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**Official Report
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Thursday 10 September 2009

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des débats
(Hansard)**

Jeudi 10 septembre 2009

**Select Committee on
Mental Health and Addictions**

Mental Health
and Addictions Strategy

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

Stratégie sur la santé mentale et
les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
Greffière : Susan Sourial

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS**

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

Thursday 10 September 2009

Jeudi 10 septembre 2009

The committee met at 0901 in the Howard Johnson Plaza Hotel, Sudbury.

**MENTAL HEALTH
AND ADDICTIONS STRATEGY
COMMUNITY COUNSELLING
CENTRE OF NIPISSING**

The Chair (Mr. Kevin Daniel Flynn): Can you hear us, Elaine?

Ms. Elaine Cousineau: Faintly, yes.

The Chair (Mr. Kevin Daniel Flynn): Good. We're all sitting here. You're our first call of the day. All the members are present right now. There are some people in the audience here in Sudbury. Everybody on this leg of the tour is being given 20 minutes to make a presentation.

Ms. Elaine Cousineau: Yes, I understand.

The Chair (Mr. Kevin Daniel Flynn): So if you would use that any way you see fit, and then at the end of the presentation, if there's any time that's left over for some questions or discussions, we'll see if we can't share that amongst the members who are here.

Ms. Elaine Cousineau: Okay.

The Chair (Mr. Kevin Daniel Flynn): Everyone can hear you at the level that you're talking at now, so just make yourself comfortable.

Ms. Elaine Cousineau: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): And it's all yours.

Ms. Elaine Cousineau: Thanks very much. Good morning to the Chairperson and members of the select committee. My name is Elaine Cousineau. I'm presently the fetal alcohol spectrum disorders education coordinator at the Community Counselling Centre in North Bay. Thank you for this opportunity to express my concerns to you.

In the 1980s, over 24 years ago, I was a member of the Focus community, one of nine anti-drug coalitions across Ontario. The members of this grassroots group in North Bay felt it was important that I be a voice for many families coping with youth caught up in the drug scene and that I should accept the invitation to make a presentation to that task force travelling across northern Ontario to address alcohol and drug issues.

I shared with this task force the grief my family was experiencing with our beautiful young daughter, who was, at the time, making suicide attempts, getting into

trouble with the law, running away from home, cutting herself, drinking and doing drugs, skipping school and suffering mentally, physically and emotionally. We had sought help from 27 different professionals—counsellors, doctors, psychiatrists, psychologists and agencies—all to no avail.

At the end of my presentation to that group of politicians, one of the members, Mr. George Mammoliti, a young MPP from Toronto, came forward, extended his hand and said, "Mrs. Cousineau, on behalf of the province of Ontario, we owe you an apology."

My daughter, like many other youth in Nipissing district, had fallen through the cracks. For the first time during our nightmare I felt heard. I knew Mr. Mammoliti understood, and I sensed that he cared. His apology meant so much to me at that time, and I was confident that there would be help soon.

Before very long, I accidentally learned through poring over the Internet that there was a disorder which presented with the following behaviours: running away from home, not understanding consequences, truancy from school, promiscuity, trouble with the law, drug and alcohol use, and depression and suicide attempts, and there had been a label for this disorder for over 10 years. The term "fetal alcohol syndrome" was coined in 1973 in Seattle, Washington. My daughter, whom we adopted as an infant, had been exposed to alcohol in the womb, so immediately I sought help, but I could not find a soul in North Bay who knew what FASD was.

Today, after many years of learning about FASD, I'm told by front-line workers that families today would not have experiences similar to mine and that there is help for families coping with FASD in our district.

Well, I'm here to tell you today that youth in North Bay are continuing to fall through the cracks because no group, no ministry, no organization is accepting responsibility for helping these individuals whose lives have been ruined by being exposed to alcohol while in the womb.

I'm assuming that most of you know what FASD is. It is not a developmental delay. It is permanent, irreversible brain damage caused by alcohol use while pregnant. It is the leading, number one cause of birth defects in North America and it's 100% preventable. If the fetus is not exposed to alcohol while in the womb, it cannot have fetal alcohol spectrum disorders.

For several years now, I have advocated mostly voluntarily for youth in trouble with the law, in trouble in

school and at home. I've visited these kids in jail where we're told it is the last place they should be because they're so vulnerable and easily led. I answer frantic phone calls from parents, grandparents and foster parents desperately seeking help. I've accompanied parents to North Bay police station at midnight because their child has been arrested and does not even have a clue why he's being arrested, even though he tells the policeman he understands the charges.

I'm presenting to you today to impress upon you the need for someone to address fetal alcohol spectrum disorders. We're told that 1% of all babies born are affected, yet we're also told at conferences in British Columbia that we don't have accurate stats and that when we do, the numbers will be alarming. Yet, we still have doctors telling young women that a few drinks won't hurt and we have school boards refusing to provide the one-on-one assistance that is needed for students with FASD because they don't have psychological evaluations on record with the school. The parents I know are struggling to keep food on the table and pay the rent so they won't be evicted. They do not have the money for a \$2,500 psych assessment from a psychologist.

We have lawyers representing youth in court who have no idea how the client has been affected by alcohol before birth. They interpret the client's inattention as disrespect for the crown. Little do they know that the client is so easily distracted, he can't even focus on what the lawyer or the judge is saying.

There are some support and services for many of the aboriginal groups, but non-aboriginals have been left to fend for themselves.

At one of the many conferences I have attended in BC—incidentally, at my own expense—a doctor specializing in FASD said in front of the audience of 700 people, "If you're a native, you will get a diagnosis of FASD. If you are white, you'll get a diagnosis of attention deficit disorder because it's more socially acceptable."

The Trillium Foundation of Ontario has just recently provided funds for providing FASD education throughout Nipissing district. We have received \$120,000 for a two-year contract and we are truly grateful for the generous gift. However, it was shame and embarrassment that I met in a family support group because the media had misrepresented the facts, stating that families were now going to get some support. The families have got nothing.

0910

Do you know what families need? They need respite workers so they can get a break from their child, who seems to be in trouble continuously. They need someone to supervise their children 24 hours around the clock so they can sleep without having to worry if their son or daughter has sneaked out of the house once again and is getting into trouble with the law.

They need legal representation because these children are targets for other youth and often end up, sometimes even willingly, taking the rap for a crime they did not

commit. Not long ago, a boy was invited by friends to break into a liquor store. When the police arrived there was no booze, there were no friends, but guess who was arrested for stealing the liquor? Last week, a 30-year-old woman came to me to learn about FASD because she just can't figure out why she may be going to jail. She's attractive and had a career, but she met a young man who saw an opportunity to use her, and today her \$12,000 savings are gone, her career is gone and she too has charges that she does not understand. In fact, she has six of them.

I sat at meetings to assist a family where we were surrounded by numerous agencies that were involved because the child was misbehaving in school or skipping school or failing to succeed in school because he was simply overwhelmed and unable to carry out the tasks given. Every single representative from every single agency around that table simply replied, "That's not my mandate," until finally the father, who was at the end of his rope, threw himself forward on the table and sobbed, "I just want help for my son." Eventually that father left a message on my answering machine, threatening suicide. These parents are absolutely devastated and can no longer cope.

Often, mums who have FASD themselves are trying to raise children with FASD. They struggle with their own addictions, and they're totally unable to help their children with their addictions. Did you know that individuals with FASD are prone to addictions?

Last week a partnering agency brought a 14-year-old young man to me, hoping I could explain to him what FASD was and how it was affecting his life. This boy is abusing both drugs and alcohol. I learned that his father, from whom he had just ran away, is a drug addict and an alcoholic. His mum, who suspects that she herself has FASD, is struggling with her own addictions. She has a new partner and they're both on the methadone treatment program. Grandma, too, is an alcoholic. When do we stop this flow of alcohol and drugs to our youth?

Who should be responsible for giving these children what they need to survive? We know what they need. They need, number one, an exterior brain. FASD guru Dr. Sterling Clarren from BC says they will need someone else to think for them for the rest of their lives. They need structure and guidelines. They can't make choices that are safe. They need quiet homes with no conflict. They need education with the proper one-on-one supervision, if necessary. They need legal representation. They need counselling for addictions, not by ordinary addiction counsellors but by counsellors who understand FASD. They need careers where they can become contributing members of society. They need respect from the community. They need assistance with handling money and life skills. They need a chance to cultivate their own interests. They need people who will help them reach their potential.

According to the Public Health Agency of Canada, there are 300,000 people living in Canada with FASD, and estimated costs range from \$2 million to \$5 million to raise each child affected by alcohol.

When these youth reach adulthood, if they can be kept alive and out of jail, they frequently are able to have a job, but they may need extra training by employers who are educated about FASD.

Children who have FASD are delightful people. They're eager to please, so much so that they frequently admit to police officers doing things they didn't do, just because they want to please them. They're conscientious when given appropriate supervision and instructions. They have a sense of humour. They love animals. They want to be independent, contributing members of society, and they can, if provisions are made.

A few years ago, the crime prevention centre provided funds to have a needs assessment done in the district of Nipissing. The gaps in services were significant: lack of adequate respite for parents, and lack of education about FASD for doctors, lawyers, police, front-line workers. Few of those gaps have been filled for the mainstream community.

In the 1980s, MPP George Mammoliti's apology was sufficient. To the Select Committee on Mental Health and Addictions on September 10, 2009, I'm saying that no apology will suffice today. Only steps toward addressing FASD problems are acceptable.

I'd like to close by reading a letter by one of the parents. I hope it will move you as it has moved many others. Others have been sympathetic, but they have no resources. You, the Select Committee on Mental Health and Addictions, are in a position to bring about the change which is so badly needed. Here are excerpts from the letter, which I have permission to read. I choose to omit the father's surname.

"My name is John, and I live in North Bay, Ontario.

"I'm a single father, struggling to raise two children. My daughter is 16, and my son, who's 14, has fetal alcohol spectrum disorder. I would like to see community agencies more aware and more involved with families like mine.

"For example, when my son was arrested, the police did not know about FASD and did not appear to care. I believe they need to know much more before these kids end up in jail.

"They have permanent brain damage and there is no cure, but with help from services in the community, my son, and others like him, could receive proper help if we had funding. In our district, we have to have our own diagnostic clinic instead of having to drive to Toronto.

"My son and I were both mistreated by the school and by the police because of their lack of education of FASD. Our frustration over agencies' apparent lack of knowledge has caused constant anguish and frustration. I've been called a bad parent because of my son's actions when, in fact, had they been knowledgeable about FASD, they would have understood the reason for his behaviours.

"There is help for drug addicts and there is help for alcoholics who choose to drink and do drugs, but there is no help for our children who did not ask for this disease.

"Sincerely,

"John."

I'm open to questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Elaine. Thanks for your presentation. You will be the third person that has spoken to us on FASD. Each time somebody else talks to the committee, we get a little bit more information.

You've left a good amount of time for questions. We're going to start with either Christine or Sylvia.

Mrs. Christine Elliott: My name is Christine Elliott. I'm one of the members of the committee. I thank you very much for your presentation today. It was quite helpful and illuminating.

One of the things that we're struggling with is—I agree with you; there is a need to educate physicians a little bit more on the effects and the presentation of FASD, as well as police, teachers and so on. But on the other hand, you have this sort of apparent contradiction that once there's a label that can be applied to it, people are reluctant to accept the label because of the stigma that seems to be attached to that.

What would your thoughts be on how to deal with that?

Ms. Elaine Cousineau: The parents that I see—their children are already labelled "stupid," "retarded," all kinds of things. They are very relieved to find a label that is meaningful. We're trying to bring it out of the closet. I try to assure these people that there is no shame. No mother ever, ever intentionally hurts their child. The circumstances: I guess she used alcohol for the pain or didn't know.

I did an FASD day yesterday in the mall, and I am shocked at the number of young girls—out of grade 12, going to university, she did not know alcohol could cause damage in pregnancy, and she has already had a baby.

I don't mind the label. The people I work with don't mind the label. I think it's how it's handled.

You did mention something about doctors needing more training. I understand they get hardly any. In fact, somebody showed me a textbook; I think there probably were 20 lines about FASD.

Mrs. Christine Elliott: Thank you.

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

M^{me} France Gélinas: Hello, Madame Cousineau. I would be interested in finding out, and if you could explain to the committee briefly, the steps you had to go through to get a diagnostic service for your son.

I'm from northern Ontario. A lot of people that I've talked to have to go through a lot of, let's just say, pain and heartache to get a diagnostic clinic mainly because we cannot get one in northern Ontario. I would like you to share your experience with the committee.

0920

Ms. Elaine Cousineau: I can share what I'm doing with many of families that come to us. I'll give you the example of a young mom who, herself, in her own words said, "I know I have FASD. My mom drank." She saw the characteristics in herself. She has three children that

she drank with, so we sent her down to Toronto, to St. Mike's hospital, to Dr. Brenda Stade's clinic, to get those children diagnosed. Can you imagine travelling four and a half hours in a car with three children with FASD and staying overnight? It's horrific. And she was a lucky one because we were able to get some financial support for her, but other families who don't have that support don't get it.

We also have tried a telediagnostic clinic. It worked well, but St. Mike's hospital paid for our five kids to be diagnosed that day. We should be paying for our own kids to be diagnosed. I tried to get a diagnostic clinic going here, even though a Sick Kids hospital representative once said to me, "Elaine, you'll never get a diagnostic clinic in North Bay." Well, I have five pediatricians interested. I've got a speech therapist. I think I've got seven people altogether.

When we met, the psychologist's first words to me were, "Who's going to pay us?" And I said, "Do you think I should have had the finances in place before I called the people together?" He said, "Yes," and I said to him, "How will I ever get financing and funding if I can't prove I've got people interested?" So he seemed to agree with me. But if we need the diagnosis now, we have to send them down to Toronto.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Are there any questions from this side?

Thank you for joining us today, Elaine. It was really informative.

Ms. Elaine Cousineau: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for taking the time out of your day. As I said, you're the third person who has approached us. We heard from people in Toronto and we heard from people from fetal alcohol syndrome organizations in Ottawa yesterday as well.

Ms. Elaine Cousineau: Wonderful.

The Chair (Mr. Kevin Daniel Flynn): So you're starting to get your message across, if you think you're not.

Ms. Elaine Cousineau: That's a relief. Thanks very much.

The Chair (Mr. Kevin Daniel Flynn): Thanks for joining us.

Ms. Elaine Cousineau: Bye.

The Chair (Mr. Kevin Daniel Flynn): Bye. Thanks to the audience for listening in.

SUDBURY ACTION CENTRE FOR YOUTH

The Chair (Mr. Kevin Daniel Flynn): It's 9:20, and our next delegation is from the Sudbury Action Centre for Youth; Mardi Taylor. Make yourself comfortable. Everybody is getting 20 minutes in this round. There are some clean glasses and some water if you need some. Use the time as you see fit, and then, if there's any time at the end, we'll split it amongst the members who are

here today. The mikes seem to work best when you're about a foot away from them.

Ms. Mardi Taylor: Okay. I'd also like to introduce Ken Wallenius. He is the youth program coordinator at the Sudbury Action Centre for Youth.

The Chair (Mr. Kevin Daniel Flynn): Welcome, Ken.

Ms. Mardi Taylor: Good morning. My name is Mardi Taylor. I'm the executive director of the Sudbury Action Centre for Youth, and I appreciate the opportunity to address the committee today.

I'd like to tell you a little bit about our agency. We were established in 1986, and we exist to serve the most vulnerable members of the Sudbury community. We offer programs through three main program areas: our casual labour employment centre; our harm reduction area, including IDU/HIV outreach and a fixed-point needle exchange program; and our youth program and drop-in.

Our casual labour employment centre is actually the original program of the agency. As you can see on your handout, it's there to offer an honest day's pay for an honest day's work. For the latest fiscal year ending March 31, 2009, we placed 304 clients—50% of them had no income; 33% of them are homeless—in a total of 3,888 short-term and casual labour jobs. We also assisted 600 employers. Who makes up the main percentage of our employers? Over 80% of them are seniors owning residences in Sudbury. So this program also provides a valuable social service in assisting people to stay in their own homes. We also offer clients assistance preparing cover letters and resumé and with their job search.

In our harm reduction area, we offer an injection drug users/HIV outreach program five nights a week. We distribute harm reduction supplies to clients, and we go to where they are located. We offer education, information and support.

With the Point needle exchange, we distribute, on average, 21,000 clean needles per month and take in almost an equal number of used needles through our needle exchange program. The needle exchange, the Point, has been awarded a national award through the Donner award foundation, and is, again, a finalist this year of over 550 agencies from across the country. We feel that we have a pretty good track record, and we feel that we know what we're doing in the area of addictions, specifically.

But I'm not here to talk to you about that today. Today I'm here to talk to you about our youth and the struggles that they face, and I'd like to tell you a little bit about our youth drop-in. Our youth drop-in is a safe, non-judgmental place, where at-risk and high-risk youth can go in the Sudbury community. We're open Mondays and Tuesdays from 8 a.m. to 8 p.m.; Wednesdays to Fridays, 8 a.m. to 10 p.m.; and Saturdays from 2 p.m. to 10 p.m. Through the youth drop-in centre, there's always a trained youth worker on duty. We offer recreational activities for the youth to engage in, all at no cost. We serve hot meals every day that the drop-in is open. We

also offer a full-time housing support worker, because approximately half the youth who access our centre are homeless. We have a new partnership that we're beginning with one of the local school boards, where we have a teacher in the drop-in daily to help the youth improve their education and to assign high school credits. And through the drop-in, we also offer a variety of programs and services.

That's why I'm here to talk to you today. I want to talk to you about the mental health and addictions awareness group that we offer through our program. Right now, it's funded through a three-year Trillium grant. We offer a weekly workshop where youth discuss mental health and addiction issues. Keeping in our philosophy to truly engage our youth, we encourage youth to set the agenda and determine the content. For example, topics from this month include pregnancy and mental health; epilepsy; positive thinking; and your body, your rights, your responsibilities.

Some current numbers for you for this past year ending August 2009: 62 registered clients, all of whom are youth between the ages of 16 and 24 years of age, accessed the program; 25 of these clients were or are actively struggling with addiction issues; 29 of these clients are struggling with severe mental health issues; and 15 of these clients are dealing with both. These 62 clients accessed the program over 230 times, but unfortunately, our funding, our Trillium grant, ends next month; it ends at the end of October 2009. Now, that Trillium grant was for a total of \$75,000 over three years, so I think that was pretty good value that was offered for the funding.

The issue in my mind is the lack of core funding to support groups such as this. The lack of core funding results in a lack of continuity in programming and services offered; also, a lack of continuity in stability in staff. For example, for this three-year project we had a total of three staff, because the problem is, it's a contract position, and as soon as they get a more stable job, off they go. I don't blame them, but it makes it very, very difficult to keep the continuity. We continued to offer excellence in service, but the problem is that when the project grant ends, the program ends.

0930

What needs to change? Well, I think we need to support community-based programs such as the mental health and addiction awareness group through core funding, because this kind of program provides immediate support. There are no wait lists, there's immediate crisis support and we're able to offer our clients referral to programs which can help them. In the meantime, we can keep them safe while they're waiting. The awareness group educates the clients about the system and how to access services and the youth also receive support through the drop-in and their relationship with our youth staff. They're here in the program and the drop-in anyway and they feel safe. It's a safe place for them.

Our staff is also well qualified to provide this service. All of our staff have a minimum of post-secondary

education in counselling or some sort of social service program. The majority of our youth staff are graduates of the child and youth worker program at community college. But we also have a registered social worker on staff, and we also have another staff with a university degree. One of our staff is even a former client of our program whom we assisted. She went on and got her social service worker's diploma, and now she serves as a wonderful example and role model for youth—that they can make it, so to speak. Our needle exchange manager has a master's degree. So all of our staff are very well qualified. Yes, we're front-line, but we do that because we choose to do that.

We offer wonderful, immediate support when the client can't access the services and programs, or inpatient or more therapeutic programs right away.

We need core funding because this kind of group needs to continue. We see it all of the time. We see our youth come in every day. It needs to continue, but it won't.

I want to talk to you a little bit about one of our clients. We're going to call her Sarah. Sarah is actually a composite of several youth who have gone through this awareness program. She's female and is aged 21. She's struggling with depression and has been addicted to opiates and alcohol for the past eight years. When she was younger, she was molested by an older man and this man had hepatitis C and was HIV-positive. When she reported the abuse and the man was sentenced to jail, he threatened to kill her when he got out. Others in Sarah's environment also threatened her and spread rumours that she was also infected. Sarah experienced several depressive episodes and attempted suicide by jumping off a building. With the help and support of the awareness group and the group facilitators, Sarah is attempting to enter rehab and get her life back on track. The group continues to support her while she waits to enter the rehab.

What's going to happen to Sarah? Our final awareness group is Wednesday, October 28, 2009. That's about six weeks away. Although we've applied for private foundations and other proposals, they've been turned down. We no longer have funding to continue this program. The awareness staff facilitator who is our registered social worker will be out of a job, and that's a loss not just for the program but for us as an agency and especially for the youth at our centre, because it takes a long time to build up that trust and build up that relationship. But most importantly, what will happen to Sarah and the other 61 youth who've been through the program this past year?

Unfortunately, this isn't an isolated problem, because most of our agency's programs on the youth side—what we do—are all funded through project-based funding. So when the project ends, the program ends. Staff turn over more frequently because they don't have job security or stability.

We're not the only agency facing this. It's difficult for all local agencies to offer consistency and programs and staff for clients who need it the most.

I'm asking you here today to consider and take the message back for the government to invest in core fund-

ing of these types of programs because it allows the community partnerships to work; for example, our partnerships with the school board and with the Greater Sudbury police. Our agency is very unique. We do what nobody else in Sudbury does. We're also very good at working with our community partners, such as the school board, such as the Greater Sudbury Police Service. Lots of times we have the police drop the youth off at our centre because they'd rather have them come to our centre than take them to jail.

We're more than happy to explore working with the medical and clinical and therapeutic system. We can offer the immediate support that our clients need. I'm sure your committee has heard clients and consumers tell you over and over again that they cannot wait, that when they are ready to go, they want to go now; they need the help now. I'm asking you to let us help. That's what we do, and we think we do it really well. Core funding will allow us to keep doing what we do best: provide immediate, front-line support for Sarah and all the others.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Just for the benefit of the committee, just to aid in everyone's evaluation, on slide number 7—it's a kind of process-oriented slide; it's not very outcome-oriented—you've got 62 clients who were registered between August 2008 and August 2009. How many of those were you able to move into active treatment, into rehab or into treatment programs?

Ms. Mardi Taylor: I don't have that information with me. I can find out.

The Chair (Mr. Kevin Daniel Flynn): Could we get it?

Ms. Mardi Taylor: Yes.

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

M^{me} France Gélinas: Good morning. It's nice to see you. Maybe I'll take you back to his question, but frame it a little bit differently. Can you talk to us about the waiting lists for services or the lack of services available to your clients? Your clients go to you, there's no waiting list, they're in that really privileged situation where they want change in their lives, either to get into Iris recovery or to get into some kind of other programs—but either those programs are not available in Sudbury or the waiting lists are very long. Sarah could have gone to Iris Addiction Recovery for Women, but how long is the waiting list to go there, or for any other services—because I know you have a long list of partnerships.

Ms. Mardi Taylor: I know that the staff over in the harm reduction area talk about their clients having to wait three to six months, depending. There is also an in-treatment program in North Bay that they sometimes go to, and there's usually quite a long wait for that as well. There's not a lot even available for them to go to, but the hospital programs—we were meeting with them last week, and usually it's at least weeks for them to get in through something at the hospital. I'm not up on everything that's available because it's more the front-line staff who know that kind of thing, but it's certainly

not immediate. So we're talking anywhere from six weeks to a matter of months, if it's more of a residential kind of treatment.

M^{me} France Gélinas: Some of your clients are very young, so if you want to talk about the issue of income support—they don't qualify for OW—and all the problems that this brings, as well as housing them.

Ms. Mardi Taylor: The 16- and 17-year-olds, specifically, have no income because a lot of them don't have adults in their lives who can act as the guarantors. So when they come to us, they have no income, no support. They're homeless.

0940

Our housing worker spends a lot of time, but there's really not a lot that they can do. So in the summer, we've got tent cities all over the city. Many of her clients are in tent cities. During the winter, of course, there's not a lot of shelters. There are two youth shelters in Sudbury—one for females, one for males—up until the age of 18, but they're very, very restricted in terms of abstinence, that kind of thing. A lot of our youth just can't follow those rules and so they basically are kicked out of the shelter and then they have no place to go. So our housing worker is doing revolving-door work.

When you combine all of these issues with issues like mental health and addictions, it creates a real problem, which is why we have our drop-in. I've given you the hours, but we need to be open more.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mardi. We're going to move on. Maria, and then Jeff, if there's time.

Mrs. Maria Van Bommel: Thank you very much. You're the Sudbury Action Centre. Do you serve just the greater Sudbury area or do you serve a greater area than that?

Ms. Mardi Taylor: People come in from outlying areas, but we're located right downtown, where most of our clients are.

Mrs. Maria Van Bommel: You talked about the Point needle exchange, the numbers. I did quick math and it works out to over 600 a day that you're distributing. That's quite a lot. Is that number trending up or trending down, and can you explain what might be happening out there?

Ms. Mardi Taylor: It's trending up. Actually, our high point was May of this year, when we distributed 33,000 clean needles. We're second in the province to the Toronto needle exchange, but obviously our population is much less. The reason our needle exchange is so successful, if you will, is because the health unit contracts us to run the needle exchange and we're located right downtown where the majority of the clients are. We're easy, we're accessible, we're anonymous and we're now getting the word out.

