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Mercredi 13 mai 2009

Select Committee on Mental Health and Addictions

Mental health and addictions strategy

Comité spécial de la santé mentale et des dépendances

Stratégie sur la santé mentale et les dépendances

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 13 May 2009

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The committee met at 1603 in committee room 1.

The Clerk of the Committee (Ms. Susan Sourial): Honourable members, it's my duty to call upon you to elect an Acting Chair. Any nominations?

Mr. Jeff Leal: I want to nominate—

Mrs. Liz Sandals: I nominate Bas. No, I was going to nominate Bas.

Mr. Jeff Leal: I would nominate that Mr. Balkissoon assume the chair.

The Clerk of the Committee (Ms. Susan Sourial): Mr. Leal has nominated Mr. Balkissoon. Any other nominations? No? Mr. Balkissoon.

Mr. Jeff Leal: There we go. We got that resolved.

Mrs. Liz Sandals: There we go.

The Acting Chair (Mr. Bas Balkissoon): Thank you very much. I hope there's a paycheque change coming with this. Okay, Jeff?

MENTAL HEALTH AND ADDICTIONS STRATEGY

AUDITOR GENERAL OF ONTARIO

The Acting Chair (Mr. Bas Balkissoon): We'll call to order the meeting of the Select Committee on Mental Health and Addictions on Wednesday, May 13, 2009. The first item of business is a deputation by the Auditor General of Ontario. Mr. McCarter, if you would introduce yourself and your guests, you have—is it half an hour?

Mr. Jim McCarter: Half an hour, I understand. I've got some remarks, and I have one overhead. I'll try to keep it to no more than half the time so we do have some time for questions.

The Acting Chair (Mr. Bas Balkissoon): Excellent.

Mr. Jim McCarter: Just to introduce my staff with me for Hansard: I have Rudolph Chiu. Rudolph was a director on two of the three audits that I'm going to be talking about today: community mental health, which is the adult mental health program, and addiction treatment programs. I also have Walter Bordne, who was the director on child and youth health services. I think you've got a copy, hopefully, of the handout in front of you. I tried to put it on one page.

I know Ms. Sandals had mentioned that maybe I should circulate something in advance, and research indicated that copies of our three audit reports had been circulated to you. But just on the off chance, I do have a two-pager, and I can distribute it if you'd like. It's basically the summary from each of the three reports. It kind of summarizes fairly succinctly what we found in the three audits. If you'd like that, I can distribute it. I don't want to overburden you with paper.

The Acting Chair (Mr. Bas Balkissoon): No, distribute it.

Mrs. Maria Van Bommel: Yes, please.

Mr. Jim McCarter: Okay. I'll just hand this to Susan, and she can distribute it while I'm talking. It just provides a bit more detail on what I'm going to be talking about.

What I'd like to do today really is just briefly give you an overview of some of the key findings from the three audits. We had a bit of a theme in last year's 2008 annual report, where we focused on mental health and addiction treatment services. We also looked at some associated areas, as you know, like correctional institutions. So we a had a bit of a mini-focus last year on mental health. I see a couple of members from the Standing Committee on Public Accounts. We have had a couple of hearings of the public accounts committee, and I suspect that some of those recommendations, which will be forthcoming in due course, may be of interest to the committee.

I'll start off by just briefly discussing child and youth mental health services. This is basically mental health services provided to children up to the age of 18. I won't spend too much time on overhead number 3; it gives you a bit of an overview of the program, what the dollars are. The one thing I'd say, though, is that it did become fairly evident to us, sort of the historical basis, that prior to 1970, children's mental health services were very institution-based, in the sense that people with severe mental health issues were treated in institutions and those with less severe issues didn't get a lot of service. That's been changing over time, where it's become much more of a community-based service. But what we've found is that each community tended to operate somewhat in isolation. I think the way we described it is that it's a bit of a patchwork of services out there with respect to children's mental health services.

