Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

SP-16

Standing Committee on Social Policy

Foundations for Promoting and Protecting Mental Health and Addictions Services Act, 2019

1st Session
42nd Parliament

Friday 6 December 2019

Chair: Natalia Kusendova
Clerk: Eric Rennie

Journal des débats (Hansard)

SP-16

Comité permanent de la politique sociale

Loi de 2019 sur les bases nécessaires à la promotion et à la protection des services de santé mentale et de lutte contre les dépendances

1re session
42e législature

Vendredi 6 décembre 2019

Présidente : Natalia Kusendova
Greffier : Eric Rennie

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

https://www.ola.org/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7400.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7400.

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et de l'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

ISSN 1710-9477

CONTENTS

Friday 6 December 2019

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Friday 6 December 2019

Vendredi 6 décembre 2019

The committee met at 0900 in room 151.

FOUNDATIONS FOR PROMOTING AND PROTECTING MENTAL HEALTH AND ADDICTIONS SERVICES ACT, 2019

LOI DE 2019 SUR LES BASES NÉCESSAIRES À LA PROMOTION ET À LA PROTECTION DES SERVICES DE SANTÉ MENTALE ET DE LUTTE CONTRE LES DÉPENDANCES

Consideration of the following bill:

Bill 116, An Act to enact the Mental Health and Addictions Centre of Excellence Act, 2019 and the Opioid Damages and Health Costs Recovery Act, 2019 / Projet de loi 116, Loi édictant la Loi de 2019 sur le Centre d'excellence pour la santé mentale et la lutte contre les dépendances et la Loi de 2019 sur le recouvrement des dommages-intérêts et du coût des soins de santé imputables aux opioïdes.

The Vice-Chair (Mr. Aris Babikian): Good morning, everyone. Welcome. We are meeting today for public hearings on Bill 116, An Act to enact the Mental Health and Addictions Centre of Excellence Act, 2019 and the Opioid Damages and Health Costs Recovery Act, 2019.

Pursuant to the order of the House dated November 28, 2019, each witness will receive up to five minutes for their presentation, followed by eight minutes divided equally amongst the recognized parties for questioning, and two minutes for the independent member. Are there any questions before we begin?

ALLIANCE FOR HEALTHIER COMMUNITIES

The Vice-Chair (Mr. Aris Babikian): Now I would like to call on the first witness, the Alliance for Healthier Communities. Welcome.

Dr. Kate Mulligan: Good morning. My name is Kate Mulligan. I'm the director of policy and communications at the Alliance for Healthier Communities, Ontario's voice for health equity through comprehensive primary health care. Our members meet care gaps for people living with mental health and addictions by providing safe spaces of belonging and by treating the whole person.

We support the recognition in this bill that "mental health is an essential element of health" and the commitment under the Connecting Care Act to "health equity and the promotion of equitable health outcomes."

We ask you therefore to keep the vital work of mental health equity at the forefront under section 4.2.4 of schedule 1 of this act, as the new centre of excellence begins to provide resources and support to health service providers, integrated care delivery systems and others related to mental health and addictions, and here's why.

(1) In Ontario, priority populations including Indigenous people, francophone populations, Black people and 2S and LGBTQ+ communities do not have the same opportunities as others for good mental health. Anti-Black racism, structural and systemic discrimination, for example, have a profound impact on the mental health and well-being of Black populations. People of Caribbean, East African and West African origin in Ontario have a 60% increased risk of psychosis.

Ontario's Mental Health and Addictions Centre of Excellence must prioritize health equity and the reduction of population health disparities through a legislated commitment to the collection and use of sociodemographic and race-based data and to build accountability for the centre of excellence to prioritize mental health equity for populations facing barriers to mental health or gaps in access to mental health services. Consultations with these populations must also be prioritized.

(2) Evidence shows that Indigenous populations experience significantly higher rates of mental illness than their counterparts and require culturally safe approaches to care. Indigenous youth between the ages of 10 and 29 living on reserves, for example, are five to six times more likely to die by suicide than non-Indigenous youth.

Indigenous people turn to Aboriginal health access centres and Indigenous primary care teams for culturally centred, culturally safe mental health and addiction services. For over 25 years, these agencies have been delivering these services for Indigenous people by Indigenous people. The AHACs and Indigenous primary care teams must be separately consulted, recognized and appropriately resourced as key mental health and addiction service providers, and we need to see a specific commitment and accountability for this in the bill before you today.

(3) Many people with complex mental health and addictions turn to community-led, equity-focused primary health care organizations for their care. Although we might not be top of mind as mental health service providers, new research shows that Ontario's CHCs currently serve some

of the most complex mental health patients in the province—a very high percentage of patients with complex and serious mental health and addiction concerns, physical health co-morbidities and material deprivation. For example, a 2018 study found that CHCs saw patients with psychotic diseases at a rate of 26% compared to the provincial average of 16% in other primary care organizations. One reason we see these clients is that there are barriers for these people to access designated supports in other mental health and addictions primary care providers.

We offer mental health and addictions together with primary care in a shared and person-centred approach under one roof. Where we don't have the capacity ourselves, we partner with mental health and addictions partners in the community, many of whom are going to be here today and offer fantastic services to ensure seamless and coordinated care.

In emerging health teams, for example, many of our members are prioritizing people facing mental health and addictions challenges as their first-year populations of focus. Many people are accessing these services through a process called TeamCare, so people who have a solo family doctor can have access to these important, comprehensive teams. Over 1,600 primary care doctors and 22,000 new patients with 100,000 encounters now have access to team-based care. Mental health is one of the driving requests for support amongst solo physicians.

The Vice-Chair (Mr. Aris Babikian): One minute.

Dr. Kate Mulligan: We also provide harm reduction services and, of course, the majority of consumption and treatment services for people who use drugs, drawing on this in a way that draws on peer leadership, creates social inclusion, addresses adverse childhood experiences, trauma and the social determinants of health.

Given the ongoing severity of the overdose and drug poisoning crisis in the province, as reported recently by the Auditor General, it's vital to explicitly name these organizations and support them at the forefront of mental health equity and harm reduction.

(4) Finally, the Chief Medical Officer of Health and Chief Public Health Officer for both Ontario and Canada have identified loneliness, stigma and isolation as key barriers to the good health and well-being of people facing mental health and addictions challenges, so we ask that you ensure that social prescribing is interpreted as a mental health support under this bill. Social prescribing is a person-centred, structured referral to social services and supports that is particularly impactful for people facing mental health and addictions. For example, big data from longitudinal studies in the UK show 272% higher odds of recovery from depression from something as simple as taking up a hobby.

The Vice-Chair (Mr. Aris Babikian): Thank you. Now I would ask the opposition to start the questioning. You have four minutes. MPP Karpoche.

Ms. Bhutila Karpoche: Thank you, Ms. Mulligan, for your presentation. Thank you for raising social prescribing.

I represent Parkdale–High Park, and the University Health Network recently committed to 30,000 square feet of land in my riding to be used for affordable housing because of the rapid gentrification and the skyrocketing rent. Access to affordable housing is very, very important because they're pushing the poor and working-class people out of the neighbourhood.

You referenced social determinants of health. I think that's really important, because we know that people's health is influenced more by social factors as opposed to their behaviour and genetics.

My question to you is, would you agree that low wages contribute to mental health stresses for workers?

Dr. Kate Mulligan: Yes.

Ms. Bhutila Karpoche: How about unstable scheduling and no guarantee of hours?

Dr. Kate Mulligan: Yes.

Ms. Bhutila Karpoche: How about stresses of managing multiple jobs?

Dr. Kate Mulligan: Yes.

Ms. Bhutila Karpoche: How about lack of respect and workplace harassment?

Dr. Kate Mulligan: Yes.

Ms. Bhutila Karpoche: So you would agree that social prescription—or the medicine, really, that the Ontario government should be prescribing to millions of low-wage workers who have mental health stresses would be things like a $15 minimum wage, a minimum of two paid sick days, fair scheduling, decent hours, paid leave, job security and respect at work?

Dr. Kate Mulligan: Yes. Good social policy is good health policy.

Ms. Bhutila Karpoche: Thank you very much.

The Vice-Chair (Mr. Aris Babikian): Anyone else? MPP Burch.

Mr. Jeff Burch: Thank you for being here and for all of the work you do.

Can you talk a little bit more about how having a specific strategy for vulnerable populations is so important?

Dr. Kate Mulligan: Yes. Community health centres have been offering support and access to these comprehensive services for over 50 years here in the province of Ontario and over 100 years across Canada. What we have found is that if you do not name, measure and prioritize health equity, it will not happen. It just doesn't happen. So we need to have very specific accountabilities in the legislation and in the objects of things like Ontario health teams and new initiatives so that we're ensuring that people don't fall through the cracks.

When you're looking at population health data, you might find a not particularly significant rate of youth suicide, for example. But as you look by different populations or different parts of the province, the data tells a different story, and if we don't ask, we won't know.

0910

Mr. Jeff Burch: How about a specific policy for children and youth? How important is that?

Dr. Kate Mulligan: Absolutely, it's important. We're seeing increased stresses for children and youth, huge demand for access to mental health and addictions services—and an uncertain world that they're moving into, and I think

that feeling of uncertainty, that feeling of social exclusion and loneliness. One of the fastest-growing populations experiencing loneliness is young women under 35. It's not just senior citizens. So, yes, we absolutely do need—and there are experts in this room who can speak to it even more than I can—a very specific strategy for children and youth.

The Vice-Chair (Mr. Aris Babikian): MPP Karpoche.

Ms. Bhutila Karpoche: Dr. Mulligan, would you say that Indigenous mental health and addictions requires its own stream of consultations?

Dr. Kate Mulligan: Yes.

Ms. Bhutila Karpoche: With regard to gathering race-based data and other key information to ensure that everyone in Ontario—

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Ms. Bhutila Karpoche: —is benefiting equally from the programs and services, do you think the Ontario Anti-Racism Directorate has a role to play here?

Dr. Kate Mulligan: Yes. In fact, health is the only ministry excluded from the requirement to collect socio-demographic and race-based data under the Anti-Racism Act. It's time for that to change.

The Vice-Chair (Mr. Aris Babikian): Now I'll go to the government side. MPP Hogarth.

Ms. Christine Hogarth: Thank you, Kate, for being here today. I thank you for all the work that you've done to date with people who are suffering with mental health issues.

Our government has taken the first step. We have the first Associate Minister of Mental Health, and he has been out there consulting with Indigenous people since he was appointed. This legislation—

Mrs. Robin Martin: And others.

Ms. Christine Hogarth: And others, of course. He has taken this role very seriously and has been consulting all through the summer and every day he's not in the Legislature, to make sure that we get this system right. It has been a long time coming, as we have a fragmented—and I'm sure everybody who is here today could attest to that—mental health system. We don't have anything together that can solidify and help people—people can go from here to here to here, but there isn't really a one-window approach.

This legislation, if passed, will create the first Mental Health and Addictions Centre of Excellence within Ontario Health. This new centre will lay the foundation we need to implement the province's mental health and addictions strategy.

With the work you do—the Alliance for Healthier Communities—how do you feel that the centre of excellence could provide better wraparound services to those suffering from mental health issues and addictions, in your professional opinion?

Dr. Kate Mulligan: I think it's important to take stock of the different places in which mental health or supportive services are happening. They're happening in different places: in family service organizations, in mental health and addictions agencies, in community mental health organizations and so on.

