility for Ontarians with disabilities. We're working with stakeholders and the community to develop standards to implement that legislation, and we're also responsible for the Family Responsibility Office, which provides neutral enforcement of family support obligations.

So you can see from this description that we're often in the position of responding to people's needs, people who are quite vulnerable in terms of, they're facing a crisis and they turn to this ministry or the programs and supports that the ministry provides to help them work through that crisis. Often, as we've found, many of them come to us in a way that they might not have had to if supports and services had been available earlier in their situation.

On slide 4, I just want to reference a few issues around clients' accessing social assistance and employment supports. We have a number of programs where the prevalence of individuals with mental health and addiction issues is quite high. The first two programs I'd like to reference are ODSP and Ontario Works, and as you can see from slide 4, over half the ODSP recipients are people with a mental health disability. That means that the nature of their illness is prolonged. To get on ODSP, your illness needs to have lasted at least a year, and it has to significantly impact on your activities of daily living. So we think there are likely many more people on Ontario Works, for example, whose mental health or addiction problems are currently either undiagnosed or they're not quite severe enough yet to qualify for ODSP, so the challenge is to try and support these people before their conditions worsen.

The addiction services initiative that I mentioned serves a very small proportion of our total Ontario Works caseload. It's less than 1%.

Also, I'd just like to mention that research does suggest that between 40% to 75% of individuals with substance abuse problems have co-occurring mental health issues. So, although it might be difficult for us to prove this empirically, we do believe that early identification and prevention of mental health and addiction issues could have an impact on reducing the proportion of people who require income assistance through our programs.

Slide 5 also references additional social service programs that are offered through the ministry, and these programs also see a pretty high proportion of individuals who are affected by a mental health and addiction issue.

In developmental services, where we provide services and supports to adults with a developmental disability so that they can live in the community as independently as possible, there are about 30% to 38% of individuals who have what is referred to a "dual diagnosis." That is, they have a developmental disability and they also have a mental health issue.

In our domiciliary hostel program, we provide permanent housing with limited supports for individuals who need assistance with activities of daily living. That could be a physical health issue, it could be a mental illness, it could be a developmental disability or it could be a substance abuse problem.

Recently we did a survey with the Ministry of Health and Long-Term Care, and 73% of the survey participants reported having been diagnosed with at least one mental health issue, and 52% reported being diagnosed with a serious mental health issue.

In our violence-against-women programs, a recent survey of women in women's shelters identified 29% of the women reporting substance use issues, and in our homelessness programs, recently a study undertaken by the city of Toronto to collect better data concerning the homeless found that approximately 86% of homeless people had a lifetime diagnosis of either mental illness or substance abuse.

As well, in our consultations that we held last summer with the aboriginal communities, as we were talking about the aboriginal healing and wellness strategy, most of the aboriginals identified the need for expanding programming in mental health as a priority for them as we look to the future.

As you can see, our ministry doesn't fund mental health services directly. However, our programs have significant numbers of individuals with mental health and addictions issues, and in some cases, we try to provide them with the supports that they require.

Obviously, we work quite closely with the Ministry of Health and Long-Term Care and the Ministry of Children and Youth Services, as we try to link our programs, I'm thinking in particular of developmental services, for example. You have children in the care of the children's aid society who may have a developmental disability. As they exit that system, we're working hard with the ministry. We're not there yet, but we're in the process of developing protocols so that we're in a better situation to help these people transition to the adult system. So there's a fair amount of work that goes on at the local or regional level.

I'll turn it over to David to highlight the three themes that we'd like to share with you.

Mr. David Carter-Whitney: As you've heard, MCSS has been mandated to provide certain types of support and assistance, and often these are programs that have very specific criteria, eligibility and assessment. Yet what we know is the mental health and addiction issues can't be addressed separately from the broader context of people, and they don't necessarily present neatly in package around the types of programs we offer.

Generally, individuals who experience mental health and addictions issues probably require a continuum of care and support that recognizes a variety of needs. That could be community-based services, income and employment, adequate housing, addictions—other things. We've been making progress. Social assistance programs, in their origins, were simply that: financial assistance. Now, as you hear, we have a number of things that are provided in addition to the basic income supports, but there are still gaps in the continuum, particularly a lack of community-based services and an insufficient quantity of services.

The scenarios you'll see in the appendix—there's a series of stories. These are actually real stories about real people who the ministry has interacted with in some way. We thought it would be helpful to convey in a context that reflected what we are experiencing in trying to serve the public and some of the kinds of stories that we have seen. If you look at page 11, the story of Maria is an example of an addictions services initiative success. This is someone who received support around her addiction and assistance in setting personal employment goals and in getting access to a range of community services to assist working successfully toward those goals.

I will say that our examples aren't all happy endings. We decided that to be realistic, we really had to reflect that there are many people where the challenge is beyond what we can offer.

In this particular case, with ASI, which we referred to several times, there are significant gaps that limit the effectiveness of the program. We currently have it available in 15 communities. In addition, in some communities there are gaps: for instance, the access to family physicians for referral, diagnosis and treatment or even access to supports such as supportive housing.

To make really significant progress around mental health and addiction, we need to address the gaps in the continuum of care and particularly community-based services. In that role, we've increasingly worked with municipalities. The ministry delivers many of its programs through the municipalities, which actually function to bind together certain types of supports—I think this is an area that has been under discussion—of continuing to build and expand to let local partners knit together those things which ministries sometimes struggle to do.

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The second issue we've identified is around the need for a person-centred approach. A continuum is a start but doesn't go far enough. Services and programs need to be coordinated and integrated in a way that puts the person at the centre and responds to their changing needs and circumstances throughout recovery. A person-centred approach has to respond to the cultural and linguistic background of the individual, and again, in Ontario, an increasingly diverse society, there are challenges around that. We also face challenges in ensuring that the right services are available in the right places in French.

Transition periods in a person's life from children and youth services to adult services, or as an individual ages,

put a spotlight on how services may not be provided in a person-centred approach as well, that people pass certain age marks, and their eligibility and access to certain types of programs change.

Also, for individuals with a developmental disability, there are stresses for their aging parents and caregivers. This is particularly the case when there is a dual diagnosis. It could be undiagnosed, or if it's inadequately addressed, then mental health issues can result in really severe behavioural changes. The story on page 12, Brian's story, demonstrates some of these issues. This is an individual who actually assaulted a family member and was charged. There are provisions in the criminal justice system to ensure that he isn't found criminally responsible, but there weren't appropriate specialized medical and mental health services and treatments for his needs in the community, so he ended up in a forensic mental health facility, due to a lack of appropriate long-term residential supports and assistance for him and his aging parents.

