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**Ontario’s Health Speech: Second session of the 28th legislature, November 27, 1969.**

Hon. T. L. Wells (Minister of Health):

Mr. Chairman, presenting for the first time to this House the estimates of The Department of Health, I would like to begin by saying a word about my predecessor in this portfolio, the hon. member for Ontario riding.

 As the members of this House know, this gentleman led this department for over 10 years and as one who has now come into the department, I can see the definite signs of his leadership in this department. From the time he took over, back in 1958 to the present time, phenomenal growth has occurred; many new programmes have been instituted, and much has been done in improving the quality of the health of the people of this province, I think that it cannot go without being mentioned in this House, that this House and the people of Ontario owe a great debt of gratitude to the hon. member for Ontario riding for the leadership that he gave to this department.

 I also think it should not go without notice that five or six weeks ago, the Canadian Mental Health Association held a meeting and paid tribute to him for the outstanding leadership that he gave in the field of mental health in this province.

 Mr. Chairman, in presenting the estimates of this department I would like to review to the House a few of the highlights, some of the things that have happened in the past year and some of the things that we are planning to undertake. I would like to begin by paying tribute to the staff of the department. In the short time that I have been in the department, I have found them to be very competent and of great expertise in many of the various areas that our department covers.

 I would like to also pay tribute to the many people not immediately on our staff; but the many people on the Ontario Council of Health, its various committees, the executives of the health organizations in this province and all those in the field of health who have been working with us as a team over these past years to bring about the great advances that we have had in the health field in this province.

 The first area I would like to review today, Mr. Chairman, is the Ontario Council of Health. I am pleased to report that this council continues to make substantial progress. As hon. members will remember, the council has been given statutory authority as the senior advisory body of health in The Department of Health Act, 1968-1969.

 There is in the annual report of this department an outline of the council's activities, including details of organization and membership. I believe that through the mechanism of the council and its various committees that we have been able to bring together a broad and, indeed, a unique spectrum of interest and experience. We have received from this council a series of major reports and recommendations on a variety of matters of priority interest in the planning and development of health service arrangements in this province.

 These reports cover such subjects as health manpower, education of the health disciplines, regional organization of health services, physical resources, health research, health statistics and health library services. I do appreciate, Mr. Chairman, that these reports have not as yet been made available to the House. The reason for that is that these reports are interrelated, both in subject matter and recommendations. If we had presented them in a piecemeal fashion, as and when they were submitted to us, there could have been misunderstanding and confusion.

 However, we have now received a sufficient number of these reports which, taken together, add up to a significant and comprehensible total effort, worthy of presentation to the hon. members and in due course for distribution to other jurisdictions.

 With this end in view, an overall report on the council's activities is now being prepared. This document will collate the major features and recommendations from the various reports which have been accepted by the council so far and will have as appendices the various individual reports. After the council has reviewed and approved this material at the council's next meeting in January, I will make the reports available to hon. members of this House and the public shortly thereafter.

 I may say, Mr. Chairman, that the Ontario Council of Health, during its comparatively short existence, has occasioned much interest, not only in other provinces but in federal circles as well. We have also had expressions of interest and requests for information about the council's work from the United Kingdom and from our friends south of the border.

 I am sure that when hon. members have had the opportunity of reviewing the quality and the scope of the efforts of the Ontario Council of Health, they will agree that this council is a most important and worthwhile advisory body to this government. It is providing an effective mechanism for the development, in Ontario, of comprehensive health services of highest quality on a planned and orderly basis.

 Mr. Chairman, as the hon. members realize the Ministers of Health from the various provinces met in Ottawa just this week on Tuesday and Wednesday with the federal Minister of Health and Welfare. The primary subject on the agenda of this meeting was a report to our conference of ministers from the committee set up by our conference on the cost of health services in Canada.

 This report is in three volumes, and I think that we made available to the both Oppositions, copies of this report on Friday. We got them down as quickly as we could. It is in three volumes with volume 1 being a summary of the work of the various task forces, with a consolidation of important recommendations. The province of Ontario established a committee to review health care costs in this province some months ago and we were prominently represented on the federal committee and its various task forces. The work of the provincial committee has been complementary to the national effort and therefore, Mr. Chairman, we were in a position to analyze the various recommendations proposed in the consolidated document before the Ottawa meeting.

 Most of the first day of our meeting at the Ottawa conference was taken up with a review of health care costs and it was decided that the primary committee, with its steering committee, should continue to function and report back to the Conference of Ministers. This decision was taken because it was appreciated that there was a substantial amount of unfinished business, particularly as related to implementation in areas in which there was a combined provincial and federal interest.

 In addition, the Ontario committee, with its various task forces, has been requested to report to me as soon as possible, putting forward recommendations and proposed methods to implement the recommendations. These recommendations will take into account the proposals of the federal committee and other features which our provincial group consider pertinent to this particular province. It might be of interest to the members, Mr. Chairman, to know that the provincial task forces are reviewing costs as related to hospitals and other health facilities, medical services, mental health, public health, dental care and drugs and biologicals. If other task forces are required, they will be set up to complete an analysis of the total spectrum.

