MH-26

ISSN 1918-9613

Legislative Assembly
of Ontario

First Session, 39th Parliament

Assemblée législative
de l'Ontario

Première session, 39e législature

Official Report of Debates (Hansard)

Wednesday 25 November 2009

Journal des débats (Hansard)

Mercredi 25 novembre 2009

Select Committee on Mental Health and Addictions

Comité spécial de la santé mentale et des dépendances

Mental Health
and Addictions Strategy

Stratégie sur la santé mentale et
les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
Greffière : Susan Sourial

Hansard on the Internet

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

Le Journal des débats sur Internet

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

http://www.ontla.on.ca/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-3708.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7410 ou le 325-3708.

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

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

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 25 November 2009

Mercredi 25 novembre 2009

The committee met at 1605 in committee room 1.

MENTAL HEALTH AND ADDICTIONS STRATEGY

ONTARIO ASSOCIATION OF NON-PROFIT HOMES AND SERVICES FOR SENIORS

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen. If we can call to order, if everyone can take their seats, I'm going to call for the first presenter today, and that is Donna Rubin from the Ontario Association of Non-Profit Homes and Services for Seniors. If you'd like to have a seat, Donna, make yourself comfortable. Perhaps you can introduce your colleague once we get going.

Just to tell you a little bit about our rules, everybody who has been asked to appear is given an equal amount of time, and that is 15 minutes. You can use that any way you see fit. If at the end of the presentation we still have any time left, we'll split that amongst the parties.

Ms. Donna Rubin: Can I just get clarification? I thought we were here with a half-an-hour slot, I was told, as an expert panel.

The Chair (Mr. Kevin Daniel Flynn): Oh, I'm sorry. Do you know what? You are, that's right.

Ms. Donna Rubin: So we go till—

The Chair (Mr. Kevin Daniel Flynn): You go till 4:30, but the same rules apply—actually, you'll go to 4:37. I wouldn't get hung up on this too much. You get half an hour. You can use that any way you see fit. If we do have any time left over at the end of the presentation, we'll try to get some questions and answers in.

Thank you for coming.

Ms. Donna Rubin: I'd certainly like to thank you for the opportunity to make a presentation to you on behalf of our members. I am Donna Rubin, the CEO of the Ontario Association of Non-Profit Homes and Services for Seniors, known as OANHSS. With me today is one of our board members, Dominic Ventresca, who is the director of senior services with the regional municipality of Niagara. He operates over eight long-term-care homes.

1610

We've provided you with a document that has the main points of our presentation for your reference. We've also provided for your consideration a detailed written submission that articulates our concerns in more depth.

For those of you who may not know OANHSS, we are the provincial association representing the not-for-profit providers of long-term care, services and housing for seniors. We have municipal and charitable long-term-care homes, non-profit nursing homes—and when I talk about seniors' housing, on the same campus a lot of our organizations may have seniors' apartments, life lease, supportive housing, a full continuum of services into adult day programs and things like Meals on Wheels and so forth.

One of the main points I want to make is that at least with the long-term-care homes, many of our members operate at the highest level of staffing. Government funds long-term care, as most of you know, but our members often operate with either charitable donations or municipal contributions. So when I'm talking about some of the issues and the challenges they face, you can assume that this applies even more so to other homes that don't enjoy those added contributions.

Just as an aside, this year we celebrated our 90th anniversary as an association, so we've been around for a long time.

Our member organizations operate over 27,000 beds and 5,000 seniors' housing units—and that is one of the areas where we've noted there's a huge gap in the system: insufficient levels of seniors' housing. I mentioned the continuum, and because of that, we are commonly known as a leader in this sector, because our members are providing the full continuum of care, which is why, I think, we wanted to share with you some of our insights across the system.

Let's move to the slide that says "Overview on Mental Health": We're very pleased that both this group and, of course, the minister's advisory group have been struck. We've had a focus on a lot of the mental health issues for some time. We'd like to work on the areas of risk reduction in the system, and we hope that the work of this group and the advisory group is going to lead to some real transformation and make some lasting change around the province. We've been at a number of expert panels before, and we really hope that this will come to fruition with some real changes.

If we just look at "Seniors Demographics," I think the point we're trying to make today is that seniors are not just older adults whose mental health problems can be addressed within generic treatment programs; they are a unique population. It's a growing population. Actually,

the number of seniors in long-term care who live with mental illness is a little bit of an unknown. Our current estimates are probably on the low side, mainly due to issues related to stigma or just lack of knowledge of seniors' mental health issues. So we're assuming that a lot of people are flying under the radar.

While mental health issues impact those over the age of 80 to a much greater extent than those in their 60s and 70s, we're not wanting to minimize the mental health and addictions issues for younger seniors—but it's the seniors over the age of 85 in our homes who we obviously see day to day.

The next slide: I just want to talk a little bit about some of the mental health issues common to the seniors we serve, and again, to show how their mental health issues are quite specific to this population. Dementia is very common in this population. Over 65% of the residents in long-term care have some form of dementia. Depression is often mistaken as a normal part of aging or a symptom of physical illness, yet if diagnosed correctly, it is treatable. And delirium can be easily mistaken for something else and can be fatal; therefore, a correct diagnosis is critical.

Our key concerns: Essentially, the homes and community services have great difficulty in maintaining the safety of residents and their staff members at this point. We've been signalling this for a number of years. Our staffing levels are low, and the number of aggressive incidents in long-term care, in particular, are occurring regularly.

To give you a little bit of an idea of the data experience in one long-term-care—well, I should say in one municipality that has five long-term-care homes. They were tracking the number of incidents, and, in 2008, over the five homes, they had over 250 acts of aggression, mostly resident to resident, and that's roughly just under one incident per resident per week.

I know that as you've been touring, you probably heard from a home in Nepean, Peter D. Clark, when you were in the Ottawa area, about their concerns around violence and aggression. Well, it was only a few weeks ago that there was a homicide in that home, resident to resident. That's on the heels of 2001, the Casa Verde nursing home incidents. We're just often realizing that it's a bit of pressure cooker in long-term care and this can happen at any time.

So the safety of our residents and the safety of our staff is a huge issue. Violence in the workplace is considered to be a priority amongst the Ministry of Labour, particularly with our sector, and it's one that we're very aware of.

But with diagnosis not always being—among doctors and service providers not often seeing what exactly is going on with someone, we see a lack of specialized knowledge specific to geriatric care in general and geriatric mental health in particular.

Some of our key concerns: Seniors are often returned to long-term care from hospital without full treatment and planning in order to comply with current legislation. The bed-holding provisions right now require someone to be away from long-term care no more than a couple of weeks; I think it's 14 or 16 days at this point. So they may be in hospital for treatment and they'll lose their bed in long-term care unless they come back. That will change, hopefully, in the new Long-Term Care Homes Act; in the new regulation, they're looking at moving that to 21 days, but even at 21 days, it's still going to be an issue. So somebody's off to get stabilized and treated, and we may be pulling them back in just to hold the bed.

Hospitals are reluctant to admit long-term-care residents because of the possibility that once they've got them in the hospital, they may not be able to discharge them because they're too severe for the home to take them back. It's the same situation in the homes. We often have people who we should not be caring for and we need to discharge them and there's nowhere to discharge them to in the system.

So this gap of appropriate alternate settings is really an issue in our sector, particularly since we can't discharge without consent of the resident or their appropriate decision-maker. The community care access centres that evaluate and admit people into long-term care and take care of those kinds of transactions are not currently required to help us locate a more appropriate setting even if the resident is posing a severe risk to our residents and our staff, our homes.

We fully recognize that reducing ALC pressures is a huge concern for the ministry, but our concern is that if the resident is not a good fit for the home, we can't meet the safety needs of the individual and the other people we're supporting. So it's a huge issue for the homes, and they're kind of caught in the middle.

Further on the key concerns around the funding model: It doesn't currently support appropriate care for those with mental illness. We often identify—in our staffing situation, we've got one registered nurse on a day shift, and it could be up to 64 residents that they're supporting. They can't have eyes and ears everywhere at all times. When we have people with these kinds of needs, we need, in crisis situations, immediate approval of funding for supplemental staffing and any other resources that are needed. They have to be available and, they must extend until the CCAC can facilitate a better alternate setting or placement, if that's even possible.

1620

We've noticed quite a range in Ontario, different levels of expertise, depending on where you are in the province. Access to geriatric mental health outreach teams is inconsistent. Those far away from urban centres are really disadvantaged. Behavioural support and special care units are pretty rare. Actually, where they do exist, they're often in not-for-profit homes, because again, they're the ones who are providing added contributions; they might be topping up through the municipality. So we see a few of them, but they're not that common.

