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Lundi 3 mars 2014

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 3 March 2014

Lundi 3 mars 2014

The committee met at 1401 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): I call the meeting of the social policy committee to order. This is the meeting to continue the review of the Local Health System Integration Act, and the regulations made under it, as provided for in section 39 of the act. I notice that not all members of our committee are here yet, but I'm sure that as soon as they hear us starting this meeting, they will be rushing down to be here. We'll leave it at that.

CENTRAL LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our first presenter is the Central Local Health Integration Network: Kim Baker, chief executive officer. Thank you very much for taking the time to come in and talk to us this afternoon. You will have 15 minutes in which to make your presentation. You can use any or all of that for your presentation. If there's any time left at the end of the meeting, we'll have some questions and comments from our committee. With that, the next 15 minutes are yours.

Ms. Kim Baker: Thank you very much, Mr. Chair. To the committee members, I'm very appreciative of the opportunity to come and speak with you here today. My name is Kim Baker. I'm the CEO of the Central Local Health Integration Network. Prior to coming to the LHINs, I provided critical care to patients as a respiratory therapist. I led the planning and design portfolio for what was at the time the largest health care redevelopment in Canada at the University Health Network. I've also led a national portfolio for community and home care.

In the next 15 minutes, I'll provide you with four examples to illustrate how system performance can be improved, how engagement shapes new models of care for young adults and seniors, how local successes to improve care transitions can be spread across the province and how change is good for patients. I'll also leave you with some suggestions for consideration with respect to strengthening LHSIA.

As proud as I am about what we have accomplished, I know that we have not done it alone. We do it together with our health service providers and other stakeholders. It's collaboration amongst people that will always be key to change in health care. With that, I am going to focus on how people figure prominently in all that we do. We have an office of about 30 people, a nine-member board and a 1.8-million population in our LHIN. That makes us the largest of the LHINs in terms of population. The providers in our LHIN are funded through 112 service accountability agreements. We have six public hospitals, two private hospitals, one community care access centre, over 50 community agencies, over 45 long-term-care homes and two community health centres.

In terms of the organizations we fund, let me tell you about our journey to improved performance. When the LHINs began their work, there were tremendous variations to access for surgical and diagnostic services. In Central LHIN, for example, we used to have significant variations in wait times for MRIs. Depending on the hospital, in any one day, you could wait 20 days at one hospital and be told at another hospital that the wait was 233 days. That's a difference of seven months between hospitals for the same test.

In 2010, we introduced the Wait Times Strategic Planning Group, and set our focus on achieving all of our targets at a system level. The group is made up of senior executives from each of our hospitals and the community care access centre, and is tasked with working as a system. They do this by putting all of the available resources on the table and working within the capacity—be it machine or human resources—that they have and looking at the performance capabilities of each of the organizations.

These meetings are an open and transparent process to develop the best plan to meet the needs and our system targets. We shifted the conversation from organizations coming to the table wanting to know how much funding they would receive to how we could find the best—to working within a set of principles that would deliver for the system.

The proof of this is in the numbers. Since 2010, this effective group helped us achieve significant gains in wait times, which led us to achieve all of our targets for fiscal 2012-13. This means that in just a few short years, patients waiting for a diagnostic MRI got it 77 days faster, patients waiting for cardiac bypass procedures received their procedure 18 days quicker, and patients waiting for cataract surgery got better vision 17 days faster.

And in case you're wondering about the variation I opened with that existed between hospitals, that's now measured in days, and it's just under a month.

So all of these improvements are not only good for patients, but we've also been able to create better stabilization for hospital staff and resources. Central LHIN residents benefit from this collaboration every day; that is, collaboration at the system level, our ability to allocate funding between the hospitals to achieve the right impact, and our understanding that diagnostic and surgical interventions are a very important transition point and ought to be more equitably accessible.

I'd like to now share with you a story of how we've created a new model of care to address a gap in service. This story is chosen because it exemplifies how LHINs are uniquely positioned to make changes in the system for people. It exemplifies how people in the community can influence real change in the context of the LHIN model, and it does have some special meaning for me, I suppose, because I'm also the mother of a child.

In 2013, Central LHIN made funding possible for seven young people with complex medical needs to enjoy a new way of life and live in a home setting at the Reena Community Residence in Vaughan. We did this by breaking through silos and bringing together health care, housing, care coordination and support services to respond to a health care service gap recognized in Central LHIN. We worked across multiple ministries, including health and long-term care, children and youth services and community and social services, as well as our care and service providers, to make it happen.

Just before last Christmas, we went to see how this model of care was making a difference in the lives of the young people living there now. We interviewed a couple of the residents and asked one of them, Andrew, why he wanted to live in this setting at Reena. You see, Andrew is non-verbal, and he relies on a communication board and his March of Dimes support worker to respond. So it took a moment, and Andrew replied to our question with, "To have a life." For 34 years, Andrew lived at home with his loving parents. Today, Andrew is experiencing the joy of living independently with his peers for the very first time in his life.

Andrew has a roommate. His name is Gurpal. Gurpal is 23, and he moved to Reena after living in a hospital for 15 years. Let's think about that for a moment. As just an eight-year-old boy, for Gurpal, the hospital became his home. So we asked Gurpal what he likes about Reena, and he just said to us, with a smile, "I love this place so much."

At Central LHIN, we have a motto: "Together, we're better." Never have I seen a better example of this than with this unique care model. Living together, in a congregate setting in the community with 24-hour care, making friends and having access to life's simple pleasures, these young men are most definitely better together.

The story of Gurpal and Andrew is shown on our website. It's in a three-minute video, and it's also there to help people understand what service is available in the community.

What you don't see in the video is the grassroots origin of this model. You don't see the mother of a young adult with complex medical needs who connected with us and passionately brought her challenges and the challenges of her child to our attention. Our research confirmed it: There was a significant care gap for people like her son in our LHIN. We heard her story.

So, for us, community engagement is not just about the formal opportunities for input but also these informal conversations as well. As LHINs, we're actually close enough to the ground to really listen, and people are benefiting from this every day.

A key reason that this gap in service exists across the province, in fact, for people with complex needs is because these adults are a new cohort. The current system is in place for kids; however, the system for those beyond the age of 18 is not adequately in place, and we're doing something about it.

Other LHINs and sectors also see this, and they're starting to benefit from Central LHIN's model. Just last week, in fact, the March of Dimes hosted an engagement forum with the GTA LHINs. At the forum, they showcased the model to help inspire the development of a congregate housing model for medically complex youth across the GTA.

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Similarly, I'd like to also tell you about a journey to improve the transitions of care and what we call being led by what we hear.

For many seniors with medical complexities and chronic diseases, a hospital admission too often results in two things: resolving the medical reason—why they went to hospital—and a life-altering move to long-term care, not back home from where they came. As you can appreciate, this is pretty frightening for many of our seniors. Because seniors have told us they want to stay home, today in Central LHIN, they have more choices because we've created that capacity in the community to keep seniors at home safely.

To make this a reality, we needed to focus on the transition of care from one provider to the other. We needed to develop mechanisms to focus efforts and measure impact and understand the change.

You see, the transitions of care are those spaces or cracks in between, where providers feel their responsibility ends and the next provider's oversight starts. No one organization owns the transition of care, and all health care organizations have not been created to focus on what happens in those spaces. Only the LHIN is focused on what happens across the whole system, between the cracks. These transitions are becoming so much more important to us as people are being discharged from hospital into the community sicker and quicker.

The result of this focus on the transitions of care is in a story that we often use to illustrate the Home First care philosophy. As a senior with Parkinson's disease, James went to hospital for a life-threatening bacterial infection. Before his hospital stay, James lived at home with his wife. During this stay, James became confused, lost

muscle tone and lost energy. Because his wife works all day, the only option, really, looked like long-term care for James.

James went home with the Home First philosophy, and after two weeks of being home, he was able to move around without the use of any assistive devices, was no longer confused, and has a much more appropriate energy level. James still accesses services in the community and adult day programs, but James has now decided that he'd like to stay home and live with his wife.

This is an example of making the health care system more responsive to what people in our communities are telling us, and it's also better for the system. We've done some of the math on our end and, by our estimates, from diverting people into this new community capacity, we have essentially freed up 35,000 hospital and long-term-care days. That's a value of about $18 million in services. These services were then available to accommodate the needs of people with higher needs. That's all in just one year.

I also know as committee members you're probably very aware of the existing challenges with respect to the mental health care system, and it is fragmented. In Central LHIN, we also continue to have gaps in mental health service capacity and access. One initiative for us has made a difference, which we created in 2008 to centralize access to mental health case management and assertive community treatment teams. Because of this program, there is one place to go to apply for services, making it easier for people to connect with the mental health and addictions services they need. In the event a person is put on a wait-list, there is a service stream that stays with that person until they are connected with a service provider.

This successful solution manages the transition of care and has been adopted by three other LHINs: the Mississauga Halton LHIN, Toronto Central LHIN and, up north, the North East LHIN—another example of a good idea that is being spread across the province and is good for patients.

In closing, I have shared with you four examples of what system transformation looks like locally. We are challenging the status quo and are here to make a change. It can be uncomfortable for some at times. We are making important, objective and informed decisions for better patient care and the sustainability of the system. We are listening and breaking through barriers in a way that's unique to LHINs. If not LHINs, who then? We're publicly reporting our decisions and our results. And we are identifying and improving care transitions between providers.

Central LHIN supports efforts to strengthen these mechanisms to enable the province's ability to transform the system through LHSIA. In your work, I encourage the committee to reflect on and consider the value to the system of making the following changes:

—enabling accountability for primary care to the LHINs, which would support achieving greater alignment among key health system providers;

—strengthening accountability for all organizations to the system and population over the needs of individual organizations. This is required to help ensure that changes are, first and foremost, about improved patient care;

—strengthening the requirement for community engagement at the provider level so that system improvements can be informed by what patients value;

—continuing to push so that the system becomes even more transparent to all; and, perhaps most importantly,

—seeking to understand why the transfer and delegation of authority to LHINs is taking so long.

I do need to emphasize that there is so much more to do. We are not there yet. Ontario needs a mechanism like LHINs to be able to respond and make the necessary system changes that we're aware of today and the ones we will find out tomorrow. The LHINs are uniquely positioned to do this work.

At Central LHIN, we like to use the image of a pinwheel to illustrate what we do. We think of our health service providers as the blades of the pinwheel, and the LHIN, powered by engagement, as the wind that propels the system forward, moving in one direction for a common goal. It's not easy to see or recognize the propulsion behind the scene, but we are there, creating a forward motion that would not happen otherwise, and we're gaining momentum. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have a minute and a half. We'll start with the government side.

Ms. Helena Jaczek: Thank you very much. Delighted to see you, as my riding is in the Central LHIN.

In the documents that you have given us, I'm looking at one where you address us, "Dear Distinguished Members of the Standing Committee on Social Policy," and you talk about LHIN boundaries. You mention that "LHIN boundaries are permeable." But you also have a statistic here that "nearly 30% of patients in Central LHIN hospitals live outside our boundaries, and over 30% of residents receive care outside of the LHIN." Is this causing any difficulties for you in doing your planning since so many of your constituent patients are provided with services outside the LHIN and vice versa?

Ms. Kim Baker: No, we don't see that as a problem in terms of our planning. Thank you for the question. We look at not only the demographics of the people who live in our LHIN, but we're also very aware of the trends in the demographics of the people whom our health service providers are serving. So we work together with our health service providers to understand the trends that we need to accommodate for planning. We see the fact that people move in and out of our LHIN for services as just a reflection of choice. Respecting whether they're residents of our LHIN or residents of other LHINs, they can choose which health service provider they would like to access in the health care system.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That does conclude the time. Thank you very much for taking that time.

Ms. Kim Baker: Thank you.

MISSISSAUGA HALTON LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presenter is the Mississauga Halton Local Health Integration Network: Bill MacLeod and Graham Goebelle, chair and chief executive officer. Thank you very much for taking the time to come in and talk to us this afternoon. We welcome you. As with the previous presenter, you'll have 15 minutes to make your presentation. You can use any or all of that time to make that presentation. If there's any time left over, we'll have questions and comments from the committee. With that, the next 15 minutes are yours, chair.

Mr. Graeme Goebelle: Thank you very much. Mr. Chairman and distinguished members of the Standing Committee on Social Policy, good afternoon, I am the chair of the Mississauga Halton LHIN. My name is Graeme Goebelle, and I'm joined by our CEO, Bill MacLeod.

Let me first say that on behalf of the board and our CEO, we appreciate the invitation and opportunity to address your committee today. It is an honour and an outstanding pleasure to be here with you in an important time in the LHINs' journey—at a moment when there's so much about our health system being fundamentally transformed. I believe that a better health care system is taking shape, and it's with a great sense of accomplishment that I address you today.

To give you a little perspective about what I am sharing with you and hoping to contribute, I want to begin by telling you that I'm a resident of Georgetown, a part of Halton Hills, a small community in our LHIN where I have lived, worked and raised my family for the last 55 years.

Along with establishing my accounting firm in Georgetown, I've been active in my community, volunteering with many organizations and charities. I have served as a cancer society president; YMCA director; president of the chamber of commerce; United Way chairman; as a director on the Sheridan College Board of Governors, Huron University College Alumni Association, and Licence Appeal Tribunal; a board member of Halton Hills Community Energy Corp.; and chairs of Halton Hills Hydro and the small practices committee of the ICAO here in Toronto.

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For over 30 years, I've been involved with the Georgetown and District Memorial Hospital Foundation as board chair, as well as organizing the annual president's cup golf tournament and Christmas balls. Most recently, I was honoured as Georgetown's Citizen of the Year.

I'm sharing this with you not to boast but to let you know I am not unique. Local health integration network board chairs and their members are people just like me. They live in the community they serve, are professional, are experts in their field, and are passionate about their local health care system. They bring a strong range of skills and experiences and spend time consulting the community and learning about current issues in order to provide good governance and good local health care decisions.

We act as champions for a system approach with other local health care governors, listening and facilitating communication and collaboration, and helping them to achieve their governance oversight responsibilities. That's why, to develop a stronger governance culture across our region, our board has established a community governance consultation group chaired by Ron Haines, our vice-chair, who is here with us today, which includes 13 board chairs from our community service providers. I can tell you, that is a lot of expertise.

We provide input based on our views and expertise as local residents, members of the community, users of the health care system and based on what is important to our local community.

Change is not always easy, however. The purpose and value of local decision-making is that it recognizes and enables local health organizations and solutions to come together, tackle the challenges and take opportunities that are unique to our local area, using local resources. We recognize that the major initiatives often cross boundaries and have shown that they can work together on such matters.

We form alliances to find solutions for health care system improvements. Projects such as the community capacity study, a joint study with our neighbour, Central West LHIN—who are also here today—that will determine our future community needs, demonstrates that LHINs can and do work together and pool funding and resources to determine the needed system level of investment.

At the Mississauga Halton LHIN, we continue to foster and drive opportunities for more efficient and high-quality services in ways that are designed to create new capacity and new partnerships in our communities and for the health system as a whole. These opportunities propel us towards the integrated network that is the core of our vision.

This concludes my brief introduction on our strong local knowledge informing strong local decision-making. I want you to know that I'm proud to be the Mississauga Halton chair, and I'm proud to be working with Bill MacLeod, who is my CEO.

Mr. Bill MacLeod: Thank you very much, Graham. Mr. Chair, members of the committee, good afternoon. As indicated, my name is Bill MacLeod, CEO of the Mississauga Halton LHIN. My goal today is to use my brief time to talk to you about innovation and the spread of innovation, and then the LHIN role in this process.

Innovation is a key process in any system transformation, otherwise known as progress throughout our society and our culture, the essence of which is to find ways of achieving the same or better result with less expenditure of resource. It is sometimes linked to and closely associated with the concept of increasing value for money.

The way the LHINs were created, with local governance and local executive leadership, freed them from the

constraints imposed by a centralized administration and management. This did not guarantee local innovation, but it certainly led to a condition that favoured innovation. Early executive leadership from the ministry at the minister and deputy minister levels also encouraged this approach to local innovation, so much so that someone once quipped, "If you want something done 14 different ways, ask the LHINs to do it," which is exactly the point.

Sometimes the local conditions are so different across our province that one centrally developed solution will not work for every part of the province. Sometimes we do not know the right solution, so the right answer is to create many tests of change to see what does work and under what circumstances. This is a process that most successful enterprises around the world have used to great advantage. However, it is a process that most central governments consistently struggle with harnessing as well.

The issue for the LHINs is that once we have developed an innovation that shows promise or indeed to show that we have a positive impact, how do we spread that innovation to all areas of the province to enhance the benefit to all?

