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Mercredi 27 mai 2009

Select Committee on Mental Health and Addictions

Comité spécial de la santé mentale et des dépendances

Mental health and addictions strategy

Stratégie sur la santé mentale et les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

Wednesday 27 May 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Mercredi 27 mai 2009

The committee met at 1707 in committee room 1.

COMMITTEE BUSINESS

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen, if we could all take our seats. With the indulgence of our guests today, I wonder if we can just do some brief committee work for your information.

We've had a late request from a group from Huron Perth Healthcare to be part of the delegations in St. Thomas. The clerk, Susan, sent out a request. The only thing we received back was people saying they were good with it or people not saying anything at all, so I'm assuming everybody's okay with the addition to the St. Thomas agenda. Okay.

Just to let you know, we invited the Speaker to join the committee during our site visit in St. Thomas, because it's his riding obviously, and the Speaker has accepted our invitation.

The people at St. Thomas have asked us what the focus of the tour should be when we're there. The four things they deal with there are forensic psychiatry, mood and anxiety disorders, assessment programs and psychosis programs. I made a bit of an executive decision and decided we'd like a little piece of each, unless there are any objections? It seemed to me that we don't know enough to know what we want to know. I'm assuming you're okay with that.

The subcommittee needs to meet regarding travel to the First Nations reserves, and we were wondering, Jeff, if we could involve aboriginal affairs in a subcommittee meeting to maybe pick out some of the appropriate reserves.

Mr. Jeff Leal: Absolutely. They'd welcome that opportunity, Kevin, for sure.

The Chair (Mr. Kevin Daniel Flynn): Okay. So maybe we could arrange that before the House rises?

Mr. Jeff Leal: Yes. We'll make ourselves available.

The Chair (Mr. Kevin Daniel Flynn): Okay. That's all the committee business I have, then.

M^me^ France Gélinas: Mr. Chair, I brought a map of all the reserves in northern Ontario. I'm just going to pass it around so that at least when we say names like Bearskin Lake and Muskrat Dam and all of that, you'll know where we're talking about and how far they are.

Mr. Bas Balkissoon: And we've got to get there by canoe.

M^me^ France Gélinas: With a GPS, you can get there, no sweat.

The Chair (Mr. Kevin Daniel Flynn): Some members were asking about the exact schedule for when we're travelling in June, Bas. I think we have that nailed down, and the clerk would be happy to let you know.

Mr. Bas Balkissoon: Yes, if we could get it, that would be great. It will help with some planning.

The Chair (Mr. Kevin Daniel Flynn): Yes. The only holdup is we're still trying to find a place to meet in St. Thomas. Apparently we don't have approval yet on a meeting room. We have to get a permit for it, and that appears to be forthcoming.

Mrs. Liz Sandals: Yes, the when and where.

The Chair (Mr. Kevin Daniel Flynn): Yes. Okay, so that should be coming out very shortly.

MENTAL HEALTH AND ADDICTIONS STRATEGY

MICHAEL KIRBY

The Chair (Mr. Kevin Daniel Flynn): Thank you for your indulgence, Mr. Kirby. Today we've got Senator Michael Kirby with us, chair of the Mental Health Commission of Canada, much talked about in a very positive way and certainly one of the first people who we wanted to hear from when we were starting our own deliberations. As with everybody else we've had before us, you have 30 minutes to use up any way you see fit, Senator. As we talked about earlier, the committee does like to ask questions, so I'll turn the floor over to you. Welcome.

Mr. Michael Kirby: Thank you, Mr. Chairman, and may I say to members of the committee that I'm delighted to be here. It's been a number of years since I've testified before a provincial committee, done it many times federally, but I'm delighted to be here.

Because I know you want to ask questions, I'm going to make a very brief statement, which I hope will also lead to some questions, and then answer your questions. I have distributed an opening statement, which, mercifully, I'm not even going to mention. The opening statement essentially tells you what the Mental Health Commission does, because I thought that was one of the things you wanted to know.

I think really what I want to do is make two main points. The first is that mental health services everywhere in the country are grossly underfunded. Let me just give

you two or three interesting statistics, only because some of the facts about mental health are sufficiently surprising that most people are quite stunned by them. Perhaps the most amazing one is what I call the hospital days. If you look at the total number of hospital days in Canada in which the hospital bed has someone in it who has a mental illness, that total number of hospital days actually exceeds the total number of hospital days for everybody who's in the hospital with cancer and heart disease combined. The reason for that is because typically an individual with mental illness is in for a fairly lengthy stay, and typically a person with cancer or heart disease is not. Nevertheless, that gives you some relative measure of the size of the economic burden on the health care system, and yet mental health itself hardly gets mentioned and, in most cases, doesn't get touched. Only 5% of the research money that is given out by CIHR, the Canadian Institutes of Health Research, goes for mental health—5%, in spite of a comment that I just made to you on hospital days and in spite of the fact that the economic impact of mental illness in Ontario—and here I'm referring specifically to employers' days lost because people are on short-term disability, days lost because people are sick, very frequently with some sort of mood disorder, such as anxiety, depression, stress and so on, and days lost because people actually show up at work and are suffering from what is typically called presenteeism, which means they're there in body but not in mind, and so the productivity goes down.

Two years ago there was a study done which showed that the economic impact of mental health on Ontario workers alone cost the Ontario economy $33 billion. So when you look at the economic impact and look at the hospital impact, you have to say to yourself, why is it that public policy, research money and funding are so far behind the rest of the health care system? There are two reasons for that. The first is the stigma that's attached to mental illness. The fact of the matter is that because the stigma is so bad—and let me just tell you, if you talk to most people with a mental illness, they will tell you about the stigma and discrimination that they face from their family, friends and co-workers, so not strangers. Family, friends and co-workers are frequently harder on them than the illness itself. So stigma is a driving variable.

The second one is the way government's organized, and I would hope you will do something about this as you go down the road. There is clearly a complete lack of a single point person or department in government who is responsible for mental health services. The health department provides those services that deal with doctors and hospitals. Community and social services provides those services that deal with community-based services. Somewhere else, your housing department provides services that deal with supportive housing, and so on.

Let me make an observation to you, having sat around cabinet tables federally and provincially. When you have an issue that comes up in which a whole variety of cabinet ministers own a small piece, but not the whole piece, their entire focus is arguing for their department on the things that they have the whole piece for. This is not unique to Ontario; this is true everywhere. So the blunt reality is that there is no spokesperson at the cabinet table for mental health. In the absence of a central focal point, it will be very hard to get the resource issue properly straightened out, and I would hope that's an issue that you would address in your final report.

A second comment is that there are three specific areas where services are desperately needed. The biggest and most important is supportive housing. What we did in this country—Ontario is no exception—was, in the late 1980s and early 1990s we closed institutional beds, the so-called asylums that we all had across the country. The intent had been to replace those beds with community-based beds. We closed them at a much faster rate than we opened the community-based beds, and the result is—and it truly troubles me to say this—that in Canada, we have made the streets and prisons the asylums of the 21st century, because vast numbers of those people either end up on the street or in prison, and they end up going from one to the other. The odd result of all of that is that, in terms of front-line workers, for people who first enter the mental health system, the two groups of front-line workers are roughly general practitioners, who get 70% to 80%, and the police, who get the other 20%, because they get picked up and charged with something. So supportive housing, that's just where we've got. You've got to build the beds that were supposed to be built 10, 15 and 20 years ago, and that requires money into supportive housing.

1720

The second comment is, you've got to increase children's services. By far the worst part of the mental health system is the children's system. A couple of numbers that are worth keeping in mind: 70% of adults with a mental illness had the first episode with that illness when they were a child. If that illness was properly diagnosed and treated, not only would the individual be substantially better off, the money you would save government is colossal because you would get those people to the point where they were able to live a reasonable life in much the same way that you get someone who has diabetes able to live a reasonable life through insulin, diet or whatever, and you would save society all the money that comes down the road when an individual becomes an adult because the mental illness continues to deteriorate and has a more serious issue down the road.