On slide number 4, what I tried to do is identify for each of these audits what I would consider to be the five key issues. We have a number of other issues in the audit report, but just to try to highlight them, I think probably the number one issue to us on child and youth mental health would be certainly more of a focus on early iden-

tification and intervention. We had feedback from the health agencies that we visited, and this was very much an audit where we spent time out looking at these mental health agencies. They indicated to us that was an issue. They also indicated to us, though, that they can't handle this on their own; they need the schools involved, they need better teacher training. Australia and the United Kingdom: In their mental health strategies, they've got this in their top three as very important issues.

1610

The second issue that we had: We felt that across Ontario, because a number of the agencies have operated a bit in isolation over time, there was inconsistent intake and assessment, which means that often you could have a child in two different parts of the province having the same basic mental health issue but getting significantly different treatment, or some might have a wait time of a month whereas some were waiting six months for an assessment.

The third area was wait lists. A bit of good news and bad news here: We found that there were fairly long wait-lists of three to six months for non-residential services, but for residential services the wait times were actually quite good. They were short and, in some cases, they could get people in right away. So it was a bit of a good news/bad news with respect to wait times.

The other thing we pointed out was that there's definitely a lack of what we would call evidence-based treatment programs, in the sense that a number of these children, the mental health issues they have—they deal with depression, aggression, anti-social behaviour—there are different ways you can treat those. Some of the other jurisdictions are having a real focus on what works and what doesn't work and trying to disseminate that across the community. We felt there needs to be more of that in Ontario, more collaboration and coordination.

The fifth issue that we identified was that the funding has been very history-based. I guess I'd have to say it's hardly kept pace with inflation over the last decade. The way we described it in the report was the agency has indicated to us that they really had a hard time even just maintaining their core services. They basically said, "We've had to rob Peter to pay Paul," if I can put it that way, to even try to maintain their core services.

Being a kind of fair-minded auditor, though—you'll see on slide number 5 there were some positives. We did note some good things being done, one of these being what the ministry calls service mapping. In 2004, at a PAC hearing—and we looked at this a number of years ago—the ministry had indicated, "It's been some time since the ministry has had a serious look at exactly what services are being provided on an agency-by-agency basis." Even during this audit, the ministry did not have a good handle on what agencies were providing what services, what the availability was or what the wait time was, so it's sort of like until you really know where your major problems are, it's difficult, I'd have to say, to cost-effectively address it. But the ministry has basically recognized that and they're doing a detailed service mapping on an agency-by-agency basis to try to get a handle on that. So we felt that was a really important first step.

They have implemented a standard intake tool. Basically it's a brief child and family phone interview. They're trying to put that across all the agencies to get some consistency and they're also using a case assessment tool, CAFAS, which they're trying to use across all the agencies, again, to try to get more standardized assessment, which we thought was good news.

We did note some good practices at some of the agencies. For instance, a few of the agencies were taking this CAFAS data and they were trying to use it to come up with good, evidence-based practices. But again, there's really no way right now of getting that collaboration across the whole system. We felt that there were some good ideas, but we felt the ministry had to take a leadership role and try to disseminate some of this good information.

Turning to community mental health, which is basically adults, there's about 2% to 3% of the population that has serious mental health problems. The community mental health services are really to address that percentage of the population. Overhead number 6 gives you a bit of detail on the dollars that are involved.

This has been a program where it was also, going back three or four decades, very institution-based. The trend, really, around the world has been to provide these services in a community-based setting. The ministry has actually made a pretty significant effort to move to a community-based setting. The issue with that, though, is when you start moving people out of the institutions, you have to make sure that you have the community-based supports there, or what happens is what we call the revolving door syndrome: They get out to the community, they don't get the treatment, they're back at a hospital, or basically you've got the ACT team having to help them out. We found that there still wasn't an adequate level of community-based support, given the amount of deinstitutionalization that actually has been very successful over the last decade.

The LHINs are involved in this as well. The LHINs responded to us in writing and said that timely access to mental health services remains a principal barrier to effective care in the community. The LHINs basically said, "We recognize this is an issue; it's a problem." There are fairly lengthy wait times for services. It can be up to 180 days. Ministry staff acknowledge that.