 I can assure the hon. members that aggressive action will be taken so that the people of this province will have available to them Health services which are of the highest quality and also which are effective and economic.

 Next, Mr. Chairman, I would like to deal with The Alcoholism and Drug Addiction Research Foundation, an agency coming under our department.

 On an ever-widening front in this province, and throughout the rest of North America, public concern about the rising incidence of drug abuse is becoming increasingly vocal. It takes only a few well-illustrated newspaper or television reports to divert public attention to a new crisis, a new aspect of illicit drugs.

 We hear the urgent pleas of parents whose children are on "speed" to help them, to tell them what to do, to set up centres where they can be given emergency treatment or helped over the long term; we hear a growing segment of society demanding research into marijuana; we hear of the great need to relieve our courts and jails of the chronic drunkenness offenders, and to make such people medical and not police responsibilities.

 There can be no mistake that these are urgent problems that we need to do something about. On the one hand we can be motivated solely by public crisis or panic reactions; on the other we can look at the whole social pattern of drug and alcohol, its use and abuse and try to devise solutions that are of infinitely more value, and have some chance of being permanent.

 It is with this permanence, perspective and stability in mind that we have given the addiction research foundation of Ontario such a broad mandate in dealing with drug dependence and Mr. Chairman, this includes alcohol from the point of view of research, education and public information, and assisting in the development of treatment programmes.

 To minimize the spread of human dependence on alcohol and drugs and to determine how best to treat the existing victims of this major health problem, the staff members of the foundation must deploy themselves across this province to stimulate action by agencies within each specific community. At this time the foundation is represented in more than 25 municipalities in this province.

 In some communities the staff is necessarily large and the functions and resources are as diversified as are the needs of that community. In other towns one staff person must wear many hats, he must be counsellor to teachers, parents, physicians; he must be the liaison person with youth groups, with media, with the local hospital and the other available health and social services.

 Let me describe briefly the deployment of foundation units, bearing in mind that no two regional centres are exactly the same, that some have more research function than others, while some are more service and community-oriented.

 The Lake Erie region which operates out of London has a community and professional education programme, and out-patient clinic, provides support to halfway houses, provides supporting staff in a mental hospital in Goderich and has set up a crisis intervention centre for care of amphetamine, "speed" abusers in the city in conjunction with Victoria Hospital.

 The Lake St. Clair region, headquartered in \Windsor, has an active clinical consultative service in that city, as well as community development workers in Chatham and Sarnia. It also provides support to halfway houses.

 In the Niagara Counties region, there are clinical and consultative services in Welland, Port Colborne, St. Catharines and Niagara Falls, and there is a counselling service in Dunnville.

 In the Midwestern Ontario region there are three distinct, but related programmes. The centre in Kitchener-Waterloo offers a programme of specialized services including information, consultation, counselling and referral assistance. The segment of the programme originating in Brantford covers Brant and Norfolk counties and the third programme in Guelph, is run independently by the Wellington-Dufferin-Guelph public health unit with initial support of a grant-in-aid from the foundation.

 The Northern programmes division operates an out-patient clinic and a psychiatric inpatient unit in Sudbury, consultative services in Orillia, Sault Ste. Marie, North Bay, South Porcupine, Kapuskasing, Kirkland Lake, Fort William and a detoxication hostel for overnight accommodation, primarily used by Indian people in Kenora. There is also financial aid and staff support for a special hospital ward and a drop-in centre in Port Arthur, as well as a halfway house in Fort William. In all of these units the primary focus is on development of community resources, professional training and preventive education.

 In eastern Ontario, with headquarters in Ottawa, there is an out-patient and consultation service within that city, a clinical research and teaching unit at Queen's University, financial and staff support for an addiction studies department at the Peterborough civic hospital. There is also financial and staff support for an independent halfway house in Ottawa, a drop-in centre in Cornwall, and there are community-based consultation services and some direct services in Brockville, Cornwall, Pembroke and Kingston.

 In metropolitan Hamilton the multi-disciplinary staff maintains an out-patient clinic, assists in teaching rounds in the community hospital, organizes weekly seminars and case conferences for local professionals; has an annual programme of fellowships, and facilitates an in-patient unit for alcoholics at the Metropolitan Hamilton Psychiatric Hospital, and shortly, in conjunction with Chedoke Hospital, a 25-bed in-patient unit will be opened.

 In Metropolitan Toronto, the foundation staff maintain out-patient clinics in central, and east, and soon in North Toronto, a halfway house and a detoxication centre, a demonstration centre for employed alcoholics referred by their employers, a rehabilitative farm for alcoholics near Elora, a speaker's bureau, and a youth counselling service. It has recently instituted a 24-hour information service which was designed primarily to tell parents, professionals, or even the young people themselves, what to do in cases of drug emergency, to make referral to the most appropriate hospital or health centre if necessary to advise on helping facilities of an acute or long-term nature available in the city.

 There are also community programmes in Oakville, Mississauga, Whitby, Oshawa, and Newmarket. In downtown Toronto the foundation with the co-operation of the YMCA has just established a consultation centre for both youth and adults where the emphasis will be on information about drugs.

