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Wednesday 18 November 2009

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Mercredi 18 novembre 2009

Select Committee on Mental Health and Addictions

Comité spécial de la santé mentale et des dépendances

Mental Health
and Addictions Strategy

Stratégie sur la santé mentale et
les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 18 November 2009

Mercredi 18 novembre 2009

The committee met at 1609 in committee room 1.

MENTAL HEALTH AND ADDICTIONS STRATEGY

The Chair (Mr. Kevin Daniel Flynn): If I can ask all the members to take their seats, please, and perhaps we could close that door. Thank you. I'd like to welcome everyone to the Select Committee on Mental Health and Addictions. Our apologies for starting a little late.

The bells may be ringing throughout the afternoon. If you see the committee up and run out the door, don't take it personally; we're going into the House to vote, and we'll be back, hopefully, in five or 10 minutes. It may delay proceedings a little bit; I hope not too much.

FAMILY SERVICE ONTARIO

The Chair (Mr. Kevin Daniel Flynn): With that being said, we're going to start with our first presenter of the day; that's Family Service Ontario, John Ellis. John, if you'd like to make yourself comfortable—anywhere you're comfortable in that front row there.

Mr. John Ellis: There are two of us.

The Chair (Mr. Kevin Daniel Flynn): That's great. Come on forward. Make yourselves comfortable. If you could introduce yourselves when your time begins.

What we've done in order to accommodate as many speakers as possible is that everybody is getting 15 minutes. John, you and your colleague can use that any way you see fit. If there is a little bit of time at the end for some questions or discussion, that seems to work well as well, but that's entirely up to you. I'm going to turn it over to you, John, and then, if you would introduce your colleague as well for Hansard, we can get going.

Mr. John Ellis: Will do. Thank you very much. I'm John Ellis, and I'm executive director at Family Service Ontario. With me is Rebecca Roy, who is a program manager at Lutherwood in Kitchener.

I'm going to speak to you first, and then Rebecca will take over after I'm finished my portion of it. We'll try to go as quickly as we can within the time limit and allow for any questions that you might have.

First of all, I'd like to say how pleased we are to have this opportunity to share a vision for mental health and addiction services in Ontario with you. We applaud the government for taking these steps towards an integrated and responsive system. It's not an easy task, we know that, with so many different ministries and departments involved in the system.

We're going to give you some background, first, from the Family Service Ontario perspective and introduce you then to an exciting model of coordinated local services that's currently operating, as I mentioned, in the Kitchener-Waterloo area that we would like to see replicated across the province.

First of all, about family service agencies: These are 40 to 50 family service agencies, as many of you know, that are situated in communities all across Ontario and integrated with services at all levels of the service delivery system. They are major providers of family counselling to individuals, couples and families with mild to moderate mental health problems.

For those people who experience anxiety and depression from family breakdown, job loss, addictions, parenting challenges and domestic violence, family service agencies are there to help. Referrals come from family physicians, mental health clinics and local hospitals, workplaces, schools, police, children's aid societies and other organizations, such as the Canadian Mental Health Association, children's mental health organizations and many others. Ideally, these referrals come before a crisis occurs.

The services of family counselling agencies mitigate the high costs of unnecessary emergency room visits in hospital and the involvement of more expensive mental health specialists. At the family service agencies, there are highly trained, experienced staff, primarily social workers, who provide a broad range of individual and family counselling services in person and over the phone, who help people of all ages and walks of life resolve their personal issues, become better parents, deal with their drug and alcohol problems and function more effectively in the community. In addition, family service social workers contribute to cost-effective outcomes through their collaborative case management skills.

Family Service Ontario sets accreditation standards as well for the organizations that are part of the network to ensure that they not only have high-quality service programs but the agency itself is run effectively and efficiently.

New data from a valid and reliable study of 2,100 clients over two years through the family service outcome measures study indicates the following: 60% of

individuals seen by family service agencies with a moderate mental health problem show significant clinical improvement as a result of treatment intervention; 98% of individuals who are under stress improve their ability to participate in the workforce; and family counselling services were found to be twice as effective as the average treatment for common mental health problems.

Currently, family service agencies are situated in what we call the second tier or level of Ontario's referral process for the delivery of mental health services. This is a level that is often forgotten by the government, where those who are most emotionally and financially vulnerable receive the least funding support. In contrast, services to individuals who enter the system through what I'm going to describe for you as levels 1 and 3 are funded primarily by the Ministry of Health and Long-Term Care.

Level 1: These are individuals who visit their family physicians and mental health clinics in hospitals. This is the level where the doctors are compensated by the province even if no service is provided, even if they make a referral out. That's level 1. It's like the primary level of contact for an individual who goes to their family doctor who realizes that there's a problem and will refer them.

The second level includes the family service agencies to which many doctors do make referrals. There are other referral sources to family service agencies, as I mentioned, but this is a sort of second level of intervention. A person has a problem, they go to the family doctor, and then they get referred somewhere else if they have been determined to have a mental health issue. Sometimes that's to the family service agencies, which is that second level, and sometimes it's actually to what we describe as the third level of intervention, which is the more specialist intervention, so they go to see a psychologist or go to see a psychiatrist.

1620

Most people can't afford to pay a family service agency's full fee, so the agencies essentially cobble together the various resources that they have, various funding, to try to provide the services. But rarely does any financial support come with these referrals that I'm telling you about. No matter where these referrals come from—they come from all over, various sources, whether it's the CAS, whether it's a family doctor, whether it's Ontario Works or another agency—no funding comes for the service that's being requested. In fact, what I'm trying to explain is that levels 1 and 3 are much better funded levels of intervention. Doctors are paid through OHIP, and so are psychiatrists, which is level 3. People who are referred to psychologists have to pay for themselves out of their own pocket. It's that second tier of intervention for people with mental health problems, the tier in which the family service agencies fall, that is an issue for us, because adequate funding does not come with the individual referral.

Rebecca is going to talk to you today about a model which we think resolves this issue. It only exists in one part of the province, and we would like you to study this model if you're not familiar with it already, because we think it has great potential for future rollout throughout the province. It's a partnership of six community counselling agencies called Health-Connect Counselling Partners, coordinated through the mental health system by Lutherwood. It's a community-based and outcome-proven collaborative of local community counselling agencies, which includes family counselling agencies, doctors, hospitals and other service providers, that aligns perfectly with the key concepts promoted in the Ministry of Health's discussion paper Every Door is the Right Door.

Again, we encourage the government to scrutinize this model carefully. Family Service Ontario and Health-Connect partners are ready to work with the government towards its expansion. We believe it will save the system money immediately, rationalize referrals, reduce wait times through inappropriate visits to specialists, hospitals and clinics, and ultimately serve those in need more effectively and more efficiently.

Here to give you some more details about that program and how it works is the program manager from Lutherwood, Rebecca Roy.

Ms. Rebecca Roy: Thank you very much, John.

The Chair (Mr. Kevin Daniel Flynn): Just so you know, Rebecca, you've got about six minutes left.

Ms. Rebecca Roy: Okay. I will try to be very concise.

The Chair (Mr. Kevin Daniel Flynn): Relax; just so you know.

Ms. Rebecca Roy: Thank you very much for this opportunity to come and talk to you today. What I'm going to be telling you about, as John told you, is our model that combines universal primary health care focusing on mental health and addictions. This is a model that exists only in Waterloo region, and we're hoping that with some understanding, this model could evolve across the province.

Our program has been operating since December 2005. We're currently funded in Waterloo region for patients of family health organizations. With the program, what can happen is that adults, children, couples or families who are experiencing mental health or addiction challenges have the opportunity to receive early treatment and intervention. What we've done is integrated mental health, addiction and physical care. What happens is the person, whether it's a young person, a child or an adult, experiences a problem. It may be very simple or it could be a little bit more complex, with combined aspects of mental health, addiction or physical health. What would normally happen or what happens in our region is that you go to your family doctor for primary care and have the opportunity to speak to him about that. The family doctors who are participating in our program can make a referral to a centralized service, so we provide counselling services, we provide psychiatric consultation, and we provide psycho-educational assessments and other psychological services.

Our intake is centralized. We have only one phone number, one fax number. In our region, we currently

serve approximately 12 family health organizations with 50 practitioners.

As John told you, we have six partner agencies. We have approximately 12 full-time counsellors and intake workers coming together from various counselling agencies in our area. Mental health and addiction counselling are provided at one family medical practice location and at other community locations across the region which are operated by our six partner agencies.

We are in both urban and rural settings. We're very accessible. We provide clients with more than 35 therapists and clinicians with diverse clinical areas of expertise and different languages and cultural backgrounds, which greatly enhances the chance of having a good fit between the client and the practitioner.

As I said, we also have psychologists who are available to do assessments and other consultations, and we have a small piece of a psychiatrist, who is available to us every Thursday afternoon.

We think this simple model could really be transformed. Many of our citizens in Waterloo region don't have access to a family doctor, so our vision would be something that would open up more partners in the program. More referral sources could be added. We could include other family doctors, urgent care clinics—we have two universities in our region where they have clinics—hospitals, and other community agencies or self-referral.

The idea is that with increased referrals, service delivery would expand for a wider range of service providers. In our community we could add in another hospital, other counselling agencies and other community agencies that focus on substance and process addictions, and we could also include organizations providing interventions and support for women experiencing violence.

This relationship with our local self-help peer support group could also be formalized. I know there's a movement towards more self-help programs.

We could add housing; we could add employment services. In Waterloo region, Lutherwood provides both of these services.

Whereas the current system is based on funding envelopes with many government funders from three different levels of government and different ministries, what we could do now is look for a new way to imagine how the system could look. Our Health-Connect model is a flexible, responsive funding system which responds to local collaboration. It's based on local solutions that are holistic and community-based. It began with a proposal created to meet local needs. Government departments could collaborate in response to design and provide appropriate funding.

Thank you very much for this opportunity. I'd like to let you know that we've created a submission for you. We had a PowerPoint, which unfortunately we couldn't share. The highlights are in the centre for you.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you, Rebecca, and thank you, John. That's great time management: You left about 45 seconds. It's probably not worth even starting on a question, but thank you very much for the thorough—

Ms. Rebecca Roy: Thank you for the opportunity.

M^me^ France Gélinas: I have one quick question.

The Chair (Mr. Kevin Daniel Flynn): Yeah, I've seen quick questions before. Okay, try it.

M^me^ France Gélinas: What is your budget right now? How big is it?

Ms. Rebecca Roy: I think we're looking at just over $2 million.