There's a critical shortage of supportive housing in some areas, but in some areas you have vacancies. There are inconsistencies across the province, but for the most part, there needs to be more supportive housing. Again, the LHINs told us that affordable supportive housing is the cornerstone of cost-effective community care. Dr. Kitts from Ottawa came to one of the public accounts committee hearings, and he said that you can't just look at hospitals; you've really got to look at the whole area. They asked him about what could be done to make it

better for hospitals, and he said that affordable housing in the community would make a big difference even to a hospital. So that's an issue.

The whole issue of historical-based funding has created significant regional disparities. The LHINs came back and said to us, "We agree, Auditor, that the way the agencies have been funded has resulted in significant inequities across the province in access to service." To give you an idea on a per capita basis, it goes from a high of $115 down to a low of $19. You can't base the funding totally on a per capita basis, but I think there's a recognition that there needs to be a new funding model based more on relative needs in the local community.

The last point, number 5, is the funding. Even though we've deinstitutionalized a lot of people, the funding has not followed that deinstitutionalization into the community. Going back about 10 years ago, the ministry felt that to reach our target, which is 35 beds per 100,000 people, we would need to have 60% of our funding in the community. Right now, they're only at 40%. So there's a recognition that we need more community-based funding to provide that level of support. On the positive side, you have to give the program credit, in that over the last 10 to 15 years they have met their deinstitutionalization targets. They're down to about 35 beds per 100,000 people. The downside of that, though, is you have to make sure you have the community-based supports.

Again, as with child and youth, there are some good local coordination practices. We also felt this is an area where they've started to put together some good data collection systems. We did give them a pat on the back for making a good start on that. They've still got some problems with quality of data, but at least they've got the underlying information systems in place to start to collect the data, to know where they stand.

Moving on to addiction treatment services, as you can see on slide number 9, the government spends about $129 million, and about 90% of that goes to 150 addiction service providers. These are now overseen by the LHINs. In the last decade, there hasn't been a significant increase in the amount of funding going to substance abuse. On the other hand, problem gambling has had quite a substantial injection of funding, because 2% of the revenue from slot machines at the racetracks goes to problem gambling. Some of the feedback we had on substance abuse is that we've got growing demand, and again, the same thing: We're having a hard time just keeping our core services.

The other thing that came up too is that these local agencies have evolved over time. It hasn't been what I would call a planned, coordinated approach. The last time we did the audit in 1999, we saw that the other jurisdictions were merging a number of their smaller treatment centres into larger, multi-faceted treatment centres, because people with addictions also often have mental health problems, they could have law enforcement issues, and they need more multi-faceted, larger agencies. They said they were going to go that way, but in the current audit it didn't look to us like they'd made a lot of headway.

With respect to the five key issues, we felt that most of the people needing addiction treatment services are not being identified. In fairness, you can't say, "Well, that's the ministry's fault." Part of it is getting that awareness out, and a lot of people just aren't coming forward saying, "I need help." There's a definite saving, if people need help, on the health care side, on possible law enforcement savings. The empirical evidence says that for every dollar you spend, you can save anywhere from $4 to $7.

On the wait times, it's probably good and bad news. I'd have to say, on one hand, there were some significant wait times, but it was actually much better than community mental health. People were getting in quicker to get an initial assessment on addiction treatment services than they were on the mental health side. Having said that, you could still wait up to six months. But the average was about three to four weeks, which was definitely better than community mental health.

1620

On the LHIN per capita funding: again significant inconsistencies between the different LHINs, because it's been historical-based as opposed to needs-based, and the range has gone from basically $40 per capita in the highest LHIN to $3 per capita in the lowest LHIN. Again, the feedback we had from the LHINs was, "You can't do it on a strictly per capita basis, but we recognize that right now there are some significant inequities in the way we fund things." The ministry is looking at it—I think they call it HBAM, historical-based allocation model—to basically try to address that. There is some recognition, but they've kind of indicated, "It's going to take us a couple of years."

What we noticed too, with the transfer to the LHINs—they've shut down all the ministry regional offices—is that that there has been some loss of corporate knowledge, as well as the ability to oversee these providers. For instance, on the addiction treatment agencies they used to get an annual operating plan, saying, "Here's how we're going to spend your money." The last two years they basically stopped that requirement of getting the annual operating plan.