MCSS works with partner ministries—the Ministry of Health, Ministry of the Attorney General, correctional services and Ministry of Children and Youth Services—on the intersections between justice, mental health and dual diagnosis, but we need to continue to make progress on making our programs work well together in response to the individual.

Many of our most important supports also can't be directed from policy at Queen's Park. We have programs where the decision-making is local and responsive to the individuals. One of the challenges, one of the incentives to make sure that these local decision-makers, whether they're in the municipality, provincial or federal office, whether they're in a school board or the LHIN or another third party, is that there's a protocol that pushes them to work together and make decisions that bring people together and reflect the whole person.

The third issue is really around the need for early identification, prevention and recovery. You've heard that many of our programs actually step in at a point when someone has reached a point of crisis, which one could argue is in fact we often are there because the system has failed the individual at an earlier stage.

You've heard from other ministries that the justice system often becomes the entry point into the system for individuals, and this means that, by this point, issue identification is expensive and punitive and often too late in some cases. From our perspective, early identification and prevention are really a key to improving outcomes for individuals and reducing the number of individuals who access inappropriate or high-cost judicial or emergency services, and particularly for us, we see that reflected in homelessness.

In the scenarios, we've included on page 13 a story of Jeff, and this is a chronically homeless individual. This is someone who had a history of childhood abuse, which led to undiagnosed and untreated substance abuse and to a heavy use of emergency hostels and emergency hospital services. As described, you'll see he has achieved some level of stability through our Hostels to Homes program, but you can imagine how differently his story might have read if his issues had been identified and addressed earlier in his life.

I think there's a tendency to think that this is a medical system issue; it isn't just a medical system issue. It can't respond to all these needs. People like Jeff need encouragement and support at various stages, in various places in their lives, and not simply a medical intervention.

Ms. Lucille Roch: To summarize, we do invest a significant amount in supporting individuals with mental health issues, and from our perspective, the key to some of these issues might be to look at a continuum of care and support, adopting, perhaps, a more person-centred approach to mental health and addictions, and focusing on early identification, prevention and recovery.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much to both of you for your presentation. You've left about three minutes for each of the parties, starting with France.

M^me^ France Gélinas: Thank you for your presentation. I'd like a little bit more info on two of the programs that you've talked about. The first one is the addiction services initiative. Are any of those 15 communities in the north? What's the name of the program so I can recognize it? That means nothing to me.

The second is the domiciliary hostel tenants. Here again, if you could give me some examples of how it works and, if it's possible, look at it through the client's perspective: What would it look like for them?

Mr. David Carter-Whitney: The addiction services initiative is actually the name of the program. It is a program you access through the Ontario Works delivery agent, so normally it's the municipality. It's available in—I can rhyme off the municipalities, if that would help: Algoma, Brantford, Chatham-Kent, Dufferin, London, Muskoka, Ottawa, Peel, Parry Sound, Prince Edward-Lennox and Addington, Peterborough, Sault Ste. Marie, Stratford, Thunder Bay and Wellington. It is also available in three First Nations: Nawash, Wikwemikong and M'Chigeeng.

M^me^ France Gélinas: How were those chosen?

Mr. David Carter-Whitney: Initially they were communities that wanted to—when we initially rolled it out, we sought willing partners, candidly, certain municipalities and delivery agents who wanted to proceed.

M^me^ France Gélinas: Okay. What does it look like? Every Ontario Works office tries to find employment, and their caseload has lots of people with substance abuse on it. What's the difference?

Mr. David Carter-Whitney: What the ASI does is that it's essentially a more intensive case management. We work closely with the Ministry of Health to try and help promote access to detox and addiction services programs that are funded through the Ministry of Health. It's a more intensive case management, candidly, that helps individuals access housing while they're treating the program, and helps individuals develop a plan of action around their addiction. It helps to make sure that

they actually are attending and encourages and supports. As I say, it's a higher level of intervention than regular clients receive, quite honestly.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David, for that answer. Let's go on to the government side.

Ms. Helena Jaczek: Thank you so much. Your anecdotal stories are useful in that they show some gaps, successes and failures.

My first point is, do you evaluate your programs? You've obviously sort of tracked people and seen where success lies and so on. Is there something in terms of what works so that you can give us positive results on some of our programs and just link that with one of your recommendations, which is to adopt a person-centred approach to mental health and addictions? In saying that, is that based on evidence of a program where you've had some intensive case management? If you could give me an example: Who's been doing the case management? Anything that you can elaborate on those lines would be helpful.

Ms. Lucille Roch: We're currently evaluating the addictions services initiative, the ASI program. Early indications are that it is successful in terms of getting people the treatment they need and then helping people get access to employment or housing. The evaluation is not complete at this point. We just have preliminary findings. But it is—

Ms. Helena Jaczek: Does that involve the sort of intensive case management component?

Ms. Lucille Roch: Exactly, yes. I don't like to use the word "handholding," but it's a lot of working really closely with individuals, making sure that they have access, they get to their appointments, they follow their programs. There's a lot of encouragement. It's very intense.

Ms. Helena Jaczek: Who does the case management? Is this a social worker?

Mr. David Carter-Whitney: Yes, I believe they are; they're trained social workers, is my understanding. We have to approve sites that are—municipalities that were a part had to put forward a plan describing how it was delivered and who would be delivering it, and then the director of Ontario Works authorizes the delivery of the program. So I believe there are requirements around criteria for staff.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David. A final, short question from Liz and then on to the PCs.

Mrs. Liz Sandals: I was just looking at the case history you've given of Brian, who's a man with a dual diagnosis of developmental disability and mental illness—he's attacked his family, so violence is involved—and who needs placement in some sort of specialized home. The local developmental services residential system can't handle the mental health/violence issues, so he's still in forensic corrections.

1700

This would be maybe partly a question for you and partly a question for MCSCS, but do we have any idea how many people we've got in that sort of suspended dual diagnosis with violence who can't get residential placement in their home community, or any community, because of the violence issues?

Ms. Lucille Roch: I don't think we have a number for you. There's a planning process at the local level, where some of these situations are brought to a committee of service providers and there's some discussion about who can provide what. In many of these cases, there's a lot of toing and froing between health and ourselves, and—

Mrs. Liz Sandals: And constituency offices.

Ms. Lucille Roch: Yes. We do have an MOU with health on trying to resolve these situations, and in some cases, we're more successful than in other situations, but I don't think we have a—

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

Mr. David Carter-Whitney: I'd just also say that the answer isn't always going back to a group home, that some of these individuals—the vast majority of people with developmental disabilities don't live in group homes; they live in family situations or more independently, and some of these people, with the right supports, can move back to that situation. So one of the things we fund is trying to help people move back in to a more independent life and not straight into a group home or some form of quasi-incarceration, if we can avoid that.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David. We'll move on to either Christine or Sylvia.

