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Mercredi 16 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

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LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

Wednesday 16 September 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Mercredi 16 septembre 2009

The committee met at 1607 in committee room 1.

The Chair (Mr. Kevin Daniel Flynn): If we could call the meeting to order—we don't have any sub-committee business to deal with. This is our first meeting since we've come back from Ottawa, Sudbury and Thunder Bay.

MENTAL HEALTH AND ADDICTIONS STRATEGY

SCHIZOPHRENIA SOCIETY OF ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our first expert presentation today is from the Schizophrenia Society of Ontario. Vani Jain and Mary Alberti are with us. Thank you very much for joining us today. You've got half an hour, and you can use that any way you see fit—I see you're equipped to do that. If you'd leave a little bit of time at the end for some questions and answers, that would be great as well, but that's entirely up to you.

Ms. Mary Alberti: Thank you very much. We would like to formally thank you for the opportunity to be here. We at the Schizophrenia Society endorsed the creation of this select committee early on in December. As you know, the issues you're working on are very near and dear to our hearts and to the population we serve. We also applaud your consultations across the province and the work you've done to date, and thank you for that.

We're going to walk you through our presentation today fairly quickly, because we do want to leave an opportunity for questions and answers at the end of the presentation.

First, a little bit about the organization: Our mission at the Schizophrenia Society of Ontario is to improve the lives of individuals and families affected by schizophrenia and psychosis. We do this through our programs and services, which support, educate and empower individuals and families and promote community awareness. We advocate on behalf of individuals and families, we work with other organizations and we promote early intervention. We also support and advocate for research. I know that many of you have had the opportunity to participate on different things with us around the table at the Schizophrenia Society as well.

We are a grassroots organization. We were founded in 1979, and our grassroots commitment to the community continues. We were founded, actually, by a group of

families who had individuals with schizophrenia in the family.

We could not do the work we do today without volunteers across Ontario, many of whom are family members and individuals with schizophrenia. I think that through your select committee consultations, you've probably heard from many of our volunteers across Ontario.

Over the past 30 years—it is our anniversary this year—we have grown to be a provider of significant services to families and consumers through eight regional programs across Ontario, which are all designed to meet local community needs.

We have a very strong history of advocacy and policy work, and have been leaders in the mental health field in advocating for services that address the needs of families. We have currently identified access to treatment as our key advocacy initiative.

Our organization differentiates between mental health and mental illness. Our focus is on providing a voice for the needs of people with serious and persistent mental illness, and that's what our presentation is going to focus on today.

A little bit more about the organization: Our operating budget is just over \$2.6 million, of which 24% is supported through government. The rest we raise on our own. We're able to carry out the work with a complement of 25 staff positions and 340 volunteers across Ontario.

In our last fiscal year, the organization invested in programs and services that had the following results: We served just over 4,700 individuals through our family education and support program; just over 1,300 individuals with schizophrenia were supported through our education program; and we reached over 3,000 individuals in our community advocacy program—we have an estimated reach of over two million in the public relations and media work that we do.

A need for a mental health strategy: A very strong and comprehensive mental health strategy that addresses the needs of our population is needed in a very timely fashion. One in 100 people will develop schizophrenia over their lifetime. The onset of early psychosis and schizophrenia is most often between the ages of 15 and 24 years of age. As schizophrenia and psychosis impact families and communities, ultimately many individuals in Ontario are impacted by this serious mental illness.

The current system or systems that are attempting to serve individuals with severe mental illness are under-

funded and currently not well coordinated. This often results in services that are strategically and not equitably delivered across Ontario, and a lack of services and supports in general.

Given the limited time we have today, we're going to focus on two priority areas for people with serious mental illness. One is access to treatment, and the other, health and justice issues.

Access to treatment: The information we are going to present to you today has been based on nine cities that we visited, with over 350 people participating in community forums. We've been advocating on the issue of access to treatment since we began this process. Our efforts culminated last year in these forums in hearing from consumers, families and service providers about the barriers they face in accessing treatment and the solutions that they felt would make a difference in improving the system. We have included a complete copy of this report in your package.