 As part of its central services, the foundation has also reinstituted its narcotic addiction unit to test the validity of methadone in treatment of heroin addicts and it is now developing a crisis intervention centre for emergency and long-term care of "speed" and multidrug users. This unit will eventually include residential and other back-up facilities for rehabilitation.

 All of these regional services, Mr. Chairman, receive support from the foundation's central educational division which develops literature, films and television material for public use; and for use in school systems and professional training; and from the research division which in the 20-year operation of the foundation has become one of the leading research centres in the world dealing with alcohol and drugs.

 To correlate more effectively such activities and to bring professionals of the various disciplines closer together, the foundation will shortly be moving into its new headquarters, which house a research block, administrative and professional offices, as well as a 100-bed hospital. Significantly, this clinical institute will be used as a teaching hospital in cooperation with the University of Toronto.

This, then, is the actual physical makeup of the foundation, featuring different priorities in the different communities. But there are, Mr. Chairman, some common elements and needs throughout the province about "public crisis," or about reports of bizarre incidents related to drug abuse, we obviously cannot afford to neglect these. But we must see them as symptoms of an underlying disorder within society.

 The foundation has studied very intensively this disorder, this social pattern. It has been trying to tell us that we cannot isolate marijuana use among youth, the "speed" user, the chronic alcoholic, the drunk driver, or the adult abuser of drugs, such as tranquilizers and sedatives. The way society generally uses drugs, they say, not only endorses this use but very actively encourages it through advertising and other means of suggestion, and bears a very direct relationship on the way the so-called subcultures use drugs.

 In a series of high school studies done by the foundation in London and Toronto in 1968, which are being up-dated at this time, at least 16 per cent of students were shown to have experimented with drugs such as marijuana, solvents, amphetamines and LSD. More than ten per cent of grade 9 students in the study had experimented with marijuana and this was, in fact, the highest level of experimentation within the schools.

 We were also shown that the way parents in a household regard drugs-even the socially accepted ones such as tobacco and alcohol have a direct relationship on the prevalence of drug use among their children. These studies also showed us that regardless of the incidence of other drug use among the student groups, alcohol and tobacco were still by far the most popular and the most used drugs of all. Of all students in the London survey, for example, 68 per cent reported having used alcohol, 46 per cent reported having used tobacco.

 Another major factor to consider-one which is underlined in a report on prescription drug use which will be released soon by the foundation-is that in one sample year, at least 1.37 million prescriptions for mood-modifying drugs-these are the amphetamines, barbiturates and tranquilizers-were issued to 1.35 million people over the age of 15. This means that in this study, on an average, therefore, this is one prescription for a mood-modifying drug for every person over the age of 15.

 Only with such scientifically-valid background, one free of rumour, speculation, educated wild guesses, or panic reactions, can we make true assessments of the scope of the drug problem and determine the best means of dealing with it.

 Relating this to the matter of amphetamines, for example, the foundation's role must be to determine the best means of treating emergency cases, to devise the means of providing long-term rehabilitation to get people who are dependent on such drugs off them. For several months the foundation has been running a crisis intervention centre for the amphetamine and multi-drug user in London.

 A similar one, with a co-ordinating function related to other social and health services in the city, is now being developed for the city of Toronto. On the basis of the foundation's experience in such units, a professionally viable approach to "speed" can be developed. The intention is not, and will not be, that other agencies will be relieved of their responsibility in this matter of service. Service must become the responsibility of the hospitals and other health and social agencies that already exist in every community.

 The foundation's role will be to assist such units, to provide information, support personnel and the community stimulus to get something effective done. For example, in Toronto there are hospital beds and facilities for "speed" users that are not being used for that purpose. Space for emergency care, therefore, is not the primary need in this case, but development of the skills and knowledge about rehabilitation and long-term care might well be more important than any bed count.

 In more direct educational activities, the foundation is now involved in production of fact sheets which are distributed widely to professional groups and the public at large. The fact sheets-one has already been done on marijuana, solvents, LSD, amphetamines and alcohol-describe the drugs themselves, their effects, dosage, what is known about them. Already one million of these have been distributed.

 Material from these sheets has formed the basis for a strong newspaper advertising campaign, which I am sure many members have already seen and which has started to show up all across this province. So far we have seen ads on the $1 cigarette, which of course refers to marijuana; "The Fun-Filled Disaster Kit," which is an ad on glue and solvents; "Some Trips Are More Dangerous," which is about LSD; and "What You Don't Know Can Hurt You," referring to amphetamines. A television campaign relating to alcohol and drugs is now also being developed.

 Throughout this spectrum of educational activities, the foundation has found that youth will not respond favourably to preaching, scare tactics or hounding, but it does have considerable regard for the facts and findings of science. Essential, therefore, to all of these educational aids developed by the foundation is their scientific responsibility.

 During the recent marijuana dialogue, stimulated by the drug inquiry hearing there has been an evident lack of this kind of responsibility. To give the commission benefit of their experience, foundation personnel have held meetings with the federally appointed group and have prepared a detailed memorandum assisting the commission, the federal commission, in developing its hearings, and are now developing an extensive brief which will be presented to the federal commission in the near future.

