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Mercredi 4 novembre 2009

**Select Committee on
Mental Health and Addictions**

Mental Health
and Addictions Strategy

**Comité spécial de la santé
mentale et des dépendances**

Stratégie sur la santé mentale et
les dépendances

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LEGISLATIVE ASSEMBLY OF ONTARIO

**SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS**

Wednesday 4 November 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**COMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES**

Mercredi 4 novembre 2009

The committee met at 1604 in committee room 1.

**MENTAL HEALTH AND ADDICTIONS
STRATEGY
ONTARIO LONG TERM CARE
ASSOCIATION**

The Chair (Mr. Kevin Daniel Flynn): Okay, if we could all take our seats and get the meeting going. Our first delegation today is from the Ontario Long Term Care Association. If you'd like to come forward and make yourselves comfortable at the end here, there's some water and glasses there. Thank you very much for coming today. Like all delegations, you get 15 minutes. You can use that any way you see fit. If you'd leave some time at the end for questions that would be good, and if you would introduce yourself the first time you speak for Hansard, then they'll know who they're listening to. It's all yours.

Ms. Christina Bisanz: Thank you very much for the opportunity to be here. My name is Christina Bisanz and I'm the CEO of the Ontario Long Term Care Association. With me is Nancy Cooper, who is our director of policy and professional development. We're pleased to have the opportunity to share with you our thoughts on the role of long-term care in mental health and addiction.

We certainly believe that long-term care can be a part of a system mental health and addictions solution for the aging population in Ontario; however, it can't happen by default. The existing structure that specializes in dealing with the health impact of aging, including dementias and behaviours, is only the foundation. The solution requires the addition of strategic initiatives and resources.

Ontario's long-term-care sector is considerable: over 600 homes in the province, with 76,000 residents and upwards of 80,000 staff. Our association, OLTCA, represents the charitable, not-for-profit, municipal and for-profit providers for some two thirds of this sector: 430 homes, with 50,000 residents and an equal number of staff. Our members provide highly specialized services that help residents manage the increasingly complex physical and mental health impacts of aging with comfort and dignity.

For the past decade, over 60% of long-term-care residents have been diagnosed with dementias, primarily Alzheimer's. With the aging population and people living longer at home, long-term-care homes have now been

noting increased acuity in mental health conditions both upon and following admissions. This is starting to show up in the data, including the resident assessment data that is now becoming available with continued implementation of the MDS care planning system.

For example, recent data has shown that 26% of residents reported signs of worsening depression over a three-month period; 13% were deemed to be at high risk for serious mental health or behaviour issues; and 2% had previously been in a psychiatric hospital.

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Homes are being challenged by these trends. Other data showed that 49% of homes reported having to call the police for assistance, and 46% reported having to use a form 1 and/or associated psychiatric leave. There's no doubt these challenges will increase.

In the US, where long-term-care trends often appear some 10 years before what we see in Ontario, we're noticing:

- middle-aged persons with schizophrenia now have an almost four times greater risk of admission;
- symptoms of depression in persons over 65 are the single indicator of likelihood of admission; and
- in the period of 1999 to 2005, the proportion of admissions with mental illness overtaking the proportion with dementia.

Clearly, both the expectation and reality is that long-term care will play an increasingly larger role in the health system's response to aging, mental illness and addictions.

This is a daunting yet hopeful challenge. The hope lies in how we can strategically build on our existing foundation and, in particular, four key elements.

The first element is the solid core of specialized training. In 2007, some 80% of long-term-care homes had PIECES-trained registered staff on two of their three care shifts. PIECES is the Ontario-developed, best-practice approach for individuals with complex cognitive and mental health needs. In almost half the homes with behaviour and/or dementia units, 75% of unregulated staff were trained in the U-First program, which is a complement to the PIECES training for nurses.

The second element is the recognition of the need for, and the development of, partnerships between homes, hospitals, psychogeriatric outreach teams, community agencies and other health care providers.

For example, in 2007:

—80% of homes with special care units had access to external psychogeriatric resources for at least one shift per day;

—94% of homes reported liaising regularly with the provincial network of psychogeriatric resource consultants; and

—64% of homes reported using additional community resources.

The third element is the promise being shown by individual mental health pilot initiatives. For example, McGarrell Place in London is partnering with a hospital outreach team from St. Joseph's to provide care for residents who were former in-patients of provincial psychiatric hospitals. Another one of our homes, in Cornwall, is partnering with a local psychogeriatric outreach team and a psychogeriatrician who conducts assessments and prescribes interventions for dementia and difficult behaviours. And the Toronto Central LHIN's mental health partnership is focused on providing effective care within the home, to avoid transfers to hospitals wherever possible.

The fourth element is the early indication of success. The results of a 2009 survey by the regional geriatric program showed that 28% of homes reported a reduction in transfers to emergency as an outcome of education and training, and 64% of homes reported a reduction in the incidence of injury to staff and residents.

The challenge now is to build on this foundation, which, although promising, remains fragmented, inconsistent and incomplete. In so doing, we need to reiterate that this promise is not as a system panacea. Instead, it is one component of a system solution that recognizes and supports the role of long-term care and the specialized population it serves within that system.

In this context, we leave you with the following recommendations:

(1) There must be an effort to comprehensively and consistently address mental health and addictions issues and opportunities across the full long-term-care sector as part of a provincial system's approach. Let's bring together what is already happening, strengthen it where appropriate and fully integrate it into a system solution.

(2) We must increase and strengthen the partnerships between homes and dedicated external mental health resources across Ontario. There must be consistent equity of access for residents of all homes to these specialized resources on both a routine and urgent basis.

(3) Homes must be supported to strategically add the specialized resources required to ensure consistent access to best-practice-based care within the home. This may indeed lead to more and/or increasingly specialized units for both higher specialized care and to enhance safety for all residents and staff. We caution, however, against the focus on a structural solution only. The term "specialized" must be taken to equally mean the appropriate space and the appropriate care resources.

(4) There must be a renewed emphasis on, and support for, ongoing formal education and training for all long-term-care home staff. This includes registered and un-

registered staff and recognizes the reality that staff work as a team to meet the full needs of the resident in a care setting that is the resident's home.

The evidence clearly demonstrates that formal education and training for all staff drives positive outcomes. We believe these initiatives will serve to build on the progress that is being made in long-term care. They will strengthen our sector's capacity to work effectively with our health care partners as part of a mental health and addictions system solution.

Again, thank you for the opportunity to present to you today and we'd be more than willing to answer any questions you have in the time remaining.

The Chair (Mr. Kevin Daniel Flynn): Perfect. Thank you, Christina. You've left lots of time for questions. We've got about two minutes for each. Christine or Sylvia?

Mrs. Christine Elliott: I'd just like to thank you very much for coming to present today. I think you've raised excellent points for consideration, and certainly it's consistent with what we've been hearing from some of the presenters in some of the different jurisdictions we've been in, so thank you.

The Chair (Mr. Kevin Daniel Flynn): Sylvia, did you have anything? France?

M^{me} France Gélinas: I'm looking through some of the recommendations that you've made. Have you costed out any of the solutions that you've put forward, as in making sure that every one of the 80,000 staff has had the new training, etc.?

Ms. Christina Bisanz: Not directly, no.

M^{me} France Gélinas: Do you have any sense of how far from there we are?

Ms. Christina Bisanz: Well, we do have a sense of how far we are from fully and adequately resourcing long-term care as it currently exists. So this would be an incremental cost and we would be happy to go and conduct an analysis of what more education, training and support services would involve.

M^{me} France Gélinas: All right. That's okay. Thank you.

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

Mrs. Liz Sandals: Thank you for your presentation; that's very helpful. I think in many cases we have the perception that long-term-care residences deal with people with Alzheimer's or other dementias and that can lead to behavioural and other issues, but what you really seem to be identifying here is that you're seeing an increasing population which has actually got a mental health diagnosis as opposed to an Alzheimer's diagnosis. Could you tell us a little bit more about that and why you think that is or what impact that has in a different way of having to manage the resident?

Ms. Nancy Cooper: I think we'll see more and more. When the data comes out from the rollout of the minimum data set we'll have much better information. What we're finding is that, traditionally, we only thought about Alzheimer's and it not being connected to a variety

of mental health issues, and we're beginning to understand there is that linkage.

The other thing is that there's a little bit of ageism in the approach to the elderly, and assuming that, as you age, you will normally become depressed. Very clearly, the evidence is showing that is not the case, that it's actually a mental health issue. I think the fact that we have better tools means that we're getting a better sense of what the resident needs and we're better able to pick up the differential diagnoses and the impact of what type of care we need to provide.

Mrs. Liz Sandals: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): I had one question. The training that somebody who is a psycho-geriatrician needs: What would that be?

Ms. Nancy Cooper: They are psychiatrists who are specifically trained in geriatric psychiatry.

The Chair (Mr. Kevin Daniel Flynn): But they have the same training as a psychiatrist; they just specialize in geriatrics.

Ms. Nancy Cooper: Yes.

The Chair (Mr. Kevin Daniel Flynn): Very good. Thank you very much for coming today. It's really appreciated.

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JOANNE PURDON

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is Joanne Purdon. Is Joanne in the audience? Joanne, if you'd like to come forward. Good to see you. Please make yourself comfortable. I think you were here at the start. Everybody gets 15 minutes. Use that any way you see fit, and at the end, if there's any time for exchange, that's always good.