Mrs. Christine Elliott: I was really struck by the statistic that over 50% of people receiving ODSP benefits have mental health issues. I was particularly struck by John's story that indicates the problems he's having with keeping employment and receiving assistance.

Are there any programs out there that you know of, other than your addiction program, that really work to educate employers about how to work with clients who have mental health and/or addictions problems, and do you think that would be a benefit if there aren't any?

Mr. David Carter-Whitney: Yes. We have a couple of approaches. One is, there was an employment strategy introduced for ODSP in 2006 which took our employment supports to what I'll call an outcomes-based approach. We stopped funding on activities and said that we'll fund it by placement and success, which meant that they could do whatever they wanted. They could go into the workplace, they could continue to—and, in fact, they're incented and paid if the individual stays employed after coming into ODSP. Many of those individuals they help are people who have episodic mental health issues and such. That's one set of things we've done to try to make the programs more flexible and, candidly, to make it easier for the response to be tailored to the individual.

Ms. Lucille Roch: In terms of programs, outreach to employers, the only one I'm aware of is really out of CAMH. I think they do some of that. We in the ministry

are trying to educate ourselves in terms of working with employees who have mental health issues.

Mr. David Carter-Whitney: Although we do also have an initiative with Canadian Manufacturers and Exporters. It's more for people with disabilities more generally, and it seeks to have 10% of their new hires be persons with disabilities. That's the target, so we're working with them around educating employers. But that's not specific to mental health; it's for persons with disabilities.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): One more short question and then we're done.

Ms. Sylvia Jones: The domiciliary hostels: How many spaces would there be across Ontario for that? Can you provide the committee with a list of where those are?

Ms. Lucille Roch: We can provide you with the information, but I don't think we have it with us.

Ms. Sylvia Jones: Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you. That was a short answer. Thank you very much for attending today. Your presence was our pleasure.

Ms. Lucille Roch: Thank you.

MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our next speakers today are from the Ministry of Community Safety and Correctional Services. If you would come forward. Make yourselves comfortable. You've got 30 minutes, like everybody else has today. We'd ask that you leave some time at the end for any questions. We'd also ask that when you speak, you identify yourself for Hansard. Other than that, the floor is all yours. Thanks for coming.

Ms. Laurie LeBlanc: I'll start by introducing myself. My name is Laurie LeBlanc. I'm the assistant deputy minister of policy and strategic planning for the Ministry of Community Safety and Correctional Services. That's a real mouthful.

I have with me today some of the operational experts from the ministry, and I know that they will be very pleased to answer any of your more specific questions. I am joined by, on my left, Judy Alton, who is a sergeant with the OPP. She's the provincial coordinator of vulnerable persons in the crime prevention section. She is our OPP expert. I have Loretta Eley to my right. She is the director of the strategic and operational initiatives branch on the corrections side of the ministry. As well, I've got Stephen Waldie, who is the director of the external relations branch. He deals a lot with our municipal police services. So that's the lineup for today.

I have a fairly concise slide deck. I'm going to take you through it relatively quickly. I'd like to leave about 15 minutes for questions and answers because I'm sure you'll want to get into that.

On slide 2, what I want to do, and we've got in the deck here, is just provide you with an overview of the Ministry of Community Safety and Correctional Services and what some of our programs, policies and initiatives are that are aimed at Ontarians whose lives are impacted by mental health and addiction issues. I'll talk a little bit about some of the typical interactions that those individuals have with the people who work in our ministry and also give some examples of training and other initiatives that we have in the ministry.

Just for a bit of background, for those of you who might not be completely aware of what our ministry does, our mandate is to serve all of Ontario's diverse communities to keep our province safe. We are the largest ministry in the Ontario public service. We have about 17,000 staff. We are for sure the largest, and one of, I guess, the few direct service providers in the Ontario government. We provide a very large range of services, including front-line policing through the OPP. We also establish policing and private security standards. We provide oversight services to police. We provide a variety of other services on the community safety side: the Office of the Chief Coroner, for example. Through the fire marshal's office, we also provide fire investigation and prevention, as well as education services. We also have Emergency Management Ontario in our ministry. So it's a wide range of services.

Of course I cannot forget half of our ministry, which is the corrections side that provides the supervision and also attempts to positively influence the rehabilitation of adult offenders, both in institutions and out in the community through probation and parole offices.

We work really closely with the Ministry of the Attorney General and the Ministry of Children and Youth Services, in particular, as well as the Ministry of Health and Long-Term Care and other ministries.

I just want to note, before I go on to the next page, that I know this committee has heard from other delegations about youth offenders. That is the responsibility of the Ministry of Children and Youth Services. On the policing side, we deal with everyone. On the corrections side, we just deal with adults. I just wanted to make that clear before we moved on.

On page 4, there are a few facts. I can tell you that understanding the nature and the extent of involvement of persons with mental health and addiction issues, in terms of the impact on the criminal justice system, as well as the impact of the system on the individual, is a real priority for our ministry. We know, and the Ontario mental health association has indicated, that individuals with mental disorders are more vulnerable to detection and arrest for nuisance offences, whether that's trespassing or disorderly conduct, and they're more likely to be remanded into custody. So we have been having discussions with our colleagues across the country. This is not just a problem in Ontario, of course.

On the federal-provincial-territorial side, we've been working on the corrections and on the policing side to gain a better understanding of the issues. We know that just over 50% of all Canadian offenders report that substance use or abuse was directly related to one or more of

the offences on their present conviction. I think you've been told, as well, that people who suffer from mental health issues also often suffer from drug or other substance abuse problems. Quite frankly, that creates some fairly significant challenges in terms of managing our institutions and our supervision of individuals in the community.

1710

Page 5: I just want to point out that in terms of our ministry, mental health and addiction issues really cross all services that we provide. On the police side, the law enforcement officers are often the first responders, so they're the ones who have the first interaction with people who have mental health or addiction issues. We do note in the slide deck here that contact between the police and these individuals has been increasing over years. That also translates into a higher percentage, an increasing percentage, of individuals who have been put into our institutions in remand, who have what we call mental health alerts on their record when they're admitted. We also indicate here that about two thirds of the people admitted to our institutions have had alcohol or drug problems, and many of them continue to have those problems.

So you can see that we're an active, interested partner with our other justice ministries, the Ministry of Health and Long-Term Care and others, to really look for collaborative solutions, to try to do our best to find better solutions to deal with individuals with mental health and addiction problems in our institutions.