The other piece that I just wanted to touch on is that we're moving to a new classification tool, MDS/RUGS, a new care planning and assessment tool. It tends to

support complex continuing care. It doesn't weight and fund well the behaviours that we see exhibited through residents with mental health and cognitive impairment. So the new funding tool is a great tool, but we've been signalling and talking to government that it doesn't capture the behaviours that are exhibited by residents with cognitive impairment and mental health.

If we can move into our recommendations, we do believe that mental health services need to be integrated throughout the health system. It would be much easier to navigate and services would be much more accessible. Seniors have to be able to access them wherever they are, whether it's in long-term care, seniors' housing or in their own homes, so if they do move, they'll continue to move and have access to geriatric psychiatrists or geriatric mental health outreach teams—that the services follow the person.

As we noted earlier, we think that behavioural assessment and support units need to be more accessible across the province. The funding model does not typically support those units. It might not have to be a specialty in every long-term-care home for the average dementia, but severe mental health, I hear often enough—a lot of our members will say, "We can do it if we have the right resources." They're willing to do it, but they need more appropriate units, staffing, training and so forth, which we'll get into even further.

On the next sheet of recommendations: If there's still going to be a lack of alternate settings, we are going to continue to be in a problem situation, because we have people who should not be in long-term care. Once that continues to hit with the media and continues to be an issue, people are going to be afraid to come into the government-funded system because they're going to hear that it's not safe and say, "You can't protect my parent or my grandparent." So we need to find a solution to the fact that there are people who don't fit in our homes—and those are the severe cases; I'm not talking about the average person with mental health problems.

Again, resources should follow the individual.

There is stigma associated with age, dementia and mental health, even amongst seniors. We believe that educational campaigns aimed at the public, to raise public awareness, would be beneficial, but also campaigns directed towards professionals, because we have to start reducing misdiagnoses, increase recognition and collaboration with other caregivers, and improve treatment in this area. We truly want to create that "every door is the right door," to get appropriate services, but we have to educate even the caregivers.

We've been saying for years that we need more staff, but we need better-trained staff to work with this sector. We need education and training of both regulated staff and non-regulated staff. It is the PSW, the personal support worker, who does provide a huge amount of care in long-term care, and they need to be better-educated to work with this sector.

We should be training families and the volunteers as well, because there is so much that can be done if they're knowledgeable. They can remain involved in the person's life in a meaningful way if they have that training. Training alone is not the solution to all the issues associated with this, but it can make a significant contribution and so would best practices in this field.

Other recommendations: We think a coordinator role would help seniors and their families to locate the appropriate level of care. It is very difficult to navigate the services in seniors' care, long-term care and what else is available through CCACs and so forth. It is hard enough—we see it even when our own administrators have to place their family members and they just suddenly realize how hard it is; they can't even imagine how the average family goes through it. So we have to have an inventory of the care that's out there; how people can access it; try to have a coordinator role in the system to assist people and have a sort of continued knowledge transfer in this area because there's quite a void.

In order to achieve a high level of success over time, we need to have some action plans with clear timelines and accountability, cost projections and funding and, of course, evaluation details in this area. There's quite a lot of work that can be done.

In conclusion, you know as well as I do, our population is aging, and if we don't address these unique needs as seniors in the near future we're going to exacerbate the current problems. I think that we're only going to increase the pressures that are already in the system, and not only does it make economic sense to take care of people in a setting that's probably less costly than hospitals, but I think we do have a moral obligation to address the safety issue. If nothing else, we have to deal with the safety of the people in our care. This is a huge concern for providers, and we need your help in order to signal that to the public and to the government.

I just want to thank you for the opportunity and end there. If you have time for questions, we'll be happy to answer those.

The Chair (Mr. Kevin Daniel Flynn): Well, that's great. You've left a lot of time. So we'll start with Sylvia.

Ms. Sylvia Jones: On page 4 of your presentation, you make reference to some of the aggressive actions that your members and staff are having to deal with right now. This is a subjective question, but I wonder if you could share with the committee: Do you believe it is because the mental health illness is not being treated, or do you think there is a different issue there with the aggressiveness?

Ms. Donna Rubin: Well, it's not always being treated properly, for sure, but we don't have the training or the staff to assist them in coping. So, for example, if Sunnybrook has a staff complement that can almost be one on one, they can take somebody with aggressive behaviours and they're able to calm them and work more closely with them. When they're in our environment—and as I said, we have one personal support worker to maybe 12 or 13 people—they're just on their own and they can get agitated; we don't have the staff to help control and calm them. There's an element of how many hands you've got

to deliver care; are they trained enough; do they know what they're doing; and we've got a bit of a microcosm now of what's on the street coming to long-term care, particularly with the psychiatric institutions that have been closed over time—people with schizophrenia, bipolar, all sorts of severe issues are in our long-term-care homes, but we don't have trained staff to deal with them.

Mr. Dominic Ventresca: I would say that, in addition, the professional resources of geriatric psychiatrists for example or even psychiatrists, as everyone knows, are scarce, and so using our example in the Niagara region where we have some hospitals with psychiatric units and then we relay to the Hamilton psychiatric, specialized psychiatric hospitals, those resources are not available at the home and sending people for that care is problematic. So it's a combination of lack of professional resources, which is of course the treatment piece, and then there's the management piece in the homes where our staff are not always best prepared to deal with these particular behaviours, also in terms of education and then of course in numbers.

1630

Ms. Sylvia Jones: Thank you.

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

M^me^ France Gélinas: It's nice to see you, Donna. Are there examples in Ontario where things work good for seniors with either mental illness or severe mental illness? Are there case scenarios or units where if we had that, then they could really do a good job?

Ms. Donna Rubin: I'm going to let Dominic answer it because he's one of the few organizations that has a dementia care centre.

Mr. Dominic Ventresca: I'd like to think that the Niagara region has one of the better records for managing folks with dementia and other related disorders. Why I think we can make that claim in part is because we have a good collaboration among some of the various practitioners in the field, whether it be the Niagara Health System, St. Joseph's Hospital in Hamilton, the geriatric mental health outreach folks, the PRCs, the psycho-geriatric resource consultants, the Alzheimer Society.

We have a good collaborative group working, but in addition to that, we have been able to cobble together one key component of a good care package for a geriatric population with mental health needs, and that is a dementia centre, which has been the product of good local work in Niagara with the municipality contributing to the base funding of long-term-care beds. Also, the LHIN most recently has stepped up and really brought us to the level where we've got a well-funded and well-staffed dementia care centre. It's a small centre. It serves the entire Niagara region, servicing 31 long-term-care homes with over 3,000 beds, and also supports the hospitals and the community support service agencies that manage people in the community as well.

So it's an example of what can happen. It has been cited in the report of the Ministry of Health in 2007 or 2008—I forget which year that was—that identified that as a good model to have on a LHIN-wide basis as one of the components within the behavioural support services that are within a community. Every community can establish precisely what works for them, but there needs to be a provincial framework to guide the local communities so that local communities can come up with solutions locally but following a provincial framework.

M^me^ France Gélinas: So how does it really work on the ground? Are those specialized unit beds that people get transferred to until we have a treatment plan for the mental illness or their dementia? How does it work on the ground, or is this something that travels to their homes?

Mr. Dominic Ventresca: On the ground, it's one component in the continuum that's available within Niagara, in that there are 17 beds that are serving a purpose of behavioural assessment and also behavioural support. So up to 90 days, people can be transferred from other long-term-care homes.

The CCAC is a key component to make this work. People can be transferred from another long-term-care home where there are difficulties managing, where these residents are aggressive and injuring other residents or staff. They've been visited perhaps by the geriatric mental health outreach team members. Perhaps they've had some psychiatric involvement, but it's deemed that there are other ways of managing that behaviour, so they come to the centre for assessment. They can stay up to 90 days. If need be, they can stay up to another 90 days with a number of interventions.

There are certainly psychiatric interventions, but there are some non-pharmacological and non-psychiatric interventions. We've got additional recreationists there. We've got an OT now, through the last bit of funding from the LHIN. And with the specialized education, we require and we work with the unions on developing this, with additional credentials they have to have. Besides their usual RN or RPN or PSW credentials, they require a geriatric mental health certificate from the local college.

So that's one element of extra training, plus there's lots of support from the PRCs in terms of education which is fulfilling their role fully to provide these staff with the added bit of knowledge and expertise to manage folks, and then, when they return to their long-term-care home or to the community in some instances, we transition and provide that package or that set of information that worked in that setting to continue on so that we build capacity with the other long-term-care homes to manage in their own facility, closer to home from that regional centre that we've developed.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Jeff, and then Maria?

Mr. Jeff Leal: Thanks for your presentation.

Comsoc, of course, has closed the last of the institutions in the province of Ontario. We have many individuals with an intellectual disability, Down's syndrome. We have aging parents who are no longer in a position to look after their loved ones. What percentage in non-profit

long-term-care homes in Ontario would be represented by that group?