Ms. Joanne Purdon: Okay, thank you. My name is Joanne Purdon. I'm a family member and primary caregiver to my nephew, who's 24 years old and lives with schizophrenia. This is my personal story and my observations along the way.

The Chair (Mr. Kevin Daniel Flynn): Joanne, you just did exactly what I was going to ask you to do, which was to pull the mike down.

Ms. Joanne Purdon: Okay. Is that better?

The Chair (Mr. Kevin Daniel Flynn): Yes, that's perfect.

Ms. Joanne Purdon: Okay. When my nephew was 12, his mother—my sister—passed away. He and his two younger siblings began living with his grandmother, who is my mother. From the beginning, I was involved in helping my mother raise the children.

When my nephew entered grade 9, he started to socially withdraw, with decreased motivation, concentration, sleep and behavioural changes, loss of function in school, problems with anger, anxiety and lower energy levels.

We had countless agencies and school counsellors attending the house, talking to him from the other side of the door. He started to get involved with the law—small,

petty offences with other schoolmates, which soon escalated. He was diagnosed with conduct disorder.

After a suicide attempt at 17, he was referred to a youth psychiatric unit of a major Toronto hospital. They diagnosed him with depression and he was discharged two weeks later with a prescription for antidepressants. This was the beginning of what is known as the prodromal stage of schizophrenia. Prodromal refers to a period of decreased functioning, disturbances to thinking and other problems prior to the first psychosis or the onset of schizophrenia:

“The timing of onset of psychosis is usually in adolescence or young adulthood when personality development and identity issues are still being resolved. Deviant behaviour during this period of untreated, unrecognized and misunderstood psychosis may cause a potentially threatening crisis such as aggressive and suicidal behaviour. Increased use of substances may all occur at this time. Effects are not only felt by the individual but by the family as well ... clearly minimizing the delay between the onset of psychosis and treatment can reduce this psychological, social and possibly biological disruption.”

Six months later, my nephew had a full-blown psychotic break and was incarcerated in the Don jail, just weeks past his 18th birthday in 2003. This was the beginning of my involvement with the mental health system. I posted his bail as his surety, and one of the conditions was that he would obtain medical and psychological help.

When he was released into my custody, he stated that he needed medical attention. He was emaciated and dehydrated. Once at home, I soon realized he would not eat or drink anything. He said to me he thought he was losing his mind. This was the last time he would have any insight into his illness until 2007.

Over the next few weeks, I tried to get him help. I spent 18 hours in the emergency department of a major Toronto hospital trying to see the on-call psychiatrist and social worker. He hadn't eaten or drunk anything other than a sip of water in weeks. His blood pressure dropped from 120 to 80. Not only did he require psychiatric help, but also medical intervention. He was difficult, but he was experiencing his first psychotic break and was paranoid. He was not admitted and I left with him 18 hours later. There was no referral and no one discussed anything with me due to the privacy issues; I was a “family member.”

The comments I overheard from the staff in the emergency department were disheartening and hurtful. This was discrimination and stigma from professional health care providers. I was shocked. I expected this from the general population but not from professional health care workers. I also experienced stigma and discrimination from municipal and government employees as I navigated the mental health system in later months pertaining to my nephew, and I was even called at work and yelled at: “Who do you think is going to pay for this legal aid invoice?”

We have to choose what is best in the course of treatment for our family members who suffer from a serious mental illness. Many battles are left behind as we cannot jeopardize the future quality of care we require for our family members.

Two weeks later, he was admitted to the first-episode unit at the Clarke for about two months, but not long enough to be stabilized for someone with a serious mental illness, who refused to eat and had lost well over 45 pounds, and was curled up daily in a fetal position. His bones protruded out all over his body. He was emaciated and his cheeks were hollow.

He was given a drug called Zyprexa. The weight gain from this antipsychotic drug can be anywhere from 100 to 200 pounds. There was only one family meeting with his nurse and psychiatrist, and a brief telephone call to me stating he had been diagnosed with schizophrenia.

We were notified almost the day he was being released and that he would be followed by the HIP team in the community. We, as a family, were unprepared and given no advance notice prior to his discharge from the psychiatric unit. No one gave us any information about what to expect, here's what to do and how seriously ill he actually was. I only knew what I had heard, that people with schizophrenia, when they take their medication, do well. What I did not know is that the medication has to be appropriate and fine-tuned to that person's body chemistry.

We were left to navigate the system by chance. Families need training about how to respond to unacceptable behaviour, when to let go, when to draw the line. For me, personally, I couldn't have gone through this without family peer support. This is where I learned of available programs and newer and better medications.

He was transferred from the HIP team to the ACT team in the community and placed in supportive housing, which was found for him shortly thereafter. A sudden change in medication was made and the daily dose was greatly reduced. He was on a clinical study so that they could administer an injectable medication. According to the terms of the study, he was given a minimum dose to start and it would be raised accordingly. He became extremely psychotic, delusional and was hallucinating. This would mark the beginning of many hospitalizations, suicide attempts and ongoing trouble with the law.

At this point, he should have been admitted to a psychiatric hospital by the ACT team to be stabilized and given another anti-psychotic medication. I was advised by his health care provider not to let him in my home when I was alone and only to see him in a public setting. During this period, I took a week's vacation. I had my nephew admitted to CAMH, where he was formed. His case was taken before the Consent and Capacity Review Board and I was not notified. He was then released back into the community.

My nephew didn't last long in supportive housing. An eviction notice was obtained against him due to noise and conduct disturbances. When I first met with the manager of this supportive housing unit I was told that we were

unable to fight the eviction order. At the entrance of the building I noticed many eviction orders pinned to the corkboard. I attended the housing tribunal to fight the eviction. When I spoke to duty counsel, they expressed that this was a regular occurrence; even those who did not create noise but maybe were late with their rent due to symptoms of their illness were being evicted. They seemed to be shocked at the number of people being evicted, especially since supportive housing is supposed to be for people with mental health issues.

There is much discrimination faced by people with psychiatric disabilities in supportive housing and the stigma is great, so that they are often given misinformation by management: "You're unable to fight this eviction order. One more complaint and you are out."

Many do not know their rights, and having a mental health disability often creates fear in people, and so they are unable to fight the notice or file a complaint. These supportive housing units are funded by the Ministry of Health and Long-Term Care, yet people are discriminated against based on disability.

How do we accommodate people with a serious mental illness? Evict them out on to the street or shelter and hopefully the ACT team will find them to maintain treatment or, in the alternative, family members are again left to pick up the pieces. There is a need for appropriate supportive housing, and sometimes many of the alternative living conditions are unsafe.

There is all this talk about putting people into the community who are to be followed by the ACT team, but sometimes the situation calls for hospitalization, and it should be made available. When people are seriously ill, they require professional care. They should not be evicted based on health-based discrimination. They should be getting appropriate treatment in a hospital setting or appropriate supportive housing that should be made available to those who require more supervision, care and understanding.

To be followed in the community creates risk for both the consumer and family members who are ultimately left to pick up the pieces. We are leaned upon to care for our relatives as case managers, provide treatment support, crisis intervention and advocacy, monitor symptoms and support in place in case of a relapse, and maintain records of treatment and hospitalization. For us, this is 24/7 and we cannot go home at the end of the day.

The important roles that family support can play in recovery from mental health and addiction problems are well documented. These roles and our value have been recognized by professional groups and government bodies, yet, despite that, we, as families, find that our observations and our opinions are rarely sought. We, as families, contribute significantly to the care of people with mental health problems and often at a personal cost.

Once my nephew was evicted, he was referred to a hostel, not a group home and, again, numerous visits to the emergency room as he was psychotic and suicidal. The 20 or so voices were overwhelming to him and he was hallucinating and delusional. On one occasion the

emergency department released him back into the community even though he said he was suicidal and had been for three weeks or so. On a few occasions, he was released back into the community with over a week's supply of medication in hand that he ingested, and we were back into the emergency department to deal with an overdose. On one occasion, the emergency department on-call psychiatrist thought it would be more cost effective to have him followed in the community by the ACT team rather than to admit him.

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Prior to this medication change, I had advocated for my nephew to be put on clozapine and accepted into the STEP program at Whitby Mental Health Centre. Over the past three years, I was constantly discouraged. He was only given older and less effective anti-psychotic medications. Sometimes even the whole half of his face would droop and his tongue would hang out, off to the side of his face. He felt that the whole side of his body was affected and had trouble walking. These were just a few of the many side effects. I was told not to worry. He was hitting rock bottom on the street, living in a youth hostel, on medication that did him absolutely no good.

He was still so young. Why would no one give him a chance? Why was he not eligible for better and effective medication, such as clozapine? I had heard all the stories in my peer support group of how well people with schizophrenia had done on this drug. Why was he not worthwhile enough to be given a decent chance for recovery? Why would he not be eligible for the STEP program, where they would administer the drug over a six-month period?

I was starting to lose faith. I questioned how long I could go on advocating tirelessly, with absolutely no positive results. It seemed overwhelming. I thought that maybe I should move out of the province, as I could not witness his slow descent into madness and his probable outcome.

Finally one nurse from the ACT team—and that was all it really took—helped to get him accepted into the Whitby Mental Health Centre STEP program, where he would be eligible for clozapine. They were discouraging about his admittance to the program, but the nurse convinced them and he was accepted into the program.

His stay in the STEP program was 11 months, and his one-on-one psychiatric nurse from the STEP program advocated to have him stay, as he felt he was not stable enough to be discharged. The STEP program educated him about his illness and how to troubleshoot his symptoms and taught him life skills.