There is core funding for that program, and our two needle exchange staff have been there for 15 years. So as you can imagine, the relationships have been built up and the numbers bear that out.

Mrs. Maria Van Bommel: Thank you.

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

Mr. Jeff Leal: Thank you very much for your compelling presentation. What's your relationship with the local LHIN that covers Sudbury—the local health integration network—in terms of their planning and work in a variety of health-related areas?

Ms. Mardi Taylor: We receive no LHIN funding. I don't have a relationship with them.

Mr. Jeff Leal: My second question: Are you also seeing—many police forces across Ontario are seeing a dramatic increase of youth using OxyContin and Percocet. Is that a trend here in Sudbury too?

Ms. Mardi Taylor: Yes.

Mr. Jeff Leal: My last question is: Our previous presenter talked about fetal alcohol spectrum disorder and talked about having 15 agencies together at a table and none of them able to help someone's son. Do you see that as a bit of a barrier, that we have multi agencies that are not getting to the core of the problem?

Ms. Mardi Taylor: I would say that many of our clients have fetal alcohol syndrome, and our workers are very aware of the problems there.

I think, in Sudbury, we do a good job of sharing resources and not duplicating services, but I think it's certainly something—it's always good when the agencies get to the table and agree to provide services in a coordinated manner.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mardi. We're going to have to move on. We're actually out of time. Sylvia's got a very brief question and hopefully a very brief answer.

Ms. Sylvia Jones: You mentioned that you had tried to access some private foundation money, knowing that the Trillium grant was coming to an end. Have you approached children and youth services with that problem?

Ms. Mardi Taylor: I wrote children and youth services and I have written them again, but—

Ms. Sylvia Jones: No response?

Ms. Mardi Taylor: Well, I got a response last fall saying that there was no funding available for us. We're not funded—any of our programs—through them.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Jeff, did you have a brief question that needed a brief answer? If we can do it—

Mr. Jeff Leal: No, I'm okay.

The Chair (Mr. Kevin Daniel Flynn): You're okay? Good. Okay. I want to keep us moving along. I don't want to cut off the debate.

Thank you very much for your presentation. Thanks for what you do on the streets as well.

Ms. Mardi Taylor: Thank you for your time.

CANADIAN MENTAL HEALTH ASSOCIATION,
SUDBURY-MANITOULIN BRANCH

The Chair (Mr. Kevin Daniel Flynn): We've got the Canadian Mental Health Association, Sudbury-

Manitoulin branch; Marion Quigley and Michael Clark. Make yourselves comfortable. There's some water and clean glasses there if you need it. Everybody's getting 20 minutes, as you've seen. You can use that time as you see fit, and at the end, hopefully there will be a bit of time for some questions. The mikes seem to be working well this morning. Hopefully I haven't jinxed them now by saying that. They weren't working well in Ottawa yesterday. It's all yours.

Ms. Marion Quigley: Good morning. My name is Marion Quigley. I'm the chief executive officer of the Canadian Mental Health Association, Sudbury-Manitoulin. I'm joined here today by Michael Clark, who is a "warm line" coordinator at our office.

The Canadian Mental Health Association was established in 1984 and is a not-for-profit organization with a volunteer board of directors, and is mandated to provide services to adults 16 and older with a diagnosis of a serious and persistent mental illness within the Sudbury-Manitoulin district.

CMHA is an agency that is primarily funded by LHIN 13 and the Ministry of Health and Long-Term Care, and also receives funds from the Ministry of Children and Youth Services, United Way, the city of Greater Sudbury, the Ministry of the Attorney General and the Ontario Trillium Foundation.

CMHA provides services through a recovery and rehabilitation approach by assessing and developing readiness for change and helping people regain a meaningful role in their community. This approach runs throughout our organization and includes how things are done, how we communicate, how decisions are made and how we live our values. It is about how we respect and value individuals and how we create a healthy environment for our clients.

Today, we're here to talk frankly about our clients' needs. First, I want to give you a few statistics: 10.4% of Canadians are living with mental illness; roughly two thirds of those who experience mental illness do not receive treatment; 86% of homeless people show symptoms of either mental illness or substance abuse.

In 2008, in the city of Greater Sudbury, there were over 1,300 people at imminent risk of homelessness and over 600 people living on the street.

It has been known for a long time that people who have lived through mental health issues have a better chance at recovery if they have a home, a job and a friend. People know this intuitively; many government officials do, too, but the complex nature of our province's bureaucracy makes it difficult to address the holistic issues of persons with lived experience, and makes it confusing and somewhat inaccessible for those persons, which can lead to homelessness, poverty and joblessness, along with attendant emotions of alienation and isolation.

Recovery is the foundation on which all CMHA mental health services are provided. Recovery is a journey of healing and transformation that helps a person with a mental health problem live a meaningful life while striving to achieve their full potential.

Psychiatric rehabilitation is the process CMHA in Sudbury utilizes to provide services to assist clients in receiving the skills and supports they need in order to be both successful and satisfied in the living, learning, working and social environment of their choice. We believe in the potential that individuals can move beyond remaining a mental health patient to attain a meaningful role in society when skills and supports are provided.

I'm happy to tell you that there has been considerable progress in the acceptance of mental health issues in our communities over the past five years due to public awareness programs. This has been proven to us through an increase in referrals to our organization. We are continually working with our northern partners to look for opportunities to inform our communities on good mental health practices.

Further, we recognize that a key priority of the select committee is to improve health system access and navigation. We'd like to identify some initiatives that are under way in our community that would demonstrate this.

The Ontario Common Assessment of Need, OCAN, project is being piloted in LHIN 13 to enhance the sector's capacity to streamline and standardize the assessment process. This common assessment tool will ensure that every consumer is assessed using a standardized decision-making tool that allows key information to be electronically gathered in a quick and secure manner. It offers consumers an effective way to voice their needs and preferences for care and is consistent with a recovery approach.

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CMHA has had an information referral program for several years to assist people in navigating the mental health and addiction system. Through ministry funding in 2003 CMHA expanded this program to the community mental health programs at the hospital. So we now have one of our staff working at their site. In our community we want people to find services they need at whatever door they enter.

We're currently working to enhance our central intake program on Manitoulin Island with our partners there.

We also want to stress the importance of case management as it improves access and coordination of services for persons who are marginalized and at risk of falling through the cracks. We have found that case management has been shown to significantly improve housing stability and community functioning, and to reduce visits both to the emergency department and hospital admissions among people with serious mental illness. As an example, this is seen through our release-from-custody program.

But in the context of our recovery-oriented practice, we see a variety of gaps in our mental health system, including in social service and health system navigation, housing, employment, social supports, and the justice and court systems. I'll address each of these in turn.

System navigation: First and foremost, as a province and as stakeholders in the mental health system here in

Ontario, we need to do a better job of coordinating policies and programs between various ministries and organizations at the interface of need, diagnosis, rehabilitation and recovery of individuals, so that they experience smoother transitions and better outcomes for themselves and society as a whole.

Primary health care: People with mental illness in Ontario often have difficulty getting primary care, such as seeing a family doctor. At the same time, family doctors are often the first point of contact with the health care system for people with mental illness, and many of these family doctors need support in pursuing treatment for their patient's recovery.

We need to ensure that all individuals have access to primary health care. Overcrowded emergency care, the lack of family physicians, few trained psychologists and psychiatrists, particularly in the north, where there is an increased need for psychiatric and psychological post-traumatic stress counselling for survivors and descendents of residential school survivors—the list goes on.

Committee members, as you can imagine, it's hard to navigate a system that has pieces missing. Just imagine that you have few coping and interpersonal skills—it's a very dark image to conjure in the 21st century.

Housing: From my experience, the most important issue facing our clients today is housing in our community. Everyone needs to live somewhere in order to be able to work or play. According to the Housing Network of Ontario, creating and maintaining stable, available, accessible and adequate affordable housing is good social policy. People in stable housing are more healthy, more productive, do better in school and become more engaged in their neighbourhoods.

Right now, CMHA provides 24 units of apartment living with minimal support; an eight-bed shared-living home with medium support; housing outreach; property services and rent supplement.

Our housing services are provided in the context of our recovery-oriented philosophy. We have an integrated approach to addressing both mental health and addiction issues to help ensure that clients receive both support and skills necessary to be successful. Our property services administer the rent supplement program, which provides some financial assistance to approved agency applicants with their rent to reduce the risk of homelessness and obtain affordable housing.

In our community, we have been in the business of supportive housing for a very long time. There's been an increased demand for housing for individuals requiring rent support. Market rent has increased dramatically, and the 0.3% vacancy rate in the Sudbury district makes it difficult for individuals to find and afford decent housing. Unfortunately, we don't have enough housing to fill the need. People who come to us are waiting for two years or more to be accepted into our housing program.

However, we also know that many, many people with mental illness, some of whom are at serious risk and who may not know of or use our services, live in substandard housing in our community that is physically inadequate,

crowded, noisy and located in undesirable neighbourhoods.

Maintaining and improving the housing of individuals with serious mental illness can contribute to a reduction in psychiatric symptoms and decrease the need for emergency and treatment services.

Supportive housing is economical. It costs far less to provide supportive housing than to provide a shelter bed to a homeless person or care in a psychiatric facility. According to the Mental Health Commission of Canada, as quoted in the *Toronto Star* this past year, it costs \$34,000 a year to support someone living with a serious mental illness in the community compared to \$170,000 to keep them in a hospital-type setting.

Housing is essential for recovery, and there is a shortage of affordable housing as well as supportive and supported housing in our area—the definitions are in your handouts today.

People who can upgrade their living conditions often have increased opportunities to sustain employment, support a life of dignity and adequacy and attain essential social resources such as adult learning. Individuals living in poverty are more likely to develop a variety of illnesses and injuries, experience hospitalization, recidivism, mental health problems and difficulties in learning.

Finally, CMHA is in the process of securing funds to develop a housing implementation plan. Our community needs a road map that will allow us to identify and address a variety of gaps, such as the development of a 24/7 high-support home, a transitional home for up to three months' stay, accommodation for people leaving the jail system etc.

People with lived experience should not have to wait for two years, and they should have a choice of the type of home environment they require.

Employment, income and social supports: Research has shown that the recovery journey in the context of mental illness is complex and unique. Individuals have different understandings of recovery. One of the greatest needs in our community is more education about the recovery process and the values of the work experience to assist individuals to integrate, or reintegrate those in recovery back as a valued member of their community. Employers still seem misinformed about employment support services. We like the idea of more formal partnerships in this regard.

Strategies that promote social inclusion create environments that foster social connections, companionship and social support. Clients need access to affordable recreation and physical activity programs in our communities, opportunities for both youth and adults to participate in arts and cultural activities and increased structured opportunities for volunteerism and civic participation.

I just want to take a minute to talk about our clients and the justice system. Recently, Dr. Phil Klassen of the department of psychiatry at the University of Toronto stated the following to a group of crown attorneys:

“Most of the risk of committing criminal offences by mentally disordered people arises from factors other than

their mental illness, including factors like homelessness, isolation, poverty and age—which are better indicators of risk of criminal behaviour.

“Many people assume that people with schizophrenia always commit offences when they go off their meds and develop psychotic symptoms. However, 100% of people with schizophrenia go off their meds and develop psychotic symptoms at some point in their lives, yet only 20% to 25% of people with schizophrenia have criminal records. The clinical factors of people with the illness of schizophrenia are not a significant factor in assessing their risk of criminal behaviour.”

There need to be better mental health supports in our jails. We need to work on those issues that put people in jail in the first place, such as the inability to cope, lack of skills, homelessness and poverty. Further, successful discharge of some of our clients from jail into the community requires enhancements of our community's supports to help those discharged to stay well. Our “warm line” and our release-from-custody program have evolved into such aids.

More housing options are needed to assist with individuals who are being released from custody and/or who are living in the community and part of our diversion program. This would address people who are involved with the justice program and have treatment needs. Some individuals are currently being sent to jail rather than receiving treatment. These individuals would benefit from a home that is staffed 24/7 and which would have a medical component, but would be less expensive and better suited to their needs than a jail or hospital bed—so a home, a job and a friend, housing, employment support, a helping hand when life is getting out of control.

I now want to let a person who has lived through these issues speak briefly about his experiences. Michael?

Mr. Michael Clark: Good morning. My name is Michael Clark. I'm a person with lived experience of mental health and addictions.

Fourteen years ago, I was an active IV drug user living on the streets of Vancouver. After coming back to Ontario, I found recovery and worked through a lot of childhood core issues. I was soon diagnosed with bipolar disorder and began a regimen of medication that lasted eight years.

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My first exposure working with mental health was in 2003. I was asked to work in a café in Kitchener whose main clientele was individuals with concurrent disorders. I got to know a lot of people on a personal basis, their struggles with their illnesses and addictions. Being in recovery for some time and then working with people with severe mental illnesses was like putting on the other shoe.

After coming back to Sudbury, one of my safe places was the Canadian Mental Health Association, and I soon learned of the various programs offered there. In 2008, I learned of the “warm line” program and filled out an application. I needed to complete some programs before

gaining employment. The organization offered another excellent program called the wellness recovery action plan. These programs assisted me in my personal growth and gave me a support system in every area of my life, and because I was in a 12-step program, they worked so well together.

The next step was a program called peer resources. This gave me a better insight into communication skills. Applied suicide intervention skills training was an intense program that involved more communication skills designed to help all caregivers become more comfortable, competent and confident when dealing with persons at risk of suicide.

I began employment as a warm line support worker, and I found a gratifying purpose. I have never felt this way before. To be able to use the training had made me more effective with callers who presented problems. I work with 10 other staff who have experience with mental illnesses who wholeheartedly give of themselves. I have much respect for these individuals. Some of them have been working since the warm line's inception. In the spring of 2009, I became the warm line coordinator.

The Canadian Mental Health Association, Sudbury-Manitoulin Branch, started up its warm line program in 2000 with the support of the Ontario Trillium Foundation, and later used the restructuring of another program to find ongoing financial resources. With the assistance of United Way funds, the program also added weekend hours for this past year. Operating seven days a week from 6 o'clock to 10 p.m., the warm line provides support during the time when many community mental health services are closed. We are uncertain if United Way will continue to fund us for weekends.

The warm line receives an average of 15 to 20 calls per evening, with many repeat callers and a higher volume of callers during the winter months. While based in Sudbury, this warm line receives calls from across Ontario and as far away as New Brunswick and British Columbia. I've explained in a recent Network Magazine article that the Sudbury warm line's popularity is due to its reputation for providing real support: "They say that at the Sudbury warm line, the people listen. There's more empathy, more of a personal touch, and that we are focused on them, the caller."

Consumer staff are there to empower callers to make their own decisions about how best to de-escalate their crisis. The goal is to have callers arrive at their own decision as to when and whether to seek help or treatment: "We don't really give advice.... Whatever their crisis may be, we always try to guide [the callers] to come up with their own answers and make their own decisions. We're there to support them through the whole process. When I finish my call, I'm always asking them to call me back tomorrow and let us know how things are going—the follow-up is really important."

The success of Sudbury's warm line is rooted in the peer support model: "I think the most important thing about a warm line is that it's run by consumers.... The callers know that the person on the phone can empathize

and this may make them more willing to talk about what's going on."

Warm lines, staffed by mental health consumers, are supportive and confidential telephone chat lines used by consumers, their families, members, caregivers and friends. Whether callers are feeling lonely or depressed, facing challenges in their recovery or even experiencing periods of positive change that they wish to share with someone, there is an empathetic voice on the other end of the line who is trained in active listening and there to offer emotional support. Information and referrals to other community programs and services may also be provided. Warm lines are proving to be a powerful approach to reducing hospitalization and are decreasing the number of non-crisis calls received by the crisis intervention program.

So to conclude, I was lucky to find the appropriate supports and turn my life around. I was an active IV user; now I am not. I am now a person with lived experience of mental illness and addiction who has a job as a warm line coordinator. I have many friends both at work and in the community, and I have a home. All this was possible because I wanted to be a helper, and as a result, I feel that I am a better person.

Thank you for the opportunity to tell you my story.

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

We've got about 30 seconds left if you wanted to wrap up.

Ms. Marion Quigley: It's okay. We'll wait for any questions.

The Chair (Mr. Kevin Daniel Flynn): There are probably a lot of questions; unfortunately, there's not a lot of time.

Ms. Marion Quigley: I know. We had a lot to say, and we had to read it fast. I couldn't read any faster.

The Chair (Mr. Kevin Daniel Flynn): You did a very good job of your presentation today. Thank you very much. Thank you, Michael.

Mrs. Liz Sandals: Could we just ask one question of clarification?

The Chair (Mr. Kevin Daniel Flynn): Sure—but short.

Mrs. Liz Sandals: The warm line sounds really interesting, but I haven't heard the term before, and I just want to understand what a warm line is. I take it from your remarks that a warm line is sort of a combination of a crisis line and peer support.

Mr. Michael Clark: It's not a crisis line. It's pre-crisis.

Mrs. Liz Sandals: Okay. But it's peer support because the people you will get to talk to are people who have lived experience of mental health and addiction?

Mr. Michael Clark: As well as the people who are running the line.

Mrs. Liz Sandals: Yes. Okay, thank you for that. Now I know what we're talking about.

Ms. Marion Quigley: There are about five warm lines in the province of Ontario. Progress Place in Toronto was

the first one, so we modelled ours after that. It's always consumers running them.

Mrs. Liz Sandals: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): I wouldn't worry about the lack of time for questions. You did a great job in your presentation. You got your point across very clearly. Thank you.

CINDY ROBIN

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning at 10 o'clock is Cindy Robin. Cindy, if you'd like to come forward. Are you all hooked up?

Ms. Cindy Robin: No. I was hooked up, but I had to unhook—

The Chair (Mr. Kevin Daniel Flynn): You got unhooked.

Ms. Cindy Robin: Hopefully that will happen quickly—

The Chair (Mr. Kevin Daniel Flynn): We'll give you some help too.

Ms. Cindy Robin: —and it won't eat into my 20 minutes.

The Chair (Mr. Kevin Daniel Flynn): Hey, I'm not that mean.

Ms. Cindy Robin: While I'm just hooking this up, I'm noticing that you folks have been sitting still for quite some time. If anybody needs to get up and stretch, please go ahead and feel welcome to.

Interjections.

The Chair (Mr. Kevin Daniel Flynn): Okay, Cindy, are you all set?

Ms. Cindy Robin: No. Actually, I had everything all set up there, but somehow from that plug to this plug it scrambled itself, so I'm having to reboot it from scratch.

1010

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

Ms. Cindy Robin: It's just going to take a couple of minutes. Sorry about that.

Mrs. Liz Sandals: We can read along here on the hard copy.

Ms. Cindy Robin: I'd like to do my PowerPoint if I can, just for simplicity's sake, because if I start with paper, then I'm not going to notice when this boots up, and I have to do some clicking to boot this up. We're almost there.

Oh, there we go. I was just going to give up and go by paper.

Welcome, folks. My name is Cindy Robin, and I'm a concurrent disorders worker with the mood and anxiety program at Sudbury Regional Hospital.

Now, you're looking at this slide and you're thinking, "Gee, this has got to be the quickest presentation that we're going to have today," actually, I wanted to start out by just saying thank you to all of you for taking the time to listen to myself and my colleagues and for taking an interest in mental health and addictions.

Before I go to the next slide, I just want to find out if folks are familiar with the term "concurrent disorder."

The Chair (Mr. Kevin Daniel Flynn): Yes, I think we all are.

Ms. Cindy Robin: Okay, wonderful. So I'm not going to go through that definition.

Folks, I'm sure, are also aware that within the category of concurrent disorders there are a lot of different people from all walks of life. Everybody know that song, "These are the people in your neighbourhood" from Sesame Street? We're looking at folks all over our community, as well as folks who are marginalized and living in poverty.

There are very high rates of concurrent disorders in the population. In one of the studies that's summarized in a document that has been published by Health Canada, 28.8% of the general population was found to qualify for having a concurrent disorder. That's more than two out of 10. Statistically, even if you look at this room, how many folks—do the math—would be potentially someone with a concurrent disorder? The rates are higher among those who seek treatment. I see folks who are seeking treatment. That's my area.

Another study in the document for concurrent disorders showed that 77% of people who were seeking help for an alcohol problem also qualified for a psychiatric diagnosis.

So the research has been done. The most effective approach for folks with concurrent disorders is integrated practice. Integrated practice, at its bare bones, is treating both the mental health issue and the substance use issue.

I'm going to tell you a little bit about myself and my viewpoint. Like I said, I'm the concurrent disorders worker with the mood and anxiety program. This is a new position for me, but I've been doing concurrent disorders work much longer. I come from the outpatient addictions and gambling services program with the hospital. We were formerly Pinegate, and then we became part of Sudbury Regional Hospital. So I'm a witness to the integration of mental health and addictions programs. All of these programs were scattered in different places throughout the community, and they all came together under one roof at 127 Cedar Street, which is our outpatient mental health and addictions treatment centre.

I formerly worked at John Howard Society, had some grassroots experience, and before that I was a counsellor for students at Conestoga College with mental health issues: stress, depression, anxiety and so on. I studied here in Sudbury and also in Waterloo, and I specialized in addictions when I finished my master of social work degree.

I resurrected the concurrent recovery group in 2007. I didn't do this alone. Actually, one of my partners in crime is sitting in the audience here, Lorie Bell, and she'll be presenting to you I think around 2 o'clock this afternoon. It's not a new group that I resurrected. However, when I left the community it had been running, and when I came back and was hired on by the hospital—by Pinegate at the time—it wasn't in the community any

more. That really saddened me, because I've been personally touched by folks in the community who have had concurrent disorders and have been in recovery.

One that stands out in my mind is a young woman whose name is Leslie. I won't give out her last name out of respect for the family. Leslie was in recovery for addiction and she also had a diagnosis of bipolar. She was a gorgeous, talented, compassionate, beautiful young woman and a dear friend. At the age of 28 years old, she put a needle in her arm and she overdosed. It was a huge loss to the community.

Leslie was the kind of person who just lived life to the fullest. You would see her and she would have purple paint all over her hands because she was making clay masks, and if she ran into somebody on the street, a bum on the street who was drunk, she would say, "Would you like help getting to detox?" and she would accompany him in a taxicab. She did achieve two years of sobriety but had a slip, and relapse is part of the recovery process.

She's one of my inspirations, and there are others in the community as well. So I just love seeing folks like our last speaker, Mike Clark. He's also a dear friend of mine. The amount of good that he does in the community is immeasurable. Most of it is anonymous, so there are no records of it, but I know from the folks I work with that he's making a huge difference.

The information that I'm going to be giving you isn't going to be at a management, executive, administrative level. It's from the viewpoint of a front-line counsellor and a citizen in the community. The folks that I work with individually generally all have concurrent disorders, and the group I've been running for the past few years involves folks with concurrent disorders. So the viewpoints that I'm sharing are coming from witnessing their lives and their struggles and their triumphs.

One of the important things to me was to change the name of the "concurrent disorders group" to "concurrent recovery group." Just take a moment and imagine that you're going in to see the doctor, and the doctor tells you that you have two disorders. You leave. How do you feel? Probably not so great, right? Probably worried, perhaps negative, discouraged. Now you go to see your doctor and your doctor tells you you're in recovery for two things. How do you feel? You feel a little bit more hopeful. So a big piece is nurturing and engendering hope in folks.

With the concurrent recovery group, of course, the aim is to provide integrated treatment, which has been shown to be the most effective type of treatment for these folks. It's a strength-based, self-empowerment structure which involves elements of collaborative therapy and solution-focused therapy. There's a skill-building component, narrative therapy and cognitive behavioural therapy. In its present form, there's co-facilitation between an addictions counsellor and a counsellor from the mental health program.

1020

What I've learned from folks is that mental health services and addiction services are very necessary. There

are lots of folks who want treatment, but it needs to be done in a respectful way. I've also learned that mental health and substance problems interact, and you need to treat them both.

I had it explained to me by a client that it's like a giant iceberg. For this client, the addiction problem was just the tip of the iceberg, the part that you see, and underneath was his depression. If he were to be well, he could be camped out right in the middle of the liquor store and he wouldn't drink, but if he was unwell and his mental illness was in a bad way, then he could be in the middle of the woods and he would find liquor and have a relapse. So they're very much intermingled.

Think of all the negative things that you've heard about folks with mental illness. Now, think about all the negative things you've heard about folks who have substance use disorders. Take all those comments and multiply them and you can get an inkling of what it's like to have double the stigma. To defeat stigma we need opportunities like this. We need to openly discuss mental health and addiction issues. We need to see the person and not the diagnosis, and provide treatment, education, supports and awareness. You'll notice in my handout—I don't actually have "treatment" on the slide. Treatment is huge and it's one of my main points.

I've seen, in the group and with my individual work with folks, a lot of strengths in people. These are folks who have various skills. They're very resourceful, extremely creative people. The non-judgmental empathy that I see in my group really touches your heart. There's a great capacity for joy. There's also a great capacity for pain, resilience, insight and hope.

I find, just looking at that insight one, that ordinary folks who don't have both a mental issue and a substance use disorder generally don't have to work on themselves as hard as folks who are dealing with these two things. What happens is, you have folks who really do a lot of deep digging into who they are. It's just amazing the amount of insight that folks gain. You'll find folks have intellectual curiosity, varying levels of education, wisdom, spirituality, self-awareness, compassion and respect.

My key theme that I want to bring out is the theme of untapped potential. When we, as a society, do not provide the treatment, services and supports that persons in concurrent recovery need, then we diminish their quality of life and we face an immeasurable loss of untapped human potential.

There are a lot of barriers to maximizing wellness, and you're going to hear about these throughout the day. We've heard from the earlier presenters about long wait times for treatment. Because I'm one of the people who provides treatment, that is very frustrating for me. I want to get to people right away. As soon as they phone in and say, "I want to do something about my addiction and mental health issue," I don't want them to have to wait two or three months. We need quality treatment, integrated treatment and funding for that.