I want to take just a few minutes to talk about police. On page 6, I list the authorities that the police have under the legislation. I'm not going to take you through that now. You can read that at your leisure.

Our ministry, through the OPP, I want to specifically note, with about 5,000 front-line officers who on a daily basis can and do interact with individuals, many of whom do have mental health and addiction issues—we have that experience. Also, through legislation, guidelines and ongoing collaborative work, we have a close relationship with the municipal police services.

I will note that on this slide we talk about diversion in the areas of mental health and substance use and abuse. I understand that when he was here, my colleague from the Attorney General spoke about diversion after charges have been laid and some of the strategies that they have there. Of course, I think we should note that on the police side, they have the discretion to lay charges or to divert some of those individuals to other community facilities or other accommodations or treatment programs. So the police can and do make those judgments on a daily basis.

On the policing side, officers play an important role. As I said, they're often the first responder. The other side to this, of course, is that that's an increasing responsibility and some pressures in terms of resources and the workload of our officers.

How do we help to ensure that our police have the proper tools? Obviously, if they're first responders, we need to make sure that they have the tools at their disposal.

On page 7, we talk about training. We do this in a couple of ways. The ministry has developed some guidelines that go out to municipal police services to help them develop policies that work locally for response to persons who are, as we say here, "emotionally disturbed or have a mental illness or a developmental disability"—that's the name of the guideline. The training begins early for police officers. In the Ontario Police College, there are about eight hours, as part of basic training, that are dedicated to responding to individuals with mental health or addiction issues. There is also refresher training, specialized training, through the course of a police officer's career.

The police college has also made quite a few connections with community organizations. They provide officers with a pocket guide, to assist them when they're on the spot in terms of recognizing basic symptoms of mental disorders and appropriate response strategies.

As well, I know that the OPP has some extra training that they have provided for officers and some innovative modules that they've created. I'm sure Judy can speak to that later, if you're interested.

The last piece on this slide is on the community safety side. The Office of the Fire Marshal has been involved with CAMH in providing assessment, treatment and fire safety to young fire-starters and their families. We know it starts early. The Office of the Chief Coroner, as well, has a database which tracks, through their death investigations, the causes of death including alcohol-, drug- and gambling-related deaths.

Just a few minutes to talk about the corrections programs on page 8: When somebody is brought in to one of our institutions, there is an assessment that's done on intake. Loretta is our expert, and she can answer any questions about that, but I did want to note that there is a health assessment that's done for those individuals and that includes an assessment of mental health issues. On the institutional side there are a number of elements that we've listed here. We have professionals who are in our institutions or available to our institutions—psychiatrists, psychologists, social workers, doctors, nurses and others—and they do provide rehab programs to sentenced offenders. I did want to just highlight that there is a challenge because the number of sentenced offenders in our institutions is much lower than those on remand, and it is a challenge in terms of offering programs to people who are there on a remand basis and not in a sentenced capacity.

The other note we make here is that community organizations will often come in to our institutions and offer programs, whether it's Alcoholics Anonymous, Gamblers Anonymous or Narcotics Anonymous, some of the examples we've listed here. We have a few specialized facilities which are particularly helpful for assessment and treatment capacity, and that's, again, for sentenced offenders. Also, on the community side, through our probation and parole offices, as part of the discharge planning for inmates, there is an assessment done, and often referrals are made and work is done with

the Ministry of Health and Long-Term Care in terms of referrals to community organizations.

On page 9, just a reminder of the collaboration we're trying to have with our other ministries, and you've heard about this from our colleagues already. We are very involved in the development of a government-wide mental health and addictions strategic plan, so I guess that's at the higher level. We've also been working on the ground very collaboratively with the Ministry of the Attorney General as well as the Ministry of Health and Long-Term Care and others in terms of mental health assessments, and we're very involved in the human services and justice coordinating committees. I know that the representative from MAG mentioned those as well. These committees establish more coordinated resources and services, in terms of planning for individuals who are in conflict with the law. We're involved in the policing and the corrections side, both at those local committees and the regional committees, so we're quite committed to that.

Lastly, in terms of next steps, you may have heard us talk about being "tough on crime and the causes of crime." I'm sure some of you in the room have heard that phrase before. For us, what that means is it's really important to strike the balance between prevention, deterrence and rehabilitation, that those are important aspects when we're looking at the people in our care. As part of our strategic plan in the ministry, we've also identified that as a key initiative an attempt to work more effectively with specialized and marginalized groups, and people with mental health issues and addictions are part of that group for sure.

I guess the last point on this page is really to say that we're very committed and we're pleased that there are initiatives like this going on, because I think the more we can do to find better, more efficient ways to deal with individuals with mental health and addiction issues in the appropriate way is better for the individual and, for sure, it's better for our institutions and other parts of the ministry.

So that's it for my slide deck, and I've left enough time for questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you. You've left us all sorts of time, so I'm going to steal a little bit of that time right now from the Chair. Can you just expand on what you mean? Not all of us are lawyers; in fact, I think only Christine is. What's the difference between a remand and a sentence as far as somebody and the service they receive?

Ms. Loretta Eley: A remanded person is someone who's still appearing before the courts and has not yet either been convicted and/or sentenced. They could be convicted but not yet sentenced, or they could have not been convicted yet before the courts. They're still awaiting trial—

The Chair (Mr. Kevin Daniel Flynn): Okay. So how does that impact on the treatment they get?

1720

Ms. Loretta Eley: It impacts quite seriously because what happens is about 63% of our population right now is on remand, so they're still awaiting, if you will, their fate. They're uncertain, unsure and still attending court, so they're in and out of the institution quite a bit. Most of them elect to have weekly remands, and if they're not being done through video port, it means that at least one day a week they're gone.

The second piece is that the median, in other words, 50% of the remanded population—we already know it's more than half—leaves in less than eight days. So by the time you get them in, they make their first appearance at court, and then they stay—they're more focused on getting out, so getting their bail set, meeting the conditions of bail and trying to get out, and 50% of them leave within eight days.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Final question, for myself, anyway. There's a school of thought out there that says that early intervention should keep people out of the justice system entirely. What does it cost to keep a person incarcerated in Ontario on an annual basis these days, just approximately?

Ms. Loretta Eley: I couldn't tell you annually. Our average per diem is approximately $160 per day throughout the system.

The Chair (Mr. Kevin Daniel Flynn): So that's all costs in?

Ms. Loretta Eley: That's all costs in—everything.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you. Who's going to ask questions from the government? First Jeff and then Liz.

Mr. Jeff Leal: Thanks very much, Kevin. Through to Ms. LeBlanc: Thank you so much for your comprehensive presentation.