Ms. Sylvia Jones: Who gives it to you?

Ms. Rebecca Roy: A variety: the Ministry of Health and Long-Term Care and other region—

Mr. John Ellis: Do you mean the Health-Connect budget or the Lutherwood budget: the organization's budget or this program's budget?

M^me^ France Gélinas: This program.

Ms. Rebecca Roy: Oh, I can speak to that. It's just over $1.3 million. My apologies.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

M^me^ France Gélinas: And it—sorry.

The Chair (Mr. Kevin Daniel Flynn): I'm trying not to be mean.

Okay. Thank you very much for coming. That was appreciated.

1630

GESTALT INSTITUTE OF TORONTO

The Chair (Mr. Kevin Daniel Flynn): Our next presenters today are JoAnne Greenham and Yvonne Brunelle, if you'd like to come forward. Make yourselves comfortable. You were here when I explained the rules the first time, so the same rules apply to you. Relax. There are some clean glasses and some water there if you need any.

Ms. JoAnne Greenham: Take my time and drink water? Not a chance.

Laughter.

The Chair (Mr. Kevin Daniel Flynn): Well, the time is yours to use as you see fit. If you would introduce yourself as well, for Hansard.

Ms. JoAnne Greenham: Thank you for this opportunity, everyone. I'm JoAnne Greenham, executive director of the Gestalt Institute of Toronto. With me today is Yvonne Brunelle. We'll introduce you to her program a little later on.

We were founded in 1970. We're a small but mighty little institute. We're a non-profit educational institute registered with HRDC. We offer personal development programs to the public and professional training in leadership and psychotherapy to professionals of all kinds. My experience is in consulting, training and supervising professionals of all sorts, and I've written those down in your handout.

Our students learn from the inside out. They are members of a group continuously throughout their four-year training program. After two years of intensive personal therapy, they learn to apply their skills to leadership that

is quite clear of their own neurotic needs. They learn to utilize feedback graciously and skilfully.

Exerting opinion onto and influence over clients is not the job of the therapist, we believe. They do not impose their values and ambitions on the clients; they learn to work with how the client is stuck.

The strength of our program is in the length and the depth to which all of our graduates are trained. They emerge as individual and group psychotherapists. Also, they're trained in co-leadership skills, a component of training that is unique to our model. This training is very challenging and creative. The students are able to adapt their skills to many different contexts, from the therapy room to the classroom, to organizations and to community groups. The value of this experiential learning model is that individuals move from victims who protest their circumstances through a process of embracing who they are and what they can do.

We urge the committee to advocate for more in-depth training for group therapists in mental health and addictions. This would enhance treatment outcomes for current programs. There is no doubt that staff training enhances their motivation, confidence and effectiveness. Most of you acknowledge the benefit and expedience associated with group work. Much time is taken in planning and delivering the content of group materials, but not in developing skills for managing the process; that is, the interaction between group members.

I just wanted to mention that we use empowerment of the client as a basis for our values, and that involves responsibility, risk-taking and emotional attachment.

We urge you to recommend the allocation of funding for more ongoing experiential learning in the areas of diversity, cultural identity, change management, trauma and abuse, and personal growth in schools, universities and community-based programs. The Gestalt Institute is available to consult around any of these issues.

Consumers of all ages are able to choose for themselves already on anger management, self-esteem, depression and anxiety programs based on models for self-support and change. We offer programs that focus on the human condition. This kind of approach has a role in prevention and in the maintenance of a healthy relationship-based lifestyle. Some people in society are motivated to take responsibility for their health and for personal problems and they're willing to pay directly. This programming can divert traffic, appropriately, away from expensive treatment in the overloaded health care system.

I just want you to consider for a moment programs entitled:

—anticipation, which is a program on anxiety;

—the trouble with anger, which attracts all kinds of people; and

—beyond belief, a program on diversity.

As a value, we would agree that empowerment and awareness are important aspects of treatment for survivors of abuse and trauma.

We recognize the need for a reinforcement of services for groups from First Nations communities, the elderly, children and youth. We are familiar with the psychiatric and addiction problems so often accompanying survivors of trauma. We believe that their recovery requires a gradual development of healing, support, responsibility, integrity and culpability, and the experience of being valued in their relationships. We're available for ongoing training both on-site and off-site.

Our students come to us from many different backgrounds. Many organizations choose to support their staff financially for the cost of the training. One such graduate is with us today. I am delighted to introduce Yvonne Brunelle from the Enaahtig Healing Lodge and Learning Centre in Victoria Harbour, Ontario. You have some of her program materials with you. She has integrated the Gestalt model over the four years of her training in her approach to healing and has effected a profound impact on her clients and her community.

I've included a summary at the bottom of my handout but I would like to invite questions for Yvonne and for myself, if you have any.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left a lot of time for questions. It looks like we'll have about three minutes for each party, starting with Christine or Sylvia.

Mrs. Christine Elliott: Perhaps Yvonne could tell us a little bit about the programs that she's responsible for and how the Gestalt approach has helped you with that.

Ms. Yvonne Brunelle: Sure. I work at an agency. It's off-reserve and we're funded through the aboriginal healing and wellness strategy as well as the Aboriginal Healing Foundation. Primarily, my work is with residential school survivors and intergenerational trauma, so working with clients who have complex trauma. My title there is senior counsellor; I oversee the residential treatment as well as the other counsellors who work within the residential treatment program.

Why I chose to get further training through the Gestalt Institute was, I did lots of research when I was considering training, and the Gestalt Institute could offer what I felt was the most compatible approach to what I was already doing. I've been working at Enaahtig for nine years. It's a holistic approach. When working with clients with complex trauma, they're looking for authenticity, and that's what the Gestalt Institute could offer me and support what I was already doing.

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

M^me^ France Gélinas: First is, if it takes a long time, don't answer it because I have other questions, but the name is weird. Where does it come from? What does Gestalt mean?

Ms. JoAnne Greenham: As my son once said when he was very little, "It means 'the whole.'" That's what he used to tell people. But Gestalt comes from that notion that one plus one is more than two. It really comes out of those days of beginning to treat the patient as a whole and the holistic movement in the early part of the century.

M^me^ France Gélinas: How much would the four-year training cost? Maybe I can ask you: How much did it cost?

Ms. Yvonne Brunelle: I was fortunate because my workplace paid for my first year. I'm a status Indian, so Indian Affairs paid for the remainder of my training. But I think it came up to $6,000, $7,000—I'm not even sure—

Ms. JoAnne Greenham: I think it's $12,000 now for the four years of part-time training.

Ms. Yvonne Brunelle: And then there's clinical supervision throughout, and therapy.

M^me^ France Gélinas: And are you recognized by the Ministry of Training, Colleges and Universities?

Ms. JoAnne Greenham: That's a big question that we're looking at right now. Because we're approved of by a higher level, we've been registered with HRDC for a long time, so we're investigating that with the college now to find out what the overlap might be and what the possibilities might be to be dually registered.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. This side? Maria?

Mrs. Maria Van Bommel: Yvonne, how do you reconcile the traditional aboriginal healing and the Gestalt method? Are they compatible? How do you work with other aboriginal people if they're looking for the more traditional type of approach?

1640

Ms. Yvonne Brunelle: I would say that they are compatible. When working within the aboriginal community, I would say that the clients are looking for someone, first, with cultural competence, so someone who has knowledge of the traditional ways. Second, they're looking for someone who has done their own personal work. Again, working with complex trauma they can see whether you're authentic or not or whether you're walking the talk, and in the aboriginal community that is so important, which is why, with traditional elders and traditional people, having done that piece of their own personal work is so important. Within the Gestalt Institute I've been able to do that for myself along with the work I've done at the healing lodge, so that's where it comes in. Then again, the approach is that you're working with what is, with the client, not imposing your agenda, and that definitely goes along with the philosophy of the traditional ways.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. It was a great presentation. We really appreciate it.

KATHY BAKER

ANN TASSONYI

The Chair (Mr. Kevin Daniel Flynn): Our next presenters are psychogeriatric resource consultants Kathy Baker and Ann Tassonyi, if you'd like to come forward. Make yourselves comfortable. You have 15 minutes like everybody else; use that any way you see fit. If there's any time at the end, we'll split it.

Ms. Kathy Baker: Okay; great. We're grateful for the opportunity to present to you today the perspectives as experienced by the many doors entered by the psychogeriatric resource consultants in the province of Ontario and we applaud you for your work towards a 10-year mental health and addictions strategy. I'm Kathy Baker, the psychogeriatric resource consultant for Hastings and Prince Edward counties, and my esteemed colleague Ann Tassonyi is the psychogeriatric resource consultant in the Niagara region. Both Ann and I have been in the PRC position since its inception in the province of Ontario.

The PRC positions were one of the 10 initiatives under the Ontario government's Alzheimer strategy from 1999 to 2004. The plan was to put in place 50 full-time-equivalent PRC positions that would support the staff in the long-term-care system, both the long-term care homes and community agencies who are providing care for those older adults with complex cognitive and mental health needs and the associated behavioural challenges that are so often accompanying those mental health needs. We've become known as the triple-hat practitioners in the province of Ontario.

The three hats that we wear: In each of our regions, the PRCs support staff in the long-term-care system when they're faced with those highly complex situations by way of education; so both case-based education and topic-specific. Many of us in the province are provincial PIECES educators, and the PIECES education model was supported also by the Alzheimer strategy—gentle, persuasive approaches in dementia care, just to name a couple.

By way of consultation, we provide case-based consultation and care planning consultation for those clients who are presenting with those highly complex cognitive and mental health needs. Consultation may also be for projects as well as policy development within organizations as well. The community development activities that the PRCs are involved in in each of the regions would be broader community activities and conferences as well as network developments. In each of our areas in the province, we've developed dementia networks.

So our focus as PRCs in Ontario is to improve the quality of life of seniors with complex cognitive and mental health needs by enhancing the capacity of the front-line staff; supporting human resources in their continued, person-centred work with these highly complex individuals, increasing knowledge at the bedside, so increasing the knowledge of point-of-care staff; transforming the system to foster linkage collaboration across the system so that the transition of these folks is seamless; and increasing access to specialty services and ensuring efficient use of these resources.

Some of the seniors' mental health issues that we often see in long-term care and in the community agencies where we provide staff support and education consultation are mood disorders, depression, bipolar disorder, post-traumatic stress, anxiety disorders, psychotic

disorders—both lifelong psychotic disorders such as schizophrenia or late-life presentations such as paraphrenia—and addictions issues, and the many forms of dementia and the behavioural and psychological symptoms that often accompany those.