A case example I would like to highlight is the Mississauga Halton Supports for Daily Living program, which was developed under the Home First philosophy. The need for this innovation came about because the Mississauga Halton LHIN has a very low number of long-term-care beds per population greater than age 75, which is the standard ratio measure. This limited access to long-term care caused an increased number of alternate-level-of-care—ALC—patients in our local hospitals. This, in turn, led to limited access to emergency patients who were admitted to hospital and needed a bed but had waited in the emergency department for that bed. Too many patients waited in ER for too long. It was a serious quality-of-care issue.

The Mississauga Halton LHIN saw that it would be possible to develop a comprehensive service, which we called Supports for Daily Living, which could be available for patients who would normally be eligible for long-term care, but it could be delivered economically in the person's own home.

We set about bringing all of the various stakeholders together to develop, refine, implement and monitor this innovation and to address this important need. In short, it has been a great success for the many seniors, clients and families who have been touched by this program and for local health care decision-making in Ontario. ALC rates are down; ER admit waits are down, all at a saving that amounts to millions of dollars over the alternative of building more long-term-care-home beds.

It is such a successful innovation that it has won a national award, the 3M national quality award, and it was this year's recipient of the inaugural minister's quality medal in Ontario.

But this is just one of numerous innovations that LHINs around the province have developed to address important health system issues, always with an interest to increase the value for money offered by the local health care system.

I know we like to talk about our successes, but it's also important, if you really believe in innovation, to talk about our failures and what you've learned from them. In our LHIN, we recognize that one of the risks of shifting care to the community is the increased burden this places on informal caregivers, usually family and friends. This creates something referred to as caregiver burnout. This led us to invest in and create a program called Caregiver ReCharge. It just made sense. Essentially, it was a week of respite care so caregivers could get away to recharge.

What we found, however, was that this was not working as we had expected. It was too restrictive, too structured, and caregivers did not find in it the flexibility to address their full needs. It wasn't being used, and caregivers were not taking advantage of the resources that they needed to give them the necessary respite.

Through a major caregiver consultation program, we were able to redesign and re-launch the program as a more flexible, complete set of resources that we expect will be more suited to caregivers' needs. We have learned from that failure and hope our revised program will successfully address the needs where we see them where the previous one did not.

But then what of the next stage, the spread of successful innovations or sharing the learnings from failures? Using my same example, the Mississauga Halton LHIN was asked by the 14 LHINs collectively to contribute to a document that together highlighted all of the various innovations and successes under the Home First philosophy. Once created, this document was used extensively around the province by all of the LHINs to look for local opportunities to implement the good ideas identified through proven success in other LHINs.

We've also seen the spread of SDL, Supports for Daily Living, to numerous other parts of the province, and this work continues.

The ministry role, in assisting with this spread, was to ensure that a proper policy framework was developed to ensure consistent high quality as the program spread throughout the province. Again, the experience of the Mississauga Halton LHIN was drawn upon to contribute to the policy development work, which ultimately became known as the assisted living policy. In this manner, innovation and spread and consistent implementation are handled appropriately and responsibly across the 14 LHINs.

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Similar approaches to innovation and spread are happening in a long list of important care processes, including palliative care, rehabilitative services, wound care, emergency services, primary care, co-ordinated care for complex patients, and critical care for life-or-limb services—and that list goes on. Each of the 14 LHINs has taken a lead role in innovating and developing and then spreading valuable change processes across the province.

In closing, I want to thank the committee for dedicating their time to reviewing our health care system. I

know that this started as a review of the LHSIA legislation, but it really is a much broader task, I see. Having made health care the focus of my whole career, I think that only good can come from openly assessing what works, what doesn't work and how we can contribute to moving the system to be a better one. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about two and a half minutes. This goes to the official opposition: Ms. Elliott.

Mrs. Christine Elliott: Great. Thank you, Chair. Thank you very much, Mr. MacLeod and Mr. Goebelle, for presenting today.

I'm really interested in the Supports for Daily Living and how you were able to make it so successful, because we know that the transitions often from hospital back into the community are the most troublesome. Can you tell us a little bit about what resources you had to switch around in order to make this program as successful as it was?

Mr. Bill MacLeod: We were fortunate in that, when I first arrived at the LHIN about six years ago, there was an aging-at-home investment developed. It was about $300 million invested in community care to look at aging at home. When we looked at this, clearly the need was in this area of early entry into long-term care. There was a lot of assessment being done, and, because it was the only option, these people were going into long-term care too early.

There were existing pockets of this service, but it was confined to rent-geared-to-income housing, not other areas where seniors lived in congregate settings: apartment buildings and condominium buildings. I myself live in a condominium building. Sometimes people say, "Isn't that a seniors' building?" Based on the average age, it probably is, but it is a place where seniors have said, "You know what? This is the lifestyle I want to live in."

What we found was that the CCAC could deliver services on a per-use basis but not in a way that covered it for 24 hours. The person had a number they could call if they got into any difficulty. There were services delivered throughout the day—not for a full hour, necessarily, but often for 15 minutes at a time, and that was just what the senior needed.

We took that and extended it to wherever we could find seniors in a congregate setting. That, I think, has worked well for us. We're now trying and innovating with a mobile SDL model to see if that will work, because that will spread to, then, other areas of the province.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes the time, and we thank you very much for taking it to be here with us.

CENTRAL EAST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next delegation is the Central East Local Health Integration Network: Deborah Hammons, chief executive officer. As with the previous delegations, you'll have 15 minutes in which to make your presentation. You can use all or any of that time as you see fit. If there's any time left over, we'll have questions and comments from the committee. With that, your 15 minutes starts now.

Ms. Deborah Hammons: Thank you, Mr. Chair and members of the committee. My name is Deborah Hammons, and I am the chief executive officer of the Central East LHIN.

You may recall that I appeared before the committee back in May 2013 as you conducted a study relating to the oversight, monitoring and regulation of non-accredited pharmaceutical companies. I'm pleased to be back today to share some information regarding the Central East LHIN that I hope will assist you in your task of reviewing the Local Health System Integration Act.

Today, I would like to focus on an aspect of the LHINs' mandate that the team at the Central East LHIN feel is one of our core functions, one that has shaped the look and feel of our organization and other LHINs and the culture since the beginning, and that is community engagement. It is by striving to meet this key objective set out in the LHIN legislation that LHINs are able to create a health care system that is better integrated, sustainable and one that is ensuring better health, better care and better value for money.

The Central East LHIN is home to approximately 1.6 million people and covers a large geography, stretching from the culturally diverse and densely populated Scarborough area up to the rural and less populated areas of north Kawartha, Peterborough county and the Haliburton Highlands, and across to Durham region and Northumberland county.

In the Central East LHIN and, indeed, all 14 LHINs, we recognize that we need to effectively engage with our diverse communities if we are going to continue to make improvements in the health care system.

In June 2006, as we got under way, the Central East LHIN published A Framework for Community Engagement and Local Health Planning. At the time, we said that the framework was our commitment to place collaborative engagement at the centre of our activities. The diversity and complexity of our province demands this type of local focus and local engagement.

In 2006, in order to better address this diversity in our communities, we invited health care providers and community residents to help us. We asked them to join three health networks—seamless care for seniors; mental health and addictions; and chronic disease prevention and management; we asked them to join nine geographically based collaboratives; and we asked them to join five task groups, such as primary care, ALC, rehab, and geriatric emergency management.

Supported by the LHIN organization, this community engagement activity saw hospitals sitting down with community agencies, physicians sitting down with patients, and front-line staff sitting down with administrative leadership. Together, these groups developed and

implemented a number of LHIN-funded initiatives that are still in place and making a difference today.

Now, because of their engagement and collaboration:

Geriatric emergency management nurses are continuing to provide care in the emergency departments of all of our acute care hospitals. The seamless care for seniors network project was the starting point for an improved system of geriatric care within the LHINs and across the LHINs.

The chronic disease prevention and management network led the introduction of a consistent chronic disease self-management model for the Central East LHIN. Eight years later, hundreds of local residents have participated in a free, six-week self-management workshop that empowers them to better manage their chronic conditions. Translated into French, Mandarin and Tamil, this program is considered a best practice in chronic disease self-management and is being used across the province and Canada and around the world.

The mental health and addiction network conducted a number of population health studies that led to new programs for disordered eating, early intervention for youth, and a system approach to providing addictions services.

Community engagement is the foundation of all activity at the Central East LHIN.

We know that being more responsive to local needs and opportunities requires ongoing dialogue and planning with those who use and deliver health services. For the team at the Central East LHIN, this means continuing to talk with and listen to all 13 of our MPPs; all 28 of our municipalities, mayors and local councils; physicians and other front-line health care providers, including family physicians and nurse practitioners; the administrative, governance and managerial leaders of all 138 of our health service providers, many of whom are involved in our planning partner teams; union representatives; patients, consumers, clients and their families; the medical officers of health from our four local public health units; police and emergency management services; the clinicians who sit on our Health Professionals Advisory Committee; chiefs of staff and medical advisory councils from each of our hospitals; other health and social service providers; and local media and the general public. In addition, we hold open board meetings, which the public is invited to attend.

Our website holds all of our public communications, including board reports, publications, technical documents, information on funding, performance dashboards, news releases, feedback surveys, calls for proposals, event calendars, and it even has an area for career opportunities. It also has links to all of our local health service providers, so that people can learn about the services available to them in each of the local communities.

We pay particular attention to key population groups in the Central East LHIN, including our aboriginal communities and our francophone residents. Together with five of our First Nations, we established a First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee.

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By working with the advisory circle and advisory committee, we have created opportunities for our aboriginal communities to meet with the community care access centre, the local hospitals and community-based agencies so that information can be shared on the unique needs of their elders and other members of the family, especially for mental health and addictions issues.

We also now have an aboriginal cancer care navigator in our LHIN, and this will be spread across the province.

The First Nations now have access to video-enabled telemedicine units, and a new adult day care program, delivered by the Victorian Order of Nurses, will soon open at the Curve Lake First Nation.

Our relationship with our francophone stakeholders is just as strong because of the partnership we have with the French-language health services planning entity number 4, a partnership that was recently noted by Ontario's French Language Services Commissioner.

Now, because of the partnership, francophone residents have access to the French version of the self-management program, designated long-term-care beds for francophone seniors are available in Scarborough and a new adult program for francophones is soon to be open in Oshawa.

There are other examples where listening to and working with our health care stakeholders and, through them, their patients and local residents, has allowed us to make improvements in the delivery of local health care services:

Cardiac rehabilitation services are now better organized in our LHIN.

New stroke services have been made available closer to home.

Patients who are suffering heart attacks or blockages in their arteries now have faster access to life-saving stenting procedures.

There are more resources in the community for people dealing with mental health illnesses.

Specialized geriatric clinics that provide access to care for seniors in four of our biggest hospitals are now going to be partnered with six new community-based teams so that family physicians are better supported in getting specialized care for their oldest and most complex patients, including how to support patients with challenging behaviour.

Highly specialized thoracic surgery is delivered in the most appropriate setting by experienced doctors and nurses who have the newest equipment.

Vascular surgical services and other clinical services have been sited in the right locations in our LHIN based on what our physicians told us was best practice.

Hundreds of seniors—about 2,200—are now accessing assisted living services so that they can age in place, and a number of integrations supported by strong community engagement have resulted in savings that have been reinvested back into front-line services.

These new and enhanced services are the result of system planning, funding, allocation, accountability

agreements and performance monitoring that all began with community engagement, initiated and supported by the LHINs.

In addition, services that were in danger of closing—such as supportive housing services in Apsley, or the local hospice services in Northumberland county, or the Consumer Survivor Initiative for mental health survivors in east Durham—are now sustainable and continuing to be available because the Central East LHIN brought the stakeholders together, engaged them to identify an integrated solution and ensured that the services were safely transitioned to new providers.

Since February 2012, we have been working with community health service organizations from across the LHIN on a community health services integration strategy to improve client access to high-quality services, create readiness for future health system transformation and make the best use of the public's investment by identifying integration opportunities.

This is an open and transparent process where the LHIN supports the respective agencies in a facilitated integration that sees the agencies engage with their communities to get their input on integration opportunities before any final decisions are made.

The Central East LHIN has supported the Scarborough Hospital and Rouge Valley Health System in a facilitated integration planning process that has seen the hospital engage with thousands of local residents, front-line staff, unions, physicians and other health care providers on a proposed merger between the two organizations.

At the Central East LHIN, we've been listening and talking to people since the beginning. We've invested in the processes, the staff, Web-enabled technology and the time it takes to build relationships, to get to know people.

Some may say that we haven't moved fast enough, that more should have been done over the past eight years. There is always room for improvement. But I would encourage you to consider that, because of LHINs, we are enabling local solutions that are making a difference in our communities through effective community engagement. In the Central East LHIN, we have seen how engaging the community, meeting with local people and working with the local health service providers always leads to better planning, better performance, better outcomes and better value.

I'm very proud of what we have accomplished and look forward to working with our communities and our stakeholders, making even more improvements.

Thank you for the opportunity to speak to you today. I hope I provided you with some valuable input to support the work that you're doing.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. There are just two and a half minutes left. The third party: Ms. Gelinas.

M^me^ France Gélinas: Just a quick question. I appreciate the example you have given us about community engagement. Would you have any recommendations for us moving forward? Are there things that would make your job easier or should be changed, improved or deleted?

Ms. Deborah Hammons: That's a very broad question. If it's related to community engagement, I think that—

M^me^ France Gélinas: No, not community engagement; about the work of the LHINs. We're here to review the LHINs. In the legislation, are there changes that you would like to see in the future?

Ms. Deborah Hammons: Yes. We would like to see the inclusion of primary care, broader than the community health centres that we currently have under our jurisdiction. We are also recommending that independent health facilities, as well, be part of the LHINs. We feel that that's important because, without them, the primary care work that we need to do is more difficult. We'd also like to see the legislation that was enacted be completely enacted, and the regulations as well.

M^me^ France Gélinas: What part hasn't?

Ms. Deborah Hammons: The regulations that are related to our role as it relates to funding; some of the primary care issues that I've just mentioned. We have a briefing that will be coming to the committee that will outline exactly what changes we're proposing in the legislation.

M^me^ France Gélinas: The independent health facilities that you would like coming under the LHINS—all of them?

Ms. Deborah Hammons: Yes.

M^me^ France Gélinas: Do you figure that the people involved are ready for this and that there is a desire, or is this something—

Ms. Deborah Hammons: No. We've actually had some discussions with the independent health facilities. I and one of the other LHIN CEOs gave a presentation in their most recent annual meeting. They welcome working with the LHINs in the future. We're starting to do that work in a very preliminary way, but we don't have the authority, at this point, to take over the accountabilities that we would need to do in managing those organizations.

The Chair (Mr. Ernie Hardeman): Thank you. Thank you very much for your presentation this afternoon. That does conclude the time.

CENTRAL WEST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presentation is the Central West Local Health Integration Network: Scott McLeod, chief executive officer, and Maria Britto, chair. Welcome, and thank you very much for being here this afternoon. I just introduced two, and we have three—oh, maybe just getting up to make sure everybody had sufficient water. With that, as with the previous delegations, you will have 15 minutes to make your presentation. You can use any or all of that time to make that presentation. If you have any time left over, we

will have questions and comments from the committee. With that, your 15 minutes starts now.

Ms. Maria Britto: Thank you very much. Good afternoon, everyone. My name is Maria Britto. I am the board chair of Central West Local Health Integration Network.

Reviews of legislation are an important part of our accountability. These discussions allows us to reflect on whether or not things are working as the legislation intended, and they provide us with an opportunity to explore ways of improvement. That's why I'm extremely pleased to be before you here today.

The act is based on a belief that the health needs of local communities are best understood by those who live in them. Because communities are as diverse as their populations, each LHIN faces unique factors that impact the ability to achieve its mandate. For example, the Central West LHIN is very much a mosaic of geographic and cultural diversity. By area, we are the third-smallest LHIN in the province, yet our landscape presents as three distinct areas: urban to the south, a combination of urban and rural in the middle, and rural to the north. By contrast, we have a large, growing and diverse population. Over half of our residents are made up of visible ethnic minorities, immigrants and those who are new to Canada within the last five years. As a realtor myself, a business leader and board chair of this LHIN, I frequently travel across all areas of our LHIN. Through my own experiences, and those told to me by the people I meet every day, I'm intimately familiar with the unique challenges that exist because of our population growth and geographic and cultural diversity. Perhaps this goes without saying, but I may know a thing or two about the challenges our local residents face when it comes to ethno-cultural diversity.

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LHINs are doing the job nobody else can do, because they have the best and only real view on the ground. As a result, they work to meet the ever-changing specific needs of each geographic area. I came to the central LHIN knowing some, but not a lot, about the LHINs. But I came knowing the value of relationship building, community engagement, knowledge exchange and collaboration. Since joining Central West, I've come to fully understand and appreciate the value that the LHINs offer to our health care system.