The numerous suicide attempts, trouble with the law and self-medication are all things of the past, and so are his psychosis, delusions and hallucinations. He was so tormented and agitated by voices and hallucinations. He was released from the Whitby STEP program in February 2007, and to date has not had one hospitalization or been involved with the criminal justice system. He is 24 now and finally stabilized, due to two psychiatric nurses who went above and beyond their call of duty.

His cognitive functioning level has been affected as the psychosis was not addressed early enough, wrong medications, a clinical study in which the amount of medication was so reduced, to a minimal amount, and/or a placebo was used that resulted in full-blown psychosis. With each and every psychotic break, the recovery outcome is lessened. Stabilization will take much longer and the cognitive functioning level will be affected.

But to date he does continue to improve slowly and steadily. We see improvements all the time. Thankfully, he doesn't hear those negative haunting voices anymore and has a quality of life. He can actually sit down and watch a movie from start to finish, without all the distractions going on in his mind. That was one of the first things he said: "I can finally sit and watch a movie to the very end." He has his hobbies, music, video games and his friends like any young man of his age.

My recommendations are as follows:

(1) Early intervention: Treating symptoms during the prodromal stage to reduce distress and disability and risk of a more serious condition. We need to educate teachers and counsellors to recognize the early symptoms regarding mental health issues and make the appropriate referrals.

(2) Reduce stigma and discrimination from the professional health care providers.

(3) Access to all appropriate treatments and anti-psychotic medications.

(4) Supportive housing with high-level supports that does not evict people for behaviours that are due to their mental illness but keeps them housed and helps them improve.

(5) Privacy laws need to be reviewed so that families are included in the treatment plan of their loved ones.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Joanne. There are some bells ringing for a vote. Unfortunately you used up all your time, but it was an excellent presentation. I can tell you that out of all the recommendations you made—they're all good ones, obviously—number (5) is one we hear over and over again as a committee. I just wanted you to be aware of that. Thank you for coming today.

Ms. Joanne Purdon: Thank you very much.

THE NEW MENTALITY

The Chair (Mr. Kevin Daniel Flynn): Okay, we'll keep moving along, then. The next presenter today is The New Mentality: Cathy Dyer, Lorraine Cardoso-Hybner and Montana Goldrup. How are you doing?

Ms. Cathy Dyer: Good. I'm Cathy.

Ms. Montana Goldrup: Hi, I'm Montana.

The Chair (Mr. Kevin Daniel Flynn): And where is Lorraine?

Ms. Cathy Dyer: She couldn't make it.

The Chair (Mr. Kevin Daniel Flynn): Well, make yourselves at home there and relax. Like all other groups, you get 15 minutes. You can use that any way you see fit.

If there's any time left over at the end, we'll use that for questions. Thanks for coming.

Ms. Cathy Dyer: We're a little bit nervous, so we're going to leave some time for questions. The alarm is making us want to hurl a little bit. But we're trying to just relax.

The Chair (Mr. Kevin Daniel Flynn): We could probably close that door, unless it's going to make it really hot in here. You get used to the bells.

Ms. Cathy Dyer: My name is Cathy. I am the project coordinator for a project called The New Mentality, which is all about engaging young people to reduce the stigma of mental illness and to improve mental health services.

We're a program of Children's Mental Health Ontario and the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. We have New Mentality groups in communities like Kingston, Toronto, Smiths Falls and Burlington. These groups get to choose what they want to do to raise awareness about mental health. All the people in a group would be 13 to 24; 75% of them would have a mental health issue. Some of them don't. Some of them just really care about mental health and they are partnered with a local mental health centre to offer supervision.

The groups have been around and have been hugely successful. We had an evaluation of our project and found that the young people are being engaged for the first time in mental health. Typically, there are no volunteer opportunities, really, for young people to get involved in speaking out.

We also have a speaker's bureau, and that's what Montana is on. So we train speakers, and our speakers go out to provincial and national conferences. Last week, my colleague Nancy and a couple of young people were talking to police officers about the relationship between mental health and corrections. So we do a whole number of things. We gave Montana a call and said, "Hey, do you want to go and talk to the government about mental health services?" She said, "Yes," and I don't think she realized what that meant until she walked into the room.

The submission that you have here sort of describes some of the recommendations that other young people in The New Mentality have made about what they think should be improved around mental health services. These recommendations came from a conference that we did in 2008. Thirty-five young people did a really brief sort of powwow, like, "Let's brainstorm what the issues are and what we think the professionals should know," and then they presented them.

Just briefly, the recommendations they had that I wanted to share with you:

Youth and professionals need youth-friendly medication education. So often young people on meds don't know what they're taking. Even the professionals don't know how to explain it to them in ways that they understand.

Young people want to know more about their rights when taking medication. There are so few services that

when young people do get services, they're so excited that they don't think about the whole rights piece or that they have the right to ask about things. They would like more information about that.

The buildings and agencies serving young people aren't as youth friendly as they ought to be. People feel really intimidated to go for help. We think the agency should be more youth engaging. We have some ideas on how to do that.

Of course, we need more access to services. That means more beds, less restrictive criteria to get in for intake and assessment, those types of things.

But to really talk about what it is to be a young person with a mental health issue or mental illness, I was really hoping that you, Montana, would say some stuff about your experience.

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Ms. Montana Goldrup: Okay. I'm Montana. I'm 21 and I'm from Hamilton, which is like an hour from here.

I suffer from ADHD, I have a mild form of OCD, and my biggest one is that I have borderline personality disorder; it's a form of depression. From my understanding, from what I've learned and been able to grasp of borderline personality disorder, it's a form of depression and it's kind of different, because I feel different. If I do something wrong, I feel more guilty than other people, and my guilt takes me to the point where I feel like I don't deserve to be here. An example of that would be that when I get really down, it's even worse. Sometimes I just feel guilty. I'm a part-time nanny and one of my kids fell down and hurt himself really badly and needed to go to the hospital. I couldn't prevent that from happening. He's four; he's going to fall. But I just felt really bad, and I was like, "Oh my gosh, my kid fell down. I'm going to be fired." But it's not the case, because kids fall down all the time.

I was at my mom's house and she made me lunch. I used up all the bread, and I thought, "If I wasn't here, my mom wouldn't have run out of bread," and obviously, you can just go to the store and buy more. So I tend to feel a lot more guilty, and then my guilt takes me to the point where I feel like I don't deserve to be living any more.

It took me a really super-long time to get the help that I needed. I first started having issues with my mental health when I was nine; I was diagnosed with ADHD. Then, when I started middle school, around the seventh grade, I just started feeling really, really bad about myself, like I didn't deserve to live, and I didn't want to live. So I tried to kill myself. I think I was about 12 or 13.

My mom took me to the hospital because she found out what happened, and these doctors were telling my mom that there was absolutely nothing wrong with me, that it was just typical, normal stuff for teenagers to do. I have an older sister; she's four years older than me, and she never experienced this. It's like no one I knew felt the way I did, and maybe they did but I just didn't know it.

But I remember when I was younger, someone in my family attempted to kill themselves, and I kept saying to myself—I realized what it had done to my family and I was never going to do that, I was never going to put my family through that. But I did it, and I kept doing it over and over again. I was 15 and I almost died because I tried to kill myself.

My mom couldn't take it any more. It came to the point where she couldn't work; she lost her job because she had to be constantly by my side. Finally, she yelled at these doctors, "Listen, there's something wrong with my daughter and you need to help her." I was placed in a group home and then for the year that I was living in that group home, I did get the help that I needed. But my psychiatrist got sick and went on medical leave, and that was it. That was the end for me. No one helped me again. To this point, since I was 16, I have never seen a psychiatrist. I still suffer from mental illness, and it has come to the point where I've just had to do it myself, because no one out there is willing to help me.

I'm 21. Before my 18th birthday, I had attempted suicide over 30 times, and I have serious organ issues because of that, because no one would help me. I know so many people—and I'm not going to lie; I've done this myself—who go to the hospital. I've waited 18 hours at a hospital. I go to the hospital one morning, and I'm still in that emergency room at 2 o'clock the next morning, just waiting for someone to help me.

Then they come, and they spend 15 minutes with you. If you don't have a plan, if you don't tell them, "I'm going to leave here and go kill myself," or even if you say that, if they ask, "What's your plan?" and you don't have a plan, they're not going to help. If you don't have a plan, then you're not going to do it. That's not true. If you are in the mindset where you just want to die, you're going to do it, automatically. I've drunk nail polish remover, I've drunk bleach, crazy things, because that's what's accessible to me.

There are times when kids just do something to hurt themselves, just because they know that it's the only way they're going to get the help they need. That's so unacceptable. Kids are dying because nobody will do something unless they've done something, and that's not good.

I don't care how old you are. If you go to the hospital and tell these doctors, "I want to kill myself, I'm going to kill myself," if you've cut yourself, if you haven't eaten in three days because that's the only thing you know, then they need to help you. I go to the hospital and they treat me like I'm garbage.

I live on my own and I'm with Good Shepherd services of Hamilton and I have a worker. She took me to the hospital, and the nurse was so rude to me, she wouldn't let my worker Catherine come into the hospital with me. I need music to calm myself down, and she wouldn't give it to me. She made me wait in that room for three hours, then came and spent five minutes with me. No doctor saw me—no doctor at all—and then she told me to go home. I was lucky I had Catherine, because

she helped me through it, but the last time I tried to commit suicide was February—not the February that just passed, but the February before that. I'd been released from the hospital a week before that happened. The week before that, I was in the hospital every day before they finally decided, "Look, this girl needs help," and they admitted me. I did not want to leave the hospital. They told me that I had to leave, that I was better because I didn't feel like I wanted to kill myself anymore. Just because I didn't feel like I wanted to kill myself didn't mean that I should have left the hospital. I told the doctor, "If I leave here, I'm going to kill myself."