There's also limited access to integrated residential treatment. We have to remember that residential

treatment isn't the magic bullet. It's very important for many folks to attend a residential treatment facility, but that's only one part of the treatment process. You also need to have the follow-up. You need to have the aftercare. You need to have maintenance programs that will help folks to continue in their changed lifestyle. Simply going for 30 days to a treatment centre and then coming out isn't enough.

Other barriers that I see are just the basic needs: poverty, housing, safety, security. When I have someone who has a concurrent disorder and they have a room in a home where people are abusing substances and partying, and this individual knows it's important for their mental health that they abstain, it's nearly impossible for them to achieve that goal being in that environment. When I think of housing, I'm thinking of private units that are clean so somebody can create their sanctuary for themselves. It doesn't have to be huge, but it needs to be clean and it needs to be safe.

There are numerous psychosocial stressors that my folks go through, and lack of supports. There's insufficient access to psychiatric care and frustrations about medications—folks sometimes feel like guinea pigs because they have to try different medications and find out which ones work, but they tend to bear with that because they know they need to—lack of medical care and stigma within medicine, lack of adaptive employment and educational opportunities, with some really brilliant exceptions like the warm line with CMHA.

There's a lack of accommodation for these folks. Sometimes places will be very accommodating for the more popular disabilities. However, because there's so much stigma attached to mental health and addiction, there's less accommodation in the workplace and in the education system. And then folks tend to blame themselves for the lack of a supportive environment: "I'm not reaching my potential; therefore I am inadequate. It's my fault."

More struggles—I'm going to breeze through these because I want to make sure I touch on what I need to touch on. When we're looking at healing, we're looking at assessment, including assessment for the addiction issues and mental health. We're looking at designing a treatment plan. We're looking at withdrawal management in many cases, individual and group therapy, education and skill-building. Knowledge is power.

We're looking, in many cases, at trauma treatment. A lot of my folks have been through indescribable trauma and abuse. So that is a piece of the puzzle in terms of making things better. With that trauma, there's a lot of self-blame that is part and parcel of the psychological repercussions of having been victimized.

Recreating leisure, feeling and facing emotions, embracing success and building healthy supports—so, witnessing the uniting of mental health and addictions under one roof, I've been able to see a lot of things that are working. Integration has provided access for addiction clients to psychiatrists. That's huge. We've also been able to put clients into the mental health groups. So my

addiction clients have been able to go to bipolar groups, social anxiety groups.

We've had service-wide initiatives. At Christmastime, at holiday time, it's very difficult for folks, so we opened it up to all of the clients with mental health and addiction issues to come to that. The holistic, multi-disciplinary approach provides what folks need.

I'm just skipping through this. Also, interorganizational collaboration has been really helpful. A lot of my folks benefit from use of the self-support groups, like Alcoholics Anonymous, and there is more of an openness now than there was in times past. With these self-support groups, they used to sometimes say, "You can't be taking your medication for mental health. That means you're using; you're relapsing." Because there are brave folks like Mr. Clark, who just spoke with you folks, who do open up about it now, the stigma is going down and folks are having that opportunity to share about it.

Effective treatment needs to be tailored to attack both the addiction problems and the mental health needs and to be uniquely tailored to the individual and their stage of readiness for change. So my request is for more funding for quality integrated treatment. There are effective treatments that work—the evidence shows it—and folks want treatment. We've got hundreds and hundreds of people on our waiting list, and we're not able to get to them because we just simply don't have enough counselors.

1030

The other asks that I'm putting out there are reducing wait times for folks who are seeking outpatient treatment for addictions and mental health, and then housing, which isn't my game; however, just working with my folks and seeing what they need, clean, private housing is huge. Also, increased access to residential treatment that involves integrated services. There are residential treatment centres. There's the Iris centre up here in the north; there's Nipissing treatment centre. We need more support and more funding initiatives for integrated treatment, both in the outpatient realm and in the residential treatment realm.

That winds me up, so thank you very much for your time and attention.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. That was good timing; you just ended on the beep.

Ms. Cindy Robin: I have this little clock up here at the top of the screen, so that kind of helped me a little bit.

The Chair (Mr. Kevin Daniel Flynn): That's perfect. Well, thank you very much for coming this morning. We really appreciate your presentation.

Ms. Cindy Robin: You're welcome.

The Chair (Mr. Kevin Daniel Flynn): I think you were very clear, and thanks for your time.

SOCIAL PLANNING COUNCIL OF SUDBURY

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning is Janet Gasparini from the Social

Planning Council of Sudbury. Janet, you've got 20 minutes; use it any way you see fit. If there is time at the end, we'll split it amongst the members for discussion.

Ms. Janet Gasparini: Perfect. Thank you, and thank you for coming to Sudbury. My name is Janet Gasparini and I'm the executive director of the social planning council here in Sudbury.

If you don't know, social planning councils are non-profit, charitable organizations that exist in some communities in Ontario and have a mandate for social research and community development in terms of social issues. So when the notice came that you were going to come to Sudbury, my office was notified and, as we often do, we convened a community consultation with a number of our partners so that we could talk about the report *Every Door Is the Right Door* that was put out by the Ministry of Health, have a look at it, and then I could come as a representative of that group and tell you what we talked about. So last Friday we met, and I have to tell you that there was very keen interest and that we had over 30 community partners come together to talk. It included people from the police department, from public health, front-line workers and families of people who were struggling with mental illness and addictions. The friendship centre was there; the Shkagamik-Kwe Health Centre was there. Mardi and her staff from the action centre, from whom you heard a brilliant presentation, were there. Three of the four school boards in the area were there.

It was a testament to the fact that mental health and addictions issues cross all of those boundaries, that we are struggling with the impact and the effects of mental health and addictions anywhere that we work in community. So it's exciting to have an opportunity to talk about what we need, not only from the Ministry of Health but from the government of Ontario, in crossing all of those barriers and boundaries and making it easy for us to work in community in an integrated fashion. We're actually very good at that, at community, when we're given the tools, the resources and the capacity to do it, and I'm going to give you some examples and hopefully some information about how we might implement this in a more effective way on the ground.

I'm going to give you just some of the feedback from the group. We did a little PowerPoint presentation. They all got the document ahead of time. We went through the basic premises of the document, and overall, people were very impressed—

The Chair (Mr. Kevin Daniel Flynn): I'm going to jump in there just for a second, Janet. Just so you don't feel sort of confined, the report was issued by the minister's advisory group. There's been some confusion as we've been travelling around; some people think we are the minister's advisory group, and we're not. So don't feel confined—you can talk about the report, but you don't have to only talk about the report. You can talk about anything you want.

Ms. Janet Gasparini: No, we realize that in fact it was not your report, but we thought it was a very good

stepping stone, right? We think the report is good. We thought it provided a very good basis for the conversation, a good place to start. So rather than talk about all the issues—and I went to the website and read a lot of the feedback that you're getting at the panel. You're hearing from survivors; you're hearing from mental health workers; you're hearing all the things you need to hear.

What we wanted to bring to you was a community approach around how to do integrated service delivery, because for us, it's a given that that would be the way we go. It would be an integrated service delivery model. We've used it in other areas and we know that it's effective. So for us, it was a good starting point, as opposed to just, in general, what are people concerned about in terms of mental health? I think you're getting a good sense of that as you travel across the province. What we wanted to focus on was what, in fact, would happen in a community if that document became the basis of the government's strategy. So I'm aware that you're a different group, but we still thought that was a good place to start.

The Chair (Mr. Kevin Daniel Flynn): We're still nice people.

Ms. Janet Gasparini: You're still very nice people; absolutely.

We talked a lot about what was in the document, and there was strong support for what was in the document. Of course, there was talk about what isn't in the document and what needs to happen to make the document come to life.

We had a good conversation about the stigma that people suffer, and I know you've heard lots of that. Different than what you might have heard, in this group, anyway, there was lots of talk about starting the education, the training and the stigma reduction very early in life. We had a member of the group who was a family member and she said, "Forget about trying to change the 50- or 60-year-old guy's mind. He's going to think, 'He's a bum. He's always going to be a bum. He's never going to change.'" But let's work with our children in the school system to help them understand, when one of their buddies' behaviour is off, what that means. What's that about? How do you talk to your parents? How do you talk to a teacher about, "I don't know why Susie's doing this. Susie didn't do this yesterday," and really start having people and children understand, so that as they become the next generation, we've done something about reducing the stigma? It's not to say that poster campaigns and that kind of work isn't important, but a real difference in the education system around, what are our children learning in schools and how easily identifiable are mental illness issues? Are we talking about them at school so that we make it safe for children to understand them?

There were lots of suggestions about using multimedia, the new tools, Facebook, Twitter, things that I'm really having a time wrapping my brain around. How do we become educated in those modalities and start using them? Television programs that educate—in some of the

stuff that comes out now in the States, they'll have a psychologist work with somebody who's hoarding in their house. They take you into their house and they show you the hoarding. I think that kind of stuff is doing more to educate people, because, "Jeez, I've got a friend and her house looks like that," you know? "I didn't know that was something we were supposed to help people with." Or, "My house looks like that. Maybe I'm supposed to get help." That kind of initiative, a very broad-based initiative, we thought was important.

Mr. Bas Balkissoon: That's my house.

Mr. Jeff Leal: We've got one.

Ms. Janet Gasparini: Sorry if—I know the two in 10, but maybe that's me.

We talked a lot about treatment. We had front-line workers, and I think a lot of what you've heard and a lot of the conversation was that the strategy has to be balanced between effective treatment and prevention, that we can't put all our eggs in either/or baskets. Typically, in what I lovingly call our disease care system—because we really don't have a health care system, right?—all of our energy and our attention is on disease. In our current system, we do lots when people get sick and we want to make them better. We don't do enough in the upfront. There has to be better balance.

Of course, you can't just move resources to prevention, because people still need treatment. When a person in your family is sick and you're at the hospital and you're demanding treatment, that's what you want. So it might mean that we have to make extra investments in the upfront until we can start to see the benefits of those investments down the line and see our calls and our need for treatment, which is a much more expensive end of things, reduced. There will have to be some lag time in doing that.

We talked about the need for immediacy of service response, real-time response, being able to meet people where they're at, being able to have mental health workers in schools dealing with young people today, not three months from now when we can get to them, because three months from now it will be way too late—and, particularly around children's and young people's mental health issues, being able to differentiate between behavioural issues, mental illness and things that need therapeutic intervention. There's some concern in our child mental health system about workers being caught up dealing with young people who have behavioural issues that really aren't about mental illness, yet there's no real way in the system of differentiating that. So we're using our very precious mental health resources dealing with issues that aren't mental health, and then the child who is having their first psychotic episode or first schizophrenic episode is being somehow missed in the system because other things are taking that place—so really being able to move between those two. The therapeutic treatment must be evidence-based, that people are appropriately trained and that there's a real attention to cultural awareness; more and more urban aboriginal folk are coming into Sudbury, so making sure that we've got people who are addressing that in an appropriate way.

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I talked about other modalities of addiction treatment other than residential programs, and you heard a little bit about that, so being able to talk about intensive day therapy and those kinds of things, and a very family-centred approach to the whole system. A doctor is not treating a person, they're treating somebody who's in the midst of a family, and the whole family is involved and integrated and suffering when you're working with one person with mental illness.

Some of the gaps that they thought were in the framework, and that I guess would be gaps for you folks to think about, were that there really was not a lot of recognition of the results of childhood trauma—so, sexual abuse and domestic violence—and lots of evidence that adults move into the system with those issues never recognized, treated and acknowledged as children—and then, as adults, not being able to function. We've got a particular program that was developed by one of our Ontario Works workers here working with very hard-to-place male cases, and we just got some money from, I think, the Attorney General to set up a special sexual abuse program for males, an area that we've not paid any attention to. We've moved into providing treatment for women in terms of sexual abuse, but really we've ignored that whole arena. When you looked at the stats of this particular Ontario Works caseworker who only dealt with difficult-to-deal-with men—guys who just weren't getting jobs, weren't getting off the system and weren't doing well—when they did psychometric testing, 98% of them were survivors of sexual abuse as children. If we're not paying attention to that in the earliest of stages and then as adults, those problems aren't going to be fixed.

You heard a little bit this morning about primary care. First of all, please don't make any assumptions that anybody has access to primary care if they've got a mental health issue; doctors don't and won't take on clients. Part of that—and I don't think it's that doctors are bad; I think it's because the system pays doctors in a particular way. If you're going to have to take 45 minutes with a client and that's going to be a \$17 visit, it's not going to work for you, right? So something has to happen around primary care and access to primary care. I think the direction of family health teams and nurse practitioners and the things that we're starting to see evolve are good responses. Especially here in the north, more than 70% of the people with mental illness don't have access to family doctors, so you can't assume that's going to be your first line of treatment.

Another area that they talked about that they didn't see in the strategy was women in the postpartum period suffering from depression and how important it was to have the proper interventions. We do have a very unique program in Sudbury—I actually think you're going to hear about it later today—making sure that's accessible. If that bond between mother and baby doesn't happen in those first stages, again, there are lifetime ramifications not unlike sexual abuse and domestic violence. We've got to make sure, if a mom doesn't do well in the post-

partum period, that immediately there are resources in place to make sure that those things are taken care of.

Locally, what the group talked about was the fact that in terms of child psychiatry in the north we are in big, big trouble. We had a school board superintendent who talked about not having been able to access a child psychiatrist in seven years for any of the referrals from their board—so, child psychiatry and the mechanisms to get access. Of course, it's a very refined specialty. We have a number of psychiatrists in Sudbury, but a psychiatrist who's not registered to practise child psychiatry can't just take those children on. That's a real gap here in the north.

We talked a lot about what it would take to build this integrated system and how we would address that in the community. It goes right down to the importance of those healthy early years and the parenting strategies. Whereas the Ministry of Health is concerned with illness and disease treatment and maybe some health promotion and prevention, what we would like to suggest is that the Ministry of Health has to be just as concerned with what you're doing over in children and youth services and MCSS in terms of Best Start programming and making sure that that baby—I'll tell you my little personal story, because I love to tell it.

My first job in the world was nursing; I figured out how hard that was and I stopped doing that. I worked on the maternity floor and I would work with moms and their babies and send them home from the hospital. At one point, we were getting about a day and a half to work with the moms and babies because the movement was to get mothers home really quickly. I would work with moms who had absolutely no clue what they were doing with this baby. They had not been parented well and they had no support systems. I remember dressing this little boy, and I had tried so hard with his mom and I just couldn't get her—going out for the cigarette was more important than the feeding. But the family was there and they were excited to bring this new toy home. I was dressing the baby in the nursery and I was crying. I thought, "I should just go down the back stairs and take this baby away because in two years, this baby will be a mess"—not because these were bad people; they were excited to be bringing this baby home. They just had no clue what they were supposed to do with this baby once they got him home, and so the damage begins.

I've had a mantra since then in the community work that I do that mom needs to be taken to the community hub, the Best Start hub, on her way home from the hospital, where she gets a massage and baby gets taken care of and all of that support network is put in place, so that there isn't a day that mom has to think about, "What do I do with this baby?" and not be able to ask for help.

To take your strategy that far back and notice the difference it would make if every single baby who was born in our communities had the kind of care, supports and resources around them in that newborn period, we would alleviate so many of the issues that we struggle with down the road.

We talked about the importance of the early years. We talked about training for those who aren't necessarily front-line workers. We had police officers at the meeting. The police and the jail system is the most expensive mental health work we do. We pay police officers a lot of money. We have them tied up at the emergency ward at the general hospital or at St. Joseph's Health Centre here guarding people with mental illness instead of being out on the street fighting and preventing crime. We have to somehow figure out how you shift that, how that doesn't become the police's job, and that when it becomes the police's job, when a person is actually a danger to themselves and others, the police have the proper training, that they're doing that right and it's not just about picking somebody up and throwing them in jail because their behaviour was odd.

The same is true of teachers and educational assistants and all of these people who work front-line who are going to become engaged with people who are suffering from mental health and addictions but maybe don't have the proper training. How do we build that system, not that they become the counsellor but that they become aware and connected to the services so that the proper things can be put in place?

We talked a lot about streamlining the process for access to the system, and I think you've heard about that. I can tell you that the people around the table who are not front-line health workers are eager to be involved in this process. Front-line workers in our homelessness network, for instance, are very aware of what has to happen and how to make those connections. We've done some good work in Sudbury around making that happen, but we have to have the structures and resources in place so that it's an easy link between a front-line streetwalker—Mardi talked about the needle exchange people. The needle exchange person might be your best access to what the next step is. But we need to make sure that the infrastructure is there so that that can happen in an easy and fluid way. If that's the person whom the addict is trusting, then let's make sure that that person has access to what they need to bring the person to the next stages.

Lots of people talked about first things first, that if we don't meet the basic needs of people, if they're not in safe housing—safe housing, you will hear over and over again—there's not even any point in sending them on for treatment, because you can go to your treatment and go to your group and then you're back out on the street. What good was that? Again, it's about the Ministry of Health influencing—you're not going to pay for housing, but you've got to be at the table with the Ministry of Municipal Affairs and Housing and really supporting and making sure that the resources are being delivered. Ultimately, as politicians, you set the overall budget for the province of Ontario. Stuff should not get in that budget unless there's a way that it's linked, unless there's a way that housing and the supports that are needed in housing and your mental health strategy are linked in the politicians' minds, in the budget and in the government's mind. If they're not, then they shouldn't get through the

budget process because it's not going to work on the ground and in the community.

We had people talk about very experienced and qualified counsellors and mental health workers taking care of things that they shouldn't be taking care of. If they're busy on the phone trying to find housing for somebody, that's not a good use of their time. The links and connections have to be made to the front-line housing workers so the front-line housing worker can find housing, but they can also be in touch with the counsellor and make sure that that next stage has happened.

We're ready in the community to do those things. We've got some great examples of how we've done them. What we need at the ministry level is flexibility and fluidity between your ministries so that somebody can say, "You know what? There is a chunk of our funding here that we can actually use." A program like Mardi's, which will be lost—it blows my mind when we hear about a warm line being funded by the United Way. Where else in the health care system—do we fund emergency departments at night with United Way funds? We'd never dream of doing that. Why do we think that's okay in terms of mental health? It's not okay. So we've got to raise that up to the level and make sure that the system is complete and robust. And it's not just the Ministry of Health's job; it has to be an integrated model between all of the ministries.

1050

Getting to housing is important. I wasn't here back in the 1980s—I was working as a nurse—but somebody who had been in the system a long time said that back in the 1980s, we actually had a good system that worked. We dismantled it and now we're starting over. So maybe the advice is: Go back to look at whatever it was we were doing in the 1980s and let's do it over again.

The Chair (Mr. Kevin Daniel Flynn): I was disco dancing.

Ms. Janet Gasparini: Me too.

How much time do I have, because I don't have—

The Chair (Mr. Kevin Daniel Flynn): I think you've got about three minutes—two minutes, actually. Sorry.

Ms. Janet Gasparini: I do want to leave you a little bit of time for questions. I think I've actually made most of the points that the group made. We're ready, in community, to provide an integrated system. Our police departments, our schools, our child care providers—we're ready to work together. What we need is the capacity delivered in an interministerial way to make that happen.

I'll stop there so that you can ask questions if you have any.

The Chair (Mr. Kevin Daniel Flynn): You've left probably time for one question. Maria?

Mrs. Maria Van Bommel: I was really interested in everything you said.

Ms. Janet Gasparini: Good.

Mrs. Maria Van Bommel: It was very excellent. But I want to go back to the parenting. As parliamentary assistant for the Ministry of Children and Youth Services,

parenting is something, of course, in the Early Years and the Best Start—Best Start, especially, is close to my heart. One of the things that we keep seeing, though, repeatedly—and it is exactly what you're talking about—is the young parents who, no matter what courses and what programs we put forward, don't take advantage of them. We have other parents who, if we hid the programs under bushel baskets all over the countryside, would find them anyway. But there is that group of parents who never seem to take advantage, and yet they're probably the ones who need it the most.

How do you suggest we can access—because, like you said, it's almost like you want to take them and force them to—

Ms. Janet Gasparini: No, and you can't do that.

Mrs. Maria Van Bommel: —but their civil rights would say, "You can't do that," right?

Ms. Janet Gasparini: That's right. What we've done in our Best Start network in Sudbury—and if you've got extra time at the end of the day, I'd love to let you know what we've done in Sudbury, because, as you know, their funding came from the feds and then got cut off, and so some got out and not all. But what we did in Sudbury is, we had already started a Best Start network, which included all of those partners that I talked about, and had started to plan for what we would do in Best Start. Even when the funding stopped, we said, "Well, we're not stopping," because the bottom line was: There was about \$30 million coming into Sudbury in terms of early years development, including schools and public health and what not, and we kept that table together.

We have opened 13 Best Start hubs in schools in our community. Our public health unit is a part of that network. As a baby is born in the hospital and it is recognized that there could be—so they're sent to public health for a home care visit. The home care visitor is in the house. The home care visitor is encouraging the connections at the Best Start hub and encouraging the mom to come. So you're right; we can't make them come, but making sure we've utilized all of the players in the system in the most effective way.

If the health care people were out here and didn't know about Best Start and weren't connected to Best Start and daycare and going to see the mom and bringing her all the great health unit publications, we'd be missing the boat, because all the pamphlets in the world are not what's going to get that mom in, but coming and building a relationship and saying, "Why don't you come with me down the street?"—that's the avenue we've taken and that's the work we're trying to do.

Those are the examples of how we need to be able to work in community, and that takes flexibility and some resources. We didn't get new resources for Best Start. We used the \$30 million we had much more effectively. Let us do that with mental health.

The Chair (Mr. Kevin Daniel Flynn): We have time for—actually, we're out of time. I took some of your time with my stupid joke. Sylvia, just a brief question and answer.

Ms. Sylvia Jones: Just a really quick question. You've done an excellent job of bringing the points of a number of agencies forward. Maybe I'm one of the unlucky ones. I am not familiar with the social planning council. Obviously, we don't have one in my area.

Ms. Janet Gasparini: Well, you should. We could have another hearing on that.

Ms. Sylvia Jones: Sounds like it. Where's your funding coming from?

Ms. Janet Gasparini: Social planning councils get funded—there are about 17 of us in the province, and it's different in every community. In this community, we are well supported by the municipality. United Way is our funder, and Trillium project finding. But we have worked tirelessly with a number of ministries, and every ministry we visit says, "It's great work. We should have one of you in every community, but you don't come under our bailiwick." So we struggle.

Across the province, in terms of the poverty reduction strategy, it was social planning councils across the province that motivated people in 30 communities to meet with their MPPs. In communities where we didn't have a social planning council, we sent social planners in.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Janet. Thank you very much for coming today. You did a great job.

Ms. Janet Gasparini: Thank you very much.

SHERI JOHNSON PURDEN

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is Sheri Johnson Purden. Thank you for coming.

Ms. Sheri Johnson Purden: Thank you for having me.

The Chair (Mr. Kevin Daniel Flynn): You're welcome. Make yourself comfortable. There's still a clean glass and water there, I think, if you need any. Everybody is getting 20 minutes this morning, and if you leave some time at the end for some questions, that would be great, but that's entirely up to you.

Ms. Sheri Johnson Purden: I just want to let you know that I'm very thankful that I have this opportunity to speak with you on behalf of the mothers who are suffering from postpartum depression or perinatal mood disorders. I believe that it is something that is very much missed in the mental health system and needs a lot of attention. So with that, I'll start.

I come before you as a person from the community to share my experiences and knowledge about the changes that are needed to help out families within the north. Up to 20% of families begin their journey of parenthood with perinatal mood disorders. I myself have travelled this journey with three daughters. I never knew that the birth of my children would lead me on such a path of advocacy for other families.

I have facilitated the peer support group called Healthy Options Providing Effective Support, HOPES,

for the last 12 years. I have spoken at many conferences across the province on my experiences and have been a member of several different provincial advisory groups for perinatal mood disorders.

I have also been interviewed by many magazines and newspapers and had my story published within the CAMH postpartum depression guide for front-line health care and social service providers. I have actively participated in research projects with Laurentian University's School of Nursing with Dr. Phyllis Montgomery and school social work professor Dr. Carol Kauppi.

Recently, I have been employed with the Canadian Mental Health Association's Sudbury-Manitoulin branch on a project funded by the Ontario Trillium Foundation. The project involves the gathering of information for the creation of a peer support program for mothers with perinatal mood disorders. I have gained insight on how the mental health system works compared to the physical health system—each system separated for the treatment process. If I am not well, should I not have access to a health care provider regardless of my illness?

I will speak to you today on the treatment of mothers with perinatal mood disorders and what needs to be in place to help out the families and society as a whole. I believe that perinatal mood disorder treatment can be a door for many to become healthy without going through the needless pain and suffering that mental illness can cause.

In my experience, mothers with perinatal mood disorders are more conscious of mental illness within their children, should it occur. If their child complains of headaches, stomach pains, nausea and fatigue for long periods of time, the parent is able to advocate for their child for mental health services.

If, on the other hand, the mother doesn't get diagnosed and treated for perinatal mood disorders, her children will have behaviours related to attachment disorder. This leads the children to low self-esteem and addictive behaviours, some leading to criminal activity. I think that we owe society the input of funding towards helping out mothers with perinatal mood disorders.

There has been a great deal of progress within the province with regard to perinatal mood disorders since I first suffered with my daughter 14 years ago. The investment of the province in early years centres, now known as Best Start hubs, is a great relief to many families that need a place to socialize. The perinatal mental health program at the Sudbury Regional Hospital is instrumental in helping out mothers in the greater city of Sudbury. The ability of mothers who are not well and must be hospitalized to have access to their babies during the day is another step.