So I absolutely think you have to do something about kids' mental health. You have in Ontario a unique resource that the Mental Health Commission has been taking advantage of. It's called the Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario. We at the Mental Health Commission have been using their skills in a whole variety of ways, and I think it would be important that you acknowledge the value of that institution. Although they're funded by the government of Ontario and defined as a provincial centre of excellence, the fact is, they've really become the national centre of excellence.

The third thing I would urge you to do is look at improving the way community services are both funded and delivered. Now, having said that, I think you've got to make some changes in the way the services are actually delivered. One of the problems with community-based services is that there are so many different little agencies doing them that there's a considerable amount of inefficiency in the administrative overhead. It would be possible to deliver the same services, either improved in quality or improved in number, with a serious consolidation of the number of players on the ground.

As all of you know, trying to change a silo-driven system is not easy because they're all in favour of progress; it's just change they don't like. The result of that is that it's very hard to get change accomplished on the ground. One of the key tasks of the Mental Health Commission is to develop a national mental health strategy, and we will in fact be dealing with the issue of how you deal with what is very much a silo-driven system on the ground.

To summarize, if you can get a single point in government, if you can increase supportive housing, do everything possible to help improve the quality and quantity of children and youth mental health services and do something about making community services better organized and more easily available, you would do a heck of a lot for the people in this province who are living with a mental illness.

I'd like to stop there, Mr. Chairman, and then take as many questions on any subject that people want to throw at me.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you, Senator Kirby. We've got about six minutes for each of the parties. Why don't we start with you, Sylvia?

Ms. Sylvia Jones: Thank you. I appreciate you coming today, Senator Kirby. It's very helpful as we begin this process. I was wondering if you would elaborate more specifically on the children's services aspect. I'm hearing some interesting things coming out of—I think it's Australia and Ireland on some of the things that they're doing, and I wonder if your commission got into that kind of detail or has some specific recommendations.

Mr. Michael Kirby: The answer is yes, I do. I don't have them with me. I'm a firm believer in not reinventing the wheel. We're going to take the best ideas that are being used anywhere. You're quite right: Ireland and Australia and New Zealand are doing superbly well in this regard, as is the US, on the issue of how you deal with people who have both a substance abuse problem and a mental illness. There are very good examples around the world, and if you give me your card when I leave, I will actually have somebody get in touch with you and give you some quite concrete proposals in that regard.

Ms. Sylvia Jones: Excellent. Thank you.

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

M^me^ France Gélinas: I'm most interested in the health promotion and disease prevention aspect leading to mental health. I was wondering if, in the work you have done, you have come across any best practices, any champions, specifically in promotion and disease prevention, so that people do not develop mental illness, or what we call secondary and tertiary prevention; that is, you already have a diagnostic, but what do you do so you don't get some of the complications that come with being diagnosed with severe depression or whatever. Have you come across any of this, do you know some best practices, do you know some champions etc?

Mr. Michael Kirby: The short answer, again, is yes. There are a number of isolated good examples around the world. Clearly, by the way, if you're going to deal with the mental health problem, you're going to deal with the health care problem. This country cannot afford the health care system we have for a heck of a lot longer unless we start really promoting people being well rather than promoting a policy that says, "Fix them up when they're sick." Do you have to do mental health promotion? You absolutely do.

There are some good things. For example, we're now working with a couple of employers to find ways of improving mental health in the workplace, because the $33 billion I talked about is actually a cost to the Ontario economy, most of which is frankly being paid by private sector employers.

One thing you might want to think about: Governments never think of themselves as employers; it's just not part of the way governments think. The reality is, you're the biggest employer in the province of Ontario, and I would think that the government of Ontario ought to be leading the fight to improve mental health in the workplace, simply because it's the right thing to do for your employees and it's a big cost-saver.

Do you wonder why it's a big cost-saver? All of you understand how benefit packages work, and you know that if someone goes on long-term disability, that's an insured service. If someone goes on short-term disability, typically what you do is continue to pay their salary—their wages—until they come back. Secondly, in many cases—for example, if you're a teacher—they actually have to hire a substitute teacher to replace you. So they have to pay the salary twice.

We've been working and have come up with a way of actually managing those cases better, so that individuals get back to work, on average, 15 days sooner. If you start saving two or three weeks' salary, even if you don't want to do it because it's the right thing to do, you'll want to do it for economic reasons. So a number of big employers are now beginning to focus on the question, because mental illness, particularly mood disorders, is the fastest-growing part of their health care system, in terms of short-term disability but also in drug costs.

If you look at the part of pharmaceuticals in a typical employer's drug plan—again, you have one, and you're the biggest employer in the province—just ask them to give you their breakdown about which drugs are going out fastest. You'll find they're all in the mood-altering category—the antidepressant, anti-anxiety category.

Again, think of the money you could save if you improved it.

The short answer to your question is: (1) there are some very specific things that can be done at the workplace level, and I think the government ought to do that for itself, and not just impose it on others, which would be a standard government strategy; and (2) I will actually get you—we're just in the early stages of going into the mental health promotion side, so if you keep in touch with me down the road, before you're finished your report, we will have stuff for you.

M^me^ France Gélinas: Okay. But so far, there are no champions for this cause or no best practices?

Mr. Michael Kirby: Well, yes. Is there a champion? Not, I think, in the sense you mean of a leading public figure who comes out. There are a lot of champions, particularly in the United States and Australia, where people and governments have started to argue very strongly in favour of increased mental health promotion, but it's early days. Again, historically what happened was that everybody involved in health care focused on fixing you up, not stopping you from getting sick in the first place. So it's early days, but clearly that's where the trend is going.

1730

M^me^ France Gélinas: Okay. I may have other questions after, but I'll let it go.

The Chair (Mr. Kevin Daniel Flynn): Super. Maria?

Mrs. Maria Van Bommel: Thank you for coming today.

You talked about how services are delivered. Coming from a rural riding—and I know it's the same approach in the north—delivery of services, especially specialized services, is very difficult. I don't think most people understand that even within psychiatry there are specialties. When we have children or adults in our communities who need services, we don't necessarily have the specialty available that we need, so we give something rather than nothing. The diagnosis may not necessarily be accurate or correct, but it is something, and parents who deliver suicidal teenagers to a hospital and say, "Please help me. My child is experiencing difficulties," take what they can.

One of the things that the same hospital would do if someone presented with a broken leg or a broken arm in our situation would be to electronically send an X-ray to a radiologist, in the city of London in my case, and the radiologist would have a conversation with the local GP and decide what's going on.

Is there room in the system, or is it a possibility, to do the same thing, where a psychiatrist in a rural community who has more of a general practice could refer to a specialist somewhere and have the specialist, by an audio-video type of teleconferencing mechanism, be able to provide therapy for a family, for a child?

Mr. Michael Kirby: Yes.

Mrs. Maria Van Bommel: When you talk about resistance to change, I am concerned that some people might say that they want the one-on-one.

Mr. Michael Kirby: I want to come back to your reference to psychiatrists in a minute, but I want to go back to Ms. Gélinas's riding. We are hoping, with the help of the federal government and potentially the Ontario government, to actually run in some of the remote areas that Ms. Gélinas talked about. She talked about reserves, but she also had some communities up there that are not reserves.

If you think of the notion of telemedicine, telepsychiatry is actually the best part of medicine for which to use the system because it's the one part of medicine in which the caregiver does not actually have to have their hands on the patient. With today's modern video conferencing facilities, you can do an extraordinary job.