 To date, the foundation has conducted animal experimentation, laboratory work; has developed in book form an important assessment of the scientific literature from around the world. An expanded version of this is now being written and is nearing completion, of a psychological and physical assessment of more than 250 marijuana users in Toronto.

 But let us not think that on the basis of such studies alone, one will be able to make a simple decision about the legal status of marijuana. There is no rational way of deciding how much harm from a particular substance or practice society is prepared to put up with. This can only be decided on the basis of general contemporary values, rather than the scientific reasoning alone.

 The foundation at present is very clear in stressing that at the present time it cannot support legalization of marijuana, but it is equally clear in opposing the present criminalization of vast numbers of experimental or curious users of the drug. It strongly urges moving legislation governing marijuana out of The Narcotics Control Act and into the jurisdiction of The Food and Drug Act.

 It is this kind of judgment, one balancing the scientific and the social values, that an organization such as the Addiction Research Foundation is particularly qualified to make. For reasons such as these the foundation was asked by Kiwanis International to assist in the continent-wide operation, drug alert programme, and it subsequently committed itself to a considerable amount of participation.

 Meetings have already been held with Ontario representatives of Kiwanis to discuss what kinds of programmes and projects the local clubs across this province could best operate in their own communities, and to define what kind of guidance the foundation could offer by way of resources and personnel. This is an excellent example, Mr. Chairman, of how citizens can themselves participate in programmes devised by their own community leaders.

 The foundation has also held discussions with representatives of the recently formed committee on drug abuse (CODA) and has offered advisory services to this group.

 It is in this role as community catalyst, as resource body, as scientific conscience that the addiction foundation provides one of its great services to this province.

 Mr. Chairman, hon. members on another subject will recall the statements made by the Prime Minister in March, 1969, that The Department of Energy and Resources Management was to be the principal vehicle for the government's programme on environmental management and pollution abatement.

 The former air pollution control of this Department of Health is now the air management branch of The Department of Energy and Resources Management, and the staff formerly dealing with waste management in this department is now the waste management branch of The Department of Energy and Resources Management.

 This has resulted in a reduction in complement of 233 persons within The Department of Health. As a result, the printed estimates no longer present expenditures forecasts in the two departments as they relate to these programmes. The Minister of Energy and Resources Management, I believe, provided the leaders of the Opposition parties with two sheets of figures which show the changes in the estimates for both departments.

 Briefly an amount of $3,258,900 is being transferred from the estimates of The Department of Health to the estimates of The Department of Energy and Resources Management.

 In consequence, the revised estimates for the public health programme and the environmental health services are as follows: And rather than reading them I will send copies over to the member.

 The revised estimates for The Department of Health to be voted now total, therefore, Mr. Chairman, $394,450,100. The statutory vote remains at $22,000.

 Mr. Chairman, in talking about the public health branch of the department, I would like to mention a few words about maternal and child health, and particularly infant and perinatal deaths.

 It is gratifying to be able to report that considerable progress has been made in the reduction of infant mortality. Over the past 30 years, the infant mortality rate in Ontario, which is a well known indicator of the quality of health care for our infant population, has been reduced from 55 in 1937 to 19 in 1967.

 This improvement has been brought about by a number of factors. Prominent among them are the general improvement in the care of both mothers and infants, including safer milk and water supplies; the control of communicable diseases by immunization; and the reduction in other communicable diseases such as tuberculosis.

 However, the greatest reduction of deaths in the first year of life has been in the one- to 12-month period. While this has been accomplished by some reduction in deaths of infants very early in their lives, at present 66 per cent of deaths of infants in the first year occur in the first week of their life.

 These deaths of newborns are often described as the hard core of infant mortality; the deaths that are most difficult to prevent because the causes are more complex.

 These first-week deaths, together with infants who are still-born are, I understand, now referred to as perinatal deaths, that is, those which occur before or just following the mother's confinement.

 In Ontario in 1967 there were 3,000 such deaths, with a rate of 23 per 100,000 total births, but while this rate was below the national average of 24, two provinces had lower rates than ours. Moreover, within the province there are variations in rates which give us cause for concern.

 While the provincial rate of 23 is commendable, rates in smaller jurisdictions within the province, both rural and urban, ranged all the way from 17 to 31. It seems fairly obvious that a major problem in maternal and child health exists here, and that there is a real need to examine more thoroughly the field of perinatal deaths.

 As is well known, the birth rate continues to fall in Ontario, in other parts of Canada and, indeed, in other industrialized societies. Surely this makes it even more important that babies who are born, not only survive, but receive care which will provide the best conditions for their normal development to productive adulthood.

 Among the main causes of death in the first week of life are immaturity, affecting babies who are born weighing less than five and a half pounds and are not quite ready for existence in the outside world. Congenital malformations are among the major causes of which we are learning much, but many questions have yet to be answered on how congenital malformations can be prevented.

 The third major condition, and perhaps the leading one in this age period, is a group of conditions of the lungs resulting in deaths from respiratory failure. However, it has been emphasized to me, Mr. Chairman, by my advisors that the most important single cause of death, as I said earlier, in this period, often associated with the other causes, is immaturity. The very small baby has not the resources to survive without highly specialized medical and nursing care in specialized facilities.