All of these initiatives are wonderful. We are lucky in Sudbury to have such access to these services, but there is room for improvement.

With my first experience of a perinatal mood disorder, I did not know that my world was so distorted with the illness that I would turn away family and friends and isolate myself in my own little world, where everything

was bleak and horrible. It was myself who would ask the family doctor about it and have him hand me medication. I would then begin to tell my family about my illness of postpartum depression.

My ability to speak out without fear of repercussions from my peers placed me in a play group that had a six-month waiting list. This play group at Jubilee Heritage Family Resources was my saving grace. The staff encouraged me to participate in the different workshops as they provided child care for me.

1100

The Chair (Mr. Kevin Daniel Flynn): Do you want to take a little break?

Ms. Sheri Johnson Purden: No, I'm good.

The Chair (Mr. Kevin Daniel Flynn): Are you sure? You have a pile of Kleenex next to you.

Ms. Sheri Johnson Purden: The staff encouraged me to participate in the different workshops as they provided child care for me. They then encouraged me to become a part of different committees related to the resource centre. They introduced me to other mothers who had been suffering with postpartum depression as well. This is why the introduction of the Early Years centres and the Best Start hubs is such a great success.

The Jubilee Heritage Family Resources centre further encouraged me to start up a peer support group for mothers. Although the numbers were low at the beginning, the numbers have grown throughout the years. The Best Start hubs are the best place to hold the peer support meetings, as there are staff available for child care.

Ideally, funding to pay a peer facilitator for the groups would increase the longevity of the groups. I have been facilitating hopes for 12 years as a volunteer. This is not the norm. I have had many supporters who have tried to begin peer support groups within their communities but needed to return to work, as the demands of raising a young family are very high. The mothers usually discontinue their role for the peer support groups. Many mothers are faced with other barriers to participation. Some are unable to come due to child care and transportation issues. This is why I believe that providing the funding to the Best Start hubs for peer support meetings is instrumental in helping our children have a brighter future.

Along my journey, I've had many people call me to help them through the health system to obtain services. Many of them will visit the crisis department, leading them to the emergency department. It is very disturbing to watch these mothers have to qualify their illness through the system in order to see a doctor. When they ask for help at the emergency, if they are not ill enough or contemplating suicide, then they do not qualify to see an emergency doctor. Why do the mothers have to be very ill before they get services? It is well known that perinatal mood disorders are very easily treated. If these mothers had a direct contact to go to, they could become healthy rather quickly. These services are needed so mothers can provide care for their infant.

The Sudbury Regional Hospital has a perinatal mental health program that has helped numerous mothers and families. It has given hope to our community that someone is willing to listen and help us. The program has recently had to start a waiting list and re-establish their qualifications for mothers to be treated. Again, we are subject to, "You are not sick enough for services."

We know that perinatal mental health programs work very well with a counsellor and a psychiatrist available for treatment plans. We need to have more of these programs available in the north. I have been working with different organizations within the north to try and establish services for these mothers and their families. Everyone wants one number to call to receive the help they need. I would like to see access to a counsellor and a psychiatrist be made readily available to the families in the north. Southern Ontario has had these programs for years. It is now time to help out the families of the north.

The next situation that I have been witness to is the hospitalization of mothers with perinatal mood disorders. These mothers are looking for comfort and a safe environment when they are ill. I have seen these mothers' anxieties heightened as they visit the emergency department hoping to be led on the road of healing. These mothers are uprooted as a psychiatrist informs them to stay at the psychiatric unit of the hospital. They are to turn in everything they own, including their own babies.

These mothers and their families are frightened as they enter the halls of the psychiatric ward. The babies are not allowed to stay with these mothers due to insurance risks, yet these mothers need to have contact with their babies.

Let's make the situation less stressful for all involved. We need a retreat for these mothers to heal. This home needs to have a peaceful setting with an inviting environment where children and family are welcome and feel welcome. Many of the mothers who are admitted to the psychiatric floor feel very stressed about their babies being in such an environment. The babies are harder to settle in such an environment. The babies need to be with mom in a home. This home should have access to child care providers so if a mom feels stressed, she can call upon them to help her. There should be a common area where the mothers could socialize with one another and slowly be introduced to their parenting role. The father or partner should also be involved in the new role that they have to play. The whole family needs to learn what will work for them.

We already have a transitional home in Sudbury for those with mental illness. Why can't we do it for families to help the baby on the road to mental health?

These are only a few of my requests to help the system work better for mothers with perinatal mood disorders: peer support groups in the Best Start hubs, a perinatal mental health program for the larger communities in the north to help improve access to the services for families and mothers, and also, for those needing more support, a home where the mothers, with their babies, can go to heal and gain self-confidence in their new roles as mothers.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sheri. You did a great job. You've left quite a bit of time for discussion, which is good, so let's start with either Christine or Sylvia.

Mrs. Christine Elliott: I don't have any questions, but I'd just like to thank you very much for your presentation. It means a lot to us that you were here. Thank you.

Ms. Sheri Johnson Purden: Thank you.

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

Ms. Sylvia Jones: I have also had some experience with the Early Years centre, now renamed. I've seen the advantage of the peer support process. I think it's a great way, as you say, to transition mothers into their new role. Well done for bringing it forward.

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

M^{me} France Gélinas: I'd like to continue on this idea of peer support for moms and families. How would you see it working? Where would those peer supports get paid from? Who would they work for? How would they become available? How would that work?

Ms. Sheri Johnson Purden: I would say that within the Best Start hubs, some of the staff members themselves have gone through postpartum depression. So it would just be a matter of redirecting that funding or giving honorariums to a mom who steps up at the Best Start hub and says, "You know what? I think I can do this."

What happens is that when you have a group, there's usually a transition of roles, where someone who's attending the group as a member wants to take on a more direct role and feel like they're actually contributing to helping out families and mothers in the community. So an honorarium system, or some sort of pot of money, needs to be put aside for those moms to pay them, because I've seen moms come and go, and they just don't have the time. They need something to make it more worthwhile for them to do the peer support role.

M^{me} France Gélinas: And they would be tied to the—

Ms. Sheri Johnson Purden: Best Start hubs.

M^{me} France Gélinas: To the hubs.

Ms. Sheri Johnson Purden: Yes.

M^{me} France Gélinas: In our community?

Ms. Sheri Johnson Purden: Yes, because that's where the moms are. The moms are at the hubs. Even when I go to visit the hubs, I know there are moms there who aren't well. They are hiding in the corners and they're not coming out. But if you give them access to something that can, hopefully, pull them out so that they can get the help they need—they are going to the hubs to get out of the home because they don't want to be home. They are afraid to be alone with their babies. They want that socialization.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Any questions on this side? Liz and then Maria.

Mrs. Liz Sandals: Just to comment, I think the model which you're talking about and which the social planning council folks were describing is actually somewhat unusual in that it has been put out into the community, the

Best Start hubs, and into the schools. A more frequent model is that you'll find that there's one Early Years centre in one large city, or maybe in an entire county there might just be one location.

I'm wondering: In that situation, where the Best Start hub isn't right in the community, how does the mom find out about the Early Years centre? How did you get hooked up with the Early Years centre and Best Start hub? Because it's sometimes that first connection with, "This is where help is." How do you get that first step of the connection?

Ms. Sheri Johnson Purden: For me it was my minister who introduced me to the Jubilee family resource centre.

We have to get public education out there, I think, and direct it towards the families and the partners, because they're the ones who are going to notice the changes first. Those are the ones who will say, "Honey, there's something wrong." The mothers are usually in denial for quite a long time, whereas the fathers or the partners are the ones who take the initiative to get help for them. That's what we've seen through our research, that the mothers heavily weigh upon their partners to take care of them and take on the additional roles. We need to direct some public education towards the fathers and the partners. We are forgetting them. That's what I've noticed. First of all, it was the baby. Everybody pays attention to the baby. Now we're slowly starting to go towards the mom, but we need to include the fathers in there too, because fathers play a very important role in the family of a baby and children, and they should not be discounted.

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Mrs. Liz Sandals: Thank you.

Ms. Sheri Johnson Purden: You're welcome.

Mrs. Liz Sandals: Interesting observation.

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

Mrs. Maria Van Bommel: Thank you very much. I really appreciate you coming in and telling us about your own personal story. As I said before, I am a very firm believer in the Best Start and Early Years centres. Something that we've noticed in my community—and having a number of grandchildren, I'm following the Best Start as my daughters and daughter-in-law go through those things. In one of the communities, in the hub, they actually have a postpartum depression clinic.

Ms. Sheri Johnson Purden: That would be ideal. That would be absolutely ideal.

Mrs. Maria Van Bommel: Yes, it's right in the hub. And very often, as you say, the mothers don't present themselves. It's because they come to the hub for other services—like you say, for the socialization of the hub—and it's the workers there who identify them and just sort of steer them towards the postpartum clinic. That has worked very well in that community.

One of the things that we have—I have a very rural riding—is the transportation issue.

Ms. Sheri Johnson Purden: Yes, definitely.

Mrs. Maria Van Bommel: It's getting moms to the Best Start, to the Early Years centres. That is because

very often, there may be only one vehicle in the family and it drives off at eight o'clock in the morning to work. Mom is left with all these kids, and she's getting progressively worse and has no way of getting herself out. Like you say, they want to be out, they're actually afraid to be alone, and yet they can't. So how would you handle that in this area, in the north? Because you have even greater distances than we do in southern Ontario and rural areas.

Ms. Sheri Johnson Purden: I would like to see some sort of a transportation system put in place with drivers—and paying for them. I know that here in Sudbury we've tried bus tickets, but you know what? Taking a bus with a newborn baby and toddler is just sometimes the hardest barrier to get over. So if we could have a bus or a van going around to pick up these moms, that would be very helpful for them. I know it's an insurance nightmare, and everything's always a insurance nightmare, but in the long run, the safety of these children and the lives that these children are having—we need to improve them, their outcomes.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Sheri, untreated, what's the outcome of postpartum depression? I mean, obviously you hear about the really tragic outcomes.

Ms. Sheri Johnson Purden: Yes.

The Chair (Mr. Kevin Daniel Flynn): What's, typically, though—it's not treated, the child grows up, the mother moves on. Does it linger, though? Is there a depression that accompanies that?

Ms. Sheri Johnson Purden: If the perinatal mood disorders aren't treated, then it leans towards more chronic illnesses. So the depressed mom will have a chronic depression. In her tending to her own needs and trying to tend to her family needs—they're neglected. Trying to take on the cues of the children and babies, those are really not so readily occurring, because the mother is not able to feel those cues. Ideally, I would like the Best Start hubs to have parenting courses on those cues and how to get those attachments starting to happen, because that first year, from zero to one, is such a crucial time frame for that little baby. It's not as simple as, "Well, let them cry in the crib," anymore. We need to be actively involved with them.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you very much for coming today. That was a great presentation.

Ms. Sheri Johnson Purden: Thank you.

The Chair (Mr. Kevin Daniel Flynn): And thanks for what you're doing on a volunteer basis.

NOOJMOWIN TEG HEALTH CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Barbara Erskine. Barbara, come on forward.

I'm going to let you pronounce your organization, just so I don't mess it up, because I've gone over that a few times in my mind. Do you pronounce the J, or is it silent?

Ms. Barbara Erskine: It's soft, so it's Noojmowin Teg.

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

Ms. Barbara Erskine: Sorry about the delay.

The Chair (Mr. Kevin Daniel Flynn): It's okay.

There you go. Make yourself comfortable. Everybody's getting 20 minutes. Use that any way you see fit. If we have any time at the end, we'll maybe get into a little bit of a discussion. It's all yours. Thanks for coming today.

Ms. Barbara Erskine: Thank you. I'm off to a good start because, as they say in the commercial, "Technology—not my forte." Anyway, I think it's just moving along maybe by itself.

It's my privilege to speak to you today. I'd like to thank you for taking the time to come to Sudbury and listen to this submission. It's a fairly dense one. I'll try and get through it as comfortably as possible. I'm very pleased and thankful that the Honourable David Caplan and his staff have pulled together *Every Door Is the Right Door*, because it's a very interesting document and they have bravely put it forward into the public sphere for comment and feedback.

I'd like to thank anyone who's here simply for interest's sake and my employer, Noojmowin Teg Health Centre, for allowing me the time to come here and to prepare this report. Most of all, I'd like to thank my clients and co-workers over the past 12 years who have educated me to whatever extent I could take it in about the lived experiences of aboriginal peoples who are facing mental health and addiction challenges.

I think I present a relatively unique perspective as a provider of psychological services to rural aboriginal people. I'm a non-aboriginal psychologist and I've worked for my employer for 12 years, as I said. We service the First Nations communities and off-reserve people in the surrounding villages and towns on Manitoulin Island, and there's where I drove from today. So where you see Aundeck Omni Kaning, that is where our centre is located. The areas in red are the First Nations that we service, but as I said, we also service people who are living off-reserve, so they could be living in the towns or communities around the Manitoulin area, anywhere south of Espanola.

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I'm using the word "aboriginal" as it is used in the document *Every Door Is the Right Door*, but normally we would use the word "Anishnawbek" for the people of our area. The document is using the word as a catchword, really, for aboriginal, Metis and different designations, and that's exactly how we'll use it today.

I've chosen to focus on one issue within each titled section of the report. So my presentation is very report-focused.

Just by way of introduction, Noojmowin Teg is an aboriginal health access centre. These are funded by the provincial government with mandates to improve accessibility to health care services and to address challenges

related to family violence for First Nations aboriginal people. There are some of our relationships with our neighbouring communities and health authorities and some of the programs that we provide—a wide variety. You may be aware that the federal government funds a lot of aboriginal health programming, but we are filling in the gaps, and that's primarily in professional services such as nurse practitioners, dietitians and psychological services, as well as some specialized programming. We have exercise specialists and a fetal alcohol spectrum disorder program as well.

We were founded in 1997 and—the one that I want to mention that I forgot is the traditional medicine program coordinator. She oversees a program that coordinates traditional healing services and arranges for cultural teaching. It's a very fundamental aspect of our organization that certainly differentiates it from a community health centre that you might be familiar with in your own communities.

One thing that I'd like to mention is that Noojmowin Teg at its inception had the foresight to hire a psychologist, and that happened to be me. No other aboriginal health access centre actually hired a psychologist, so it was kind of a unique step in a certain direction. We have grown, largely because of the demand for services, to 2.2 FTE for psychological services.

We provide assessment and treatment services exclusively for aboriginal people across the Manitoulin area and, as I said, we also offer services off-reserve. We provide direct clinical services—that's our primary work—and we have serviced hundreds of aboriginal clients over the years, with a high rate of satisfaction, I may add. We had some of our services evaluated in 2007.

The Chair (Mr. Kevin Daniel Flynn): I think your slide show has developed a life of its own as you've been talking here.

Ms. Barbara Erskine: Yes, a life of its own, exactly. So when I need it, I guess—as I said, not my forte.

The first chapter of *Every Door Is the Right Door* is that mental and addictions touch lives, and I want to say how mental health and addictions touch aboriginal lives. In that chapter they speak a lot about the prevalence of mental health disorders in the general Ontario population. I just want to say something. You've probably heard a lot of news or headlines about the difficulties that aboriginal communities are beset with in terms of suicide rates and unintentional injury rates and other things that are related to mental health—substance abuse, of course, being one of the ones that gets a lot of press.

I want to just situate this in a context. Aboriginal peoples in Ontario have histories and legacies that are different from non-aboriginal people in Ontario. Just as an example, the original people of Manitoulin are from a group called Odawa. After contact with Europeans began, they could see that things were changing and they formed an alliance with a couple of other aboriginal peoples—Pottawatomi and Ojibwe. They also tried to form alliances with the government that was moving in—the white government and the British. They tried to forge

a nation-to-nation relationship with these non-aboriginal governors. In this effort, they did things like help the British out in the War of 1812 and sacrificed a lot of warriors in this cause.

In spite of their sacrifices, though, the settlers continued to move in. Sir Francis Bond Head, who was the Lieutenant Governor of Upper Canada from 1836 to 1838, tried to protect First Nations to a certain degree by saying that if the Ojibwe people signed over Manitoulin Island to the crown, that would be protected as Indian territory forever.

Less than 30 years later, as you can imagine, a new case was presented to the aboriginal people in 1862 because there was new land needed for settlers. The government applied pressure and renegotiated the agreement, possibly with the use of liquor in the bargaining process. So the land base for First Nations on Manitoulin Island was drastically reduced. This kind of history is just our local history that is repeated throughout the province.

There are other issues that came with that: the introduction of European diseases, legislation against culture and traditions, forced assimilation and residential schools—and on Manitoulin, many residents went to either Spanish River or Wikwemikong—and racism. So you may ask, "What does all this history have to do with mental health anyway?" I think that there's a lot of discussion now, especially, I would say, in native American psychological literature, about the phenomenon—perhaps the intergenerational phenomenon—of historical trauma. It would be likened to an anxiety disorder that bears some similarities to post-traumatic stress disorder. When we think about post-traumatic stress disorder, I think we pretty much have in mind some of the mental health challenges that are part and parcel of that, and the debilitation and impairment.

Fortunately, aboriginal people have survived these events and have preserved enough of their culture and language to sustain them—a spirituality, a holistic worldview, clan systems and other strengths that are allowing them to prosper to a certain degree, and certainly, their population is increasing. But I think anyone working with aboriginal people in a mental health or addictions social services setting needs to have some understanding of how the historical context may actually bear on the problems that you're seeing before you.

I would recommend that the government ensure that health care providers receive some education about the history and culture of aboriginal people somewhere in their curriculum as it may relate to health conditions and treatment.

The next section in the report is, "Can Services Do a Better Job of Meeting People's Needs?" They're talking about doorways into mental health services, and I want to talk about a doorway that wouldn't necessarily come to mind unless you were thinking about aboriginal health services. This is the doorway of traditional medicine and cultural practices. Within our agency and with some community partners, we have integrated our traditional medicine program and our mental health services such

that we take referrals from the traditional medicine program. Healers come in, they see people for the various either physical or mental health issues—they wouldn't call them that; they have other, more cultural ways of putting it—and they can see a need, that maybe this person needs to get into some treatment services. They will forward that name into our intake system, and we will take up that intake and coordinate our services with traditional medicine.

Similarly, we, as mental health practitioners, are asking all of our clients, “Do you have need of traditional medicine? Do you want some healing services? Do you want some cultural teachings? If you do, then we can direct you to them,” and we make a referral back to the traditional medicine program. So we're trying to integrate our services the best that we can, and we are now starting some preliminary case management for clients who are using both types of services within our organizations. We are meeting and discussing them in kind of a case review and putting our best minds together and trying to think of, from both perspectives—the mainstream mental health perspective and the traditional practice perspective—what would be best for these clients. That's exciting for me, and I think that it would be good to acknowledge that traditional medicine programs for aboriginal people can be doorways to mental health services.

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I think the success of mental health programs in reaching aboriginal people is intertwined with the accessibility of traditional medicine programming. In our traditional medicine program, there is a set of policies and procedures that safeguards the clients who come in, much like any other health care policies and procedures do. I think that that also needs to be a bottom line for funding or implementing traditional medicine services, so I would recommend that the government fund traditional medicine programs in aboriginal health centres, maybe even at a level equal to the funding allotted for physical health programs and services.

The next chapter is “Transforming Services: Can We Make Every Door the Right Door?” This talks about diversity and culturally competent services.

I've brought up a definition of “culturally competent”: “A process in which therapists develop an awareness of their own culture and clinical expertise, and subsequently enhance this information by allowing each client to express what is important for them about their culture as well as their treatment preferences.”

Each service provider, aboriginal or non-aboriginal, I would say, needs to develop and have access to supports that will help them develop knowledge about aboriginal people.

One of the most daunting problems, though, I think, in providing mental health services for aboriginal people is that there is virtually no literature on what works. There is in fact an article that I've cited, by Joseph Gone, about his trying to survey the literature—he's a Native American psychologist—for studies of evidence-based

practices with Native Americans, and he comes up with nothing.

In other words, we're sometimes guessing at what works. What I would suggest, as a preliminary step, is to fund a conference to bring best minds together to start talking about this, and also to fund research in aboriginal mental health and addictions treatment so that we can have things like randomized controlled trials, clinical trials, for culturally adapted treatments, or even just develop treatments out of the practices within the aboriginal culture. But there is a lot that needs to be done.

The next chapter is “Act Early.” As some of your previous presenters have said, there is absolutely no question about the importance of early identification and intervention.

We could briefly take a look here at the demographics of the aboriginal population. The median age is 24.7. That means that 50% of the aboriginal population is 24 years old or younger. When you look at the “Under 14 Years of Age”—I'll get that back—you can see that for the aboriginal population, that is 33% of the population, whereas for non-aboriginal it's 19%. When we talk about, “Do we need early intervention and early identification?”, it is very urgent in this population.

It just mentions here too that on Manitoulin, we really have no children's mental health services coordinating committee. Largely, some mental health services are branches of services that are based in Sudbury or another urban centre, so that our issues are discussed but sometimes they're discussed in an urban setting. It isn't clear, maybe, sometimes, in an urban setting, how urgent it may seem in the field. When we're on Manitoulin Island, when you break down the population, almost 50% of the population is aboriginal: so, 5,000 non-aboriginal and about 5,000 aboriginal. Aboriginal people are our reality, whereas in an urban situation, they may be less than 10% of who is living in that area.

I would really like to see a children's services mapping exercise for just Manitoulin Island so that we could coordinate across aboriginal and non-aboriginal services and get a true picture of who is providing services and where the gaps are, and then to fund some sort of support at a lead agency on Manitoulin to coordinate a children's services planning table.

The next issue is how to meet people on their terms. In the document *Every Door Is the Right Door*, it talks about respect and value for diversity and going out and meeting the people who have mental health challenges. I think one of the best examples I can see of an organization going out and meeting people where they are would be the Northern Ontario School of Medicine, which has, as one of its requirements for its first-year students, to live, work and observe in First Nations communities for six weeks. That's kind of radical, I think. Congratulations to them for getting that done.

The Chair (Mr. Kevin Daniel Flynn): I'm going to jump in, just to give you some idea of where you're at. I think you've got 20 recommendations, you're at number 7 and you've got two minutes left. I don't want to hurry

you along, but you might want to focus on some of the things you absolutely want us to hear.

Ms. Barbara Erskine: All right. Anyway, the more time people can spend in aboriginal communities during their formative education years, especially in mental health and addictions, the better. If that could be facilitated, great.

The next item is the seamless and comprehensive provision of services across mental health and addictions. This is one point I really want to make, and it is that it is a fairly frustrating patchwork at this point in time of federal and provincial funding to serve aboriginal people, and making sense of it is very difficult at times. We do our best to collaborate together, but the funders sometimes are funding initiatives that go in different directions. They do not have integrated data collection systems, so we often have incompatible data systems. What I would recommend is that the LHIN and other LHINs that have a 10% or greater population of aboriginal people actually have a position where someone is trying to sort these things out, because it is above and beyond, as someone who is trying to do clinical work all the time. I think that would be a great step and very helpful for increasing understanding across all the borders.

Another point I wanted to make is about racism as an issue for mental health. It's just to say that the less racism people encounter, the lower the risk for some related mental health and physical health issues. I just cite some research about some possible impacts of racism on depression and other things like that. There's certainly more research than what I've cited, but I would encourage the government to sponsor any racism programs, to fund aboriginal culture centres to maintain and expand cultural recovery, and to fund institutions to have translation services.

I go on about education, the other thing, too.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. This is really thorough and you've laid it out really well. Even though we weren't able to get to the end of it, I think all the members will spend some time with it. It's very easy to read; I read a little bit ahead as you were talking, and I think I get it. Thank you very much for coming out today and for all the work and the effort you've put into this.

I just ask, without promising or anything like that: Would your organization be open to a visit?

Ms. Barbara Erskine: Absolutely.

The Chair (Mr. Kevin Daniel Flynn): Okay. We have paid some visits to some First Nations communities, and that may or may not happen again. We're looking for some direct contact with people who would like us to come to their community.

Ms. Barbara Erskine: I could leave the name of our executive director with whom you could communicate about that. I'm sure that would be more than welcome; absolutely. Thank you so much.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Jeff, did you have a brief question?

Mr. Jeff Leal: Very brief. I looked at your 19 recommendations and I'll just give you my personal—I am parliamentary assistant for the Minister of Aboriginal Affairs. I happen to think that INAC is one of the great barriers in providing services. Through your experience, would you support the notion that the provinces, in particular the province of Ontario, should have 100% jurisdiction in delivering health services to our First Nations people? It's a controversial question, but—

Ms. Barbara Erskine: Oh, yes. That's why I want to turn the mike off.

In terms of organizing, there are so many political issues about land settlements, self-determination and these issues that need to be settled that are way beyond me.

Mr. Jeff Leal: But I specifically asked—

Ms. Barbara Erskine: About health care? Yes.

Mr. Jeff Leal: Because you've made 19 recommendations here and they all targeted on Ontario, which would have to provide 100% of the funding.

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Ms. Barbara Erskine: I know. I would—

Mr. Jeff Leal: So it's yes?

Ms. Barbara Erskine: Yes.

Mr. Jeff Leal: Thank you.

Ms. Barbara Erskine: To me, the province has the expertise in health care; that's their business.

Mr. Jeff Leal: I appreciate that.

The Chair (Mr. Kevin Daniel Flynn): Thanks for coming today, Barbara. We appreciate it.

COLETTE PILON

The Chair (Mr. Kevin Daniel Flynn): So if we can ask Colette Pilon to come forward and maybe start to get ready.