I tried to kill myself at my grandmother's house. My grandma has always been my support, and I made a promise to her that I would never, ever do something in her care. I was so down that I left the hospital, and instead of returning to my group home I went to my grandma's house, and that night I tried to kill myself. If you're willing to break a promise like that to the most important person in your life, then you're obviously needing the help. It just shouldn't come to that.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Montana, for coming. Thanks for telling your story. You still have time left. Can we ask you questions?

Ms. Montana Goldrup: Sure.

The Chair (Mr. Kevin Daniel Flynn): Or do you need a minute to calm down?

Ms. Montana Goldrup: I'm okay.

The Chair (Mr. Kevin Daniel Flynn): It took a lot of guts to tell that story.

Christine, Sylvia, do you have any questions?

Ms. Sylvia Jones: Thank you, Montana. Your story is important for us to hear. Can I ask you how long you've been involved in the New Mentality project?

Ms. Montana Goldrup: When did The New Mentality start?

Ms. Cathy Dyer: Two and a half years.

Ms. Montana Goldrup: Two and a half years, since day one.

Ms. Sylvia Jones: And you've been on their speakers bureau?

Ms. Montana Goldrup: The speakers bureau just started this summer, but we had a New Mentality project in Hamilton and it failed completely. We lost our adult ally and then we had to wait months to get a new one. We were working with Good Shepherd and then we had the mental health nurse who worked with all the street youth, and then she left to get a new job. So when they hired the new one it was, like, four months, and then she had to train for that job and be our adult ally as well. It just kind of didn't work, but I still stayed involved in its other stuff and I work with other organizations. I work with PCMH and I work with a consumer advocacy network in Ottawa.

Ms. Sylvia Jones: Well, I'm going to take a wild guess that you are a very effective speaker for The New Mentality.

Ms. Montana Goldrup: Yes.

Ms. Sylvia Jones: Thank you.

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

M^{me} France Gélinas: When you reach out for help, do you have a primary caregiver like a nurse practitioner or a physician?

Ms. Montana Goldrup: This is my mom's issue too: My family doctor is a learning doctor's office, so whenever I go to the doctor's, I see a different doctor every time. We're trying to change that, but even if I just go to the doctor's and tell them that I'm feeling down, they automatically send me to the hospital and they try to give me medication. I don't think medication is good for me because even as a general thing, unless I'm seriously dying, I don't like to take medication at all. If you've tried to overdose 30 times, then that's not something you're going to want to do. I'm still prescribed medication, but I can't take it. Just the whole process of taking medication is not something that I can do.

The other thing is that I'm on a waiting list and I've been on a waiting list for two years. I'm admitted to the hospital, I go on this waiting list, then when you're readmitted to the hospital, you're taken off the waiting list because you're in the hospital, so you're getting the care that you need. So you leave the hospital and you're taken off the waiting list; two months later you're readmitted to the hospital, you're taken off your place on the waiting list and put back at the bottom.

The waiting list for care can be up to two years and that needs to change. My parents had to put me in a group home; it was an either-my-kid-doesn't-live-with-me-or-my-kid-doesn't-live kind of thing. It took a really long time for that to happen as well.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any quick questions over there?

Mrs. Liz Sandals: Yes. Thank you so much for coming, Montana, and sharing your story with us. When you say you're on a waiting list for care, what sort of care or treatment—

Ms. Montana Goldrup: Just to see a psychiatrist.

Mrs. Liz Sandals: When's the last time you actually saw a psychiatrist?

Ms. Montana Goldrup: Probably when I was 16.

Mrs. Liz Sandals: So you haven't really had any—

Ms. Montana Goldrup: It's just when I go to the hospital and it's, like, nothing. They sit with you for five minutes and treat you like you're a piece of trash.

Mrs. Liz Sandals: But in terms of sort of an ongoing relationship with a particular psychiatrist, you haven't had one for a very long time.

Ms. Montana Goldrup: No.

Mrs. Liz Sandals: How did you get involved with the New Mentality program?

Ms. Montana Goldrup: I was living in a group home. On the girls' floor, there was a bulletin board and it had all this information about The New Mentality, and I thought it was something that I really wanted to do.

It's really, really helped me. Even Cathy and Nancy were saying today at lunch that I've grown up a whole lot since I first began and this has helped me.

My life has been pretty much hell since the day I was born—so if I have to do this, at least I can take something out of it. I have a three-year-old niece, and I don't want anyone, especially her, to ever have to go through what I've been through. So if sitting here today can make that happen, then that's definitely something I want to do.

Mrs. Liz Sandals: Thank you so much for coming. We really appreciate your courage.

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

Our next two speakers aren't here, and we're faced with a 13-minute break. Is any one of our speakers here who is going to speak? Is there anybody in the audience who is scheduled to speak? If not, we're going to adjourn.

The Clerk of the Committee (Ms. Susan Sourial): Recess.

The Chair (Mr. Kevin Daniel Flynn): Recess. I tried. I thought I could sneak one in there.

We're recessed until after the vote, anyway.

The committee recessed from 1648 to 1708.

HDH/KGH MENTAL HEALTH PROGRAM

The Chair (Mr. Kevin Daniel Flynn): Okay, if we can call to order again. Our guests have arrived, and we've had a little bit of a change in the agenda.

Our first presenters are Peter Kennedy and Roumen Milev, if you'd like to come forward. Thanks to Dr. Brown for allowing the change in the agenda.

Thank you for coming. Like all other presenters, you have 15 minutes; you can use that any way you see fit. If there's any time at the end for any questions and answers, we'll try to split that evenly amongst the groups here. The floor is all yours.

Dr. Roumen Milev: Thank you for inviting us and listening to us. I think this is our first presentation to any such committee, so we are a bit nervous. I'm Roumen Milev, and I'm a psychiatrist who works in Kingston. I'm the head of the Queen's University department of psychiatry and also chief of psychiatry for the affiliated hospitals—Hotel Dieu Hospital, Kingston General Hospital, Providence Care and also Quinte in Belleville—and also for some of the community services in Kingston, Frontenac Community Mental Health Services and some other smaller community services.

I've been in Kingston for about eight years now, and I have learned quite a lot about the organization of mental health in Ontario from that experience. In the past, I have worked in other jurisdictions in Canada. I've worked in the UK and Russia, and I originally come from Bulgaria, where I also worked as a psychiatrist. I've seen a variety of different ways of organizing, from the point of view of administration of mental health, from one extreme communist dictatorship to the other and everything in between.

I think that what we came here to do is really to ask you to consider several important things in our mind

which we would like to see happen in the future of mental health in Ontario.

Mental health is in a unique situation amongst the medical specialties because, on one side, it is regarded as a medical specialty. Now, with more and more that we know about mental health, we find more and more that mental health is based on some medical changes of the brain. But we also know quite well that the environment is very important for mental health for both developing mental health problems and also healing, and it has to be taken into consideration.

Mental health is also unique because of the stigma attached to mental illness. For example, I don't know how many of you can come here to work today and say to your colleague on the left or the right, "My suicidal thinking actually got worse last night, totally worse. I didn't know what to do." It's not accepted. You can say, "Yes. I had a migraine. I had diarrhea," even, or something, but you cannot say that your voices started talking to you again.

So, in a way, it has a lot of stigma still. It has a stigma also within the medical profession. In general medical offices we see that quite a lot, when psychiatry is treated as a poor child of all the other specialties, specifically surgery, medicine, and that interferes significantly with our ability to attract new students to come and see us.

What we really want to see is planning for the services being population-based. We see this as talking about that, but when it comes to deeds, when it comes to things done, nobody uses population-based planning anymore. There are examples galore. For example, last year, one of the associated hospitals decided to cut eight in-patient beds due to fiscal constraints without any consideration of what the population-based needs are and the wider impact that might have. We saw exactly the same situation in another hospital this year. It's a constant issue which arises and it's not really based on sound grounds.

The other important thing we need to talk about is the need for a system approach. Mental health, again, is unique in that way. It cannot function without looking at the whole system, without looking at all the other players who provide services for the same population. I can make an analogy. In surgery, whether your surgical department is integrated with the next hospital doesn't matter that much. You can get your operation here or there; that wouldn't matter. In mental health that matters a lot, because unless the hospital talks to the other hospital, unless the hospital talks to the community mental health services, unless the hospital is aware of what is done elsewhere, and the same for the community, the patient will not receive the best service because the patient travels from one place to another. I think the need for a system approach is very important.

Local health integration networks seem to be the natural place where such an integration can occur, but we don't see that happening in the LHINs. We know now the LHINs are talking about a surgical program being integrated across the LHIN, or emergency room or wait list

strategies, but mental health is never on the agenda. This is why I think that this is a very important issue that we need to raise.

From my point of view, as the chair of a department of psychiatry, I work with each of these local hospitals and all the community providers and I can see how they don't talk to each other. It happens that I attend many of those meetings. I run like crazy from here to there to there all the time; I get a stack of parking tickets that big. But the thing is that those people don't talk. They don't know about the other one. We have attempted some of those local integration things, but unless this is really taken seriously by the LHIN and requested, I don't think this will happen and go anywhere more than just local initiatives here or there.