 If we consider again the 3,000 perinatal deaths which occurred in 1967, and look at deaths in adults from that year, it is not until the lO-year age group of adults between 45 and 54 is reached, that we find a greater number of deaths. In that group there were 4,400 deaths, and that is the only place in that grouping where the number exceeds those in the perinatal death group.

 We are investing significantly in the study and treatment of heart disease and cancer which are the leading causes of death in the 45 to 54 age group, and no one would decry these important investments.

 How often, however, do we hear of campaigns to provide resources to study the cause of immaturity and so prevent these infant deaths. The saving of infant lives is as important to this province and, indeed, to the nation, as any health problem we have to face.

 For these reasons, the department intends to extend its activities in the study of perinatal deaths, begun a number of years ago with the study in university hospitals in Ontario, which was reported in 1967 and widely distributed since then. This new undertaking will study such deaths occurring in all hospitals in this province.

 The emphasis will be on factors in the mother, or in the care of the mother, which were revealed by the former study to be closely related to successful or tragic outcome of her pregnancy.

 In the planning of this province-wide programme, every effort will be made to use information on documents and reports already required of physicians and hospitals so as not to increase the burden of reporting already carried out by these groups.

 An advisory group of clinical authorities, statisticians and administrators will assist the department in the planning, so that the most pertinent information will be sought and processed as efficiently as possible. This plan to gather such information and to do this study has the endorsation of the council of the Ontario Medical Association.

 This information will hopefully reveal aspects of medical and nursing care, as well as aspects of the mother's care of herself which may influence her health and the survival of her baby. These include such things as how early the mother seeks the advice of her physician; her nutrition; the number of other children she has borne; her resources, both financially and physically which have been shown to influence the outcome of her pregnancy.

 This kind of information will give us a more sound basis on which to plan regionally to bring the highest level of care to mothers who are at the greatest risk of complications of pregnancy.

 Included in this is the transport of mothers or infants already born to facilities where they can get the necessary care. Perhaps many of us are not aware that there are 200 hospitals in Ontario which provide care for mothers and newborn infants at delivery. A significant number of these hospitals have relatively few maternity and newborn patients during the year and, therefore, cannot possibly have the resources either in professional personnel or equipment to cope with all the types of complications which may arise.

 Many of us are aware, I am sure, of modern hospital facilities for intensive care patients who have suffered coronary heart attacks. Maternal and newborn intensive care facilities are operating or being developed as well for the intensive care of mothers and newborns. They are located most often in hospitals in health science centres, where families and highly trained personnel are likely to be available.

 I understand that remarkable progress has been made in recent years in the care of both mother and infant during this precarious experience of birth. This has resulted not only in lives saved, but in the reduction of the hazards of births so that such babies have a much better opportunity to develop into normal productive individuals. This programme, has, therefore, a very definite preventative purpose-to save mothers' and infants' lives and to help reduce the causes of long-term disabilities, such as mental retardation and cerebral palsy, which have often been associated with the survival of immature or very small babies, for whom today's high standards of care were not available.

 I am sure that the people of this province are as prepared to invest in the salvage of new lives as they have been in investing in the salvage of adults with serious heart disease who have fewer, perhaps, productive years to look forward to.

 I would like to say a word on the subject of family planning because I believe it is closely related to what I have been talking about. With the long-awaited amendments to the Criminal Code, whereby family planning services and advice are no longer illegal activities, we look forward to an extension of family planning services in this province. This, too, has its preventative aspects, enabling parents to plan their families in relationship to their resources to care for their children; not merely their financial resources but their human resources.

My department is providing financial support for this development through local health services grants and is actively urging the setting up of these facilities, the family planning services, across this province. A home environment of warmth and acceptance, which will foster not only physical health, but normal mental and emotional growth as well, is our aspiration for all children. I am sure that these two programmes will go a long way towards their achievement.

 Mr. Chairman, the incidence of venereal disease as a public health problem is of continuing concern. The number of cases that are reported each year does not reflect in any way the actual extent of the occurrence of syphilis and gonorrhea, but rather represents directly the amount of effort that is directed to obtaining notification. The fact that most cases of venereal disease are not reported to the venereal disease control section of my department is of serious concern. It is a matter of record that the number of positive smears for gonorrhea and positive blood tests

for syphilis performed each year in the provincial public health laboratories far exceeds the number of reported cases for either of these diseases, and it is a valid measure of the significance of the problem of underreporting. The operation of an effective venereal disease control programme is dependent upon several factors. The first of these is an awareness, a high index of suspicion, that a venereal disease may be present in an individual, often in an inapparent form, and that appropriate laboratory examinations are the only way in which a diagnosis of the condition will be made.

 It is noted that of all cases of syphilis reported in Ontario in 1968, only 123, or 15.5 per cent were in the infectious stage; and 595, or 74.6 per cent in the latent stage. This latter group constituted a majority of reported cases, and were in a stage which presented no symptoms or signs of disease, being diagnosed by routine serological examination. They were not detected, therefore, during the infective stage when the identification and examination of contacts is of the utmost importance.