Why are we here? I'm not going to go over lots and lots of numbers because the numbers are staggering, and they speak for themselves. I'm sure you've been presented with many numbers. The Canadian Coalition for Seniors' Mental Health say that by the year 2021, 18% of Canadians will be over the age of 65 years, and 45% of this group may be over the age of 85. In your document, Every Door Is the Right Door, you mention that, "Ten to 25% of seniors experience mental health disorders," and by the age of 80, one in three of us will be affected by some form of dementia. The prevalence of mental health disorders in long-term-care homes in Canada is between 80% and 90%; that's from the Canadian Coalition for Seniors' Mental Health.

The needs of the long-term-care system, as the PRCs in Ontario see it: We need to focus on mental health and mental illness. We need to recognize the diversity of these clients and also the complexity. An interdisciplinary approach to support these highly complex clients is so very important. The collaboration and linkages in the continuum of care are also very important. We need a knowledgeable workforce that has the capacity to provide the social and physical environment to support clients with mental health and addictions issues.

Ms. Ann Tassonyi: I'm going to continue on. I'm Ann.

As a community of practice, we got together a couple of weeks ago and looked at the themes from your strategy. We thought, "We already address a lot of these themes in our mandated role as psychogeriatric resource consultants." It was great to have a discussion about how we can further move these themes forward in our local communities and institutions. We thought about how we can help with the strategy.

We really do think we do help people act early. We're always teaching people about person-centred care in our case-based consultations and our education programs, looking at early identification and trying to reduce stigma.

We often in long-term care find that people think people with mental health disorders do not belong in long-term care. We'll always have people saying, "Well, he's mental health," or, "They're schizophrenic. They belong in the provincial hospital." Unfortunately the provincial hospitals have reduced their beds to the point where we have to manage people in our own community unless they really have behavioural problems that are very difficult to manage and really exceed the resources that we have.

We are trying to enhance the capacity of the workforce. We're involved in development of best practice guidelines, dissemination and implementation of guidelines such as the registered nurses' association guidelines on screening and management of dementia, delirium and depression. We've been involved in dissemination and implementation of the Canadian Coalition for Seniors' Mental Health guidelines to increase best practices in the long-term-care system.

We do pre-licensure education for personal support workers in colleges. We mentor students in the long-term-care system. We do a lot of on-the-job training and also postgraduate education. For instance, a program at McMaster, the clinical behavioural sciences program, which is a postgraduate diploma program, has a geriatric mental health component to it. There are other universities around the province that have similar things that we are involved in. As part of our job in education, we are linking with other professionals. We're collaborating, forming partnerships and always trying to get the people who are working with complex adults to make referrals, pull in palliative care, stroke experts, pastoral care, geriatric psychiatrists, geriatric medicine—whatever is needed in the complex system.

1650

In our consultation role we do case-based consultation. One of the things that is important in long-term care is that there are many unregulated staff. The way they get their information is by talking to each other, and that has been shown in the research. Also outreach and coaching has been shown in the research to be an effective method of knowledge transfer.

We've been involved with universities such as in the Murray Alzheimer Research and Education Program; McMaster University in terms of piloting and evaluation of, for instance, a gentle persuasive approaches workshop; and best practice implementation activities, as I mentioned before.

Again, we're trying to strengthen the workforce, getting people to identify persons who have capacity issues or consent issues, use best practices and certainly try to evaluate what we're doing and collaborate with researchers in the field of aging.

In our community development role, we're also working with many caregivers across a continuum of care, especially—Kathy mentioned the dementia care networks, which were actually given some seed funding a few years ago when they looked at the research done by Dr. Lemieux-Charles at U of T. Larry Chambers and Ken Le Clair were involved in evaluating networks and their efficacy, and it was deemed appropriate for dementia care networks to be supported across the province. That funding hasn't recurred. There were requests for proposals twice and they have not been supported since then, but they're an important way to draw people together to identify gaps and build capacity in the system locally, regionally and provincially, because the networks have banded together in the LHINs and also provincially to move forward the issues facing the elderly population.

I think that the cross-sector collaboration and linkages are really important and we do support those. Hopefully, we are helping to transform the system with those efforts. In terms of what needs to be done, we're hoping that the Minister of Health and Long-Term Care will invest in

specialty geriatric services. We certainly need increased access to specialty services, outreach programs for people who can't access services or won't access them because of mental health difficulties, case management for public health, outreach services, community care access centres—they're all stretched. We need more triple-hat practitioners such as us, the psychogeriatric resource consultants. We have large areas of responsibility, and certainly helping people implement best practices is a challenge with the large numbers that we face.

There are other services that really enhance the care of the elderly, such as geriatric emergency medicine and nurse practitioners who also span long-term care and acute care. These kinds of things will all prevent admission to the ER and long-term care and save the system some money.

The other thing that's very helpful is sustained funding for knowledge transfer activities such as through the Alzheimer Knowledge Exchange, the Seniors Health Research Transfer Network and funding to organizations such as the Canadian Coalition for Seniors' Mental Health and the Registered Nurses' Association of Ontario that actually disseminate and facilitate implementation of best practices across the systems.

Also, the Stroke Network and Palliative Care Network have received sustained funding for knowledge transfer activities, and that's something that we can certainly use to facilitate education. We're funding coffee and doughnuts out of our own pocket to get people to listen to us.

The Chair (Mr. Kevin Daniel Flynn): Where are they?

Ms. Ann Tassonyi: I really forgot those doughnuts.

I think that's—hopefully, if anybody has any questions.

The Chair (Mr. Kevin Daniel Flynn): Good. You've left a little bit of time for questions. France, did you have one?

M^me^ France Gélinas: Where are you located? As in, I understand there are 50 of you. Do you work as part of a team or are you all alone, servicing a geographical area?

Ms. Ann Tassonyi: Originally, when the positions were funded by the ministry, there were requests for proposals for community collaboration. There are 50 of us serving geographical regions, and some populations—for instance, I think Toronto region has five—

Ms. Kathy Baker: Eleven.

Ms. Ann Tassonyi: They have 11. In the Niagara region, we have two. But for instance, in the Niagara region, there are 32 long-term-care facilities, plus I don't know how many provider agencies. It's a lot. I don't know, Kathy, how many you have.

Ms. Kathy Baker: We cover a geographical area, and each PRC, or psychogeriatric resource consultant, is sponsored by an agency. Myself, I'm sponsored by Providence Care Mental Health Services, a geriatric mental health outreach team. Ann is sponsored by an Alzheimer society in Niagara region. Other PRCs are sponsored by CCACs, but we cover a geographical region.

Ms. Ann Tassonyi: One of the PRCs did say to me that in different areas, the funding has been used in different ways, and they were worried about the use of the funding, not maintaining the positions. So they may receive the funding, but they've been asked to do case management instead of education, so it is useful.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your time today. It was a great presentation.

ONTARIO CONSUMER AND FAMILY ADVISORY COUNCIL– CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is from the Ontario Consumer and Family Advisory Council from the Canadian Mental Health Association of Ontario, Dennis Reid. Dennis, if you'd like to come forward.

Like everybody else, you get 15 minutes. Use that any way you see fit. Probably at some point, you'd like to introduce your colleague.

Dr. Dennis Reid: Sure.

The Chair (Mr. Kevin Daniel Flynn): I'm assuming you're Dennis?

Dr. Dennis Reid: I am.

The Chair (Mr. Kevin Daniel Flynn): The time is all yours.

Dr. Dennis Reid: Good afternoon. My name is Dr. Dennis Reid. I'm an Ottawa physician. I'm currently a member of the Ontario Consumer and Family Advisory Council—that's OCFAC—of the Canadian Mental Health Association, Ontario division. I will be presenting today along with my committee colleague, Earla Dunbar. We will be speaking about our personal experiences, and then we will make recommendations which we believe will improve the mental health system in Ontario from both a consumer and family perspective.

Our major recommendations are:

—early intervention: treating symptoms during the early years for a better recovery. This includes educating teachers and counsellors to recognize the early symptoms of mental health conditions and to make the appropriate referrals;

—reduce stigma and discrimination from professional health care providers. This is a significant problem;

—invest in supportive housing. This housing will require high-level support whereby people are not evicted for behaviours that are due to their mental illness, ensuring that they maintain housing, which is central to their recovery;

—reviewing privacy legislation and considering the inclusion of families in the treatment plan of their loved ones; and

—supporting the formation of a provincial family network. I'll get into the details of that in a minute.

My daughter is 32 years old. She's the youngest of four children and has three older brothers, who are all

professional men. Rebecca has a degree in social science from Western and a diploma in journalism from Algonquin in Ottawa, and up to three years ago, she was the managing editor of the Canadian Plastics magazine.

The current cycle started three years ago: anxiety, panic attacks, depression, impulsive behaviour, suicide attempts, cutting, and anger levelled at her mother, brothers and friends, who, for all intents and purposes, have abandoned her.

She saw a psychiatrist and therapist and was placed on medication. Eventually, she went on long-term disability from work. The diagnoses are post-traumatic stress disorder and borderline personality disorder.

She was admitted to CAMH on a form 1, having told friends she was suicidal. She was discharged with no planned follow-up. Since then, she has made multiple visits to emergency departments and non-medical shelters such as Gerstein, and uses crisis hotlines frequently. She had a five-week stay at Homewood in Guelph, but was discharged for acting up. You can't act up in a mental hospital.

She has been on multiple medications and developed a dependence on medications, and as a result lost her driver's licence. Her financial situation, her apartment, are in total disarray. She has moved apartments three times, has caused significant disturbances and been threatened with eviction. I hired a lawyer and we attended a hearing at the Landlord and Tenant Board, where we settled through arbitration. She has had dealings with the police, and recently was arrested for assaulting a neighbour. She has been bound over until December 10, while we find a lawyer.

1700

There were signs of problems when she was a teenager. She had several quarrels with teachers and coaches—she was a provincial ringette player—and developed mood changes and decreased academic performance in Grade 13. These were signs of mental illness. We should have recognized them and got help at that time.

There is considerable public education on the early recognition of other diseases. Every day you get it in the mail: heart disease, stroke. The same thing should apply to mental illness. We need considerable public education.

My daughter has been admitted in crisis to all the downtown Toronto hospitals. This year, she has also been admitted to Toronto East General and Ottawa General.