If you have somebody who has Down's syndrome at 40 years old, I know the challenge often is that sometimes their needs—because their medical condition can deteriorate significantly more rapidly than others.

Ms. Donna Rubin: We had figures from the Ministry of Health. Just a couple of years ago, there were about 1,200 in the system. They tend to be in their late 40s or 50s, who often have parents in their 70s. They're often coming with their parent into long-term care—and they transition very well into long-term care. They fit in better than other people with mental health illnesses because they're sort of taken care of. They live with the seniors in a very, I would say, happy kind of existence.

Mr. Jeff Leal: But in terms of staff training, because this is kind of a unique challenge—

Ms. Donna Rubin: Well, that's what we're saying: that there's no additional staff training in the average long-term-care home other than what people have cobbled together through their own opportunities. We're signalling that there needs to be a much higher level of understanding, and it can make such a difference.

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

Mrs. Maria Van Bommel: I was reading your more extensive document just quickly, and you note that one third of older adults with alcohol addictions actually come to that in their old age. I'm just taking this a little bit further, because we do talk about mental health and addictions here: What are the situations around, say, prescription drug addiction and that sort of thing as well? When you say that one third of the adults who you see with alcohol addiction come to it in old age, is this self-medicating—you're suffering from depression, anxiety or whatever, and you decide to start self-medicating with alcohol and prescription drugs and that sort of thing?

Mr. Dominic Ventresca: I think a lot of what happens is what you've identified already. There are additional pressures that come with aging, whether it be loss of a spouse, loss of independence, uncertainty around living arrangements, the trauma of potentially moving into a long-term-care home and so on. So I think those are contributing factors.

One of the points made in the paper, of course, is that it's a heterogeneous group. So we can't summarize too much about what happens in most cases, but I think you've identified a number of the issues already. I think it really is an individual matter. Nevertheless, it does happen to a greater extent because of some of the additional challenges faced by many older people.

Mrs. Maria Van Bommel: Are you seeing an increase in that? Are you noticing it trending upwards?

Mr. Dominic Ventresca: I probably wouldn't be the expert to comment, except to say that with increasing longevity, we're seeing more happen in mental health issues because people are living longer, where perhaps people would have died earlier due to some physical ailment. So probably there is a greater increase in that phenomenon.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dominic, and thank you, Donna, for coming today. We do appreciate it.

MARYSE BÉLANGER

The Chair (Mr. Kevin Daniel Flynn): We're in a bit of a quandary now for the next presenter. In about nine minutes or less, we're going to have to go and vote, and the next presenter has 15 minutes to present.

Maryse, you could start and we could do maybe eight or nine minutes, then we could come back and ask you questions, and that way we won't be tying you up as much as if we made you wait 15 minutes.

Ms. Maryse Bélanger: Not at all. I don't mind.

The Chair (Mr. Kevin Daniel Flynn): So you'll get 15 minutes. You use that any way you see fit.

Ms. Maryse Bélanger: You tell me when you have to leave to vote.

The Chair (Mr. Kevin Daniel Flynn): At about eight minutes you'll see us all sprint out of the room, and don't take it personally. It's all yours.

Ms. Maryse Bélanger: It's okay. I've been a journalist on Parliament Hill for five years, so I know the drill.

Thank you very much for having me today. I'm Maryse Bélanger. I'm here representing myself. I'm going to talk to you about perinatal mental health, which involves pretty much postpartum depression. The reason why I'm talking to you about it is because, when it comes to identifying problems in mental health, especially in mental health systems, we never hear about postpartum depression. It's not mentioned in the Every Door Is the Right Door paper, presented in June; neither is it mentioned in the Mental Health Commission of Canada's paper for a national strategy. So it's a bit worrisome when you think about the fact that 16% of women who have children suffer from severe postpartum depression. I don't know if it's because people don't think it's serious or what, but it's a bit alarming. So that's why I just want to mention what I know about postpartum depression.

Obviously, you've noticed that I'm a francophone, so sorry for the mistakes in English, but just cope with me.

I just want to mention also that postpartum depression is the leading cause of disease-related disability in women, according to the World Health Organization. So it is the leading cause for disability.

I want to talk about untreated postpartum depression. It has a permanent impact on the infant's development. What do I mean by that? I mean that the child is going to be impacted if the depression is not treated. If the mother is not treated, there's going to be an impact on that child for the rest of his life, and it can have very severe consequences later in life.

An untreated postpartum depression can increase the risk of:

—the severity of the depression, so the cost, at the end: Often, the mother is going to think, "It's just going to go away. It's going to get better." If it doesn't get

better, that's where it costs a lot more money. Sorry, I have a sore throat, so I'm going to have some water.

—maternal morbidity: One thing that, as a news producer, I've covered a lot are murder-suicides.

—adverse effects on the mother-infant relationship: When we're talking about the attachment, the bonding, between the child and the mother, if it's not treated, that relationship will not be proper for the rest of their lives. That means the mother is going to resent that child for the rest of her life, thinking the child took away part of her life and it's the fault of the child, where the mother has to somehow come to a conclusion to the fact that she was depressed. So she and her child are both impacted by the depression. The child was not the cause of that depression, but if you don't treat the woman, that's what she will think for the rest of her life.

—the vulnerability to neglect the child: That means the parents could neglect the child.

—emotional abuse by the parents; and

—parenting and marital breakdown.

I want to talk also about the father. Can you imagine a father who discovers how powerless it can be for a man to not be able to do anything for the woman he loves and who sees that it's not going anywhere? So it's very devastating for the fathers as well, and that could lead to the placement of the child into the care system.

So we're seeing the cost of an untreated postpartum depression increasing really fast here. Eventually, it could lead to the emotional state of the infant being impacted and the cognitive development being impacted.

There are multiple barriers as to why screening doesn't happen often by health care specialists. Often, it's time constraints. It's easier to write a prescription than to listen to someone for an hour or so. It's also caused by the clinicians' discomfort with psychiatric disorders—you've heard that before on this committee—and the lack of knowledge about the resources to screen women.

You have to go?

The Chair (Mr. Kevin Daniel Flynn): We're going to have to leave in about a minute or so. If you could just choose a nice place to stop, we'll start up when we come back.

Ms. Maryse Bélanger: I'll just give you the stats for the survey on family physicians by the Best Start program. Sixty per cent were comfortable with making a diagnosis of postpartum depression, so we've got to wonder about the other 40%. Only 22% were aware of the common screening tools—22% knew what to do—78% felt they needed more resources and 81% said they wanted to learn more about postpartum depression. These are the people caring for the women.

So please go vote, think about it and we'll be back.

The Chair (Mr. Kevin Daniel Flynn): When we come back, you've got about nine minutes left to talk to us.

The committee recessed from 1643 to 1655.

The Chair (Mr. Kevin Daniel Flynn): Okay, let's call back to order. We do have a quorum; I'm sure the others will join us in process.

You've got just over nine minutes left, Maryse, so use that in any way you see fit. If there's any time at the end, we'll just split it.

Ms. Maryse Bélanger: Okay. I was telling you that there are still 40% of family physicians who are not comfortable making a diagnosis of postpartum depression. Even when women are referred for treatment, that doesn't mean they're going to comply with their treatment. Imagine a woman with a newborn: All you're thinking about is your breastfeeding timing, naps and all that. The last thing you want to do is wrap that kid up and go for a session with a psychiatrist. That's really the last thing you want to do. It is not suitable, and that's why a lot of women are going untreated, even if they are diagnosed in the first place.

As you know, hormones affect women in many ways. I'm not going to make jokes about it today, but we all know that hormones have a big impact on women's lives. Women are more likely to suffer from mood disorders during and after pregnancy than at any given time in their lives, because hormones are highly involved in pregnancy. Like I said, 16% of all women who have children will suffer from severe postpartum depression. According to Stats Canada, if you do the research, there were 138,000 births in Ontario in 2007. That means there were 22,000 women who suffered from severe postpartum depression in 2007. If we look at breast cancer in Ontario, just to give us an idea, it's estimated that 8,500 women suffered from breast cancer in 2007. So we need more money in mental health, for sure. They have the good-paying ribbon campaign. We need to find something serious, a very good campaign for mental health.

1700

Some 70% to 80% of mothers diagnosed with postpartum depression, if they are treated successfully, will recover. That's the good news. That's why we need to invest in funding and the delivery of adequate services for the mothers and their families. The problem right now is the lack of coordinated systems, as you've heard. I'm sure many representatives have mentioned that many times.

What's needed specifically for postpartum women and families who are living with postpartum depression? I'm just going to mention diversity to start with. We want to make sure that the services are culturally competent, given the high rates of postpartum depression and low rates of social support for immigrant women and refugee new mothers. If you think Ontarians have it bad, just imagine yourself coming to give birth in a different country.