Everybody in Sudbury has laptops. This must be a cultural thing. Is it?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): All set? You've got 20 minutes. You can use that any way you like, and maybe there'll be some time at the end for some questions.

Ms. Colette Pilon: Thank you. My name is Colette Pilon. I am a social worker. I have been involved in the planning and implementation phase of a transitional outpatient service to facilitate the transition of people who are admitted psychiatrically back into the community and give them that immediate support they need. I have about 10 years of experience working as a social worker in different functions in the system, and today I would like to speak more specifically in regard to my experience with the transitional outpatient service. I will conclude my presentation with some comments in regard to the broader context in which the current mental health system transformation is occurring.

I just need one second here.

The Chair (Mr. Kevin Daniel Flynn): These were supposed to make our lives easier.

Ms. Colette Pilon: It doesn't always work that way, let me tell you.

I would like to thank the select committee for providing me with this opportunity to share my experience and my perspective as a service provider.

In 2006, the need for a transitional community-based program had been recognized in order to facilitate the timely discharge of schedule 1 patients to community-based programs in order to alleviate the burden of bed shortages and the expected bed cuts that will be occurring again as a result of all services moving under the same roof. Ken White has recommended that funding be allocated to begin the process of developing the transitional community-based program.

We are about five people employed under the TOPS program, five clinicians of various disciplines. We underwent the preliminary research to guide the development for a service that truly responds to the needs of the community.

Our research has generated a wealth of information, and after a year in planning, TOPS was implemented in May 2008. TOPS is short—we're known as TOPS. Sometimes people confuse us with the weight-loss program. We like to say that TOPS is mental health weight loss, for the redirection.

In the planning process, we thought it was very important for us to align ourselves with the principles of the mental health direction. We looked at the documentation and we found a little bit of a formula that we used as the foundation of the program. We used the principle of the reform of the mental health system. Onto that, we added collaborative practice, and we ended up with a shared-service model of care; some of those highlights were described by the provincial ministry.

In alignment with the ministry's guiding principles, the Transitional Outpatient Service embraces the vision of a mental health system where:

- mental health and addiction services are fully integrated;
- primary care and mental health services work in collaboration to increase the capacity to meet clients' needs;
- access to services is seamless;
- services are coordinated to ensure the continuity of care of the patient upon discharge; and
- services are tailored to the needs of the clients.

Everybody talks about that, but what does that look like in real life when you try to design a program according to those criteria?

Collaborative practice: Collaborative mental health care describes models of practice in which consumers, their families and caregivers, together with health care providers from a variety of settings, will work together to provide better-coordinated service or more effective services for individuals with mental health needs.

Working in that direction, we have proposed the adoption of a shared-service model of care where service providers would work in collaboration to support

individuals transitioning from the in-patient setting to the community.

Central to the success of such a model is the ability to recognize that any specific intervention with a client needs to be seen as a part of a system of care. You need to be willing to consider other system adjustments or changes that need to be made to support the model.

Since its implementation in May 2008, TOPS has been a key player in facilitating the timely discharge of schedule 1 patients by providing immediate support to serve to people being discharged.

As the program expands, we are hoping to offer its support to individuals from the community as well. Initially, when we planned the program, it was designed to be some kind of a step up, step down. When people come out of the in-patient unit, they're stepping down from a higher level of service. The initial mandate was to design the program also toward the other way, to respond to the needs of the people in the community, should they be given that extra support in times of vulnerability with the immediate access as opposed to being put on a wait list. If we could provide that immediate access, we would be able to prevent many admissions and help people develop coping skills and deal with adversity in life. At this point, we have implemented only the former part where we are accepting referrals strictly from the in-patient unit because we simply do not have the resources at this point, the financial and human resources, to be able to accommodate the other component of the service, but eventually we're hoping to get there.

1150

One of the challenges is that, when we accommodate people coming from the in-patient unit, we're called upon to provide services to a group of patients that come out of the hospital and present with diverse diagnoses and also different levels of needs. That is definitely a challenge that we're facing regularly. Our admission criteria to the program are not diagnosis-specific, but rather, we base the admission criteria on the need for support after hospitalization. When most new services come up with their admission criteria, oftentimes the criteria are more exclusive as opposed to inclusive. But if we need to move patients from the in-patient unit to the community, we have to deal with that diversity of needs, and it is very challenging. If we say that we're going to respond to the people's needs, then we really need to adapt our service to those needs. That's why we keep our criteria flexible, providing that we do not compromise the safety of people participating in the group; we need to screen people carefully.

In terms of the diverse population, I kind of listed them there. I'm not going to go over that.

We have a crucial stakeholder in the planning of the services. We need to really work very closely with the in-patient unit. By working closely with the in-patient unit, we contribute to the seeding of a culture of shared treatment planning throughout the system; we need to start somewhere.

When we talk about shared treatment planning, this is basically one of the recommendations that the ministry

had put forth in its document *Making It Happen*. Shared treatment planning is actually necessary in order to be able to respond to people who have complex needs. What we have noticed is that when people are admitted to the hospital, they are a lot more ill than they used to be. There are lots of social and economic factors, all kinds of complex issues that people have to deal with, and when we need to provide for clients with complex needs, we need to have a coordinated approach to the discharge planning in order to ensure proper continuity of care.

When we work with the in-patient unit, we basically work towards the early identification of patients before they are discharged from the hospital. “Best practice” says that you meet the people on the in-patient unit; you present yourself; you introduce your program; and you invite them to come and participate in a couple of group sessions prior to discharge. We have noticed that when we do that, we have a much higher compliance with the referral or follow-through. We’re seeking, actually, to establish contact with 95% of the clients before they are discharged. It’s not always possible; sometimes we have a quick discharge and we don’t have a chance to meet them. Then we’ll follow up with a phone call.

I would like to provide you with a brief review of the successes and challenges that the program has registered so far. The program is currently accommodating an average of 90 active clients in the system at all times. Because of the need to accommodate a high volume of clients, the core service of the program consists of its recovery group, which is provided three times a week. As the name implies, the focus of the group is recovery. We need to keep in mind that “recovery” means different things for different people, and the quality of life and meaningfulness of life varies greatly from person to person. The culture of respect has been seeded and the clients have often commented about the safety of the group and the opportunity to interact with others and receive support from other people who understand.

In the first few months of the operation, we averaged between eight to 12 participants per group session. However, the number of participants has steadily increased. Lately, the average participants per group, after about a year of operation, is between 18 and 22 participants. We even have broken a record of 26 participants last week. So it kind of gives us an indication that maybe we are filling a gap in the system that had been expressed, and people are responding to that.

We try to gear the delivery of the program according to the comments that we have received from consumers when we conducted the initial needs assessment. The program is still developing. We are not quite embryonic, but not too far from there.

Challenges: Like I mentioned before, we have only achieved half of the mandate that we had initially set out to do, which is that we are offering the step-down level of service from the in-patient unit. We have put forth three recommendations: to hire one full-time position to dedicate to the screening of potential candidates, to ensure the continuous flow and smooth transition of pa-

tients; we’re also asking to have additional resources deployed to further develop other groups and deliver groups, as well, in collaboration with other service providers. As it stands now, with the high volume of patient flow that we have—it keeps growing—we end up facing a challenge in terms of location, space and human resources to deliver the program.

The collaboration between service providers is something that has been talked about, and in your document I did elaborate a little more on that. But a crucial stakeholder is the acute in-patient unit, as I mentioned before. In order to effectively deliver the program, we go directly on the in-patient unit. We do participate in the case conference of patients where, every week, all patients in the unit are reviewed and they talk about the discharge plan and follow-up. We do participate in that so we have an idea of the population that we may receive in the program upon discharge, and we try to meet them in the in-patient unit before they come out. However, even though we are present on the in-patient unit, TOPS simply cannot assume the role of the discharge planning because we don’t have, again, the human resources to coordinate the discharge planning of all patients. What we do is, when patients come to us, throughout the program, we do assess to see if there is any need for additional service providers to get involved.

The Chair (Mr. Kevin Daniel Flynn): Just so you know, Colette, you’re down to about two minutes.

Ms. Colette Pilon: Two minutes. Okay. I think the documentation is pretty well explicit overall, at least I hope so. With constraints of time, I didn’t have time to elaborate as much as I would have wanted to, but I would like to comment briefly on the fact that we have been speaking about mental health reform for many years and the need to integrate mental health and addictions services with the rest of the health care system. We have gathered lots and lots of information. Needs assessments have been conducted. We have the national survey, the Kirby report, which has yielded a whole bunch of information. They speak about gaps in the system, gaps at the policy level. They speak about the experience of the people. Services providers’ voices were heard, and consumers’ voices. We do have a whole bunch of information. In spite of a difficult economic reality, we’re currently experiencing a positive political and social climate to guide the mental health and addictions strategy at the national and provincial level. The formation of the Canadian—

Interjection.

Ms. Colette Pilon: I’m out of time?

The Chair (Mr. Kevin Daniel Flynn): You’re not exactly out, but you’re getting out. You’re near the end.

Ms. Colette Pilon: What I mean is that the ministries at the federal and the provincial levels do recognize that there is a need for a mental health and addictions strategy, and there is also a big receptivity in what we have noticed on the in-patient unit. There are lots and lots of dedicated staff in the community as well. Everybody seems to be—if not everybody, many workers seem to be

really engaged in improving the system. I think that it's the prime time to act now with the information that we have.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Colette. That was a great presentation. Thank you very much for coming today, and thanks for the work you put into it.

Ms. Colette Pilon: You're welcome. Thanks for having me.

CANADIAN MENTAL HEALTH ASSOCIATION,
NIPISSING REGIONAL BRANCH

The Chair (Mr. Kevin Daniel Flynn): Our last presentation before lunch is a phone conference with the Canadian Mental Health Association over in Nipissing; Georges Kristolaitis. We're just getting him on the phone as we speak.

The committee recessed from 1203 to 1206.

The Chair (Mr. Kevin Daniel Flynn): All set? George, are you there? Hello? George, are you there?

Mr. Georges Kristolaitis: Yes. Are we back on?

The Chair (Mr. Kevin Daniel Flynn): You're back on again. It's Kevin Flynn, the Chair of the committee, speaking right now.

Mr. Georges Kristolaitis: Excellent.

The Chair (Mr. Kevin Daniel Flynn): The entire committee is with us this morning. You've got a couple of people in the audience here in Sudbury.

We've been giving everybody 20 minutes. We've been keeping on schedule to a certain point, I think; we're not too far off schedule. You've got about 20 minutes, and you can use that any way you want. If you could leave some time at the end, maybe, for some questions, that's great, but it's not necessary.

Mr. Georges Kristolaitis: Absolutely.

The Chair (Mr. Kevin Daniel Flynn): Okay, it's all yours. Thanks for joining us today.

Mr. Georges Kristolaitis: Thank you for adding CMHA Nipissing to your list of deputants. I know you have a very busy schedule and it's probably lunchtime now, so we thank you for your extra work and duty on this. What you're doing is a very important task of going out to meet the field.

I'm Georges Kristolaitis. I'm the executive director with CHMA Nipissing. With me is Rhea Funnell, who is the program manager with our Bridges housing and Bridges Voluntary Trusteeship service.

Our presentation will be brief: about 10 minutes. I'll be sending a written summary of our speaking points to the clerk of the committee.

By way of background, CMHA Nipissing is a community mental health service provider. We operate in the district of Nipissing. We serve adults who are living with mental health disabilities. Our budget is just over \$2.2 million. We have a staff of about 35. We serve just over 550 clients.

CMHA has been operating since the late 1980s. We've grown organically during the last 30 years, such

that right now, CMHA provides a wide array of services related to housing, case management, social rehabilitation, mental health promotion, mental health justice services and referral assistance.

We operate in partnership with all of our local mental health agencies. Very importantly, we're constituent members of two key groups: the Nipissing common referral form protocol, which helps people access support services in the district in a coordinated fashion, and the Nipissing housing selection committee, which facilitates placement in supportive housing programs.

We basically have one key message to the select committee: We want to describe for you a current innovation in service delivery in our district that we're very much a part of. CMHA, along with a couple of other agencies, has a shared-service delivery model, and one of our programs, CMHA's Bridges voluntary trusteeship service, illustrates that model very well. Our strong recommendation is that every community would benefit from adopting a shared-service model and also that they should have, in our view, a voluntary trusteeship service as an essential component of that model.

I will ask Rhea Funnell to present to you elements of the shared-service model and how the voluntary trusteeship service illustrates that.

Ms. Rheanon Funnell: Good afternoon. Again, my name is Rhea Funnell. I'd like to thank you for this opportunity.

As George has already stated, the services offered by our agency have evolved from the identified needs of our community and the people we serve. Because North Bay has a schedule 1 facility within the municipality's geographic boundaries, the percentage of individuals living with serious mental illness within this district has always been slightly higher than the provincial average. The sheer size of the hospital's catchment area and the remoteness of the geography and the population centres have meant that the service provision has to be given in as innovative, collaborative and resource-saving a manner as possible.

The shared-service model found at CMHA Nipissing is used in all levels of service, including access, assessment and service delivery. Shared services are designed to provide holistic supports that are planned around an individual's needs. Supports are not duplicated, but enhanced. The Bridges voluntary trusteeship service exemplifies this model. Bridges currently serves almost 100 adults living with serious mental illness in the district of Nipissing, and the wait list stands at almost 80. Of the 100 current clients, almost 80 are shared-service clients with other formal supports in place.

The service works collaboratively with other supports to create a service plan with the person being served that is self-directed and inclusive. The service also allows primary supports to concentrate on the therapeutic relationship, while the removal of financial worries also helps alleviate stress.

Currently, the common referral and triage process provides streamlined and coordinated access to long-term

community supports, including the Bridges voluntary trusteeship. There are five agencies that actually belong to that process. The Ontario common assessment of need, or OCAN, will enhance the communication between services by providing a shared language.

Wait lists remain a major obstacle for individuals seeking service. The shared-service model allows agencies to stretch resources in a coordinated and integrated manner to serve more of the population in need.

We have also chosen to create a shared-service model for our housing. Nipissing was one of the first districts in the province to approach housing of individuals who are living with a serious mental illness from a systemic level where the supports actually access the housing through a committee, a selection process. We believe that the shared-service model will help to stretch resources in a way that will, in the end, lead to better service overall.

Mr. Georges Kristolaitis: That's the end of our prepared presentation. We're quite open to any questions or comments the select committee may have.

The Chair (Mr. Kevin Daniel Flynn): George, thank you very much. Thank you, Rhea. Let's start with France.

M^{me} France Gélinas: Good afternoon, and thank you for your presentation. There are themes that have been coming up that I wanted to run by you to see if they hold true for your agency.

A lot of people have presented to us about the need to formally recognize and fund peer support. I was wondering if this is something that you use and if you have been creative in finding ways to fund peer support.

Mr. Georges Kristolaitis: There are strong peer support organizations operating in Nipissing and they're a very important ingredient to the whole complexion of services and active groups in the community.

Some of our programs may have clients who provide leadership. They are peers or are people who have gone through, I suppose, the psychiatric disability and recovery experience. They are very much needed. One of our first programs, the Centre of Friends, which is a social rehab recreation service, has a pal program. What that does is it extends service, activity, conversation etc. in that centre.

Ms. Rheanon Funnell: The use of peers certainly does enhance the service provision. The formalized creation of peer support positions has been something that has been happening on a regular basis in the Nipissing district. Our ACT team has peer support workers. We do have consumer-run organizations here as well. I think what we've discovered is that, again, that is another piece of service provision that has evolved naturally as much as anything else.

We also provide coordination of something called the TAMI program, which is Talking about Mental Illness. That has been a very intrinsic part of our education and mental health promotion service where individuals who are consumers of mental health services go out into the community, into schools and businesses, and talk about their experience in the mental health system and help educate people and also alleviate some of the stigma.

Mr. Georges Kristolaitis: And these presenters are the stars. Wherever presentations occur, they want to hear the real-life experience, they want to meet individuals who have recovered from serious mental illness, and we recognize that very strongly. The TAMI program is one of the projects that we are involved with with other agencies as well.

The Chair (Mr. Kevin Daniel Flynn): Thank you, George. Let's move on to Liz Sandals.

Mrs. Liz Sandals: Thank you very much for your presentation. You mentioned the Bridges voluntary trusteeship service. I wonder if you could explain what that is.

Ms. Rheanon Funnell: Back in the 1980s, when CMHA Nipissing first began, it started as a social rec program, primarily because the schedule 1 facility, which was then called the Ontario Hospital, was discharging individuals into the community and there weren't any real supports for them and certainly no social supports. So the social rec program started from that, and then as time passed, people recognized that there was a need for individuals to have help with finding housing, because there was no way for them to find housing. So the original Bridges service started that way, and within a short space of time evolved from that because what was happening was, people would find housing and then they wouldn't be able to keep their housing because they wouldn't have any help with their finances. So the voluntary trusteeship service actually started in the late 1980s from that recognized need within the community.

Since then, it has evolved on its own to become, really, a clinically based psychiatric service for individuals living with serious mental illness within this community. The workers work with people to develop a monthly budget and they also help them recognize the connection between the stressors of their finances and their mental health. They also work in collaboration and case conferencing mode with the other supports that the person has, the formal supports that they have.

We have, as I said, almost 100 people currently on our roster. It is a voluntary program, so the individuals we're serving are people who have chosen to come to us and to work with us on their financial issues. The goal is to move people off so that they become totally financially independent and can actually work for themselves and move forward that way so that we can take other people off our wait list.

Mrs. Liz Sandals: So are the people who are involved in that program voluntarily signing over financial trusteeship to your service?

Ms. Rheanon Funnell: That's correct.

Mrs. Liz Sandals: But it's strictly a financial arrangement; it's not got anything to do with medical decision-making?

Ms. Rheanon Funnell: No, it's just finances and it's totally voluntary. People can leave it at any time. We have arrangements not just with the people we serve but also with the Ontario disability support program and other financial supports. It's a fully audited service, so

we're very careful to make sure that everybody knows exactly how much money is theirs and where it is on a monthly basis. The budgets are designed around what the individual wants and needs. They change on a regular basis, depending on how they want it to proceed.

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

Mr. Georges Kristolaitis: I would add the comment that I think on an annual basis there are 10,000 cheques that are cut for our 100 clients in the program. It's amazing how supporting it is to know that your rent's paid, your utilities are covered and you have a plan for your food and clothing needs.

The other thing we find is that when people are starting to have difficulty with their mental health, it shows up in how they spend their dollars. How we help them spend their dollars according to their plan supports recovery. So the program has four field staff, a part-time manager and a full-time administration clerk who keeps track of all the cheques, the invoices, etc. People have the choice of coming in once a month for that one cheque that they might need or two times a week or three times a week—whatever they need to sustain their financial life and also their tenure in the community.

The Chair (Mr. Kevin Daniel Flynn): Thank you, George. We've got one final question: either Christine or Sylvia.

Mrs. Christine Elliott: I just have one quick follow-up question, if I might, on the same subject. I can understand that normally this would be a function that the public guardian and trustee would fulfill, but there are some personal service elements to this that I can appreciate, being in this area, make it preferable to the public guardian and trustee handling that. I'm just assuming that you've got some kind of a relationship with them and that they are on board with this.

Ms. Rheanon Funnell: We actually do have individuals who are with OPGT. Occasionally we do take on people who are with OPGT at the same time as they're with our service. However, the prerequisite for us is that the individuals we serve need to be able to come off the service eventually.

The individuals we are serving are people who are perfectly capable of making decisions about their finances and about other things in their lives. They are living totally independently and capable of doing all of those things, but they have asked us to help them. That's where the voluntary aspect of this comes in.

The other big difference, of course, between us and OPGT is the fact that if people want off, they just say, "I want off." There's no hold to them about their finances or anything else. It's totally their dollars, and we help them handle them.

Mrs. Christine Elliott: So it's really a capacity/incapacity kind of test that you apply, then, because these are people who are otherwise fully capable of managing their own finances.

Ms. Rheanon Funnell: Absolutely. We don't even apply a test. The criteria for accessing the service has to

do with whether or not the person has a serious mental illness.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): George and Rhea, thank you very much for joining us today. That was great input.

Mr. Georges Kristolaitis: Thank you very much for this opportunity.

The Chair (Mr. Kevin Daniel Flynn): Our pleasure; any time.

Ms. Rheanon Funnell: Hopefully you'll enjoy your lunch.

The Chair (Mr. Kevin Daniel Flynn): I know; we can't wait.

Mr. Georges Kristolaitis: Okay. Good day.

The Chair (Mr. Kevin Daniel Flynn): Nice meeting you both. Goodbye.

We're adjourned for lunch now. We've managed to ask the conference call that was scheduled for 1 o'clock to move to a different time, so we actually have time to enjoy our lunch a little bit. We'll have about an hour for lunch. So we're back at 1:20. Okay? We're adjourned.

The committee recessed from 1223 to 1323.

SOCIÉTÉ ALZHEIMER SOCIETY SUDBURY-MANITOULIN

The Chair (Mr. Kevin Daniel Flynn): Okay, if I can ask you to come forward. You must be our next delegation. Are you?

Interjection: We thought that was a teleconference.

The Chair (Mr. Kevin Daniel Flynn): No, actually, that's been changed. So if you're Patricia or Debbie, you'd be up next.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): No. You pick whichever one you're more comfortable at. There should still be clean glasses there if you need some water. You guys can get settled. Everyone has been getting 20 minutes for their presentation, and you can use that any way you see fit. If you want to leave a little bit of time near the end, if that's possible, for questions and answers, that seems to work out nicely as well. So if you want to get nice and settled—

Ms. Patricia Montpetit: Is it the one with red flashing—

The Chair (Mr. Kevin Daniel Flynn): They'll turn it on for you.

Ms. Patricia Montpetit: This will be the one that works?

The Chair (Mr. Kevin Daniel Flynn): Yes. All you have to do is have a thought.

Ms. Patricia Montpetit: A thought?

The Chair (Mr. Kevin Daniel Flynn): I don't know how it works.

Okay. We've got everybody in the room, so let's get going. It's all yours.

Ms. Patricia Montpetit: Okay. Thank you very much. Mr. Chairman, members of the select committee,

ladies and gentlemen of the audience, thank you for this opportunity to address your committee. I'm here today on behalf of the Société Alzheimer Society Sudbury-Manitoulin. With me is my colleague Debbie Szymanski. Debbie is the manager of the utilization department at the Laurentian site of the Hôpital régional de Sudbury Regional Hospital.

The Société Alzheimer Society Sudbury-Manitoulin is a non-profit charitable organization that has been operating for 24 years. We are one of 39 local chapters of the Alzheimer Society of Ontario. We provide services to support people with Alzheimer's disease and other degenerative cortical dementias such as Lewy body disease, vascular dementia, Creutzfeldt-Jakob disease, Pick's disease and Korsakoff's syndrome. Our chapter provides support groups, First Link, family counselling, education sessions, an adult day program, in-home respite services, a resource library and staff training for agencies that also serve clients with dementia.

We are currently providing services to over 550 families throughout the districts of Sudbury and Manitoulin. Demographic data projections estimate that there are currently 2,700 persons with dementia in our two districts. These numbers are expected to rise to 4,650 over the next 20 years.

The Alzheimer Society has a partnership with the Sudbury Regional Hospital and several other community agencies to address the needs of a particularly vulnerable part of this client population. Debbie and I are here today to highlight for you the growing need for specialized care for patients in the later stages of dementia who demonstrate complex and difficult behaviours.

Why is this a problem? These behaviours affect their ability to live and function in both the community and present health care facilities. Some of these patients have had mental health problems in their past life, and these are now compounded by their dementia.

Did you already hear a presentation from my colleague in North Bay, Linda Brown? She was going to be talking to you via teleconference.

The Chair (Mr. Kevin Daniel Flynn): No. She's the person we were supposed hear from at 1, but we were late for lunch, so we put her off to 2:20.

Ms. Patricia Montpetit: Oh, I see.

The Chair (Mr. Kevin Daniel Flynn): But we are hearing from her, for sure.

Ms. Patricia Montpetit: I believe she will be talking in her presentation about stigma and dementia. It's important to understand that dementia is a highly stigmatized condition.

In 2006, a nationwide public opinion poll revealed that Alzheimer's disease is the second most feared disease by Canadians, preceded only by cancer. This fear is rooted in the misconceptions and stigma surrounding dementia. One of the greatest misconceptions about dementia is that the condition causes people to become aggressive or violent. In fact, only a small percentage of people with dementia exhibit these behaviours.

In the past, these behaviours were referred to as aggressive or volatile behaviours. We prefer to call them responsive behaviours, as they actually are the person with dementia's response to a trigger in their environment that they perceive to be threatening. These behaviours can and do cause harm to the persons themselves or to others around them, including other patients, and also caregivers.

As a result of their unique challenges, these clients often cannot be cared for in the community. They frequently end up living in an acute care hospital setting with no discharge designation. In fact, during the past year, Sudbury Regional Hospital has averaged seven to eight alternative-level-of-care patients per day who have responsive behaviours resulting from dementia.

The long-term-care homes and other facilities often cannot accept these patients for admission into their facilities as they feel they are unable to meet their specialized needs. They are concerned for the safety of their other residents and their staff. These patients therefore become homeless, and as a result they end up living in an acute care hospital setting. This has created a huge bed management challenge. At the Sudbury Regional Hospital, this patient population accounted for approximately 2,555 patient days in acute care beds in the past year, and this scenario is being repeated in hospitals throughout the province.

1330

Quality of life becomes a huge issue for these patients. Persons with dementia need to be supported in caring and dignified environments, with opportunities for meaningful and therapeutic activity consistent with their individual strengths and potentials. Hospital wards are not designed for, or resourced appropriately, to provide the care that they need. As a result, behaviours often escalate in these settings, and sometimes chemical restraints are the only alternatives available to defuse difficult situations.