What we're hoping to do, and launch, before the end of the year is a pretty detailed comparison. We'd like to do it both in some aboriginal communities and some non-aboriginal communities, in part to understand the cultural difference between the two. A psychiatrist from CAMH would actually be in Toronto, but the facilities would be locally done, and you would have a local nurse practitioner up there, or whoever runs the local clinic would be able to provide service.

Let me just comment on the psychiatrist question. One of the mistakes—in retrospect, it's a mistake: Medicare pays for doctors and hospitals, full stop. The reality is that the vast majority of mental health services aren't provided by doctors. They're provided by all kinds of other health care workers. We have people from the Canadian Mental Health Association in Ontario commenting, and they will tell you all the services they provide that aren't provided by doctors. None of those services are insured under medicare. But if you think of the kind of, let me call it, talk therapy, the kind of work that goes in when you do a session with a psychiatrist, there are literally hundreds of psychologists and social workers in this province who can do every bit as good a job, assuming that the individual does not have an extreme mental illness but in fact has the kind of illness for which talk therapy can be pretty effective. None of those people can get that service paid for because the people who are giving them the service, if they're not psychiatrists, are not paid for. The result is that we have the absolute classic two-tier health care system with respect to mental health, because people with income can afford to send their children to a local psychologist, a local social worker who does counselling—because you'll probably wait a year to get a child psychologist, which, by the way, when someone is threatening suicide, is hardly desirable, to put it mildly. And even for an adult psychiatrist, you'll wait darn near close to a year; it may be a little less.

So there are two issues here: First, can you at least, for children, get the service—because I understand the expense, but at least for kids, can you get the services of psychologists and counsellors like social workers paid for? Because otherwise, frankly, unless you do something dramatic like that, solving the children's problem will be almost impossible because there are so few child

psychiatrists around; and secondly, can we do the kind of stuff we want to do in your rural area?

The Chair (Mr. Kevin Daniel Flynn): Okay. Jeff?

Mr. Jeff Leal: To the senator, I know in your review you spent some time looking at mental health services for First Nations communities. If you were to pick three things that we could do immediately to service First Nations communities, what would they be, based on your experience?

Mr. Michael Kirby: Housing more than anything else. By the way, if you do—I've got to tell you a funny story. Three or four years ago, the federal Minster of Health—I guess it was Tony Clement at the time—asked the government of Nunavut at a meeting, "What would you do if I suddenly came up with $20 million?" expecting they'd say, "Build a hospital, do whatever"; they said that they'd build housing. That's issue one.

Issue two is, focus entirely on children. The number of children, First Nations and Inuit, who are committing suicide is outrageous. It's important to understand that the second-highest cause of death among Canadians between the ages of 15 and 24 is suicide—and by the way, women are higher than men, which is an interesting observation—and the number for First Nations or Inuit is somewhere between six and seven times the Canadian average. By the way, the Canadian average is third-worst in all of the 27 OECD countries, and yet we don't—let me describe it to you in a way that's pretty dramatic. Every month, the equivalent of a 747 full of Canadian kids crashes. That's the number that are killing themselves. Because they're all done in ones and twos, you don't hear anything about it. So number two, I would focus on kids.

Number three, I would put in place, because of the practical problems of shipping people out for a couple of days, an absolutely first-class telemental health system. I think if you could do that, you could save an awful lot of First Nations children in this country.

Mr. Jeff Leal: Thank you so much.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Senator. Liz?

Mrs. Liz Sandals: Again, I'm focusing on children, so that's good, although the same thing may apply to adult services as well. My observation of children's mental health services in the community is exactly what you have described, which is very fragmented: different communities, different services, different agencies; it's all over the place. Aside from the silos and fragmentation, I guess the thing would be, if you were building a system, what are the services that you actually need from the local community mental health providers in a community? Because my sense is that different communities have different services simply because that's the service that the agency in that community happens to provide. There's no rationale to it.

Mr. Michael Kirby: Yes, that is true. The specific services needed in a particular community: You'd have to ask someone who really knows all the details, but you're quite right.

The historical development of mental health services—and keep in mind, by the way, that more services in mental health are provided by non-health care professionals than are provided by health care professionals. The amount of free labour governments get from family members—you take cases where someone has to quit work in order to look after a child with a mental illness or, in many cases these days, an aging parent who gets dementia and so on. They're quite extraordinary.

The problem on the ground is exactly the way you described it. A need for a service would be recognized—who knows? —a few years ago, decades ago, whatever.

1740

Mrs. Liz Sandals: Fifteen years ago.

Mr. Michael Kirby: An organization would be formed to deliver the service—and I'm not arguing the service isn't good, but it's so totally fragmented. How anyone with a mental illness or even not a mental illness can find their way through the system is beyond me. Again, I think the picture really works.

You've all heard of the downtown east side of Vancouver, which is supposedly—I guess is—the worst homeless area in the country. There are 400 different private sector agencies, not-for-profits, delivering services on the downtown east side of Vancouver, which is roughly 10 blocks square. By the way, I only know the number because somebody went to the trouble of counting it up. But I would be very surprised, if you went into any sizable city in Ontario—it may not be 400—a comparable kind of province, where people begin a service, do a really good job, and now try to organize it in a manner that is really designed to be focused around the individual with a mental illness rather than the service provider.

The unique part of this business is that it's a service business organized, by and large, for the convenience of the service providers, not for the convenience of the person being served. I ask you to think of any of the other services you take. If you need something done to your house, if you need a plumber or whatever, they actually, believe it or not, try to work to a schedule that works for you, and in a manner that works for you. The mental health system does not work that way on the ground. It's organized absolutely for the convenience of the service providers. That's why changing it is going to be very difficult, but, frankly, it's got to be done. I think that, in the end, our mental health strategy will get machine-gunned by all kinds of people, but that's okay because that will start the debate that will get the change done.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Senator. We've got time for one more question. Helena?

Ms. Helena Jaczek: We had a most instructive visit to CAMH earlier today, and Dr. Goldbloom sends his regards. We understand you go back a very long way.

Mr. Michael Kirby: Forty years. I met him when he was 14.

Ms. Helena Jaczek: I'm really interested in your comment related to early recognition, the front-line, the family physician and the police. One of the things that I

feel would be really valuable for family physicians, in particular, since they're simply put into that position, is some sort of assessment tool. We've heard from parents of children, in particular, saying, "We knew there was something wrong, but we were kind of given the brush-off," and then obviously ending up in a catastrophe and a crisis situation.

In all the work that you've done—we heard a little bit at CAMH about various tools that are out there. I know, having been a family physician, websites don't cut it. The family physician needs something really simple to say, "Yes, I need to refer. This is urgent" or "I can cope with this." I still don't have that sense of comfort that there are tools out there for, as you described them, front-line workers.

Mr. Michael Kirby: You're absolutely correct. We're in the process of doing some work with the—and you can help me because you were a member of the Canadian College of Family Practitioners—is that the—

Ms. Helena Jaczek: Physicians.

Mr. Michael Kirby: Physicians; okay. They absolutely need that tool and it doesn't exist—point one. Point two, there are a number of good self-assessment tools—and I'm hoping we will be able to get them up and running on websites across the country—which at least would allow a parent or an individual to fill out and give you some indication of whether you ought to go for help or not. Because the stigma attached to this issue frequently is such—you would know this as a family doctor—that people will phone up your nurse and say, "I've got a pain in my stomach. I need to come in and see the doctor." When they get in, they will break down and tell you that the real, fundamental problem is that they're depressed, but the stigma is such that they're not even going to tell your nurse that.

The big advantage of an in-home or private initial assessment or screening, if you want, would be extremely helpful. They are two different tools, obviously. The one the doctor wants is different from the other one. But there's an example where technology could play a huge role. The short answer is: We will get you one, but it does not now exist anywhere, to the best of our knowledge. It's not just in Canada; it just doesn't exist.