At the Central West LHIN, we've always worked to ensure health services are working together, more collectively and collaboratively. Because our board members reside locally, within the LHIN, we are better able to understand the needs of our communities, and we also have a professional and personal investment when it comes to ensuring its operational effectiveness.

Most importantly, however, the ability to effectively understand the needs of our local communities rests with meaningful community engagement and relationship building, both of which are at the heart of how we work at Central West. I am particularly proud of the relationships we've been able to cultivate in our area with our residents, our health service providers, and those organizations that are not funded by the LHIN, but play an important role in the design and integration of their local health care system.

We have the fewest number of health care service providers in the LHIN, a unique factor that enables us to build very strong and meaningful relationships with all of our health service providers, at a governance level and beyond. It allows us the opportunity to regularly bring them together for educational purposes, as well as to provide input into planning and funding priorities, all with a focus on improving access to high-quality, person-centred care for our local residents. I know for a fact that, as a result of these efforts, governance in the Central West LHIN is right on track.

Since the LHINs were introduced, an increasing number of local residents feel their health care has changed for the better. With system building there will always be room for improvement. We are further ahead today than when the local health integration networks were first established, a point that cannot be lost on this committee, and one for which I am extremely proud.

I would now like to invite Scott McLeod, my CEO with Central West LHIN, to take you through some aspects that we feel are important from the perspective of how the Central West LHIN operates within the LHSIA framework. I'll also remind you that I've been told by the communications people to nudge him a bit to make him smile more.

Mr. Scott McLeod: There you go. I'm smiling.

Thank you, Maria, and good afternoon. My name is Scott McLeod, and I am the CEO of the Central West LHIN, a role that I've had for the past 17 months. I've been in health care all of my career, and bring a diverse experience—from three different provinces and a number of health authority provider and planning organizations—to the work that we're doing in Central West, and collectively across all LHINs. Having followed with interest the discussion of the committee these past months, I want to take some time to address some key areas we feel warrant perhaps further discussion and further understanding.

An area of interest that has emerged from these discussions seems to be around performance measurement. How do the LHINs measure their success, and by extension, have they been able to improve the health care system? During your meetings, you've heard many stories of front-line impact, the difference that LHINs have been able to make towards attainment of better, high-quality, person-centred care. They are strong, moving, and important testaments of how residents are experiencing their local health care systems.

You have also heard a lot about our accountability agreements and system indicators that are used to measure performance on a more quantitative basis. I do believe we have meaningful system indicators that demonstrate how improvements have been made and are continuing to be made.

In addition to the ministry-LHIN system performance indicators, Central West also reached out, through public polling, to local residents of the LHIN to understand if

we are making a difference. Over the past eight years, we have been able to assess our local residents' overall satisfaction on a number of important areas, including access, quality, sustainability and equity. Our latest poll, conducted in September of last year, involved a random sample of 600 residents from across the LHIN. The results reveal 88% of the residents indicated they are satisfied or very satisfied with the quality of the health care services, and that's an increase of 11% since 2009. Results also show improvements in satisfaction with accessibility to local health care services, including doctors and specialists. Some 82% of local residents are satisfied with the system's capacity to accommodate diversity, and 78% with the system's ability to provide fair and equitable services for all.

With respect to performance, our residents have let us know that, in collaboration with our health service providers, we're on the right track, that our planning and investments are making a difference. While these are positive results, it also demonstrates that there are real opportunities to continuously improve.

Our communities in Central West have seen significant population growth over the last 15 years: 27% growth since 2001. Today, there are about 840,000 people living in Central West, and the population is projected to continue to grow at one of the fastest rates in the province. By 2021, the population is projected to grow by 23%.

In contrast to the growth we have seen, Central West has the fewest number of health service providers of any LHIN in the province. Our providers have struggled to keep pace with growing demands for health care across all sectors. This poses a challenge for decisions related to resource allocation, but it also has resulted in great innovation within and among our health service providers, who continually look for ways to become more efficient while driving quality improvements. However, we are especially pleased that new approaches to funding based on population and quality will, over time, enable continued local investment to better match the demand for health services. Continued investment in Central West is essential.

Residents often leave Central West to access mostly speciality services in neighbouring LHINs. From a patient/resident perspective, LHIN boundaries are permeable. This means that we must, and do, work closely with other GTA LHINs to ensure access, flow and as much consistency as possible.

To support our collective work, we have established purposeful structures where we table issues, consider solutions, advance consistency, and look for opportunities for spread. Two examples include the GTA CEO meetings, and the central Ontario eHealth steering committee, both of which meet monthly. We also work together on joint planning initiatives such as the community capacity study referenced by Bill MacLeod. In fact, you will see considerable cross-LHIN planning on many, many fronts. And there is always room for improvement.

As you may know, MPP Cansfield has four LHINs and four CCACs that intersect within her constituency. She will tell of the concerns raised about variability in access to CCAC services, depending on where you live. This is an area where, in collaboration with CCACs, we have work to do to ensure greater consistency.

This has sometimes been referred to as a LHIN boundary issue. If I can impress upon the committee one thing, it is that there are no perfect boundaries. Structural change is comparatively easy to make and is where many across the country have gone first when system change has been required. We should learn from the experience of other provinces: Structural changes have not solved the problems, and arguably, they have set the system back because of the disruptions they cause. I believe we'd be much better served by focusing on consistent integration strategies to address issues and challenges across the LHINs with local execution, rather than focusing on boundaries. That is what we focus on across the GTA LHINs and across all LHINs.

In Central West, our size provides us unique nimbleness, an ability to quickly find common ground and sense of common purpose so that we can move quickly to implement new programs, services and initiatives, such as health links and Telehomecare. Telehomecare is a highly successful program that's seeing great results. Central West was one of three pilots to implement this innovative approach beginning in February 2013. The purpose of the pilot is to help residents with chronic conditions, such as congestive heart failure or chronic obstructive pulmonary disease, better manage their conditions more effectively. Patients with these chronic conditions often go to emergency departments or are admitted to acute care. The program leverages technology put into patients' homes to allow them to monitor their conditions more effectively.

To date, close to 650 residents have been enrolled in the program with dramatic results. We have tracked ED and acute care utilization pre- and post-enrollment, and the results demonstrate a remarkable 48% reduction in ED visits and a 76% reduction in admissions to hospital. The results are compelling and other LHINs are now looking to implement this innovation.

Central West, along with our providers, has enthusiastically adopted health links. Again, by being nimble, through the development of strong, productive relationships, we were among the first to have our entire LHIN covered by five health links. As you know, health links are being established to help fundamentally transform our system by focusing first on the highest users, ensuring that care and services are wrapped around individual patient needs.

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One of the things that I believe makes health links so potentially game-changing is that many of the solutions to improve the health of the patient come from outside the health care sector, and that's certainly been our experience in Central West. Health links enable us to bring a broad mix of social and health service providers to the table to help find better solutions for individuals.

We are still in the early days of health links, and there will be bumps in the road, but, together with our local steering committee, we identify and problem-solve to ensure the five health links learn from each other and are implemented consistently across Central West.

We have much to be proud of, and we work collaboratively with our stakeholders and health service providers. But I don't want to leave you with the impression that everything's perfect. We don't always agree and there's lots of healthy debate. However, with strong relationships in place, difficult conversations can be held with the best interests of local residents top of mind.

When we speak of change, it's important to remember that while our Canadian health care system—a system that the majority of Canadians have come to embrace as a part of their identity—formally emerged in the 1960s, it has been around for over 100 years. I have never heard anyone say that if we were designing the system today, it would look the way it does today. When we talk about transformation, we talk about changing how things are done, and change, as we know, is difficult. My point here is that, with all the positives and ongoing opportunities, it is a system that has taken a century to create and will take more than eight years to fundamentally transform and integrate.

The act is incredibly powerful legislation. Incorporating the changes you've heard about and the recommendations put forward from the LHINs will enable us to further advance change and transformation.

So, in closing, have we made collective improvements to the system? Absolutely. Are LHINs committed to the fundamental transformation required? Absolutely. Do we need to challenge the status quo and resistance to change? Absolutely. Do we still have a lot to accomplish? Unquestionably. Are we up to the challenge? Let there be no doubt, the answer is a resounding yes.

Members of the committee, once again, my thanks.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have just over a minute. Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much. Ms. Cansfield is not able to be here today. She's on another committee. So thank you for addressing her issue. She's been talking about it for many years.

What are the barriers to you achieving that consistency between CCAC services, between the four of you that service her community?

Mr. Scott McLeod: There are probably a couple. There are different allocations of resources, basically. I think part of it comes down to a funding issue, but the other part is a practice issue, and agreeing on what the upfront priorities need to be across the four, particularly where they intersect. While it may apply to the GTA in particular, I think it applies to all CCACs, not just the four within MPP Cansfield's riding.

Ms. Helena Jaczek: Thank you. Go ahead.

Mr. Vic Dhillon: Thank you very much for—

The Chair (Mr. Ernie Hardeman): Thank you very much for your time. That does conclude the time. Thank you very much for your presentation.

Ms. Maria Britto: Thank you.

Mr. Scott McLeod: Thank you.

CANADIAN MENTAL HEALTH ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next presentation is from the Canadian Mental Health Association: Camille Quenneville; Marion Quigley, chief executive officer of the Canadian Mental Health Association, Sudbury/Manitoulin; Steve Lurie, executive director, Canadian Mental Health Association of Toronto; and Tim Simboli, executive director, Canadian Mental Health Association of Ottawa.

The committee will be aware that this presentation is one that fits with the first opening days of our committee hearings, which will be a two-hour presentation in its entirety, and which will consist of half an hour allotted for the presentation and half an hour for each caucus to ask questions. We'll allow everyone time to get settled in.

Thank you all very much for coming in and taking the time to be with us this afternoon. We will have a two-hour time slot allotted for the presentation. We'll hopefully have about a half an hour for your presentation, and then we'll have a half an hour for each caucus to have questions or comments about the presentation. For those in the audience who are present, the difference between the presentations is that we had a number of these from different organizations—general, province-wide organizations—when we started the hearings to, shall we say, enlighten the committee about the scope of our review. At that time, we set up the two hours for each one of those organizations. This is one of those as opposed to, we then went about getting everybody a 15-minute presentation and hearing from as many of the LHINs and other organizations that we possibly could.

With that, welcome. Your time starts right now.

Ms. Camille Quenneville: Thank you, Mr. Chair and members of the committee. We're very pleased to be here today to share our views on the Local Health System Integration Act with you. I'm so pleased to introduce my colleagues, leaders in three of our branches: Marion Quigley from our Sudbury-Manitoulin branch; to my far left is Tim Simboli from our Ottawa branch; and of course Steve Lurie from our Toronto branch. Marion, Tim and Steve all agreed to participate with me today to offer up a regional perspective when we are answering your questions.

I know that a few of the MPPs around the table today also served on the Select Committee on Mental Health and Addictions. Before the select committee began its deliberations, a number of you publicly expressed your interest in improving the mental health and addictions sector in our province. I know from experience that the MPPs who served on the select committee, amongst others, continue to have a keen interest in shining a spotlight on the tremendous need that exists in the mental health and addictions sector. While our task today is to

discuss the Local Health System Integration Act, I think it's important to point out that the MPPs here possess a better-than-average understanding of the mental health and addictions sector, and for that, we feel very fortunate.

About CMHA, Ontario: Let me tell you a little bit about who we are. Before we get into the details of the act, I'd like to share some background on our organization.

The Canadian Mental Health Association was founded in 1918 and is amongst the oldest voluntary organizations in Canada. Across the country there are 120 branches, and here in Ontario there are 31. We serve approximately 50,000 Ontarians each year through a myriad of programs that include housing supports; public education programs; counselling; court supports and justice-related services; seniors programs; family programs; wellness; workplace mental health etc. I could go on. Our mission is to make mental health possible for all.

I'd like to offer a personal observation about our work for a moment. The success of CMHA is directly related to our branches offering programs that respect their local population and reflect the community they serve. As a relative newcomer to this organization, it has been my observation, as I've travelled across Ontario, that our branches have responded to the changing needs of their communities. In some cases, for example, this means offering programs to support seniors suffering from isolation and depression in communities where the population is aging.

Fort Frances is a good example. As the paper mills closed and industry moved out, so too did the next generation—not surprisingly. The CMHA branch has a clubhouse model which seniors can access daily, providing them with a social network and additional supports for living independently, which helps them remain in their home and out of more expensive mental health or long-term-care programs and facilities. This is "community-based" at its best, in my view.

This is one example of many across the province which serves to reinforce the value of community-based services. The Drummond report references the value of the community-based system and the importance of ensuring that any changes to the system put the client at the centre, and that has always been our belief. I'm proud to tell you that our work puts the client at the centre.

I would like to share two brief stories to give you a further sense of our work across the province.

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A gentleman who we will call "James," which is not his real name, was referred to the Mental Health Court diversion program of our Leeds-Grenville branch, in Brockville, following a charge of causing a disturbance. James was 48 at the time, of aboriginal origin, suffering from bipolar disorder and, when he was unwell, presented very loudly and with rapidity of thought and expression. He came across as agitated, belligerent, argumentative and verbally combative. At six feet tall, he may be perceived as threatening, but he was not acting out. At the time of his referral, it was learned that James was a survivor of childhood sexual abuse and a chronic user of cannabis, and was not taking his medication. He had also not seen his physician for a significant period of time and was estranged from his case manager.

Through the Mental Health Court diversion plan, James agreed to reconnect with his physician and participate in the psychiatric outpatient referral, be amenable to treatment recommendations, have regular contact with a case manager and check in regularly with the CMHA court diversion worker while maintaining the peace. James successfully completed the plan in May 2013, and his charge was stayed. Throughout the diversion process, James attended appointments and maintained contact with his case management team. He has subsequently ceased use of cannabis, re-engaged with his psychiatrist and is medication compliant. At his request, he maintains contact with the court diversion worker and now drops in to say hello. There has been no known additional police involvement at this time.

One last brief story: Larry Woodhouse, a gentleman I spoke to again this morning—which, I should tell you, is his real name; he insisted, in fact, that I use it. He has been accessing service at CMHA Oxford County. Larry came to learn about CMHA when his supervisor noticed that he was not coping well in the workplace and invited staff from CMHA in to speak with him. Larry said that at the first meeting with these staff, he learned coping skills and was given the number to the CMHA crisis line in the form of a fridge magnet. He used the number frequently and subsequently received case management services with our branch. Larry had a history of mental illness and suicidal ideation, and he has indicated that in no uncertain terms, he is alive today because of CMHA. He has been asked to speak publicly about his experience by Mike McMahon, the executive director of the Oxford county branch, which he has done, raising money for the local United Way, which also funds the branch. Larry described his numerous speaking engagements as "kinda cool" and a highlight of his life.

The Local Health System Integration Act: One of the advantages of not being amongst the first to present to the committee is that you have the benefit of hearing and reading what others who have gone before you have said to understand different viewpoints. I read the presentation by Saäd Rafi, the former Deputy Minister of Health and Long-Term Care, with great interest. The matter of how the regionalization or decentralization of health care services came about and the evolution of the LHIN structure is a matter of public record. So too is the purpose of the act, "to provide for an integrated health system to improve the health of Ontarians through better access to high-quality health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks."

We're not the first province to go down this road and, while we could debate today whether we should have, what we could do or what should exist instead of the LHINs, we would prefer to focus our comments on the

existing structure and offer up some observations to share with you. In part, this is due to the fact that, representing 31 branches across 14 LHINs, it is perhaps not surprising that experiences differ. Overall, we are supportive of the LHIN structure. We would like to highlight what has worked particularly well, and offer up some areas where there is some room for improvement which we hope will assist you in your deliberations.

For the purposes of this presentation, we'll mirror the contents of the Local Health System Integration Act and provide comments on community engagement, funding, accountability and integration. We'll also provide further thoughts on quality improvement and governance, both of which are integral to the system, in our view. We'll also reflect on the recommendations contained in the Drummond report, which we understand have been referenced throughout this review exercise as well.

Community engagement and governance: Some LHINs operate with an openness and transparency to their work. They engage local boards as well as staff of community-based organizations. But this is not always the case. CMHA welcomes interaction at a governance level with LHIN boards. It has been our experience that this has been a fruitful endeavour for both parties and has been mutually beneficial and necessary when large undertakings, such as an amalgamation of organizations, takes place. It is a good example of how working together brings change to community, LHIN and CMHA local branches.