I think it's important that harm reduction is considered to be an important priority for populations facing significant barriers to mental health and well-being. I think it's very important to look to things like social prescribing to support—particularly for mild and moderate mental health—people who are stigmatized on the basis of mental health, or who experience loneliness, social isolation and other barriers. Social prescribing is a way to help address the material social determinants of health, but also the emotional, mental health and community connectedness components. We're seeing significant improvements in health and well-being for people, who are asked not just "what's the matter with you?" but "what matters to you?" In that shift, being asked to give back to the community, to be a volunteer—people perceive a different sense of self-worth. Social prescribing is a way to do that, but it's also a way to help us make better connections between one another, to make referrals across silos, across agencies—between mental health, primary care, public health, social services, acute care and so on. So it's a form of care coordination at the more social end of the spectrum that's really needed. We'll need to have the data supports and other structures in place to help support this work, but it's quite a low-cost intervention that can be quite significant.

Ms. Christine Hogarth: Thank you very much for that answer. When we have a one-window approach that we can send people to, that might help the situation.

Dr. Kate Mulligan: I hope so.

Ms. Christine Hogarth: Understanding that the purpose of the centre of excellence is to fulfill Ontario's health objectives for our mental health and addictions system—what we want to do is operationalize ministry strategies and develop clinical quality and service standards. We want to monitor performance and provide resources and support to front-line providers.

What would your organization like to see prioritized within the system?

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Dr. Kate Mulligan: Again, when it comes to those resources and supports, we want them to be prioritized for health equity. We want health equity, data collection, deep engagement of populations and people facing barriers to mental health and well-being, and the kinds of social prescriptions that people require to thrive in their lives.

The Vice-Chair (Mr. Aris Babikian): Thank you to the witness.

Dr. Kate Mulligan: Thank you.

ADDICTIONS AND MENTAL HEALTH ONTARIO

The Vice-Chair (Mr. Aris Babikian): Now, I would like to call upon the second witness, Addictions and Mental Health Ontario.

Welcome. Please identify yourself.

Ms. Adrienne Spafford: Adrienne Spafford, CEO, Addictions and Mental Health Ontario.

The Vice-Chair (Mr. Aris Babikian): Welcome. Go ahead.

Ms. Adrienne Spafford: Okay, great. Thank you very much for having me here today. We are pleased to support Bill 116, and particularly the establishment of the new Mental Health and Addictions Centre of Excellence. We've been waiting years for this type of action.

The need for reform in mental health and addictions was first identified in 2010—a full nine years ago—in an all-party select committee report. Since then, the need for more evidence-based services that connect people to the care they need quickly and with dignity and ease has only grown. Ontario can no longer afford to overlook the urgent need for system redesign.

While there are pockets of excellence and good alignment in some communities and some infrastructure in different parts of the system, provincially, as a whole, we lack capacity, coordination and transparency. We don't currently know that the types of services that are available in downtown Toronto are also available in Sarnia, Belleville or Marathon. Making matters more complicated, there is no consistency in the definitions describing services or a standard against which to measure their quality of care. We have no way to understand whether people are waiting longer than research says that they should to access services to improve their health or, at times, save their lives.

Hospital emergency rooms are overrun by the rising number of overdoses. There were more than 7,000 emergency room visits related to opioid overdoses in 2017, a 72% increase from the year before. These trends continued through 2018 and 2019. At the same time, 24% of hospital long-term-stay beds are currently filled by patients with mental health conditions who would be better served in the community.

The average wait time to access residential treatment for addictions support—treatment that isn't even funded as a provincial resource—is 50 days across the province. The wait-lists for youth are even worse. The wait time at Pine River Institute in Shelburne is one and a half years.

Our challenges are real, but they aren't insurmountable.

The Mental Health and Addictions Centre of Excellence needs to be a driving force behind reform, in the same way Cancer Care Ontario improved cancer outcomes by arming health care professionals, organizations and policy-makers with the most up-to-date cancer knowledge and tools to prevent cancer and deliver high-quality care in every corner of the province.

Today, fewer people are dying as a result of a cancer diagnosis. This outcome was not by accident or a coincidence. Lives have been saved because of system redesign. Consider the possibilities of this approach for mental health and addictions here in Ontario.

The steps the government is taking with Ontario health teams to better integrate services around clients' needs are a critically important change. But as we continue to move ahead with health transformation, we need to ensure the foundations are there to best support Ontario health teams to be able to deliver locally on the promise I know we all want to make: that no matter where you live in this province, if you have a mental illness or addiction, you will get access to the best quality care.

With the centre of excellence as a central nervous system for the sector, front-line agencies can be better supported to excel in the Ontario health team mode and better supported to improve transitions and connections between themselves and other parts of the health care system: primary care, hospitals, and specialists like psychiatry and addiction medicine.

With a stepped care model, we will be able to do a much better job of matching treatment to individual client need and context in terms of income, housing, family status and concurrent medical conditions, and also in matching what services are being provided by what part of the system so that the majority of care is delivered locally, in community, and is sustainable for future generations.

While we look to improve and better coordinate the quality of care, let's keep our eye focused on what is working. Many of our clients have had the door shut on multiple requests for help before a door was finally opened by one of our members. Let's balance the development of quality standards and evidence with the knowledge that our members bring from having been on the front lines of care for a very stigmatized population for decades.

0920

It's also important to make sure that evidence and standards take into account the unique needs of individual communities, particularly Indigenous communities—

The Vice-Chair (Mr. Aris Babikian): One minute.

Ms. Adrienne Spafford: —racialized communities, women, the LGBTQ/two-spirited communities, people experiencing homelessness, people who use drugs, and other diverse populations that would suffer, along with our health care system, if an equity lens is not applied to the work of the centre of excellence. While undertaking its work, the centre must also understand that there are fundamental differences between cancer and mental health and addiction.

I will end with a message of urgency around funding. Some may say that we need a perfect system before we can invest confidently, but we believe that we can walk and chew gum at the same time. People are dying because of a lack of access to services and supports for mental health and addiction. I urge the Legislature to support investments in what services we know will have a great impact and are evidentiary now. Prioritize building up capacity in the community so that acute settings can be maintained for those with more complex and chronic conditions. Particularly, ramp up investments quickly in child and youth services. There is no sounder investment than recovery for a child or youth. You can have confidence that the positive impact of these investments today will be good while we build the system for tomorrow. Thank you.

The Vice-Chair (Mr. Aris Babikian): The government side has four minutes. MPP Martin.

Mrs. Robin Martin: Than you for your presentation. That was very good. I was reading along with you here so I could catch all of the things you were saying. There was some information in there that was new to me, so that's helpful.

Our government has introduced this legislation based on that 2010 select committee report. We're hopeful that it will provide a locus for organizing. You mentioned Cancer Care Ontario as our example of how we would like it to improve care in the area. There are probably important differences, as you noted, between the two sectors, but it maybe works as a kind of way of organizing, particularly with data—we know how important data is; I think the previous presenter also mentioned how important data is—and outcome measurement. Right now, the ministry doesn't seem to have a good line of sight on whether people are actually getting well with the services being provided, which services are helping people more etc. So we're trying to get a handle on some of those things, and we really think this mental health and addictions centre will help us organize that.

How does your organization think that the creation of this new centre will improve the quality of mental health and addictions services in Ontario? If there are any other points you'd like to add other than what you've already said, I don't know—

Ms. Adrienne Spafford: Yes, I think I'd agree with much of what you just said. As I understand it, the ministry—working with the minister, of course, and the government—is responsible for the development of a comprehensive and connected mental health and addiction strategy, and then the centre of excellence's purpose will be to implement the direction that comes from government.

In last year's budget, the government indicated what it thought the fundamentals behind that strategy were. They talked about core services work; they talked about the stepped care model; they talked about a data framework and performance measurement and reporting. If those are the cornerstones of a strategy and then that gets implemented by the centre of excellence, we would be very complimentary of that approach.

I think ultimately what will happen is a few things. The government will be able to ramp up investment in mental health and addiction services because it will have knowledge of how those investments are turning into progress on the ground. Right now, just like you said, we can't tell you where those investments are working really well or where those investments need to be tweaked and the service programs need to be tweaked. We also don't know what geography needs the most investment. We don't know, by geography, what part of the full continuum of services and supports needs investment.

I think another cornerstone is that if I have cancer right now, I can go online and I can see what my wait time is and I can look at options to see which specialists I might be able to see. There are possibilities for me to understand how to navigate the system as a patient. If I have schizophrenia, I don't have the same access to that ability to navigate my own care.

Mrs. Robin Martin: It is, I think, very disorienting for people. I remember when I was first appointed to be in the Ministry of Health and the minister told me she wanted me to focus on the mental health and addictions file. I went on the ministry website and I looked up mental health and addictions. There wasn't anything. It was all under "children's mental health." You don't really think, logically—

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Mrs. Robin Martin: —of looking for adult mental health under "children."

The only other thing I was going ask is how you think it would help the community providers to have a centre of excellence.

Ms. Adrienne Spafford: I think that if the community sector is supported to be able to implement the standards—hopefully, the centre of excellence understands the difference between the standards and the best evidence and what the front-line service delivery looks like right there; there's a lot of will to get there—then you'll be able to have confidence to invest in-community.

The Vice-Chair (Mr. Aris Babikian): Now I would go to the opposition. MPP Karpoche.

Ms. Bhutila Karpoche: Thank you, Ms. Spafford, for your presentation.

I was going through your organization's website. I understand that AMHO represents over 220 addiction and mental health organizations across Ontario. Is that right?

Ms. Adrienne Spafford: Yes.

Ms. Bhutila Karpoche: And that the services and supports that your members provide are quite comprehensive. They include counselling, case management, peer support, family support, employment services, residential treatment, withdrawal management, supportive housing, hospital-based programs and so forth. Is that correct?

Ms. Adrienne Spafford: Correct.

Ms. Bhutila Karpoche: And together with your members, AMHO has been working for the last many years on building a comprehensive and accessible system of addiction and mental health care in Ontario. Is that right?

Ms. Adrienne Spafford: Correct.

Ms. Bhutila Karpoche: So you're subject matter experts.

Ms. Adrienne Spafford: I would say so, yes.

Ms. Bhutila Karpoche: Okay.

Ms. Adrienne Spafford: I hope so.

Ms. Bhutila Karpoche: Has the government consulted you or your organization on the new Mental Health and Addictions Centre of Excellence?

Ms. Adrienne Spafford: We were contacted by the minister's office ahead of the bill being introduced in the Legislature. The announcement actually happened at our conference.

Ms. Bhutila Karpoche: Okay. So you were given a heads-up about the announcement of the bill and the announcement of the centre, but were you consulted on it in terms of what the centre governance was going to look like, what the structure was going to be?

Ms. Adrienne Spafford: We were given a verbal briefing on what the bill would look like, which is a relatively short bill.

Ms. Bhutila Karpoche: Right. I think that sounds like the same information that we had in terms of what the bill is going to look like, but there's not much in the bill beyond the creation of the centre. I'm just curious, in terms of your organization representing such a large number of

organizations across Ontario not being consulted, are you concerned about the transparency, particularly at Ontario Health? The centre of excellence is going to fall under Ontario Health, like all the other agencies that have been folded under this super-agency. We know the Ontario Health board has already met. The first meeting was closed-doors; there was no patient on the board. Are you concerned about transparency?