Some 80% of the people who enter the system or have their first contact with the health care system have it through GPs. These are just round numbers, but the other 20% are because the police have become involved. You can get the exact number for Toronto, but will find, if you talk to a typical big city police chief, that you will be stunned at the percentage of their calls that are mental-health-related. It runs on the order of 50% and up, which is a number that blows your mind. But remember, a lot of the times that they get called on what is a so-called family disturbance is in fact a mental health call. The cause of the family disturbance is that someone's having a psychotic episode in the house. Now, it may get recorded. That's why you have to not just look at the data, you actually have to talk to people like the chief of police and others, who will, in a sense, categorize their calls differently than they may be categorized by the 911 operator, for example. Anyway, you've identified a dead-on problem that we've got to deal with.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Senator Kirby. Unfortunately, I'm going to have to end it there.

Mr. Michael Kirby: Sorry, I talked too long.

The Chair (Mr. Kevin Daniel Flynn): No, you didn't talk too long; you've just got too many interesting things to say, and we all want to hear about them. Would it be too much to impose on you to ask that you would come back at some point in the fall?

Mr. Michael Kirby: No, let me be very clear: I'm happy to help any of you, either individually or collectively, and so would the staff of the commission. The work you're doing really matters, because in the end, if we're going to deal with the stigma problem and deal with the problem of the need to improve services, that's really—the need to improve services is entirely in your bailiwick. We can explain to you what needs to be done, but we can't do it and we can't fund it.

On the stigma issue, we're going to need a lot of help from you people. We will be launching in the next couple of months an anti-stigma program, for which we are funded for the next 10 years. As time goes on, I'm going to be coming back to you and saying, "How do we get you involved in your local community?" You're leaders in your communities. I need leaders in communities who are going to help me. I would like to find a way to have this whole issue debated on the floor of the Ontario Legislature, because I think that the members of the Legislature—and this has nothing to do with partisanship; it covers everybody. I think people ought to go on record as recognizing that the mental health problem, the stigma issue, has got to be dealt with. One of the ways to do it is, if I go down into Kent county to do an event, to have you with me would be really helpful because it sends a signal.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Your attendance was really appreciated.

CANADIAN MENTAL HEALTH ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): While I call up the Canadian Mental Health Association and ask them to come forward, the question of time allocation for the questions was raised, and the clerk informs me that we still operate on the party system. If at some point you want to change that, we need to get together as a subcommittee. But I think we also need to take into account that we've got eight members on the committee, and generally the presentations are taking on average anywhere from 15 to 20 minutes, which means we'd have eight people splitting 10 minutes. It hasn't been a problem yet, but it may be something that we want to address in the future, just for the equity issue.

But for the time being, that's not of your concern, Mr. Zon and Ms. Gold: You've got 30 minutes. The time is

yours to use any way you see fit. Any time you leave at the end we'll try to split amongst the members as fairly as possible.

Mr. Lorne Zon: Thank you. We'll try and leave as much time as we can at the end. I believe we'll probably leave about half our time for questions.

Before I get to the remarks that I had prepared, there are a couple of things coming out of Senator Kirby's remarks that I just wanted to touch on. One is that I think it's important to realize that the Canadian Mental Health Association focuses on adults for the most part. Although we have worked in schools etc., our focus tends to be on adults, because they obviously are of tremendous interest in children's mental health.

The other is that we share a lot of the interest in mental health promotion, and we will be touching on it today, but Michelle is leading our research in that area and certainly she can add to your knowledge there and answer some of your questions. With that, I'll start.

On behalf of CMHA, Ontario division—we have 33 branches across Ontario—I very much want to thank you for the opportunity to come and speak with you today. My name is Lorne Zon, as you know, and I'm the CEO of CMHA. Michelle, who's with me today, is our senior director of policy and programs and certainly has a wealth of knowledge to bring here.

For those of you who are not familiar with the Canadian Mental Health Association, we're the largest and longest-serving volunteer-led mental health organization in Canada. CMHA is working in every province and in most communities across the country. We have almost 100 years of experience and thousands of volunteers and staff who have been working tirelessly to improve mental health for all. That's one of the things that's different about CMHA than some others: Our focus is on mental health and not a specific mental illness, so that gives us a slightly different perspective.

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In our province, CMHA Ontario has been active for almost 60 years. Our organization undertakes policy analysis and knowledge transfer on mental health and mental illness, utilizing the social determinants of health approach. Our 33 branches, taken together, are the largest providers of community mental health services in the province.

In the short time we have with you today, we have chosen to address a few high-priority issues, and you will see some overlap with what Senator Kirby had to say. We believe that the committee needs to consider and deliberate on the findings and recommendations. When you do that, you need to look at these issues.

It's essential to understand that addressing mental illness is complex, and as such we cannot be successful by choosing simplistic solutions. Effective support for consumers and families requires a holistic and integrated approach to policy, planning and service delivery. For mental illness, unlike many physical illnesses, there is no cure. Instead, we speak of recovery. By recovery, we're talking about maximizing the opportunities for each individual experiencing a mental illness to live as full and productive a life as possible. In the mental health field, we often speak of three cornerstones of recovery: a home, a friend and a job. Without a place to live, a social support network and enough money to pay for basic necessities, recovery cannot take place.

I'd like to take a couple of moments to highlight some of the very positive innovations happening around Ontario. Firstly, compared to many other provinces, Ontario has in place a more comprehensive basket of services for those living with a serious mental illness. But it is also important to note that comprehensive does not mean balanced, integrated or adequately funded. This is a fundamental point to understand, and certainly Senator Kirby referred to that.

Over the past few years, we have seen two significant investment periods for mental health services totalling some $227 million. These investments have realized some important outcomes and learnings, which are discussed in the information packages we have brought for you. Certainly the next presenter, Dr. Goering, will be speaking to that as well.

Some of the important innovations in Ontario relate to matching supports to an individual's particular needs. I had the honour of chairing a steering committee that made recommendations to the Ministry of Health and Long-Term Care regarding a new initiative called Ontario common assessment of need. This initiative will lead to a uniform assessment process for every consumer entering the community mental health system. It's very much a partnership between the consumer and the provider and will enhance individualized care planning. As well, Ontario now has a provincial information and referral registry through ConnexOntario, which provides up-to-date, comprehensive information and referral to services across Ontario on a 24/7 basis. At the local level, we are seeing the development of coordinated access to community mental health services. Two models used most frequently are centralized assessment and coordinated joint assessment programs, and these are covered in the material we've left behind for you.

Finally, I'd like to mention the increasing availability of intensive case management, which can improve access to services and system navigation. Intensive case management has been shown to significantly improve housing stabilization, quality of life and reduced hospitalizations for persons with serious mental illness. These positive developments do not mean that the job is done. While progress in service delivery has taken place, there's a substantive level of unmet need.

Since the province has moved to decentralization of the health system, and as a result of the creation of the LHINs, concerns have been raised, which we agree with, that there has been insufficient attention to mental health services and supports from a provincial perspective. In particular, there are major inequities in the funding of community mental health services across the LHINs, a difference of more than 600% in some cases.

As well, we caution that the proposed HBAM model for future funding of the LHINs is not appropriate to

addressing equity issues for community-based services. Also concerning us is the fact that much of the existing funding for community mental health services is no longer protected by provincial policies and can be reallocated by LHINs to other pressure points or priorities within their regions. There's a real risk of service reductions happening in a system that still needs to build capacity.

I'd now like to turn the presentation over to Michelle to discuss some of the priority areas we wish to address.

Ms. Michelle Gold: As you know, a key government priority is reducing emergency room wait times. In the case of patients with a mental illness, emergency room repeat visits are oftentimes the result of hospitals having insufficient information to refer individuals to more appropriate and long-term resources in the community. This has been referred to as a "treat 'em and street 'em" approach. Placing community mental health workers in the emergency room has been shown to effectively divert people to more appropriate community care. Research is demonstrating decreased rates of readmission to hospitals with approaches like this.