They've also lost some knowledge, and that would vary by LHIN. The central LHIN actually did a very good job. They picked up a number of the ministry regional health people. But some of the LHINs haven't been so lucky, either because of funding or they haven't been able to get the people.

Again we felt, with respect to addiction treatment services, that there needed to be better coordination. There wasn't a lot of information at the ministry with respect to availability of service: "Where are our gaps?"

But we did see some positives. Again here, we felt that there were some good information systems that had some good potential. Especially ConnexOntario is doing some good work.

We had to say, "You know what? There's definitely been significant recent attention on problem gambling." They've definitely pumped a fair bit of money into it and they've taken a pretty aggressive stance on problem gambling. The big concern they have is that there has been limited uptake. Maybe "concern" is not the right word, but there's a feeling that there are problems out there but people aren't coming forward.

As I've said here, it's probably a positive side. While we have some longer wait times, it's better than mental health.

In my last slide I kind of tried to say, "Well, okay, Auditor, you looked at all these different areas. If you had to pick the top three issues, what would they be?" So we kind of talked about it and decided that of the top three issues, we felt number one would be early mental health identification and intervention for our young people. If you can get people early, and get them intervention and treatment early, it can make a big difference for a lifetime, both for society's benefit and the person's benefit, and also from a cost-benefit point of view.

The second thing we felt was still pretty significant was the significant deinstitutionalization. We felt that the community supports still were not up to where they probably should be for the adult mental health, and even the hospital community came back to us and said, "We know that we've got probably 10% to 15% of people in the hospital with mental health issues who could be in the community if we had the supports."

The last thing here that we noticed across all three programs was that—more needs-based funding as opposed to historical-based funding, because there are a lot of inequities in the system.

I've kind of rambled on for about 15 minutes. I'd be happy to take any questions you might have.

The Acting Chair (Mr. Bas Balkissoon): Thank you. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much, Mr. McCarter, for your presentation. It's extremely helpful to us as we're working through this whole process. You have a particularly good vantage point from which to see things.

I just had two quick questions. One was on children's mental health, and you mentioned better teacher training for children in Australia and the UK as being good examples. Were there any specific studies that you could point us to?

Mr. Jim McCarter: What we were looking at—I think I was looking at national strategies from the UK and Australia. In both, I was looking to see what their top issues were. Actually, when you look across the studies by parent groups, by UK, by Australia, even someone like—I had a good chat with Agnes Samler, who is a former child advocate, but she was retired, so she could be very honest and open. That was her number one too. They all basically said, "You've got the treatment agency, but very often it's the schools that have to identify where you have problems."

But often teachers are really overloaded, and a lot of them don't necessarily have the training to be able to do that. So it's working, I think, in partnership with the schools and family physicians, and trying to get that identification there and get them referred to the provider agencies. So if you've got a child that has anti-social behaviour or aggression or DDD, all these different things, you can get the treatment started at an early stage. But I would refer you to the UK and the Australian national studies, because they kind of have a good list. I think the UK has their top 10, which is quite interesting.

Mrs. Christine Elliott: Thank you.

Ms. Sylvia Jones: I actually wanted to go back to—I don't know if you referenced it in your slides. "The majority of addiction service providers did not," as required, "report wait times for some or all of their services": That's out of your original report. Can you expand on that?

Mr. Jim McCarter: Yes. I might get Rudolph to help me out. There was a requirement that they were basically—part of the funding is you're supposed to report your wait times, but I think three of the four that we visited weren't reporting their wait times through to what's called ConnexOntario, and they were supposed to be tracking that—and also availability of services. Again, we said, "You need to have a lot of that really hard data to be able to know how good a job you're doing and where your needs are. How can you allocate the funding better if you don't have that data?"

Ms. Sylvia Jones: Do you think that was as a result of the switch to the LHINs?

Mr. Jim McCarter: I would have to say it probably wasn't, in the sense that if I was to go back, four years ago, I suspect they weren't reporting the wait time there either. But what I'd have to say with respect to the LHINs is, they probably have less capability now to maybe oversee the addiction service providers than they did before because they've lost some of that corporate knowledge. But on the other hand, the benefit they do bring is that local knowledge to try to address the whole issue of having a more seamless, coordinated delivery of service.