Ms. Adrienne Spafford: With respect to the question around us being consulted on the bill, we have been engaged in consultations around the general strategy. To me, the centre of excellence was one lever of that strategy, so I was comfortable with that.

With respect to transparency at Ontario Health, I'd agree. I'd echo your concern about the board meetings and the agendas and the minutes not being transparent. I'd also really hoped to see the government take steps on bringing more of the clients and people with lived experience into Ontario Health at a governance level. At AMHO for the first time ever, we've had someone come on our board, Betty-Lou Kristy, who represents the voice of people with lived experience. I can say first-hand that it has changed the conversation at the most senior level of our organization and it's changed the way we're doing our work.

I know the government has talked about transparency at Ontario Health, as well as a client voice, being a future step. We're happy to see that's a future step—

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Ms. Adrienne Spafford: We'd urge them to move quickly on that.

Ms. Bhutila Karpoche: Thank you.

The Vice-Chair (Mr. Aris Babikian): MPP Kernaghan.

Mr. Terence Kernaghan: The government has joined the class action opioid lawsuit, but they continue to delay action on the province's opioid strategy. Can you speak to the need to move forward with the province's opioid strategy?

Ms. Adrienne Spafford: Yes, absolutely. We are in a crisis—

The Vice-Chair (Mr. Aris Babikian): Thank you very much. Unfortunately, the time is over.

Ms. Adrienne Spafford: Thank you.

CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO DIVISION

The Vice-Chair (Mr. Aris Babikian): I would like to call upon the next witness, the Canadian Mental Health Association, Ontario division. Please identify yourself.

Ms. Camille Quenneville: Thank you. Good morning. My name is Camille Quenneville. I'm the CEO of the Canadian Mental Health Association, Ontario division. Thank you for the opportunity to present to the committee today on Bill 116.

0930

CMHA is the country's oldest nationwide mental health charity and has been in existence for 101 years. We were founded in 1952, and today we have a network of 30 local branches covering the entire province that provide front-line support to thousands of Ontarians and their families living with a mental health or addiction issue. My remarks and submission are informed by the experience of those branches and the expertise of my colleagues across the province.

CMHA Ontario supports both schedules in Bill 116. I will begin with our endorsement of the creation of the Mental Health and Addictions Centre of Excellence within Ontario Health. We support the overall philosophy behind the centre, which is the creation of an integrated mental health and addictions system that Ontarians can navigate easily. We recommend that the centre focus on three areas: implementation of core mental health and addictions services across the province, rigorous data collection and health quality improvement.

Ontarians, across their lifespan, would benefit greatly from having easy and seamless access to a standardized set of mental health and addictions services and programs, regardless of where they live in the province; in other words, having the right services when people need them, no matter where they live. By providing standardized core services, you help to ensure consistent treatment delivery across Ontario, reduce emergency department visits, help clients navigate the system, create greater health system integration and improve client overall health outcomes.

On data collection, the community-based mental health and addictions sector urgently requires a data infrastructure and one that is just as robust as the hospital sector's. Stigma comes in many forms, and in our experience, the infrastructure has lagged behind for decades. Without valid, comparable, consistent data, our branches and the sector cannot adequately measure our performance. However, with the right data, we can identify and implement effective treatment delivery models worthy of ongoing government investment. We believe the centre of excellence in mental health and addictions must invest and implement a data strategy for the community-based mental health and addictions sector.

Our third recommendation for the centre is to drive continuous quality improvement. Data and quality improvement go hand in hand. Quality improvement is something we take very seriously, and I'm proud to say that, along with our partners at Addictions and Mental Health Ontario and the provincial system support at CAMH, we are leading the way. Our QI initiative is called the Excellence through Quality Improvement Project, or E-QIP for short. This is the only program of its kind in the community-based mental health and addictions sector. E-QIP ensures that dedicated and skilled service providers have the support they need to improve the quality of care they offer to clients. The project provides coaching, training and resources to help providers streamline service delivery and implement cost-effective and efficient methods that improve the quality of care. We hope to expand our innovative E-QIP program with support from the centre of excellence in mental health and addictions at Ontario Health.

With my few remaining moments, I'd like to speak about the second schedule for Bill 116, which would allow the

province to take action against manufacturers and wholesalers of opioid products to recover opioid-related health care costs. We endorse this aspect of the legislation and any action that will combat the opioid crisis which has sadly taken the lives of more than 4,000 Ontarians since 2016.

From an addictions lens, CMHA Ontario and our branch network operate from a harm-reduction framework. Across our network, you'll find evidence that our branches are implementing innovative approaches to combat the opioid crisis. For example, we have several branches that operate rapid access to addiction medicine, or RAAM, clinics to help individuals with opioid replacement therapy. One of our largest RAAM clinics is just down the road. CMHA Peel Dufferin operates five sites across their region, supporting one of the largest populated areas in Ontario.

In addition to RAAM clinics, two of our branches are also applying to become a consumption and treatment services site.

The Vice-Chair (Mr. Aris Babikian): One minute.

Ms. Camille Quenneville: Should funding be recouped from opioid manufacturers through litigation, we would urge the province to direct those dollars into the front-line addictions care. Increased funding could support more evidence-based RAAM clinics or allow the province to expand CTS sites beyond the current cap of 21, which, in our opinion, is not enough.

To close, I would like to thank the committee for your generous time. On behalf of all our CMHAs across Ontario, I would like to reiterate our support for the two schedules within Bill 116, which, if implemented, can have a significant positive impact on how we support Ontarians living with a mental health and addictions issue. Thank you. I'm happy to take questions.

The Vice-Chair (Mr. Aris Babikian): Thank you. MPP Burch.

Mr. Jeff Burch: Thank you for being here, Ms. Quenneville. As you know, Bill 116 does basically two things. It creates a central agency and makes it easier for the government to sue opioid manufacturers. What it doesn't do is provide any more funding to the front line. We hope it will lead to that. Can you talk a little bit more about, as the use and need increases but the funding does not, what kinds of stresses you see on the system?

Ms. Camille Quenneville: I think one of the things that was really gratifying in the last provincial election was that all three parties actually spoke about mental health and addictions and had it as a significant part of their respective platforms. As a result of that, I think there was general agreement that there was a strong need to start investing in and focusing on this area.

So through the last negotiation of the federal health accord, and the commitment of this government today, we know that over the course of the next 10 years there will be a $3.8-billion investment in our sector. It's critically important that we get started with those investments. That's a tremendous amount of money for a sector that isn't used to those kinds of investments and we want to make sure they're in the right place.

We fundamentally think that the centre of excellence, if we do the kinds of things we've described—and I'm not alone; I think the two deputants before me were really in the same vein around where we focus our attention—around core service delivery, around data collection, around the infrastructure needed within the system, that that would be a wise place to begin to invest.

Mr. Jeff Burch: The federal funding has flowed, but the provincial has not, so your position would be that that needs to happen and it needs to happen soon, I would assume.

Ms. Camille Quenneville: Our position is, it would be fantastic to have a transparent plan of what the investments will look like over a long period of time.

Mr. Jeff Burch: Okay, thank you.

The Vice-Chair (Mr. Aris Babikian): MPP Karpoche?

Ms. Bhutila Karpoche: Hi. Thank you for your presentation.

Should there be a dedicated fund from any money that might be recouped through a court case? Should that be legislated, that it goes into addiction care?

Ms. Camille Quenneville: We would certainly support that. From my understanding, Minister Elliott has been quite clear that those dollars would be earmarked for reinvestment on the front line of combatting the opioid crisis.

Ms. Bhutila Karpoche: Right, but it's not in the legislation in its current form.

Ms. Camille Quenneville: It's not in this bill, no.

Ms. Bhutila Karpoche: Do you think it should be in this bill?

Ms. Camille Quenneville: I don't think it's a bad thing to add, to be quite honest.

Ms. Bhutila Karpoche: Thank you.

The Vice-Chair (Mr. Aris Babikian): MPP Harden?

Mr. Joel Harden: Do you think we have had adequate time to have consultation on this bill? I just travelled in from Ottawa this morning. We have a mental health crisis in our city, with kids and adults in abject need of mental health services. Many of your compatriots in our city do great work. Do you think we've had enough time, with eight deputations, to actually have thorough consultations with experts in the field?

Ms. Camille Quenneville: My sense of it is that there is general agreement around the major tenets of this legislation. I think this sector is of the view that there has been a need for this kind of infrastructure, and in the form of a centre of excellence, it's a positive step.

Mr. Joel Harden: I totally understand. But do you believe eight deputations on a bill in a context of an opioid crisis and of a mental health crisis, all over our province, is adequate? That's my question.

Ms. Camille Quenneville: It's a fair question. I'm not a legislator. I am grateful to have the opportunity to be here today to offer our views on this.

I think that we would be delighted to see this expedited, quite truthfully, and to move forward.

Mr. Joel Harden: Chair, in my last remaining seconds, I would just ask for a motion of unanimous consent, on the issue of mental health, which is important in our schools, to be able to wear this button, which talks about class sizes,

which is important to children and education workers. I would just like to move that motion of unanimous consent, please.

The Vice-Chair (Mr. Aris Babikian): Thank you. Your time is over.

Is there unanimous consent to wear the button?

Interjections.

Mr. Joel Harden: I'd just like to note for the record that two of my Conservative colleagues have opposed my unanimous consent motion—

The Vice-Chair (Mr. Aris Babikian): Your time is up, MPP Harden. Thank you.

MPP Harris?

Mr. Mike Harris: Thank you for being here today on this blustery Friday morning.

I wanted to highlight a couple of things. I've actually had a chance to work very closely with Helen Fishburn—

Ms. Camille Quenneville: I know, she told me.

Mr. Mike Harris: Well, there you go. So I don't need to go too much into detail on it—

Ms. Camille Quenneville: She told me, "Go see Mike Harris."

Mr. Mike Harris: Obviously the IMPACT program is something that we've been really promoting in Waterloo region and in Waterloo-Wellington with the Waterloo Regional Police Service and also the Waterloo-Wellington OPP. For those who are unfamiliar with the program, essentially what this does is it embeds Canadian Mental Health Association clinicians with officers, and they're able to go out and respond to calls together, rather than just having the officer go on their own and then have to deal with the situation that they may not necessarily be prepared to deal with.

0940

I was just wondering and wanted to know, in your estimation, what you think having a centre of excellence on mental health and addictions and developing this strategy going forward—what that would mean to this program and how you think it would be able to proliferate across the province and be able to essentially help more people.

Ms. Camille Quenneville: Thanks for the question.

Very briefly on the program, I would just offer that your government has talked extensively about ending hallway health care. There are many ways to do that. The program you described ends hallway health care. So when you have those clinicians with police officers and you're immediately diverting from having to take that individual to an emergency department—I could talk at length about what our other branches are doing. Very briefly, in London, Ontario, we have a crisis centre that is attached to our branch, and in effect it does the same thing. Police officers have the ability to take those individuals right to our branch, which again diverts them out of the ED.

What will a centre of excellence do around that? Hopefully spread and scale these great ideas, because many of them exist across Ontario in our partner organizations, in our organization. There is a wealth of experience and understanding of what it takes to serve people in-community.

What I hope the centre doesn't do is focus solely on the role of hospitals in the health care system. The community system is and always will be responsible for keeping people healthy in-community. We're there before they have to go to hospital and ideally keep them away from that door. If they are ill enough and have to spend time in hospital, we're there when they get out. I think we need to recognize the importance of that role, and I would hope that the centre—if we do the things that we've described in this deputation and again, as my colleagues have reiterated, it will help us move forward and really have some more success there.