I have written to all the relevant personnel at these hospitals—emergency docs, emergency heads, psychiatric heads, patient advisors—just to request that she be assessed and treated appropriately. I've been told—I've gotten replies—I am not entitled to receive any details because of privacy legislation. None of her psychiatrists or therapists have ever asked me for an interview to discuss family issues or to take a family history of psychiatric disorders or addiction. When I have requested to meet with the psychiatric team, I have been told that privacy laws preclude my input or my ability to receive information; however, I'm the first person to be contacted in a crisis and am expected to bail out my daughter and the system.

The family of a mentally ill person is usually the only support left at the end of the day. They are afforded no support, no input and given little information, but expected to pick up the tab and bail the system out.

There needs to be an amendment to privacy legislation. This should state that an appropriate family history and profile must be obtained from the next of kin and the next of kin be apprised of the treatment plan and the discharge strategy wherever possible. It's not always possible.

There is an urgent need for a provincial family network to assist family members with the problems they are likely to encounter as they navigate the complex and frightening world of mental illness. Dealing with mentally ill patients is difficult and I can understand why some hospital staff have problems coping with disruptive behaviour. It's not pleasant. However, there is no excuse for trained personnel, professional caregivers, to use demeaning language such as "nutbar" and or "GOMER," which means "get out of my emergency room."

The College of Physicians and Surgeons and the College of Nurses of Ontario should issue guidelines for dealing with the mentally ill patient, and deviations from these guidelines should be reportable and subject to discipline. They've done the same for sexual abuse. Only then will we be able to eliminate the stigma attached to mental illness.

A crucial part of treatment is psychotherapy—$150 an hour. It's not covered by OHIP. It's covered by WSIB. Insurance companies usually pay a maximum of approximately $300 total. The cost of psychotherapy needs to be addressed by our public and private health care insurers. People with mental illness require more than just medication.

My daughter has never been referred to a social worker or any social organization for community support. Her social support is me, 480 kilometres away, and her boyfriend, who has his own mental health problems. People with significant mental illness require a designated social worker and network to help deal with the problems of daily living. This should be mandatory.

I can honestly say that dealing with my daughter's mental illness is the most difficult thing I've ever done. I've found support groups to be therapeutic; I've heard a lot worse stories than mine. I'm angry at the health care system. I'm angry at doctors and nurses who use demeaning language, but I really have the utmost respect for the few who genuinely care.

I'm angry at Homewood for discharging my daughter during a crisis and forcing her to take a taxi to Toronto at a cost of $200 and telling me at the last minute. I'm angry at the Ottawa General Hospital who discharged my daughter home without informing me, after she had been admitted in crisis, having physically assaulted her mother. So much for communication.

On a positive note, my daughter has regained her driver's licence. She's talking to her mother again and

trying to get back on speaking terms with her brothers, but that could change—that could change tomorrow. Life is one day at a time, never be too optimistic and always expect the worst. That's the family perspective on mental illness.

I'd now like to ask Earla to present the consumer's perspective.

Ms. Earla Dunbar: Thank you, Dennis. Hello. I'm very happy to be here but very nervous. My name is Earla Dunbar and I am presenting as a consumer-survivor.

At the age of 44 in 1998, I finally found help for my social phobia, agoraphobia, panic disorder and depression. When I was five, I started to feel different, not wanting to leave the house without a family member, feeling sick and not going to school.

Then, when my father died when I was nine, the depression set in. The psychiatrist I was seeing at the time told my mother to take me to the Penetanguishene mental hospital and said that if I did not straighten up, this was where I would end up. The hospital terrified me, and from that day forward I became a happy little girl. Then the other disorders set in.

In the years following, I became agoraphobic, depressed and socially anxious, and the panic seemed to be with me all the time. Then I began to disassociate. There were many suicide attempts during all this time.

When I finally got help at the Centre for Addiction and Mental Health, I was relieved but terrified to tell my family since there was so much stigma about mental health. When I finally told my mother, she took me out of her will and would not talk to me for awhile. She blamed me for putting the family to shame. Only when I started being interviewed on TV and in the media, and her friends found out and thought it was so brave of me, did she accept me back as her daughter.

Because of my disorders, I could not even finish grade 10, and in my work, never was able to get further in my workplace. People thought I was stupid and/or a snob. My terror of everything and everyone put me in a shell, a terrifying, scary and very dark place.

If we could reach out to all children, what a wonderful chance they would have to be able to continue in school, make friends, join in family gatherings, work at what they want, grow and have a life, instead of hiding, which is what I did.

I am the founder of the Social Phobia Support Group of Toronto. When I talk to them, I say, "It is up to you to talk about your mental illness. If you do not, who will?" But so many feel embarrassed by their illness.

Social phobia is the third-largest mental health illness we have, yet there are so many still suffering. We must speak up and tell people not to be ashamed and that they can get well.

I feel very fortunate that I do have my life back and that I've had such wonderful support with professionals and still do. Also, what is so refreshing is that I am not terrified of people. I am now making friends. I never thought I would be where I am in this world today, and I'm so glad I'm still here.

These are my recommendations and the support for them.

To be successful in helping others, early intervention is necessary. Education in mental health to parents, teachers, family doctors and young adults is needed. Every person who is part of a school community is a teacher for mental health and well-being.

One out of four young adults will experience a mental disorder within a 12-month period. Early recognition and treatment reduces long-term treatment. As young adults, they feel powerless, guilty and utterly alone.

Thank you for your time.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Earla. Thank you, Dennis. You've left time probably for one question, perhaps two. Starting on this side, any questions? No? Christine? Sylvia?

Ms. Sylvia Jones: I just wanted to thank you for bringing the presentation forward. You are not the first family member or supporter who has talked about the need to change the privacy issues. I appreciate you bringing your personal story, and thank you for sharing. I'm glad that it has worked better because of the supports you were able to get. I'm just disappointed that it took as long as it did.

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

M^me^ France Gélinas: I took in all the anger you had towards the health care system. It's certainly justified, with what happened to your family.

You made a recommendation that "The College of Physicians and Surgeons and the College of Nurses should issue guidelines"—I'm reading what you said—"for dealing with the mentally ill patient and deviations from these guidelines should be reportable and subject to discipline." I'm really surprised that it is not. I mean, they all have codes of ethics, don't they? You said you were a physician. I take it that it's more of a culture that people don't report when one of their members actually displays the behaviour that you've given as an example?

1710

Dr. Dennis Reid: When you work in the acute care situation in the hospital and if a mentally ill patient comes in, it's quite amazing the type of stigma they're subjected to by professionals. I'm not talking about porters and other staff, but physicians and nurses.

No, it is not reportable. There are no guidelines on how to deal with it. The mentally ill are treated, really, quite badly when they go to the emergency department, particularly if they're triaged through the regular system. If they're triaged through a mental health triage system, then very often they can bypass the major triage systems where all the heart attacks and other patients go. But by and large, they are triaged through the regular system and left to lie on a gurney for several hours. They may be screaming and yelling. My own daughter was told, "We're not going to talk to you unless you behave yourself." Well, when your brain's malfunctioning, it's different from your heart malfunctioning.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dennis, and thank you, Earla, for coming forward. It really is appreciated.

ONTARIO ASSOCIATION FOR SUICIDE PREVENTION

The Chair (Mr. Kevin Daniel Flynn): Our next presenter—this is going to come down to a very tight thing, here. We've got the Ontario Association for Suicide Prevention. All the members are going to have to leave for a vote in about 15 minutes, so just so you don't take it personally, if we hear from you and sprint out of the room, it's nothing you said.

You were here for the rules, so why don't I just let you go. Walter Mulkewich told me you were coming.

Ms. Rahel Eynan: Chairman, members of the committee, thank you for the opportunity to appear in front of you and to discuss the tragic public health issue of suicide and the urgent, challenging questions associated with its prevention.

To those not suffering from depression or another mental illness, suicide fundamentally is an inconceivable act, but for others, it is all too real—

The Chair (Mr. Kevin Daniel Flynn): I'm sorry, I should have asked you to introduce yourselves.

Ms. Rahel Eynan: Okay. I'll go back. My name is Rahel Eynan. I'm the president of the Ontario Association for Suicide Prevention. This is my board member Wayne Hobbs.

I'll continue the sentence.

The Chair (Mr. Kevin Daniel Flynn): I didn't mean to disturb you, but we had to get that in for Hansard.

Ms. Rahel Eynan: Okay. No problem—but for others, it is all too real, and it claims the lives of nearly 4,000 Canadians each year, people of every age, both men and women, within every group of our population regardless of socio-economic status. In fact, in Canada, more people die by suicide than motor vehicle accidents; more people die by suicide than by homicide and HIV combined. The suicide rate is nearly 11 per 100,000, which exceeds those of homicide, which is 1.9 per 100,000, and HIV, which is 1.3 per 100,000.

In Ontario, suicide is one of the leading causes of death—it's actually number 10. In 2005, 1,115 people died by suicide, so each day, three people killed themselves. The number of suicides increased from the year 2000 to 2005 by 21%, and there are as many as 20 attempts for every suicide. From April 1, 2001, to March 31, 2002, there were over 24,000 ER presentations for self-harm.

In 1999, there was a report written to the Ministry of Health and Long-Term Care and the Ministry of Health Promotion that indicated there were 83,000 self-inflicted injuries. Of those, over 9,000 were hospitalized and 73,000 were non-hospitalized injuries. The same report assessed the cost to our economy, and the cost of suicide and self-harm, in direct and indirect costs, was $886 million. Ninety per cent of the people who kill themselves have depression or another diagnosable mental or substance abuse disorder, so suicide is a major public health issue.

Now I'll let my colleague continue.

Mr. Wayne Hobbs: Thank you for the opportunity. I commend the committee for tackling this very complex issue. The number of presenters before us and the variety of topics just underlines how widespread this issue is and how it touches every part of our society.

Just for my background: I've worked in school boards for over 30 years in London, Waterloo, now Grand Erie. I'm on the board of Parents for Children's Mental Health and the first presenters on Health-Connect. I'm on the board of K-W Counselling Services and the Ontario Suicide Prevention Network, so I've got a bit of perspective to bring to this topic.

Certainly, our previous presenter talked about attitudes and stigma that continue to exist, and they exist within the health care system. I think that the Honourable Maria Van Bommel from London area knows the old Victoria Hospital. I was in there years ago getting stitched up after a hockey incident and the emerg room there was not divided; it was just curtains that would be drawn around individual beds so you could hear everything that was going on. The doctor stitching me up stopped in mid-stroke because of a commotion in the bed next to me. A young man had tried to harm himself and came into the hospital and the hospital staff were yelling at him for taking up their valuable time. That kind of attitude continues and it results in inequitable access to service for people with mental illness and addictions.