We'd also like to mention that emergency rooms are an appropriate point of entry for some people when they are experiencing a psychiatric or medical emergency. People with a mental illness presenting in the emergency room often experience stigma, leading to delays in receiving services, which can, of course, increase wait times. Health professionals need to receive in-service, anti-stigma training to ensure that people with mental health needs are treated with dignity and respect in the ER, to ensure that they receive services in a timely manner.

With regard to primary health care, while many Ontarians with a serious mental illness lack access to primary health care, there are innovative solutions being used in areas across the province.

Family health teams, which include multidisciplinary professionals such as social workers and nurse practitioners, have been shown to significantly enhance both access and delivery of primary health care to people with mental illnesses. However, these teams are still early in their development, and they're only available in select communities of the province.

Having access to primary health care resulted in a 50% reduction in emergency room visits in one Ontario community. These primary health care services were provided by placing a CHC, a community health centre, right in a community mental health agency.

Elsewhere in Ontario, community mental health agencies have partnered, in many cases, with community health centres and family health teams to develop integrated approaches to meet the mental and physical health needs of individuals with a mental illness, but the challenge is that these initiatives are not readily known across sectors and they've not yet found a champion because they cross jurisdictional and funding boundaries.

We would be pleased to arrange for the committee any visits you would be interested in making to see any of these types of programs.

With regard to mental health promotion, I'm sure you've heard the saying, "There's no health without mental health." Mental health is a resource for good health. Everyone experiences mental health somewhere along the continuum, and that's why it's a fundamental requirement for all Ontarians that we need to address.

We know that the key factors that make a difference to positive mental health can be categorized as three key determinants: social inclusion, freedom from discrimination and violence, and access to economic resources.

Mental health promotion policies need to give direction by focusing on individuals, communities and the broader environment in which we live. For example, social and sports programs and arts and cultural activities enhance social inclusion, which in turn generate a sense of community, belonging, social ties and social supports.

Access to economic resources means that people have the education, income, employment and housing to access the essential amenities of life.

Good mental health also leads to productive workplaces, and there are many programs taking place in the workplace. These types of strategies require inter-ministerial and inter-sectoral collaboration that rally together all levels of government, business, non-governmental organizations, community groups and individuals.

There was a question asked about champions. There's a lot known about what promotes mental health. VicHealth in Australia has been at the forefront of evidence-based approaches. CMHA Ontario, with four other provincial organizations—CAMH; Health Nexus, which was formerly called the Ontario Prevention Clearinghouse; the Centre for Health Promotion at the University of Toronto; and the Ontario Public Health Association—have prepared a call to action on what needs to happen for mental health promotion in Ontario.

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Mr. Lorne Zon: In Ontario, we've done many things right. However, we have more work to do to ensure that people living with a mental illness receive the services and supports they need anywhere in the province. We also need to ensure that families and informal caregivers have the support they need to continue to help their loved ones. Senator Kirby talked to that as well. Often we forget how big a part that plays in a person's ability in recovery.

We have work to do to make Ontario a model for our vision at CMHA: mentally healthy people in a healthy society.

We've brought with us an information package that expands on all the issues we've raised and other matters we did not have time to touch upon. We thank you for your time and we're pleased to answer any of your questions.

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

Mr. Lorne Zon: Perhaps if I could just make one comment before we do that.

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

Mr. Lorne Zon: Michelle talked about going to visit some of our community mental health agencies. I've

been working in health care for almost 35 years and I've seen most systems and been close to most. I've worked at the provincial level, regional level and within a hospital. When I came to this job a couple of years ago, one of the requirements of my job was to go out and visit all of our agencies. I was, frankly, just blown away by what they're doing at these local community mental health agencies, how they have pulled together and worked around all the barriers that we've put in place to actually offer an integrated package of services to people who need them, despite what we've done to get in the way and not necessarily help them. So it would be really interesting for you to do a couple of visits like that, and certainly there are many, many good examples across the province.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. We've got about 15 minutes left for questions. We'll start with France.

M^me^ France Gélinas: I was taking notes like mad, and I got social inclusion, access to economic resources, and I missed the other one.

Ms. Michelle Gold: It's freedom from discrimination and violence.

M^me^ France Gélinas: Okay.

Ms. Michelle Gold: Within those broad categories are so very many evidence-based strategies that are available—hundreds that are known to impact mental health.

M^me^ France Gélinas: Okay. Thank you.

Mr. Lorne Zon: Perhaps one of the things we can do is make sure that we send you a copy of that paper. You might find it quite interesting that it was done jointly with the others.

M^me^ France Gélinas: Absolutely. I'd love to read it.

Two questions: One has to do with the francophone population of Ontario—a minority no matter where they are. How many of your 22 branches reach out to the francophones of Ontario?

Ms. Michelle Gold: I think it's four of them. They provide bilingual services.

M^me^ France Gélinas: And are there any—here again—best practices or champions that focus specifically on treating francophones with mental illness?

Ms. Michelle Gold: It's not something that we're aware of today, but we could link you up with them and they would be able to answer those questions. Or we could provide you with that information.

M^me^ France Gélinas: And that would be the four CMHAs in Ontario that have bilingual services?

Ms. Michelle Gold: Yes, and they probably would be aware of other resources as well.

M^me^ France Gélinas: Okay. I wanted your point of view as to something that Senator Kirby raised, which is that there is no ministry that deals with mental health. You cut across a series of determinants of health that you've talked about—housing, income etc. Is this a strategy that you studied through your policy analysis? Is this something that you are presently trying to move forward? Or is this an idea that solely rests with the Canadian organization and has not emerged in Ontario?

Ms. Michelle Gold: No, not at all. I think in terms of the broad determinants of health that whole-of-government approaches, where there's a strategy and there is delegation to a number of different ministries, levels of government and others to be accountable and work towards it, are very important.

I think one of the important things to think through is that we're not starting from scratch. Policies in many of your ministries in Ontario can impact mental health, and it's a question of taking inventory of what currently exists, bringing it together within the impact of a strategy that's set out for the province and looking at who can contribute to it. But there needs to be leadership, which is to answer your question that without leadership to drive those changes, it will not be as effective, because everybody is then otherwise working within their own mandate. The mandate needs to be on mental health, to drive through and implement a strategy.

M^me^ France Gélinas: Are you looking at an ADM position for mental health? Are you looking at a ministry of mental health? Have you thought those through?

Mr. Lorne Zon: It's not that simplistic a solution, unfortunately. We have had that route. When I was working in the Ministry of Health, we had an ADM for mental health. We had an entire division focused on mental health, and certainly that helped a lot at that time. We had the big investments into community mental health when we had that division. As Michelle was talking about, it goes beyond a division of the Ministry of Health. It goes beyond the Ministry of Health. It goes beyond even just the social policy field, and it also goes beyond the province, as we heard about. Some of the things we're talking about are within the realm of local municipalities; some are within the realm of the federal government. So it's, how do we get the leadership and champions rather than a position—because I don't think we'll ever get a position. How do we get a coordinated effort and coordinated leadership?

One of the reasons we're excited to be here today is because when you look at what's happening in Canada today, and particularly in Ontario, the amount of energy that's being focused on mental health has never been this great. The opportunities are tremendous. But where's the championship and the leadership that's going to be developed out of this to make sure it's sustainable?

M^me^ France Gélinas: My last question has to do with the LHINs. In my riding, lots of mental health providers have come to see me. The LHINs have been so overwhelmed with the ALC crisis in our local hospitals that, frankly, community mental health has not even registered on the radar—read into this, never got a penny more as to their budgets. They haven't even started to talk about an accountability agreement for those agencies—all of their brainpower being on the ALC crisis in hospitals, basically. Is this something that you hear? Is it only the North East LHIN that has this, or are your agencies struggling throughout, since the LHINs have been put into place, to have a little bit of light shine on them?