Mr. Mike Harris: Thank you.

The Vice-Chair (Mr. Aris Babikian): MPP Kusendova.

Ms. Natalia Kusendova: Good morning. Thank you so much for being here and thank you for all the work that you do.

I'm sure you're very aware that the Select Committee on Mental Health and Addictions from 2010, the all-party committee, made a recommendation to actually establish the centre of excellence. Do you think that for eight years of the mandate of the previous government, it was appropriate to be sitting on this recommendation and not moving forward at all?

Ms. Camille Quenneville: I'm going to be honest with you, at the risk of aging myself, and tell you I was very closely involved in the work of that standing committee. I worked at Children's Mental Health Ontario at the time. I spent seven years in that organization before I came to my current role. Minister Elliott was, without question, an extraordinary leader in that process, and she was in large part responsible. The really neat thing about that committee is that it was completely non-partisan. All members felt the importance of the work that happened at that committee, and that ultimately led to where we are today.

The references I made at the beginning of the questions when we talked about investments: All three parties—you know better than I—had it in their platform in the last election.

The Vice-Chair (Mr. Aris Babikian): Thank you.

PROVIDERS FOR PUBLIC LISTING OF HIGH-DOSE INJECTABLE HYDROMORPHONE

The Vice-Chair (Mr. Aris Babikian): I would like to call upon Providers for Public Listing of High-dose Injectable Hydromorphone as our next witness. Please identify yourself.

Dr. Ahmed Bayoumi: I'm Ahmed Bayoumi. I'm a physician and researcher here in Toronto. Thank you for inviting me to appear before the committee today. I'm here on behalf of 410 care providers and researchers who have signed an open letter to Minister of Health Christine Elliott and to Premier Doug Ford asking that Ontario ensure access to high-dose injectable hydromorphone, an evidence-based therapy.

The opioid crisis has been called the defining health crisis of our time. Over 3,600 people died from opioid-related overdoses in Ontario from 2016 to 2018. These are preventable deaths. Immediate action is needed to prevent

more people from dying. There is a strong consensus among care providers, public health officials and researchers that ensuring access to high-dose injectable hydromorphone is the most important next step in addressing opioid overdose-related deaths.

The current drug supply contains extremely potent and toxic drugs, such as fentanyl. As a result, people frequently don't know the composition or concentration of drugs that they are injecting. One solution is to establish programs that provide access to a safer supply of drugs. High-dose injectable hydromorphone is a crucial component of such programs. We can only address the opioid overdose crisis in Ontario by having a broad range of approaches, including injectable hydromorphone.

Health Canada has approved supervised injectable opioids for selected people who use opioids, and a national clinical practice guideline has been published outlining how this drug is best prescribed. The only remaining barrier to implementing programs that incorporate supervised injectable hydromorphone is that the high-dose concentrations are not covered by the Ontario public drug plan.

The evidence for injectable hydromorphone comes from a high-quality 2016 Canadian study that compared hydromorphone with prescription heroin, known as diacetylmorphine, in people who used opioids and had previously stopped taking other treatments, such as methadone. In both treatment groups, there was a significant and comparable drop in the use of street drugs. In the context of a crisis, when people are dying daily from opioid overdose, decreasing the use of drugs that people buy on the street has the potential to be life-saving.

Hydromorphone belongs to a class of drugs known as opioid agonists. Two opioid agonist therapies, methadone and buprenorphine, are already listed on the Ontario Drug Benefit Formulary. However, about 15% to 20% of people will stop using these drugs and will therefore require alternative treatments.

While low-dose injectable hydromorphone, at a concentration of 10 milligrams per millilitre, is listed on the Ontario Drug Benefit Formulary, it is impractical to prescribe to people who inject drugs, who would need to inject large volumes. High-dose hydromorphone formulations, at concentrations of 50 milligrams per millilitre and 100 milligrams per millilitre, are not listed on the Ontario Drug Benefit Formulary. It is these concentrations that are the focus of our request.

A 2018 cost-effectiveness analysis, using a discounted price for hydromorphone, projected that hydromorphone prescribing for people similar to those in the study would result in cost savings of over $100,000 per person over their lifetime compared to methadone. As a major purchaser, the Ontario government could negotiate such price discounts.

The Toronto Board of Health has also endorsed hydromorphone as a treatment for people who use opioids and has called on the Ontario government to list hydromorphone on the public drug formulary. Our group includes experts and leaders in substance use treatment, public health, health economics and resource allocation. We have reached out to the Ministry of Health to indicate our willingness to work collaboratively to draft listing criteria that ensure that injectable hydromorphone is used appropriately and efficiently.

We fully support the goals set out in Bill 116 and are pleased to see that Ontario aspires to be a leader in providing excellent care for people who use drugs. Section 2 of this bill, which focuses on suing opioid manufacturers, is a positive step, but these processes will take time, which we don't have. Suing manufacturers will not address the toxic supply of drugs. More immediate action is needed. We hope that you will ensure access to all necessary therapies to address the opioid overdose crisis.

Thank you.

The Vice-Chair (Mr. Aris Babikian): Thank you. I would like to call upon the government side to start the questions. MPP Martin.

Mrs. Robin Martin: Thank you very much for your submissions, Doctor. Our government, as you know, is committed to addressing the harms associated with opioid use and supporting people living with addictions and mental health needs, obviously. Ontario has entered into a suite of policies, or created a suite of policies, to help address those, focused on appropriate prescribing and pain management, treatment for opioid use disorder, harm reduction services and supports, and surveillance and reporting.

Our proposed legislation is part of our commitment, as you know, to roll out $3.8 billion over 10 years to support mental health and addictions. That of course includes the Consumption and Treatment Services funding program, which does save lives by preventing overdose deaths and connects people who use drugs to primary care, treatment, rehabilitation and other social services.

I recall one of the first things we did in our Ministry of Health when we were appointed there, the minister and I, was to conduct a number of consultations with people in the sector, all the experts, which I believe included yourself, because I remember meeting you at one of those.

Dr. Ahmed Bayoumi: Yes.

Mrs. Robin Martin: We got a lot of great information from people. We also consulted with people with lived experience about what their needs were as we developed that new model.

We know that new investments are still required. We've invested in the RAAM clinics, which we think are very important, and over 30 communities in Ontario now have them. The ministry appreciates your interest in funding high-dose injectable hydromorphone to help address the crisis and is currently reviewing the implications for Ontario of the recent federal announcement of approving injectable hydromorphone for the treatment of opioid use disorder. At this point we haven't made any decisions on that specific part of your presentation, but we're looking all the time for what we can do better. I appreciate you bringing this to the attention of the committee today, and I appreciate you saying in your submission that you support the goals of Bill 116.

On that note, can you tell us how you think Bill 116 will help us support the response to opioid issues in Ontario?

Dr. Ahmed Bayoumi: I'm extremely glad to hear that the government is actively considering the listing of high-dose injectable hydromorphone. This is a request that we made several months ago. It's a request that the Toronto Board of Health made last year. I can't stress strongly enough that this action needs to be taken quickly. I would urge the members to think about how to operationalize this in a very timely manner.

0950

Thank you very much for your comments. It's really heartening to hear you say that the government accepts harm reduction as one of the components of the response. It is an essential response. As I said in my notes, we need a broad response, and that includes all aspects of treatment. We need to make sure that we reach those people for whom conventional treatments are not working. Those are sometimes the people with the most complex needs, and my concern is that if we don't think innovatively and look at evidence-based new therapies, we won't reach those people.

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Dr. Ahmed Bayoumi: I also urge the government to consult broadly. As you said, I think the consultations around consumption and treatment services were quite broad, but I am concerned that the opioid task force has not met in a very long time. I am concerned that we don't have a visible opioid overdose coordinator. I encourage the government to really show strong leadership. I think the Auditor General's report outlined some of those issues.

The Vice-Chair (Mr. Aris Babikian): Thank you. MPP Karpoche?

Ms. Bhutila Karpoche: Thank you for your presentation.

Dr. Bayoumi, I have read that letter that was signed by 410 care providers and researchers, asking Ontario to ensure access to high-dose injectable hydromorphone as an evidence-based therapy. Can you let the committee know when that letter was sent?

Dr. Ahmed Bayoumi: That was in the summer of this year.

Ms. Bhutila Karpoche: Summer?

Dr. Ahmed Bayoumi: Yes.

Ms. Bhutila Karpoche: So about five or six months?

Dr. Ahmed Bayoumi: Yes.

Ms. Bhutila Karpoche: Thank you. Have you received a response from the Minister of Health and Long-Term Care, Christine Elliott, or Premier Doug Ford?

Dr. Ahmed Bayoumi: We have not received a direct response from them. We have written to the director of the Ontario public drugs program, who has told us that it's under consideration and that we will hear from them at some future date. We've sent follow-up emails but received no response.

Ms. Bhutila Karpoche: Okay. So since you've sent the letter, you have not received a formal response from the minister or the Premier, and in the meantime we've seen an increase in the number of opioid-overdose-related deaths, correct?

Dr. Ahmed Bayoumi: Yes, correct.

Ms. Bhutila Karpoche: Dr. Bayoumi, why did you feel compelled to write the letter?

Dr. Ahmed Bayoumi: Because there was an urgent need. This is not a therapy that is on the fringes; this is a therapy that has Health Canada indication. This is a therapy for which there are national clinical practice guidelines endorsed by experts in treating people who use drugs. This is a therapy for which there is a strong evidence base and for which there is evidence of cost-effectiveness.

My concern is that for every other therapy where we had all of those things lined up, we would expect to see that therapy implemented quickly, particularly in the context of a crisis. So the letter really was to urge the government to look at the body of evidence, to act quickly.

Ms. Bhutila Karpoche: Thank you. So this evidence-based therapy would not only save lives but, as you just referenced, would be cost-effective as well in terms of the burdens on our health care system? Can you expand on that a little bit?

Dr. Ahmed Bayoumi: The cost-effectiveness analysis indicated that for people who have not done well on methadone, to continue methadone doesn't make a lot of sense; many people will continue not to do well. Switching them to another treatment like injectable hydromorphone saves costs to the system overall, in part by reducing criminal activity, which also has other societal benefits that are quite obvious. That cost-effectiveness analysis is at a negotiated, discounted price, and it is imperative, I think, that Ontario enter quickly into negotiations with a manufacturer to achieve those discounts.

Ms. Bhutila Karpoche: So here you have now a proven therapy for drug users that would save hundreds, maybe thousands, of lives in the meantime and makes great economic sense in terms of the cost-effectiveness, reducing the burden on the health care system and reducing hallway health care. Do you think that the reason why the government has not acted is perhaps because of the stigma around the use of drugs and the criminalization of drug users?

Mrs. Robin Martin: Chair, point of order.

The Vice-Chair (Mr. Aris Babikian): Point of order, yes?

Mrs. Robin Martin: I believe the question imputes motive, which is not allowed under the rules. I think it's 23(i) of the rules.

The Vice-Chair (Mr. Aris Babikian): Can you move forward with the question? I'm listening closely for—

Dr. Ahmen Bayoumi: I should answer the question?

Ms. Bhutila Karpoche: Yes.

The Vice-Chair (Mr. Aris Babikian): Yes.