But we know from science that suicide is preventable. There are a lot of beliefs out there that this is fate, that it's inevitable and don't waste your time trying to help people who want to harm themselves, and that couldn't be further from the truth.

One of the other areas, though, that I'd like to talk to you about is the lack of coordination of policies and services. On your second page—as I said, I work in a school board, and over the last six months to 10 months this is an example of the number of policy statements that I have coming to me. It started with the Mental Health Commission of Canada and then this July with the release of Every Door is the Right Door. When I went to a meeting chaired by somebody from the Ministry of Children and Youth Services, they were unaware of the Every Door is the Right Door policy statement. Minister Wynne has talked about mental health being a priority in school systems. There are so many competing messages that come to service providers, and I'm sure that you've heard many times before about the importance of co-ordinating initiatives and collaborating instead of competing, as it takes a lot of our valuable time.

Ms. Rahel Eynan: Other provinces in Canada have initiatives and strategies for suicide prevention: Prince Edward Island, Newfoundland and Labrador, Nova Scotia, New Brunswick, Quebec, Manitoba, Alberta, Saskatchewan, British Columbia is just issuing their strategy at the end of the month, Nunavut, Yukon and the

Northwest Territories. Ontario doesn't have a suicide prevention strategy as yet. In Ontario we do have, however, an endowed Chair in Suicide Studies at St. Michael's Hospital, which is part of the University of Toronto, and the Ontario Association for Suicide Prevention is working on developing a provincial suicide prevention strategy.

So what are our recommendations? We need to establish an interministerial leadership body for suicide prevention and mental illness and substance abuse and addiction. We need to establish a mental health and addictions strategy that encompasses a comprehensive suicide prevention strategy. It also requires interministerial collaboration and coordination. For example, we cannot have screening of children in schools without involving the Ministry of Education. So if we have a true strategy of reducing suicide, we have to work with other ministries beyond the Ministry of Health and Long-Term Care.

To save lives in Ontario we need a provincial strategy for suicide prevention, a strategy that will promote awareness that suicide is a public health problem that is preventable. We need to develop and implement strategies to reduce stigmas that are associated with being a consumer of mental health, substance abuse and suicide prevention services.

Just to go back to what Wayne and the presenter before said regarding stigma in hospitals by professionals, one of the terms that is used in hospitals for individuals who repeatedly attempt suicide and frequently come to the hospital is "frequent flyers," which really debases their distress and suffering. It's a term that's used. I work in a hospital and I'm aware of it.

We need to promote the implementation of community-based suicide prevention programs that ensure early identification and effective intervention. We need to have screening of school children, in high schools and universities, but hand-in-hand with that, we also have to have services to which they are going to be referred if we discover that they are depressed, bipolar or they need any other help.

We need to improve the access to community linkages with mental health and substance abuse services. We need more detox centres, we need physicians, we need therapists; we need to support the fees that individuals have to pay for services that are not covered by OHIP.

We have to promote efforts to reduce access to lethal means and methods of self-harm. Twenty per cent of the people who kill themselves kill themselves with firearms. The other high number is self-poisoning with medication. We need medications that are lethal in large quantities which are given for depression to be dispensed in a different way so that it will limit the number of prescriptions that individuals have access to. We also need a registry where people cannot get medications from different pharmacies, but the pharmacies are all coordinated so they cannot shop all around in order to get medication, hoard medication and then take it.

We need to promote and support research on suicide and suicide prevention, so we need dedicated funds that go to suicide research. We also need to be able to evaluate the programs that are implemented when they are implemented.

We need to improve the reporting and portrayal of suicidal behaviour, mental illness and substance abuse in our entertainment and news media. It must not be sensationalized. It has to be factual reporting and must also include a crisis line number when it's reported.

We need to improve and expand our surveillance system. We really don't know how many suicides there are. We are talking about 4,000, but all of us in the field know there are many more incidents that are undetermined or are suspicious deaths that most likely are suicides. We need to develop protocols for our coroners that will accurately determine the cause of death. Also, we need to have protocols for collecting information on non-fatal attempts and we need to standardize those protocols all across the province.

That's our presentation. Again, thank you very much for giving us the opportunity to discuss it. If we can be of any assistance to this committee in any way, we'll gladly do that.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We're really glad you came today. We probably have time for one quick question. Christine or Sylvia, do you have anything?

Mrs. Christine Elliott: I just wanted to say thank you very much for putting the time and thought into this paper and for appearing in front of us today. There are a lot of things that I'd like to have time to address, but unfortunately, I don't. I did just want to assure you that we are aware of the need to coordinate programs with all of the various ministries because we know that it's not just the Ministry of Health and Long-Term Care; it goes across virtually every government ministry, so point well taken. Thank you.

Ms. Rahel Eynan: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming.

We're recessed for about 10 minutes, so members of the audience, that means that members of the committee will go up to the House, we'll vote, and we should be back here in 10 minutes.

The committee recessed from 1722 to 1732.

NORTHUMBERLAND POVERTY REDUCTION ACTION COMMITTEE

The Chair (Mr. Kevin Daniel Flynn): Okay, if we can come back from recess, then. Our next presenter is Lois Cromarty, chair of the Northumberland Poverty Reduction Action Committee. Have a seat, Lois. Make yourself comfortable. Thanks for waiting.

Ms. Lois Cromarty: Great. No problem.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else before you, you get 15 minutes. Use that any way you see fit. If there's time at the end for any questions, we'll try to split it amongst everybody here.

Ms. Lois Cromarty: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Let me get my timer going.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): There may be another vote coming in half an hour. That may make it a little problematic, but let's give it a try.

Ms. Lois Cromarty: Thank you for allowing me time to speak today. I am a lawyer and I'm the executive director of the Northumberland Community Legal Centre, out in the county of Northumberland, in Cobourg.

I'm presenting to you today in my capacity as chair of the Northumberland Poverty Reduction Action Committee. Part of our mandate, as a broad-based coalition, is to try to shine the light of poverty reduction action on different agendas. The members of our committee are—we're quite broad-based. We include everything from the faith community to the county of Northumberland itself, the United Way, labour and education.

We're quite broad-based, but we're all with that focus of trying to take action to reduce poverty and to get that on every agenda, which is really why we're here today, because as you know, poverty and mental illness are very closely linked.

Lack of health care is also tied to poverty and to mental illness. Because health care falls into one of our poverty reduction action areas within the county of Northumberland, we wanted to be sure that poverty reduction forms a part of any mental health and addiction strategy that is to be put in place.

So I'm here today to deal with not only the low-income aspect of mental health and addiction but also the rural nature, and the problems facing rural residents who have mental health and addictions issues.

I'm not a mental health expert. I did some research and found that there are huge numbers of reports on mental illness and what the mental illness strategy should be in this province. I think 20 were issued within the last 25 years, as listed by the Canadian Mental Health Association, all endorsing the principle that services should be moved from institutions into the communities.

Other studies out there that you may not be aware of—one in particular, dealing with the relationship between mental illness and poverty, is one done by Dr. Gina Browne, a researcher with McMaster University, who did a study for Hamilton, Wentworth and Halton regions called When the Bough Breaks. Her study dealt with whether you could influence the length of stay on social assistance by providing things like mental health supports to social assistance recipients. In her study on the prevalence of mental health issues amongst social assistance recipients, she found that in that region—Hamilton-Wentworth-Halton—60.4% of social assistance clients had two or more mental health problems.

Her study also went on to prove, or show, that if you gave full intervention services—that is, if you gave that client base of sole-support parents employment services; in-home visits by a public health nurse who was dealing with mental health issues; quality child care and recreation; income; pharmacotherapy and counselling—25% of sole-support parents would exit the social assistance system within one year, versus 10% if you did nothing for them, quite a significant difference. The investment upfront in those types of services to social assistance clients with mental health issues—there's quite a savings when those people leave the system.

1740

There's also a big tie-in between homelessness and poverty and mental illness. The Kirby report certainly found a rather tragic relationship between homelessness and mental illness. There's quite a link between mental illness and abused women. The local statistic from our women's shelter is that 80% of their clients have mental health problems. In the health care sector, there's no question that those with serious mental illness have greater difficulty in getting general health care services and they, in turn, receive a poorer quality of care compared to those without a mental illness. That has been studied as well, both in the United States and in Canada.

What's probably not too apparent in the studies is the on-the-ground effect on those with mental illness or addiction issues. The funding turf war between programs—it's health versus some other agency—means that there's a lack of treatment for people with dual diagnoses; that is, with both a mental illness and a concurrent disorder. Certainly those studies don't give you the full flavour of the disproportionate effect that mental illness has on low-income people, that those mental health issues and addiction issues, if they're left untreated, can lead to and leave you in poverty.

There's certainly a lack of sensitivity amongst the service providers in public programs. I see that in my work as a lawyer with the legal clinic, that clients with mental health issues or addiction issues are often seen as non-compliant and they consequently lose their income. They put their housing at risk. If they're in social housing, they face a greater chance of eviction.

The way the social assistance rules are written, if you're hospitalized for more than three months, you're going to lose your income and you are going to lose your housing. You're even further behind the eight ball when you come out of hospitalization.

From a rural perspective, that are lots of barriers that discourage individuals from even accessing the services that are there. Transportation is a big issue, or lack thereof. There are studies that show that the hub model of providing services in hubs has no reach beyond about 10 kilometres, that if you pass that distance, you're not going to go to those services, and that's a big barrier in a rural community like our own.

Funds: For a low-income person, it doesn't matter what the fee is for a service; if it's not covered by OHIP and you have to pay for the service, a fee for service will cut out that portion of the population regardless of the size of the fee. There are obviously long wait lists in the "free" services.

The poverty reduction action committee wanted you to hear a bit about what we see on the ground in North-

umberland county. We're a rural county. We're about 70 miles east of here. What we've seen and what our day-to-day circumstances are for those with mental health issues and addiction issues are: There are no crisis beds in our county. The crisis beds are in neighbouring counties, in Oshawa, Peterborough or Belleville. So if you're a low-income person with a crisis issue, you're going to have to travel and your family is going to have to travel to get to you—70 kilometres or more if you live in Cobourg.

There are no methadone clinics in our county. Again, if you're taking daily methadone treatment, you either have to go to Belleville, Peterborough or Oshawa to get that service—a huge consideration in terms of the cost of travel for low-income residents.