What we need, as well, is the creation of centres or units for patients and service providers. We don't have day treatment units or centres and in-hospital care to ensure that all care providers and professionals know how to assess women, because obviously, with the survey, we know that they are not sure about how to go about that. So we need a centre that will focus their attention on that and give the information about it to assess and treat.

We also need all health care providers to be involved. I'm talking not just about psychiatrists and psychologists, but also midwives, obstetricians, pediatricians. They should all be involved in screening women for postpartum depression.

We also need intensive treatment units for severely ill women and their babies. Can you imagine just giving birth to your baby and, because you have to be treated for severe postpartum depression, we just say, "Sorry, we can't accommodate your child or your husband. They will have to leave, but you'll have to stay with us"? It's just not serious. We have to have intensive treatment units to accommodate that reality.

I'm also going to talk about screening. I mentioned it a little bit. I think the well-child visits with the pediatrician and the postpartum gynecologist visits are key and instrumental in early identification of postpartum depression. It should be mandatory. It should be part of their service. Right now, they do it as a courtesy. It's not part of their mandate. We check the woman's belly but not her head, which is totally ridiculous. It's a little bit like everything else: We go to the dentist, but we don't go to check our head every year.

There are no guidelines for screening in the province either. Health care providers should be informing all pregnant women—I'm going to talk about the high-risk factors first—of the high-risk factors for postpartum depression. With all my reading and research, I came up with, if possible—pregnant women should be told. I'm going to send you my document later. Sorry, I didn't bring it today. It's all there. It's something that is possible. It would need to be adequately reviewed by peers, but that's a start.

We should tell the women; we should inform them: "If you have suffered from sexual abuse, there's a very high risk for you, during your pregnancy or after, that you will develop postpartum depression." As a woman, if you know these things, you can at least know what you might be getting into. But not knowing, I think, is very silly at this point, and that's what society is doing. It's like, "Oops. We don't know about mental—oh, it's just happening. Let's hope it's not too bad." The reality is, we can inform women and they can follow and recognize the symptoms, and it won't be that bad, or it can be not too bad.

Guidelines and treatment: There are no official guidelines in the province for treatment of postpartum depression, or treatment during the pregnancy. I'm talking about medication. There's no official line about whether we should medicate a woman with depression during pregnancy or not. The stats are there; research has been done by Motherisk that proves that a woman left untreated for depression during pregnancy is far worse off, as is her child, than if she is treated with medication. The impact of medication is, in a way, a ridiculously—it's not a big worry, when you think of the very serious consequences that the untreated depression will have in the child's life.

The Chair (Mr. Kevin Daniel Flynn): You have about a minute left, Maryse.

Ms. Maryse Bélanger: Sure, I can do that. I just have two more pages.

You all have my document, so you'll be able to see what's needed. You've heard from many people what's needed in the system. Everybody wants a piece of you, but that's okay.

All I want you to remember is that postpartum depression is real; it's affecting one woman in five. Therefore, every woman with a big belly that you see, there is one in five who's going to have depression. I don't think we see that as being a problem. I think, as a society, we should see that as being a serious problem that could be, and should be, and can be resolved.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maryse. That was a wonderful presentation. Sorry for the interruption in the middle.

Ms. Maryse Bélanger: It's okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. Unfortunately, there's no time for questions, but thank you very much for coming here.

Ms. Maryse Bélanger: Okay. If you want to e-mail me the questions, I'll be glad to answer them.

The Chair (Mr. Kevin Daniel Flynn): Okay, and you're going to get us some written information.

Ms. Maryse Bélanger: Yes, I will, for sure.

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

CONCERNED FRIENDS OF ONTARIO CITIZENS IN CARE FACILITIES

The Chair (Mr. Kevin Daniel Flynn): Our next presentation today is Concerned Friends of Ontario Citizens in Care Facilities. Phyllis and Lois, if you'd like to come forward and make yourselves comfortable. You have 15 minutes to present, and we don't have to leave during your presentation.

Ms. Phyllis Hymmen: I was very carefully noting that.

The Chair (Mr. Kevin Daniel Flynn): That's right. You've got to have a degree in math to chair this committee.

I'm going to leave that to you. We don't need any more time. Fifteen minutes; you use that any way you see fit. If there's any time at the end, we'll ask you some questions and then we'll take off and vote.

Ms. Phyllis Hymmen: Thank you very much.

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

Ms. Phyllis Hymmen: Concerned Friends of Ontario Citizens in Care Facilities really does appreciate this opportunity—

The Chair (Mr. Kevin Daniel Flynn): If you could identify yourselves for Hansard so we know who is who when we're recording it.

Ms. Phyllis Hymmen: Okay. That was coming later, but anyway, I'll do it right up front. I'm Phyllis Hymmen. I'm the president. Today I'm accompanied by Lois Dent, who is the past president.

We are aware, from hearing the tail end of the OANHSS presentation, that your attention was drawn to this area earlier this afternoon.

Just to tell you a little bit about ourselves, for almost 30 years we have been a volunteer consumer group that undertakes advocacy at both the system and individual level to improve the quality of care in our long-term-care homes. In order to retain an independent perspective, Concerned Friends is funded solely by our memberships, donations and the occasional grant.

I'm sure you've heard before, in the earlier presentations before you, that there are now approximately 622 long-term-care homes across the province, with some 75,000 residents, These homes, as again I'm sure you are aware, are regulated and funded by the Ministry of Health and Long-Term Care.

In our presentation this afternoon, we're going to describe the needs and challenges that the long-term-care sector currently faces, and we'll suggest some possible partnerships to address the current needs and the challenges that Ontario faces over the course of the next 10 years.

1710

I speak from some personal experience, as I first became acquainted with the long-term-care system when my mother, who was so proudly independent, developed dementia and could no longer live on her own. We had had no prior experience as a family in this area.

And so we come to the needs, as we see them. Of the approximately 75,000 residents currently in Ontario's long-term-care homes, a reported 60% to 70%, or some 45,000 to 52,500, suffer from Alzheimer disease or a related dementia. This really frames the care that they require.

The caregivers of these residents, from the personal support workers, registered practical nurses, registered nurses, physicians, social workers, activationists, physiotherapists, occupational therapists, dietary and housekeeping staff, all require knowledge and skills to deal with dementia management. The behaviour of these residents can be very challenging and can, in some circumstances, be of danger to themselves, staff and fellow residents. This has been evident in the sad deaths in 2005 of two long-term-care residents who were attacked by another resident. This led to an inquest that resulted in recommendations. Unfortunately, there has been another incident like this in the current year, and for this an inquest is likely to follow.

As can been seen from the number of long-term-care-home residents with great needs, and the list of those needed to care for them, there are funding needs to provide the quality of care that we all would want.

In the future, more skilled caregivers in all categories will be required for a growing aging population, as indicated by figures reported by the Ministry of Health and Long-Term Care's health systems strategy branch. By 2019, 10 years from now, projections for Ontario's aging population by Statistics Canada and the Ministry of Finance indicate that just under 10% of the population will be 65 to 74 years of age, and that's an increase of some 5% from 2009. There will be further increases in populations aged 70 to 84, and to those over 85. This represents over 15% of the total population. With initiatives such as aging at home, the current trend of residents entering long-term care as older, sicker and frailer will increase even more over the course of the next 10 years. This is underscored in the report of the special Senate committee on Canada's aging population released in April 2009. The specialized care that residents will need to deal with their mental health will increase as well.

That brings us to the challenges. There is a challenge for attracting people to enter fields such as gerontology, geriatrics and long-term care. It is difficult to attract people to areas where they will be dealing with the elderly who have hard-to-handle behaviours, those who may be seen as past it or as having lived their lives, in other words, that stigma of aging. Attracting qualified nurses and doctors is difficult when the work is demanding and the salaries in hospitals are more attractive. Personal support workers who provide much of the hands-on care often take this role because the training required is relatively short. We have heard that some take this training as they are urged to do so in order not be on Ontario's social assistance rolls. In addition, because of the pay levels, it is currently not unusual to have personal support workers working in two long-term-care homes to meet the financial needs not only of themselves, but of their families.

Disseminating and acquiring knowledge of the long-term-care system and its mental health care is a challenge. It is something that one doesn't like to think about as being needed by them or by a loved one. It is thrust upon a loved one when they are no longer able to care for themselves, or when the family caregiver is no longer able to cope.

While there is increasing knowledge about Alzheimer disease and related dementias, as well as treatment for depression, the challenge for more knowledge and approaches to care remains. This challenge will increase as the population lives much longer than in the past.

With the diverse population of Ontario, there are the challenges of meeting mental health needs of long-term-care residents from a variety of cultures and the customs and characteristics that accompany them.