I know in my own community, these days the substance of choice seems to be a prescription drug, OxyContin. I'm interested in knowing if it's getting to people who are in our corrections system. I notice we have $50 million to do some targeted work. It's a growing concern, particularly with high school students, whether we can stem the flow and what we're doing to try to target that group. It's a very troubling situation that leads to other ramifications down the road that are perhaps much more serious.

Ms. Judy Alton: I don't have a specific answer, if we're looking at that particular drug—

Mr. Jeff Leal: Could you get back to the committee?

Ms. Judy Alton: Yes, we can.

Mr. Jeff Leal: I appreciate that. Thank you so much.

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

Mrs. Liz Sandals: I was just going to ask a little bit more about the remand versus sentenced issues. You've got this large population that's on remand, much of which is not going to be there for long, and another portion of it which is unco-operative. And because they haven't been convicted, you can't force them to participate. There's probably also, though, part of the remand population that's just undergoing a very long, complicated trial and clearly has mental health issues. Can they voluntarily access service if they wish? I understand that most of your remand population is either too unstable or

too contrary to seek service, but in those cases, where they are seeking service, can you provide it while they're on remand?

Ms. Loretta Eley: Yes. We have a couple of options. When I talk about programs we have, our programs are difficult. By the time we assess someone and try to put them in a program, which perhaps runs once a week, you can see the logistics of that don't work too well. But for our offenders who are mentally ill, they're seen by the psychiatrist; they can still see that person.

We have discharge planners who are part of the Ministry of Health who see all of our people in custody who have been diagnosed with a mental illness. They see those people with a view to, "What are you going to do when you get out? How are you going to manage?" They also will often see a nurse on an ongoing basis, and, in not all of our centres, but in five of them, we have a treatment program. That's not limited to remand or sentenced. If the need is there and they're in one of those facilities or can be transferred to it, then they can go to it.

The one exception is the Ontario correctional institute in Brockville, where we have the Brockville treatment centre that is run by the Royal Ottawa Hospital. We don't generally take remanded people, but we have had a few who were quite disturbed.

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

Mrs. Liz Sandals: Can I—just a quick yes or no?

The Chair (Mr. Kevin Daniel Flynn): Very briefly.

Mrs. Liz Sandals: If you've got somebody who is a likely candidate for Penetang, can you start treatment while they're still on remand?

Ms. Loretta Eley: Absolutely. We can also send them to a mental health facility.

Mrs. Liz Sandals: Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Loretta. Sylvia?

Ms. Sylvia Jones: I guess this would be to Sergeant Alton. I don't know all the details, but I understand there is a program, probably through metro Toronto police, where they have nurses specially trained in mental health available for front-line officers. Are you familiar with that program, and if you are, are there other jurisdictions that offer that to their police services?

Ms. Judy Alton: Yes. There's the COAST program in Hamilton, and they do crisis intervention training. Again, they have a psychiatric nurse available to them.

I'm not aware of the metro program. Maybe my colleague can answer that question.

Mr. Stephen Waldie: The metro program is actually a ride-along program, so the mental health worker actually rides along with a designated police officer and is available to assist in those calls.

Ms. Judy Alton: I believe Windsor just started that program as well.

Ms. Sylvia Jones: And it's called COAST?

Ms. Judy Alton: The COAST program is strictly for Hamilton.

Ms. Sylvia Jones: So they're all sort of customized?

Ms. Judy Alton: They're all customized for their own areas.

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

Mrs. Christine Elliott: I would add that Durham regional also has a ride-along program with a nurse who has been seconded from the Whitby Mental Health Centre, and it's working very successfully. It's very effective.

Two quick questions: One is with respect to the discharge planners when they're working to locate people once they're released back into the community. Are they doing all right, in terms of their placements? We keep hearing about the lack of psychiatrists in many parts of the province. Are they having any increased difficulties, or are they finding that things are pretty easy to do?

Ms. Loretta Eley: With people who are discharged from the facility, there's the pre-discharge period where they work with them and the post-discharge period, which is up to three months, and then they're supposed to be linked with straight community resources. They're just starting the evaluation of that work now, because it has only been about a year that we've had the discharge planners throughout our institutions.

Mrs. Christine Elliott: Just one other quick question: Where do you need help the most? Where do you think your programs could use assistance, or what's the greatest stress on your system right now, in terms of mental health and addiction issues?

Ms. Loretta Eley: I think that for corrections, one of the largest issues is that people see people as either criminals or sick persons, and it's sometimes difficult getting past that mindset, in terms of services.

Our other issue is trying to get the foot in the door to get services for our people, because they aren't always—I don't know how to say this—the most pleasant, and they're sometimes very difficult, high-needs people; they aren't all, but some of them have gone untreated for a long time and they're a real challenge.

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

Ms. Laurie LeBlanc: I think, as well, Sergeant Alton would like to—

The Chair (Mr. Kevin Daniel Flynn): Very briefly.

Ms. Judy Alton: From the policing perspective, I think our biggest challenge when we bring an individual in to the hospital to be assessed is the wait time for the police officers at the hospital. They're waiting anywhere from four—and I'm hearing up north up to eight—hours with a patient before a doctor will even come in and give an assessment. I think that is one of the biggest challenges for us.

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

M^{me} France Gélinas: You've mentioned that you do an assessment of all the inmates before they go to a correctional institution. Can you talk to me about whether there is mandatory health care staffing in all the jails? Do they include specialists in mental health—a mental health

nurse or a psychiatric nurse? And what's the ratio of health professionals to inmates, if such a thing exists?

Ms. Loretta Eley: In all of our facilities there is a health assessment and it's done by a registered nurse. All of our nurses have expertise in mental health. They may not be technically a psychiatric nurse, but they all have that background. So there's a health assessment and a mental health assessment, and then a referral to the psychiatrist if there is a need to do so.

In terms of the ratio, there is a ratio—I'm sorry, I'll have to get back to you with what it is. I don't recall it offhand.

M^me^ France Gélinas: So after the assessment, somebody is tagged—I forget what you call it, but they have a mental illness; everybody knows. There may even be a diagnosis. Will there then be treatment? If somebody comes in with a wound, whether he's remanded or sentenced, they will dress it. If somebody comes in with an acute mental illness, will there be a nurse there to look after them?

Ms. Loretta Eley: I'm sorry, I misunderstood. Yes, there will be. What happens is that in most cases, in most of our facilities, we have a designated area that may not provide specialized programming, but it's called a special needs unit, where we put people together who have issues, usually mental health but occasionally serious physical health issues, and those people are seen by the physician and the nurse regularly. As well, our correctional staff receive specialized training in dealing with mentally ill offenders.