There are no supportive housing units in our county for those with a dual or a concurrent disorder—that is, a mental health and an addiction issue. The few units of supportive housing that we do have are only for what I would call a select group of mental health problems. They don't take clients with mental health disorders that aren't on their particular list.

There's no supportive housing in our county for those with addiction issues. There are no residential treatment programs in our county. Our local community counselling centre that was started and funded by the United Way needs ongoing operational funding and has a wait list of clients who are waiting to use those services. We definitely have a shortage of mental health professionals, and the one wellness centre that we have in our county accesses psychiatrists by videoconference, which is not an appropriate service for lots of different types of mental illnesses. For myself, I couldn't imagine sitting in a room by myself looking at a camera trying to describe my mental health issues by Skype to somebody who's sitting somewhere else out of my view in a different town.

One of the other large problems that we have in our county are the decisions of the LHIN, the local health integration network. We're in a LHIN that starts at Scarborough and ends at our border, so when you talk about where the resources are going to go, if you're including Scarborough, Pickering, Ajax, Whitby, Oshawa, Peterborough and us, we're way down on the list of where those resources are going to go. In fact, some of the LHIN decisions directly impacted us. When the decision was made by the LHIN to distribute $16 million worth of supportive housing in the central east LHIN, they decided that they were going to place those in blocks of eight units. Scarborough got the largest chunk of blocks of eight and it funnelled down to the last block of eight, which got to Peterborough. That was all that was left—none for Northumberland county.

One of the other things that I wanted to bring to your attention is the form 1 process, when someone is brought in as a danger to themselves or others. We have two hospitals in our county. That form 1 process bears extensive costs not only for the community but for the individual themselves, especially the low-income individual. If you're brought in on a form 1 to the local hospital in Cobourg, you have two police officers who stay in the emergency room with you. In a small police force, that's a big investment of resources. You're stripped of your belongings, and if you're a homeless person and you've only got your ID, everything you have is on you. When you're stripped of that, that's placed in somebody else's care and custody. Then you're transported out of Northumberland county to Peterborough. In that ambulance ride, you're accompanied by a registered nurse—again, another health care cost. But your belongings may or may not go with you, and may or may not come back with you when you're discharged from Peterborough. I don't have to tell you what the loss of identification documents means. Everything in our lives depends on that. Health care depends on that. Accessing social assistance depends on that, so when you lose your birth certificate, your driver's licence, anything that identifies you as you, it's very hard in our society, in the system as it is today, to get those things back and to get back on track, get your identity back.

It doesn't also factor in travel costs. If you're a form 1, as I say, in Peterborough and you're housed there in Peterborough and you live in Northumberland county there are costs for your family to come and see you; there are those costs of the health care provider who goes up and has to wait in Peterborough until you're admitted; there's the cost of the police officers, as I say, to remain in the ER while you're awaiting transport. But the other costs that are sort of hidden are: When you are released on a form 1, there really aren't any local services to help you when you come back to Northumberland county, so we lose people. There's a lack of repatriation because you've got nothing to support you when you do come back to our community.

The poverty reduction action committee has asked me to make the following recommendations to you when you're drafting any sort of provincial mental health or addictions strategy. We urge you to put poverty reduction measures in the strategy and to ensure that the strategy addresses low-income concerns. The strategy should supply supports to low-income residents in accessing service—should cover travel costs, child care, that sort of thing. We want the strategy to address the rules and policies in both social assistance and social housing that put your housing or your income at risk for those with mental illness or addiction issues. I'm not just talking about the hospitalization; I'm talking about the compliance issue as well. We want you to look at eliminating those barriers to accessing service and to provide supports in the strategy to municipalities if you want to create that full intervention method, as Dr. Gina Browne showed was so effective in Hamilton-Wentworth-Halton.

1750

The strategy should also address the concerns of a rural population. We have 88,000 people who live in Northumberland county. We want you to deal with transportation costs and focus on creating locally-based services, because studies have shown that a satellite method is not as effective as place-based service for clients.

The Chair (Mr. Kevin Daniel Flynn): Just so you know, Lois, you have about a minute to summarize.

Ms. Lois Cromarty: Yes, okay.

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

Ms. Lois Cromarty: Lastly, we want you to integrate mental health and addiction strategies with the other strategies that are at play at the moment: the poverty reduction strategy, the affordable housing strategy. Nothing should be considered a stand-alone strategy, because mental health cuts across all of those sectors.

I'll leave you with the rest of my list of recommendations from the Northunberland Poverty Reduction Action Committee. We certainly hope that in the development of any strategy, you look at what is the impact on the low-income and the rural person in accessing those services.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Lois. I was reading ahead a little bit, and you've done a very good job of summarizing the recommendations for the members. Just because you didn't go over them, don't think that they won't be paid attention to.

Thank you very much for your time today, and thank you for appearing before the committee.

Ms. Lois Cromarty: Thank you.

WATERFORD FAMILY COUNCIL

The Chair (Mr. Kevin Daniel Flynn): Don, this leaves me with a little bit of a challenge. We could either not start you for about half an hour, or we could start you and stop and go and vote and come back and do whatever time you have left after that. It's entirely up to you. I wish we weren't in this position, but we are. It would be unfair to you for you not to make the call.

We're going to have to go and vote in about 10 minutes. We could hear the first 10 minutes and we could come back for the summary.

Mr. Michael Leaker: Okay. We can do that.

The Chair (Mr. Kevin Daniel Flynn): Okay. You can all come forward, if you'd like, to give him some moral support here.

Mrs. Christine Elliott: Chair, is there a written presentation?

The Chair (Mr. Kevin Daniel Flynn): Is there any written presentation or is everything just oral?

Mr. Michael Leaker: Everything's just oral.

The Chair (Mr. Kevin Daniel Flynn): Okay, super. If you'd identify yourself—I know Don, but if you'd identify yourself for Hansard, we'll take it from there.

Mr. Michael Leaker: My name is Michael Leaker, and this is Don Moffat. We are here on behalf of the Waterford Family Council. First of all, I'd like to thank you for inviting us to address your committee.

The Waterford Family Council is a group of concerned people whose family members reside at the Waterford long-term-care facility in Oakville, Ontario. Our purpose is to help other families whose loved ones have moved into the home, to make living at the long-term-care home a better experience for our loved ones, and to become their advocates as they lose the ability to advocate for themselves.

Many of our loved ones have moved into a long-term-care facility because they are no longer able to take care of themselves, or their families are no longer able to take care of them.

Before coming here, I was talking to a few of the doctors who tend to the residents in the long-term-care homes throughout Halton, and also to the Halton Geriatric Outreach Program. They estimate that just over 80% of their patients are on some form of antidepressant or antipsychotic medication. That is why I am really glad to be here today to address you.

Some of our loved ones were on these medications before they moved into these facilities. My mother-in-law lived with me for a number of years before she developed a severe case of clinical depression and anxiety. She had suffered bouts of depression for decades. The biggest hurdle we had this last time was the fact that she was over the age of 65. The mandates of organizations such as CAMH, many outpatient services, community services and experimental therapies do not include those who are over the age of 65 and thus were unavailable to us.

In cases where we have elderly spouses trying to care for their elderly loved ones, the spouse needing the care can receive some help through the CCAC; however, the elderly caregivers themselves are not eligible. We see cases where one person's laundry is being done and not the other's. Only one person's bed is being made; only one person is receiving meals. While this does help the caregiver a bit, the caregiver could use some support themselves.

The wear and tear on the caregiver sometimes results in both individuals moving into a long-term-care facility. When the families have compared the costs of assisting a person to stay at home to living in a long-term-care home, they discover that it would have been less expensive to the province as a whole to have increased the amount of in-home care. Also, hopefully the couple ends up in the same facility. It is not uncommon for them to end up in different facilities, and that brings about its own type of mental anguish for them.

In terms of getting community support and applying to move to a long-term-care home, the CCAC has been a consistent source of disappointment for us. Fundamentally, we believe that they are understaffed. I once called their 24-hour helpline, and my call was returned two weeks later. In the meantime, my mother-in-law was admitted to hospital. Another family member from our council ended up going directly to their offices in the hopes of getting hold of someone.

Part of the purpose of the long-term-care homes was to bring together people with similar backgrounds, life experiences and conditions in the hopes you could help them cope and become better. However, we are also now seeing a more broad spectrum of individuals moving into the homes. We have one individual, a 26-year-old, who's

a quadriplegic. We've had wheelchair-bound autistic teenagers stay at the home for respite care. There is a growing number of individuals in their early 50s suffering from alcoholic dementia moving in as well.

Some of these individuals I just described do not have the same life experiences as those who live there normally. I imagine it is also quite shocking for some of them to find themselves living in a long-term-care home filled with seniors. It also makes some of us worry that the long-term-care facilities are being used to house those that we, as a province, do not know what to do with, turning the homes into the institutions of old, the ones that we have closed.

Also, some of these individuals are quite demanding in terms of needing assistance. We feel that the ratio of personal care providers to residents is too low to begin with. They do not have the time to help everyone get up in the morning, eat their meal and go the washroom after a meal in a timely manner. For example, the workers have about 10 minutes per person to wake them, dress them and have them ready for breakfast in the morning. I know it takes me longer to do that. A number of us have hired outside help to assist with feeding our loved ones. Some of us have also hired caregivers to assist them with getting up in the morning, allowing them, say, half an hour to get ready, and taking them to the washrooms after meals while they are still living in a long-term-care home.

Personally, my wife and I are in the latter group. We hire five individuals for a total of 42 hours a week to assist my mother-in-law, and it has made a great difference. A number of other council members average about 10 to 16 hours a week in additional care, mainly to help with eating. Given that people are living longer and the province is behind in building long-term-care facilities, space is already at a premium, and we are worried about the effects of expanding the mandate to include other people who do not share the same life experiences as many of the seniors we have.

Also, there's an increased number of individuals coming into homes with severe behavioural problems or mental health issues: Alzheimer's, dementia, depression, schizophrenia and others. This is in addition to the individuals who develop Alzheimer's, dementia and depression after moving in. We are finding that the staff in these homes, while equipped to deal with some of the simpler forms of dementia and Alzheimer's, are not equipped to deal with all the mental health issues that are coming in.