Dr. Ahmed Bayoumi: I think stigma and discrimination against people who use drugs are very prevalent in our society and are issues in clinical care; they're issues in the criminal justice system. I would like to believe that they are not issues at the legislative level. You would know that better than I would.

The Vice-Chair (Mr. Aris Babikian): Thank you. Time is up.

Dr. Ahmed Bayoumi: Thank you.

ONTARIO SHORES CENTRE FOR MENTAL HEALTH SCIENCES

The Vice-Chair (Mr. Aris Babikian): I would like to call upon Ontario Shores Centre for Mental Health Sciences. Welcome. Can you identify yourself, please?

Mr. Scott Pepin: Yes. Good morning. My name is Scott Pepin. I am the regional director of mental health and addictions for Ontario Shores Centre for Mental Health Sciences.

Ontario Shores is one of four specialty mental health hospitals in Ontario. Our main hospital campus is located in Whitby, in the region of Durham. We provide specialized care to those with the most acute, serious and complex mental illnesses, from adolescents to seniors, and have both a provincial and a large regional mandate for some of the populations we serve.

Ontario Shores has been a leader in developing quality standards for schizophrenia care, major depression and dementia. We have adopted a recovery model of care that is patient-centred and respectful of those reaching out for help. Ontario Shores has been a leader in implementing a shared electronic medical record system and in advocating for clinical quality standards for mental health.

On behalf of Ontario Shores I would like to thank you for this opportunity to address Bill 116, the Foundations for Promoting and Protecting Mental Health and Addictions Services Act. I will specifically address the first component of the bill, the proposed Mental Health and Addictions Centre of Excellence.

From the time that the tri-party Select Committee on Mental Health and Addictions, led by the current Minister of Health, released its report nine years ago, Ontario Shores concurred with the need to "manage and coordinate the mental health and addictions system" and ensure that "programs and services are delivered consistently and comprehensively across Ontario." We support the creation of a Mental Health and Addictions Centre of Excellence.

It has been said that there is no health without mental health. We would add that unless there are coordinated services throughout the province, we do not have an actual system. As they currently operate in Ontario, mental health services are fragmented; they do not have standards of care nor do we have consistency across the province. A true system for mental health would provide for transitions from youth to adults to seniors. It would be capable of accommodating the regional and cultural challenges that exist in Ontario. Also, and essentially, we believe that the centre of excellence could provide for appropriate long-term planning and allocation of resources in a comprehensive and thoughtful approach.

In our analysis of the centre of excellence model, we will continue to advocate for the province to leverage leading mental health organizations that don't fit traditional Ontario health teams to coordinate and align providers into one system through establishing regional leads. A regional leadership structure facilitating the work of the centre of excellence would be the mechanism where Ontario Health could more effectively ensure and influence accountability agreements and other key drivers that will be needed to develop a true mental health system. Regional leads, transcending multiple OHT jurisdictions, would address the language needs that differ across Ontario. It would demand and command attention for the exceptional needs of our First Nations and other unique needs of Ontario communities.

Ontario health teams will play a critical role in coordinating services across the continuum. However, without a regional level of scrutiny and with the volume of OHTs being proposed, it will be difficult to ensure that mental health is maintained as the priority that the government and the select committee have identified it to be.

The province has organizations like Ontario Shores, whose entire specialty is in mental health and addictions, and who have been thought leaders and innovators. We believe organizations like ours have the expertise to help develop the standards that are needed. We have the experience of delivering the programs and working to address the needs of the whole person. We have a strong reputation for innovation and effective use of resources.

1000

The Vice-Chair (Mr. Aris Babikian): One minute.

Mr. Scott Pepin: We are proud of the work we do and we look forward to contributing to the development of a full mental health and addictions system in Ontario.

Thank you for your time and I look forward to your questions.

The Vice-Chair (Mr. Aris Babikian): Thank you. The opposition side questions: MPP Harden.

Mr. Joel Harden: Thank you for your presentation.

As an expert in the field, why do you think we still carry a stigma around mental health? Why is mental health, given the knowledge that has been spread at the federal level, consistently underfunded relative to other health needs that we have in our provincial system?

Mr. Scott Pepin: Thank you for the question.

Mental health has traditionally been underfunded, from a non-partisan point of view. There are a lot of different priorities. We think that with the new funding that possibly can be coming, we can start doing some work towards that. There have been a lot of social campaigns that have really decreased stigma, and we're just getting people now who feel like they're able to come out and speak to it and seek treatment, so now we need to have a system that can be responsive to that population.

Mr. Joel Harden: Thinking within the continuum of stigma, if I can use that term, the opioid crisis carries a unique burden in that regard because—in the city of Ottawa, I can tell you, we've had 94 people pass away, given tainted supply. We've met with police, public health and local impacted small businesses. I'm wondering why we have a different standard for the mental health needs of drug users. I ask because when we had a listeriosis crisis in this province, we took immediate action to hold the producers accountable. When we had a tainted water crisis in Walkerton, we took immediate action to make sure to secure the water supply. Why do we have a different approach at the moment? Why are we reviewing a public

health emergency that is literally killing people every week in this province?

Mr. Scott Pepin: Thoughts are evolving on this. I think we're just getting to the point with mental health that we're seeing it as an illness. There still has to be a lot of public awareness that addictions is a medical illness and that it is something that needs to be treated. There still needs to be significant work, both in the public and in other sectors, to really recognize that.

Mr. Joel Harden: Understood. One of the things we're pressing upon the government is to release the $174 million they've promised to twin with the federal funding. Would you join us in asking our colleagues in government to make sure that that $174 million they promised in the provincial election would flow as immediately as possible, so experts like you and folks on the front line helping folks with mental health needs get the funding they need?

Mr. Scott Pepin: We clearly would love to be able to access all possible resources to work on the work that we have planned—

Mr. Joel Harden: Can I take that to be a yes?

Mr. Scott Pepin: We would definitely look to receive all possible funding. We need everything we can to do the work on the ground to help start tackling both the issues of mental illness and of addictions.

Mr. Joel Harden: Okay, thank you.

The Vice-Chair (Mr. Aris Babikian): MPP Karpoche.

Ms. Bhutila Karpoche: Thank you for your presentation. You referenced recognizing that mental health is health. We've heard from presentations earlier today linking the social determinants to mental health needs. Would you say that in order for the government and for the province to move forward on a mental health and addictions strategy, it is critical—that the social policies in other areas in other ministries, like employment standards and labour, housing and such, are going to influence mental health and addictions in a big way?

Mr. Scott Pepin: I think so, incredibly. I don't think mental health and addictions should be just under one view of just health. I think we need to look at it from all aspects—

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Mr. Scott Pepin: —of our ministry. I think we need to look at it from the labour perspective; I think we need to look at it all that way. If we just look to health to tackle this issue—this issue crosses multiple sectors, and it's not only a health issue.

Ms. Bhutila Karpoche: Right. The work that you and others in the sector are doing would actually—you would face greater challenges and burdens on other fronts like on the minimum wage, on scheduling—

The Vice-Chair (Mr. Aris Babikian): Thank you, MPP Karpoche. Your time is over.

MPP Kusendova.

Ms. Natalia Kusendova: Good morning and thank you so much for being here.

I was listening to your deputation very attentively. I'm very proud that mental health is a priority for our government. We were very clear during the campaign about this. But also, very early in our mandate, we appointed an associate minister whose sole responsibility is to advocate for mental health and addictions. So to respond to the previous comments that were made, Minister Tibollo—actually, his sole responsibility is to be at that cabinet table and talk to his other colleagues across the ministries about the needs and advocacy in mental health.

Our government has been very clear that we have invested $3.8 billion over the next 10 years and we have moved forward with establishing the new centre of excellence very early in our mandate. This is something that was recommended nine years ago. We take those recommendations very seriously, and that's why we're moving forward with the centre of excellence. Furthermore, we are working on the mental health and addictions strategy, and this will be coming forward.

Can you tell us a little bit more about how you see your hospital working with the new centre of excellence?

Mr. Scott Pepin: So far, we've been consulted at different points and we're very much looking forward to continuing to work with the centre of excellence. We see that it is very important that the centre taps into the regional expertise of the four major hospitals—but also my colleagues here, who have presented today, in the community. I think having that close connection with consultation will be very valuable. We're looking to see that the centre looks at regional areas, looks at regional models to be able to help promote the work of the centre.

Ms. Natalia Kusendova: It is anticipated that there will be local Ontario health teams with a regional level of resources and a provincial level of resources as well. Do you have any comments about that?

Mr. Scott Pepin: Thank you for that question. That was a big piece of our presentation today.

There will be local OHTs that will not have access to all the regional and even provincial mental health services. So a hospital like Ontario Shores, which has provincial services, has to be somehow responsive to OHTs within the province. We're still looking at ways in which we can possibly meaningfully engage the entire province at that level but also do it at a regional level. We are looking forward to working in that field, but tapping some of these hospitals as regional leads will also be very important.

Ms. Natalia Kusendova: We know that mental health services are fragmented and around the province, regionally, the needs are very different. Do you believe that this new centre of excellence, with the data that will be gathered locally but also fed into this one model, will help us to plan for future mental health services?

Mr. Scott Pepin: Absolutely. I think that is one of our challenges—that we're not planning as a whole, as a system, and we want to make sure that the data is helping us, informing us, where investments need to be in the future and that we're investing in evidence-based care.

The Vice-Chair (Mr. Aris Babikian): MPP Harris.

Mr. Mike Harris: I know we don't have a lot of time left, but I just wanted to get a quick understanding of—

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Mr. Mike Harris: —how you've moved to electronic health records and what that has meant for outcomes for your patients.

Mr. Scott Pepin: It's extremely valuable being able to have an electronic health record that allows us to be across all our sites—easy access. We also have a patient portal that allows patients to interact with their clinicians. It's something that really should be happening. It should be available across Ontario, where patients can actually see their appointments, connect with their therapist using different modes of—

The Vice-Chair (Mr. Aris Babikian): Thank you.

Mr. Scott Pepin: Thank you very much.

TORONTO OVERDOSE PREVENTION SOCIETY

The Vice-Chair (Mr. Aris Babikian): Our next witness is the Toronto Overdose Prevention Society. Welcome. Please identify yourself.

Ms. Zoë Dodd: Thank you to the committee for the opportunity to comment on Bill 116. My name is Zoë Dodd. I'm a co-organizer with the Toronto Overdose Prevention Society. For almost two decades, I have worked on the front line in harm reduction, supporting people in the downtown east of Toronto. For the last number of years, I have been heavily involved in addressing the overdose crisis, and I am just completing a master's degree with a focus on drug treatment.

I am here today speaking on behalf of the Toronto Overdose Prevention Society, which is a group of people who use drugs, front-line workers, health care providers, harm reduction workers, advocates and allies. We formed in 2017 as a response to the lack of government action on the overdose crisis and were responsible for the opening and operating of two unsanctioned overdose prevention sites that ran illegally in Moss Park and Parkdale. We also worked with the then Liberal government to establish the provincial overdose task force, which I was a member of. The task force has not met since August 2018, despite the overdose crisis raging on unabated, taking the lives of thousands of Ontarians.

1010

I have witnessed first-hand the devastating impact of state neglect regarding this crisis, feeling it both professionally and personally. I cannot tell you how many people I have known and who I have supported in my work who have died. I have lost count. I attend more funerals then celebrations and I say "I'm sorry for your loss" almost every day. This last week alone, I have been to two memorials for friends and colleagues who have died. In just over two years in this province, we have gone from two people dying a day to four—the majority of these preventable overdose deaths related to illicit fentanyl.