Mr. Lorne Zon: If there's one thing we've learned, it's that it's a very different situation in every LHIN

because they're starting from a very different place. Certainly, all the community agencies, including all the community mental health agencies, have now signed accountability agreements with the LHIN or else they wouldn't have had their funding after April 1.

I think you're right, the investment this year was minimal. The focus of attention, certainly, is on other provincial priorities. That's the relationship between the LHINs and the provincial government in terms of how they focus their attention. It's something that certainly needs to be worked out, but it's not uniform across the province.

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

Mrs. Liz Sandals: I was just noticing that one of the papers that you gave us talks about employment supports for persons with mental illness, and I would think that that would be a very difficult area because you're dealing with stigma and having to engage with the broader community. I wonder if you could talk a bit about strategies that you find successful in communities in terms of reintroducing people to employment.

Ms. Michelle Gold: Employment supports is a particular program that's directed for people with serious mental illness to get back to work. Often, it's either a place-and-train model or vocational support before that. It is a challenge, but with the right preparation, people can go on to succeed. Their mental health is better as a result of working. They have more income.

One of the biggest challenges is not getting into the workforce; it's getting access to the programs. The challenge is that employment support programs are funded by multiple ministries. The Ministry of Health funds many of them; some of them are funded by the Ministry of Training, Colleges and Universities; some of them are funded under the Ministry of Community and Social Services for people under ODSP, and there's conflicting eligibility criteria and unintended consequences where people on ODSP might not be eligible for programs. So you have a range of ministries providing funding or supports, but people don't have access.

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The other things is that there are just not enough employment support programs, period. "One size doesn't fit all" is what's often said around employment supports. Different people, depending on the severity of their illness, their previous history, how much education they have—there are different ways to re-enter the workforce or enter for the first time.

There needs to be flexibility, but there needs to be a way where people can access services and the eligibility criteria are aligned so that there's not that chance that people won't be able to access what they need.

Mrs. Liz Sandals: I'm just thinking, for example, then, you might find that a program from TCU is really set up to address unemployment that is due to somebody having been laid off or needing additional education, that to qualify you have to be unemployed because you've been laid off or—

Ms. Michelle Gold: No. The Ministry of Training, Colleges and Universities now has a disability division, and they are open to suggestions on how to work with people with mental illness. They've also come to the table—some of our staff are involved with this—at a policy level, looking at how to integrate. So there are steps being taken, but it's slow and there needs to be a real review of how to enhance supports to people to get them back to work or to get them to work for the first time.

Mrs. Liz Sandals: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any further questions?

Ms. Sylvia Jones: I wanted to expand on the primary health angle. We've already heard that 80% who are accessing services have that first connection with their family physician. I'm familiar with family health teams in my community that have the position of a mental health worker but are unable to fill it. I wonder if you have some examples from your agencies of where there are some successful collaborations, and sort of give an overview of what those collaborations look like.

Ms. Michelle Gold: There are a lot of community mental health agencies interested in collaborating with primary health care providers, and one of the ways that's taking place now is that in some cases community mental health providers are supervising staff in family health teams. Another way is that they're actually co-locating. The primary care provider will provide the medical care and the medication prescriptions, and the community mental health worker will take on other elements like housing, employment and those types of things. The response we have is that these things are working very well, that there needs to be a concerted approach that's comprehensive. These types of things are happening. At other times, there are secondments, where a community mental health worker will go in.

Community mental health agencies were set up to deal with people with serious mental illness, so that's one element. The other part is people with mild to moderate mental illness, and they sometimes fall through the cracks. This is something we're hearing a lot from the community mental health agencies. As Mr. Kirby said, they're sort of caught betwixt and between. They're not eligible for community mental health agency services; they don't have a serious mental illness, and there's sometimes a hesitancy by primary care providers to provide services. Even if primary health providers can screen for mild to moderate mental illness—and anxiety and depression are very common—the screening will not be impactful unless there's the self-efficacy so the provider feels confident that they can then treat people with depression and anxiety. That's another place where there are many things going on but still more needs to happen.

There are shared-care models going on where family physicians are linking up with psychiatrists. This has been going on for about 10 years. There are very many models. It depends on the needs of the patient, but even before that, even access to care.

Ms. Sylvia Jones: Do you find that those co-location models are working, are successful—because you're dealing with the stigma issue as well—that you're not

ending up with that you have to be in that critical state and therefore be referred?

Mr. Lorne Zon: I think there are a couple things, if I can just comment and sort of take a different angle from what Michelle was doing.

You talk about the position of a community mental health worker within a family health team, and certainly that's an enhancement to what we might have had in a solo practitioner's office or in a more traditional primary care model. But the kind of things that Michelle's talking about—and it's outlined in one of the Network magazines that's in your package—is that when you partner with another agency, you're avoiding building another silo. I mean, even if you have an excellent community mental health worker on your family health team, it's still within that. If you work in partnership with a community mental health agency, they also have the opportunity to access the other range of supports that individual is going to need. So I think it's a better enhancement to the primary care model than just the position, and we do talk about some of the interesting innovations in that and in one of the things in your package. If there's an interest, we can follow up and perhaps even arrange a site visit for you if you'd like to see how that works.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Lorne and Michelle. Your time was certainly well-spent and appreciated. Thank you very much and thanks for the package. I glanced through the magazines; they look pretty interesting and they look like an easy read. Even I could understand them.

PAULA GOERING

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Dr. Paula Goering. Professor Goering is associated with U of T and CAMH. She's a project lead with the Mental Health Commission of Canada.

Dr. Paula Goering: Hello, everyone.

The Chair (Mr. Kevin Daniel Flynn): Hello. As with everybody else, you have 30 minutes. You can use that any way you see fit, but the committee probably would like some time near the end to ask you some questions, if that's okay with you.

Dr. Paula Goering: I would much prefer to answer your questions than to tell you things you're not interested in, so I'll keep my remarks very brief.

I first just wanted to tell you that it's very nice to be here, and it's quite exciting for me to see the level of interest that we have right now about mental health and addictions. I've been around for a long time. You were at CAMH today; I started out as a nurse in the old asylum; that was my first job. I watched those towers that you saw today being built and that are now being declared decrepit and torn down, which gives you some indication of how long I've been around. In that entire career, which is a fairly long one, I have never been as excited as I am about the opportunities that we have in front of us. I'm sitting on the minister's advisory committee, I'm working very closely with the Mental Health Commission, and it just feels like our time has finally come and that you will be helping us to accomplish things that we've been wanting to do for a very long time.

But I'm coming here mostly as a researcher. That's what I've spent most of my career doing, doing research and consulting and working very closely with government. So my kind of high-level message for you is to remind you that research and evaluation are really important tools for you. For you to be able to do what you've set out, which is very ambitious, you will be doing lots of consultation, you'll be hearing lots of very important first-person stories, but you also need to know that there's lots of knowledge and information there that can be of help to you in figuring out how to solve the problems you'll be uncovering.

I'm going to just give you a couple of examples to convince you, if you're not already convinced. I see a lot of head-nodding; that's nice, but sometimes this is a hard sell. I want to talk to you about one study that's just winding up and another study that's just getting under way, to give you a sense of what I'm talking about and hopefully to whet your appetite so then you'll want to read more and know more than I can possibly tell you in the time we've got together this evening.

The study that's winding up is the one that is being circulated with the bright orange cover. Actually, it's hot off the press. We just got this from the publisher yesterday, so it was nice that we got them in time that we could give you one. These are the results of a four-year, $2-million evaluation effort that your government funded and that a lot of different universities and community mental health agencies were involved in actually carrying out. It was an evaluation of what happened when a lot of new money was put into community mental health.