At the Waterford, it seemed that when my mother-in-law moved in, she was the first person they had really encountered with severe depression and anxiety. Many of the staff asked us if they'd be receiving any training in how to deal with someone with severe depression. None came. The geriatric outreach program has been asked to examine a number of people's medications in long-term-care homes, only to find that those individuals only needed more socialization, more human interaction, and were given anti-psychotic medications to calm them down instead. The impression many of the family members have is that drugs are used to sedate residents so they are easier to care for.

Seniors present health care providers with complex medical, functional and psychological problems. It's not an easy thing. This creates difficulties in obtaining proper diagnoses. Improper diagnosis can lead to premature loss of health, independence, well-being, and increased time in the hospitals.

In the Halton, Hamilton and Brant area, there are a total of 20 beds to deal with individuals with severe behavioural and mental health problems; 10 of those beds are usually taken up by individuals waiting for some place to move to. That leaves 10 beds to circulate the patients through. To handle just the senior population that resides in Halton region who could use these facilities, the doctors in the geriatric outreach program in Halton would actually like to have a 20-bed unit for every three to four long-term-care homes. That would be a few units within the region, not just one for many.

The Chair (Mr. Kevin Daniel Flynn): Michael, you've got about two minutes left, so you choose the appropriate time when you want to end the first part of your presentation.

Mr. Michael Leaker: Actually, I think I might be able to finish it off, and you can come back for questions.

The Chair (Mr. Kevin Daniel Flynn): Okay, perfect.

Mr. Michael Leaker: I don't want to leave you with the impression that there is nothing out there. The Seneca program in Oakville is wonderful. It has a long waiting list and is great for seniors with mild cognitive problems. Caregivers who have used the VON Alzheimer's program cannot say enough about how great that program is. Sadly, the programs available to seniors are limited, and we wish there were far more available.

In closing, we'd like to see more programs available to seniors, like CAMH, even if it's just available for residents of Ontario. We would like to see the personal care providers at the long-term-care home be better prepared to take care of residents with mental health issues and we'd like to have more of them so our seniors can receive what we consider an adequate level of care. We get the feeling that seniors are neglected by our society, and that's a shame because they helped build it. I hope that as you consider changes to the care seniors receive for mental health and addiction, you consider what sort of care you would also like to see when you reach your golden years.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful, Michael. Thank you. A good spot to end; when we come back, we'll go straight to questions.

We're recessed.

The committee recessed from 1759 to 1808.

The Chair (Mr. Kevin Daniel Flynn): If we can reconvene. Thank you very much for the presentation, Michael. You've left quite a bit of time for questions. I think it was either France or the government side that was going to start, so why don't you start, France?

M^me^ France Gélinas: Actually, I was quite surprised by what you were saying about the amount of extra help

you had to bring for your mother-in-law in the long-term-care home. Do you figure that this extra help is needed specifically because she has a mental illness, or is it throughout this home that basically the regular staff can't cope and people end up having to hire their own?

Mr. Michael Leaker: I believe it's throughout the home and it's not just this home, to be honest. It also occurs in other homes; a lot of people supplement the care.

Mr. Don Moffat: A lot of people in the home have dementia and/or Alzheimer's. There are three personal support workers for every 29 people in the home area. When you're talking about trying to feed those people—my mother has severe Alzheimer's. It takes 45 minutes to feed her on a good day. How does the math work? It doesn't. That's why you pull out your wallet and pay.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Anyone from the government side have a question? No. Sylvia?

Ms. Sylvia Jones: Thank you for coming. You've raised a few issues that I was not familiar with. I'm not sure if it was Don who talked about the—

Mr. Don Moffat: Michael.

Ms. Sylvia Jones: —Michael who talked about how after your mother-in-law reached 65, there were no avenues of support for her mental health issues?

Mr. Michael Leaker: Unless we admitted her to the hospital, yes.

Ms. Sylvia Jones: So anything that you were getting from community mental health, any of that, it just outright stops? What was the process? How did that happen?

Mr. Michael Leaker: I called up CAMH for help and I was told, "Oh, I'm sorry, but your mother-in-law is over 65. We cannot help you. It's outside of our mandate."

Ms. Sylvia Jones: And was she receiving help prior to 65?

Mr. Michael Leaker: She didn't need it—oh, sorry. When she was younger than 65?

Ms. Sylvia Jones: Yes.

Mr. Michael Leaker: Yes, she had received some help, but she really didn't need it. Her case was that she might suffer from depression for six or seven months, some medications would resolve the issue, she'd be fine for five to seven years, then suddenly the medications would stop working. One time, she had to take ECT or electroshock therapy. It worked wonders the first time. Last time, it was ineffective.

Ms. Sylvia Jones: Okay. You also raised your frustration with the community care access centre.

Mr. Michael Leaker: Yes.

Ms. Sylvia Jones: Are you receiving any assistance from them as they provide service within the long-term-care facility?

Mr. Michael Leaker: I wasn't aware they could provide services within a long-term-care facility.

Ms. Sylvia Jones: So they're not doing any at all?

Mr. Michael Leaker: No.

Ms. Sylvia Jones: Okay. Thank you.

Mr. Michael Leaker: That was in their mandate?

Mr. Don Moffat: No.

Ms. Sylvia Jones: Just one point of clarification: You hire 42 hours a week?

Mr. Michael Leaker: Forty-two hours a week: six hours a day, seven days a week.

Mr. Don Moffat: And my family probably hires 20 hours a week.

Ms. Sylvia Jones: In a regulated—

Mr. Don Moffat: Government—

Mr. Michael Leaker: Publicly funded, privately run, for-profit long-term-care home.

Ms. Sylvia Jones: They all have the same rules. Thank you.

The Chair (Mr. Kevin Daniel Flynn): I have a question. I was talking to some of the senior staff down at Oakville Trafalgar Memorial Hospital, and they were saying how often somebody will exhibit behavioural problems that are the result of some mental health issues and will end up, because of the inability of the staff at the home to deal with that, at the hospital. The home will then, when they have been triaged at the hospital and it's time to send them back to the home, often say, "We aren't equipped to deal with this person," and the poor person is caught between the hospital and the long-term-care facility that used to be their home. Have you seen examples of that at the Waterford?

Mr. Michael Leaker: I have not. Have you?

Mr. Don Moffat: No. I've seen a lot of people go to the hospital that possibly—if they checked for urinary tract infections on a regular basis, that would probably stop a lot of people from exhibiting signs of dementia and things like that. Being proactive rather than reactive would probably help out a lot. When you've got people in long-term care, it seems that they treat reactively and not proactively.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you. Any other questions? We've got time for one more.

Thank you very much for coming today. We certainly appreciate you taking the time out of your day to do that.

Mr. Michael Leaker: Thank you.

RANDI FINE

The Chair (Mr. Kevin Daniel Flynn): Our final presenter of the day is Randi Fine. Come forward and make yourself comfortable. Like everybody else, you have 15 minutes. Use that any way you see fit. If there's any time left over, we'll split it just like we did then.

Ms. Randi Fine: We'll try.

The Chair (Mr. Kevin Daniel Flynn): Very good. It's all yours.

Ms. Randi Fine: Okay. Thank you so much for seeing me as a person. I could have come here with many different titles and many different hats, or my one big hat, as I like to say, but I chose to come here as someone who has been affected by mental illness in my own life at every stage.

I'm here as a daughter of a father who was bipolar for over 50 years; as a sister—two sisters: one who suffers from bipolar disorder and one who suffers from an anxiety disorder; as a mother of a daughter who had childhood depression but has done unbelievably well; and then there's me. I fight my own demons, but some of them I have chosen to fight as an advocate for seniors' mental health services. I want to tell you a little about my own journey and how I got there.

Many years ago, I found great interest and delight in working with seniors. I've had the privilege of doing so for many years and hope I always will, and I've always been an advocate for seniors. As my dad grew older, and so did those I was working with, I began to wonder what was being done about seniors' mental health. I found that, in fact, there was very little being done.

Sitting here today, I learned a few things and heard much of the things I've heard before, but it's fascinating that we're all here because, until a few years ago, none of us were talking about seniors' mental health.

During this time, specific incidents piqued my interest and concern. My dad's heart attack made me realize something had to be done. Let me tell you a little about that.

My dad had been hospitalized at the time in a very well-recognized psychogeriatric unit for almost three years—one of many long hospitalizations—and he was so seriously depressed that he was constantly and actively suicidal and totally withdrawn.

One night, he complained of terrible pain in his stomach, which was very unusual because he barely spoke to anyone at that time. Sadly, the staff dismissed his pain and offered him orange juice. In fact, it turned out he was in the middle of a serious heart attack, which, by the way, presented as stomach pain because he was diabetic—something I've learned. It was not discovered until the next morning that he had had this serious heart attack, when he was found in a coma.

Luckily, with lots of adventures in between, he did come back to us. Though we were told that he had two weeks to live, he was very stubborn and he managed to live for 18 more months. What was really fascinating was that, with this heart attack, his depression finally lifted for the first time in many, many years, and so he had a wonderful last 18 months.

But what I want to emphasize here is that because he was on a psychiatric unit, his physical symptoms were not taken seriously. One important lesson is that older adults are complex folks, and those with mental illness often have medical problems and vice versa. So we can't think of older adults with mental illness as just people with mental illness who age; there are both issues to consider.

1820

Around that time, while all this was going on, I had the opportunity to focus on seniors' mental health and began networking with contacts across the sectors. I'd been around for a long time so I had lots of contacts. Eventually, I was able to form, with many other people, an organization called the Older Persons' Mental Health and Addictions Network of Ontario, which brought together people from across the sectors of seniors' mental health and aging and which made great strides in bringing together older adults and people who had never been involved in this conversation before. It managed to survive as an organization until 2008, when we couldn't achieve sustainability, which is, indeed, very sad. So there is, in fact, no network that cuts across the issues of seniors and mental health in this province.

Since then I've been out advocating, sitting on committees and boards and doing my favourite thing, which is training with seniors, caregivers and staff. Let me assure you that seniors do want to talk about mental illness. I'm often asked to speak both for seniors' groups and for staff. They're hungry for information, but I'm limited in what I can do as a volunteer, and they have no funding to buy education, so there is a huge gap.

I want to put before you certain conclusions and recommendations that are probably no different than any you've heard before. I've heard some of my colleagues today; I've read most of the submissions you've had from the various seniors' organizations, but I'm here with my passion and with no title because I really want these to be my recommendations, because I have often been accused of being too passionate, so now I have my chance. Here are my thoughts.