In the long term, I think that's the philosophy, and the LHINs basically said, "We know where we're going, but in the short term, we're struggling a bit," if I could put it that way.

Ms. Sylvia Jones: Yes, I agree. I guess in the situation that I'm faced with, LHINs can't coordinate services that aren't there. It's great that they want to play that coordination role, but if the community-based services are not accessible, particularly with children's mental health, then we can't refer them to something that doesn't exist.

Mr. Jim McCarter: The LHIN CEOs basically said to us, "Mental health is a big issue with us; it's a high priority. We have to get a handle on it." We said to some of them, "Well, it's part of your role to reallocate money if need be to look at the high-priority areas in your local

community," and they said, "Yes, that's one of our roles, but we're not there yet."

Ms. Sylvia Jones: Now, did you feel that that was part of the LHINs' role? Because when I've spoken to them, they have said, "Part of our job is not to advocate for additional resources in particular areas." You're getting a different feel?

Mr. Jim McCarter: My sense was that if they felt—and they indicated to us, with respect to mental health, that they felt that there were concerns. My sense was that they were struggling. My sense was that it was their job to make that known, that if there were issues in their community, they could go forward and say, "We're wrestling with this. We're trying to provide this coordinated service."

They said to us very clearly, three of them, even, in a joint statement: "The services across Ontario—we believe there are inequities in service, and it's due to the historical funding model." Some of them said, "We don't necessarily agree, Auditor, that you can just do it on a per capita basis. It's too simplistic." They said, "You have to look at demographics and the different things." But they basically said, "The way it is now, there are definitely inequities, and we've got to somehow get that resolved so that two children with identical needs have a pretty consistent wait time and are entitled to a consistent level of service."

Ms. Sylvia Jones: Do we have access to that part, the three LHINs and their report to you?

Mr. Jim McCarter: It would be in the detailed report, the three LHINs that would have said that. If you go to the response—that would be in the response to the recommendations, where they would have said that.

Ms. Sylvia Jones: Okay, thank you.

The Acting Chair (Mr. Bas Balkissoon): Ms. Jaczek?

Ms. Helena Jaczek: Yes, looking at slide 8, under your positives, number 3, the "2007 mental health scorecard and two new data collection systems are good initiatives": We did actually have the deputy from MOHLTC here and we didn't get too much information on this. I was wondering if you could expand—

Mr. Jim McCarter: Yes. The mental health scorecard: What they've done is they've got 29 performance indicators where they're going to try to track what the results are. It could be that the reason the deputy didn't get into it too much is that it's just getting off the ground.

1630

We said in our report that what they're trying to do is a good idea, but they've really only got half of them where they even know exactly what data they want to collect. At least they've identified that. My feeling on all of this is you have to define what is success and what is reasonable. In a pragmatic, reasonable way, how would you define success in community mental health? How would you define success in addiction treatment services? It looked to us like, on the mental health scorecard, they were trying to do that.

It's the same thing with respect to the services being provided, like in children's mental health. There are no standard services, no legislated services. We sort of said to the ministry, "You really need to, at some point, decide what services will or won't be provided, what's the level of service that you're aiming at. If you don't try to set up some consistency there, again, you're going to have every different municipality delivering different services in different areas, having different priorities." That's the mental health scorecard.

The other two: They're trying to develop common data sets or common data elements. Again, whereas on the addiction side, where they're doing a better job, they're actually starting to collect individual client data, which is really helpful, they're not there yet on the mental health side, but at least they're collecting aggregate data. We have problems with the reliability of the data, but at least they're making a start. Would we say the data's reliable right now? Probably not, but at least they've recognized that and they're trying to tackle that issue.

Ms. Helena Jaczek: So is the goal of the mental health scorecard that it will be used on each individual client?

Mr. Jim McCarter: It seems to be more of a high-level scorecard. I see Rudolph nodding, but to get to that high-level scorecard, you need to have the data from the individual providers to be able to roll it up. Then you can start looking at it on a LHIN-by-LHIN basis to see with respect to funding and where we have service gaps, but you need that underlying data, and it has to be reliable.