This government has brought forward many initiatives in reforming the health care system. The LHINs are an important example, but so, too, are the more recent service collaboratives and health links. They are all valuable, and there are many examples where they have been very successful. However, community-based organizations, such as our branches, often struggle to keep up. There is a strong desire to be at every table, and indeed there is an expectation that we will be. But the administrative burden is high, and without a clear provincial objective of how all of these initiatives interrelate, it can become unmanageable. We are hoping that, with the pending implementation of years four through 10 of the 10-year strategy, we will have assistance in providing clearer provincial direction.

Provincial governance: We are pleased to be part of the ongoing discussion about years four through 10 of the mental health strategy with the Ministry of Health and Long-Term Care. While the ministry considers its future priorities regarding mental health and addictions, we would simply reflect that dramatically changing the governance structure of mental health and addictions, as stated in the Select Committee on Mental Health and Addictions report, is not a priority for us at this time. The resources necessary to do so would be far better spent providing additional housing and other mental health and addiction related supports. Much can be done within government and the community-based system to better coordinate programs and service delivery, including through the LHIN structure. There are currently far more ministries than there ever have been focused on mental health and addictions, and there are structures and processes within government that could link them together. They need to be utilized. The Canadian Mental Health Association is currently exploring options, along with other community partners, on how best to achieve efficient system-wide planning provincially.

Funding: To begin with, we would like to offer up some data to show both the size and scope of the need for mental health care from a global, national and provincial perspective. Some of this information comes from a document that my colleague Steve Lurie has produced on the current system titled Why Can't Canada Spend More on Mental Health; it's in your package. This will be formally published very shortly, and we have provided copies for your interest. These statistics are really just to demonstrate the scope of mental-health-and-addiction-related issues and why it's necessary to get the funding and delivery system right, first and foremost for the client and their family, for our health care system in communities and for the economy as a whole.

It is worth noting, from a global perspective, that the World Health Organization notes that mental illness accounts for 13% of the world's disease burden. We are falling behind other high-income countries when it comes to spending on mental health, at 7.2 %, compared to most others which spend 10% or more.

In Canada, the following points reflect the impact of the lack of available treatment and supports nationally, the resulting effect on our economy and also how mental health compares to physical health issues. The Mental Health Commission of Canada has indicated that as few as one in three adults and one in four children receive mental health treatment and support when needed. The commission has also noted that the cost of mental-health-related issues is $50 billion per year to our economy. Some 6.7 million Canadians out of a total population of 37 million are living with mental illness, compared to 2.2 million who live with type 2 diabetes. The Mental Health Commission of Canada recommends that at least 9% of health spending should be on mental health, and a further 2% increase in social spending is also needed.

In Ontario, the Drummond report cites that "estimates of the economic costs of mental health and addiction are pegged at $39 billion annually, with productivity losses accounting for 74% of the costs."

According to public accounts, community mental health funding comprises 2.5% to 3% of LHIN funding. As previously mentioned, the mental health commission has stated it should be 9%.

There are 441,027 unique individuals served by all community mental health and addictions programs annually in Ontario, at a cost of $51 for these services compared to $138 for in-patient/physician-based mental health services. As stated, these figures demonstrate the tremendous need and funding shortfall that exists. We use this information in working with the Ministry of Health and Long Term-Care and with the LHINs to reinforce the need to make further strategic investments.

The Drummond report recommended the following: "Support a gradual shift to mechanisms that ensure a continuum of care and care that is community-based. Funding for community-based care may need to grow at a higher rate in the short to medium term in order to build capacity to take pressure off acute care facilities; on the other hand, with a shift away from a hospital focus, hospital budgets could grow less rapidly than the average."

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There is evidence of this over the past few years, and there's no doubt that further investments in housing, peer support, employment, case management, assertive community treatment, early psychosis intervention etc. will further alleviate the higher costs associated with hospital or institutionalized care.

Funding coordination: There are some practical implications to having two funders for some community-based services. Specifically, the funding for supports within housing is the responsibility of the LHINs; the funding for bricks and mortar and rent supplements lies with the Ministry of Health and Long-Term Care. As previously indicated, housing is the highest need across Ontario when it comes to supports for those living with mental illness and addictions. The process for getting approval for new housing with supports, however, is exceptionally difficult to navigate because it requires coordinated funding. In one particular branch example, the Ministry of Health had provided funding for rent subsidies, but this did not correspond with additional staffing dollars from the LHINs, leaving the agency to manage considerably more service with existing staff. That same agency received a sizable investment of additional dollars from the city where they're located for considerably more rent subsidies over a five-year period, but again, the LHIN would not approve additional resources in the form of additional staff to manage increased service delivery. This makes any attempt to sustain a "housing first" approach extremely difficult within communities, despite the fact that considerable literature points to this as a worthy goal.

Funding transparency: While soliciting feedback from our branches for this presentation, it was noted that often funding is not applied equitably or consistently across the system. Perhaps not surprisingly, there is strong competition for dollars and a lack of clear direction on priority items as it relates to funding. Dollars may be provided to new start-up programs, leaving those programs that had proven successful without resources. This points to the need for better coordination more than anything else. Strong partnerships must rely on healthy communications so that all partners feel engaged and included in how decisions are made.

Definitions: There is a further sense of a lack of coordination amongst LHINs around fiscal matters. This is best evidenced by different definitions that are used across LHINs. Some branches are advised that their administrative budgets include rent; others do not. Some suggest that the cap is a certain percentage, and it may be very different in the neighbouring LHIN. This is clearly not deliberate and not intended to handicap any organization; however, simple agreement amongst the LHINs on the terms and their use across the province will help organizations achieve their targets and share best practices more easily with one another.

Accountability: Considerable effort has been made to engage the community-based organizations on the refinement of the M-SAA, or multi-sector accountability agreement. The M-SAA table has met very regularly under the able leadership of Louise Paquette of the North East LHIN. There has been a respectful exchange, and ideas raised by the community sector were listened to and taken into consideration for further decision-making. It has been a good process, and we're pleased that it will continue into the future. This partnership-building is important for all parties. The community-based sector worked hard to do their homework, to offer up important insight, and provide the best possible information and feedback to the larger group, which we hope and believe was beneficial to the LHIN table and will ultimately be seen in a much more workable, agreeable M-SAA template for all parties.

Quality improvement: As you know, The Excellent Care for All Act legislates annual quality improvement plans for every health care organization. The Canadian Mental Health Association in Ontario has embraced this requirement. Before we were mandated to do so by the local health integration networks, we set to work provincially to develop our own template for use in mental health and addictions. Leadership for this exercise began with our executive director network, made up of the CEOs of all 31 branches, who meet regularly throughout the year. Linda Gallacher, CEO of the Durham branch, spearheaded our efforts in this area by engaging a small working group of her colleagues to initiate a plan of action.

It was recognized early on that the templates that were being developed by hospitals had little relevance to the community-based system of mental health and addictions, so we set out to develop our own. Surveys were conducted to see what amount of work had been done on quality improvement within our branches. Armed with that information, a working group of skilled staff in our branches was struck, and they, in turn, developed a draft template. The template was then shared with Addictions and Mental Health Ontario for their input. To their great credit, they were very willing and anxious to work with us to ensure that the template was suitable for their agencies as well, so that ultimately we would have one template for the entire sector.

David Kelly, executive director of Addictions and Mental Health Ontario, and I have worked together to bring this template to provincial officials including Health Quality Ontario and the Health Quality Branch at the Ministry of Health and Long-Term Care. The template has been well received, and we have subsequently been asked to consider what resources might be necessary for its implementation. We have done so and submitted a proposal to the ministry.

I raise this with you to demonstrate our efforts in partnering and ensuring we are meeting and exceeding all requirements of the ministry and our LHIN funders. This partnership is one example of many that happen provincially to ensure the best use of resources across mental health and addictions as well as other broader social service organizations.

It must be said that while a focus on quality is important, for us to achieve success, quality must be objectively measured through standardized methodology using consistent definitions. Having the capacity within organizations is also critical and, at the moment, all of these criteria are missing. We will continue to advocate for these needs.

Integration: Since the advent of the local health integration network, a considerable amount of integration has taken place across the health care sector. Some of it involves bringing programs together and, in some cases, organizations, in an attempt to enhance service delivery. The CMHA has done a great deal of work in integrating primary and mental health care, and we will continue to play a role as a resource to the LHINs for this work.

It has been our experience to date that the most successful integration of community-based organizations has resulted from local decision-making by interested parties. The parties identify where they could collaborate or, in some cases, merge to benefit the consumer, and present the concept to the LHIN. With LHIN support and guidance, these mergers have worked well to the benefit of the most important stakeholders—those accessing the service. It is our view that the decision to integrate services or merge organizations should be taken with only this stakeholder group in mind: the consumer. These decisions should focus on how the consumer can best access the most appropriate service in the right place, at the right time. As the Drummond report recommended, "The system should be centred on the patient, not on the institutions and practitioners in the health care system." We are pleased that many of our branches have expanded as a result of integration with other organizations to provide better access to the most appropriate treatment for our consumers.

We have been concerned in some situations where the focus appears to be integration for the sake of integration, with simply having fewer organizations being the objective. In some cases, the decision to integrate organizations has not followed a constructive process involving stakeholders. We would respectfully recommend that the following steps be considered before formal action is taken to merge organizations:

—focus solely on client service as the primary objective;

—analyze client data from across the catchment area to ensure there is evidence of the need for system change. This can be done by using the Ontario perception of care tool for mental health and addiction services. This will allow for a representative sample of the needs of the community;

—conduct a thorough cost analysis in a transparent fashion. It should include the following measures: a human resources cost impact analysis of merged unionized and non-unionized positions regionally, if applicable, as well as hospital and community-sponsored wage grids; harmonization costs across sectors, as well as pension, benefits, employment contracts and severance costs to be borne by the LHIN; incorporation and dissolution costs attributable to agency mergers to be borne by the LHIN; long-term lease and mortgage commitment transfer costs where applicable to be borne by the LHIN; and legal costs inherent to dissolution and new incorporation to be borne by the LHIN;

—consider that there is comprehensive literature that exists detailing the negative impacts of forced mergers and the benefit of strategic alliances. The alliances can be more successful at less cost; and

—consider all options, including other investments, that may prove more beneficial for local service delivery, such as electronic infrastructure, to assist in the effective utilization of records for all providers.

Most concerning is the myth that integration saves money. Often there are insufficient resources to start, leaving no savings at the end of the process. Instead, CMHA, Ontario recommends that the decision to integrate be made based on what makes the most sense from a client perspective, including how to access the system.

In conclusion, we're pleased to partner with the local health integration networks across the province to provide the very best service to consumers in need of mental health and addiction supports. We believe that only through respectful collaboration can we ensure that the system is operating efficiently and well, and to the benefit of the consumer.

We provided a number of recommendations through this presentation, all of them doable, and we are happy to be engaged with all 14 LHINs across the province in achieving our collective goals.

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Our recommendations include:

—additional emphasis on openness and engagement with the boards and staff of community-based organizations;

—transparency in funding decisions;

—a recognition of the need for further investments in our sector to meet the needs;

—clearer definitions on financial matters;

—agreement on standardized methodology to ensure our quality improvement work is successful and meaningful;

—integration for the sole purpose of improved client service; and

—an open, transparent, engaging process with community partners before proceeding.

Thank you for the opportunity to appear here today. A special thanks to the Clerk of the Committee: Valerie, thank you. We appreciate your efficient response to our request to appear. Along with my colleagues, I am very pleased to answer your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will have half an hour

for each caucus. It starts with the official opposition. The questions will not necessarily be the full half-hour for each one. We'll make rotations until all three parties have either ended their questions or run out of time.

With that, Ms. Elliott.

Mrs. Christine Elliott: Thank you, Chair. Good afternoon, everyone. Thank you so much for your great presentation.

I had a question regarding the examples you gave us about CMHA, Ontario and the Mental Health Court diversion plan, how you were able to connect with them and get them to work with you, because some of the presenters who have come have talked to us about integrating not just health services but some of the other social agencies that are involved with the police, with the courts. I'm wondering if you could give us any guidance on how you went about that and how we could integrate other groups that have an impact on mental health into—

Ms. Camille Quenneville: That's a great question. Thank you. One of the nice benefits of having the folks here who run these organizations is that they can give you very specific examples. So what I might do is just ask if all three of you could maybe respond briefly to that, and then I'll give you a provincial—

Mr. Steve Lurie: Well, I think that at both the provincial and regional tables we've got the Human Services and Justice Coordinating Committees, and that brings together hospitals, the police, the crown attorneys. That's often where many of the ideas to develop a mental health court or build a diversion program come from.

I think the HSJCCs have been, actually, since 1998—and I've been chairing the Toronto group since that time—a very effective means of joint planning and collaboration across the sectors, but their challenge is the same one that Camille mentioned. The resources aren't on the ground, so you can't develop a diversion program if there isn't money to fund it. If you fund a diversion program and the services that people need to be connected with don't exist in the community, then there are similar problems.

The Making a Difference report which was done around the service systems evaluation initiative launched by this government showed that in fact the court diversion programs are quite successful and they were able to lower the amount of time to get services, but after three years, the range of services that people needed in the community weren't available.

Mrs. Christine Elliott: I see.

Mr. Tim Simboli: I'm with the Ottawa office, so we're in the Champlain LHIN. Two things that I think have worked well for building that kind of integration are, first, we actually have a number of subgroups that work on a local level, mental health community support services, a network of community health and resource centres that operate in Ottawa that have a connection to the mental health services. So there's a number of bodies where front-line middle management and senior management connect together, and I think it's important that each level—we mention governance levels in here, but that there's a connection at each level.

The other thing that I think has been effective for us is, we do a fair amount of outreach services. We have teams that go into the courts, the shelters and the hospitals. That's where they go to find the clients, and, for the most part, agencies that are working with these clients are well advised to be there on the ground and make those kinds of connections. It's a doorway. It's a personal invitation that can be made to people so that they can then connect with our more fulsome services.

Ms. Marion Quigley: I'll just add that in northeastern Ontario, what happens is there are good connections with the human service justice programs where the other programs don't have as close a connection because they don't have the same types of tables. They do have the mental health and addiction table. But some of the community support agencies in the north, we find, don't have the resources to come to all the meetings to make those connections. That's where I see a bit of a lack with the outreach.

Ms. Camille Quenneville: And finally, I think it's worth noting that, as my colleagues have referenced, the justice coordinating committee, which we call HSJCC, the Human Services and Justice Coordinating Committee—that work is done through the Ontario division office. We have a full-time person who works on that.

Mrs. Christine Elliott: Well, I would agree with you just on what I've seen. They seem to be very, very effective in triaging people out of the criminal justice system when they don't need to be there.

Ms. Camille Quenneville: Yes.

Mrs. Christine Elliott: Another question I had was just on the issue of integration. You have expressed some concerns that any integrations done be done for the purpose of improving service for people. Do you get the feeling now that integration is happening more than it should be? Is it being pushed a little bit more than you'd like to see?

Ms. Camille Quenneville: In some cases, yes. I think, in part, there's sometimes a lack of understanding of the partnerships that already exist within our branches and how on the ground there is very good collaboration amongst different community organizations that are working to serve a particular client or group of clients. It's really the broad spectrum, to be quite honest. We've had very successful integrations and a couple of our branches have grown quite dramatically as a result, and they've gone very well in large measure because those decisions were taken locally and there was a real desire to come together and it made sense for the community in terms of how best to serve clients. Others have been entered into without the homework having been done, so they really haven't been quite as smooth.

I don't know if my colleagues want to comment on any of that.

Mr. Steve Lurie: Well, I guess there is a literature on integration. Just to briefly summarize what Camille referred to in the brief, there's lots of evidence, actually, that 80% of mergers in the public and private sectors fail. So if merger is your default, you're likely not to succeed.

Strategic alliances are known, according to the Harvard Business Review, to be an effective way of bringing groups together. For example, I think you could say a human service and justice committee or a mental health and addiction network is a kind of strategic alliance. I think the approach needs to be on what's going to actually work, and form has to follow function.

So there are areas where integration isn't about merger but building better connections. A number of the CMHA branches in the province have developed some strong relationships with primary care to get at the fact that lots of people, especially with serious mental illness, tend to die 25 to 30 years earlier. The Windsor branch developed a satellite community health centre. CMHA, Durham, as you know, has a fabulous program that integrates primary care and mental health care. So I think we need to be thoughtful. It's not about structure, in some cases; it's about process and resources.

I think that's what the health links are about: how you can get people to work together. Of course, the challenge on health links is going to be, can process improvement do it all, or are there some real capacity gaps in the system? I would argue that I think if we're objective we'll see that there are capacity gaps.