With that, I'll stop here and let Peter talk a little bit, and then we'll be happy to answer any questions.

Mr. Peter Kennedy: My name is Peter Kennedy. I'm the program operational director for the mental health program at Hotel Dieu Hospital as well as Kingston General Hospital.

What I'd like to do is refer to the handout that was provided, and really that drills down to the specific areas that we see are priorities for creating that integrated system of care that is so desperately needed. It's probably been talked about now for 20 to 30 years without it being realized, and we've lived through a series of reports, operational frameworks, and none have been executed, I believe, successfully.

In terms of the existing system organization, building on what Dr. Milev just said, the need for a senior manager in each LHIN having responsibility for mental health services across a LHIN for primary, secondary and tertiary-level care, in-patient and outpatient services—we see that as a critical way of creating that systemic quarterback who can really have that overarching view of the services that are required.

1720

We also are left with benchmarks that are outdated. We often have to look at recommendations for staffing models and services that are 10 or more years old, which really does not reflect the current state of the acute in-patient services or specialized services within our communities.

Further, we would look to help with ensuring that we create a systemic way of gauging our human resource needs, whether they be psychiatrists or other mental health professionals. Again, we're left with some data that's available from out of country or older data that is 10-plus years old. We really need to be able to say, for the needs of our communities these are the staffing requirements to be successful in delivering the type of care expected by residents.

Further, I'm challenged every day by what the medical-surgical areas are challenged with, and that is ALC patients. Those are folks who have completed their acute care needs and need to be transitioned to the community. But we find, again, as a result of stigma and behavioural issues and challenges, that often the long-

term-care facilities and complex-care facilities are reluctant to take clients who have completed their acute care. That leaves us with the difficulty of having people who may be housed in our emergency department for a weekend or longer, not receiving the right care in the right setting. So we would suggest that if there are opportunities or ways of strengthening the resourcing of the long-term-care facilities in terms of their ability to care for our clients with coexisting psychiatric disorders, that would be very helpful.

Further, as I have said, we have experience with a series of strategic planning documents, operational frameworks and so forth in looking at mental health services in Ontario; however, we continue to have significant gaps in the continuum of services which would allow us to step down people to less resource-intensive care levels if those services existed. They simply don't, and so we have gaps between acute in-patient care and then outpatient services without any services that can work with the individual in the intervening period.

I would also suggest that there is not a balance in the system in terms of care that's required. I recently had the opportunity to work with the Limestone school board around children who are at risk. Between the acute hospital setting and the school board and whatever services they can provide within their system, there really doesn't seem to be that mid-level service. Really, it was quite fascinating to look at how an individual who may be at risk has to migrate through these various levels of care before we can engage them appropriately. Based on the experiences with the Limestone school board and other providers who provide services to children and adolescents, it's clear that there is a real resource deficiency for the children in our communities.

One of the things that I would also like to point out is around the benefit that we've enjoyed as a result of Dr. Milev having the headship and also the psychiatric leadership responsibility for multiple agencies, both hospital- and community-based. That has allowed us to work with other agencies much more effectively in terms of coordinating access, improving access, working through the barriers of different organizational cultures and allowing us to ensure that we can provide timely and appropriate care to individuals. That's not through additional resources being infused; it's simply by having the architecture of an overarching psychiatric leadership position, which allows us to engage other organizations much more effectively.

I would also like to briefly speak to the need for looking at opportunities to work with those persons with chronic, recurring psychiatric illness in the same way that we have looked at providing care to other individuals, whether it be those people with asthma or diabetes. Certainly the government has invested huge amounts of resources in working with those persons with diabetic illness. Likewise, I think there are real opportunities to look at disease management programs for disorders such as depression, which has a much higher illness burden, based on the WHO classifications, than diabetes mellitus.

So I think there are some real opportunities to provide care in a different way that is proven and it's an opportunity to do so without infusing large amounts of resources.

I think that at this point I'll conclude my comments.

The Chair (Mr. Kevin Daniel Flynn): That's pretty good timing because you just used up the 15 minutes.

Mr. Peter Kennedy: Did I? I'm sorry.

The Chair (Mr. Kevin Daniel Flynn): That was excellent. Unfortunately, you didn't leave any time for questions, but I'm sure the committee understood your presentation. It was very thorough. Thank you for coming all the way from Kingston to make it, and I hope you make your train on your way back. If you do, you'll have Dr. Brown to thank.

Dr. Roumen Milev: Thank you.

ALAN BROWN

The Chair (Mr. Kevin Daniel Flynn): Alan, if you'd like to come forward; make yourself comfortable. I think you were in the room when I outlined the rules. They're pretty simple. You get 15 minutes; use them any way you see fit. If you could leave some time at the end for any questions, that would be great.

Dr. Alan Brown: Thank you very much, Kevin, and members of the committee, for allowing me to speak to you today. I'm here for a couple of reasons. One is to provide some back-up support to a program at the Woodview Manor, which exists in Hamilton, for the residential treatment and support of autism spectrum disorders; and number two, there are particular gaps in the service for autism spectrum that I think need to be addressed along with that.

I'm a child and adolescent psychiatrist. I am the medical director of the child and adolescent in-patient service for Halton Healthcare Services. Halton Healthcare Services, again, is a three-hospital group—Oakville, Georgetown and Milton hospitals. I'm also chief of the department of psychiatry for Halton Healthcare Services.

What is autism? It's a complex neurodevelopmental disorder. It's a brain disorder that occurs throughout the course of development and affects the function of the brain. It causes two particularly important concerns. One is impaired communication and social interaction; and two, repetitive behaviours and restricted interests that become problematic for reasons I'll explain later.

How prevalent is it? It affects 1% of the population. That's 70,000 people here in Ontario. It's just as prevalent as schizophrenia. There are subtypes. I don't want to bore you with the subtypes other than to note that there are autism spectrum disorders with intellectual disability, i.e. IQs under 70, and autism spectrum disorders without intellectual disability, which is what we call higher functioning, with IQs of 70 or above, and they include things like pervasive developmental disorders not otherwise specified and Asperger's syndrome.

Fifty per cent of autism spectrum disorders have normal intelligence. This is important to understand because

while they have normal intelligence, they are just as disabled, given the continuum of concerns, as those who have IQs below 70. There are particular challenges these individuals with ASD must face: communication difficulties due to difficulty understanding verbal communications, verbalizing thoughts and feelings, and processing verbal information. This problem leads to frustration and, in terms of their interaction with others, socially disruptive and, at times, dangerous behaviour.

1730

Socialization difficulties: Many of these people want to participate in social activities and may have difficulty engaging and not have the social skills to maintain social fluency, but their difficulties lead to particular problems understanding social rules, things that we take for granted—for example, not to pick your nose in public; that may seem like a very obvious thing. There are certain things that people do and they're just not aware of the social impact of them.

Anxiety: Most of these individuals suffer from a pervasive and very significant degree of anxiety that's overwhelming and causes catastrophic reactions on their part. They're just feeling overwhelmed, can't manage the environment and what's going on around them, and then develop markedly disruptive behaviour as a result of this, sometimes self-injurious and sometimes other-injurious.

They have difficulty with executive functioning. We have a part of our brain up here, right at the front—one of my autistic patients refers to this as the “oval office”—the dorsolateral prefrontal cortex. When I ask him why he's had a particular problem, he says, “The President wasn't in.” I've used that description with many of my patients when we talk about executive functioning, and it certainly captures it.

Difficulty with change: One small change in an environment for these patients—you know, you move a book or you move your vase—they come into the office and they start to become markedly agitated and you don't know what's happened. They just can't tolerate changes as small as that.

Perseveration: They fixate on topics. They feel the need to complete tasks. For example, a student in school who is doing his math homework in a math class, when the bell rings, won't get up and want to leave. The teacher will say, “Come on, you've got to get up and get on. People from the other classes are coming in,” and it can lead to very simple disruptive episodes that can in fact become violent at times.

This pattern of perseveration also interferes in their social skills because they start to talk about an area they like very well. They keep talking and talking and don't see the eyes glassing over on the people around them, so they drive people away from them even though they want to be socially engaged.

Emotional responses and reactivity: Many withdraw and isolate themselves. They may appear anti-social, like they don't want to be part of things, when in fact they do. They just don't have the skills to engage. They may become clinically depressed and may suffer from rapid

and significant mood swings, or they can even develop psychotic symptomatology, like paranoid delusional thinking or hallucinations. In a recent study, 43% of ASD adults endure significant symptoms of depression on standardized psychiatric questionnaires.

So the issues arising are that they are extremely isolated and alienated without significant supports in trying to engage in our communities. They are terribly misunderstood. They don't just misunderstand others, they themselves are obviously significantly misunderstood, and they fail socially. They're unable to cope with our traditional educational system. They fail academically because they don't fit socially, they persevere and they get stuck, and they can't process information the same way. They're marginalized.

They develop mental health disorders. Psychiatric comorbidity, as I said, is very significant with this population. One of the interesting things is that this population falls within the developmental services sector, but the mental health interface is huge, and I think we have to look at addressing the interface that these individuals have to deal with, rather than getting segmented out by systems in the way our social support systems are in fact structured.

They can become, as I say, behaviourally disruptive, explosive and potentially dangerous. I run an in-patient service. The most common reason they're in my unit is they've assaulted people, they're threatening or they're acting in such a way as to place themselves at marked risk.