The Acting Chair (Mr. Bas Balkissoon): Ms. Gélinas?

M^me^ France Gélinas: I have to congratulate you because I'm one of the people who sit on the committee, and I would say your top five key issues and your three concerns would have been mine also. Very well done, and a very helpful little one-page thing that sums up lots of hard work.

You're an auditor, you're very good at crunching numbers—

Mr. Jim McCarter: I know.

M^me^ France Gélinas: —and you have talked about inequity, from $19 to $117 per capita on a historical basis. We all agree that per capita is too simplistic. In your work, have you come across a good list as to what you should be including? You've hinted towards supportive and affordable housing, but what else should we look at if we want equity between all parts of Ontario? Have you come across anything good in that respect?

Mr. Jim McCarter: I have to say, I don't think anything comes to mind, but I know, in talking to the LHIN CEOs, they all had pretty definitive opinions on what they thought, depending on the needs in their particular area. However, I'd have to say, if you got the 14 of them in a room, I don't think they'd agree on just how to do it. The answer to you is I can't refer you to a specific document. I don't think we have a specific document, and I'll turn to my colleagues, but—

Mr. Walter Bordne: The way they do it for children's mental health services is, basically, they count kids as one of the justifications for funding. That's very simplistic, again, because a child getting 24/7 supervision in a home program shouldn't be counted the same as a child who goes to counselling once a week or once a month.

Value-for-money, I think, by definition looks at the relationship between what you're getting and what you're paying for. What you're getting is really the hard part because a lot of these agencies are autonomous; they're funded by independent boards. We know roughly the types of services they're providing, but we have no idea as to the quality and really the quantity in a quantitative way. What they have to do, I think, is much more detailed work as to not necessarily how many buildings they have and how many staff they employ but how efficiently and effectively they're used. If, for example, you're paying for a child to go to counselling once a week, and if there are three kids in the session with one counsellor, and a counsellor makes $100 an hour, one child for that one-hour session should be $33.

Mr. Jim McCarter: I'll jump in and give you an analogy. I think of long-term care, where they basically take long-term-care residents and divide them into six or seven categories, from people with severe Alzheimer's who need significant care to basically someone who's living there but they don't need a lot, and there's different funding for that. That would be a more simplistic example.

But even something like that, when it comes to children, what are the relative needs in your community? As Walter said, there's a big difference between somebody needing 7/24-hour care and someone who might be in for an hour of weekly counselling. And I don't have anything I can refer you to—

M^me^ France Gélinas: But you haven't come across anything good?

Mr. Jim McCarter: No. I'm being very honest.

Mr. Walter Bordne: The other issue is it's really a zero-sum game, so to give somebody else more because they really deserve it, you have to take it away from somebody else. That's the other hard part.

M^me^ France Gélinas: But at least we would know what we're shooting for. That would be something, to start.

My second question has to do with children's mental health, and here again, in the work that you have done, I know that the deputants and people talking to your report talk a lot about a mandated basket of core services for children's mental health. Sometimes they talk about legislated services for children's mental health; it has different names. Here again, in your studies have you come across either provinces or other jurisdictions where you find those mandated core services for children's mental health, as opposed to what we have here?

Mr. Walter Bordne: Not in mental health per se, but for example, in children's aid societies those are mandatory services, so children's aid societies have to be funded to the level of the service that they're providing. If they're short at the end of the year, somehow we have to make that up because we can't turn a child away from a care situation because the money isn't there. So we have to provide that service—

Mr. Jim McCarter: I know what you're saying: Did we come across something like Illinois or B.C., that if you wanted to make that recommendation, here would be a good template to use? The answer to that is no. Some of the jurisdictions are going that way, but we didn't see anything that we would say, "Here's a great template that could be used," which is of maybe a reasonable level of care.

M^me^ France Gélinas: And how about within Ontario: Of the people that you interviewed, are there people who are working towards developing something like this, or are we really on our own?

Mr. Jim McCarter: My sense is they tend to—as you know, these are very dedicated provider agencies. They do what they can as far as providing core services but there's a lot of firefighting in the sense that when little Johnny or little Susan comes in and they've got a real problem, they will drop everything and make sure they see them. But what happens, as I say, is if they rob Peter to pay Paul, then somebody else is not going to get the treatment.