Seeking support for substance use within the current treatment system can be a challenging experience. Long wait times, a lack of diversity in programming and models, a lack of evidence-based programs, limited access in rural and remote communities, limited access in high-density urban areas and cost are many of the barriers.

The drug treatment system should have regulations, standards and oversight; it does not. There should be options that are non-abstinence-based, culturally safe, cultural programs, LGBTQ2S and gender-specific. Government needs to support this system in transformation with resources and funding and bring it into the publicly funded and administered system.

The newly proposed centre of excellence does not, by all accounts, have funding or resources attached to it and may continue to focus the majority of its attention on mental health, neglecting a system that has historically been left to the private public sphere. According to the newly released Auditor General's report, "The ministry also does not measure the effectiveness of addictions treatment service providers, which results in funding being given to service providers without consideration of whether their programs are effective." This needs to end. Why are we throwing millions at a system that does not work and is not effective?

We are living in unprecedented times. The urgency has long since passed. We are now years into this crisis that went from 867 deaths in 2016 to 1,473 in 2018—a 70% increase. This crisis is one fueled by a tainted drug supply of illicit fentanyl and carfentanil, and without the harm reduction measures that we currently have in place—consumption treatment services, overdose prevention sites, naloxone distribution—double the amount of people would be dead.

Communities are desperate to implement these measures with urgency. We need an emergency response that helps to expand these services. Drug-related emergency room visits are continuing to climb, and our overdose death rate is going to surpass British Columbia's by the end of the year.

People on the ground are sick of begging for a proper response. We are demanding one. The solutions to ending this crisis are here. You can't ask the federal government to give us more money for health care and, at the same time, cut our public health units, which prevent further health care costs, and on top of that, cut funding to life-saving supervised and overdose prevention sites. It's totally hypocritical.

Expansion of overdose prevention needs to happen immediately. All first responders, including fire, should have access to naloxone. Funding should be immediately restored to Street Health and St. Stephen's overdose prevention sites. They are located in the epicentres of the overdose crisis here in Toronto, and we need them. These programs work. They save lives and they connect people to immediate counselling, supports and referrals.

The Vice-Chair (Mr. Aris Babikian): One minute.

Ms. Zoë Dodd: There are communities desperate to have these sites. They need to be able to open, fund and support them.

We need government to support and fund safer supply programs and help us to bring in a non-toxic drug supply

to people who are using so they reduce their risk of overdose and death. We need high-dose hydromorphone on the formulary, as Ahmed spoke about, injectable heroin programs, a scale-up of proven interventions and the reinstatement of the overdose task force.

At the same time, the factors that exacerbate people's mental health issues and put people into peril are structural. They are our social conditions. We could save money in the health care system if the government ended their austerity agenda and worked to improve people's quality of life—a higher minimum wage, an increase in social assistance rates, investments in affordable housing, introduction of rent controls, reversal of cuts to education and investments in community.

We are in an emergency, and this bill does nothing to help us get out of it. This is a distraction and not a concrete solution. Trying to recover money from pharma takes years, and there is no guarantee that these funds would be used adequately. We are in an emergency. It's time we acted like it.

The Vice-Chair (Mr. Aris Babikian): Thank you. MPP Martin.

Mrs. Robin Martin: Thank you, Zoë, for coming and for your comments. I recall meeting you at the opioid symposium, which was a two-day symposium down at the Globe and Mail building, and speaking with you there. It was very moving, actually, to hear the testimonials of the people who were there—some parents of children who had been lost in the opioid crisis. I recall especially the young man who spoke at the very end and talked about how he had finally gotten off using. He showed a picture of himself with his wife and two children. He said that it was very important to him that there was a consumption site available and it saved his life. I think he said he died eight times—it kind of stuck in my head—but was brought back, and then he finally was able to get off of using and make a life for himself. It was very moving and made a real impression on me, and helped me to relay to my colleagues how important the opioid sites are for people, to keep them alive so that they have a chance to get better.

As you know, our government set up this new consumption and treatment site model, and that was after a number of consultations with experts in the sector and people with lived experience, including Dr. Bayoumi, who was here earlier. What we heard mostly was that—

Interjection.

Mrs. Robin Martin: Oh, you're still here. I'm sorry, Dr. Bayoumi. I didn't see you there.

What we heard was that the model that existed at the time, anyway, the model then, didn't have enough wraparound supports and services for people, that it was really simply a place for them to inject, which is one thing; but there are better models in the sense of getting people more help and more access to help.

The minister and I went and toured a number of sites, including the one at Regent Park—

Mr. Jeff Burch: Point of order, Chair.

The Vice-Chair (Mr. Aris Babikian): Point of order.

Mr. Jeff Burch: We would like to hear from the presenter at some point. Is there a question—

Mrs. Robin Martin: I'm getting to my question.

The Vice-Chair (Mr. Aris Babikian): It's her time, and she can use it as she wishes.

Mrs. Robin Martin: Sorry, I'm getting to my question.

The Regent Park one seemed to us the best model, in the sense that people, when they walked in, were greeted with harm reduction supplies, if that was what they wanted. They were offered a place to do their laundry, a place to shower, a primary care physician upstairs. If they would like, they got on a list for affordable housing. That really inspired us to say that we can do better and make some of these sites better for people, to give them these wraparound services.

I think that that is the basis of the model we have, and that's why I wanted to ask you if you agree with what we heard from all those other experts, which was that this is the better way to help people.

Ms. Zoë Dodd: Yes, I just wanted to point out that those were the models. Before you came in and did the review, those were actually the models. They were always the model. The Regent Park Community Health Centre model was the model. They have primary care they've embedded in a community health centre. Street Health is in a nursing clinic with wraparound services with nurses and harm reduction—I used to work there. It has an extensive 30 years.

All of the models always had that, even before the government did their review. That was always the model that we created. We created wraparound services for people.

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Ms. Zoë Dodd: So I thank you that you supported consumption and treatment services, but I think we don't need to misconstrue this. Those were the models to begin with. You called it something else, but it is the same model.

Mrs. Robin Martin: But not everyone had all that.

Ms. Zoë Dodd: No, we had all those things. We always did.

Mrs. Robin Martin: Not everyone we visited did—

Ms. Zoë Dodd: No, because you didn't visit all the sites, but they do. They do, actually. They always did.

Mrs. Robin Martin: Some of the ones I visited did not.

Ms. Zoë Dodd: Yes, even the one that I worked at has primary care and access to hepatitis C treatment. We always had them. We always built them in. That was always the plan—

The Vice-Chair (Mr. Aris Babikian): Thank you.

Mrs. Robin Martin: Thank you.

The Vice-Chair (Mr. Aris Babikian): MPP Karpoche.

Ms. Bhutila Karpoche: Thank you for your presentation.

I want to thank you and all the other harm reduction workers for stepping up and for the courage you showed in opening the unsanctioned sites—one was in my riding of Parkdale–High Park—because we knew that when the government was creating barriers and causing delay in the opening of the already approved sites, it was really up to the harm reduction workers to step up to save lives. So thank you very much for that.

Ms. Zoë Dodd: Thank you.

Ms. Bhutila Karpoche: You're on the front lines, on the ground when it comes to saving people's lives, when it comes to the overdose crisis. As you mentioned in your presentation, the opioid task force has not reconvened since the election. The government, when it should be listening to experts like yourself in terms of addressing the public health emergency that we are in the midst of—we are seeing that they are not.

Given that the government is not listening to subject matter experts like yourself when it comes to addressing the overdose crisis, would you say that the government does not have a full grasp of the scale of the crisis?

Ms. Zoë Dodd: I think the government maybe does know the grasp of the crisis, because they could receive the coroners' reports. I think the interest in actually addressing the crisis in a proper way does not exist.

They should reinstate the overdose task force, which had 40 representatives representing a number of stakeholders and was non-partisan. I was on that task force, and we were doing a tremendous amount of work. I think you need a body like that and oversight to actually show that you're addressing a public health emergency.

I wouldn't blame the Conservatives alone; the Liberals also neglected this, so they adopted it. But we have a responsibility—and that's just not what's happening on the ground. We watch people die constantly. We can't just be reversing overdoses forever. This is so unprecedented. You can't let thousands of people die—but, apparently, in this province we can. And that is what's happening here. We just bury people. We go to identify bodies. We do their memorials.

1020

If that was happening in Queen's Park where your colleagues were also dying, you would definitely act. But where we are, we're losing our co-workers, and there is no support for us. There's no trauma support for us. There has been no money that has been funnelled to help us with therapy. And then what about all those grieving people, those thousands of people? You talk about mental health. What about all those people that are going to have to access mental health supports in the future? Why not prevent their grief and their trauma? Because we are really, really traumatized.

Ms. Bhutila Karpoche: Thank you. The government came up with their consumption and treatment sites and put a cap at 21. Is that enough to address the crisis?

Ms. Zoë Dodd: No, we need more. Even in the city of Toronto, there are pockets where the epidemic is so high, like at Church and Wellesley; they could use a site. Just like addiction or mental health treatment, they should be where there is a need. We need to expand those services. There are communities so desperate to have what we have, because right away, you walk in the door, you can get counselling on the spot, you can meet with someone, you have people to talk to, you can reverse overdoses. Thousands of overdoses have been reversed in the city of Toronto. Why cannot every community have these, when there is a need? There is such a need right now, and it is a great opportunity to then build in other programs and look at treatment in a different way.

Ms. Bhutila Karpoche: Toronto OPS was already doing the important work on the ground of saving lives to address the overdose crisis. With the announcement of the review under this government when they came into power, and then the capping of the sites and the other barriers in terms of the delay in the funding flow, what kind of chaos did it create in the work that you were doing and how did that impact people's lives?

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Ms. Zoë Dodd: It was absolutely traumatizing. We didn't know if we were going to get funded or if we were going to cut—if people were going to be able to live. We didn't know if our sites were going to exist or if we were going to be abandoning people, and then we watched sites that did get cut and we didn't understand why, because they met all of the qualifications. Then we were short-staffed while we waited for funding. While we had carfentanil, we would have six overdoses in like five hours—four at a time where we would be responding short-staffed. It was actually dangerous to have people short-staffed, but it also was traumatizing to us.

The Vice-Chair (Mr. Aris Babikian): Thank you very much. Time is up.

Ms. Zoë Dodd: Thank you.

CHILDREN'S MENTAL HEALTH ONTARIO

The Vice-Chair (Mr. Aris Babikian): I would like to call upon Children's Mental Health Ontario. Welcome. Please identify yourself.

Ms. Kim Moran: My name is Kim Moran. I'm the CEO of Children's Mental Health Ontario.

The Vice-Chair (Mr. Aris Babikian): Go ahead.

Ms. Kim Moran: Thank you for having me here today. Children's Mental Health Ontario is the association representing Ontario's publicly funded child and youth mental health centres. With the combined strength of our members, we advocate for government investments, policies and programs that are responsive to the needs of children, youth and families seeking mental health services in Ontario. My remarks today are focusing on schedule 1 of the bill, the Mental Health and Addictions Centre of Excellence Act, 2019, and are grounded in what we hear from youth, families and our member agencies.

It's our understanding that Bill 116 is intended to support implementation of the forthcoming mental health and addictions strategy, including clinical, quality and data standards, monitoring metrics and providing resources and supports to service providers. These are critical pieces for systems building in mental health and addiction and are long awaited and much needed.