I'll give you an example, and Kim Baker is sitting in the back, from our LHIN. We had meetings with the community support sector and the community mental health sector and North York General trying to find resources for people who were showing up in their emergency department. One of the case examples which typifies the capacity gap is that North York General brought to the table the case of an elderly Chinese woman who was living with her son and his wife, who was soon to have a baby. The woman had dementia. She wandered and she got violent at times. They had just brought her to North York General to say, "Here. We've got this baby coming and we can't cope with mom anymore." So we had this collection of people in the LHIN—community support service folks and mental health and addictions folks—and we were trying to figure out what we could do. One of the partner agencies stepped up, even though they don't provide services in Mandarin, and said, "Look, we could pick this woman up and take her to our day centre five days a week," which appeared to be a partial solution. Then there was silence, because there was no service, whether it was respite or otherwise, to deal with what would happen between 5 p.m. and 9 o'clock the next morning or on weekends.

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I think that as the LHINs do their work on health links, it will be really important to look at where the instances are, in fact, where we have to keep investing, as Camille and the Drummond commission said, in community capacity to reduce the reliance on hospital services.

Mrs. Christine Elliott: Great. Thank you.

The Chair (Mr. Ernie Hardeman): Go ahead.

Mrs. Christine Elliott: Another question? All right.

I was interested in your comment under section 4, community engagement and governance, speaking about the different tables, speaking about the administrative burden being high, "and without a clear provincial objective of how all of these initiatives interrelate, it can become unmanageable."

I'm wondering if you're feeling that you're missing something from the province, or the LHINs are, in order for them to be able to do their work, and what the concern is there, a bit more specifically.

Ms. Camille Quenneville: It's a good question. The feedback I had from some of our CEOs is that there's an expectation that they will sit at all of these tables, and it's a difficult thing to do. It's not that they don't want to be there; it's just very cumbersome for them to be there.

There doesn't appear, sometimes, to be an overriding plan in place. All of these are distinct efforts, and I think that's where some of the confusion is: We have to be here and over there at the same time, and we're not sure how all of this works together.

Mrs. Christine Elliott: Well, that has been expressed to us by others in the sense that it's important for each LHIN to be able to respond to local health needs, but that there is a lack of an overarching plan determining what the priorities are, because there are many, many priorities in health care. Do you think it would be helpful to have a more clearly delineated plan from the provincial level?

Ms. Camille Quenneville: Absolutely.

Ms. Marion Quigley: I think that once we see the implementation of the four-to-10-year plan, once it gets implemented, we'll have a better idea of where the priorities are, because right now everything is a priority, and we're all trying to be at the right tables to look at improving the system.

Ms. Camille Quenneville: And they're all worthy too.

Ms. Marion Quigley: Yes, and so what happens, for a community service provider, is that the table wants a decision-maker to be there. Well, there are only so many of us around, so if we know what the priority is—and I know the LHINs look at what the priorities are, through their integrated health services plan, so that's helpful, but there are also provincial strategies that are also coming down. So I think it's just to have a better coordination of the system.

Mrs. Christine Elliott: I would certainly agree with you in respect of years four through 10. We've had the focus on youth for the first three years, but I think we all want to know what the priority is going to be for the next few years. That's a very fair comment.

Ms. Camille Quenneville: Yes, absolutely. I think Tim wanted to add something.

Mr. Tim Simboli: Integration has become a bit of a flavour du jour for not only the LHINs and the Ministry of Health, but just about everybody in all levels of government. There are coordination and collaboration tables springing up very quickly, expecting the leaders of organizations to show up, and there isn't the cross-pollination or integration of these priorities through various different sectors, through various levels of government. I could be at three meetings a week, talking about

integration, and in the end there are no more services, so it has a an "organizing the deck chairs on the Titanic" feel to it.

It doesn't mean that the LHINs have to drop their priorities or defer their priorities. It just is a matter of integrating the priorities with the other things that are going on.

I might also say that the experience is different in every LHIN in this province. When we get together and we gather and start to compare notes—I would say there are probably no two LHINs that have had common histories over the last couple of years. They all have different personalities, different leadership skills. The priorities change if you happen to span a couple of different LHINs or you're in a couple of different municipalities. The need for meta-integration is really high.

Mr. Steve Lurie: Just a follow-up comment on that: It's actually a good-news story. Central LHIN and Toronto Central actually have worked together on coordinated access almost as an alternative to trying to merge organizations, to try and get the front door to work together. I think Camille Orridge spoke to that when she gave her testimony to this committee. It's actually quite a success story in that there is now one number to call, one application form.

Unfortunately, on the housing side, the waiting list has grown to 7,300 people from 700, when we first started the work. But the good news is that 42 people are waiting for ACT services and about 400 are waiting for case management. So it's one of those examples of when you talk integration, and you create a mechanism at the LHIN level, you also have to be able to go the next step and incent that by making sure the capacity exists so that you're not talking about just integrating a waiting list, but you're actually talking about creating better capacity and better access for people who require health care.

Mrs. Christine Elliott: Thank you, Steve. Those are all my questions right now, Chair.

Interjections.

The Chair (Mr. Ernie Hardeman): Questions?

Mrs. Jane McKenna: Thank you so much for coming. It was a good presentation here. I think the one thing that we heard over and over again was that—exactly what you're saying, right?—one hand is not communicating to the next. As MPPs, we'll say, ourselves, trying to get information for us is difficult enough, so I can't understand how anybody out there in the real world can get the information.

I get the fact that you've got subgroups, and you've got all these people and you're going to three meetings a week to talk to people, but if things aren't implemented, then what's the point of all this conversation?

I think what we've heard consistently is that we need to get our priorities straight, and put them down. I realize that one priority is as important as the next, but if we don't have some type of streamlining of where we're going and what goals we're going to, we're going to continue on the spin over and over again.

The other thing I'd just like to say is that I realize trying to get everybody in a room is very difficult, but in this 21st century, it is not impossible to get all these people together and talk through—there seem to be a lot of reasons why not as opposed to why we're doing it. So I think that's what I'd like to say here today. If you have any suggestions of how you do that, let me know.

Mr. Steve Lurie: I actually do, and it's not a suggestion I came up with. It's a suggestion that the LHIN Collaborative came up with when the 2011 mental health and addictions strategy was announced. They recommended use of the mental health and addictions networks in each of the LHINs to basically drive the kind of collaboration and priority setting that's required, because you can't do everything at once.

For example, I'm co-chair of the Central LHIN Mental Health and Addictions Network, and we recently presented to the provincial treasurer on what our priorities were. We had developed this list of priorities working with Central LHIN on their IHSP. So, just to give you an example, we came up with a list of more funding for supportive housing, continued funding for behavioural supports, continued funding for coordinated access projects, improving linkage to primary care, enhancing mobile response, and there's a list of others.

The point would be that the LHINs could engage with their mental health and addictions network in the context of, let's say, years four to 10 of the strategy and say, "What are the things we could do in two to three years? What are the things we could do this year?" Because you can't boil the ocean, but I think most of the mental health and addictions networks in the province, which CMHA across the province is part of, could provide that kind of programmatic advice to the LHIN. That way, it wouldn't have to be one size fits all. If emergency services is important, let's say, in Central LHIN but not in the South West, the mental health and addictions network can shape within provincial parameters.

Mrs. Jane McKenna: Thank you.

The Chair (Mr. Ernie Hardeman): Okay. The third party: Ms. Gélinas.

M^me^ France Gélinas: I'll start. We went back and forth. We both have questions.

The first question I want to ask—there was funding made available for mental health workers for schools. In my little brain, I always saw those workers going to your agency, but they didn't. They went through the community care access centre. So I will ask the three executive directors: What were the discussions that you had with your LHINs as to who was best able to offer that service?

You get to be the first one, because you're first on my list.

Ms. Marion Quigley: Our LHIN had no discussion with us. We brought it up with them and asked, what was the rationale? Because they were coordinated and looking at more than mental health—that mental health would also connect with primary care, with family—they felt that the CCAC was a better place to put the nurses.

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We actually brought all four CMHAs from the north to meet with our CCAC about it, prior to them starting

their job, and asked if we could help build partnerships with them, and we have. It has been fairly successful, I would say, up to now. The biggest downside I see is that there are not enough nurses in the schools. They're just meeting a small amount of individuals who need that support, but they are working collaboratively, the ones that we have in the north that I can speak to.

M^me^ France Gélinas: Sticking with the north—I still don't get it. You work with family physicians and you work with primary care at many, many levels. Why couldn't you have worked with primary care and family physicians at the school level?

Ms. Marion Quigley: We could have. That would be a question for the LHIN.

M^me^ France Gélinas: Okay. I'm going to go to Ottawa. How did it go—

Mr. Tim Simboli: I'm Ottawa.

M^me^ France Gélinas: Sorry. Toronto, then Ottawa—I'll just—

Mr. Tim Simboli: Toronto always gets the turns.

Mr. Steve Lurie: I guess it shows how truth travels. What we were told is that the decisions were not made by the LHINs, but that basically the ministry had decided that this is what was going to happen. After the fact, the CCACs actually have approached the mental health and addictions network, we've met with them and talked about how we might work together. But I think the issue is very much as Marion raised: It's a question of resources.

The other dimension of this is that there's a whole sector—the children's mental health sector—which is doing its transformation on its own. When you're talking about children's mental health and potential collaboration between the sectors, particularly around the needs of transitional youth, the LHINs actually can provide a useful table for those discussions.

In the instance of the mental health nurses in the schools, I know that our colleagues, certainly in Central LHIN, and I think in Toronto Central, were a bit perplexed about why there wasn't any conversation with them about how this was going to roll out. But I don't think it was the LHINs' fault; I think this was a decision made at the ministry level.

M^me^ France Gélinas: Okay. Sorry, Ottawa, you get to be—

Mr. Tim Simboli: It would be the same experience in Ottawa as Steve described: not a lot of discussion; it was kind of a command decision, it seemed, that came through. We didn't have an opportunity to debate it, and we haven't had much of a conversation since then about how it might roll out. We've done other things with youth and youth mental health, but it has not been associated with schools at all.

M^me^ France Gélinas: I'll start with Ottawa. Do you think your agency would have been a good host for those kinds of resources to roll out to the schools?

Mr. Tim Simboli: We participate in a network, and that network would have been a good host, and none of the people in that network are part of this. There's a thriving organization, the Youth Services Bureau of Ottawa, that we collaborate with an awful lot. They would have been instrumental in doing that sort of thing. As far as I know, they were never asked.

M^me^ France Gélinas: We are looking at making changes to the LHINs, so what kind of changes would need to happen? I'm not too impressed with what you're telling me happened on the ground. What kind of changes would need to happen so that things like this go to your mental health and addictions collaborative or network so that, next time, if there are resources, they are allocated in the way that the network has an opportunity to have input and influence? Any one of you can tackle that one.

Mr. Steve Lurie: I think Tim gave you the clue. The word is "network." It seems to me that the LHINs can make use of networks and they can help create networks where they don't exist. We've seen examples—the dual diagnosis initiative has rolled out over the last 20 years, where there was a dedicated professional to help staff a network, and then you build the linkages to services.

It seems to me that the LHINs have actually, to their credit, in seven years, changed the conversation. This is no longer what one agency can do on its own, but it's how agencies can act together and work together. So I think the encouragement for the LHINs to look at where they do need to bring tables together—I know, for example, that Central has brought the community support network and community mental health and addictions together to talk about quality issues.

It seems to me that you can be purposeful around networks and look at where it makes sense to have groups collaborate. For example, going back to children's mental health and the transitional age piece, that's not an issue that either the children's mental health group can solve on their own or the adults can solve on their own, so you actually need to create a table. But if you designate it as a network and you say to the network, "We're looking for your advice"—and in fact, at the beginning of the establishment of the LHINs, Kim's predecessor, Hy Eliasoph, came to our network and said, "The network is the group that the LHINs would look to on advice for investments." So it seems to me you can strengthen that role and build the collaboration at the program level, and also that the LHINs could see these networks as colleagues having to sort of take off their individual agency hat and work together to create a shared vision for where things need to be invested and how to roll out programs.

M^me^ France Gélinas: So from what you're telling me, am I right in thinking that, as legislators, we should make sure that if resources are going to be invested in a field that is covered by the LHINs, then we make sure that the LHINs have an opportunity to do their work of engagement in communication and consultation?

Mr. Steve Lurie: Yes.

Ms. Camille Quenneville: I just want to add to what's been said. I think this falls into the grey area that I referenced in my document around the housing example that I gave, but it's the same concept, where the Ministry

of Health is a direct funder and so are the LHINs. So in situations like this, it's a little ambiguous in terms of who's taking the lead.

I came from seven years in the child and youth mental health sector and was certainly there when that funding was provided, so I would concur with my colleagues that this was not a LHIN decision. It really was directly through that ministry, rightly or wrongly.

But at the end of the day, there is an appetite to engage and collaborate. If those dollars are flowed in such a way through the LHINs where it can go to a table in most cases and those decisions can be made with respect to service delivery, I think everybody benefits.

M^me^ France Gélinas: Okay.

Ms. Cindy Forster: Hi. Thanks for being here today. My question is very specific and it's kind of a follow-up to what Ms. Elliott raised.

We know there's a large number of inmates in correctional facilities in this province who have mental health issues or have a long history of a diagnosis of a mental illness. I had the opportunity last week to meet with a couple of nurses, who actually work in corrections, here at Queen's Park. They say that the ratio of a nurse to an inmate is 150 at a minimum and 250 to 300 at a maximum on a shift. Many of these inmates come out of a history of living in poverty, with no access to primary care. They may have multiple complex medical issues in addition to their mental health issues, and they have no access to CCAC funding or services. It's all done through corrections.

I have two questions. Are there any services available to these inmates with mental health issues, particularly, through CMHA? And if not, is this an opportunity to talk about some integration with respect to funding in corrections? Should that funding actually be through the Ministry of Health and Long-Term Care and filtered through the mental health system, as opposed to the corrections system?

Ms. Marion Quigley: I'll start. Right now, funding for supports for individuals in jail is provided through the LHIN through the Ministry of Health. That is discussed at the human services and justice provincial and regional tables. Most CMHAs that have court diversion programs would have a release-from-custody worker. They would have case managers, court diversion workers, and they do work quite closely with the social worker and the nurses in the jail. The capacity is more than the resources that we have, and it is an issue. It's an issue around medication for inmates when they first get incarcerated. So there are many issues around the jail system.

Ms. Cindy Forster: I think the other issue that they raised for me was the fact that they're not reporting in the corrections system to anybody with a medical background; they are reporting to a military regime type of superintendent. Right?

Ms. Marion Quigley: Well, there is a superintendent, but there are psychiatrists. I can speak to the Sudbury experience, and there are psychiatrists and a family doctor who go into the jail. The nurse works quite closely with them, and so do the staff of the CMHA program, for court diversion. I'm not sure if my colleagues can expand.

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Mr. Steve Lurie: I'd like to do it in two respects. One is about the services available. As Marion said, CMHAs and other community mental health providers in the province—and certainly in Toronto and Central LHIN, there's a range of services available. There are safe beds, or what we call crisis prevention beds. People who don't necessarily need to be taken to hospital and shouldn't be taken to jail can access those beds, where there's a comprehensive plan and stable housing for a month. But it's only a month, so if there's no housing at the other end, you've got a problem.

We operate in two of the five courts, but we lead a court support consortium here in Toronto. Again, the same issue: People are able to access services when you do have a court support program, but then it's what's behind that. So if somebody has, let's say, a concurrent disorder and there isn't sufficient concurrent-disorder capacity, you've got problems. The mental health and justice housing that was funded from 2004 to 2006 in Toronto has been a tremendous success: close to 500 supportive housing units. We've done an analysis where the average length of stay of people who were going through the justice system with mental health issues is four years of successful tenancy, but those beds are now full. You can't get at them. So I think there are services, but I think the other piece is that the demand is far greater than the services that are available.

Greg Brown from your part of the province did a wonderful study a few years ago where he looked at the incidence of mental illness in the Ontario correctional population. He looked at 300 in-patients, and what he found was that about 40% of the inmates, in fact, had a diagnosable mental illness, but only about 6.9% were serious mental illness. However, something like 28% of a predominantly male population had reported being victims of abuse, 60% of the total population had been victims of abuse or had observed abuse, and 66% had a concurrent disorder.

I think the jails are really under-resourced, and that's not where you should be getting your mental health treatment. Paul Kurdyak, who's doing the work for ICES—we met with him recently. He said he has been looking at the OHIP records of people in the provincial jails, and what he finds is that, for many of the people with mental health problems, the first time they see a psychiatrist is when they're in jail. That's not a LHIN problem; that's an overall resource problem.

The other part that I think is something that, as legislators, you could recommend is that—even when the program services are available, one of the problems that we see across the province is access to physicians and psychiatrists. Many psychiatrists don't want to follow somebody clinically if they've been involved with the justice system. They seem to think it's forensic.