M^me^ France Gélinas: Do you see a trend toward more people with mental health illness or issues going into correctional facilities, or are some of the programs working and you're seeing a downward trend? I visited a jail—I used to work with the homeless—and I was amazed to see how many of my clients were in there. So I'm thinking, is it the same thing everywhere?

Ms. Loretta Eley: With the closures of the mental health facilities, we have experienced an upswing in the number of people who are not caught in a social safety net. I think that may be changing as a lot of these programs have been developed. They're working interministerially, so that there is a strategy for trying to deal with these people before they come into jails and correctional centres. In terms of—

M^me^ France Gélinas: Would you say that there is a downward trend or that you're hoping it's about to happen? Or is it not happening?

Ms. Loretta Eley: I think what we're discovering now—we have some research being done under the auspices of health that says that about 36% of our clients who are in custody may not have a major mental illness, but if they were to go and be assessed at, say, Queen Street or any of the Ministry of Health facilities, they would be deemed to be eligible for those services. So somewhere on the continuum they're there. I think that's an increase over years ago, but what I'm hoping is that it's a decrease over a few years ago. But we don't know that yet.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. Your input was appreciated.

MINISTRY OF CITIZENSHIP AND IMMIGRATION

The Chair (Mr. Kevin Daniel Flynn): Our final presentation today comes from the Ministry of Citizenship and Immigration. We've got Minister Chan with us and his staff. If you'd come forward, Minister Chan, and make yourself comfortable. Thank you for coming today. Like all other delegations, you have 30 minutes. If you could leave some time at the end for some questions, that would be appreciated by the committee. If each speaker would state their name for Hansard, that would be appreciated. The floor is all yours.

Hon. Michael Chan: I think my time is 29 minutes. Good afternoon, and good early evening, Chair, committee members, colleagues, ladies and gentlemen. It's an honour for me to speak to you today. With me today is ADM Katherine Hewson from my ministry. I will be having opening remarks and Katherine will go through a few slides with you. After that, we can answer a few questions, if we do not exceed the 29 minutes.

First of all, I would like to note my full support for this work on mental health and addiction. I applaud Minister Caplan for his commitment to this issue and for bringing it into the spotlight.

Mental health and addictions are difficult issues, issues that many are uncomfortable talking about. Yet we need to examine, as a province, how we support those who are impacted. Almost all of us have been touched at some point in our life by mental health or addiction, whether by direct experience ourselves or through our loved ones. You have already heard that one in five people will experience a mental health or substance abuse problem n their lifetime, so developing a comprehensive provincial strategy on mental health and addiction is critical.

I commend you for taking a holistic approach to this issue. I note your early discussions quickly focused on the need to look not only at the health sector, but also at sectors such as housing, justice and education, recognizing that solutions to mental health and addiction challenges must be multi-layered. In addition, your mandate identifies some specific groups to look at—groups such as seniors, youth and ethnic minorities—that may face very specific challenges. The points I would like the committee to consider relate to the sometimes unique mental health needs and experience of newcomers, and it's important to keep in mind that much of our future population and economic growth will come from immigration.

As the Minister of Citizenship and Immigration, I am keenly aware of the many challenges newcomers to Ontario face. Some newcomers, such as many government-sponsored refugees, arrive having escaped horrific conditions like war, famine and displacement, and clearly exhibit signs of post-traumatic stress disorder. Others

may arrive with great hopes and expectations, yet face isolation and cultural shock. Uprooting oneself to move to another country, often leaving behind family and friends, requires courage. It can also be traumatic, resulting in the loss of support networks, one's place in society and meaningful employment.

As one of your previous presenters from Parents for Children's Mental Health notes, loneliness and not being connected can be an impediment to receiving appropriate care for mental health issues. For immigrants without a support network or family and friends, loneliness and not being connected are often a sad reality, particularly for those without employment. Isolation can both trigger addictions and mental health issues and prevent newcomers from accessing services to help them.

Other issues unique to newcomers may include cultural barriers to recognizing mental health issues and the stigma associated with seeking treatment. People from some cultures may not be able to describe depression or anxiety in terms familiar to North Americans. Admitting to feeling overwhelmed may be seen as a sign of personal weakness. As well, language itself can be a barrier for newcomers. They may not be able to effectively communicate their mental health concerns to a doctor or to another service provider who might take appropriate actions, and timely interpreter services are not always available.

Unfortunately, many immigrants from a wide area of source countries still report facing discrimination and harassment in various aspects of their lives. They may also face stresses such as unemployment, underemployment and lack of credential recognition. The current economic situation may compound this. While this affects all Ontarians, research has shown that newcomers are particularly vulnerable to economic downturns. There are also stresses on available services when many of our residents need help in dealing with difficult issues beyond their control, and in some instances, costs can be a barrier to accessing services.

My goal as Minister of Citizenship and Immigration is to try to help ensure that our newcomers have the opportunity to participate fully in the economic, social and cultural life of this province. Like other Ontarians, they cannot do so if they have unaddressed mental health or addiction issues.

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There are many challenges that we need to be aware of when speaking about newcomers and mental issues: post-traumatic stress disorder, cultural taboos, economic stresses, language barriers and isolation, among those I have briefly touched upon. Having said that, I must acknowledge that there has been some good work already done in this field. Settlement agencies and other committed organizations are often the first point of contact for newcomers. Many of these agencies have trained staff who are well positioned to provide referrals to mental health practitioners, so a lot of these necessary linkages are in place. To ensure access, service providers must be sensitive to the unique mental health challenges newcomers face.

Another task is to ensure that newcomers know how and where to access services for their mental health and addiction needs and know what supports are available. In the coming weeks my ministry will be initiating discussions with some of the stakeholders on these issues. I am committed to supporting your work, and we will be happy to share the results of our discussion with you.

Again, thank you for the opportunity to talk to you. Now my ADM, Katherine, will go over the slides with you and afterwards we can answer a few questions.

Ms. Katherine Hewson: Thank you, Minister. Katherine Hewson; I'm the Assistant Deputy Minister in the Citizenship and Immigration Division of the Ontario Ministry of Citizenship and Immigration. I'll try to go through these slides fairly quickly in order to leave committee members time to ask questions.

In the presentation I'd like to just provide some context and background on immigration in Ontario, identify some of the mental health and addiction issues facing immigrants and the kinds of circumstances that might lead to that, identify some challenges to obtaining treatment, and also mention some best practices and potential next steps for working in this area.

On slide 3 you'll see some of the factors that can increase the incidence of the mental health problems and addictions. We know that poverty, unemployment, discrimination, low education, literacy issues and lack of social supports can all lead to more mental illness and addiction issues. The challenges that newcomers face can make them particularly vulnerable to these problems.