However, at the same time we should have announced significant investments to expand front-line services for children. Right now, children are waiting far too long. They've been waiting and waiting over successive governments, and we're still not seeing action. We have to sort out what the biggest problem is and what the biggest

priority is, and that is to get kids off extraordinarily long wait-lists. Right now, in each and every one of your ridings, kids can wait up to 40 months for treatment. That's just not okay. All of you know that because you've heard from the families. You know first-hand because you've heard from families directly about how terrible this is. I know first-hand that kids can't wait that long. My daughter while on a wait-list went from sad to depressed to suicidal in two and a half months. She ended up in hospital.

We have a real issue with hallway health care right now. These are kids, tens of thousands of kids every year, who are going to hospital who don't need to be in hospital. We know that's not the best place for them. So not only should we treat kids because they're on the wait-list; we need to treat kids because they create pressure in hospitals that's completely unnecessary.

Another young boy we know, Matthew, has been to the hospital over 50 times in the last two years—50 times. He can be aggressive because of his mental health issues. He thinks about suicide every day. He can't get the ongoing intensive treatment that he needs. His care in hospital costs hundreds of thousands of dollars, and his care in the community would be substantially less. The impact on his family is immeasurable. His family is, honestly, the best people I have ever met, who have supported their child through amazing things. But they need help, and they can't do it without people like you acting.

While the mental health centre of excellence is very much important in terms of building up foundational supports, it should have come accompanied by significant investments to reduce these very long wait times in children's mental health.

The Ontario health teams are very promising, and we're looking forward—and our member agencies are working with them. But they don't in themselves solve an undercapacity problem, and so this capacity problem, in order to enable Ontario health teams, has to be addressed.

Imagine if it was your kid. Imagine the desperation you would feel. Certainly, I feel it, but I hear it from parents all across the province—that they need help and they need help from government. We sounded the alarm on this almost five years ago. There has been no action on this, and it has to be addressed.

Remember that mental health stigma has fallen over the last couple of years. The service system has depleted over that same period, so we have much-increasing demand while we have a hugely decreased supply of services. That has created a big gap.

The other thing we know is that prevalence is starting to rise. The prevalence of mental health issues is starting to increase. That pushes demand, as well as help-seeking behaviour. The good thing is, because mental health stigma has fallen, more people are seeking help. The reason why that's good is because, as you heard from the last speaker, if we don't get kids early, they will be in our social service and health care systems for the rest of their lives.

Early intervention works. We know it, so the most important thing we can do is get these kids treated and off of the wait-list promptly.

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Ms. Kim Moran: We have a plan that we've presented to government multiple times, to say that we can get kids off of the wait-list and actually result in a savings to government in total health care costs.

This is the right thing to do. We urge all of you to work together to make sure that kids get the help they need within 30 days.

The Vice-Chair (Mr. Aris Babikian): Thank you. MPP Burch.

Mr. Jeff Burch: Thanks for being here, Ms. Moran.

My wife, Linda, works at Pathstone children's mental health in Niagara, so I understand the stresses that the system is under.

Can you talk a little bit about the need or the importance of a specific strategy for children and youth within the system?

Ms. Kim Moran: Absolutely. Children are not little adults; they have a unique service system. There are certainly parallels with lifespan mental health, but they have unique needs. They have unique needs in terms of service standards. They have unique needs in terms of service delivery systems. So the strategy, which we've been waiting for for a very long time, has to absolutely deliver on the unique piece that children have, as well as the fact that early intervention works. That has to be a foundation for the entire strategy.

Mr. Jeff Burch: We've heard a lot about strategy, and this bill actually creates a central bureaucracy, if you will. It makes it easier for the government to join opioid lawsuits. We've heard about the dedicated minister—all things I think we can all agree on. But the one thing we're not seeing is funding going to the front line. How successful will any of these measures that the government is engaged in so far be without the funding?

Ms. Kim Moran: Well, they won't be. Families have to see action. Families want high-quality services, for sure. But the desperate moms and dads I hear on the phone every single day want to see an expansion of front-line services right now.

Mr. Jeff Burch: Thank you.

The Vice-Chair (Mr. Aris Babikian): MPP Karpoche.

Ms. Bhutila Karpoche: Thank you for your presentation. You shared with the committee that there are children waiting for up to 40 months and ending up hospitalized. How many children and youth are currently on the waiting list?

Ms. Kim Moran: We're just doing a study right now, so we don't have all of the results right now. It's climbing—we know from the last time we collected data—but I don't have the specific data. What we do know right now is about wait times. Wait times, say, for example, in Thunder Bay are close to a year. In London, they're over a year—in many of these hot spots.

1030

Ms. Bhutila Karpoche: And how much investment would be needed so that children and youth do get the services in a timely manner, within 30 days?

Ms. Kim Moran: We estimate, at $150 million, that we can—that's the right expansion of services.

As I said, the cost we've estimated in hospital right now annually for kids who don't need to be there is $260 million, so obviously it provides a strong return on investment. The investments need to go to counselling and therapy, which are the biggest pressure points, where we have the longest wait-lists, as well as intensive treatment.

So for those kids like my child who, because we waited, became very seriously ill—like Matthew, who I referenced previously—who have very serious mental health issues. They need intensive treatment. And actually the system has been depleted over the last number of years due to underfunding. That needs to be shored up because those are the kids who are actually being readmitted over and over and over again into hospitals.

Ms. Bhutila Karpoche: The government announced $174 million in mental health and addictions, which is the federal money. And according to the federal-provincial agreement, the province is supposed to match that. So the province is supposed to now cough up $174 million. The FAO's report—the Financial Accountability Office—showed that the government actually cut funding by $69 million.

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Ms. Bhutila Karpoche: Given that we're already in December now and that the budget cycle ends in March, do you think we will see the provincial $174 million?

Ms. Kim Moran: Well, we want to see it. I can't speak to that, but kids desperately need to see this money come to them, in terms of expansion of front-line services. So we urge the government to make sure that kids get the services they need as soon as they need them.

Ms. Bhutila Karpoche: So you haven't seen the provincial $174 million yet?

Ms. Kim Moran: There was an investment in base funding and an expansion of services—

The Vice-Chair (Mr. Aris Babikian): Thank you. Time is over.

Ms. Bhutila Karpoche: From the federal—

Ms. Kim Moran: Yes.

The Vice-Chair (Mr. Aris Babikian): MPP Hogarth.

Ms. Christine Hogarth: First of all, I just really want to thank you for your presentation and I want to thank you for all the work you do. I'm sure it's rewarding, but also probably frustrating.

Ms. Kim Moran: A little frustrating.

Ms. Christine Hogarth: I can hear that. Our children are our future, so we have to make sure we look after them, for sure. The more we learn and we talk about mental health—the importance is to get it looked at early. I can't even imagine being a parent and going through what some parents have to go through, so my heart goes out to those parents out there.

I went on a tour with Minister Elliott of our St. Joe's hospital, just down the road from my riding of Etobicoke–Lakeshore, to see the great work that they put together. They put together some wonderful rooms. When we talk about mental health, we have to also talk about wellness. If we go back in time, it was a scary thing. So we are at least moving forward as people to make sure that these kids aren't afraid.

And we can do so much better. We do agree with you that more needs to be done. That's why we want to move forward with this. And I know the one thing, transferring the responsibility of child and youth mental health to the Ministry of Health, was a big first step.

Ms. Kim Moran: We're very supportive of that effort. I think that what we had hoped, though, is that we would see action very quickly on this. I get phone calls from parents every single day. That's where my frustration comes; it's just hard to listen. It's hard when you know that there's nothing we can do at this point. That's where the impatience comes from.

Ms. Christine Hogarth: I understand that, and we are investing the $174 million annually, which will, over 10 years, be $1.7 billion from the province. So I just wanted to clarify that money is in addition, and in the system and being spent.

Ms. Kim Moran: It is, and I completely—I appreciate all that. I think that the problem is, though, that there is an urgent need for more. The government announced more money than that, and we really need to see it get to front-line services as soon as possible.

Ms. Christine Hogarth: And we are working on a mental health strategy which will be announced in the future. We just don't have a date yet.

But I just really want to talk about what Children's Mental Health Ontario feels are benefits to having a stand-alone body, such as a centre of excellence. What do you think that will be?

Ms. Kim Moran: As I said at the very beginning, we are absolutely supportive of implementing the strategy through that body, including clinical, quality and data standards, monitoring metrics and providing resources and supports to service providers. That work is important work and it's been delayed over the last successive governments. So we're happy to get it going. I think that the way we look at it is, we have to do both things at once. We have to expand front-line, and do those foundational elements at the same time.

Ms. Christine Hogarth: How do you see that this new centre of excellence will work with the Ontario centre of excellence in child and youth mental health through CHEO?

Ms. Kim Moran: I think that's still sort of TBD at this point. What we said to all involved is, let's make sure it's seamless, make sure every single dollar that's invested, in terms of the support functions, is driving really good results, so there's no overlap or duplication. We're happy to help out with that.

Ms. Christine Hogarth: Wonderful. And really, the reason why we need to do this is because we do have a fragmented system and it lacks standardization. It lacks data. To get the outcomes we want, we need that data. Do you want to just expand a little bit on that?

Ms. Kim Moran: Absolutely.

The Vice-Chair (Mr. Aris Babikian): Thirty seconds.

Ms. Kim Moran: I think what we've talked about is that we have a plan to reduce the fragmentation. We have a plan where we would brand our child and youth mental health centres with a quality strategy. So if you can achieve certain quality standards, then you would achieve the brand as well. That would reduce fragmentation, increase quality, and enable that centre of excellence to improve the quality throughout the sector.

Ms. Christine Hogarth: We look forward to continuing to work with you as we move forward with this legislation. Thank you very much for all you do.

Ms. Kim Moran: Thank you.

The Vice-Chair (Mr. Aris Babikian): Thank you.

CANADIAN MENTAL HEALTH ASSOCIATION, TORONTO BRANCH

The Vice-Chair (Mr. Aris Babikian): Next is the Canadian Mental Health Association, Toronto branch. Welcome. Please identify yourself.

Mr. Steve Lurie: Steve Lurie, executive director of CMHA Toronto.

The Vice-Chair (Mr. Aris Babikian): Go ahead.

Mr. Steve Lurie: I want to thank everybody for inviting me here, and I want to just briefly comment a bit about my background. I've been working in mental health and addictions at the community level for CMHA for almost 45 years, so I've seen a lot of reforms come and go.

In addition to my work in the sector, I also teach health and mental health policy at the faculty of social work. I think my academic experience is fuelled by what I've observed in the sector.

I have been involved in a number of provincial initiatives beginning with, in 1987, I helped write the Graham report, Building Community Support for People, which I think has been a foundational framework for much of the work the government has attempted in mental health for the last 32 years. Also in that year, and I've appended it to my submission, I helped former MPP David Reville develop Bill 50, which was a private member's bill, An Act to provide for Community Mental Health Services. I think that's very relevant to your discussion today, so I'll be commenting on that later on.

In 2005, I worked with Senator Kirby to do a fiscal review of mental health funding in his report Out of the Shadows at Last, which led to the establishment of the Mental Heath Commission of Canada, and I chaired the MHCC Service Systems Advisory Committee and was on their advisory council.