When most long-term-care residents are elderly and have some form of dementia, there are challenges for the care of younger residents who also require the care that homes provide. There is the additional challenge for older residents who are mentally alert and competent but who require care to keep them mentally active and to avoid depression.

That brings us to partnerships. In addition to the essential aspects of the workforce and the funding for long-term care, collaborative partnerships are essential. This includes acquiring and sharing knowledge about long-term mental health and the techniques of care. There is great potential in the continuation of the existing collaborative partnerships between the Ontario govern-

ment, capable residents, family members, the scientific and medical communities, and the long-term-care associations. It is possible that new partnerships will emerge over the next 10 years.

So, more specifically, these partnerships include: the Ministry of Health and Long-Term Care's performance improvement and compliance branch; local health integration networks—the LHINS; community care access centres—CCACs; regional geriatric mental health outreach programs; the long-term-care associations that I mentioned, the Ontario Long Term Care Association and the Ontario Association of Non-Profit Homes and Services for Seniors; Alzheimer Society of Ontario and the Alzheimer Knowledge Exchange; a new group, Ontario Caregiver Coalition; residents' councils and family councils.

In conclusion, as the Select Committee on Mental Health and Addictions, you have the opportunity to influence the mental health care of loved ones who are now unable to receive the care they require to live in their own homes. We have outlined the needs, challenges and partnerships for long-term care. Concerned Friends recommends that you consider the essential funding, staffing and education required as you consider the mental health of seniors and, particularly, for all those living in long-term-care homes. The mental health strategy, and the addictions strategy that goes with it, that will be developed, will impact all of us, and particularly for us in the future, when you and I have similar needs.

Lois and I would be pleased to answer any questions that you may have.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you very much, Phyllis. You've left time for probably one question from each side, starting with France.

M^me^ France Gélinas: I don't know if you were here when I asked the question of OANHSS, but I'll ask you the same question. Are there best practices out there, are there services or long-term-care homes where you know that we have gotten it right, it really works well there and there's something to be learned so that it can be repeated in other long-term-care homes?

Ms. Phyllis Hymmen: Well, one of the things that's currently happening that is an example of the great collaboration between the people who have responsibility for the care in homes, the people who are receiving the care, the residents and the families, and the related associations that go with that, is the Ontario Health Quality Council's initiative now on quality improvement, and best practices is certainly going to be a part of that. I know it's a term that's used.

As Concerned Friends, what we have done in the past is, because we received the compliance report for every inspection that's done in all of the long-term-care homes, we've been able to look at the unmet standards, so that we can look at an individual home and say, according to what we have reported from the most recent compliance report and what we know of the history of this home, this is one that we would recommend.

I personally can speak very positively about the home where my mother was. It was certainly not perfect, certainly has the staff needs, the education of staff needs, and all of that comes back to funding, which is in very short supply, which we fully understand. But as we go forward, and these collaborations that have developed with the discussions around Bill 140, the act and now the regulations so that very often when we sit around the table we are sitting with the same people—so from the compliance transformation that's being undertaken by the Ministry of Health and Long-Term Care, by the most recent activities of the Ontario Health Quality Council, I think we're leading to where we want to go.

The Chair (Mr. Kevin Daniel Flynn): Questions? Liz.

Mrs. Liz Sandals: Could you give us an idea of what you would see as the necessary characteristics of a program for someone who has very serious behavioural issues related to either dementia or mental health? As a family member, what characteristics would you be looking for?

Ms. Phyllis Hymmen: I'm going to start quickly and then I'll pass it over to Lois so that she has a chance. What I'm looking for is someone who has the knowledge to care for that person. But I'm so aware, as a family member—fortunately, I have a background in psychology so that when my mother developed dementia I was able to pull some of that, but what I was certainly aware of is that what I learned in graduate school had developed greatly since then, so there's really the education need—a program that has an education need, ideally before, but also staff who are able to cope in terms of knowing strategies. That's where the partnerships that I referred to come in.

Ms. Lois Dent: I'd just like to bring your attention to one kind of example of what I think is a concern. A best practice is, for example, the program at Sunnybrook Hospital. It's a—the name isn't coming to me now, but it's a small unit that is specifically designed for caring for people with behaviours that are too difficult to manage in a regular long-term-care home. They have a higher staff level. It's just an amazing program. It's a behavioural unit, is what it is. The staff there, who are well-trained and know how to deal with many of these behaviours, learn how to best manage each individual. Then, ideally, they can go back to the long-term-care home with some advice and support as to how to deal with that person. I think we need many more of those.

The Chair (Mr. Kevin Daniel Flynn): We're going to move on to Sylvia.

Ms. Sylvia Jones: In your partnerships section you make reference to a number of agencies, but the one that I'm surprised I saw was the CCACs. Can you tell me how the long-term-care homes would—where that partnership would develop? What do you envision in that partnership?

Ms. Lois Dent: I think that comes to mind particularly to avoid, perhaps, horrendous incidents like that one that was mentioned in our presentation where a newly

admitted resident attacked and actually killed other residents. The reason—

Ms. Sylvia Jones: So at the placement level?

Ms. Lois Dent: Yes, it's the placement. The CCACs need to get the information that they need and they need to get that information to the homes so that especially in a crisis admission, as this was, they would be ready to deal with it.

Ms. Phyllis Hymmen: And that's the very beginning. That's where you have to start.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Lois. Thank you, Phyllis, for coming today. Wonderful presentation.

We're going to recess so we can vote in about four and a half minutes. We'll be back shortly after that.

The committee recessed from 1721 to 1733.

ONTARIO COMMUNITY OUTREACH PROGRAM FOR EATING DISORDERS

The Chair (Mr. Kevin Daniel Flynn): Okay, we can call back to order. I think we have the whole committee here, just about.

Our next speaker is the Ontario Community Outreach Program for Eating Disorders. Gail McVey, come forward. Have a seat, Gail. Make yourself comfortable. We shouldn't have to leave on you. You should get 15 minutes all the way through. Use that as you see fit. If there's any time at the end, we'll just split it.

Ms. Gail McVey: That's great. Thanks very much. I'm Gail McVey. I'm a psychologist and a research scientist at the Hospital for Sick Children, down the street, as well as with the University Health Network. I am here today in my role as director of the Ontario Community Outreach Program for Eating Disorders. That's a provincial training program in the area of eating disorders that's funded by the Ontario Ministry of Health and Long-Term Care. You have with you a bookmark that has our website, should you have any questions around that.

I wanted to just spend a few minutes describing eating disorders and the treatment of them here in Ontario, have an opportunity to identify two existing gaps and to see if there are opportunities to integrate with mental health and addictions.

Eating disorders are complex psychiatric and medical complications and disorders. They're actually the third most chronic illness among youth. They require highly specialized treatment and comprehensive, multidisciplinary care. In-patient or hospital stays are long, and outpatient follow-up is even longer. For example, we often have clients coming into the hospitals for three to six months, followed by at least two years of outpatient care for them to reach recovery. Intensive, family-based work with nutritional rehabilitation alongside weight restoration and medical and psychiatry stabilization are essential first key elements of treatment for clients to maximize the benefit of outpatient care in order to address the underlying issues to prevent relapse.

In Ontario, we have a very innovative, coordinated system of specialized care, which is one of a kind. Our network is dedicated and has standardized assessment and treatment protocols across all pockets of Ontario—across the 14 LHINs. Our network is not yet fully developed to meet the heavy demand for specialized services. In the meantime, as we work to expand our network, we are being strategic and collaborative to make sure that any new investment is allocated to the expansion of programs that can help relieve pressure on the entire system; in other words, looking at ways in which it can have the biggest impact on the province.

We have well over 85,000 individuals who suffer from eating disorders in Ontario, and that includes only those that we know about, as only 30% present for treatment. The longer eating disorders persist, the harder they are to treat. We are seeing eating disorders in children as young as seven and eight years of age, both male and female.

The cost of eating disorders are multiple. On the one hand, there's a strain on families who have to leave their jobs to participate fully in treatment. Family-based treatment is recommended. Secondly, there are financial costs to families related to travel and accommodation, as families need to travel away from home to access intensive programs. Currently, we only have intensive programs in Ottawa and Toronto. There's a further strain on the clients themselves—on their physical and emotional health—often leading to social isolation, where they're having to take a hiatus from their work or their schools. A burden is felt on all family members as the mortality rate for eating disorders is 10% to 20%, due to heart failure or suicide.

In addition to a need for additional in-patient beds for both adults and pediatrics—we currently have 20 beds for adults and 16 beds for pediatrics in the entire province; these beds are always full, with overflow of clients seeking treatment out-of-country, which is costly; not very effective, in most cases; and further disruptive to families.