Sixty-five per cent of the residents who currently live in long-term-care homes in Ontario have some form of cognitive impairment. As their diseases progress, some of these residents also develop responsive behaviours, and the homes have difficulty managing their care appropriately and safely. This can result in emergency room admissions or transfers to hospital, and in other instances it has led to resident injury and even death. One such tragedy occurred at a nursing home in Sudbury two years ago when a resident killed his roommate. The Casa Verde home in Toronto experienced an unfortunate violent resident death in 2001, which led to a provincial inquest. One of the 85 recommendations of that inquest was to implement specialized units to meet the needs of individuals with assessed mental health and behavioural challenges. I have to say that we are disappointed in the progress that has been made to date since that inquest made those recommendations.

So what is the solution? The province needs to put in place additional specialized geriatric mental health services which provide added expertise in diagnosis,

behavioural strategies and pharmacological treatment. Key resource requirements include the following. First, staff throughout the continuum of care need specific training on how to prevent people with dementia from developing responsive behaviours and how to care for those who do. There are several training modules that have been developed specific to working with this population. One is called PIECES, another is U-First, and the gentle persuasive approach is another. However, there is insufficient funding in the system to provide this training to all those who need it.

Second, integrated support teams need to be available in each community which would take a case management approach to support the individual's needs regardless of where the client is residing.

Third, specialized responsive behavioural assessment units need to be established in every region across the province. These units need to have specially designed environments, security and trained staff. They need to have sufficient resources to provide a safe environment for both residents and staff. These behavioural assessment units would provide assessments and treatment plans for individuals who are presenting challenges in their current settings. Then they would be transitioned back to their referring facilities, allowing the unit to be able to serve additional people. There are only a few examples of behavioural assessment units currently operating in Ontario. These include the Dorothy Macham Home at the Sunnybrook Hospital and the T. Roy Adams Regional Centre in St. Catharines.

The North East Local Health Integration Network is very aware of the need for these resources. In 2007, ALC task forces across the North East LHIN identified the need for this range of services, and this past year, Sudbury's ALC steering group identified specialized services for this population as one of its 10 priorities.

Here in the Sudbury area, several agencies and facilities have been working together to determine what our community needs to address this population. This cognitive working group was spearheaded by the Sudbury Regional Hospital, and we're developing a proposal for both an integrated community support team and a behavioural assessment unit. We hope to receive funding from the North East LHIN to address this gap in our continuum of care.

What can you do about this? Besides the need for additional resources, some provincial policy barriers currently exist that make integration of the support system difficult. For example, some of the rules around discharge, time away and readmissions to long-term-care homes need to be revised to allow enough time for behavioural assessments to be effectively completed, and there is some policy work required on wait-list management for specialized units.

In conclusion, we would urge the select committee to include in your report a specific recommendation to government to establish a system of supports for persons with responsive behaviours.

Thank you very much for your attention to the needs of this vulnerable group of Ontarians.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Patricia. You've left some time for questions, about two minutes for each side. Let's start with France.

M^{me} France Gélinas: Thank you, Pat. I was interested in the "key resource requirements include"—the first one was about training; the second one, integrated support teams. Can you talk to me a little bit more about how this would work?

Ms. Debbie Szymanski: I guess one of the biggest challenges we see is, you don't just want to build a unit; you want to build it so that it can continue the flow. We need some expertise, which we have a little bit of—there are very limited resources in the northeast, specifically—where the teams would come to the patients and clients to avoid moving them. It's the same as the aging-at-home strategy. It's the same idea.

If you're in a long-term-care facility, we don't want to be uprooting you. A lot of that work has occurred with our limited resources already. What we're suggesting is that there's actually a specialized team, some resources put to that so they don't end up going to emergency. You have people coming in with the expertise to support them in a group home, in a long-term-care facility, to do the assessment, do the medication readjustment and then escalate them to the specialty-care unit if required.

I think one of the biggest challenges with the units they presently have in the province is that you just don't move them there, and of course you're going to end up with a huge wait-list and you'll never have enough resources. I think it's the same as the challenges with the long-term-care homes.

Having the integrated team is a key part, not just building the unit. You want to keep as many of the clients and patients as you can where they are, safely. I think that that's the key part that we're lacking.

M^{me} France Gélinas: As well as, we don't have the unit.

Ms. Debbie Szymanski: We don't have the unit. That's right.

M^{me} France Gélinas: The second is, at the very end, when you said there are some policies that need to be revised, I'm thinking that you're talking about the 21 days if you're gone—21 days from your bed, then the bed is given up.

Ms. Debbie Szymanski: Yes.

M^{me} France Gélinas: How long do those specialty-care units need to work for—and how do you see this working?

Ms. Debbie Szymanski: I think there are two points with it. The wait-list management that's managed through CCAC deems that, unless there's a specialty unit—for example, right now on the wait-list, if you apply for a placement but you have specialty needs, you're put into the big bundle and pot. So if a specialty bed comes up and, say, we had our unit right now in Sudbury somewhere, that particular patient would not go on a specialty responsive behaviour list. So if the bed came up in that unit, CCAC could not offer it to the appropriate patient. There needs to be that policy change

on how specialty units, the specialty process, has to be defined.

On the second part of the 21 days, I'd hate to see empty beds in the system, as there isn't enough, but we would like to guarantee that the patient would get back to the same facility. We're not really saying as a policy that you'd want to hold the bed, because right now, with the mental health—they could stay 45 days. Understanding that, in our hospital right now, we have about 85 to 90 placements waiting for that particular bed, it would be statistically kind of—a lot of empty-bed days in the province. But I do believe there's some opportunity to allow those clients to have a priority to get back to their facility. That's home.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Debbie. Anybody from this side? No? You're good? Christine or Sylvia?

Mrs. Christine Elliott: A quick question: You mentioned earlier the Casa Verde inquests and that you were disappointed at the lack of uptake, I guess, on some of the recommendations with respect to the specialized units. Do you have any idea how many of them have been created?

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Ms. Patricia Montpetit: How many specialized behavioural assessment units?

Mrs. Christine Elliott: Yes.

Ms. Patricia Montpetit: We're only really aware of the two that we mentioned. There are a number of projects around the province that are trying to get funding to get started but they have not yet succeeded, I guess, because there is no pot of money for this. You have to kind of—

Ms. Debbie Szymanski: Create. And I think that for here we've done as much from subgroups and working groups. We've done the integration, the education, the communication, but now we actually need the mortar and the bricks—

Ms Patricia Montpetit: The money.

Ms. Debbie Szymanski: —and it's not there structurally, because it's a unique and growing need. Many of these patients we highlighted have had a mental health diagnosis in the past, which actually compounds the care of them because: Is it the dementia? Is it their past mental health challenges or diagnosis? Often you need a team of a psychiatrist, family physician and gerontologist, so you have three or four pods. I think statistically we did a study here regionally: At least 30% to 40% of those with the dementia also have a mental health diagnosis. So that's why we're here. It's not in isolation. And if you know that one out of every three people have some type of mental health challenge throughout their life, statistically that makes sense. Once you've been labelled with that, that stigma comes back and it becomes very difficult to find a home, as you're probably hearing from other speakers. So it's a very complex patient and a challenging situation.

Mrs. Christine Elliott: Just one quick follow-up: Do you need to have a different kind of specialized team to

work with this group of people, as opposed to some of the other integrated teams we hear about that work in other areas of mental health and addictions, for example?

Ms. Patricia Montpetit: Yes, because this is a geriatric population. For example, the ACT teams that are in the community wouldn't touch this group.

M^{me} France Gélinas: Do we have a second left?

The Chair (Mr. Kevin Daniel Flynn): Yes, we do.

M^{me} France Gélinas: Can I have it?

The Chair (Mr. Kevin Daniel Flynn): That was it.

M^{me} France Gélinas: Is there an appetite out there within the nursing home operators to have those special responsive behavioural assessment units or are they a tough sell?

Ms. Patricia Montpetit: Well, the opportunity for them to get such a unit hasn't come up. I think we could probably find a long-term-care facility that would be willing to implement this if we were able to come up with the funding. It would probably require either a retrofit or choose one that's about to be built, for example, and ask them to take this on as a specialized need.

M^{me} France Gélinas: But the funding would be over and above what they get for the daily—

Ms. Patricia Montpetit: Definitely. They could never do it with the per diem rates that they have for long-term-care facilities.

Ms. Debbie Szymanski: We researched that in coming up with a proposal that I'm just finishing up, and one of the things they're saying is that at minimum, with the ones that are functioning, you'd need an additional \$100 to \$150 a day on an operational basis, so yes—

Ms. Patricia Montpetit: Per patient.

Ms. Debbie Szymanski: Per patient. Really, because if you look at their specialty needs, often needed is one-on-one for the first assessment period, a totally different type of challenge, and the challenge out there is that there are not a lot of data because there are not a lot of units to establish the cost per patient day that's required.

M^{me} France Gélinas: The two that are there, who pays for those?

Ms. Patricia Montpetit: The Ministry of Health.

M^{me} France Gélinas: Do they? Okay.

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

TERRIE PITFIELD

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is getting set up, and it's Terrie Pitfield.

Hi, Terrie. Thanks for joining us today. Everybody has been given 20 minutes today, and you're exactly the same. You can use that any way you see fit. If you'd like to leave some time at the end for discussion, that's entirely up to you. It's not necessary, but it usually works best.

Ms. Terrie Pitfield: Okay, perfect. Thank you for having me.

I do a lot of presentations, and I have to say, this is one that makes me—I put it a lot of thought into this presentation. It's about my personal struggles with mental health and addiction issues. It is by far the most important presentation, I have to say, that I've probably given. Changes need to be made to a mental health and addiction strategy, so I'm so grateful that you're all here and you're having these meetings across the province. So I'll get started.

I titled this *Bringing Mental Health and Addiction Treatment into the 21st Century: Strategies Based on Science as Opposed to Ideologies*. I have two quotes in this presentation. Both are from Dr. Gabor Maté's book *In the Realm of Hungry Ghosts*. I'm sure some have read it. It is an amazing book, and I think anybody who is in the field of mental health and addictions should read it. He's right on.

"So what is addiction, really? It is a sign, a signal, a symptom of distress. It is a language that tells us about a plight that must be understood."

Who I am: I'm an aboriginal two-spirit woman. For those don't know the term "two-spirit," I identify as lesbian. In aboriginal teachings, two-spirited people were very much revered and honoured. Since the arrival of Europeans and colonization, homophobia is very much, unfortunately, ingrained in aboriginal communities. It is not an original aboriginal value. I'd just like to say that.

I struggle with mental health issues which have resulted in a predisposition to alcohol and drug use. I was adopted at three months into a wonderful, loving adoptive family. Despite that, I began using alcohol at 14. I got sober at 29. When I was 17 years old I had a major identity crisis. I realized I was lesbian at that time and had been adopted—this was hidden from me. I felt completely lost, disconnected and alone. My parents just never felt it was the right time to tell me I had been adopted, so I had a major, major identity crisis at that time, as you can imagine.

A key factor, I believe, was the adoption. Also, my birth mother was 45 years old, possibly drug-addicted, definitely homeless. She was a sex trade worker, incarcerated while she was pregnant with me, and had a history of mental illness. I'm not sure what exactly. My siblings insist that she was schizophrenic at the time, but I saw her at the end of her life and I don't believe she was schizophrenic. She was never clinically diagnosed. She also had a history of extremely abusive relationships with men.

According to Dr. Maté's book *In the Realm of Hungry Ghosts*, "Numerous studies in both animals and human beings have found that maternal stress or anxiety during pregnancy can lead to a broad range of problems in the offspring, from infantile colic to later learning difficulties and the establishment of behavioural and emotional patterns that increase a person's predilection for addiction. Stress on the mother would result in higher levels of cortisol reaching the baby and, as already mentioned, chronically elevated cortisol is harmful to important brain structures especially during periods of rapid brain development."

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He goes on: "Any woman who has to give up her baby for adoption is, by definition, a stressed woman. She is stressed not just because she knows she'll be separated from her baby, but primarily because if she wasn't stressed in the first place, she would never have had to consider giving up her child: The pregnancy was unwanted or the mother was poor, single or in a bad relationship, or she was an immature teenager who conceived involuntarily or was a drug user or was raped or confronted by some other adversity. Any of these situations would be enough to impose tremendous stress on any person, and so for many months the developing fetus would be exposed to high cortisol levels through the placenta. A proclivity for addiction is one possible consequence."

This is what I believe: There is a definitive link between mother-to-child cortisol levels that have set the stage for my mental health and addiction struggles.

Also, the primal wound that is created when an infant is removed from their biological mother creates additional issues that need to be widely researched and addressed as they relate to mental health and addiction.

If future adoptive parents are made aware of the scientific evidence and the potential for addictive behaviours and/or mental health challenges, they can be given the tools to aid their child's development. These tools may include proper diagnosis by a mental health professional, medication, exercise, and techniques such as meditation and introduction to spiritual outlets, such as native teachings and Buddhism.

If I had been properly diagnosed at a young age, given proper medication and alternative outlets to deal with anxiety—why I felt the need to use drugs and alcohol to cope with life—it might have saved years of struggle for me.

Moving along in my journey: I was sober for 12 years. I attended AA meetings. I still struggled with some mental health anxiety issues, and I was told it was because I wasn't really "working a program."

Ten years into my sobriety, I started self-medicating with Tylenol 1s, occasionally OxyContin and Ativan, to deal with stresses in my life. Not surprisingly, I picked up a drink in December 2008, drank twice after that and, in order to deal with the shame and guilt around that episode, continued to self-medicate with Tylenol 1s, T3s if I could get my hands on them—they're not hard to find—and Ativans.

I thought I was intrinsically flawed. That's what Alcoholics Anonymous told me. I was unable to deal with life on life's terms, incapable of being honest with myself and others.

After pleading with my doctor, being honest about my drug use and self-medicating and drug seeking, he prescribed trazodone 50 milligrams in addition to the 300 milligrams of Effexor that I'd been taking for about eight years.

Since I've started that medication, things are much better. I no longer need to go and buy Tylenol 1s over the

counter to deal with my anxiety and everyday stresses that someone who is not suffering from a mental health issue would have no problem dealing with.

He also made a referral to a psychiatrist, and I am still waiting for an appointment.

If I had not insisted, with him, “If you do not prescribe something for me, I will continue to find the drugs that I need to deal with my stresses”—at that point, I think he got it, and he agreed. So I’m very grateful.

I feel stable today, able to focus, concentrate and do those things that aid in my recovery and allow me to be a contributing member of the community.

What I know for sure: My mental health and addiction treatment requires a combination of therapies, not all in this order: medication, exercise. Meditation has been a wonderful outlet. Meditation is really, really important for people who are dealing with mental health and addiction issues.

AA meetings: I still go to meetings. I still “work a program”; I guess now I’m really working the program. Counselling: I see a counsellor once a month, and I have a really, really good spiritual connection which I have developed and found a lot of help with through Buddhism principles and teachings, native teachings and, of course, the 12-step program.

My hopes:

- a mental health and addiction strategy that would encompass extensive research into the links between trauma, stress and the biology of addiction;

- culturally based mental health addiction services specific to the aboriginal population and their unique issues: This would include education around the history and impact of colonization, residential school trauma, adoption and foster care issues, loss of culture and generational trauma. As a people, many believe we are intrinsically flawed when there are legitimate reasons why we are collectively so unhealthy as a people;

- multi-faceted approaches which would include all possible treatment options—spiritual, physical, emotional and mental;

- a widespread campaign to address stigma and discrimination;

- education and training around harm reduction as a legitimate and effective strategy in dealing with mental health and addiction issues;

- implementation of harm reduction as one of the core principles of a mental health and addiction strategy for Ontario;

- a spiritual component that provides easy access to all spiritual options. That may include access to spiritual retreats, spiritual teachers and the healing powers of mindfulness meditation; and

- training for mental health and addiction professionals around the benefits and legitimacy of medication as a combination therapy instead of just another attempt by drug users to obtain drugs.

Finally, something that is really, really important for people is a loving non-judgmental connection with other human beings. That can be done through spiritual teach-

ers, an elder, 12-step sponsors, a peer or people who volunteer and want to spend time with individuals who are on a healing journey.

As for my birth mother, I did meet her two years ago. She was 85 then. She had suffered a stroke eight years before that and was living with my birth sister. She did not acknowledge that I was one of her children, which was okay with me. I was one of two that she had relinquished at birth. For the very limited time that I spent with her, she never talked about the past, except to say that her childhood was wonderful. Unable to have any loving relationships throughout her life, including with her seven children, she lived much of it in poverty and isolation. She passed away at 87 in May of this year. I sat at her bedside the evening before she passed, and she gave me a smile. That was good enough for me; she acknowledged that I was there with her.

So full circle: It is not surprising to me that I do the work that I do, involved in street outreach on the same street where my birth mother worked and lived in the late 1960s here in Sudbury on Elgin Street. I also do programming in the Sudbury jail with high-risk aboriginal men and women around safer sex practices, harm reduction techniques around their drug use and the services that are available to them in the community. You see, I am them. Fortunately for me, the combination of a loving family life as a child, my involvement with AA meetings, personal research into the biology of mental health and addictions, therapy, medication, meditation and a strong spiritual connection through aboriginal teachings and Buddhism have brought me here.

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In the search for truth, human beings take two steps forward and one step back. Suffering, mistakes and weariness of life thrust them back, but the thirst for truth and stubborn will drive them forward. And who knows? Perhaps they will reach the real truth at last. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Terrie, for coming forward with your story. That was excellent. You’ve left a little bit of time for questions. Helena?

Ms. Helena Jaczek: Terrie, thank you so much for coming and for sharing your story and also your recommendations. I think we’ve heard quite a bit about your recommendations already—the issue of peer support or a friend, someone to connect to. But we’ve also heard the need for—and I don’t like the term, but I guess it’s being labelled case management. You seem to have found your way, it sounded through your story, almost as an individual, and you’ve obviously had a lot of insight into your condition and so on. In this greater Sudbury area, do you see examples of case management that are working? Is it missing? How would you like to see that piece help others?

Ms. Terrie Pitfield: I think what’s missing is—in this area, there is a lot of co-operation between agencies that do a lot of street outreach. I don’t think everybody’s on board in terms of harm reduction. There are no harm reduction policies in place. If people get it, things are sort of under the radar.

Ms. Helena Jaczek: We did hear from the Sudbury Action Centre for Youth. We were actually quite amazed by the numbers that they were seeing.

Ms. Terrie Pitfield: Yes. When I actually started working in this field, I started doing street outreach with them. Their harm reduction program has been going on for years. They do amazing work, but again, those agencies are very few and far between that openly have a harm reduction approach. I think it's still so misunderstood, what harm reduction means. People think that if you mention harm reduction, you're promoting drug use. We all know that drugs are going to be here for probably long after we are gone, so we need strategies and harm reduction programs that deal with the harm from those drugs.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We'll move on to the next question, if it's okay with you, Terrie.

Ms. Terrie Pitfield: Sure.

The Chair (Mr. Kevin Daniel Flynn): Who's next? Sylvia?

Ms. Sylvia Jones: Thank you for coming in, Ms. Pitfield. I want to delve a little deeper into your experience with peer support. Obviously, AA—it's a huge component of their program. It's all volunteer-based. How do you formalize peer support, or how would you envision formalizing that role?

I didn't say it was going to be an easy question.

Ms. Terrie Pitfield: No. The support that I've received from people in AA has been phenomenal. Of course, the issue with AA and NA is that they are abstinence-based programs. Is it possible to create positions for professional friends? I don't know.

Ms. Sylvia Jones: Does peer support work because it is a "been there, done that" sounding board as opposed to, "I'm the expert; let me tell you how you must do it in order for you to recover"?

Ms. Terrie Pitfield: Absolutely. "Been there, done that"—that's exactly what it is. There is an understanding, I think, between drug addicts, alcoholics; we understand each other.

Ms. Sylvia Jones: And does that, by extension, go into, "One route is not the only route to recovery," with peer support?

Ms. Terrie Pitfield: Yes.

The Chair (Mr. Kevin Daniel Flynn): We have time for a very short question and answer, France. We have the Alzheimer Society on the line.

M^{me} France Gélinas: You are the first one who insists so much on including meditation in the treatment option. Where did it come from and why is it so important to you? If it's personal, you don't have to share.

Ms. Terrie Pitfield: No, absolutely not. There's one component I did not speak about. This is a partner who has been with me since I sobered up, so we've been together about 13 years. If it had not been—I'm angry with her right now because she's insisting I quit smoking, so I didn't want to include her in my presentation.

Ms. Sylvia Jones: You should listen to her.

Ms. Terrie Pitfield: I will.

She has literally forced me—and not wanting to lose that relationship—to look in other places for techniques that will help me heal, that will keep me sane, and meditation has been a godsend.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. That was a wonderful story and I think you got your point across very well.

Ms. Terrie Pitfield: Good. Thank you.

ALZHEIMER SOCIETY, NORTH BAY AND DISTRICT

The Chair (Mr. Kevin Daniel Flynn): Waiting on the phone is the Alzheimer Society of North Bay and District.

Ms. Linda Brown: Yes, hello.

The Chair (Mr. Kevin Daniel Flynn): Hi, Linda. How are you?

Ms. Linda Brown: Very good. Can you hear us okay?

The Chair (Mr. Kevin Daniel Flynn): Yes, you're coming across like you were sitting in the room.

Ms. Linda Brown: Oh, that's good.

The Chair (Mr. Kevin Daniel Flynn): In fact, a friend of yours is sitting in the room. Patricia Montpetit is with us as well.

Ms. Linda Brown: Hi, Pat.

The Chair (Mr. Kevin Daniel Flynn): All members of the committee are here. I'm Kevin Flynn. I'm the Chair. Everybody has been getting 20 minutes to make their presentation. You can use that any way you see fit. If you can leave some time at the end for some questions and answers, that would be wonderful, but it's not necessary.

Ms. Linda Brown: Okay.

The Chair (Mr. Kevin Daniel Flynn): You're coming across really clearly right now. So if you're sitting in a comfortable place, stay right there. It's all yours.

Ms. Linda Brown: Mr. Chair, members of the select committee, ladies and gentlemen, we thank you for the privilege to speak with you today on behalf of the Alzheimer Society of North Bay and District. Let me introduce myself as Linda Brown, the executive director and the caregiver counsellor of the Alzheimer Society of North Bay and District, as well as my colleague Kathy Gaudaur, the education coordinator of the society.

Prevalence and impact: More than 180,000 people in Ontario have dementia and in less than 25 years the number will double. Dementia is the leading cause of disability in Ontarians over 60, causing more years lived with disability than stroke, cardiovascular disease and all forms of cancer.

Dementia has a dramatic impact on the health system as well. Persons with dementia use one third of alternate-level-of-care-bed days. Dementia is highly correlated with hip fractures, and persons with dementia occupy over 60% of our long-term homes; 57% of older persons

presenting at one emergency room had a cognitive impairment. Today, there is no cure. Dementia is fatal.

Our mission statement: Our mission at the society is to alleviate the personal and social consequences of Alzheimer disease and related disorders and to promote research. Our goal is to foster excellence in service, education and research.

What is dementia and Alzheimer's disease? Persons with Alzheimer's disease or dementia face stigma on a daily basis that is associated with mental illness and ageism. Our aged population quite often feels excluded and their value diminished because of how our society views the elders. We are all so busy, we sometimes not knowingly force these individuals into isolation.

Dementia symptoms include the loss of memory, judgment and reasoning. Changes in moods, behaviours and communication are also noticeable. These, in turn, affect the person's abilities to function properly in normal daily activities such as work and social interactions.

Alzheimer's disease, the most common form of dementia, is a progressive, degenerative disease of the brain, which causes thinking and memory to become seriously impaired.

The disease impact: The majority of clients on our caseloads have an average age of 70 years. They are living with a spouse of similar age or older. The spouse is usually assuming the majority of caregiving duties in the face of their own advancing age and ill health. Children who are caregivers for aging parents are usually in their 40s and 50s. They face daily stress by having to balance parental commitments to their own children and/or the demands of outside employment. Older caregivers often endure self-imposed isolation. This is because of the embarrassment and stigma created by the deterioration of personality and behavioural changes associated with the progressive and unrelenting course of the disease. When they do seek help, they are often in the midst of a full-blown crisis.

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Help and accessibility: Establishing a First Link referral process in the community can provide an early access for families into the system so that they could gain awareness of the disease. This allows them to plan effective coping strategies as their family member progressively degenerates with the disease. Part of effective planning and adoption of healthy coping patterns is knowing when and where to access the community resources that can offer relief. This will help decrease stress and avoid crisis that can unnecessarily lead to a premature facility placement for their individual family member.

The family's ability to access either in-home or day respite becomes a critical factor in prolonging a dementia person's continuance in their home environment. Respite care allows the caregiver time and freedom to pursue their own personal, social, and recreational endeavours. They can also involve themselves in caregiver support services and education that provide benefits from information sharing, strategy building and mutual support.

There is evidence that education, support, and counselling for caregivers can increase the length of time they can provide care for family members at home, delay death of the care recipient, improve interactions between caregivers and care recipients and significantly reduce depressive symptoms in caregivers.

People with dementia need more time to engage with in order to have them do their care with the least amount of stress and confusion possible. In the later stage of dementia or Alzheimer disease, we can see the physical effects of these illnesses but we can't see the mental and emotional effects. It takes time to get a simple message to be understood, such as personal health needs and nutritional needs. Agitation and mood changes can be experienced when trying to get someone with this disease to co-operate and help with any given task. As the communication diminishes, so does our emotional and mental contact diminish. Looking after someone with Alzheimer's disease or dementia becomes a heavy responsibility and can cause a great deal of stress on the caregiver.