In this province, I recently co-chaired the HQO committee which developed the schizophrenia standard for care in the community. That's why I am so excited about the role of the centre of excellence, to push the implementation of those quality-based standards.

I was one of the founding board members of CAMH, and I'm currently a board member of Addictions and Mental Health Ontario.

You've seen my relatives here today: Camille Quenneville from CMHA, Adrienne Spafford from AMHO and Kim Moran, who is on our board of directors. We all try to work together as a happy family.

Now I want to turn to some main messages. I want to say to you that Bill 116 has great potential to end the mental health and addictions system's status as what Dr. Paul Garfinkel has referred to as health care's "orphan child." He made that statement at the turn of this century. This is the opportunity, more than 15 years later, to build on that.

The establishment of the centre of excellence provides Ontario with opportunities to expand and scale evidence-based practices such as assertive community treatment, intensive case management, Housing First, supported employment, peer support, family support and early psychosis intervention. All of these things exist but not in sufficient supply in Ontario. So, to Kim's point, we need to invest in capacity as well.

The centre must also ensure that existing investments in mental health and addiction services are protected and enhanced, and not diminished, as OHTs are established. So the notion of a unified budget, without an ability to protect current investments and build on current investments in mental health and addictions, may result 10 years from now in people getting fewer services than they currently require. There needs to be a strategy to protect and enhance.

It also has an important role to ensure that the federal health accord investments and, I must say, the provincial match investments that this government committed to—the only province in the country—are invested in evidence-based care, innovation, and we need proper monitoring.

There is also a great opportunity to work collaboratively with the sector on implementing the quality standards from HQO that have been developed for mental health and addictions, as well as monitor and support the work of the OHTs in mental health and addictions as they develop.

1040

I now want to turn to some brief commentary on the following areas: the legacy of Bill 50, which was done 32 years ago; and the need for investment and implementation, which will echo some of Kim's comments.

The legacy of Bill 50: The case for improved access to mental health and addictions services and increased funding, as well as the need for a mental health and addictions strategy, draws on the recommendations of the Select Committee on Mental Health and Addictions, which was co-chaired by Minister Elliott. You have well-captured that in Bill 116's preamble—

The Vice-Chair (Mr. Aris Babikian): One minute.

Mr. Steve Lurie: One minute. Okay.

They laid out principles for care delivery which I believe need to be stated, and I'll probably end with these:

—planning and service delivery based on the needs of the person;

—encouragement of service users to participate in the development of treatment and service plans;

—a whole-person and lifespan focus;

—entitlement to live and receive age-appropriate services and least-restrictive alternatives;

—individual service plans;

—coordinated delivery; and

—including community housing and psychosocial services.

Given that my time has run out, hopefully you'll ask me some questions about funding and implementation.

The Vice-Chair (Mr. Aris Babikian): Thank you very much. MPP Harris.

Mr. Mike Harris: I'm not sure if you were here earlier when Camille had a chance to address the committee, but we were talking a little bit about some of the programs that the Canadian Mental Health Association is running. I'm really involved with one of those back in our community, which is the IMPACT program. I'm not sure if you're running something similar to that here in Toronto, where you have embedded clinicians with police services, but I was curious to know: What are some of the other things you're doing here in Toronto that are really helping to benefit the community, and how do you think this centre of excellence that we're proposing can help you do that job better?

Mr. Steve Lurie: I think I mentioned we provide assertive community treatment, stepped care. Our stepped care program in Scarborough, which is a combination of ACT, case management and a nurse practitioner, has created conditions in Scarborough where they actually have some bed capacity in the hospital because people aren't returning.

We do a lot of work in mental health and justice services, including community-based forensic services. We're running a national employment program. I'd be remiss if I didn't talk about the work that I and 26 other agencies do in supportive housing. The Housing First model works. It can reduce homelessness. We need much more investment in that area, both on the capital side as well as in services, to make sure that people who are struggling—it's been said that there is no health without mental health, but there's no mental health without housing.

That's just a sampling of some of the programs that we run.

Mr. Mike Harris: Thank you.

The Vice-Chair (Mr. Aris Babikian): MPP Kusendova.

Ms. Natalia Kusendova: Thank you, Steve, for being here. You've mentioned that services exist but not in sufficient supply, and that certainly has been my experience as an emergency room nurse dealing with mental health issues. Anecdotally, a lot more patients are coming into our emergency rooms with mental health issues. That's why I think the creation of this mental health centre of excellence is so important. We will now be able to collect data that will feed into the system so that we can better plan for locally driven, community-based services to keep patients outside of the emergency room—because patients should really be going into the community first. The emergency room should be the last resource—which is not happening currently.

Can you tell us a little bit more about the challenges that community-based mental health and addictions service providers currently face in Ontario, and how the new centre of excellence can potentially address those challenges?

Mr. Steve Lurie: Well, for one thing, the major challenge is the F-word: the lack of funding. It's interesting that New Zealand recently approved a mental health and well-being budget annualized at $1.9 billion. Even with this government's commitment for $3.8 billion over 10 years, that gets us about a third of the way to the target of the 9% of health care spending and the 2% of social spending that's required to actually ensure that Ontarians receive the mental health and addictions services they need.

When the mental health commission did this work on the funding piece, we actually looked at the GDP of the countries that were spending more. The average GDP of countries that were spending 9% or more was about $22,000. Ontario's GDP is $48,000, so we can afford to make these investments. These kinds of investments would significantly reduce wait times and allow us to scale up evidence-based services, so I think it would be—

The Vice-Chair (Mr. Aris Babikian): Thirty seconds to wrap up.

Mr. Steve Lurie: I think it would be really important that the centre for excellence develop a multi-year spending plan with targets for both housing and the related services.

Ms. Natalia Kusendova: Thank you.

The Vice-Chair (Mr. Aris Babikian): MPP Karpoche.

Ms. Bhutila Karpoche: Thank you for your presentation. You referred to mental health and addictions, for a long time, being considered the health care system's orphan child. It has been said several times right now that the centre of excellence in mental health and addictions should be modelled after Cancer Care Ontario. But we know, right now, under this government, that that has pretty much been folded under Ontario Health, the superagency.

Given that Ontario Health is now going to be responsible for all of these agencies, do you think that mental health and addictions will be given the priority they need under Ontario Health, or are we in danger of keeping mental health and addictions as an orphan child?

Mr. Steve Lurie: I think the fact that this legislation directs Ontario Health to actually implement a plan for mental health and addictions, and hopefully take Kim's advice and implement funding to increase capacity—without it, I'd be very worried, but I think this is a once-in-a-generation attempt to do for mental health and addictions what Cancer Care Ontario did for cancer care.

I think the integration with Health Quality Ontario also has some real promise. For example, we should be focusing on implementing things like the schizophrenia standards. Dr. Phil Klassen has identified there are four out of the 15 that actually delivers the goods: a comprehensive

physical examination, injectable medication, CBT for psychosis and family intervention therapy. If we just said that in year 1, we're going to focus on making sure that people who are providing services to people living with schizophrenia do those things and make sure that they have the resources to do those things, that would be absolutely fabulous.

Ms. Bhutila Karpoche: With regard to the funding, it's been repeated several times that the government is investing $174 million, but we know from the federal-provincial agreement that it's federal dollars. Given that we're in December now and the fiscal year ends at the end of March, do you think we will see the provincial matching of the funding?

Mr. Steve Lurie: I hope that will be tied to the rollout of the mental health and addictions strategy, and I hope it will be a multi-year plan. There is about $52 million more of federal monies to come into the system. It's backend-loaded, so that's good news. I think the opportunity is for the centre of excellence to help the ministry say, "Okay, so here's what we're going to be doing in year 1 and here's what we're going to be doing in year 3."

To give you an example of that, with the previous government, we tabled a plan for the development of 30,000 supportive housing units across the province, which is actually an achievable target over 10 years. That will cost about $550 million in program funding and rent supplements, and then the capital costs are in addition.

Having a structure that isn't able to leverage more dollars won't make much of an impact. But on the other hand, if you can tie to having multi-year targets and working collaboratively with the sector to invest—as I said earlier in my remarks, we really need to scale up the evidence-based care that's already in place. We have a lot of these things; we just don't have in sufficient supply.

Ms. Bhutila Karpoche: To address the need in mental health, you mentioned that it's critical to have housing. People have talked about how we can keep people outside of hospitals and in the communities, but we can't do that without supportive housing.

On the supportive housing front, have you seen any action from the government in terms of meeting the demands and keeping people out of the hospitals?

Mr. Steve Lurie: There were some investments announced for mental health and justice supportive housing as part of the last budget, as part of that $174 million. There are three buckets, and one of them is a $78-million province-wide bucket for mental health—

Ms. Bhutila Karpoche: Has that flowed?

Mr. Steve Lurie: Yes, it's flowing now.

I suspect that there are probably a few hundred new supportive housing units that have been created across the province for people involved in the mental health and justice system. Here in Toronto—

The Vice-Chair (Mr. Aris Babikian): Thank you very much. Your time is over.

That concludes the witnesses' testimonies. Thank you very much to all of you for taking the time to come and share your input with the committee members.

Mr. Joel Harden: Point of order.

The Vice-Chair (Mr. Aris Babikian): MPP Harden.

Mr. Joel Harden: I just want it noted for the record that I wish we could have had far more deputations today.

The Vice-Chair (Mr. Aris Babikian): Well, that's not a point of order.

Mr. Mike Harris: We could have. No one signed up.

Mr. Joel Harden: You didn't give enough time.

The Vice-Chair (Mr. Aris Babikian): Order, please.

The deadline to send written submissions to the Clerk of the Committee is today at 5 p.m. The deadline to file amendments to the bill with the Clerk of the Committee is 12 p.m. on Monday, December 9, 2019. Amendments must be filed in hard copy to room 1405 of the Whitney Block.

The committee will meet for clause-by-clause consideration of the bill on Tuesday, December 10, 2019, from 9 a.m. to 10:15 a.m., and from 2 p.m. to 9 p.m.

Thank you very much. Now we stand adjourned.

The committee adjourned at 1051.

STANDING COMMITTEE ON SOCIAL POLICY

Chair / Présidente
Ms. Natalia Kusendova (Mississauga Centre / Mississauga-Centre PC)

Vice-Chair / Vice-Président
Mr. Aris Babikian (Scarborough–Agincourt PC)

Mr. Aris Babikian (Scarborough–Agincourt PC)
Mr. Jeff Burch (Niagara Centre / Niagara-Centre ND)
Mrs. Amy Fee (Kitchener South–Hespeler / Kitchener-Sud–Hespeler PC)
Mr. Michael Gravelle (Thunder Bay–Superior North / Thunder Bay–Supérieur-Nord L)
Mr. Joel Harden (Ottawa Centre / Ottawa-Centre ND)
Mr. Mike Harris (Kitchener–Conestoga PC)
Ms. Christine Hogarth (Etobicoke–Lakeshore PC)
Mrs. Belinda C. Karahalios (Cambridge PC)
Mr. Terence Kernaghan (London North Centre / London-Centre-Nord ND)
Ms. Natalia Kusendova (Mississauga Centre / Mississauga-Centre PC)
Mrs. Robin Martin (Eglinton–Lawrence PC)

Also taking part / Autres participants et participantes
Ms. Bhutila Karpoche (Parkdale–High Park ND)

Clerk / Greffier
Mr. Eric Rennie

Staff / Personnel
Mr. Ian Morris, research officer,
Research Services