 The public health aspect of a venereal disease control programme is directed to a location and examination of all contacts of each case of a venereal disease as soon as possible after exposure has occurred, so that effective treatment measures can be instituted to minimize further spread of infection. The names of the relevant contacts can be obtained only by careful and often repeated interviewing of the case, either by the personal physician or by an appropriate member of the staff of the local health agency.

The Venereal Disease Protection Act provides for notification of all cases of venereal disease to the provincial Department of Health rather than to the local medical officer of health. There are several reasons supporting the principle of central reporting. The maintenance of a case registry by a central agency is of value in providing a standard method of disease classification, of recording the treatment that has been used in each case, and of providing a reference file for physicians to obtain information about an individual's past history of venereal disease.

 In addition, it provides the mechanism to follow contacts who may reside in municipalities other than that in which the case occurred. It is of prime importance that absolute confidence concerning persons suffering from venereal disease be maintained, and it is considered that central notification is the most effective way of ensuring it. It should be appreciated that central reporting does not in any way interfere or prevent the development of a good professional relationship between the practising physician and the medical officer of health in conducting an effective venereal disease control programme in their own area. The confidence of the case of venereal disease remains with the personal physician, and he has the responsibility for the release of any information concerning the case of venereal disease under his care, and according to his best judgment.

 The interviewing of each case of venereal disease, depending on the stage of infection, to obtain the names of relevant contacts is essential in the control of the spread of this disease. In certain circumstances it is recognized that personal physicians will prefer to accept this responsibility and to examine and treat, if necessary, those so named. In most situations, however, he does not have the time nor the facilities to carry out this important function, and would prefer to make use of the services of skilled personnel of the local health departments.

 It has been shown that repeated interviewing is necessary to obtain the confidence and co-operation of the case in obtaining the names of the contacts in sufficient detail so that they can be located and brought in for examination and treatment.

 An important reason for the failure to control the spread of venereal disease within this province is that interviewing either has not been done, or has not been successful in obtaining the names of contacts involved. This is supported by the fact that the number of reported contacts per case, for the province of Ontario, is less than one, on the average, and control measures cannot hope to be effective until this situation improves considerably. In areas where careful and intensive interviewing techniques have been practised the average number of contacts per case is four.

 If the same ratio of contacts to cases applies in Ontario, and there is no reason to suspect otherwise, there are a large number of people who may be suffering from venereal disease and have not had the benefit of a laboratory examination to determine whether or not they are infected, who consequently remain untreated, and continue as a source of the spread of infection.

 Recognizing that the control of VD has been ineffective in the areas mentioned previously-namely, notification by physicians, and interviewing by either physicians or local health agencies, and appreciating, Mr. Chairman, that questions have been raised on treatment and other aspects-I have authorized, as I told the House a few weeks ago, the establishment of a task force with terms of reference as follows:

 To examine all aspects of venereal disease control and make recommendations concerning: (a) Diagnosis and treatment, including provision of free drug therapy. (b) Reporting procedures, including report forms. (c) Epidemiological procedures, both central and local. (d) The provision of clinic services. (e) Educational programmes, both professional and lay.

 The task force will also have the authority to invite special resource personnel to provide information in related fields such as laboratories-public, private and hospital-clinics, legal aspects, law enforcement, sociological factors, education-both elementary and secondary-and it will also have the benefit of working with the Ontario Hospital Services Commission and the Ontario Health Services Insurance Plan.

 The task force on venereal disease is comprised of individuals with expert knowledge and experience in various aspects of venereal disease. They represent those groups with particular interests and involvement in treatment and control programmes. The task force is made up of the following people: Dr. Frank Addlery, general practitioner, Scarborough; Miss Ella Beardmore, director of public health nursing, Scarborough; Dr. Harry Brown, general practitioner, Sarnia; Dr. Anne Kyle, clinic director, Toronto; Dr. W. T. R. Linton, dermatologist, Toronto; Dr. G. W. O. Moss, associate medical officer of health, city of Toronto; Dr. W. E. Page, medical officer of health, Brantford; Dr. Carol Voaden, general practitioner, Toronto. And the chairman of the committee is Dr. J. Stewart Bell, chief of the epidemiology service in The Department of Health.

 I have instructed the task force to place before me recommendations as soon as possible for an aggressive and complete venereal disease programme for this province.

 Mr. Chairman, man's health is directly influenced by his environment-the air he breathes, the water he drinks and the food he eats. All have influence on his state of well-being. The quality of man's environment has been affected by increasing changes in technology, the introducing of new chemicals and the trend to urbanization. While the evidence that these environmental changes are associated with changes in the disease picture in man is not conclusive, there is concern among health people about them. The environmental health services branch in our department brings together a group of specialists who serve to keep watch on the environment and the possible effects of these on the health of the public of Ontario.

 In recent months there has been much discussion about the significance of pesticides in our environment. Because of the concern about contamination of our environment, an Order-in-Council was passed last May banning immediately from use in agriculture, aldrin, dieldrin and heptachlor, and prohibiting all other use after January 1, 1970. One exception was made to this in that these substances could be used by a person holding a licence to do termite extermination while engaged in this work.