To show you a little bit around the numbers of immigrants coming to Ontario and some of the top source countries of immigrants, you can see on slide 4 that in 2007 we received about 111,000 immigrants to Ontario. They come from about 250 countries, and you can see on the chart the top source countries.

Ontario and Canada share the responsibility for providing integration language services and settlement services to newcomers. Ontario spends in the neighbourhood of about $188 million a year on these kinds of services. The federal government is a larger funder and is funding approximately $407 million a year.

On slide 5 you can see some information, and if you just take those numbers and apply what we know around the incidence of mental illness and addiction, if we assume that one in five Ontarians—and this would apply to newcomers as well—will experience mental health challenges in their lifetime, that means there would be 22,000 newcomers a year who would be facing mental health challenges. Similarly, if you take the 5% of addictions for the general population and just apply that to newcomers, then you're dealing with about 11,000 newcomers. We don't have good information on the incidence of newcomers and that is certainly a gap.

On page 6, you can see the kinds of issues that newcomers face just as a regular part of the immigration process. They can be away from family and friends, they can be away from a familiar culture, and learning to settle and making the decisions that are necessary to settle

effectively in Ontario can be stressful. Securing a place to live, finding social services, finding health services and learning to speak the language can be very considerable; getting their children into proper schools and understanding the school system. Finally, a big issue is gaining Canadian work experience or finding work that is appropriate for their experience, education and expectations.

What we also find is that many newcomers have less than successful outcomes, especially early in their integration process, and this can contribute to mental health and addiction problems; for example, being unemployed or working in low-skill or part-time jobs; having difficulty in speaking English or French; being unable to work in their field because qualifications that they have from their home country are not recognized in Ontario; experiencing discrimination and social exclusion; experiencing a loss in social status; and having left behind the kinds of supports that we all have from family and friends.

Refugees, we know, are at even higher risk than general immigrant populations. Out of the 111,000 newcomers who arrived in Ontario in 2007, 14% were refugees. We know that especially government-sponsored refugees, but all refugees, may have experienced severe trauma, and they have distinct mental health needs. There have been some studies that have tried to assess this. There was a study of about 7,000 global refugees moving to western countries. Of those, 9% were diagnosed with post-traumatic stress disorders, 11% of the children had post-traumatic stress disorders, and 4% to 6% of all that population had significant depression.

In addition to the kinds of experiences that can add to the stresses, the fact of being an immigrant can also create barriers to accessing the kinds of services that we have in Ontario. People may not be aware of the services that exist; there may be limited services that are culturally appropriate outside of large urban areas; people will have difficulties expressing their issues in a language that is not their native language; and there are cultural and interpretation difficulties.

Not all cultures look at mental illness or would even describe mental illness in the same terms as we in Canada or in North America would, so this creates some issues as well. As you know, there is a stigma generally that's attached to mental illness, and this can be even more so in some newcomer communities.

Finally, because sometimes immigrants are in precarious employment, they may not have employee benefits that would support payment for some of the other services.

In addition to the provincial action that you're leading and contributing to, there is also, you may well be aware, some national action happening, and our ministry has been invited to participate in some of that. The Mental Health Commission of Canada has developed some recommendations and will be consulting on these recommendations on how to improve the mental health of Canadians from ethnocultural and newcomer communities. They have identified four pillars, which are coordination, information, community engagement, and more and more appropriate services.

I just want to spend a moment on some of the Ontario resources to assist newcomers in making the transition successfully into life in Ontario and then what we know of some specialized services on mental health. I won't go into this in detail, but the Ministry of Citizenship and Immigration provides general services—settlement programs. So we fund community partners to provide information and referrals for newcomers, we provide language training for adults, and we also provide more specialized—what we call bridge training programs that help people who have professional accreditation and experience make that bridge into Ontario so that they can be licensed professionals and get jobs that are appropriate to their experience and education.

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These programs do help, when they are successful, to reduce the stresses of unsuccessful integration. They can get people into good jobs, reduce their lack of status—and of course just financial ability.

We also, through our programs, provide information generally to newcomers on a variety of issues, including the availability of mental health supports. The newcomer settlement program does that by providing funding to settlement workers and community agencies. We have a portal, www.OntarioImmigration.ca, which provides a wide range of information. We also have a specialized service for victims of domestic violence called language interpreter services, and this is interpretation that can support a victim of domestic violence who doesn't speak English through a number of programs that they need in order to get help. It can be courts, but it can also be mental health issues.

You can see that on page 13 we've tried to just show the range of where services can be provided to newcomers. They can have some counselling and information and referral from settlement agencies; multicultural agencies also can refer. Community health centres quite often have a specific focus on newcomer populations, and hospitals as well. There are some good programs, as I'm just going to mention.

For example, the Canadian Centre for Victims of Torture is renowned for providing counselling, support groups and crisis intervention for people who have experienced torture—many refugees—and we fund them through the newcomer settlement program; a small amount of funding, but funding specifically to help.

I think, just in the interest of time, I'll go on. The other issue that agencies that we work with are addressing is trying to help general mental health service providers understand and be more responsive to the needs of cultural communities and newcomer groups. For example, Across Boundaries, an ethno-racial mental health centre, gives cultural competency training to general providers of mental health services, and that helps them be more specific and appropriate. Similarly, there's an interesting project that the Ontario Council of Agencies Servicing Immigrants has been working on with Hong

Fook Mental Health Association, which is going to be providing training for front-line settlement workers so that they have a better understanding, when their clients present mental health challenges, where the referrals can be made, and they're getting more intensive training on how to identify and provide good referrals.

Having said that, there certainly are ongoing challenges. There is a need for ongoing cultural sensitivity training of staff, the ability to provide services in multiple languages. Sometimes there is a lack of connection between the settlement sector and the mental health services that are available; regional differences in services and resources. There's just a wide variation in the needs of newcomer groups.

As the minister mentioned, we are working with our community partners to consult with them on issues regarding mental health. We've just also been dealing with a number of groups, asking their advice on the next stage of the Canada-Ontario immigration agreement, and it's very clear that mental health is an issue for settlement that needs to be addressed more strongly in the next version of that agreement.

Finally, we would just want to emphasize the importance of maintaining services for immigrants, especially during economic downturns. As the minister said, we know that there can be particular bad effects on immigrants in the job market during an economic downturn, and that's a very significant factor for mental health. We need to improve our ability to integrate newcomers so that we minimize the challenges they have on mental health and addictions.

Collaborating between the Ministry of Health and Long-Term Care and our ministry has been very effective, and we'll continue to do that. We will continue to support the development of cultural competency training for our settlement and mental health service staff.