There's a good-news story on the forensic side: Both Tim's branch and my branch have been partners with the

Ministry of Health in what's called the transitional housing program for patients who are high-need, not so much in terms of risk but in terms of activities of daily living. These are people who've been in psychiatric hospital forensic units for a long time. We've been able to successfully integrate them into the community. This is now spreading province-wide, but again, once you finish your 18 months in transitional housing, you need some other housing to live in.

I think there's lot of evidence of the fact that the Ministry of Health's initial investment, in the earlier part of this century, in mental health and addiction programs focused on the population who was involved in the justice system was a good thing. It's just that we need a lot more of it.

Ms. Cindy Forster: Thank you.

Mr. Tim Simboli: Could I throw my two cents in?

Ms. Cindy Forster: Yes.

Mr. Tim Simboli: There's an overwhelming problem that underlies all this, and that's the criminalization of people with mental illness. As Steve says, sometimes the first time they get any help at all is after they've broken the law. The other thing is that we've got to remember the sheer volume of people who are clogged in the system. There are almost as many people on remand as there are who have been sentenced in the system. These are folks who are clogging up the system constantly. Our failure happens before the doors of the courtroom. If our successes could happen before the doors of the courtroom, then everybody is going to benefit. It's going to reach a tipping point where that, in fact, can be resolved.

Ms. Cindy Forster: So if the resources were at the front end, we wouldn't experience the expenditures that follow?

Mr. Tim Simboli: Absolutely. Yes.

Ms. Cindy Forster: All right.

M^me^ France Gélinas: Do I still have time?

The Chair (Mr. Ernie Hardeman): Oh, you have plenty of time yet.

M^me^ France Gélinas: I'm on the top of page 4, just before the heading "Funding." I don't know if your document is identical to mine, but the second-last sentence: "There are currently far more ministries than there ever have been focused on mental health and addictions, and there are structures and processes within government that could link them together. They need to be utilized."

Could you elaborate on this with a view of, we are here to review the LHINs? Do you see a role for the LHINs regarding what you had stated in there?

Ms. Camille Quenneville: Yes, although perhaps somewhat indirectly. What I think we're referencing here specifically is if you looked at the machinery of government and were able to put all of those ministries that have some involvement in mental health and addictions together regularly to provide perhaps more direct engagement, if you will, on where funding should go. It's a little indirect to the LHINs, in that it's more an opportunity—given that there are nine, at last count, ministries—to put them in a room together on a regular basis to coordinate the services a little better from a provincial perspective before funding flows to the LHINs so there is perhaps more clear direction. Again, that can be done a number of ways.

M^me^ France Gélinas: I saw that you opened up your remarks by saying that you're not interested in Mental Health and Addictions Ontario, which was to bring those—there were 11 at the time—nine ministries together so that we give mental health and addictions a home, the idea being that those nine different pots of money that end up in our community funding different things are often at cross-purposes and have silos of their own.

Ms. Camille Quenneville: I think the point really was to say that we don't think we need to build another structure that would be a larger overriding mental health and addictions structure. I think there's a lot that can be done to coordinate services better within existing structures. Whatever money you would want to spend on putting that together could be better spent providing direct service.

M^me^ France Gélinas: So you're saying that you think that it would be sufficient for those nine ministries to have a meeting together every so often—

Ms. Camille Quenneville: Right, but I would think it would be something more significant than having a casual meeting together. I think what we're contemplating is—and again, it's not just our organization but our community partners who have come together to think about this: Is a cabinet committee an option on mental health and addictions? Is there a Premier's council? There are lots of things that we could look at, the idea being that—I have to tell you, I've sat through some of the other presenters before this committee. This was before Christmas time. I recall one of the presenters referencing, kind of with anguish, that there are nine ministries now, like: "Isn't it awful?" As somebody who has been in the field for some time, although not nearly as much time as my colleague Steve, I wanted to cheer from the back row because I thought that it was a few short years ago that we were trying to get two other ministries interested in mental health. If it's on the agenda, let's put it on the agenda formally and build a structure of government around what the priorities are and how we want to proceed.

M^me^ France Gélinas: Given that the treatments for people with mental health and addiction are often based on the social determinants of health and go way beyond the Ministry of Health but yet your funding comes to you through the LHINs, would it make more sense to broaden the mandate of the LHINs so that other pieces of government that support the social determinants of health that your clients depend on also are coordinated by the LHINs? Give them, not necessarily funding, but authority to plan?

Ms. Camille Quenneville: My sense is, not necessarily an expansion of the mandate of the LHINs. I do think—having worked in government myself, and I've seen it happen with great success—it's a matter of ensuring that the internal structures of government are

there. I quite agree with you: It is much broader than Ministry of Health funding.

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But if clearer direction comes from the province and it's done through a process where all of those ministers are at the table, and potentially with an advisory committee of other community partners who raise these issues on a regular basis and inform a cabinet committee or another type of vehicle, I think we could have great success with that.

Do my colleagues want to add anything?

Mr. Steve Lurie: Yes. I think actually there was a precedent. The mental health and justice funding that rolled out through the LHINs between 2004 and 2006 was driven by a multi-ministry table. Then the LHINs and actually the ministry regional offices which preceded them rolled that money out. So I think there's the notion of what the Mental Health Commission calls in their national mental health strategy a whole-of-government approach, which I think is absolutely critical so that all the departments involved have a plan and decide how they're going to work together.

Certainly there has been experience in the UK in what they call pooled funding. We had a small example of that with the mental health and justice funding, although it was the Ministry of Health that had to come up with the money, as opposed to the other ministries. But the point is that you could have a pooled-funding approach and then, if it made sense to administer it locally through the LHIN, you could do that.

We did some work through the Mental Health Commission looking at the housing side. Ironically, it was the province of Newfoundland that had a one-government-window approach. It didn't matter what target group you were doing the housing from; there was one place you went to get at least the housing dollars that you could then match the service dollars to.

So I think it's this notion of building on a whole-of-government approach, a pooled-funding approach, and then stepping back and saying, "Are the LHINs our vehicle at the regional level or do we need something else?" because in some cases, for example, you've got to bring in the municipalities.

While we're on housing, I wanted to make a pitch, just to follow up on Camille's earlier remarks. The LHINs are to be commended. Toronto Central and Central put money out for housing first. That was based on the experience with the Mental Health Commission's At Home–Chez Soi project, which showed that you could improve housing outcomes for people, that 70% of people were able to be stably housed, as opposed to 30% who got treatment as usual. But the problem is there's no money for rent supplements. There's no money for housing. So how can you do housing first without the money to rent the places or, in parts of the province where there's no rental market, make sure you can at least access the housing? That's where that whole-of-government approach is so important, that the service dollars and housing dollars come together somewhere.

M^me^ France Gélinas: You're going exactly in the direction that I wanted you to go. Maybe I'll pull in the other two. If you look at the integrations of the different parts of government or the whole of government, as you are calling it, to better meet the needs of the people who have mental health and addiction, who live with mental health and addiction, it—I have a hard time spitting it out. You said, "Let form follow function." So is it more important that we focus on bringing the whole of government, bringing this cabinet committee or whatever it's going to be called—that we bring all of the different ministry players that help people with mental health and addiction, and this is housing and poverty and jobs and health care, or is it more important that you be integrated with hospitals and long-term-care homes at the LHINs level? I'm trying to see how this fits. We've been on this long enough. Almost every community support service agency loves the LHINs. They are respected; they are talked to; they are listened to; they are participants. We get that.

I'm a step further than this as to, to meet the needs of your client, you need way more than health care to come together. I don't see it happening through the LHINs. You seem to be agreeing that a big part of it will come from outside of health care.

How do we marry the two? What's the place for the LHINs? Why are you under the LHINs when you maybe should have something that focuses on mental health and the social determinants of health to help the population you serve?

Who wants to tackle this? We'll start with Ottawa.

Interjections.

Mr. Tim Simboli: Thanks. I feel like I'm in school again, and I was just called upon to answer a question I didn't study for: "I didn't know this was going to be on the exam."

The things that work in my world are making sure that the work gets harmonized. It doesn't have to be brought together all at once in one grand, super-organized kind of way. I think—borrowing on complexity theory—it's chunked. It's a little bit here, a little bit there.

The two things that I would say are probably guiding principles for this are that in my world, if the integration between organizations only happens at the ED level, it doesn't work. If it only happens at the front-line level, it doesn't work. It's got to happen at multiple levels.

The second part of it is that the funding stream, the government stream, the folks who feed us the money to do the good work with, need to be every bit as integrated as they expect us to be on the service side, and that's not happening.

Where it does happen, there are wonderful things to show for it. There really are. There's success out there. It's not like we're wishing for things that, "Maybe this will work and let's try it. What have we got to lose?" There are examples of coordinating bodies that actually work. They don't have to be universal or across the board, but they do need to have some involvement at every level, as a whole-of-government approach, starting

and working its way down. I think it can be as simple as sharing priorities and sharing the new things that are coming out so that you don't have to cover all of the existing stuff.

Start someplace; start with the new stuff. What are the priorities for funding coming out of one department compared to another or one level of government compared to another? I think it's almost that simple at this stage.

M^me^ France Gélinas: I'll go to the north—your take on it. Is this what I call horizontal integration, where you have housing and income and mental health, correctional services and Attorney General—all of this brought together, or this way, where you have the LHINs and you get your health funding like the hospitals, the long-term-care homes and the mental health?

Ms. Marion Quigley: To me, it doesn't matter where I get the funding from. I just need the funding to provide community supports. So whoever wants to give it to us, we're here. That being said, you need to have a system that coordinates the work, but then you also have to have the services on the ground that can implement, so that there's change for individuals. Whether the money flows from the LHIN—we have mechanisms, I would say, across this province, with CMHAs, where we're talking to each other.

From a community perspective, I think everybody does talk well together. We have our differences once in a while, but we're looking at what is the best way of providing service to the system. Where it breaks down is, we don't have enough service capacity to provide the housing supports or to provide case management. We can do lots of talking, but we have to have the programs to implement.

Looking at those multiple ministries from a larger scale helps to find out what everybody is doing, because you need to have direction to come down to implement.

The Chair (Mr. Ernie Hardeman): Speaking of talking together, we're going to let the government participate in this conversation. It's going to the government: Ms. Jaczek.

Ms. Helena Jaczek: It'll be a continuation of the conversation. I'd like to start off with Drummond's recommendation around integration, acknowledging totally what you've said about forced mergers not necessarily achieving the benefits that instinctively one assumes there are going to be savings at some level—certainly not at the front-line level, possibly at the ED level if you're going to merge two organizations, though often not. Often there's one ED and one assistant ED in merged organizations.

I think what Drummond was getting at was that it was a logistical problem for LHINs to put together service accountability agreements with so many different agencies. As I think we all freely acknowledge, there has been quite a bit of concern that the LHINs are an administrative, bureaucratic body with excess administrative costs to the system as a whole. So it struck me that that was more the argument from Drummond's recommendation, that it would simply be so much simpler to manage the system if there were fewer of these agreements. Do you have any comment on that?

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Mr. Steve Lurie: Yes. I think you could get to fewer agreements without necessarily merging organizations. In fact, I think it's really important to do the due diligence on most of the mergers in the public sector. The ceiling becomes the floor, and so, often, you get increased wage costs by the partners coming together and you actually don't add services. Camille laid out the principle: Is it going to be better for people? At the end of the day, if you're talking about a merger, it's not how many organizations a LHIN can manage; it's whether more people are going to get better service. If you can argue yes and that a merger is the way to do that, then you proceed.

But I think that it would be possible—especially since one of the areas that I think the LHINs have started to look at is, you've got the regional table at the LHINs, but you've also got, increasingly, especially with health links, local tables that are emerging.

So it would be possible, for example, in Scarborough or North York, for the Central East LHIN or Central LHIN to have a memorandum of understanding or an M-SAA with all the partners about what they're going to provide in that locality. You'd have to build a process where people would learn to negotiate together, but I think you could reduce the number of M-SAAs by looking at sector-based work.

You could, if you wanted to keep it at a LHIN level, conceptually do an M-SAA with the mental health and addictions network, where people could still specify their units of service. One of the challenges that I think the LHINs face is that they actually have fewer resources than the Ministry of Health regional offices that preceded them, and they don't have an ability to do program management. So I think that there are some creative ways where the LHINs and their partners could figure out how to have fewer M-SAAs to administer but better service.

I think that there is also lots of work that is now going on. Camille referenced in her brief the collaboration that's going on with the LHIN/M-SAA table around improving data quality. So I think that if we start to look at what the critical things are that we should measure and at what levels we measure them, and how we resource the system appropriately, I think that there are ways that you could at least be more efficient.

But I don't buy the notion that having fewer organizations necessarily reduces the complexity of the system, because you still—for example, in my organization, a manager of a case management program supervises 15 staff. That's about what it should be, and I think that's the other side of this. We've sort of built structures, but you need to look at what needs to be in place for the service you're trying to operate. This is where, for example, the coordinated access project that I've mentioned previously—that brings together 31 supportive housing organizations and at least another 20 to 25 case management and ACT organizations, including CMHA.

We are all signing—we all have memorandums of understanding with the coordinated access group here in Toronto, so there's no reason why you couldn't build on that and say, "Okay, what services are you going to provide?" and they could report on our behalf to the LHIN. We'd all be signatories.

Ms. Helena Jaczek: So in other words, a more flexible way of structuring those service accountability agreements.

Mr. Steve Lurie: Yes.

Ms. Helena Jaczek: Now, since there are quite a few members from the select committee on mental health here, of which I am one, the reason, of course, that we did suggest Mental Health and Addictions Ontario was because, since time immemorial, we've had all these ministries involved in mental health. They've been given every opportunity to have some sort of structured meeting to bring the pieces together, and it has never happened. Our recommendation, definitely, was to, I think, challenge the government, to say, "This has got to work."

Since we produced our select committee report, have you seen any more efforts between all of the ministries to work together? It has been two years—actually, it was 2010; three and a half years.

Ms. Camille Quenneville: Yes; it's hard to believe how time flies.

We have. I've seen concrete examples of the ministries of children and youth services, education, and health coming together very regularly, along with the Ministry of the Attorney General. We work very closely with many ministries because we have such a broad base of policy work that we do. So it's certainly better than at any time that I recall. There's far more collaboration.

Mr. Steve Lurie: Especially on the human service and justice file. There has been a real effort on the part of the Ministry of Health, as the lead in that, to work with the Human Services and Justice Coordinating Committees, both provincially and regionally. For example, the police project that they just completed was a joint venture. I think those are the kinds of things that can be built on.

Back to our earlier discussion: If you had a whole-of-government approach to the next iteration of the mental health strategy, and you said, "In the next three years, we're going to focus on housing, employment and concurrent disorders," then you would bring together, hopefully, the relevant parts of the system, both at the governmental level and then, ultimately, at the community level.

If it was going to be housing and homelessness, you would certainly have the mental health and addiction folks who are involved in that area, but you might also be involving the municipalities and you might also be involving the LHINs, and then there could be a decision made about, "Is it a pooled-funding envelope that we'll ask the LHINs to administer, or will the money go to the municipalities, and the LHINs will contribute their share through that mechanism?" because I think there's no perfect structure to fund.

What my colleagues have said is that you need to, at the governmental level, if there is going to be a 10-year strategy—what are the priorities? Importantly—and the WHO did some research on this—jurisdictions that didn't set targets and didn't allocate funding didn't meet their objectives. If you come up with a mental health and addictions strategy, saying, "We're going to do all these things," but don't specify the money available, then you won't hit your targets. But if you did come up with a plan with targets and funding, then you'd have the flexibility, as you mentioned earlier, to say, "In this instance, should we actually ask the LHIN to take on the convenor role, or is this a better job for the municipality because they have more action in it?"

I think the important thing is to get away from the siloed behaviour where the municipality would say, "That's the LHIN's problem," and the LHIN would say, "No, it's your problem in the municipality." There are areas, for example, for people with complex issues that we're going to see in the health links where the CCACs and the mental health sector need to be able to come together to deliver the right range of services, because the mental health sector isn't funded for personal support workers, but the CCAC envelope provides that opportunity.

Ms. Helena Jaczek: Did you have something?

Ms. Marion Quigley: I just wanted to add that in the last year we've seen in the north a real increase in the youth ministry bringing the school boards, the CCACs and the adult mental health system together to work on collaborative projects and to really look at how we can work better together and transition youth into the adult system, so I have seen an increase there.

Mr. Steve Lurie: Again, because I think it's also important in your review to look at the things that have worked well: The behavioural supports initiative that the LHINs and the Ministry of Health rolled out for seniors with behavioural disturbances and dementia is actually one of the best examples of that focused collaboration. What happened was, the ministry and the LHINs developed a provincial strategy and then, in each LHIN, they pulled a series of partners together to both deliver the service and implement a quality improvement approach as they go. While I'm sure the people who were involved in that initiative would say they need more resources, they also can tell you that the resources were targeted appropriately and that they have learned from the things that didn't work. So this kind of, "This is our project for the next three years, here's the money attached for it, here are the partners that need to come together"—those things work really, really well.