You've probably heard of the young woman who strangled her autistic child this past week in the Mississauga area. Last summer, an autistic late adolescent either fell or was pushed into the lake and drowned at a dance when he was socially inappropriate.

These particular issues they deal with break apart the families in which they live. It leads to 98% of ASD families reporting that they've suffered from significant ongoing crises in their lives in a recent survey by Autism Ontario. They often end up hospitalized on mental health units such as mine that aren't equipped to manage the complex levels of care that are in fact needed for these individuals. Once they're on our unit, because there's not a full continuum of care and not step-down programs like residential programs such as the Woodview Manor offer, they remain on our units, an inappropriate setting. I've had one young man in the last year, it was a 12-month period—my unit is designed as an eight-day length-of-stay unit; he was on that unit for nine months. That per diem cost to the health care sector is huge compared to what a comparative residential program in the community would in fact be. When they're on our units they still don't fit in and staff have a hard time managing because our staff are not trained to deal with autism spectrum disorder. They're learning to be trained over time as we see more and more of these individuals come to our attention.

The needs: Obviously the intensive behavioural intervention services for the lower-functioning IQ, language

and social skills component of the ASD spectrum have been extremely helpful. They're occurring in the younger age groups, and that's tremendously helpful. Social skills training, though, is something these individuals need throughout the age continuum, but especially during developmental transitions: the time they enter school as young children, the time that they enter adolescence because of the change in their peer structure, and the time that they leave adolescence and go into adulthood. These are critical times for social skills training.

Respite services: They need respite services from families because the pressure and stresses on families are profound. These respite services need to be structured in such a way that they're with people of a similar functional level, because of the continuum of ability. To place a higher-functioning autistic spectrum with a lower-functioning autistic spectrum just doesn't work. We need to understand that breakdown, and we need to understand when we talk about high-functioning autism, these are not people who don't need help. These people need help just as much. This is the segment of the population that I think we need to address at this point in time more fully.

Residential treatment services, especially from mid-adolescence to adulthood: We need residential treatment services for these individuals. They are often available for the lower-functioning end of the ASD spectrum and continuum, but they are significantly lacking for the higher functioning, i.e., average or above-average IQ and verbal skills. Brief in-patient mental health services are often required. They need to be brought into hospital for reassessment, for medication management and to contain risks to self or others, but to leave them on a unit for nine months because we don't have a suitable placement to transfer them to is clearly inappropriate.

Access to mental health social workers, psychologists and psychiatrists—in other words, people in the mental health field with training in the recognition, assessment and treatment of ASD: We need to enhance our training programs for all of our mental health workers in dealing with the autism spectrum disorder, because while they may be segmented to the developmental services sector, this really leaves them out in the cold. We need help in being able to offer the kinds of services in mental health to manage these people and transition them back to the communities. We need seamless transitions along a more fully developed continuum of care, from outpatient to day treatment to residential services and in-patient treatment, in-patient treatment being a last resort but many times being useful.

But again, if you clog up one component of your treatment continuum and you can't move people out, then other people can't access it: 20% to 30% of my in-patient days in my unit are filled by autism spectrum patients, again, typically because we have nowhere to place them to. The families can't manage them and so we're leaving them sitting at our in-patient services. It becomes inhumane to them over time. An eight-day program becomes repetitive for anybody.

Occasional rehabilitation services to enable ASD individuals to go find and maintain whatever meaningful employment is possible: Certainly, moving towards the adult range, many of these people can in fact be employed, but the kinds of supports we need in terms of employer supports and job coaching to help them function are very significant. Many of these people have particular skills and talents that are quite amazing, and I think not to utilize them and help them fit into our culture does both them and us a tremendous disservice.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Alan. We appreciate the presentation. You've left about two minutes for some questions. France, you're first.

M^{me} France Gélinas: Wow. I'm very grateful that you came in and talked to us today. You are the first psychiatrist who concentrates on autism who has come, so that makes it that much more interesting. Are they common?

1740

Dr. Alan Brown: One percent of the population, so—or the psychiatrists?

M^{me} France Gélinas: No, I'm talking about the caregivers.

Dr. Alan Brown: Actually, less than 1% of the population.

The Chair (Mr. Kevin Daniel Flynn): That's a lot of psychiatrists.

Dr. Alan Brown: I think they're having to learn by the seat of their pants. I deal with my adult colleagues; many of them are very uncomfortable treating the disorder. They just don't know enough about it. It hasn't been included in their training. They need backup and support. Other child and adolescent psychiatrists I see are also uncomfortable. I know several who are but it's a skill and an awareness that's tremendously lacking.

The Chair (Mr. Kevin Daniel Flynn): Time for one brief question. Liz?

Mrs. Liz Sandals: Thank you so much for coming. I take it that you've also got a bit broader issues than autism that you're interested in as well. What I find really interesting is that you're talking about respite services similar functional level and residential similar functional level. I've heard from people maybe who were suffering from depression and participating in some sort of a community peer support group that it wasn't very effective because it wasn't of a similar functional level in terms of education. Is this something that is becoming more of an issue, that as you set up supports, if you don't get the right mix of people then the support isn't all that effective?

Dr. Alan Brown: That's exactly right; one size doesn't fit all. As we first of all try to support the developmental health services, that's a wonderful thing, but I think the more aware we become in terms of our knowledge, we begin to understand that "different strokes for different folks" is really still important. Subspecialization, as in other areas of medicine, is also true in mental health.

The Chair (Mr. Kevin Daniel Flynn): We probably can take the clock down to three minutes if Christine or Sylvia has a question of the doctor. Christine?

Mrs. Christine Elliott: Thank you very much, Dr. Brown, for coming. As some of my colleagues have said, you are the first specialist in this area who's been able to come to the committee, so we're very grateful because we have been struggling with how to deal with autism as part of this committee. We know that people with autism have the needs that you've described. You've described it as a neurodevelopmental disorder. So the mental health piece: Is it that there are some pieces of that neurodevelopmental disorder that express themselves as mental health issues, or is it because of the lack of treatment that the mental health issues are emerging?

Dr. Alan Brown: Both. The parts of the brain that are involved in terms of developing or causing the development of an autism spectrum disorder also are involved in the promulgation of anxiety, and there's a greater susceptibility to significant mood issues in depression. There's an overlap here that I think is important to understand. It's very important to understand that so we know that we can't just deal with it from one sector, developmental services. It's got to be a mental health and developmental services sector interface. Both are, in fact, critically important.

Mrs. Christine Elliott: Thank you for clarifying that.

The Chair (Mr. Kevin Daniel Flynn): For those members of the audience who think everybody's just going to take off and leave them, we have to go upstairs and vote in three minutes. That should take maybe five minutes. So you'll probably see us all again in about 10 minutes. Thank you. We're recessed.

The committee recessed from 1740 to 1749.

WOODVIEW MANOR PARENTS' COUNCIL

The Chair (Mr. Kevin Daniel Flynn): Welcome, Michael. Thank you for coming. If you'd introduce your colleagues. You've heard the rules: 15 minutes and leave some time for questions. It's all yours.

Mr. Michael Noga: Okay. After the introductions, the 15 minutes start, okay?

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

Mr. Michael Noga: Cindy l'Anson, director at Woodview Children's Centre, and Rick Ludkin, director of autism services development. My name is Michael Noga. I am representing the Woodview Manor Parents' Council. My son is autistic and is at Woodview.

Without further ado: the problem.

The prevalence of autism spectrum disorder, ASD, has increased from four in 10,000 in the mid-1980s to 61 in 10,000. This means that today, approximately 75,000 Ontarians have ASD.

Three quarters of this increase occurred in people deemed to be high functioning. The term is misleading. It simply means they have an IQ above 70. They are still affected by the triad of symptoms that characterizes ASD; namely, qualitative impairments in social inter-

actions, qualitative impairments in verbal and nonverbal communications, and restricted and repetitive interests or behaviours. In short, they have difficulty leading normal lives. However, with the appropriate supports and environment, they can live fulfilling lives.

High-functioning ASD adults seem to be more prone than those with ASD and an intellectual disability to have comorbid psychiatric conditions. These are mainly mood and anxiety disorders. It is estimated that 40% of the adolescents and adults with ASD have comorbid psychiatric problems. They have difficulty making friends with adults their age and, when isolated and lonely, the mood and anxiety issues are exacerbated.

Adults with ASD simply don't fit into everyday society. Without employment, isolated and with nothing to do, they are challenging or impossible for parents to deal with. Frustrated, they often lash out at those around them.

Typically, these individuals do not receive services until they are in crisis and have been hospitalized for treatment of their mental health issues. Hospitals find that there are no resources to discharge them to. They become bed blockers. There is no cure for ASD or the comorbid mental health issues.

The supports for adults with ASD and their families are virtually non-existent in Ontario. These adults need an environment apart from their parents where they can gain confidence by learning to look after their basic daily needs, learning social and communication skills so they can cope more effectively and have a community where they fit in and a social support network. Without this support, they often end up back in hospital or worse each time there is a crisis in their lives. Rarely, some individuals end up in jail and prison, most often for offences that are related to obsessional tendencies or impaired social understanding—both typical autism traits rather than criminal intent.

The "high-functioning" ASD group does not receive services through the Ministry of Community and Social Services because their IQ is above 70, and they are not eligible for services through the Ministry of Health and Long-Term Care because they have a developmental disability—ASD. By default, the servicing of this group falls onto the Ministry of Health to provide the ongoing psychiatric support and crisis intervention with very costly and scarce resources.