Another issue that could be addressed is more and better interpreter and language services and more communication and outreach to newcomers. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left a little bit of time for questions. Starting with either Christine or Sylvia, you've got about three minutes.

Ms. Sylvia Jones: I'll be fast. You mention on slide 8 that 14% of newcomers who arrive in Ontario arrive as refugees. Knowing that refugees would be at higher risk, are you doing stuff in your ministry to track that 14% to—I guess for lack of a better word—fine-tune your resources to the people who are most likely to need them?

Ms. Katherine Hewson: I would say that some of that happens, perhaps not so much in our ministry. The federal government, in selecting refugees overseas, does provide through their refugee assistance program some special supports to refugees generally for the first year that they're in Canada, and there are some specialized services through settlement agencies and other agencies that support them.

Other than that, we provide settlement funding to agencies to help refugee claimants. Refugee claimants are not eligible for services from the federal government, so we are filling a need just in that area.

Hon. Michael Chan: I think that's very important to know about the services provided by CIC compared to us. The conventional refugee COIA agreement and CIC will be supporting them, keeping them serviced, but as you know, a lot of refugees just cross the border and become refugee claimants, and they will not be served by the federal program. Our financial resources are quite limited, as you can see from the percentage. So that is the challenge in terms of servicing them based on the financial resources we have, and on the renewal of the COIA agreement, which is coming up, we're trying to talk to CIC about expanding the eligibility of servicing refugees, in whom you've mentioned there seems to be a higher percentage of risk in the mental health issue.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Christine, you've got about a minute.

Mrs. Christine Elliott: I'm just interested in the supports for service providers that you mentioned. Across Boundaries, is that here in Toronto?

Ms. Katherine Hewson: Yes.

Mrs. Christine Elliott: Is that the only one of its kind in the province that you're aware of?

Ms. Katherine Hewson: No. There are other agencies that provide those kinds of services, but they're not widespread. For example, there are some services in Ottawa.

Mrs. Christine Elliott: The other was on the Hong Fook Mental Health Association. Is that also in Toronto, and could we get some additional information regarding that? I'm really interested in the training for front-line workers and, as well, in the cultural competency training.

Ms. Katherine Hewson: We could certainly provide that to the committee.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): You have about a minute.

Hon. Michael Chan: I was there last weekend attending the volunteer honour function, and this is an organization that serves the Chinese, Vietnamese, Cambodians and Koreans.

They told me, "We are relatively small. We are kind of like struggling on the funding." But they're good people. They've been really trying hard not only to outreach to one group, like one from China, but really outreaching to them, and I think they're doing a good job. There are good people out there, good organizations, but again when we engage in more talk about that, it is really the financial resources.

Also, they mentioned one thing very specifically on these newcomers, the four countries that I mentioned. They wanted me to be there just to raise the awareness because they feel that these people, the community, don't want to talk about it, okay? They wanted me to be there to raise the issue. I was there, and then the newspaper reported, the ethnic newspaper. They encourage the groups to come forward, meaning that there may be more people having this issue, but because of culture or cultural habits, they just don't want to talk about it.

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

M^me^ France Gélinas: Thanks for your presentation. I'm on slide 13, where you talked about service delivery. I take it that's for newcomers who already have a mental illness or are struggling with a mental issue.

Ontario is such a rich province. When you look at our newcomers and our immigration, do we have any centres of excellence? Do we have any best practices that we can copy? Who is active in trying to really focus on the mental health needs of the newcomers?

Ms. Katherine Hewson: There are organizations that we have a funding relationship with that I would say excel at this. One would certainly be the Canadian Centre for Victims of Torture. I think they're well known. There are settlement agencies such as OCISO in Ottawa—I'm forgetting what the acronym stands for—that provide counselling services as part of their settlement services. I think the OCASI activity with Hong Fook that I mentioned could be seen as a best practice. There certainly are organizations that we would see as trailblazers or leading in this area.

M^me^ France Gélinas: When you presented slide 5, at the end you used the statistics of one in five and one in 10, and then you did an extrapolation. Do we know, when a newcomer comes, if he or she is in need of mental health support? Would we know that when they come, or do we have to wait until they get in trouble?

Ms. Katherine Hewson: Before they come, people have to pass medical exams as part of the selection process so that they would have some mental assessment at that point, but no, generally we wouldn't know. There's no tracking mechanism. People arrive when they have their visas, and there isn't really a planful way of knowing that.

Hon. Michael Chan: And by the way, the tracking is the federal government. The health and also security would be done by the federal government.

But one statistic we have is that when the newcomers are here longer, the percentage of the mental health issue seems to be rising. When they come here, they seem to be okay. But when they're here one, two, three or four years, it seems to be that they are not as okay as before. That's the trend that we've started to notice.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Minister. A final question, Jeff.

Mr. Jeff Leal: Thank you, Minister Chan, for your presentation. I just want to ask the ADM a question: In any given year, how many foreign-trained psychiatrists would be arriving in Ontario? How quickly are we putting these foreign-trained psychiatrists through the accreditation process so they can start practising? We all know there's a Canada-wide shortage of psychiatrists.

Ms. Katherine Hewson: I don't have that information, Mr. Leal, but I think we can provide that to you.

Mr. Jeff Leal: Could you get back to the committee clerk with that? I'd appreciate getting that information from you.

Ms. Katherine Hewson: Sure.

Mr. Jeff Leal: Thank you so much.

The Chair (Mr. Kevin Daniel Flynn): Thank you for being here today. Sylvia, did you have one more question?

Ms. Sylvia Jones: Not related to the presenters, but I did have one before we—

The Chair (Mr. Kevin Daniel Flynn): Okay. Let's allow our guests to leave first. Thank you very much for being here today. It's appreciated.

Hon. Michael Chan: Thank you.

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

Ms. Sylvia Jones: Mr. Leal reminded me that we have asked presenters to bring back stuff over the course of the last number of weeks. If that has not arrived—and I certainly haven't received it—can we follow up?

The Chair (Mr. Kevin Daniel Flynn): Yes. I'm sure it's all being tracked. I think at some point in the near future, we'll have heard from all the ministries that are presenting. I would hope all the information would start to come in by that date.

Ms. Sylvia Jones: Okay. So you'll do a letter for stuff that hasn't come in?

The Chair (Mr. Kevin Daniel Flynn): Anything that comes in to the committee I will circulate immediately through Susan.

Ms. Sylvia Jones: No, I'm sorry—you'll do a letter to the ministries that have not brought back the requested information?

The Chair (Mr. Kevin Daniel Flynn): If it looks like it's necessary, I will, yes.

Any other questions? If not, thank you for your attendance today. We're adjourned.

The committee adjourned at 1802.

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