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In 2004 we had a significant expansion of the resources in community mental health, both because of the accord funding and because of the human service and justice funding that went into the system. This amounted to about an additional $165 million, and that was about a 50% increase in the base operating budget of that sector of our system. That was quite extraordinary. Your government decided to not only put the new money in the system but also put money into evaluating and seeing what happens when you put new money into the system.

That is unusual. Policy does not oftentimes get evaluated, and I think as politicians you should be aware of how important it is, not just to make decisions and allocations but then to follow up and see whether it works the way in which you intended it to work. That's what we got a chance to do and the report is a summary of the nine different studies that were done over the three or four years to look at different aspects of what happened in the system.

I'm just going to give you one example of a difficult problem that I think that study helped point the solution to, and that is the problem of the increasing numbers of individuals who have mental illness and addiction who

end up in our criminal justice system. The issue of legal involvement and the number of people who, because they're not getting adequate supports, end up being arrested or charged or sometimes imprisoned is a huge one, and yet if you look at the literature and you look at some of the studies we've done in Ontario, there are solutions to that.

We know how to provide court support programs that are particularly targeted to individuals who've been arrested or are appearing before the courts and get them into the mental health system, which is where they belong, rather than leaving them to be treated as if they were criminals without a significant disabling mental illness.

One of the court support program evaluations was done in Ottawa. Tim Aubry was the principal investigator. He followed 120 people who had been treated in a few years and the findings about those individuals and what happened to them were very encouraging. They had less homelessness. They had fewer symptoms. They were more integrated into their community. So a lot of very positive findings not only for the individuals but also for the courts and the justice system—very pleased with this program because it helps them deal with what for them is also a difficult problem.

So there's part of the solution, but when you look at the other findings that we had—one other study looked at several court support programs across the province—what we found there was a bit more disturbing in that people had, over time, less continuity of care. What that means is that it was getting harder and harder for the programs to actually refer people and get the services they need, which kinds of makes sense, doesn't it? If you put money into one part of the system, it can create demands in the other parts of the system. That's what's happened and that's what we're observing.

The thing you need to think about when you're trying to think about problems and their solutions is that you have to be careful about targeting single programs and not thinking in terms of systems and the effect on the system of care. Also, whatever you're doing, you need to add in the idea that it needs to be monitored to make sure that it's actually doing what it's intended to do.

That's an example from that study. There's a lot more in that report and there are lots of reports on the website from the various studies.

The other example I want to talk about is one from the demonstration model on homelessness and mental illness that—I came in late. I don't know if Mike Kirby referred to it. It's the Mental Health Commission study that's being done across the country.

Interjection.

Dr. Paula Goering: He didn't talk about it? Okay.

This is extraordinary. It's a very important part of what the commission is doing as a catalyst across the country to help us learn and do things. They actually got the federal government to allocate $110 million for a demonstration project in five cities in Canada. I'm acting as the lead researcher in that project, and Jayne Barker, who is the policy and research director in the commission, is the lead within the commission. We're under way trying to put in place services, rent supplements and housing in these cities, and study it at the same time. That size of research project is quite unusual, and our ability to do something at the same time we're learning something, so that we'll actually be serving individuals while we're studying them, is very exciting.

One of the cities is Toronto, so Ontario has one of the sites, and there are very interesting things that are going to be learned here. In particular, they're looking at developing an innovative ethnocultural approach to providing housing and services for the homeless. But you're also going to be interested, I hope, in what we're learning in the other cities. We're very pleased to be in Moncton; everybody always asks, "Why are you in Moncton?" because we're in Vancouver, Montreal, Winnipeg and Toronto. But actually, there are a lot of mid-sized and rural areas in Ontario which have problems with homelessness, and our evidence base there is extremely weak. So we're really pleased that we're also getting a chance to learn about how to deliver services in that size a city.

This is a four-year project, and you may be thinking, "Well, what has that evidence got to do with what you're going to be doing over the next year?" I would say to you that it's an example of where research can help you learn what works. But without political will, without public policy, it will be of very little value to know what works, because we won't be doing what works. Thinking now about homelessness, and the intergovernmental action plan, the consortium, that takes seriously the fact that we could end homelessness, we could. If we did it together and did what we know works, we could tackle the problem. It's an example of where research can be one of the tools, but without people picking it up and using it and doing other things with it, it will be limited in its value.

I'm going to stop there and hope you have questions or comments.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We certainly do, starting with Helena.

Ms. Helena Jaczek: Thank you, Dr. Goering. I couldn't agree more with you on the value of evaluation of programs and obviously wanting to get solutions, instances of programs that work. I'm just quickly glancing through, and on page 7 you've got some very concrete examples of specific programs that have been assessed and seem to be having positive outcomes.

My colleague Madame Gélinas is very interested in health promotion, as am I. Can you give us any examples of mental health promotion programs that work, above and beyond physical activity and eating well, which was one example that we were given today at CAMH?

Dr. Paula Goering: Yes. I think that we have a much broader range of programs for you to look at. If you look at one close at hand, at CAMH, which has been very well researched, you would look at the anti-bullying program that Dr. David Wolfe has been involved in, in terms of developing and putting into schools. There's an example

of a kind of intervention that has been studied and makes sense; if you can help individuals at a young age to learn how to be more civil and how to protect themselves when others are abusive or attacking, that will assist us in them developing longer-term solutions. That would be just an example.

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Ms. Helena Jaczek: So you're saying this is a program that is delivered to all kids, it's sort of a population health-based initiative and there has been some sort of randomized, controlled study that compares those who have received the program with those who have not, and as we follow them over time, we see different outcomes?

Dr. Paula Goering: Yes. To be honest with you, health promotion is not my area of expertise and I'm not entirely sure of the design of the David Wolfe studies, but I'm pretty sure that they're trials. I can check on that and let you know.

Ms. Helena Jaczek: I'd be really interested—

Interjection.

Dr. Paula Goering: I know they're very solid and well researched, but I'm not sure what the design was.

The Chair (Mr. Kevin Daniel Flynn): I had a question myself, just from the Chair: How much of the existing system we have today is process-based and how much of it is outcome-based? Do we pat ourselves on the back because we saw 30 people today or do we celebrate that we made six people well?

Dr. Paula Goering: Well, one of the things that gets in the way of being outcome-based is that our information system is about outcomes. It is something you do need to be attending to. It's not just a matter of needing to fund research and evaluation; we also have to have the data in order to do the research and evaluation. Oftentimes, it's not available to us and not available in easily accessible forms.

That being said, I think on the whole there is a great interest in quality of life, housing stability, employment and reducing disability at work as being the things that people most want to see happen. It's our ability to track that and account for that in our day-to-day work that I think is more problematic. It's not that people don't care about the outcomes; it's just that it's harder to see them and see them as a direct relationship to what is being provided in the service. Quality of life, for example, is a major concept, and what we do in a treatment program is only a small part of the picture. What we do as a society about housing, income and jobs probably has a far greater impact on people's quality of life than the health care piece of it.

The Chair (Mr. Kevin Daniel Flynn): Thank you. There's time for one more short question from the government side. Anybody? If not, we'll just move on to Sylvia.

Ms. Sylvia Jones: I'm interested in—as your studies and your research move forward, are they going to be accessible to all levels of government? I understand that the feds have funded the 10-year project. Is that right?

Dr. Paula Goering: I'm sorry, I didn't hear the last phrase.

Ms. Sylvia Jones: The feds—the federal government—has funded you now. So as your research moves forward and you bring forward these reports, are you—

Dr. Paula Goering: No. The homeless project is being conducted as what we call "integrated knowledge translation," which means we don't wait until the end to start talking to the partners. In fact, we've got all levels of government talking to us about how to do the research, how to design the intervention and what do we make of the findings. So it will be very interactive.