Seniors' mental health must be a priority not only because of the demographics and costs but because it's the right thing to do. I have been in this business for a long time—I'm getting to be able to say that myself—and we have been talking about these issues for the last 40 years. It's time to stop talking and start doing. We all know what's coming in terms of the growing seniors' boom. We know that with more seniors there will be more mental illness. We will have a crisis. It is time to do something now.

We need to be talking about various groups of seniors when we're talking about mental illness. We need to consider the needs of those people who are growing older with mental illness as well as those with age-onset mental illness, which includes dementia. Dementia itself is devastating and important to address but seniors' mental health is much broader. Often, when we are talking about seniors' mental health we're talking about dementia, and that's really very limiting. In fact, until seniors reach 80, depression is a much bigger problem and every bit as debilitating. The difference is that dementia always progresses but depression can be prevented, treated and often cured, yet it gets almost no attention in our system, which focuses on so-called "serious and pervasive" mental illness, and that's a shame.

In Ontario there has never been a framework to address seniors' mental health and addictions, and we need one. We have to begin by dealing with the deadly duo of ageism plus the stigma of mental illness. We need public awareness and targeted education for seniors, family members and staff who work with seniors from the mental health perspective and from the seniors'

perspective. In fact, anyone who has contact with older adults should know what is normal about aging so that they can help to identify what is not normal or may be a mental illness.

We need more and better prevention programs. Seniors' centres, clubs and organizations, housing superintendents, as well as everyone who works with or cares about older adults need resources and help to understand the role they can play. Seniors can and want to play a significant role in helping to design systems that will meet their own needs. We are not using that wonderful population nearly enough.

We need to intervene early, and that means overcoming the self-stigma of older adults, making proper diagnosis more readily available by having more properly trained staff and then having direct links to appropriate services, not only medication, which is important and plays an important role—and by the way, older adults respond to antidepressants at twice the rate and do much better per person than other age groups, which is not well known—but we also need social support and people need someone who will listen.

We need specialized community mental health services, home support and intensive case management. You heard before the issue of services being cut off. The reality is, there is no law that cuts mental health services at 65. However, the services have the choice of whether or not to serve older adults, and many of the people who are working in community mental health themselves don't even realize that they can serve people over 65. We have lots of education to do.

When or if it becomes necessary or more comfortable for someone to live where more support is available, we need to consider supportive housing and assisted living alternatives, not only long-term care. Long-term-care homes as they are now are not resourced nor are they necessarily most appropriate for most older adults dealing with mental illness. Right now, long-term-care homes are dealing fairly well with people with dementia. People with other mental illness are not doing well in long-term care.

We need clear direction and leadership at the government level across many ministries. We need to clarify policies about whether or not adult mental health services can meet the needs of older adults or if we need a separate stream of services. For me, it doesn't matter at all as long as we meet the needs somehow.

I have a few suggestions for specific roles that people can take. The Ministry of Health and Long-Term Care certainly should be taking the lead on clinical services in the community and in long-term-care homes, as well as around home support. I'd like to suggest that the Ontario Seniors' Secretariat can take the lead on public awareness and seniors' education using peer mentors as models and trainers, which they do in many other spheres. The Ministry of Education has a large role to play in terms of training across disciplines. Mental health agencies need to educate their own staff and decide to what extent they can meet the support needs of their own community, if separate services need to be in place or if there need to be combinations. Seniors' services can themselves act as early identifiers and work on the realms of prevention and reintegrating people into the community. Seniors themselves can certainly be identifiers and supporters, and all of us have a role as champions and advocates.

I'm leaving you with a copy of a user-friendly piece we did as the Older Persons' Mental Health and Addictions Network for your information, to show you how easy it is to get the information out. I want you to know that this was funded by the government. Almost 20,000 of these were handed out in a few short years and you have the last copies; I have literally three copies left. My card is on it. There's much more I would like to talk about. If anybody wants to talk about this, please be in touch.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. We've got time for a few questions. Let's start on the government side.

Mrs. Liz Sandals: Yes, you mentioned a couple of ideas that I found really interesting and I'm wondering if you could expand on them. One of the issues for seniors with mental health disorders is clearly how you even get those identified and recognized, and you said seniors' services as identifiers. How do you see that working is question 1. Question 2: If you were to do supportive housing as distinct from long-term care, what would be the supports that you would need in supportive housing?

Ms. Randi Fine: In terms of the first question—now, I forget.

Mrs. Liz Sandals: Seniors' services as identifiers. I wrote it down.

Ms. Randi Fine: Well, that's cheating.

Laughter.

Ms. Randi Fine: Seniors' centres—I worked in one many moons ago—for example, are places where supposedly well seniors come, but people are well before they become not well. Depression in particular, which is this huge issue, is relatively easy to recognize when you know what you're looking for. We also know where the risk peak times are. If someone loses a spouse, for example, we know that we should be checking on that person, because out of five people who lose a spouse; two will develop a clinically significant depression. We could intervene. Seniors' centres know those people; they know who has had a loss, so that's one particular area.

There are programs of early screening and high-risk identification that are done in other constituencies, not in Ontario. We are picking up people that way, but we haven't tried that here. That's one way—and certainly education for seniors themselves about again, what's normal and what's not so that they can self-identify and they can help other people to identify. That's one.

In terms of supportive housing, we have, actually, wonderful models of supportive housing for people who have long-lasting mental illness. In fact, many of those people who are living in those places cannot live in long-term care. In Toronto, for example, we have LOFT Community Services; I don't know if you're aware of that. LOFT is a major supportive housing provider, and

in downtown Toronto has five buildings specific to seniors with mental health and addictions, many of whom have been in long-term care, couldn't function in long-term care, were sent back out into the community and really were very lucky to end up in supportive housing. They now have programs starting in the Jane and Finch area as well.

The services that they provide are intensive case management, but in the sense of very practical case management. So people have help with making sure that they have groceries, that kind of thing. There is often one meal a day. They live independently, but there is somebody there 24 hours a day, should someone have a crisis.

They have great research that's being done that shows that they reduce costs, they reduce hospitalization, and the most important part is that people are living dignified lives. They're independent to the extent they can be, but with supports should they need them.

Mrs. Liz Sandals: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation, Randi. It was really nice of you to come today.

Did you have a question, Sylvia? A brief one?

Ms. Sylvia Jones: Thank you for coming, Randi. I wanted to specifically zone in on—you talked in your recommendations about peer mentors. We've heard a lot about that in other addiction and mental health treatments but not related to seniors' mental health. So, briefly, for the benefit of the Chair, can you sort of extrapolate on how that would work?

Ms. Randi Fine: Well, it does work. We've already had many, many instances. There are peer mentors in the areas of widows' groups, for example—sometimes, you know, they pair off and have a one-to-one. There are senior peer helper programs in a general sense around seniors.

One of the seniors' organizations in Ontario is taking on a role of developing a speakers' bureau, teaching seniors who have experienced depression themselves or as family members to go out and speak to others about that by way of education.

So there are lots of different ways that this could happen. It doesn't have to be formalized—that's the nice part of peer support—but it needs some coordination to happen.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Randi, and thank you for your patience.

Before we adjourn, members of the committee—we should try it at least, anyway, because we got off to a bit of a late start today in our pre-meeting. Staff have something here that may be time-sensitive, and that's on the discussion points for the report writing. We asked them to come back with an inventory of those programs that, as a result of the presentations, were deemed to be innovative programs. Some of that information's been easy to come by from the Internet; some of it's a little tough. So the first question they're asking is, would we be satisfied with an inventory for the time being of those programs for which we can find details on the Internet, or do you want to include all the programs? France?

M^me^ France Gélinas: What I was thinking is that, the ones that you can easily find, sure, put them on, but give us the names of the programs that you think are innovative, because in the end, it could be that you will do a whole bunch of work for things that we won't deem were worth all that work. The flip side is, it could very well be that because some information is easily available, it will make it on to the list when, really, it was not that innovative or vice versa. So I think to prevent you wasting your time, bring the list forward so we can have a first say: "Don't bother with this"; "This is fine"; "We don't need three of the same. We'll pick one"—whatever. So then at least we'll have a better idea of the workload that we're putting on your shoulders.

The Chair (Mr. Kevin Daniel Flynn): Okay, thanks. Sylvia?

Ms. Sylvia Jones: That's fine.

The Chair (Mr. Kevin Daniel Flynn): You agree? Great. Any problems over on that side? That sounds reasonable?

Mr. Jeff Leal: Fine.

The Chair (Mr. Kevin Daniel Flynn): Great. At what stage in the process would you like to receive the inventory: before the interim draft report, or between the interim draft report and the final draft report?

M^me^ France Gélinas: As soon as you've got it.

The Chair (Mr. Kevin Daniel Flynn): So it's not important, just as soon as possible.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): I wouldn't say it's not important, but there's no critical deadline to get it. Good. Thank you.

I mentioned—just before we go, this is something you can think about—that so far, we've heard from a number of people on a number of issues. Two issues that haven't come up a lot have been on gambling addictions—people just haven't come forward and really talked about it much—and the other is on sex addiction.

Ms. Sylvia Jones: At the very beginning we did.

The Chair (Mr. Kevin Daniel Flynn): Yes, but we really haven't heard a lot and it may be interesting to note those, because when you talk to people in the field, they talk about it a lot, and yet when we hear the presentations, it's not coming out a lot. It's just something, I think, to think about.

M^me^ France Gélinas: What was the second one?

The Chair (Mr. Kevin Daniel Flynn): The second one is sex addiction.

Mrs. Liz Sandals: I was going to say on gambling addictions that the gambling addiction research institute is in Guelph. I'm sure that if you contacted them, they would be delighted to come and present.

The Chair (Mr. Kevin Daniel Flynn): Yes. Okay, well, perhaps that's something—but it's just something that I think is noticeable by its absence.

Mrs. Liz Sandals: They're actually the government-funded body that's responsible for doing the research. I can tell Susan where to track them down.

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

M^me^ France Gélinas: Maybe I got that information from another committee, but I though we had received quite a few written submissions from problem gamblers. They didn't come and present, but I thought we had written—no? I got this through public accounts, not through you?

The Chair (Mr. Kevin Daniel Flynn): I can remember two or three people who talked about it. The one group that talked about it were the people that were proposing we add a nickel to a drink—because that's kind of what we do with gambling, that part of the treatment is built into the business itself. But outside of that, I think I've only heard about it in passing from the presentations we've heard before the committee. Just something to think about.

Thank you. We're adjourned.

The committee adjourned at 1832.

CONTENTS

Wednesday 18 November 2009

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