 In September of this year, another Orderin-Council was approved providing for a prohibition on the use of DDT after January 1, 1970. There were three exemptions to this ban. The Order-in-Council made provision for DDT to be available under permit for bat control, tarnished plant bug control in apple production, and cutworm control in tobacco.

 It should be stated that to date there is no concrete evidence that DDT is posing a threat to the health of the people of Ontario. However, there is concern about it as an environmental pollutant which has affected certain groups of our wildlife and fish. It is hoped that as suitable alternatives become available for DDT in the case of the three exemptions, the latter will also be withdrawn. As the hon. members know, aldrin, dieldrin, heptachlor and DDT are members of the chlorinated hydrocarbon group of insecticides.

 I might also say here, Mr. Chairman, that our action in banning DDT in this province came about directly as the result of our pesticides advisory board. This board carried on hearings at the instigation of my predecessor and they have made a very thorough report which is presently in the process of being printed and will be made available shortly to all the hon. members. It was on the basis of this report and the expertise of our pesticides advisory board and those they consulted with, that we took the action we did last September.

 As a result of an incident or incidents involving the death of ducks at Ward's Island, Toronto, this past summer, in which the insecticide diazinon was suspect, a one-man commission has been appointed to look into this matter.

 Dr. Martin E. Edwards of the Royal Military College, Kingston, is the commissioner. Hearings will be starting shortly and Dr. Edwards will be reporting his findings and recommendations to me on this matter.

 During the past summer, the pesticides advisory board has been used extensively as an advisory body to the department. The board was asked to look into the use of aldrin, dieldrin and, later, DDT. And it was, as I said, as a result of their investigations and recommendations that we took the action we did.

 The department is not complacent about the use of pesticides in Ontario. It is the intention to have a systematic investigation of all the persistent pesticides now being used. Action taken by the department will depend largely on the findings of these investigations and the recommendations accompanying the report.

 Mr. Chairman, I would like to conclude my remarks by saying something about the whole matter of mental health.

 Ontario has long been recognized as a leader in mental health services. Having met with our people and seen them at work, I can understand why. Since I became Minister of Health, I have had an opportunity to visit several of our mental hospitals and training centres for the retarded. I say, Mr. Chairman, I intend to visit all these facilities within the space of the next several months.

 Talking with our staff in the hospitals and in the central offices, I am becoming more familiar with this very large and important programme.

 We are very fortunate to have such an advanced programme, and a staff of dedicated people who are trying very hard to provide the best possible care, treatment and training for our mentally ill and retarded. And I say this very sincerely, Mr. Chairman, having met most of these people, they deserve every support and encouragement we in this House can give them.

 Even with these advantages, we must do more to raise the level of care that is provided for those who are mentally sick and disabled. Considerable work needs to be done in our older hospitals to turn them into more modern treatment centres.

 We do need more staff, particularly the more highly trained and skilled professional people, to achieve a level of care that will provide the best results in the shortest period of time. We do not have enough beds to care for all of the retarded who would benefit from placement in a residential training centre.

 The resident population of some of our facilities for the retarded, particularly the two largest at Smiths Falls and Orillia, should be reduced so that more space would be available for training activities. We also need more staff in our facilities for the retarded to help these children to reach their maximum potential.

 Closer working relationships are being developed with public health and other agencies, but more could be done, needs to be done, and will be done, to prevent mental disorders.

 For too long our attention has been focused on the provision of beds. Many years ago when a safe and comfortable haven was all that could be offered to these unfortunate people, this was appropriate. With the knowledge and skill now available to us, there are increasing opportunities for prevention; diagnostic and treatment services can now be provided without the necessity of the individual leaving his home or community, often without leaving his job.

 With fewer people having to enter hospital to obtain the treatment they require, and the length of hospital stay becoming shorter and shorter, rehabilitation takes on a new meaning for those who require extended care.

 I can assure the Legislature that as Minister of Health I propose to give particular attention to the further development of the programmes in this province for the mentally ill, the retarded and for emotionally disturbed children, and I would like to mention some of the highlights of the progress that we have made in the last few years.

 The reorganization of the central offices in 1966 has greatly strengthened the overall administration of the programme, and added new resources for giving leadership and guidance to those in the field who are endeavouring to meet the changing needs and priorities for services. This reorganization programme has been extended out into the provincial hospitals and facilities for the retarded where a new organizational pattern has been established which makes provision for a functional grouping of activities and services into departments.

 It is our intention to place a university qualified and experienced hospital administrator in charge of the overall administration and management of all our facilities, and to place the responsibility for all clinical services in the hands of a senior psychiatrist or physician as the medical director, or director of treatment and training.

 During the past two years, 11 administrators have been appointed, and the remaining appointments will be made as quickly as well qualified administrators can be recruited to the programme.

 We have also designed and introduced a new cost accounting system in all of the provincial facilities. The new accounting system reinforced the new departmental organization, and provides a basis for comparison of cost data within our facilities, and with other hospitals or similar operations.