We find that some of the agencies specialize in different areas. We found that there's still not a lot of coordination and collaboration across the system, i.e., a central access point that if I think, "I've got a real problem with my son Colin. Where can I go where they have a central access point and they can tell me the whole range of services, where they can tell me, 'Here's what's available; here's the waiting time'"—that sort of availability is not there, although they are making some attempt, but they still have a fair way to go.

M^me^ France Gélinas: Okay. My last question is—in your top three concerns, you said children's and youth mental health, early identification, and intervention. I'm trying to remember who it was who came and presented and basically said that in other jurisdictions—I think it was Quebec—they test all kids in grade three and they test them again in grade whatever for early identification. They found that this had a tremendous effect on kids acting out later on etc. Again, my question: Do you remember who that was?

Mr. Jim McCarter: I can't remember which jurisdiction it was, but that sort of thing, or more attention. I know even just in talking to Agnes, who's got a lot of experience—30, 40 years' experience dealing with these situations—she basically said that this was a really key issue. She was blunt. She said in getting the school boards onside, you're going to have a challenge because it's going to require some teacher training, once you start implementing something like this. But she said, "In my opinion, Jim, that would make a big difference."

The Acting Chair (Mr. Bas Balkissoon): Members of the committee, I still have two requests for questions. The 30 minutes is up, but I'm happy to carry on if I could

have a motion of acceptance by all committee members to carry on?

Ms. Sylvia Jones: Yes.

The Chair (Mr. Bas Balkissoon): Unanimous consent? Carried.

Okay, Mr. Leal.

Mr. Jeff Leal: Jim, thanks for your presentation. Do we know, in the province of Ontario—do we see a spiking in problem gambling with the introduction of slot machines in Ontario? Do we have any baseline information on problem gambling in the province of Ontario?

Mr. Jim McCarter: I'm not sure that they have good data on that. They are pumping major money into it in the casinos. The issue is that there just isn't a big uptake. It's kind of like, why isn't there more uptake? We think the problem's out there. We think it's out there, but we don't have the uptake.

1640

We didn't come across anything which was solid enough for us to put in the report, saying, "Problem gambling is becoming more and more serious in Ontario." We didn't come across anything that gave us enough support to say that. The suspicion is kind of there, but we didn't have enough evidence to say that.

Mr. Jeff Leal: My next question, just as a follow-up: Over the years, you've looked at the activities of OLG. Maybe I should know this, but does OLG have a system to monitor or to identify clients using their sites as problem gamblers?

Mr. Jim McCarter: No. Actually, we haven't been the auditors of OLG now, I'm guessing, for about 15 years. But I suspect that they wouldn't have that system, and it could be because of privacy. I know what you're getting at. Also, if I can put it this way, do they track the demographics of the people who buy lottery tickets, how much do they buy, and with what percentage of their income?

I know where you're heading with that, but I don't know if they track that.

Mr. Jeff Leal: I'm trying to see a correlation between—you know, we're taking money from the proceeds of gaming in the province of Ontario to use it as treatment and to find the people we're trying to treat.

Mr. Jim McCarter: Yes, and they're taking 2%. They're actually hiving off about a third of that to go to the Ministry of Health Promotion—I think it's about a third.

Mr. Jeff Leal: I just noticed on your summation sheet, you had said one service provider served only three clients per counsellor at a cost of $26,000 per client for the year.

Mr. Jim McCarter: Yes, we noticed that in a number of the areas, where you'd have residences where they would have eight staff and two people in the residence. We've got a smattering of those types of details on all three areas, but we noticed it with the ACT teams. Do you know the ACT teams? Some of the ACT teams are very busy; other ACT teams had more staff than they had clients.

So again, the part of that that gets to us is the overall monitoring of all the stuff. As auditors, I guess we look for that, saying, "How do you control that? How do you know you're getting good bang for your buck?"

Mr. Jeff Leal: Well, it's the old value-for-money-type—

Mr. Jim McCarter: Yes, when you see examples like that, we'd have to say, "Well, surely you would have asked the question."