1740

In addition to a need for in-patient beds, we have two significant gaps in our system. One is a residential care program, which is nonexistent right now, to house clients whose eating disorder symptoms have subsided but require residential care for the complex, co-morbid conditions that underlie the eating disorder.

We cannot rely on the existing mental health system, due to stigma and fear of caring for clients with eating disorders. As a result, these clients take up in-patient eating disorder beds for the treatment of co-morbid psychiatric disorders and/or complex family situations that need to be attended to.

If we were to house them in a residential care program integrated with continued specialized eating disorder treatment, we would be able to free up the in-patient beds, allowing us to rotate clients more efficiently throughout our in-patient programs here in Ontario.

A second gap is the lack of treatment for concurrent eating disorders and addictions. Eating disorder programs

don't have the resources to treat addictions and vice versa, leaving these desperate and high-risk patients without care, heightening their vulnerability for relapse or suicide risk.

We would like to initiate dialogue with your committee members to discuss ways in which we can combine our resources to better meet the unique needs of individuals with these complex and life-threatening disorders. Solutions can start with collaboration across sectors or ministries.

I want to leave you with two success stories as examples for a rationale for expansion and possible cross-collaboration across ministries.

One is an example of pediatric care. At Sick Kids four years ago, we had a young client, 12 years of age, who had a very severe eating disorder with complex co-morbid conditions. She was treated over the course of four years, with several in-patient stays at Sick Kids, eventually sent to the US for residential care, away from home and from family, and returning very ill here to Ontario.

Sick Kids partnered with Youthdale, which is funded by a different ministry, the Ministry of Children and Youth Services, with an agreement to offer support to Youthdale staff for the treatment of her eating disorder. We integrated family-based eating disorder treatment and medical stabilization to the client and her family while she stayed at Youthdale, closer to home.

This child, four years later, at the age of 16, has now fully integrated back into school and is on her way to recovery.

Another example is in our adult services. At Credit Valley Hospital, we have an adult eating disorder program that includes a day hospital and an in-patient program. Also at Credit Valley is an excellent day hospital for addictions, the only one in Ontario.

The eating disorder program will often send their clients for treatment in this addiction program. Once they finish the intensive part of their addiction treatment, and after four months of follow-up care, they're invited back to the eating disorder day treatment program down the hall at the same hospital.

It's great to have the substance abuse expertise in the hospital at the same location where we have an eating disorders program.

Credit Valley has submitted a proposal to the Ministry of Health and Long-Term Care for two more beds at Credit Valley so they can be used in a more flexible kind of way for medical stabilization and the treatment of concurrent disorders. This could be a step along the way to meeting the special needs that we have for people with concurrent disorders.

The Chair (Mr. Kevin Daniel Flynn): Thank you. You've left a lot of time. Let's start with the government side. Liz?

Mrs. Liz Sandals: You raised a number of questions, but a couple that I'm wondering if you could address: first of all, the concept of treating the whole family—if you could talk a little bit about that. Then, you're talking specifically about a youth program. What is the cut-off age for youth programs that you're familiar with? What's available in terms of the transition from youth programming to adult programming?

Ms. Gail McVey: Our network is comprised of programs that treat pediatric eating disorders. That would go up to 18 years of age. Our adult programs, available across the province, would start treatment at 18.

Where possible, we try to transition clients, because they often continue to need treatment beyond the pediatric stage. There is no existing transitional program in Ontario. Right now, our programs really work in a collaborative way to try to smooth out that transition as much as possible.

In the 20 years that I've been working in eating disorders, I've been very optimistic about family-based treatment, because it's showing up as something that is giving families an opportunity to restore a bit of empowerment in the treatment of their own children. Traditionally, we would take them away from their families and put them into in-patient units, and when the children returned to their families, they would often relapse.

What we're finding very helpful and evidence-based is involving parents in the treatment from the get-go. Not only are we doing individual family-based treatment, but we're doing multi-family therapy as well, where we treat six families at once, looking for innovative ways to complement our in-patient programming.

Mrs. Liz Sandals: But the model, then, would be that the child or children would be in-patients at the program, and the families would need to co-locate in that area and would be coming in during the day for treatment sessions.

Ms. Gail McVey: Correct. Sometimes, children need medical stabilization in a very acute way, so whether they are participating in an in-patient program, a day treatment program or an outpatient program, family-based treatment is recommended. For example, we have a case where a family from Thunder Bay is getting treated in Ottawa. These are long treatments—three to six months minimum—so the family has to relocate to Ottawa, pay for their travel and accommodations, and take time off from work to be able to help their child recover from this life-threatening disorder.

Mrs. Liz Sandals: That's a huge commitment.

The Chair (Mr. Kevin Daniel Flynn): A short question from Jeff.

Mr. Jeff Leal: Thanks, Mr. Chair. Do you work with school boards, at all, for early identification?

Ms. Gail McVey: Yes. The other hat I wear is as a researcher, where I've dedicated my work to the prevention of eating disorders. I spend a lot of my time working with the Ministry of Education and with the 36 public health units across the province to standardize prevention techniques in the schools.

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

Ms. Sylvia Jones: Thank you for your presentation. I want to ask you a little bit more about concurrent disorders and access to care. I understand—we have heard

this from other people—that trying to find treatment for concurrent disorders is almost impossible.

Ms. Gail McVey: Exactly.

Ms. Sylvia Jones: That being the case, what do you treat first?

Ms. Gail McVey: This is the issue why clients have difficulty getting access. When they come to an eating disorder treatment program for treatment of an eating disorder, part of the criteria is not having addictions, because right now, we barely have enough resources to treat the actual eating disorder and all the things that go along with that. So we need resources where we can actually treat both concurrently. There's one at CAMH, the Centre for Addiction and Mental Health, which has had some good success. Replicating something like that in different areas of the province would probably be a good short-term solution.

Ms. Sylvia Jones: Do you know how many beds there are at CAMH that are doing this?

Ms. Gail McVey: They don't have beds; I believe it's all outpatient at this point.

The other part of the answer is, when people go for addiction treatment, there's a real lack of—we've specifically trained practitioners to work in the area of eating disorders, but often in other areas of mental health care, people don't have the skills to offer the treatment for eating disorders, and they're often left untreated.

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

M^me^ France Gélinas: Would you know the percentage of concurrent: an eating disorder and an addiction?

Ms. Gail McVey: I can give you that information in terms, perhaps, of the research, but I know that anecdotally in Ontario, when I speak to the clinicians who work across our 30 eating disorder programs, it's not uncommon to see as much as 50% of clients who have both.

M^me^ France Gélinas: I'm interested in the prevention of eating disorders that you do with the health units. Is it through the development of a tool, that public health nurses go through the school? How does it work?

Ms. Gail McVey: Absolutely. I could have brought another bookmark for you. What I want to mention is that all of this is being done through research, and as scientists, we're very committed to doing knowledge translation. So in addition to doing the research, we often will share strategies with different stakeholders so they can use them.

We've developed best practices, and then we've made them accessible through community-based workshops that are funded through this outreach program, as well as an online training and curriculum program. To make it user-friendly for teachers, we've matched all of our strategies to the Ministry of Education's learning outcomes, so that teachers don't have any extra work; this is integrated into their normal workload. One of those websites is called AboutKidsHealth, The Student Body, and I'd be happy to share that with the committee.

1750

The Chair (Mr. Kevin Daniel Flynn): Gail, I have a brief question. I've had a number of constituents come into my office who are parents of children with eating disorders, and I think to a person they've complained about the treatment they receive when presenting themselves at emergency rooms when a crisis—

Ms. Gail McVey: Yes.

The Chair (Mr. Kevin Daniel Flynn): I'm sure that doesn't happen at Sick Kids, but in a typical Ontario hospital, as part of the outreach, do you talk to the health care practitioners themselves?

Ms. Gail McVey: Yes. We've reached out to a good 5,000 practitioners, if not more, across Ontario, where we do community-based workshops for people who will not necessarily devote their careers to the treatment of eating disorders but who could perhaps identify or incorporate better opportunities to support them into their care. Probably the ones who are the hardest to target are the physicians. We continue to have difficulty, particularly in emergency rooms, which is often the first point of contact.

So some of our network members have come up with some innovative physician education projects—completely unfunded at this point, but a strategy to try to reach out to the family health teams. But certainly, one of the gaps is to reach out to emergency rooms across the province.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful to hear. Thank you very much for your presentation. We certainly appreciate your coming.

Ms. Gail McVey: Thanks very much.

ONTARIO FEDERATION OF COMMUNITY MENTAL HEALTH AND ADDICTIONS PROGRAMS

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this afternoon is the Ontario Federation of Community Mental Health and Addictions Programs: David Kelly, executive director. David, come forward and make yourself comfortable. You have 15 minutes, like everybody else. Use that any way you see fit, and we'll use up any time you don't.