The alternative is Woodview Manor's autism program centred in Hamilton. It is proactive in that it provides a wide range of services and supports that begin, ideally, when the person is young and allows them to move through a graduated system, learning age-appropriate skills with their peer group, and leads ultimately into a supported independent residential program, when needed. The programs are delivered by people with specific knowledge of and training in autism. Woodview's services are not a reaction to people or families of ASD individuals reaching a crisis in a service vacuum. Rather, they are an education and support program to keep them from getting to a crisis situation. Last year, none of the

clients serviced by Woodview required outside crisis management or hospitalization for mental health issues.

Woodview's program is cost-effective. It currently supports more than 65 children and youth and over 65 adults with ASD, and a further 18 adults with schizophrenia, on a budget of less than \$700,000, or \$5,400 per client per year. The program builds life skills from an early age and helps youth to develop a social network through a seamless program, resulting in many adults requiring reduced levels of support as they age. Further, those supports are targeted to meet very specific needs. Research shows that adults with a satisfying quality of life rarely need the significantly more expensive hospital services when their lives fall apart.

Woodview Manor's autism program was started in 1988 and has been called on to provide services to the surrounding regions. For the past 20 years, on a limited basis and as space and resources have permitted, they have admitted youth from Halton—ironically one of the wealthiest areas in Ontario—Brant and Niagara. Each area has identified the need for a similar array of services. In the present climate of monetary restraint, Woodview has been instructed not to admit youth or adults from surrounding areas. Yet the demand for this program from these regions is ever increasing. The increasing demand for services can only be met by increasing the special training through funding that reflects the savings that this program provides the health care system.

Woodview has been approached by other jurisdictions in Ontario and across Canada to set up this unique autism program in their areas. They all face the same challenge, that of managing the growing population of ASD children, teens and adults with co-morbid mental health issues in a more cost-effective fashion.

Kevin Flynn, MPP, has toured the Hamilton facilities and met staff and some of the clients.

There is no cure for autism and the comorbid mental health issues. This population is growing in numbers and will need mental health services on an ongoing basis throughout their lives. The less costly approach for the Ministry of Health is to provide this intervention on an ongoing proactive basis by people with specific knowledge of and training in autism rather than through the more expensive psychiatrists and hospital psychiatric wards.

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The Woodview Manor autism program is an excellent model of service delivery for the ASD group. It is cost-effective, proactive and readily duplicated. It is an ideal model for interministerial collaboration in the funding of service elements—collaboration that could include MCYS, MCSS, MOE, MOH and MOHLTC. Some costs are already being borne by the respective ministries. Collaboration in this new direction could lower the overall cost of providing supports to this population now and in the future.

The Standing Senate Committee on Social Affairs, Science and Technology issued a final report in March

2007 on the inquiry on the funding for the treatment of autism, entitled Pay Now or Pay Later: Autism Families in Crisis. One of the recommendations was that the federal government convene a federal-provincial-territorial ministerial conference which, among other objectives, would define the feasibility of introducing measures such as supports for caregivers, including respite, family training and assistance, assisted living support, as well as career and vocational training. Woodview Manor's autism program already meets these objectives.

Ministry of Health dollars will be spent for ASD individuals. Would it not be more efficient to spend these dollars providing the ongoing supports with less costly resources, so that crisis intervention can be avoided, resulting in a better outcome for all?

The Chair (Mr. Kevin Daniel Flynn): Thank you, Michael. You've left a lot of time for questions, probably over two minutes for each of the parties. Anybody on the government side with a question? Liz?

Mrs. Liz Sandals: Yes. I'm not trying to be obtuse, but is Woodview Manor a residential program where people live permanently or is it a community support program where people come frequently?

Mr. Michael Noga: Rick would be the best to speak to it.

The Chair (Mr. Kevin Daniel Flynn): Could you identify yourself, Rick, for Hansard?

Mr. Rick Ludkin: Rick Ludkin. I'm the director of autism services development for Woodview. In fact, it's both. There are some individuals who require ongoing support and other individuals are living in the community with limited amounts of support, and we offer a full spectrum.

Mrs. Liz Sandals: I'm interested again in the fact that you're identifying high-functioning people with ASD as being more likely to have the comorbid; right? Often with mental health disorders we find that it's during adolescence that those start to show up. With the ASD population, is that similar, that it's during adolescence, or is it when they age out of school and become young adults and no longer have the school supports?

Mr. Rick Ludkin: No, it's starting to show up in school, especially when they make the transition into high school.

Mrs. Liz Sandals: Okay.

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

Ms. Sylvia Jones: You mention that you have been instructed not to admit youths and adults from surrounding areas. Was that from the LHIN? Where did that instruction—

Mr. Rick Ludkin: From the Ministry of Community and Social Services, our region.

Ms. Sylvia Jones: I guess you didn't get to question why.

Mr. Rick Ludkin: Yes, we have questioned why and they're saying the funding has come to the Hamilton region and we're supposed to limit it to Hamilton, despite

the fact that historically we've always provided services to Niagara, Brant and Halton.

Ms. Sylvia Jones: Or that it's not available in Niagara, Brant and Halton.

Mr. Rick Ludkin: We've stressed that for the last 20 years, but it's gone nowhere.

Ms. Sylvia Jones: Okay. Thank you.

Mr. Michael Noga: I live in Oakville and my son is in the residence program. So I'm the individual who is saying that out of the richest city in Ontario, we've had to go to Hamilton to get the services.

Ms. Sylvia Jones: And I'm assuming that's because it was not available to you in Oakville and your son has been grandfathered because he was already in the program.

Mr. Michael Noga: Correct.

Mr. Rick Ludkin: Our program is the only program that provides these services for high-functioning people in the province, and it's an artifact of the way the funding was in the late 1980s.

Ms. Sylvia Jones: And you've been specifically told not to accept—

Mr. Rick Ludkin: Yes, within the last four months.

Ms. Sylvia Jones: Thank you.

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

M^{me} France Gélinas: Where does your funding come from and what is it for?

Mr. Rick Ludkin: Three quarters of our funding comes from the Ministry of Community and Social Services, and that's to provide a range of residential supports; 25% of it comes from the Ministry of Children and Youth Services, and that's what provides some of our respite and children's and teen group programs that give us the opportunity to provide a range of seamless service on a proactive basis.

I should say as well, though, that our whole vocational program is funded by grants. The Ontario Trillium Foundation is the largest factor in supporting that.

M^{me} France Gélinas: What's your total budget?

Mr. Rick Ludkin: It's around \$640,000 at the moment for the whole range of children, teens and adults.

M^{me} France Gélinas: Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming. And as you noted, and for the committee members, I've toured—it's a group of town homes that you couldn't pick out from any other town homes in the community. It looks like one of those things—well, obviously, I'd like to see one in my community. I think any one of us around this table would want to see one. It seems to be one of those examples where you can save money and do the right thing at the same time, and those opportunities don't arise often. That's why I actually encouraged the group to come before the committee, because there's really something special happening there.

Mr. Michael Noga: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thanks for coming today.

SENIORS HEALTH RESEARCH TRANSFER NETWORK

The Chair (Mr. Kevin Daniel Flynn): Our last presenter of the day—and thank you for changing and allowing the folks from Woodview to go first—is Robin Hurst, from the Seniors Health Research Transfer Network and—no? Robin didn't come?

Dr. Lisa Van Bussel: I'll go ahead and start and then maybe I'll clarify the introductions. Robin's not here.

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

Dr. Lisa Van Bussel: I think there has been a handout passed to the committee. Is that correct?

The Chair (Mr. Kevin Daniel Flynn): Should be, yes.

Dr. Lisa Van Bussel: I'm Dr. Lisa Van Bussel, a geriatric psychiatrist with St. Joseph's Health Care, London, which includes Parkwood Hospital and Regional Mental Health Care, London. And I have Julia Baxter, who is the manager for the geriatric mental health outreach programs through Hamilton.

Interjection.

Dr. Lisa Van Bussel: Yes. Mr. Hurst knows that we're here. He couldn't be here today. He's in Winnipeg, in Manitoba, and he asked us to present on behalf of a leadership group that works provincially with regard to seniors' mental health needs, including SHRTN.

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

Dr. Lisa Van Bussel: All right. So I'll go ahead and start. You have a handout, and I'm hoping we'll have a little discussion at the end.

I am presenting on behalf of our leadership group, which is part of a provincial leadership group for seniors' mental health outreach teams, as well as specialized clinicians that work with seniors who have mental health illnesses.

We know that you've already talked to individuals with lived experiences and with other organizations that have represented various faces of seniors' mental health issues, including the Alzheimer society, the Ontario Seniors' Secretariat. You've heard from CAMH and the mental health commission. We're hoping that this will build on the previous presentations you've had in the last several weeks.

We want to thank the committee for not only allowing us to speak today but taking on the opportunity to learn more about mental health issues across the lifespan.

So why are we here? Julia and I are here to help review, reinforce and highlight some of the important demographic issues for seniors with late-life mental health issues; the impact of mental health on seniors and their families, in particular that in late life there usually is mental health in context with medical illness, increasing disability and a range of psychosocial issues, which means maybe changes in their life—moves, losses, those kinds of things. We want to help you recognize some of the obstacles in terms of what we're currently working with, and service gaps. Julia will then talk about three

opportunities for transformation for our health care system.

For many of you, you may have already understood from the previous presentations that seniors suffer from an array of mental health issues and illnesses, including depression, anxiety, psychotic disorders and addictions. Also, there is evidence of emotional, behavioural and cognitive complications of many brain disorders. You've heard about Alzheimer's extensively in the past presentations.