Mr. Jeff Leal: Thanks.

The Acting Chair (Mr. Bas Balkissoon): Ms. Jones.

Ms. Sylvia Jones: Just a quick question: On slide 5, under "Some positives" you say, "Service mapping by ministry under way." Is that Ministry of Children and Youth Services or Ministry of Health?

Mr. Jim McCarter: Ministry of Children and Youth Services. They had said about five years ago that it's been some time since we've had a serious look at exactly what each agency is delivering. They didn't have a good feel, not only on the service availability or the wait times; they didn't even know what services each agency was delivering. I mean, maybe it's kind of a backhanded pat on the back, but it's kind of like, "It's good you're doing it, but it's about time," if I can put it that way.

Ms. Sylvia Jones: And is there a timeline on when that is expected to be finished?

Mr. Jim McCarter: They were before the public accounts committee. I think they indicated that they were still looking at probably another year, to get all the data in. But there are comments on that specific issue in the Hansard of that particular meeting at public accounts.

Ms. Sylvia Jones: Thank you.

The Acting Chair (Mr. Bas Balkissoon): Thank you for taking the time to be here.

Mr. Jim McCarter: Thanks very much for the invitation.

SUBCOMMITTEE REPORT

The Acting Chair (Mr. Bas Balkissoon): Committee, we have a couple of pieces of business to do. Subcommittee report: Ms. Jaczek, can you read it into the record? No? Oh, Mrs. Van Bommel, can you read it into the record?

Mrs. Maria Van Bommel: I'd like to move the report of the subcommittee on committee business.

Your subcommittee on committee business met on Tuesday, May 12, 2009, to consider how to proceed with public hearings in Windsor, St. Thomas, Hamilton and Kingston, and recommends the following:

(1) That the committee start its hearings in Windsor on June 15, followed by St. Thomas on June 16, Hamilton on June 17 and Kingston on June 18.

(2) That the committee clerk arrange a site visit of the Regional Mental Health Care hospital in St. Thomas on June 15, following the hearings in Windsor.

(3) That groups and individuals be offered 20 minutes for their presentations, including time for questions.

(4) That the committee clerk contact groups from Toronto, Mississauga, Chatham and London that requested Hamilton, and inform them that the committee is oversubscribed in Hamilton.

(5) That the Chatham and London area groups that requested Hamilton be accommodated in St. Thomas and Windsor—and that's a correction to the written document.

(6) That the Mississauga and Toronto area groups that requested Hamilton be added to the list for the Toronto hearings.

(7) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Acting Chair (Mr. Bas Balkissoon): Any comments? Can I have a motion to adopt the subcommittee report?

Mrs. Maria Van Bommel: I so move.

The Acting Chair (Mr. Bas Balkissoon): All in favour? Carried.

A couple of housekeeping things: Distributed today in your package are the follow-up answers of the Ministry of Health Promotion. You also have a paper from research.

Just a reminder: On May 27, we have to be at CAMH at 12:30. The committee clerk will be in touch with members re travel arrangements.

Mrs. Liz Sandals: This is the 27th?

The Acting Chair (Mr. Bas Balkissoon): May 27, and the time we have to be there is 12:30, so I assume we'll be leaving here about 12 or 12:15.

Interjection.

The Acting Chair (Mr. Bas Balkissoon): We will get instructions.

That's it. We're adjourned—no, sorry. Ms. Elliott?

Mrs. Christine Elliott: If I could just raise one item. I have received a request from the Schizophrenia Society of Ontario to appear before the committee. I would ask that the committee members consider that and I would ask for a favourable recommendation.

The Acting Chair (Mr. Bas Balkissoon): Susan, you have a comment?

The Clerk of the Committee (Ms. Susan Sourial): Here in Toronto?

Mrs. Christine Elliott: Yes.

The Acting Chair (Mr. Bas Balkissoon): If you could just ask them to contact the clerk's office, and they'll be put on a hearings list for here.

Mrs. Christine Elliott: Okay.

The Acting Chair (Mr. Bas Balkissoon): Okay? Anybody else? We're adjourned.

The committee adjourned at 1644.

CONTENTS

Wednesday 13 May 2009

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