Mr. David Kelly: Okay, great. Thanks very much.

If you notice, the title of my presentation today is Embracing Challenges Together, and that's sort of the theme, because as you're understanding and hearing from all your other presenters, the complexity of issues in mental health and addictions requires all of us to come together to solve those issues.

I thought I'd start by giving you a general idea about the Ontario Federation of Community Mental Health and Addictions Programs. We work with over 240 providers who are providing the full range of services in mental health and addictions. Withdrawal services, community withdrawal, housing and treatment services are housed under the federation.

I wanted to include our objects of incorporation, our vision statement and our mission statement so you understand why I'm here today and why we're coming. I'm just going to highlight some of the words in that: collaborative; enhancement of the system; accessibility; flexible; comprehensive and responsive to the needs of individuals, families, communities; partnerships; high-quality and effective services.

We come to you today to build a better mental health and addictions system. We are a transfer payment agency of the Ministry of Health, and we are also a member organization. But in our membership we truly believe in building that better mental health and addictions system.

In this time period, there's an unprecedented focus on mental health and addictions issues. We have this committee, the all-party committee on mental health and addictions in Ontario; we have the minister's advisory group, which I'm proud to say I'm a member of; we have priorities in many LHINs, local health integration networks; and we have the Mental Health Commission of Canada also working on these issues. If you look to the poverty strategy and the soon-to-be-released housing strategy, many of the other works the present government has passed also reflect the needs and issues faced in mental health and addictions.

I come today first to give you special thanks; recognition must be extended to this committee for its work. Being out having public hearings like this—hearing from communities and travelling across Ontario—is helping to build the momentum we need to overcome all these challenges. We encourage collaboration between this committee and the minister's advisory group, and also the use of work being done by the Mental Health Commission to leverage more support for people in Ontario.

A quick example of that is the recent announcement of the housing research study being conducted by the Mental Health Commission, which is resulting in people being housed and services being provided to homeless individuals with serious mental illness in order to do research to demonstrate the success of different models in providing those services. There are great opportunities with all of this work, and we need you to grab and reach those opportunities.

However, all that success also means changes for all the parts and pieces of addictions and mental health services in Ontario, and I'm here to tell you that providers across the system—and I think families and consumers are encouraging us to go on, but we are ready to collaborate and coordinate. We want to be accountable for the services that we provide not only to you, the government, as funders, but also to the people who access those services. We want to focus on harm reduction and recovery. We just had a cited example of where we see blocks in the system where often people with an addiction have to have that addiction resolved or stop using a substance before they can access services. What that means is many, many people never access the supports and services that will help them get past that addiction. We want the system to focus on recovery and harm reduction, and we want to integrate right from that hospital system, that emergency room, out to the community. It's crucial and key to your success and the success of the report from this committee.

I come to you now, though, to tell you that it's just too great for us as providers; it's too great for families and persons with lived experiences. We need coordination of governments and their different ministries to focus programs impacting mental health and addictions. Hats off to Minister Caplan for bringing together 12 different ministries, ministers and their ADMs to look at how they fund and the issues in mental health and addictions. We will still wait for the results of that work, but just having justice, education, Comsoc, health and other ministries coming together to talk about mental health and addictions, how they fund it and what actions they are taking is making a difference already. We encourage that work and urge you to encourage the government to continue that work.

Too often, we have different initiatives coming at us, and people with serious mental illness and the focus and the dollars are lost because we are not coordinating that work. What happens at the Ontario disability support program has a direct impact on people in the community, the services that are being provided. Those links have to be made. We obviously want the coordination of different health and social services and to end all the silos within health care. We've brought addictions and mental health together as a first step. We now need to bring other components of the health care system together with mental health and addictions and make sure those supports are available to them—for example, family health teams—so we can better build a system.

The next point is about investments in community-based services and the broad determinants of health. I would be a fool to come here and not acknowledge and recognize the incredible problems we are facing on an economic level. I would challenge you that we cannot use that as an excuse again. I'm going to give you a quick example. Depression impacts women on a much higher level than men, and we know a precursor to depression is obviously often low self-esteem. Girls and boys up to the age of 12 often have the same levels of self-esteem. When puberty hits, often girls' self-esteem will decline dramatically, which then starts building them up to be more susceptible to depression in their later years. If we were to put self-esteem programs targeting girls and young women in our schools, in 20 years we would hopefully—and could—see the levels of depression decline. That's why I go back to our theme about us coming together, because this is not a one-off solution; it's not a four-year solution. We're talking a long-term commitment. Honestly, I will say the field is looking to this committee and the minister's advisory group to help us get there.

Understanding that we have huge challenges on funding levels, let me say that the continuing ballooning of the health care budget—the solution lies in community services, those services that wrap around the broad

determinants of health. Housing is a solution for mental illness and addictions.

Investments in the structures that support these services: Every presenter who has come to you has talked about different programs that are having successes, different standards and policy frameworks that are needed. We need those structures and we need those investments now to be able to make a difference within the 10 years. We need standards, we need evaluation tools, we need assessment tools, we need to use research, not just academic research but lived experience research, to better build a system and we can't wait for the economy to get better for those processes to start.

1800

Understanding that your report may not be available within this next budget system, I would hope or love to see some advice on the next budget coming from this committee. One of the other real, true commitments we need to see is a commitment from the government, opposition parties and the civil service to follow through on implementation.

This committee came together realizing that this is a non-partisan issue, that this is impacting all Ontarians, and the solutions and the ideas are so complex that we had to come together. We could fill this room with reports, coroner inquests, human rights tribunal outputs; we could fill this room and then wonder why the system has not changed. We need to follow through on implementation.

You may ask, "That's all well and good, what is the federation doing to help change that system?" I just want to flag a few things that we are doing that we've provided for the committee to feed into that. First, I want to talk about consumer-survivor initiatives. If we are going to a recovery-focused system, if we are going to be making sure that people with lived experience and serious, mild or moderate mental illnesses or addictions are empowered and are going to be on the road to recovery, we have to make them central to our service delivery. We've brought to you today the results of a joint project with consumers from across Ontario to give you some advice on how to build consumer-survivor initiatives and utilize well-documented and researched work that shows the outcomes of peer support. For example, people with a serious mental illness helping someone with a serious mental illness—the impact of that is tremendous and results in huge savings to the health care system as a whole.

Also included, embracing cultural competence in mental health and addictions, which is about getting supports out to all providers of mental health and addictions to understand that they must meet the cultural needs of all Ontarians. Unfortunately, we are not equipped as a field to do that work and it's crucial to have positive outcomes in mental health and addictions services.

We also brought together our work that we're doing around meeting the accessibility standards for customer service. Those standards have been coming out from the office of disabilities and the federation is presently working with providers to ensure that they are meeting all of those disability standards. You will soon be hearing from us, as your committee does your work, on primary care, emergency room diversions, and we are presently working with our partners in mental health and addictions to start looking at how we can implement the change that is needed to build a better system.

I just wanted to also give a special recognition and a thank you to this committee. Putting aside the partisanship and developing an all-party committee in Ontario to look at mental health and addiction issues is putting us on the road to success. I also want to let you know that we are here as an organization to ensure a more accessible and responsive system of supports and services to all of Ontario. We're here as a resource for you and a resource for all Ontarians.

The Chair (Mr. Kevin Daniel Flynn): Thank you for a wonderful presentation. Unfortunately, we don't have time to get a complete question in, but I think we got your point very clearly and we appreciate your offer of assistance.

Mr. David Kelly: I will say we will be back to the committee with some more of that work on primary care and emergency rooms.

The Chair (Mr. Kevin Daniel Flynn): And we're planning a joint meeting with the advisory committee. I think we've finally got a date set before the end of the year.

Mr. David Kelly: That would be excellent.

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

RAKESH MODI

The Chair (Mr. Kevin Daniel Flynn): It appears our 5:30 presentation is not going to be here, so our next presenter today is Rakesh Modi. Rakesh, if you'd like to come forward. Rakesh has asked if he can film his presentation. I have no objections to that, unless any member of the committee has any objections. No?

Make yourself comfortable. Like everybody else, you get 15 minutes. Use that any way you see fit. The floor is all yours.

Mr. Rakesh Modi: Thank you for giving me this opportunity. My name is Rakesh Modi. I'm an Ayurvedic physician and an acupuncturist by profession. I'd like to present to you a combination of Ayurveda—which is an Indian health care system, one of the oldest systems in the world—and acupuncture, and some yoga.

What is Ayurveda? Ayurveda is the traditional ancient Indian medical science, the origin of which can be traced back to the Vedas, which are the oldest available classics of the world. Vedas are the ancient books of knowledge, or science, from India. They contain practical and scientific information on various subjects beneficial to humanity like health, philosophy, engineering, astrology etc.