Stigma versus diagnosis: Today we still see people waiting to seek medical help for their memory impairments. When you talk to these individuals, you notice that the fear of Alzheimer's disease kept them from seeking the medical attention needed early on. Many view this disease as a crazy person's illness linked to aging. It is viewed as a mental illness, and in part this opinion is correct. The person who has Alzheimer's disease or a related dementia suffers from short-term memory loss. They also lose the ability to do familiar tasks such as bathing and dressing properly for current weather conditions. They may wander or get disoriented when they leave their home even if they are just in the front yard. They forget names of family members or friends, and keeping a normal conversation becomes quite difficult. Persons suffering from this illness tend to isolate themselves, and caregivers, not knowing what to do, accept this isolation. Caregivers commonly don't tell friends, neighbours or family that their loved one suffers with a cognitive illness. They know if they do tell, it is common for friends, neighbours and family to become fearful and stay away. Now we have a situation where the caregiver is alone to face this disease, and the person who is ill usually is in denial. This, combined, will become a crisis situation in a short amount of time. With early diagnosis, there are medications that can help with behavioural issues, depression and mood changes. In turn, this makes the illness more manageable and can give longer stabilization with the disease.

The stigma of cognitive illness is noticeable particularly in smaller communities which are common in northern Ontario. People do not want neighbours knowing there is a loved one residing there with Alzheimer's disease or a related dementia. Helping these people takes time and becomes more of a challenge. Embarrassment and fear of judgment tend to create isolation and anxiety. People do not want other people to know when there are cognitive problems within their own family unit. It is surprising to see just how many people believe that

generally uneducated individuals are the ones affected by Alzheimer's disease.

Alzheimer's disease is frightening for the victim, caregivers and professionals. It is a progressive disease that we cannot really change, nor can we avoid the ultimate outcome.

Community health care cost-containment strategies, aggressive hospital discharge policies, limited day program spaces as well as an aging caregiver population have intensified the need for respite care over the last several years.

As the population ages, the number of individuals affected by Alzheimer's disease and related dementias is expected to increase dramatically over the coming years. The need for a coordinated response for all of those dealing with dementia is crucial.

Recreational activities, education and support services help those affected by the disease to maximize basic motor functioning and reasoning abilities, build confidence and socialize more effectively, as well as to plan for their future.

It is our pleasure to thank you for recognizing our efforts in providing the necessary services that assist our community in accepting and respecting the dignity of these people and their caregivers.

I'll now pass you through to Kathy Gaudaur, our education coordinator.

Ms. Kathy Gaudaur: Can you hear me okay?

The Chair (Mr. Kevin Daniel Flynn): That's good, Kathy.

Ms. Kathy Gaudaur: Thank you. If you look up the word "stigma," Wikipedia says, "Stigma is often based on ignorance, irrational or unfounded fears, mass hysteria, lack of education, or a lack of information pertaining to a particular person or group. Social stigma often leads to marginalization."

It's interesting to explore this definition as it pertains to Alzheimer's disease and related dementias. Stigma is often based on ignorance. There can be many misconceptions about Alzheimer's disease and related dementia due to ignorance. One misconception is that many people believe that once a person has Alzheimer's disease or dementia, they are living in a long-term-care facility. In actual truth, most Ontarians with dementia today are supported outside of institutions, in their own homes, with their families.

Stigma is often based on irrational or unfounded fears. Alzheimer's disease and related dementia are often mistaken as diseases that affect only old people. In actual fact 15%, or one in six, people with dementia are under the age of 65. It's interesting to note that as the baby boomers age, it's often said that 50 is now the new 40, and society generally portrays aging in a negative light.

Stigma is often based on mass hysteria. One excellent example of a stigma is the common belief that all old people get Alzheimer's disease or dementia. Alzheimer's disease is the most common form of dementia. It is a progressive, degenerative disease of the brain. It is not part of normal aging. That being said, as baby boomers

age with longer life expectancy rates, there certainly will be a rising tide of people, with Alzheimer's disease and dementias having an impact on Canadian society.

Stigma is often based on the lack of education. The Alzheimer Society strives to help educate people in the early stages of the disease, caregivers and family, professional caregivers and the general public. One study concluded that for every person affected by Alzheimer's disease, 10 to 12 others are directly impacted. These include caregivers such as family members, friends and neighbours, and employers and health care workers.

Stigma is often based on a lack of information pertaining to a particular person or group. Many families are embarrassed or feel a sense of failure if they place their loved one in a long-term-care facility. Often, when faced with a diagnosis of Alzheimer's disease or dementia, many families feel shame and try and hide their loved one from society. This action further isolates the care partners. Stress levels have been reported as three times greater in care partners of people with dementia as those caring for people with other chronic diseases, and depression is nearly twice as common.

Social stigma often leads to marginalization. Support groups and caregiver counselling can help keep patients with Alzheimer's disease and related dementia at home. One study found that a caregiver support program resulted in a 28% lower risk of nursing home placement compared with usual care. Caregiver support in Canada may depend on a network of the diagnosing doctor and on local resources and availability, which is why First Link is tailored to services in an individual community.

In conclusion, the written definition of "stigma" that I've tried to explain doesn't fully portray the difficulties faced by people diagnosed with Alzheimer's disease or related dementia.

Imagine sitting in a doctor's office with your spouse of 30 or 40 years and being told that you have a disease that will slowly rob you and your family of your life's work, future dreams and past memories over the next 10 or 15 years. There are no survivors.

Thank you.

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Ms. Linda Brown: We're open to any questions now that anybody may have.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you, Kathy. Thank you, Linda.

We'll start with this side. Any questions from this side? Let's go to Sylvia.

Ms. Sylvia Jones: It's not so much a question as a statement. You're not the first committee that has raised the stigma relating to Alzheimer's. I guess I'm surprised that there is that much stigma associated with it. Maybe that's because personally I've been affected by it. But it amazes me that your focus and that of others presenting on behalf of Alzheimer's societies is that it is such an issue that you must overcome on an obviously regular basis.

Ms. Linda Brown: This is Linda talking. Yes, it is. I'm the executive director here at the society, but I also

do the counselling with families. I do the counselling in smaller communities as well. It's so amazing to see the people we are meeting, how they are still back in the olden days when you had a family member who had Alzheimer's disease and they did relate it as a crazy person's disease, where they automatically took that person and locked them up in the psychiatric hospital and they were never to be seen again. So there are a lot of people who are afraid to come forward when they're starting to have cognitive problems. They don't want their friends or their neighbours to know, because they are afraid that that's what people are going to think—"Oh, my God, there's mental illness in the home. Stay away. Keep your kids away, because there's a great amount of danger there"—when in fact that's not the case. That's why it's so important to get the education out there so that people know this is not the fact. This is a disease, it does cause a mental illness, but you don't have to be afraid of the person who has the disease.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France and then Maria.

M^{me} France Gélinas: Thank you for your presentation, Linda. You mentioned that for a number of reasons—aggressive hospital discharge, limited day program space etc.—there is a need for respite care that has grown over the last several years. Why don't we put in place more respite? Is this a question of funding? And what types of respite work best, or are there a series of respite options that work best with people with Alzheimer's?

Ms. Linda Brown: I'd like to give you an answer for sure as to why there was not enough respite in the communities. Funding certainly is a big issue surrounding it, but the type of respite care that our clients are looking for—they really need to have somebody in the home to help with bathing issues and personal care issues, but they also need the break as well. If you're looking after somebody who has Alzheimer's disease, it's a 24/7 job, and quite often these people are up during the night as well. If you're up during the night with somebody who has an illness and then you have to be up during the day, it's not going to take very long before you're going to have burnout. So respite care is so, so relevant. We're not asking for 60 hours a week of respite care. The clients we have who are receiving up to 12 and 16 hours a day of respite care are happy with that and they're very grateful for that, but sometimes that's just not enough. Sometimes overnight respite would be great so that they could get a really good night's sleep.

We run support groups and education sessions, and quite often our clients can't make these groups at the times that we set out. We try to accommodate everybody, but it's very difficult to do. If we were able to access some respite services so that these people could come to our sessions, that would help as well, but that's not always looked at as a need to provide respite services in the home.

M^{me} France Gélinas: Where does the money come from right now for the respite that you do offer?

Ms. Linda Brown: Our agency itself does not offer respite services. The Alzheimer Society of North Bay doesn't have that. The people have to access the community care access centre or our community support services, and their funding comes through the LHIN.

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

Mrs. Maria Van Bommel: In your presentation you talked about the education, support and counselling for caregivers that would increase the length of time that they could provide care for their family member, but I was also glad to hear you say you're caring for the caregiver. My husband has been involved with the VON. On a volunteer basis, he would visit with the Alzheimer's patients at their homes. But he found over time that very often, although the intent was that he would stay and give some respite to the caregiver, the caregiver actually, over time, had lost all social contact with friends. He provided as much social—actually, he probably provided more social activity and conversation with another adult for the caregiver than actual help with the Alzheimer's patient.

So I was glad, and that was my question to you: What kinds of programs have you got for the caregivers to help them take care of themselves and keep up their social contacts and do that sort of thing? It's not just about going out and having time to go get the groceries, or maybe even a night's sleep, but just that whole social aspect of being a caregiver who gets isolated because they're doing this 24/7.

Ms. Linda Brown: A couple of things that we do—first of all, the support group does allow them an opportunity to come and meet other individuals who are going through the same thing as they are. I can tell you, from running my support group, sometimes we enter into a group and the only thing we do is cry, perhaps, for an hour and a half, whether it be for a loss of somebody who has Alzheimer's disease or just for the loss of a life that people have built together. Sometimes we go into that session and we just laugh for an hour and a half because that's what we need to do. Friendships are made and support systems are made. Those are very, very important.

Here at the agency, we run a teddy bear club in which we try to get some of our caregivers together once a month, or whatever they can, to knit and crochet. What we do is we crochet these teddy bears and we hand them out around the holiday time to long-term-care homes and to hospitals. These teddy bears are like a therapeutic item. They offer comfort and a form of security to people who have Alzheimer's disease.

We're also taking a look at starting an art therapy program. This is going to be for individuals with Alzheimer's disease, but it's going to be a way for caregivers to come out as well, in a different kind of environment where there's more socialization. It's very, very difficult to get caregivers out on any form of a regular basis because a lot of them can't go out on their own. They have to have somebody staying with their loved one. This is where the difficulty sometimes arises. Out of a group of 10, you might be able to get three to come out for

something, for an event, at the same time, and the next time you might get a different three. It just really depends on the circumstances at home and how much time they can afford to get somebody in to look after their loved one while they're out at an event.

The Chair (Mr. Kevin Daniel Flynn): Speaking of time, Linda and Kathy, we're out of it.

Ms. Linda Brown: Oh. I was just getting into it.

The Chair (Mr. Kevin Daniel Flynn): I know. I could tell you were on a roll there. I didn't want to jump in. Thank you very much for joining us this afternoon.

Ms. Linda Brown: Thank you very much for giving us this opportunity. We really do appreciate it.

Ms. Kathy Gaudaur: Thank you so much.

LORIE BELL

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this afternoon is Lorie Bell. Lorie, if you'd like to come forward. Thanks for accommodating our phone call there. Just make yourself comfortable. You've got 20 minutes, like everybody else. Use that any way you see fit.

Ms. Lorie Bell: Do I have to put the mike on?

The Chair (Mr. Kevin Daniel Flynn): The mike will turn itself on. You just have to have good thoughts and then the light comes on.

Ms. Lorie Bell: Oh, there you go.

The Chair (Mr. Kevin Daniel Flynn): If the light doesn't come on, I don't know what that means. If you stay about a foot away from it, it works great.

1430

Ms. Lorie Bell: Okay. Hello. My name is Lorie Bell and I work as a concurrent worker in the transitional outpatient program at the Sudbury Regional Hospital, mental health and addictions. However, I'm not going to be presenting on that because my colleague, I heard, did a wonderful presentation on our program and another colleague did one on the concurrent. So I'm going to be presenting as an aboriginal citizen who lives in Sudbury. I'd like to talk about my vision of what I would like to see from consulting and speaking with other aboriginal people in the area.

I had many ideas when I began this, but was able to find my general themes as partnership building, cultural space and education research. I am presenting the general comments I have heard from the aboriginal community in Sudbury over the last few years. Many are based on the concept of connected services that are all on the same page.

Partnerships: The aboriginal community in Sudbury is interconnected, and the feedback I am getting from the aboriginal community is that we need to work in partnership with Shkagamik-Kwe Health Centre native mental health program and N'Swakamok Friendship Centre addiction programming to develop and enhance the understanding of concurrent programming to meet the needs more effectively.

I am proposing an allocation of funding to provide a safe cultural space and human resources within the Sudbury hospital's outpatient services in order to create a bridge between our services to address increasing aboriginal populations and plan preventive strategies to service the increasing aboriginal youth populations. As you are aware, the mainstream populations are aging, and planning is under way to prepare for this increase in services to deal with this. However, there's a rapid increase in aboriginal youth and we need to prepare services for that as well. This partnership will allow us to build on our strengths and decrease any duplicate services that may be in the area.

The next theme I had was an educational initiative to enhance best practices for aboriginal services within cultural-specific programming and mainstream programming.

Another area of concern is the focus on evidence-based practice. Although many aboriginal people want evidence-based practice, there is a great concern about the studies conducted that may have excluded aboriginal populations and thus would not be applicable in some cases. Although there are features of cognitive behavioural therapy in many holistic approaches to healing, they are generally interwoven through a process and there is not such a strong focus on the manualized content, but rather the relational aspects would be of primary concern.

With this in mind, I am proposing a collaboration of partnerships with the Sudbury Regional Hospital mental health and addictions services, Shkagamik-Kwe Health Centre and N'Swakamok Native Friendship Centre to work in partnership with the native human services and native studies department at Laurentian University to develop case study research to identify best practices within aboriginal populations in northern Ontario. As you are aware, this type of initiative cannot be achieved without funding for a researcher.

Implementing a specific space for aboriginal people to utilize the mental health and addiction outpatient services: Align the spiritual with the emotional, mental and physical holistic healing. Many, if not most, studies have identified a holistic manner of healing for aboriginal populations. In order for that to be achieved, particularly in the mental health and addictions area, a safe cultural space is necessary to practise the spiritual aspect of our healing, a space which will allow aboriginal people utilizing our services to smudge, which is the use of sacred medicines, which in some cases means burning medicine in a safe smudge bowl. This space can also act as a visual symbol of inclusiveness for aboriginal people.

Of course, by now you are wondering how much this will cost, I'm assuming. I think it's a good investment that will pay off. When one segment of the population is overrepresented in almost every area of the system, we are all affected and there is disharmony within the groups.

The next was relationship-building with aboriginal inmates at the Sudbury District Jail. Although the jail

does have medical services, they are not designed for mental health and addiction treatment. I believe we could also partner with the native healing program and make the referral to our organization smoother. A high percentage of aboriginal people are in jail as a result of mental health and addiction issues and they are falling through the cracks. We have an opportunity to provide education regarding concurrent issues and develop relationships to motivate some of them to access our services and thus decrease the revolving door within the jails. Of course, this would require the allocation of at least one employee to go to the jail and work with the medical and native liaison services to assist in the process.

Lastly, I'd like to request that more monies be invested in DVDs and literature for people who are developmentally delayed or illiterate. When people are facing these challenges it is very favourable to their recovery to be able to direct them to literature that is specific to their presenting issues. Unfortunately, we are often not able to offer these services to people who are not able to read at a college or university level. I would especially like to see more materials developed for concurrent recovery.

With that, I would like to say meegwetch and thank you for your time and consideration in allocating funds to build strong partnerships with the aboriginal agencies providing similar services in Sudbury and for your consideration of grounding these partnerships in research, education, infrastructure and the inclusiveness of our worldview on healing practices.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Lorie. That was a great presentation. You've got some time for questions, and we're going to start with France.

Ms. Lorie Bell: I'll try my best.

M^{me} France Gélinas: Thanks, Lorie. Nice to see you.

I wanted to ask you: You identified, under "An Educational Initiative," "identify best practices within aboriginal populations in northern Ontario." Another presenter, this morning, who comes from an AHAC, an aboriginal health access centre, mentioned that she would like to see a symposium where we would gather all the best and brightest minds to put together best practices in mental health for aboriginal people. I was wondering what you think of that idea.

Ms. Lorie Bell: I think that's a wonderful idea as well. The reason I came to this conclusion is because we have a wonderful university here in Sudbury and a wonderful program. The BSW is in native human services, and there are only two programs like that in Canada, and the native studies. So they are training social workers there to go into the field. I thought it would act as a multi-level part of developing case studies in the work that we do and, at the same time, training the new social workers and exposing them to the environment at a hospital. I was thinking along those lines, but the other area is good too.

Our issues are a little different from southern Ontario's. Sometimes when we do come all together like that—we're all different groups, so we don't quite get the

same information as we might if we were in the northern Ontario area, I was thinking.

M^{me} France Gélinas: And Laurentian University sounds like a good ground to you?

Ms. Lorie Bell: It does, yes. I graduated from that program years ago and it was a very empowering experience where aboriginal people were encouraged to heal themselves before they go out into the workforce and work with people, and that was stressed. So the healing methodologies were done right there in the school to make sure that you were okay before you went out there. I've had a close relationship with them and all the new graduates coming out since then. I won't tell you the date.

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

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any questions from this side? Maria?

Mrs. Maria Van Bommel: Your concept of having a cultural space within the hospital is something new to me. This is the first time I've ever heard anyone talk about doing it. We did see it actually at Moose Factory in their hospital, where they had a traditional healing area, but in the mainstream general hospital thing I hadn't ever really envisioned anything quite like that, although quite honestly we have chapels in our hospitals that allow for that.

When you talk about it, would that really be a very expensive thing to do because, like you say, it really is just a matter of proper ventilation for the smudge pot and that sort of thing?

Ms. Lorie Bell: And an actual room. We're kind of bursting at the seams right now in terms of our space and resources. I don't imagine it would be too expensive to do, but we would—

Mrs. Maria Van Bommel: But where would you do that? Would you do that in all hospitals or would you do that where there's a significant aboriginal population in the area?

Ms. Lorie Bell: I certainly think where there's a significant aboriginal population in the area—and although we do have Shkagamik-Kwe Health Centre. It's a different service. Ours provides treatment. We're focused on mental health and addiction treatment, so we're not just emergency services or a clinic per se.

Mrs. Maria Van Bommel: Thank you.

M^{me} France Gélinas: The Sudbury Regional Hospital is under redevelopment right now. It is scheduled to be finished in April. They have a smudge room. They have a traditional herbs cabinet and they will be able to provide traditional healing and traditional treatment in a culturally appropriate environment. It's a beautiful room. It's not open yet because it's under construction.

Mrs. Maria Van Bommel: So when did that become part of the planning process? That would have had—

M^{me} France Gélinas: Way back, 10 years ago.

Mrs. Maria Van Bommel: So, 10 years ago it was decided that there would be such a room?

M^{me} France Gélinas: And it took that time to get it built. Dr. Koka is laughing because he's been in the planning stage for the last 20 years.

Ms. Lorie Bell: I'm looking at the outpatient mental health addiction services, which is a part of the hospital.

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

Mrs. Christine Elliott: Thank you very much, Lorie, for joining us today. I really appreciate your insights. One thing that you've touched on that we've heard a lot of about is that there are a lot of people with mental health and addiction problems in correctional facilities and we haven't heard much about solutions for that, never mind aboriginal populations in those facilities. Could you tell me how that works now? Does the John Howard Society facilitate discharge or working with people? How is it now and how would you like it to be?

Ms. Lorie Bell: I certainly don't want to take away from the good work that John Howard does or Elizabeth Fry. They certainly do good work with them. They also have a wonderful native healing program in there that has been going on for quite a long time.

My awareness of the aboriginal inmates came when I began doing educational programming for them in terms of prevention of HIV, hepatitis C and things like that. After doing that for such a long time, I heard a lot of stories of trauma, a lot of stories of childhood abuse and addiction, the lack of support and the lack of understanding of mental health symptoms and almost a normalized view of addiction for people. But I think I may have gone off what your question was.

Mrs. Christine Elliott: No, I think I understand that there really isn't that specialized understanding ability to work with those issues that people need to deal with. They're dealing with housing issues and getting people back out into the community and perhaps medical needs, but I'm getting the sense not maybe mental health needs in a culturally appropriate way.

Ms. Lorie Bell: Yeah. This is what I'm thinking. Those basic needs are probably getting met by those services, but for actual mental health treatment and addiction treatment programming, besides being referred to treatment centres, like my colleague said earlier, that's not always the solution. Sometimes it's good to keep them in the community working through an outpatient program. I don't believe that's available for them.

Mrs. Christine Elliott: A big gap, then.

Ms. Lorie Bell: Yes.

The Chair (Mr. Kevin Daniel Flynn): Lorie, there was a lot in your presentation about what you need. I was just wondering, what do you have to give? The reason I'm saying that is that I know, for example, that a lot of psychologists now are using mindfulness as part of their treatment, and a lot of that is based on the Buddhist faith, and it's used by people who aren't necessarily of the Buddhist faith.

Ms. Lorie Bell: That's right.

The Chair (Mr. Kevin Daniel Flynn): I'm just wondering what the general population of North America

that is experiencing a lot of mental health issues can learn from its aboriginal peoples.

Ms. Lorie Bell: Actually, I'm glad you asked me that because I do attend ceremonies and participate in a culture as well as work with it.

We do have an increasing number of non-aboriginal people coming to us and wanting to be part of the sweat lodge and wanting to sit in the healing circles and to smudge and to help, to know where that centre is, to get connected to their whole self.

What we don't do is push the spiritual part on anyone. We identify what we do, but that choice is always there, for people to choose, particularly with the historical pain that some people have experienced from that area. Yes, so we do; we have people coming to the sweat lodge and healing circles. I'm pretty sure non-aboriginal people are able to access the traditional medicine person at Shkagamik-Kwe Health Centre and all the other services that they have, like the drum making, which is a part of the therapy too, to rebuild. So it's quite open.

To be honest with you, not all aboriginal people are open, but some are. That would be the only place that I would send people to, where someone is open and respectful.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you very much for coming out today. That was a great presentation, very enlightening.

Ms. Lorie Bell: Thank you very much.

DR. RAYUDU KOKA

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Dr. Koka, if you'd like to come forward, sir.

M^{me} France Gélinas: You missed Maureen McLelland?

The Chair (Mr. Kevin Daniel Flynn): No, Maureen's at 3. We've moved Dr. Koka up from 4.

M^{me} France Gélinas: Okay.

The Chair (Mr. Kevin Daniel Flynn): That's right. I've got it all figured out. How are you doing?

Dr. Rayudu Koka: That's true, Mr. Chair. We did change it.

The Chair (Mr. Kevin Daniel Flynn): They're keeping me on my toes here, Doctor.

Everybody has 20 minutes; you've got 20 minutes. You can do anything you like with that 20 minutes. If you could leave—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Yes, that's right. If you could leave some time at the end for some sort of a discussion, that seems to work best. Other than that, the time is all yours.

Dr. Rayudu Koka: It may be a mistake to say that I can do anything.

M^{me} France Gélinas: You've obviously never met Dr. Koka.

The Chair (Mr. Kevin Daniel Flynn): Is that right? All right. I can't wait to see this, then.

Dr. Rayudu Koka: First of all, Mr. Chair, thank you very much, yourself and all the honourable members who are here, for coming to Sudbury and giving us the opportunity to present this, to me, very important matter, very dear to my heart.

As I stated in my presentation, I'm Rayudu Koka. I'm a psychiatrist here. I've been here for 23 years. I came straight here from the UK. I'm staying here and nobody's going to take me anywhere. I'm a proud Sudburian.

I'm part of the department of psychiatry; I'm medical director of the program here. I'm also an associate professor at the new Northern Ontario School of Medicine, and I'm section leader for psychiatry.

I'm also a very actively practising psychiatrist, although I do a lot of other things. I have in-patient/out-patient community psychiatry and outreach programs that I do. As I said, I do clinics at Elliot Lake, Blind River and Sucker Creek, otherwise called Aundeck Omnikaning First Nation community. I've provided services to these communities for the last 20 years.

I have 12 adult psychiatrists in my department and one child psychiatrist. We provide service to a population of about 250,000. That is one psychiatrist for every 20,000 people. In comparison, if I may say so, Mr. Chair, for Toronto it's about one psychiatrist for every 3,500, I believe. Is it because they have more mental illness? I'm not sure.

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I have been a strong advocate for a number of years with regard to mental health and I still continue to pursue that route.

I think this document on the 10-year strategy by the Honourable David Caplan and the team is a welcome opportunity for our mentally ill population. I'm going to represent on their behalf more than anything else. It's a very good document, a lot of good ideas. He's taken a very personal interest in mental illness and addictions. That's great. I hope there will be meat and potatoes provided to give the service that we need for our patients. All of the LHINs except one had the highest priority for mental health, which is a good thing.

I'm going to be speaking on mental health issues. I'm sure all of us in this room have had some impact on us through family, friends or ourselves having had exposure to mental illness and the enormous effects one may have experienced. We all know that, and I don't have to tell you about this.

First of all, I of course welcome this on behalf of the patients and also the colleagues of mine. Also, I think that integration and collaboration are the most important things in this day and age. We have to collaborate, cooperate and work together with different programs and primary care. I think psychiatry has been in the lead with regard to collaborative care while the other ones are trying to do it now. We can probably enhance that part—collaboration and integration.

I must say that we had two organizations here a few years ago. Through public support we managed to get them integrated into one organization with one board of

governance, one administrative structure. Now it is a one-stop shop for the other mental health programs in our community together under addictions. It is a great success, and I think my colleague Maureen McLelland will be talking about it more. I want to concentrate on this now.