 We are now in a position to develop indices and standards of performance which will help use to raise the standards of care throughout the system, and lead to improved efficiency and increased effectiveness in the delivery of mental health services.

 In keeping with these changes, a number of new senior positions have been established within the various departments of the hospitals and hospital schools which are being filled by staff with the required training and experience. At the same time, an extensive programme of in-service training has been undertaken with special courses being arranged where indicated to assist the staff in upgrading their skills.

 Now let me talk for a minute about the children's programme. This province was the first to formulate an overall programme to co-ordinate the services for children and adolescents suffering from mental and emotional disorders. A new administrative branch has been established within the mental health division to be responsible for the further development, planning and administration of the government programme for children.

 Headed by a child psychiatrist with many years of experience in the clinical and academic fields, with a professional staff of programme co-ordinator and inspectors, this branch will also provide technical advice and guidance to all agencies serving emotionally disturbed children and adolescents.

 The children's services branch will coordinate the services provided by all agencies and special units for children and adolescents coming under the jurisdiction of The Department of Health, and maintain close liaison with the other departments and programmes provided by the government for these children.

 Regional centres are under development at eight locations in this province, as indicated in the White Paper, and special units with programmes and staffing particularly designed for the needs of children and adolescents have been established in six regional psychiatric hospitals.

 Nine agencies operating under a local board, which provide special services for emotionally disturbed children, have been brought under the jurisdiction of this new department so that they can be identified with the government programme and receive financial assistance in maintaining their services.

 Closer liaison has been developed with public health nurses, school authorities and children's aid societies in the identification and treatment of children in need of assistance. Increasing emphasis is being placed on treatment of the child in his own home and community wherever possible, using residential units only where there is specific reason to remove the child from his natural environment, and for as short an interval as possible.

 I am pleased to be able to tell the House that Dr. Naomi I. Rae-Grant has been appointed director of our new children's services branch, and also Mr. Douglas Finlay has been appointed co-ordinator of this programme.

 As I said, this branch was established within our mental health division to provide leadership and direction in the further development of the provincial programme for children suffering from mental and emotional disorders.

 Dr. Rae-Grant and her staff will be responsible for the planning, development and co-ordination of all special facilities and programmes for emotionally disturbed children and adolescents.

 Prior to her appointment as director of the children's services branch, Dr. Rae-Grant held a number of senior clinical and consulting appointments in Baltimore, Maryland, and was a member of the teaching faculty of the University of Maryland, Johns Hopkins University, and Coppin College.

 Dr. Rae-Grant has also contributed generously to the literature in the field of child psychiatry, and has been particularly interested in the development of community programmes which emphasize the prevention of emotional disorders among children and adolescents.

 Dr. Douglas Finlay is returning to this province, his native province, to co-ordinate the programme in this division. A University of Toronto graduate, he studied social work at the University of British Columbia. Mr. Finlay is well known and respected in his field by reason of his extensive experience in the development and operation of programmes on behalf of emotionally disturbed children, both in Canada and the United States.

 In 1961, he was sent to Thailand by the United Nations as an advisor in child and family welfare. Prior to this present appointment to our department, he was director of a residential treatment centre for emotionally disturbed children in British Columbia.

Over the past few years a new organizational pattern has been introduced in our facilities for the retarded to divide the larger hospital schools into smaller units, each to specialize in the training of children and adults according to the degree of their disability.

 The progressive activity units provide a total training programme of purposeful activities directed toward increasing the child's ability to care for himself, and to the development of social skills. These units are designed for those who are unable to participate in more structured programmes because of the degree and complexity of their handicap.

 The educational units provide a complimentary and stimulating residential training programme for progressive emotional and social growth for the educable retarded. The adult training and rehabilitation units are designed to provide training programmes geared to different levels of retardation which will assist in the rehabilitation of the retardates who are able to return to the community, or do productive work in the sheltered setting of the institution.

 In addition to these three activity units, a hospital unit is maintained to provide outpatient and inpatient diagnostic and assessment services, as well as medical care and nursing services for the institution.

 An entirely new training course has been developed to teach the particular knowledge and skills required by the mental retardation counsellors identified with each of the units. The educational programmes, under the direction and supervision of The Department of Education, have been expanded, and special classes are provided for those with particular disabilities, such as impaired vision, or hearing. Additional beds have been provided for the severely disabled and the multiple-handicapped child, and an extensive programme has been developed in collaboration with the public health agencies throughout the province to give assistance to the management and training of the retarded in the community, and to assess the degree of urgency when there is a need for residential placement.

 In summary, Mr. Chairman, these are but a few of the highlights of the changes which have been introduced, and the advances which have been made in our mental health programme during the past few years.

 We must do more to bring to the mentally ill and the retarded the advantages of the most effective methods of prevention, diagnosis, treatment and rehabilitation which are available, and to provide a standard of care that is comparable to that which we consider essential in the care and treatment of other forms of illness and disability.

And to these ends, we are working.

Mr. Chairman, the other major sections of our votes deal with the Ontario health services insurance department, and the Ontario hospital services commission. Rather than talk about those at this time, I will reserve my prerogative to talk about these two major aspects of our department's programmes when these votes are arrived at.