Ayurveda is the only ancient independent scientific system of medicines. In the medieval period, however,

the system faced utter neglect at the hands of foreign rulers. Some authentic literature was destroyed in these turbulent times. Even then, Ayurveda contributed to the public health system due to its safest and most effective herbal formulas and easy availability. The seers who initiated Ayurveda inducted in it sufficiency, soundness and sustenance, and that is why it survived.

The literal meaning of Ayurveda: Ayurveda is a holistic healing science. "Ayu" means life. "Veda" means knowledge or science. So the literal meaning of the word "Ayurveda" is "science of life." Ayurveda is a science dealing not only with treatments of some diseases, but is a complete way of life. This becomes clear when we see the meaning of "life." As mentioned above, Ayurveda is a science of life, so to know more about it, we must know what life is. Life, according to Ayurveda, is a combination of senses, mind, body and soul. So it's clear from this definition of "life" that Ayurveda is not only limited to the body or physical symptoms but also gives a comprehensive knowledge about spiritual, mental and social health.

Names of the Ayurvedic/ancient herbs which are useful for mental disorders: Number one, which is most commonly used in India for mental issues and hair loss or hair-related issues, is called brahmi, which is an Indian name. The Latin name is Bacopa monnieri. The drug class is brain tonic, hair nourisher and rejuvenator. The indication is for depression, hysteria, epilepsy, insanity and other mental disorders. Another simple thing that is available anywhere around the globe and that we are all familiar with is the walnut, which is called Juglans regia in Latin. The drug class is brain tonic, antiseptic, stimulant, expectorant. If you open a walnut, it looks exactly like a brain. Some more herbs are also available.

There is an eightfold classification of the Ayurveda:

(1) Kayachikitsa, known as internal medicine and therapeutics;

(2) Kaumar-bhritya, for gynecology and pediatrics;

(3) Shalyatantra, which is surgery—in 200 BC, in India, we used to do plastic surgery without anaesthesia;

(4) Shalakyatantra, which is ENT;

(5) Bhutavidya, which is spiritual therapy and psychiatry;

(6) Vishatantra, which is toxicology;

(7) Rasayana, which is rejuvenation therapy;

(8) Vajikarana: virilification therapy.

1810

Now the treatment process in Ayurveda: What do we do? How do we do it?

—We do a pulse diagnosis to find out what imbalance is causing the factor and figure out the body type of the person, according to the country's own climate zone.

—We suggest proper diet as per the body type, customized for each individual.

—We provide herbs.

—If it's required, we also add PanchaKarma, which is rejuvenation therapy. It consists of full-body massage; medicated steam bath; Shiro Dhara, which is oil dripping on the forehead, as you will see in the next slide; head massage; nose and ear therapy; and enema.

This is one of the most effective treatments we have found, which is called Shiro Dhara. It is a flowing stream of medicated warm oil on the forehead, as you can see, after a head massage. Shiro Dhara is a sacred Ayurvedic healing practice that involves placing a continuous fine stream of warmed oil on to the forehead. It has become one of the most sought-after treatments in the spa industries of Europe and North America, but this system is originally from India. It is a great, helpful tool for any mental disorders.

Now let's come to acupuncture. We have found that 15 to 20 continuous sessions, with a duration of 30 to 60 minutes per session, can help you get rid of alcohol addictions, food addictions, nicotine addictions, drug addictions—any type of addiction. But it requires some commitment from the client as well. When a client comes to us and wants to quit smoking or any other addiction, we ask them, "Sir"—or ma'am—"how much willpower do you have? Because if you don't have any willpower to start with, it's not going to help." Sometimes, as I say, it's 15 or 20 sessions. With continuous, regular sessions of acupuncture, a person can quit smoking within 15 to 20 sessions.

At the same time, when we add acupuncture, we use one point which is available at the centre of the head, the crown, which is called the master point of the body. It treats all types of psychiatric and neurological disorders, including addictions.

Also, we use the heart point, available on the wrist line of your hand, which is very useful for improving willpower for addiction therapy and mental disorders.

At the same time, we suggest a couple of others things, like yoga and meditation, some kind of asanas and breathing exercises to get more oxygen flowing to the brain.

Also, if they have dental coverage, we tell them to go to clean up their teeth and gums. Why? Because the tongue moving over the teeth, touching your gums and teeth, will send a message to your brain to go and have a smoke. Why? Because a nicotine layer stays on your gums and teeth. If you remove that, it will help clients get rid of addictions probably 20 to 35 times faster than in normal conditions.

There are small tricks available. If you also help them with some herbs, and sometimes with combinations of Ayurveda, yoga and acupuncture, a person will come out of it faster.

And it could be cost-effective, because not only are they getting rid of the smoking, but at the same time, when using these points on the ear, which are most likely the lungs and the large intestine—because generally, when people are smoking, the toxins are contained in the lungs and large intestines—we help them shake up their body so they can get rid of all the toxins from the system naturally. Slowly, gradually, they can go over 100% of their willpower and then they can quit smoking, or food, or sex, or shopping, or any type of addiction.

Thank you very much. That is the end of my presentation.

The Chair (Mr. Kevin Daniel Flynn): Thank you. That was very interesting. The first question, I think, is from France.

M^me^ France Gélinas: It was most interesting. Very different from the other presentations we've had, and I thank you very much for coming here.

Mr. Rakesh Modi: You're welcome.

M^me^ France Gélinas: The people who go and seek treatment through you—I kind of recognize you from the picture—do they have to pay for it, or is there insurance or something?

Mr. Rakesh Modi: If they have acupuncture coverage, we give them all the information. Either they pay from their pocket if they don't have any insurance, or, because I'm a certified acupuncturist, I can give them a bill for acupuncture treatment. Then, yes, insurance generally pays for it, so there's no problem.

M^me^ France Gélinas: And if we look at somebody with alcohol addiction—I realize there are no guarantees in life or anything, but would you be able to tell the clients that come to see you, if they go through with the 15 to 20 sessions, what the percentage of success is?

Mr. Rakesh Modi: As I just mentioned, we always ask a client beginning with one question: "How much willpower do you have?" Let's say that you're drinking and your husband, your wife, a brother or sister is forcing you, it's not going to work. We want your passion—100% involvement in it. If they say, "I have 15% willpower," and if they come continuously and follow all the restrictions and all the diets or whatever, definitely they will get a 100% result.

Actually, when we did research in 1997 in Sri Lanka with homeopathy and acupuncture together—according to our own understanding, a general smoker can quit smoking within 10 days with this type of therapy. When it comes to alcohol, it also depends. When we ask a question—we also ask a second question: "How much are you drinking" or "How much are you smoking?" So based on how long you were smoking, we may give them—"Okay, ma'am or sir, you will be out of this habit in 15 sessions."

Generally, what we do is—because you asked me if it's going to be cost-effective for them—we say, "Okay, we'll give you 15 sessions, but it's capped at the 15 sessions. If you have to go five sessions more, you don't pay for it." We only charge for up to 15 sessions, because we know that it could be quite a lot money for them to go through.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Rakesh. Let's move on. Anybody on this side? Maria?

Mrs. Maria Van Bommel: I noticed that you brought a device. Is that your warm oil—

Mr. Rakesh Modi: Yes.

Mrs. Maria Van Bommel: Can you sort of show us a little bit—

Mr. Rakesh Modi: Sure. Definitely.

The Chair (Mr. Kevin Daniel Flynn): You're trying to get a spa treatment out of this, aren't you?

Mrs. Maria Van Bommel: No, but I might need one. I just saw that you brought it in, and I thought, "It's interesting," but I didn't know what it was.

Mr. Rakesh Modi: That is the unit that we were saying—it's this one right here. I just brought it because it's—so it doesn't move, it doesn't fall on anybody. What happens is, you lie here. About four inches down your head—this is your forehead, and it's oil continuously dripping on the forehead; then, it dries through and collects at the bottom. After that, we do the full head massage and just help you with it.

Mrs. Maria Van Bommel: How long do you lay under that?

Mr. Rakesh Modi: They last between 15 to 45 minutes. But it's a very soothing effect. Honestly speaking, it's very hard to explain, but when you go through it, it's out of this world. I cannot write an essay on it. When you explain, when you go through it—we have seen people before and after. I'll tell you that 95% of the people under this treatment are falling asleep—they're tongue is out, they're snoring and you have to wake them up: "Sir, your time is up."

Mrs. Maria Van Bommel: I would fall asleep too. I'd be very relaxed.

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

Mr. Rakesh Modi: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you, members of the committee and everyone who presented today. That's our last presentation of the day. We're adjourned.

The committee adjourned at 1815.

CONTENTS

Wednesday 25 November 2009