What we do know, especially for those of us who are clinicians and practitioners in this area, is that people present with very different faces when they have mental health issues and problems. We may know a lot about dementia, but an individual may present with depression when they have dementia.

So why is this important to understand? Seniors with late-life mental illnesses are, unfortunately, in a unique and complex situation. One of the slides on page 5 outlines a number of areas that I'm going to highlight briefly.

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You may have already heard about the stigma and discrimination against those individuals with mental health issues. Older adults have double jeopardy: It's the ageism and the mental health stigma that often prevent or result in lack of identification, lack of health promotion, prevention and treatment of these issues. The other part that is very clear from our working in this area is that seniors themselves buy into the stigma and the myths of aging and often will not understand or appreciate the importance of early identification and treatment.

There is a real diversity and difference in demographics. Individuals, as they age, present very differently; this is not a homogeneous group that we're dealing with. As a clinician, I can tell you that. The issue is very complex and there's a lot of chronicity with illness. We need to understand the context that people are living in. Again, to reinforce that, often there is a hidden or unrecognized illness, and it's very difficult for clinicians or the health care sector to get them into treatment.

There is also a concern around threshold. Individuals with mental health problems often have multiple areas of vulnerability. That also often increases the risk to themselves and to others. For example, an individual who has a mental health problem may have difficulties driving, so there may be a risk to themselves and to the community. They may have an increased suicide risk. They may have increased frailty from their medical problems. So you can see, as there are mounting issues, there may be quite a significant increase in risk.

Working with older adults with mental health and medical issues, we know that it takes a lot more time to help assess the problem and help to develop a plan, and that plan often includes not only the individual, but their support system and their family. We are wanting to be more proactive in dealing with this, but often, what practically happens is that we're in a reactive situation of

trying to do things more quickly and cut corners, and in the end, we don't have as good an outcome as we'd like.

Just to review a little further, older adults often are at higher rates of mental health issues; one in five older adults may have a mental illness. Despite this high prevalence rate it's often under-recognized and under-treated, and 50% of those with recognized mental health disorders do not receive mental health services or appropriate treatment. Older adults frequently do not like to use the traditional mental health clinic or access their care services through the traditional kind of care.

This is kind of highlighted: It can often be very complex for older adults to access appropriate care. That includes transportation, working with their family doctor, getting to the specialist on time or working with the homemaker. There are many, many layers that may be involved with dealing with the care.

Again, to highlight, mental and physical issues are very common in older adults. Eighty-two per cent of those over 65 may have one or more chronic conditions; 43% may have three or more. We know that this is often seen through their primary care office; 80% of the primary care visits and 67% of all hospital admissions are for a chronic condition.

How does this fit with mental health disorders? The following slide is a bit more pictorial for you to take one example. For example, depression is very common among individuals who have a stroke. There's a very high prevalence rate of depression after stroke. We know that individuals with diabetes also have a high risk in rates of depression and so forth and so on. You can see that even for one example, there are a lot of concurrent medical and mental health issues.

This is a very simplified way of presenting this to you. On top of this, if you start to look at the psychosocial losses or changes for some older adults, you can see that it becomes a very complex picture for those individuals.

Why is this important to understand and review? We know that currently, many of these individuals have poor quality of life, increased morbidity or poor health outcomes from their medical issues, and there's often an increased reactive approach to individuals who come for care. We may only be looking at the medical issue, but not really treating the mental health issue that may actually be exacerbating the medical issues.

What we'd like to do now is have Julia speak on some approaches and concepts that we have that may help transform our health care system.

Ms. Julia Baxter: Hi. My name is Julia Baxter. I'm the manager of geriatric mental health outreach programs at St. Joseph's Healthcare in Hamilton. I'm also co-lead for a community of practice with the Seniors Health Research Transfer Network, SHRTN.

Thank you very much, Lisa. I think Lisa gave us a great overview of why we're here and why we need to have some considerations when we're looking at mental health and addictions and looking at the population of seniors.

So how can we help? We believe that in our roles as clinicians, educators, administrators etc., we have opportunities and responsibilities: firstly, to look at the evidence, be it a randomized controlled trial or even just an experience of one. We have a responsibility and an opportunity to see what we can learn from this. Can we apply it? Does it catalyze the need for more exploration or more research?

Another opportunity or responsibility is to reflect, acknowledge and seek experience. That experience is from multiple perspectives, be it the lived experiences of seniors and their families to those paid and unpaid caregivers surrounding them.

I guess thirdly is looking at the opportunities and responsibilities for us to consider how best to enable and promote exchanges: exchanges of information, of knowledge, of ideas and resources. Those could be at the individual level, at the team organization level or the system level. We would be doing all of that, trying to put together evidence, experience and exchange, knowing and recognizing the senior at the centre.

More specifically, what needs to be done? In spite of the efforts of dedicated professionals, a fragmented service structure has developed over time. In some cases, it is not the absence of services that is the challenge, but rather it is a lack of coordination, integration and accountability. In other situations, it may be a lack of adequate supports or services that has created a service gap in our delivery system.

What needs to be done? We're suggesting for people to consider implementation of a framework, a framework that fosters integration, coordination and collaboration across a continuum to support the needs of seniors and families. We want people to review earlier work that holds great possibilities and directions; so, build on existing solutions and efforts.

We bring to your attention three documents. There could be more, but these are three documents that are out there—dedicated work has gone on in our province over time—one being Building a Better System, which was developed in March 2007, a report that examines the components and approaches required to care for residents in long-term-care homes in Ontario exhibiting aggressive behaviour. Another document, Specialized Geriatric Mental Health Outreach Teams Policy and Accountability Framework, again, is setting the policy stage for more than 60 teams that exist within Ontario today. A third example of previous work is the Canadian Collaborative Mental Health Initiative. That federal initiative created a tool kit for planners and providers establishing collaborative initiatives between mental health and primary care services looking at seniors.

Many service components already exist in a greater or lesser degree, depending on a range of local factors. It could be the location; it could be resource availability, the local context or demands. What we're promoting for people is, if a framework were to be developed, we could explore whether it is a lack of coordination, integration and accountability, or if there's truly a service gap. One

of the service gaps that we do know exist across the province is higher-level immediate care—possibly looking at the promotion of services to support seniors in community or long-term-care settings. A responsive policy or operational framework will help to define necessary service elements and create alignment in a provincially consistent, locally appropriate direction.

What else needs to be done? Delivering direct service is not enough, so we're asking for an investment in those services that practise a triple-hat mandate. What is a triple-hat mandate? Well, the breadth of stakeholders involved in determining seniors' health is not sufficiently recognized. There's a lot of people who go into trying to support a senior with mental health and/or addictions or behavioural issues. What we need is partnership in collaboration. Needs being met is a very complex affair with many dependencies. The interplay between knowing and doing and being able to do is key. What we're looking for in the triple-hat mandate or the triple-hat practitioner are individuals, organizations or systems that are committed to that clinical shared care but also to learning and development and looking at the developing of partnerships and alliances that bring community or system development all together. That interplay will create a multiplier effect and some synergy. The impact can be felt across systems and sectors, be it community, long-term care or hospital, health or justice, mental health or addictions.

Even now, when we actually look at priorities to promote ER diversion, inappropriate presentation at the emergency department or trying to move our individuals from acute care, we hear a lot about ALC. Looking at that triple-hat mandate, not just the clinical care but the education and system development, can help move us together in alignment. Ontario's geriatric mental health outreach teams have that triple-hat mandate. They are seen as a resource to transform the system for seniors.

Thirdly, what else needs to be done? We need to strengthen the support mechanisms for knowledge transfer and exchange. There's a limited pool of professionals across sectors that possess specialized formal training in seniors' health. We need to build linkages. We need to build on people's inherent want to provide good care. We need to lever existing mechanisms at the individual level; it could even be client self-management or it could be at the individual level, as it relates to a staff person, a team, an organization, a network or the system.

We have examples in our province today that we would like to say are good examples. Ontario had an Alzheimer's strategy, and it created more than 50 psychogeriatric resource consultants who are scattered across the province. These individuals have the mandate where they look at doing staff development in long-term care, at CCACs, in adult day programs and supportive housing. Again, they're reflective of the multiple settings; you will find them in the multiple settings where you would find seniors affected by mental health and/or addiction issues. We need to foster innovation with respect to knowledge transfer and exchange.

The second example is SHRTN. I want to highlight SHRTN as an innovative and responsive network of people involved in seniors' health. Through effective use of technology, knowledge brokers, information specialists, communities of practice and research networks, it connects people to knowledge, to expertise, to ideas, to innovations and research; it inspires, and it can actually do that and I don't even have to leave my office.

In conclusion, there are many avenues or directions this committee, the advisory group or the government may choose to take to enable and ensure the achievement of the collective vision: Every Door is the Right Door. From evidence, experience and exchange, we encourage you to consider and reflect on the development and implementation of a framework, the investment and

promotion of a triple-hat mandate, of strengthening and supporting knowledge transfer and exchange. We believe that if you were to consider these directions, we may be able to collectively create and sustain synergies to achieve better health for seniors affected by mental health, addictions and behavioural issues.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for a great presentation. Unfortunately, you used up all your time, and actually, a little bit more, but I think your presentation was very clear. I'm sure all members understood what you were talking about. Thank you for coming today. It was really appreciated.

For the committee members, we're adjourned.

The committee adjourned at 1820.

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