There was a meeting in Toronto on Tuesday in which the city, the province and the LHINs were a part of the discussion about the launching of the Toronto site. Very much, we want to keep the conversation going because we don't think it makes sense to go away, do a federal study and at the end of it, come back with the findings, hand them over and say, "Okay. Now what are you going to do?" That doesn't make sense.

Ms. Sylvia Jones: As you're discussing how you're going to study, do you get into the kind of detail of length of stay? I know, for example, the federal homelessness money—right now, it's a very limited window of how long a young person is able to stay in a homelessness shelter before they have to flip over, before the funding stops. Is there any discussion going on—

Dr. Paula Goering: Not that I know of at this point, and it wouldn't be a direct discussion about this project because it's about how to get people out of shelters and into homes and into society. But there will be opportunities around this project for other issues to arise and be dealt with around how the system is operating, because we're encouraging the groups who meet to think about their responsibilities for systems issues and integration, not just think about the project per se. So it could be an issue, but I don't know that it has been.

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

M^me^ France Gélinas: I'd like to try my question of leadership on you as well to see what you think of it, basically either through the lens of a researcher or whatever vast experience you have in the field of mental health. We've heard the first two presenters talk about the issue that there isn't a point of leadership within the provincial government for mental health. Mental health goes across housing, income support, health and a vast array of other silos of government. Has any thought been given as to what this leadership to bring mental health forward should look like, how it should be structured, nurtured? Are there best practices out there that exist? Do you know anything about that, basically?

Dr. Paula Goering: Yes, I've spent a lot of my career thinking about that and at various points of time putting forth ideas that could be considered about how to deal with it. I have to acknowledge, though, that this is an area where you don't have good research evidence. It's very hard to study and compare different models of governance and leadership at a systems level. So what we learn is mostly by looking at jurisdictions that seem to be working really well and comparing them to other juris-

dictions and trying to kind of distil out the component. We did that about 15 years ago in a best practices document that we did for Health Canada, where we reviewed all the literature and the other jurisdictions, and in our section on governance we said that we need a single point of accountability at a high level in government in order for us to move forward in the area.

At various points in time we have discussed in this province having regional mental health authorities that would have the responsibility for the mental health system, as opposed to being integrated into a regional health system, so it's the question of separating out and doing it. It has never had much traction, and people are quite concerned when you talk about it that what you lose there in terms of the connection with primary care and the rest of health care is the liability. So I'd say there was controversy about that. If you asked me my personal feeling about it, I would say we would be better off with mental health authorities and we'd be better off with an ADM for mental health.

M^me^ France Gélinas: Okay. My next question—do I still have time?—will have to do with the LHINs, local health integration networks. I realize you talked about mental health regionalization. Do you figure that having the community-based mental health agency under the LHINs—is this something that we can build on? Is this the right direction to go? Are there ideas there, best practice, or are we having a tougher time because of it?

Dr. Paula Goering: The concern is that when mental health is put in with everything else, as it is in the regional authorities, it gets lower down on the priorities, that it won't be able to compete with acute care and with cancer care and with a lot of the other priorities that are higher in the public's mind in terms of where we should be investing our resources for mental health and addiction. So that's the worry.

So far, in Ontario, because of very active advocacy on the part of provincial organizations, and on the part of patient and family groups, mental health is on the LHINs' agenda, so it continues to be a priority. The question is, what does it mean that it's a priority, and will it be translated into allocations and protection and expansion of an under-resourced sector? I don't think we have the answer to that yet, in our current LHIN environment.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): I have a question that I keep asking: Are we seeing an increased incidence of mental health issues? Are we talking about it more? Do we understand it more and do we recognize it more? And in particular, the knowledge I seem to be getting back is that it was always there and we just recognize it more. Are we seeing an increase, though, in teen suicides, and are we seeing an increase in addictions?

Dr. Paula Goering: I don't think that we can say that there's a trend over time for a higher prevalence rate. I think it is more visible and it is more acknowledged.

The one place for which I might qualify that is with regard to young people. We've done a couple of epidemiological surveys. Years ago, we did the Ontario mental health supplement, and we were very surprised at that time to see that the highest rates of mental health and addiction problems were in 16- to 24-year-olds. That was the window we had on young people.

I was involved in the national community mental health survey across the country, which was released two or three years ago—again, very high rates in that young group, which I find very perturbing in terms of thinking about what that means for the future. I think that's a new phenomenon. To go back and try to test that would be somewhat difficult, because in the surveys, people don't always define in the same ways what we're looking at. But we were surprised at it in the supplement, and when we saw it again across the country, in the national epidemiological survey, it caused me great alarm.

The other problem there is, they don't go for help. So they have both higher prevalence rates and they're less likely to at least tell us that they're getting services or getting help.

There are so many subgroups—people who are on the street, young people. We should be very worried about, and thinking about—surely we can do a better job than what we're doing.

The Chair (Mr. Kevin Daniel Flynn): And on suicide and addictions, are we starting to call suicide what it is? Have we stopped using the code words, and are people starting to address it? Has it always been there, or are you seeing an increase?

Dr. Paula Goering: You know, I'm a bit hesitant to give you the answers without going back and checking the data, and I'm sure we have it. My recall is that in Quebec, we've seen increasing rates, but not in the other provinces over time. But I need to check that, in order to give you an honest answer about it.

I do think we're being more open about it, and even in obituaries, you are sometimes seeing people acknowledging that someone has taken their life, and that can be said publicly. You wouldn't have seen that 20 years ago.

But the rates that are based on the administrative data and the reporting of suicide—I don't think we've seen a significant increase in Ontario.

The Chair (Mr. Kevin Daniel Flynn): Okay. And is there an increase in addictions, in your opinion, or just a change in substances?

Dr. Paula Goering: Addictions is such a big field, in terms of all the different things underneath it, including alcohol. And it's not my area of expertise, so I'm not going to try to answer that question. But I can get back to you about it, because my colleagues can answer it, so I'll let you know.

The Chair (Mr. Kevin Daniel Flynn): I think we'd all be interested in that answer.

Dr. Paula Goering: Okay.

The Chair (Mr. Kevin Daniel Flynn): France, for the last question.

M^me^ France Gélinas: Just very, very quickly: You made reference to a study you did 15 years ago. You had a chapter on governance. If we were to try to track it

down, can you give us some hints as to—do you remember the title?

Dr. Paula Goering: It's called Best Practices in Mental Health Reform. It was published by Health Canada, but the easiest way of getting that is to come to me and I'll get it to you.

M^me^ France Gélinas: Okay.

Mrs. Liz Sandals: Could you get a copy for the committee?

The Chair (Mr. Kevin Daniel Flynn): I think we'd all like one of those.

Dr. Paula Goering: Okay. Well, you should also know that as part of the minister's advisory committee work, the government has commissioned us to do some updating, because that document is quite old. So we're working with them now, and I'm hoping that the kind of materials that the advisory committee is getting, you'll also be interested in and have access to. I don't know how that's going to work. Maybe you should hold off and get the newer version.

The Chair (Mr. Kevin Daniel Flynn): Okay. Well, thank you, Dr. Goering. We really appreciate your time and the information you gave us today. Thank you for appearing.

Dr. Paula Goering: Glad to be here.

The Chair (Mr. Kevin Daniel Flynn): Thank you, members. Our next meeting is next Wednesday, and just a forewarning: It's a long one. It goes—

Mrs. Liz Sandals: So we start at 4?

The Chair (Mr. Kevin Daniel Flynn): I guess we start at 4 and we'll probably go till 7, by the sounds of it, just so everybody can plan their schedule a little bit.

As well, thank you very much to all those members of the audience who attended today.

The committee adjourned at 1842.

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