I think the gaps with this integration, what we have experienced, of course are: We'll need more for our homes for specialized care; supportive housing with minimal supervision; more case management programs; more counselling and treatment services; psychological rehabilitation programs; day treatment programs; also, most of the patients are on disability pension or Ontario Works, so they need some transportation facilities as well; and some employment work opportunities and training opportunities.

It's amazing. I'll just tell you one story. This morning I saw one of my patients. There's a gender identity problem. She is a female, dressed as a female for the last two years, functioning in the community. Then we sent her to the clinic for the second-time follow-up visit to CAMH. They said she was following everything. They said, "You have to be working before we can do anything for you." So she goes to apply anywhere, they see her dressed as a female and won't give her a job. That is a terrible thing for this woman who wants to be female, who wants to get something done for her, and she cannot get anything done.

This afternoon I saw her. I've been seeing her for the last two years. Nothing is done and she's discouraged, depressed. She had been to Toronto about three weeks ago, and that's why I saw her today.

These are the kinds of things we need to try to somehow accommodate our patients on. I'm sure the same thing happens with other patients who have mental illness. They can't get jobs, and for a recovery model we need them to get jobs and be functioning normally.

I note that the minister stated somewhere in the document that we can do it without any further increase of resources. I don't know how we can do it. We are already lean meat projects in the mental health system, at least in my place. We can only do it properly if we freeze the programs or we cancel the programs—no more enhancements or further development, I think. One of the leading psychiatrists from Alberta, Dr. Bland, has produced in the Canadian Journal of Psychiatry. He showed that Ontario lags behind all of the provinces except Saskatchewan in terms of total percentage of health care funding directed towards mental health services, and it is far below mental health funding compared to other countries such as Australia. We believe successive governments over the years have not paid much attention to mental health funding, and that's where we are today.

We appreciate that this government is trying to put some money in here and there but is not ready to commit to be able to provide desirable adequate services to our patients and families. We have a lot of catching up to do, Mr. Chair. Kudos to anybody who can say that yes, we can provide service without increasing the resources,

financial or otherwise, because we'll be needing more. In this document we say we have to do case finding and screening and more early diagnosis, early finding of the cases. If we all do that, we need more resources rather than less resources or the same resources, because we're already under-resourced now. That's what I wanted to bring to your attention.

What happened in the last decade with the Putting People First document—it was just mind-boggling to us. We're just hitting our heads against the wall whenever we say we want to provide service to these moderately depressed patients. No, no, our funding doesn't allow that. We can care for only the seriously mentally ill. That was the problem we had. In this document, at least they talk about all illnesses put together. That's great. We appreciate and welcome that recommendation from this group. If we're going to treat all these cases, and we need services to meet the needs of this group, then of course we need more resources; definitely.

Prevention is an excellent idea. Of course I've been talking about it to my police chiefs and others in the city. How can we do this? We have to go to schools and start with kids, from early life, educating them about mental illness and mental health issues. Again, for the families of children of mentally ill, we have no way to provide service. These are all the things that we can do with regard to prevention of mental illness, and to try and help them early on to recognize some of the risk factors and what can be done. Educating, again, is important, both employers and employees and all areas.

Primary care and collaborative care: As I mentioned before, the family health teams and family health programs are helpful, but we need more and to do more in other settings also. Somehow, if we can have access to programs through other disciplines for psychiatrists in the communities maybe, or in the hospital systems we need more—so that they can concentrate more on diagnosing and treating the seriously mentally ill, or even get the primary diagnosis done and then pass it on to other disciplines, including primary care physicians. Primary care physicians don't want to take any mentally ill patients, because of their reasons—I don't have to explain; I'm sure you all know about it. If you ask me, I can talk about it later on. I think it may help if we can include mental illness in the chronic disease management programs, like diabetes and management of other cases.

Integration of children's services: Again, I really applaud this document including getting all the ministries together: the correctional system I already mentioned, children's services, MCYS, all included. In our own community we have a big problem. In the last two years our children's services have been separated for various reasons and more political reasons. We're trying to get them back together with the adult mental health system as it was before, but we're not able to. It costs more money. We cannot get the access to children's services. Although they stay in the same city, they won't provide any service to the emergency department because they're different organizations, different governance. They say their mandate is different, but anyhow.

Those are the things that are happening, so if we can integrate them when they reach 16 and onwards, we can also transition these people into the adult mental health system for the severely mentally ill group. I think it's important that we try to recommend this across the board.

1500

Person-directed or family-centred approaches: Of course, we always follow this philosophy in our programs here. We called it client-centred, but now we can say "person-centred," as in the document, and family-centred approaches as well. Families are very important in supporting the patients. Just this afternoon, before I came here, I saw a teacher who has bipolar disorder. The husband is a retired college professor. He has been such a tremendous support to her, so she's managed in the community in spite of the bipolar disorder. She was telling me today, "Dr. Koka, I'm feeling better today. Now I'm able to cook a little bit and do things, more than what I've ever done before." I said, "Your husband must be very pleased about that." So those are the things that are very important—for the family to be supportive. Family is a very important part.

On occasion, we have problems with families, in the sense that patients don't want us to do anything with the families. That's a problem we have sometimes. If you can do something to help us get family access somehow without getting us into trouble with the law, that would be appreciated.

Peer support, the role of physicians—diagnosis and treatment: I accept what is mentioned about the patient's role, the family's role and the peer support programs. In fact, I work with the ACT team also. I have a bipolar disorder patient with substance abuse problems. I've been seeing him for the last 15, 20 years. He came from out west and now he works in our ACT team as a peer support worker. He's a fantastic worker. He has kept well, he takes his medication and follows up—fine. We support them. He does help when I go on home visits with him. He says, "Look, I am one of them. Look how I am. You can be helped the same way." That helps a lot when we go to provide services to these patients because they get more insight and they can relate to them.

But at the same time, we cannot say they'll be able to diagnose and treat. You need somebody with expertise in diagnosing and treating because there could be somebody who has a thyroid problem and they can present as being depressed and withdrawn. Unless you recognize and treat that medical problem—they cannot, so you need a medical background, training and experience.

There have been cuts in services in residency programs in the past. We need more psychiatrists in the field. We don't have enough of them, so we need to attract them to the field of psychiatry. Being a teacher and an examiner for a while in college, I know how difficult it is to get these people in. So we need to do something about it.

There are gaps in services. I must say it is difficult to get primary care physicians for psychiatry patients. I'd mentioned that. We can do something. What we do in our

program here is, we have a family physician to whom we pay a stipend for him to come and provide a clinic in the hospital. In our community, we have 30,000, 40,000 people who don't have family physicians, especially our patients—90% of them don't have a family physician. So we help them by providing primary care through that route.

Aboriginal communities: Again, when I go there, they say, "We want more services, but we don't have funding," because they're federally funded programs and they don't have enough funds to get psychiatrists to the communities to provide their services. So if anything could be done through our programs here, it would be appreciated. I think my friend mentioned aboriginal programs earlier on.

Medication coverage: I'll give you an example. A patient of mine, a chronic schizophrenic, has two kids. He takes care of them because mom has gone away somewhere else. He does function well. This gentleman has a cholesterol problem. He doesn't want to take pills because he can't afford them. He has got hypertension but he doesn't want to take the pills. I want him to go for blood tests; he doesn't want to go for blood tests, and I cannot force him because he's competent enough to make the decision, and he can't afford them.

He can have a stroke. He has diabetes. He can get all the complications, but because he's on CPP, not ODSP, he can't get—I wrote a letter to the ODSP people and they said, "No, we can't." If anything can be done for those people, those low-income people who are working, those who are on unemployment benefits or CPP, it would be helpful.

In conclusion, I say I support this document. It's very well put together. I'm sure a lot of people will be supporting this and also giving some suggestions. Collaborative care is excellent. Integration, of course, is the way to go. Removing barriers from children's services, adult services and seniors' programs is great. We believe we need adequate resources that should be put in.

I think in mental illness, the patients' peers and families have a role to play. Other health care professionals can be of assistance in screening and further assessments and diagnostic help—for example, psychological assessment for personality disorders or the OT placement. These things are helpful. They also provide an important treatment team.

In conclusion, I would be happy to work with the government. I've also been section chair of psychiatry at the OMA.

I'd be happy to take any questions. I speak fast, I guess, because I wanted to get through a lot of stuff.

The Chair (Mr. Kevin Daniel Flynn): Well, you did go through a lot of stuff, and you left a little bit of time for questions. We've maybe got time for one—unless you give short answers. Christine or Sylvia?

Dr. Rayudu Koka: I'll try.

The Chair (Mr. Kevin Daniel Flynn): But you're a psychiatrist, so you probably don't.

Ms. Sylvia Jones: You did an excellent job summarizing a lot of what we've been hearing the last number of days.

I wanted to touch specifically on the fact that you have one child psychiatrist.

Earlier today, we heard of a Sudbury district school board saying that they had not been able to access child psychiatry for seven years. Where's the disconnect there?

M^{me} France Gélinas: It was a francophone boy. The child psychiatrist didn't speak French.

Ms. Sylvia Jones: Merci.

Dr. Rayudu Koka: There are two child psychiatrists with the Northeast Mental Health Centre, which is a regional program. That's where we have a disconnect. We don't have any contact or connection with them within the last two years.

We don't have any francophone psychiatrists. I went to Quebec and also signed an agreement, but we were not able to get them. It's very difficult to get child psychiatrists here—any francophone psychiatrists. I've been trying hard. That's where the problem is, I guess.

We have one child psychiatrist in our program, so we're trying to recruit more.

The Chair (Mr. Kevin Daniel Flynn): One small one, France.

M^{me} France Gélinas: Okay, we'll try for a yes or no, but I don't think it'll go. We've heard many times that family physicians are reluctant—all sorts of adjectives have been used, but at the end of the day, they're not seeing clients with mental health diseases. Do you solely put it on money, or are there other reasons why family physicians don't get involved with mental health?

Dr. Rayudu Koka: I don't think money is the only reason, because we have some provision for the money and they're not taking them. Comfort, I guess, is one. The newer physicians who are trained now are better trained and they're more comfortable in managing them.

I think it's a combination of things. Time is one and money is one, and they don't want to take too much trouble. Even, for example, in the ACT team, what we have for patients in my ACT team is we provide 24-hour, 365-day psychiatry service to them, backup. When I tell my family physician colleagues, "Look, if you take these patients, you don't have to worry about any kind of psychiatry problems. Just treat their physical health problems," there are still no takers.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Doctor. We really appreciate it. Thanks for your time today.

Mrs. Liz Sandals: Can I ask a question?

The Chair (Mr. Kevin Daniel Flynn): Oh, a very short question. What time is our plane?

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

The Chair (Mr. Kevin Daniel Flynn): Okay, a very short one.

Mrs. Liz Sandals: I'm really interested in your comment around the integration of children's services and the fact that you can't get children's services in

emergency. I think from what we've heard previously about your outpatient services, they're adult outpatient services. How would you fix this problem?

Dr. Rayudu Koka: Well, I have written to the minister about it suggesting that we should try and integrate those services back into the adult programs. We used to provide an on-call service for the children's services as backup. It would save a lot of money. We used to provide on-call services in the emergency department as adult psychiatric backup. In collaboration together, we could function quite well and provide service integration. I have advocated and requested, and hopefully that will happen. We had a study done from Ottawa and they recommended what to do, what might be the best option, so that is one of the recommendations as well.

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Mrs. Liz Sandals: Okay. A technical follow-up: Is it because it's specifically not funded at the hospital to do this backup or is it because of the general problem that children's mental health is at one ministry and adult mental health is at another ministry?

Dr. Rayudu Koka: That didn't matter, I think; it was more locally here. Governance and administration is with one different organization. If that could be with, say, a Sudbury Regional Hospital transfer—we're building a centre of excellence for pediatrics as well. So with all this, that makes sense, to integrate what children's services are in Sudbury—we provide service for the whole of northeastern Ontario if it is with the regional hospital. Because it is Northeast Mental Health Centre of North Bay, we are not in connection with them, so that's what happens. If we can transfer the governance or administration to one side, it's solved, easy, with a lot of cost saving.

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

MAUREEN McLELLAND

The Chair (Mr. Kevin Daniel Flynn): Okay. Just so everybody knows, the bus leaves for the airport at 3:45. So our final speaker for the day is Maureen McLelland. Thanks for sitting through all the others. You've got 20 minutes like everybody else; use that any way you want. It's all yours.

Ms. Maureen McLelland: I'll try to tie together some of the themes from the last few presentations that I've been listening to. Thank you for the opportunity to speak. I'm speaking as an administrator of a large multi-site, multi-faceted mental health and addictions program. Colleagues have spoken before me, and I can talk a little bit more about integration opportunities and some of the successes that have happened with integration.

I'm a registered nurse by training, with 23 years of nursing background, and most of that career has been spent working with marginalized and stigmatized individuals—HIV and AIDS patients, injection drug users, people who have been victims of sexual assault and domestic violence. All of that experience leads me to be

in a position, now working in a mental health and addictions program, where it really does all tie together. If you think about the tragic things that happen early in your life, it doesn't stay buried for very long. It starts to bubble up, and as an adult it comes out in various ways, often as a mental health issue or an addictions disorder.

I'm very pleased to see that this is an inter-ministerial committee looking at ways to work smarter for the people of Ontario.

Who we are: Sudbury Regional Hospital's mental health and addictions program is a two-year-old program. We have a rich tradition of history with the previous district programs that were attached to Network North, Northeast Mental Health Centre and Sudbury Regional. Two years ago, by direction of Minister Smitherman, they were brought together under one single lead agency responsible for the treatment of mental health and addictions in the district of Sudbury-Manitoulin.

We have about 300 staff working in our program on a variety of sites. We're in 10 locations. We've got in-patient beds on two sites and we've got eight community programs. In each of those sites it's a completely integrated program; it's a mental health and addictions program. We don't separate: "Mental health goes through this door and addictions goes through this door." It's one door, it's one system, it's one staff, and I'll talk a little bit about our successes with that.

We are a district service, so we serve Sudbury-Manitoulin district, with about 250,000 people in our catchment area and a fair bit of geography to cover when you look at where our employees work and where our clients live.

Since 2002 there have been some targeted investments in mental health, and I've listed where those have happened. These are some of the programs that we operate through our integrated mental health and addictions program, but there's been a large investment in crisis intervention. It allowed us to make our service run 24 hours a day, seven days a week, 365 days a year. We have a mobile component where we partner with the police.

We have safe beds in the community now that weren't there before. Safe beds are a diversion away from hospital. If somebody needs to have a safe place but are not necessarily in such acute distress that they need to come to hospital, we're using safe beds.

Early intervention for psychosis has been an investment in the province. We used some of the funding for early intervention to direct to our postpartum population. Women with postpartum disorders need an awful lot of early intervention, and it's a very good illustration of how intervening early can change a life.

We've expanded our eating disorder services with these investments, intensified case management services and have streamlined access through a central intake for mental health and addictions. We've added peer support to our ACT teams, and Dr. Koka spoke about that, just the meaningfulness of being able to have a lived experience and contribute to the healing of others. And

we've expanded rapid response for seniors, so the presentation on Alzheimer's disease—our seniors' outreach team actually works as the treatment team for those with Alzheimer's and other age-related disorders.

Despite that, there are some community gaps that we still see. I sit at a district table, a table of other health providers and social service providers, and there are some really big issues that we still, despite funding, are not addressing effectively in the community.

Lack of access to primary care—Dr. Koka spoke about that. Just a little story I'd like to share: I've got a friend who has struggled over the years with depression, anxiety and alcoholism, and recently her family physician retired. She's a woman in her mid- to late forties. She's got two kids and a husband, and they had to be interviewed by a GP to be considered to be accepted into that GP's practice. The husband and the two kids were accepted into the practice and she wasn't. I think that's, first of all, a disgraceful thing to have happened, but to try to explain to her kids why that happened is hard to put into words. So it is happening in our community, that there is this sifting and sorting of who gets to see a family doctor and who doesn't.

We have a lack of access to affordable housing, and Dr. Koka has mentioned that. I'm not going to belabour the point.

I guess from a treatment perspective, and that's what our role is, we've got a long, long waiting list for treatment of serious mental illness—particularly mood disorders, so I'm talking about depression, anxiety and bipolar—as well as no in-patient services whatsoever for people suffering from eating disorders. We're flying people out of this community who are deathly ill and have nothing to offer them in terms of intensive eating disorder treatment.

What is working: We talked about vertical integration. By vertical integration, I mean we have a very seamless system at all of the levels of care, community flowing quite nicely into hospital and quite nicely back out again. So to have all of that under one organizational lead is making a big difference for our patients and families. They're not having to tell their story twice or three times or four times. We've got an electronic record that allows that information to be shared quite nicely, and I think vertical integration is really working in our community.

We've also done a lot of horizontal integration, and by that I mean all of these various little small teams with all of these little funding pockets have been collocated. So we have a building right downtown here in Sudbury, a seven-floor office building with many programs and services. We're seeing several hundred people a day coming through those doors for a variety of treatment groups, case management support, family support etc. So having everything in one stop, directly across from the bus station, is a really important message to the community that we belong on the main street and that we shouldn't be in the back alleys of Sudbury, two stops away from the nearest bus.

Being in one place has allowed us to really increase our ability to collaborate on treatment planning for

people with mental health and addiction. So lots of good stuff happens with hallway conversations: "I have a client; you have this expertise. Can you help me develop a treatment plan that would consider his needs?" And so there's a lot of synergy that happens when you move people together under one roof.

We also have collocated mental health and addictions staff in communities outside Sudbury, on the island, Manitoulin Island, in Elliot Lake, in Espanola—to our east, in east Sudbury, collocated with the primary health care centre.

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So we've leveraged a lot in the last two years, building on the richness in our mental health team and our addiction team and bringing them together. We've made significant improvements with taking our existing resources. None of this is funded; it's just how we've made the money work smarter. So by taking pockets of funding and putting that funding together in one big envelope, we've been able to add some additional resources to what we offer the community, family support being one thing. Rather than having infrequent family support meetings when you can get it together, we're able to leverage our resources and say, "Every Tuesday night we have family support. It doesn't matter if one person shows up or 21 people show up—every Tuesday night." And it's just scheduled, because you've got larger groups to schedule from. So there's obviously some opportunity there.

What's still needed? What our community's telling us, where the demand is in our community: long, long waiting lists for the treatment of mood disorders. It's one area that has not had an investment. There's been no investment in counselling and treatment; in the treatment of mood and anxiety disorders or bipolar disorders, no investments in over 20 years, save and except the inflationary increases that we've seen in the last couple years—you know, 2% here—across the board.

By not having timely access to the treatment of a mood disorder or an anxiety disorder, we're really doing a disservice to the community. People are falling off the rails at work or at school. They're losing their function, they're losing their family and social relationships, and it's leading to, maybe, chronicity that doesn't have to be there. If we can treat and develop a model and invest in—this is one of the highest-volume groups that we see through our doors. It's what they're looking for, and yet there's been no investment. So I think that's an important gap.

The same with day treatment for addictions: The Every Door Is the Right Door strategy talks about withdrawal management services and it talks about residential services, but there's no mention made whatsoever about outpatient addictions treatment. Not everybody can leave their community and enter a 28-day program in some other community; they've got obligations at home. There has been no increase in addictions treatment in an outpatient capacity, again, in over 20 years. Same story: If you're not well in that regard, it shows in your work, it shows in your school. You fall off the rails, and pretty

soon we have a bigger problem than if you were able to get in and get some counselling, involve your family in that counselling earlier rather than later.

Access to child and adolescent psychiatry: It's been spoken about. I just want to reiterate the point that we've got a huge gap in our community. Lots of the issues that we see are that we're treating the adults and in the back of our minds, we're thinking, "My God, they're parents. Who's treating their kids?" We'd love to be able to say what's happening there, but it is really two siloed systems and we've got no mandate to really go there. So if we want to look at families and the health within families, breaking down that silo between adult and children is really critically important to the health of our future, our children being our future.

As an administrator, the silos within mental health and addictions—we've done a great deal within our organization to work despite the silos, to play both sides of the equation and leverage resources between mental health and addictions, but we're stymied at some things. There are just some things that we cannot do, because there's an addictions fund—it comes in an envelope with a program number—and there's a mental health fund—it comes in an envelope with a program number—and never the two shall cross. So that doesn't really make sense, in light of where the province wants to go with an integrated system. We need to have integrated funding.

Just a story: If you have an addiction and come through our door, if we weren't as creative as we are, we might say to you as you come through the door, "Do you have an addictions issue or do you have a mental health issue? If addictions, line up here, and if mental health, line up there." That's really sort of silly, yet the funding envelopes kind of encourage that to happen and the reporting of data encourages that to happen.

The silo between the Ministry of Health and Long-Term Care and the LHINs, which fund the adult world, and then MCYS—and MCSS. I want to mention MCSS because of the adults with developmental disabilities. Many of them have mental health and addictions issues, and again, they are funded through a separate stream, a separate access point and separate data collection. It just is not working for us, the provider.

Solutions: Eliminate the silos; I think that's very important. We have standard assessments that are done. These standard assessments have different names; they ask the same kinds of questions, and it doesn't make sense that, depending on your answer to the question, "Do you have a mental health issue or an addictions issue?", your information resides in one stream and not both. Because if you scratch at the surface long enough, you'll see that the person with the addiction probably has some underlying mental health issues, and the person with the mental health issue may in fact have some compulsive behaviours around drugs, alcohol or gambling that also need to be addressed.

We need to assess and treat families. We talk about person-centred and family-centred. It just makes no sense to me, as a member living in the community with a

family, that I might go to one agency to deal with my issue, knowing full well it's having an impact on the rest of my family, on my kids. Why wouldn't my kids see the same treatment team? Why wouldn't my kids have the same access to support? Why wouldn't we be treated as a whole? Because I think our objective would be to keep families whole and not keep them apart.

It's really important, if we're going to work on a family-centred approach, that we start thinking about across the lifespan. It doesn't make sense that youth would have to give up their support system the day they turn 18 and completely switch to a new set of providers and have all of that rich information about them lost.

One idea that I have is, we've got no discretion as administrators to use our funds creatively. I'm not suggesting that we are—and I know the focus on accountability certainly is very important, given some of the front-page headlines, but if there could be some discretion with our funding to allow for creative opportunity based on what the community has identified as a priority. Right now, there is no ability for us to submit a budget that has 20% of the funds unallocated. Every dollar has to be allocated, and when you account for how you spent the money, it had better match up or there are questions to ask. Yet that doesn't allow any flexibility to the funder to address the priorities that come up through the year, to address those situations where we know that if we could just work outside the box, we could make a difference in people's lives. So, having some discretion in our operating budgets, while still having accountability, I think, is an important thing to consider.

In summary, our current waiting lists, I truly believe, are confounded by the disproportionate effort that's going into siloed and duplicate assessments. If we could free up people from doing double the work at the front door, it means we could take somebody away from the front door and put them behind the front door to actually deal with treatment and move people along who are waiting for treatment. Taking that into consideration, I think—it's not an ask for more money; it's a way of saying that if you just took something off our plates, I think we could work more efficiently.

The intergenerational effects of mental illness and addiction is again why I think we need to be thinking about family-centred care differently than the way it's organized in the province today.

I hope I haven't exceeded my time.

The Chair (Mr. Kevin Daniel Flynn): No, you haven't. You've left about three minutes, so let's start with Christine or Sylvia.

Mrs. Christine Elliott: This is great. Thank you very much, Maureen. I'm really interested in some of your ideas. I guess we're looking at creative ways, and certainly this siloing in the ministries is something that we've heard about from a number of people, because it forces you into pigeonholing certain things that really are more across the board. Any further suggestions you have on how that can be achieved would be most appreciated.

The idea of the operating budget and having some discretionary funds makes a lot of sense because, of

course, needs change over time and different priorities are identified.

Thank you very much for your innovative ideas.

Ms. Maureen McLelland: You're welcome.

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

M^{me} France Gélinas: Nice to see you. We've heard from another presenter, who had been very frustrated at using the DART database, the request to have them separated, as in mental health, mental health and addiction, and addiction only. But then we've heard from a number of presenters who really look at integration, where mental health and addiction would always be linked together. You'd get the services you need, no matter what they are. Are those two ideas compatible or not?

Ms. Maureen McLelland: You know, I don't have a particular opinion about which database is better, and I wouldn't want to express which I think is better. I think we have to pick one, and whichever one we go with, it needs to be optimized to still get into the details around—if it's more towards mental health that I'm coming, or more towards addiction, there has to be some ability to optimize that database.

There are thousands and thousands and thousands of person-hours per year, just in my agency alone, going into the data entry to these databases and the reporting from the databases, yet the data sets don't link up.

As an administrator, it's really an exercise in futility for me to know, who are we serving, what are their needs, is this person the same as that person, were they

entered here and entered there? It just doesn't make sense from a planning or from a service delivery perspective. I think we just need to have one, and that one should follow us through our lifespan so that the day I turn 18, my information isn't lost.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maureen. Is there one more question? Liz?

Mrs. Liz Sandals: Mine actually isn't a question, but I'd just like to comment that with everything we've heard here today, I would really like to congratulate all the people who are working in your cluster of services. In all the travelling that we've done around, this is the best example of service integration and really having your act together so that you're concentrating on how to deliver service rather than silos. We totally hear what you're saying about children and all these silly boundaries.

Ms. Maureen McLelland: God bless you.

Laughter.

Ms. Maureen McLelland: Thank you very much. It has been a lot of work on everybody's part. We're working rather well as a team.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maureen. Thank you very much for coming today. That was a great presentation.

Ms. Maureen McLelland: Safe ride back.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We're adjourned now to Thunder Bay. The bus leaves for the airport at 3:45.

The committee adjourned at 1531.

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