Ms. Helena Jaczek: If we could just turn to resources, our wonderful researcher Carrie has put together some numbers for us. When it comes to the Central LHIN, for mental health and addictions she has been able to determine that there are some 661 people actually working in mental health and addictions, compared to Toronto Central with 1,794 employees. Now, that's a threefold difference, and I would hazard a guess that in the Central

LHIN, most of those workers are actually within the Toronto portion of the Central LHIN, the North York portion.

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How are you as an association looking at these types of discrepancies across the province in terms of resourcing and hopefully advocating to have some sort of equity of opportunity to access those services? What sort of table do you use to do that?

Ms. Camille Quenneville: Well, I speak directly to government, elected officials, and senior bureaucrats. It's generally in a context not specific to staff in LHINs, to be quite honest, but rather more global figures around our funding not being nearly as high as it should be. So in our report, thanks to Steve, we reference the fact that the Mental Health Commission of Canada indicates we should be spending 9% of our health budget on mental health and addictions, and we're spending 3.2%. We don't tend to get into the nitty-gritty of how many staff or what's happening in each independent LHIN, but rather to say that from a provincial perspective there are not nearly the resources that there need to be—

Ms. Helena Jaczek: In total.

Ms. Camille Quenneville: —in mental health.

Ms. Helena Jaczek: I'll have one last question, and then my colleagues, I know, want to jump in. When you have a client attend one of your agencies, do you find out where their place of residence is, and is that reported in any way to government, to the LHIN, to anyone?

Ms. Marion Quigley: Not to the LHIN, but we keep it within our documents, and we can show the LHIN where we have capacity, where there are individuals living, like in the downtown core or in the southern part of the city. Steve?

Mr. Steve Lurie: Yes, we can track the number of people from Toronto Central LHIN who use our services, the number of people from Central and the people from Central East, because we provide in Scarborough. I would make a point that, for example, most of the resources in Toronto are concentrated downtown, right around here, not in North York, not in Etobicoke and not in Scarborough. So even within a municipality like Toronto, you've got huge, huge resource gaps.

I think the critical thing is to start with the recognition that one in three people with a mental health issue is fortunate enough to get services. You've got basically six or seven people out of 10 who don't get services at all. So when we're talking about how many staff should be delivering the services, we have to look at, what would it be like if our goal was to meet the needs of 70% of the population rather than 30%?

Ms. Soo Wong: Thank you very much for your presentation. I'm here also on behalf of my colleague who had to leave early. We both have similar questions dealing with mental health nurses in our schools.

If I heard the presentation correctly, you commented on the fact that the ministry, all the LHINs, never consulted your association when it came to the rolling out of the $257 million when it comes to children and youth mental health in the system. So how do we improve it? Because at the end of the day, that's what this committee is charged with: to improve the system. Consistently, we heard that across the city of Toronto we have five LHINs and now multiple bodies going in, and yet we're not getting enough services from the mental health nurses in our schools. So can you suggest to this committee how we improve that? Because very, very clearly, your agency, being the lead agency when it comes to mental health, has not been consulted. How do we improve that delivery? We have funding, yet it's not getting to our front-line young people.

Ms. Camille Quenneville: Right. Our understanding is that the Ministry of Health directed those dollars specifically, and it didn't go through funding for the LHIN. So as a result, that left out processes which exist around the province in communities where those collaborative relationships come together and decision-making is done about how to carry out specific service. So to answer your question specifically, let's just erase the grey area where the Ministry of Health provides that direct funding in those instances and instead provide it to the LHIN so that it can remain in the existing processes.

Ms. Soo Wong: Right now, the LHIN is responsible for the funding, but it's going through CCACs, not through public health agencies across Ontario. The concern that we have consistently heard as MPPs in our area is the fact that the public health nurses are in our schools, yet they don't have funding to deal with this mental health piece. So I'm asking you, as the expert in the field, how do we improve the delivery? Because very, very clearly, the CCACs are not able to get into the schools, into the classrooms, to support young people. How do we improve that?

Mr. Steve Lurie: First of all, I think in that particular initiative there was a limited amount of money and they were looking to get it out quickly and they felt that the CCACs had the infrastructure, so the decision was made. But I think if you step back, it's a dialogue with school boards about, "What are your mental health needs? What kind of services do you need on the ground?" and looking at what is the experience in other jurisdictions about that kind of delivery—

Ms. Soo Wong: The school boards weren't even consulted.

Mr. Steve Lurie: Well, that's my point. You have an opportunity to improve these kinds of approaches. One of the nice things about innovation is that most of the time you fail and then you learn from it and you scale it up and you try to do things better. I would argue in this instance, if there have been gaps in the mental health nursing in the schools, it's a good opportunity to talk with the schools about what went right, what went wrong, look at what other jurisdictions have done. And sometimes you need benchmarks. If there's a jurisdiction that says, "Well, actually, for every thousand students, we need one nurse," then that becomes your target.

I think what happened here was there was a decision that it would be a good thing to put some nurses in the schools, but some of the mechanics of how it might work

and the consultations about the best way of doing it didn't happen. But I don't think it's too late to revisit that with the sectors involved to say what would work.

At the same time, there was money, as Camille knows, given to the children's mental health centres. Many of them are working in the schools as well, so there could be an opportunity to say, "If our goal is to improve school mental health service, what's gone right about the past initiative over the last three years and what could be improved?" and to encourage local communities to come up with plans.

Ms. Soo Wong: I also have a question on page 5 of your report—as a matter of fact, several questions.

You talked about "Funding transparency"—that's the heading there—and the last point that you commented was, "This points to the need for better coordination more than anything else—strong partnerships must rely on healthy communications" etc. Can you be more specific when you talk about better coordination in terms of the funding transparency?

Ms. Camille Quenneville: Sure. I think with that point, we were referencing some feedback that we had from one of our branches where they had had a number of very successful programs. Not surprisingly, within communities there is a lot of competition for dollars. New programs start up, and funding is stopped for existing programs and given to new programs, so there doesn't seem to be a lot of coordination in terms of how those decisions are made. The feedback we received was that if that was a somewhat more transparent process so that the agencies could better plan in terms of service delivery, that would be a positive thing.

Ms. Soo Wong: The other question I have is that on page 6, you talk about the inconsistency of definitions.

Ms. Camille Quenneville: Right.

Ms. Soo Wong: Can you elaborate for the committee on this whole clarification? If there are challenges between different LHINs in terms of interpretation of the definition, does your organization centrally write to the ministry to ask for clarification or do you get stuck in a local LHIN to get it interpreted?

Ms. Camille Quenneville: Well, I think Tim made the point earlier that a lot of the LHINs—when we come together as an organization, as we do regularly, and we talk about the direction the LHINs have provided, very often it's quite different. The example cited here is that when we talk about the administrative part of our budgets, in some cases the LHINs would say that your rent is included and it would be a higher percentage of your budget. In other cases, the rent was not included and it was a ridiculously low, frankly, part of the budget that was allowed. It just struck us that if there was some consistency in terms of how all of the LHINs were defining these things, it would be so much easier for our organization, to say nothing of all the other community-based organizations, to share best practices, to come together, to collaborate more easily.

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Ms. Soo Wong: Has this been brought to the ministry staff about this confusion—

Ms. Camille Quenneville: Yes, absolutely.

Ms. Soo Wong: —and were there changes made after you brought that to their attention?

Mr. Steve Lurie: It has actually been brought to the LHIN/M-SAA table, and there's a group now that is looking at what should be the amount of money spent on administration and how it should be defined. We were quite happy at that table, where there was an agreement that the LHINs would have a look at it and then bring it back to us for discussion.

But I think the more fundamental problem is—former Minister Smitherman asked David Reville about five or six years ago to look at this myth about too many agencies and high administrative costs. He came out with a report that actually encouraged partnering and actually demonstrated that there was a lot of partnering going on at the service level, but that most community organizations didn't have much in the way of infrastructure. So the assumption that our administrative costs are too high is something that really needs to be tested.

For example, my organization—I've got about 300 staff and two people to run the IT, and that's a real challenge. I've got one and a half people for human resources. I think we need to be very, very thoughtful about how we define administration and, for example, what it should be used for. When money gets tight, the first things you start to cut are things like staff training, but, in our field in particular, the ability to train staff and encourage their learning and help them with career development is critical. So I think not only consistency in definitions but a thoughtful approach to how it's going to work is very important.

Ms. Soo Wong: And then my last question: I notice that in your entire presentation, you never alluded to the diversity of the province, the challenge of delivering diversity and so many different groups across Ontario. So I want to hear your comments and/or your suggestions, because one size doesn't fit all—

Ms. Camille Quenneville: Yes.

Ms. Soo Wong: —and definitely we see the concerns across my riding in Scarborough but also across the greater Toronto and Hamilton area in providing adequate services to the diverse community. Steve, you talked about the Chinese community, but there are multiple ethnic communities in the province. I was just surprised in your presentation that you didn't make any effort to talk about that.

Ms. Camille Quenneville: Yes.

Ms. Soo Wong: If you could elaborate, that would be really helpful.

Ms. Camille Quenneville: Well, I appreciate that, and I appreciate the feedback. I can tell you that we have, amongst our small staff, one full-time person who works on health equity policy, and we have considerable work that we've done in this area that has educated and helped to provide service for multiple organizations.

We're actually seen as leaders in this area. I can point to probably 20 areas off the top of my head that I didn't get into today because, again, our policy work is so

diverse. So, while you're quite right in pointing out that that was absent, this wasn't really an attempt to look at the diversity of the policy work we're doing.

That said, I can tell you that, as an organization, the Canadian Mental Health Association, Ontario division, has undertaken significant work in terms of our own board, diversity and equity, and we hope that serves as a guide as well.

I'm really very proud of the work that we've done in this area. Our staff person Sheela Subramanian, who does the work, is well regarded across the LHINs that she has worked with, and has provided great knowledge transfer in this area.

Mr. Steve Lurie: I think, since you did mention Toronto, we know that we're in one of the most diverse cities in the world. Toronto is actually a majority minority city, where over 50% of the population are visible minorities. So our branch, for example, has a program that is targeted at the Tamil community, the Somali community and the Afghan community. We've just engaged Dr. Lin Fang at the faculty of social work to do a review of it, which shows that actually their ability to access targeted case management services using case aides from their community really had a good impact on outcome.

We've been very fortunate with the LHINs. For example, in that access project I mentioned earlier, we did a health equity impact assessment as that was being developed. We recognized that, for example, to assume that the Somali community or the Chinese community or the South Asian community would necessarily go to some central access point to try and get services—so we built in that with organizations like Across Boundaries and Hong Fook and ourselves that had dedicated programs, there would be abilities to build those access points within communities. So I think you're absolutely right; it's a critical issue.

The LHINs have also been quite helpful in funding interpretation services. Both Toronto Central and Central have made money available for us actually to increase the language capacity both on assessment and involved in service delivery. So while it wasn't mentioned formally in the brief, it's top of mind for many of our organizations.

Ms. Marion Quigley: I'll just add, too, that I would say most branches in the province of Ontario also look at it. I can speak to Sault Ste. Marie looking at having their brochures interpreted into Italian. In our community, it would be French and English and aboriginal.

The Chair (Mr. Ernie Hardeman): Three minutes left. Mr. Colle.

Mr. Mike Colle: Steve, I think you mentioned something about an initiative with the police, I think taking place in Toronto, in terms of intervention with mental health situations. Has there ever been a quantification of how many dollars the police are using in terms of their resources in being first responders to mental health situations?

I've mentioned this before: I talked to my local superintendent. He said that the number one cause of calls in his division are now the calls for mental health issues or addictive behaviour issues—drug addiction etc. Essentially, if he goes through his logbook, he can see that it's basically repeat situations where people with personality disorders or mental health issues, that are on remand or whatever it is, are almost the number one—it's no longer the domestics, and it's no longer the violence on the streets; it's basically mental health issues.

Mr. Steve Lurie: Well, I think two years ago the Ontario chiefs of police had done the calculations, and they said that they don't want to be the first responders, and this last summer the Canadian chiefs of police said the same thing, so that's a statement about the lack of mental health services and the gaps on the ground.

But I know in Toronto, Mike Federico, the deputy chief, has tabled some interesting perspectives about the number of calls. Toronto police get, I think, three million calls a year, of which 20,000 relate to mental health, and they end up apprehending about 8,900 people a year, so in some divisions that would be a lot of calls, depending on location. I haven't seen the comparison with other types. Deputy Chief Federico simply identified the number of mental health calls they get.

I think everybody would agree that when mental health services aren't available to you and you're worried, or you don't even know what mental health services are available and you're worried about your safety, you call the police. For example, in Toronto, we now have had an expansion of the police crisis intervention teams, and most of the divisions will have them, but they're not available 24/7, unlike COAST in Burlington and Hamilton.

Mr. Colle, it's a big issue, but I think you have to come at it in two ways: One is the lack of resources in the civil system, which then have people defaulting to the justice system because they're scared and they don't know who to call.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. Any further questions? Ms. McKenna.

Mrs. Jane McKenna: The beauty of this committee is to have your recommendations, and then we get together, obviously, because it is about being patient-centred—and doing what's best for the patient, ultimately, in the end, is what we're trying to get to the bottom of here.

I guess I struggle at times, because if we're not part of the solution, then we're part of the problem, so I want to go back to two questions. Ms. Wong said that the school boards weren't consulted and, Mr. Lurie, you said that you obviously learn from things if they're not done properly the first time. I guess my question to you is, where is that information put so that next time we don't do it again? I guess we're always learning from the mistakes that we make, unless there's something that we're implementing to change it the next time around. Where does that information go, besides saying that here? Who gets the recommendation that the school boards weren't consulted from CCAC?

1650

Mr. Steve Lurie: Well, I would think that if that's been a concern you've heard, not just from us but from others, if that becomes part of your report, the operating ministries would obviously have to respond to it, and should respond to it. I think if you were to recommend that they revisit and evaluate the initiative of the last three years, and what's gone right and what hasn't gone right, and how it could be improved and come up with improvement plans—I mean, that's what quality improvement is all about.

It's always easy to catalogue all the problems, but I think it's also important to be able to identify the things that have gone well. So with respect to the LHINs, I mentioned the behavioural supports program, which was really a success; and the fact that the LHINs have been able to develop and support mental health and addiction networks that they can build on. But I think, again, we talked about whole of government. Hopefully, your report will be read by the government of the day, and then the things that you're recommending in terms of improving the system, the various ministries that need to be involved in the implementation—I think that the important thing that Camille's remarks talked about, and that we've tried to address, is the importance of engaging the community locally, to make sure these things actually happen, because if it's just a report to government—

Mrs. Jane McKenna: Yes—

Ms. Camille Quenneville: If I could just respond in part, as well—I appreciate your concern around this, and I think it's worth noting that the Ministry of Health is actually reviewing the process under which those dollars were provided and the program itself. I know that was built in when it was originally announced, that it would be reviewed. I think they've had considerable feedback and questions about how some of that was rolled out locally. So I think that they will have that information available to them.

Mrs. Jane McKenna: I guess, when we're talking about the cabinet committee that you spoke about earlier and looking at the inefficiencies, I have a two part question here: Who is saying what the inefficiencies are, and how effective are you finding that with the gaps and the overlay that there is?

Ms. Camille Quenneville: I'm not sure—

Mr. Steve Lurie: Inefficiencies in relation to?

Mrs. Jane McKenna: Well, if there's gaps and duplication, who is saying what gaps and duplications they are? I guess my question is, there's lots of information here, and the most important thing is that we have to look in-house first, because ultimately in the end, if there isn't any more money, the people that are going to be affected are the people on the front line. Right? Especially in government—it's the exact same thing here—when the money's gone, you've got to look at in-house, to figure out where that money needs to be to make things better, so that people are still getting the services that they need. If you have the cabinet committee identifying the gaps, what is actually happening with that information? So you can see where you've got duplications, so you can look to see where money is being wasted, I guess, is my—

Mr. Steve Lurie: I'd first challenge—I mean, there's a lot in rhetoric over the last 20 years about all the duplication in the sector. First things first, we can estimate based on the health indicator tool—it's not an estimate, it's actual: Last year, 441,000 people used community mental health and addiction services, which is far more than used hospital services. But if you extrapolate from the Mental Health Commission statement of 6.7 million people living with mental illness, that would suggest that there are probably over two million people in the province who need services. Rather than focusing on duplication, I'd be focusing on, did two million people get the mental health service they need, and how?

Then, I think in terms of gaps, that's where the LHINs have been able to, through system planning and through their IHSP process, have a dialogue with their respective communities about what are the gaps in service. That's where the service registries, whether it's the mental health and addiction access to case management—we in Toronto now can tell you that there are 400 people waiting for case management, 42 people waiting for for ACT and 7,300 people waiting for supportive housing. I think if you had that capacity across the province, that would help you decide where you need to invest.

Mrs. Jane McKenna: So who's responsible, I guess my question is, for the two million people who haven't been seen?

Ms. Camille Quenneville: Could I just take a step back to your last question with respect to looking at gaps and inefficiencies? I think it's useful to note—and we talked earlier about a cabinet committee or a similar type of structure internal to government. By its very nature, when you put those cabinet ministers around a table, however many there may be, you are in essence bringing the machinery of government together, because all of those ministries have to get in line around the agenda of that cabinet committee.

It's not as though we can today tell you where the gaps and inefficiencies are, but I think as those ministries come together it will allow for a better dissemination of priorities to communities, funding to LHINs and overall direction of governments.

When we look at years four through 10 of the strategy, if it had an accompanying—as Steve pointed out, certainly the dollars that need to go with it, but also the internal structure within government that will drive that. Frankly, as we've all talked about today, it is more than the Ministry of Health. It's not simply a matter of saying the Minister of Health is responsible. It is across government.

Are there gaps and inefficiencies? I would argue that we operate on a shoestring and we do the best we can. We don't have enough money. But I think if we come together and collaborate, it would become very evident that there needs to be considerably more dollars to meet the need.

Mr. Steve Lurie: Just a final bit on the numbers: We've been very fortunate that the government com-

mitted $257 million to child and youth mental health, and before that, $220 million to adult mental health, but the reality is that $18.5 billion went into other areas of health care. The per capita investment in this province was $16.45 compared with New Zealand, which invested $198.

I would hope that if your committee is going to talk about gaps and wants to address mental health, you have to recognize that something as small as—we say we don't have money, but I think there's a deficit in mental health care. The select committee said there was a deficit in mental health care. An investment of $160 million a year in enhanced mental health services, which would solve some of the problems—not all of them—that we've talked about, would account for less than a third of 1% of current health spending. I think we have to be careful and not be penny-wise and dollar foolish. The assumption that there isn't money when we can demonstrate with our figures that lots of people in need aren't being served—and Mr. Colle's comment about the police being called, that's a symptom of an underfunded mental health system.

I would urge this committee to recommend that over time the government move to putting the right level of resources—that 9% of health spending that could be directed at mental health—and that the LHINs, through their mental health and addiction networks, can do what our LHIN has done very well. There are requests for proposals. They never have enough money to give us all we ask for, but I think if there's money on the table the system will step up.

Mrs. Jane McKenna: I totally agree with what you're saying in that sense, because I did my white paper on children and youth and it was amazing exactly what you're saying, that there are $257 million and each one of those people who came in to see me who were on the front lines said there were no performance-based outcomes and there were no evidence-based outcomes, and that the money they're getting is being used for the best resources and where it should go.

I think our biggest thing is that more money doesn't mean better, and I think we need to look at the resources of money that we have and know that there are evidence-based outcomes, that where it's going is what it says it's going for, and that it is giving the people who are getting the money—like children and youth—better outcomes of where that money goes. So I thank you for that.

Mr. Steve Lurie: I think on the adult side, we have a lot of evidence, both in Ontario and internationally. We know, for example, that case management and ACT can reduce hospital admissions by 50%. We know that supportive housing—as the mental health commission project showed, if you have access to the right kind of services and a rent supplement, you can stay housed.

So it seems to me the important thing is to fund based on the evidence, and there is evidence. And then, I know that we are able to provide the LHINs, and we have to as part of our accountability agreements, with evidence that we are meeting our service targets.

1700

There could be, over time, through the quality initiative that Camille talked about, a focus on some selected outcomes, but actually, I have to believe—and I've been working in this field almost 40 years—that we know more now than we ever knew about what works, and we're actually doing the kinds of things that work. The Housing First approach works; case management works; ACT works; early psychosis intervention works. We don't have to reinvent that wheel, and we don't have to over-research it. It's a question of recognizing that the kinds of things that the government has invested in that I just mentioned actually are effective interventions and they actually do lower costs in hospitals and improve people's lives in the community.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes all the time, and we do thank you for taking your time to come here and talk to us this afternoon.

Ms. Camille Quenneville: Thank you, Mr. Chair, and thanks to all the members of the committee.

COMMITTEE BUSINESS

The Chair (Mr. Ernie Hardeman): While we're just concluding that part, I just wanted to point out to the committee that the information that was asked for about the employment has already been discussed. It has all been presented.

Interjections.

The Chair (Mr. Ernie Hardeman): And there is another report that goes with that chart that you have. So I want to say thank you, and we can all now study it, as we need some bedtime reading. Right? Very good. Thank you.

That concludes the hearings for today. Do we have any other business? Or do you want to go in camera to have more committee report writing? Yes, Ms. Gélinas.

M^me^ France Gélinas: I have no idea if I'm supposed to move my motion during open or closed—

The Chair (Mr. Ernie Hardeman): That motion would be in open session.

M^me^ France Gélinas: Do I do it now?

The Chair (Mr. Ernie Hardeman): This would be a good time, if you wanted to do it now.

M^me^ France Gélinas: Are you going to circulate them?

The Chair (Mr. Ernie Hardeman): It's being passed around. Ms. Gélinas is going to move a motion for the committee before we go in camera. In camera, we can't move any motions.

Interruption.

The Chair (Mr. Ernie Hardeman): We would ask those in the back who want to have a discussion if they would have it out in the hall.

M^me^ France Gélinas: You may have to repeat that louder.

Mr. Bas Balkissoon: Bang your gavel.

The Chair (Mr. Ernie Hardeman): Those who want to speak, speak in the hall, please. The committee would like to carry on with their business. We thank you all very much.

With that, Ms. Gélinas, you have the floor.

M^me^ France Gélinas: Well, this has nothing to do with the LHINs—and it does. I'll read it first.

I move that, pursuant to standing order 111(a), the Standing Committee on Social Policy study and report on all matters related to the mandate, management, organization and operation of Ontario's system of community care access centres (CCACs). The study shall include but not be limited to:

(a) Review compensation policies of CCAC executives and organizational policies in regards to compensation.

(b) Review of administrative practices including competitive bidding and procurement policies.

(c) Invite input from expert witnesses, including CCAC leadership and staff, health care service organizations that fall under the CCAC mandate, health policy experts, as well as patients and their families.

I so move.

The Chair (Mr. Ernie Hardeman): Ms. Gélinas has moved the motion. You've all heard the motion. Yes, Ms. McKenna?

M^me^ France Gélinas: Don't I get to make comments before we move on?

The Chair (Mr. Ernie Hardeman): I don't know. We haven't heard whether there's any objection to the motion.

M^me^ France Gélinas: Ah.

Mrs. Jane McKenna: Although we are not against a comprehensive review of the CCACs, we think the timing is inopportune. There is currently a motion before public accounts which will commit the Auditor General to conduct a thorough review of the CCACs, and the committee should wait until the report is made public.

The Chair (Mr. Ernie Hardeman): I'll call the member to order. That is debate on the motion, and the first debate on the motion goes to the mover of the motion.

M^me^ France Gélinas: All right. First, I wanted to state publicly that we will be supporting the call for the Auditor General to do a full review of CCACs. In 2010, in chapter 3, section 3.04, the Auditor General had reviewed home care services and given us a whole bunch of information about CCACs at the time. But having had the pleasure to be on public accounts—and if you read the Hansard, you will see that the Auditor General's docket is quite full. Last week, she was asked to look at—and it just escapes me—a study which she will take, and she made the point of saying that she does not think that she will be—

Ms. Cindy Forster: Winter road maintenance.

M^me^ France Gélinas: Oh, yes, winter road maintenance. How could I forget? Winter road maintenance, which she agreed to do, but she made it clear to the committee that her resources were stretched, and the soonest that she could do this would be in March 2015. Now, I have no problem adding that to her to-do list, but I know quite well that we are now looking late into 2015 before we would hear from her. But that doesn't mean that we shouldn't ask her.

In the meantime, the problems at CCACs have come to the surface. So many people felt that the only way to talk to the Legislative Assembly was to come and talk to us while we were doing the LHINs review. We were all there, or most of us were there. We went to nine different communities. In each and every one of those communities, people came and complained to us about CCACs, about home care services etc. Those people have spoken to us. We cannot ignore them. To me, we have a responsibility to show that we heard them and we will do something about this.

The nice thing about bringing it here is that—without sharing any secrets of the gods or anything—the diluted chemo drugs should be wrapping up soon. As soon as this has wrapped up, there should be time on the social policy committee to start, even if it's just to give people a means to be heard. It undermines our health care system to no end when there is a pent-up disappointment in our health care system and there is no way for people to be heard, no way of giving them hope that we will listen to them and we will make changes. This is what I'm asking to do. Certainly, there have been questions about the salaries of the people who work at the CCAC, which are enough to knock you off your chair, but there are more serious issues regarding quality of care for people who depend on CCAC services, home care services, and those people deserve to be heard. They tried to be heard through the LHINs review. It was not the place, but we should give them this outlet. It could happen quite quickly. It doesn't have to be long, but it needs to happen.

The Chair (Mr. Ernie Hardeman): Further debate? Ms. McKenna.

Mrs. Jane McKenna: I'll start again. Although we are not against a comprehensive review of the CCACs, we think the timing is inopportune. There is currently a motion before public accounts which will commit the Auditor General to conduct a thorough review of the CCACs, and the committee should wait until the report is made public. This report will be a valuable resource that will pave the way for a future review that is more effective and efficient. For example, the AG report will provide us with direction on what areas of the CCACs need the most focus and who the committee should call in as a witness. So to be clear, we are not against the idea of this committee reviewing the CCACs; we just feel that we can get more bang for our buck once the AG report has been brought to the attention of the public.

1710

For this reason, we propose the following amendment. I move that the following be added following "Invite input from expert witnesses, including CCAC leadership and staff, health care service organizations that fall under the CCAC mandate, health policy experts, as well as patients and their families":

That this review is subject to the passage of the motion that is currently before the Standing Committee on Public Accounts, that calls on the AG to conduct a review of the CCACs; and that the review should commence on the first regularly scheduled meeting day following the presentation of the Auditor General's report.

The Chair (Mr. Ernie Hardeman): Before we can put that amendment forward, we need a copy for all the committee members.

Mr. Mike Colle: Could we also have a copy of the motion before the other committee? It was mentioned by Ms. McKenna.

The Chair (Mr. Ernie Hardeman): I think in process, it is not an appropriate time to ask for other information as you're discussing the motion on the floor. This is an amendment.

Mr. Mike Colle: But she referred to that in the motion.

The Chair (Mr. Ernie Hardeman): No, no. Everything that's in this motion, you will have, but the other motion is not up for discussion at this committee. If you want to make that amendment as to the way it was printed, but it's not part of this debate.

We do have to start the next debate. The debate is now on the amendment, not on the original motion.

Yes, Ms. Jaczek?

Ms. Helena Jaczek: Yes, thank you, Chair. I'm leaning towards supporting Ms. McKenna's amendment. I honestly think that the AG is the best person to conduct this kind of assessment. That's really all I have to say. I think it makes sense to do it that way.

I'm going to be supporting Ms. McKenna's amendment.

The Chair (Mr. Ernie Hardeman): Okay. Before I can call the question, we have to have a copy for every committee member.

M^me^ France Gélinas: Just before the Clerk goes out, could the Clerk check, is it in order that in the motion of one committee, we dictate what another committee will do?

The Chair (Mr. Ernie Hardeman): No, and that's why, to make sure we clarify it on that, we get the copy of the motion because—

M^me^ France Gélinas: But the Clerk will decide that, not us. She is the one who gets paid the big bucks to decide if it's in order or not.

The Chair (Mr. Ernie Hardeman): Yes, it will, but we have to see the motion. The amendment can include a direction of doing something when something else has been done somewhere else, but it can't direct that someone else to do it. That's why it's important that we have a copy of the motion before we can actually call the question.

Mr. Mike Colle: I just have a question for clarification. Ms. McKenna is saying we shouldn't proceed with this motion because there's another motion before another committee, so if I'm going to decide this is better, that Ms. Gélinas's motion is better than the one before public accounts—I think we've got to see the other motion, to see if it includes some of these things that you have mentioned that are not included.

M^me^ France Gélinas: This is where I saw that we are ruled out of order because the motion at public accounts has not been presented to public accounts.

The Chair (Mr. Ernie Hardeman): There is no other motion at this time. Okay? The suggestion, through this amendment, is that there is a motion going forward, but we do not have a copy of that, nor does anyone else.

Mr. Mike Colle: It doesn't exist.

M^me^ France Gélinas: Well, it's in the process but, no, it doesn't exist.

Interjection.

M^me^ France Gélinas: But there's only a notice of motion. The motion itself, whatever people will be voting on after debates and everything—

Mr. Mike Colle: It's not there.

M^me^ France Gélinas: No, it will be there Wednesday afternoon.

The Chair (Mr. Ernie Hardeman): We don't know that. We'll wait until we get the copy of the amendment. If the amendment is strictly about using the issue with public accounts, it sets a time. If, in fact, public accounts never gets the motion, then this motion would never happen because the timing wouldn't be there, the trigger point would not be there.

Ms. Helena Jaczek: So, Chair, I guess I'm going to move in some fashion that we deal with this motion that we've just received next week.

The Chair (Mr. Ernie Hardeman): That's in order.

Mr. Mike Colle: Until we see what they really do, and that it's going to be before public accounts—

The Chair (Mr. Ernie Hardeman): Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you, Mr. Chair. I would tend to agree with my colleague on the basis that I think we're all after the same—

The Chair (Mr. Ernie Hardeman): Before you can make another motion, before that motion is in order, we have to see a copy of the one that we're waiting for.

Mr. Bas Balkissoon: But if I could just comment, the auditor has the folks within his organization who have the skills to do a much more thorough job than what this motion is saying. To me, if the committee does it, we can't do a similar job. Neither will we do justice to the process similar to the AG, and I've been involved in audits before, so I—

The Chair (Mr. Ernie Hardeman): Who will do the best job is not a topic for this motion either. It doesn't deal with that.

We will adjourn until we get a copy of the amendment.

The committee recessed from 1716 to 1721.

The Chair (Mr. Ernie Hardeman): We're back in session.

The amendment is out of order as the motion says that the review is subject to the passage of a motion that is currently before the Standing Committee on Public Accounts. I've been informed that there is no motion in

front of the public accounts committee to do that review, so that would make this out of order because it's referring to something that doesn't exist.

With that, we're back to the original motion.

Ms. Helena Jaczek: Mr. Chair, I'd like to move that—I guess it's an amendment to this—that this motion be considered next Monday.

The Chair (Mr. Ernie Hardeman): No, that's just a motion to defer it to the next meeting.

Ms. Helena Jaczek: Okay. Is that a motion to defer? Can I do that now?

The Chair (Mr. Ernie Hardeman): A motion to defer to the next meeting?

Ms. Helena Jaczek: Yes.

The Chair (Mr. Ernie Hardeman): You've heard a motion of deferral. All those in favour? The motion is deferred.

Mr. Mike Colle: Are we dismissed?

The Chair (Mr. Ernie Hardeman): No. Is there any other business for the open committee? If not, we'll go in camera, a closed meeting.

The committee continued in closed session at 1722.

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Chair / Président
Mr. Ernie Hardeman (Oxford PC)

Vice-Chair / Vice-Président
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Mr. Bas Balkissoon (Scarborough–Rouge River L)
Mr. Ted Chudleigh (Halton PC)
Mr. Mike Colle (Eglinton–Lawrence L)
Mr. Vic Dhillon (Brampton West / Brampton-Ouest L)
Ms. Cheri DiNovo (Parkdale–High Park ND)
Mr. Ernie Hardeman (Oxford PC)
Mr. Rod Jackson (Barrie PC)
Ms. Helena Jaczek (Oak Ridges–Markham L)
Mr. Paul Miller (Hamilton East–Stoney Creek / Hamilton-Est–Stoney Creek ND)

Substitutions / Membres remplaçants
Mr. Garfield Dunlop (Simcoe North / Simcoe-Nord PC)
Mrs. Christine Elliott (Whitby–Oshawa PC)
Ms. Cindy Forster (Welland ND)
M^{me} France Gélinas (Nickel Belt ND)
Mrs. Jane McKenna (Burlington PC)

Also taking part / Autres participants et participantes
Ms. Soo Wong (Scarborough–Agincourt L)

Clerk / Greffière
Ms. Valerie Quioc Lim

Staff / Personnel
Ms. Carrie Hull, research officer,
Research Services