We've identified basically three pillars when we define access to treatment: psychiatric treatment, which refers to medical models of treatment such as care by a psychiatrist or hospital-based care. It also includes medication, one of the cornerstones of treatment for schizophrenia. We must ensure that there's open access to all medications on the provincial formulary. Community services such as case management, ACT teams, counselling and peer support are also vital in the treatment process. Finally, addressing the social determinants of health such as housing, income and employment support must be protected. These three pillars need to work together.

What did people tell us across Ontario when we looked at barriers? We know that people with schizophrenia and their families face many barriers to accessing treatment services and supports. The full list of barriers are in your package as well, but we want to walk through some of them for you.

Lengthy wait times are a major concern. The average wait time from referral to treatment by a psychiatrist is 17 weeks. In rural parts of the province, this number is even higher. We find this length of a wait time an unacceptable statistic. Emergency room wait times are another concern, which the Schizophrenia Society has addressed, and we have put our full policy paper in your package, which talks to this.

In terms of the system capacity, consumers and families face many issues. We see this in hospitals where even psychiatrists have told us that they feel pressured to discharge patients prematurely simply because there are not enough psychiatric beds. Overall, the lack of services is a major problem, particularly in non-urban centres where we see that even more.

We also learned about the gaps which exist in our current system. Many people told us they couldn't access services when they really needed them. For example, one might have issues that are too complex for one program but not serious enough for another. The consequence is that many of our people fall through the cracks.

Community-based services are usually only available on weekdays. People who need help in the evenings or on weekends have nowhere to go and just turn to an emergency room.

Finally, there is a lack of outpatient follow-up care for people who are discharged from hospital. This makes it difficult for people to transition back into the community and receive services and supports that they need. In terms of stigma and discrimination, one of the biggest concerns we heard was discrimination by health care providers. Many people told stories about doctors in their communities who would not take on patients with complex mental illness.

The social determinants of health are also extremely important. We must not forget that mental health is influenced by more than just the provision of health care. Many people with serious mental illness are dependent on the Ontario disability support program for income. Unfortunately, ODSP income is a maximum of \$1,020 per month for a single person. We must ask, could any of us around this table afford to pay for shelter, food and other basic needs with just over \$1,000 a month? There's also a serious lack of supportive and affordable housing in this province, leaving many people to wait on lengthy wait lists for housing.

Employment, which is significantly important for people with schizophrenia in contributing to their quality of life and their own value and self-worth, has had a very negative impact on people in their recovery process. Employment is almost virtually impossible for people with schizophrenia to access.

In terms of system integration, our system is currently designed in silos whereby people get their health care from one system, their income support from another system, and their community services from yet another system. None of these systems seem to speak to each other nor do their policies align with each other in many aspects.

Another major barrier to accessing treatment is difficulties with system navigation. The families we work with tell us time and time again that they didn't know enough about the signs and symptoms of psychosis and schizophrenia to know there was a problem. Oftentimes our illness area is misdiagnosed and unrecognized. Once the issues had been identified for their children and for their family members, people did not have enough awareness of where they could actually go for help. And just remember again, oftentimes you're waiting for a long time before you're actually able to see a psychiatrist. So when we talk about issues of early intervention and early identification, they are compromised because of that.

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The final barrier to accessing treatment we will mention is our current laws governing mental health in Ontario. While these laws have been designed to protect people with mental illness, there are ways in which they pose challenges in helping people get into treatment. One of the concerns we hear most often is the difficulty in getting help for someone who doesn't believe they have a

mental illness. This is especially true at the early intervention stage where there are many difficulties in helping the individual to get an initial assessment, and part of the aspect of having a severe and persistent mental illness like schizophrenia is that oftentimes you have a real lack of insight that you do have the illness.

There are elements of our privacy laws which make it difficult for people to get the proper treatment. We have included in our package a submission regarding amendments to the Personal Health Information Protection Act, which provides more detail on that. We understand that this is a complex issue with no easy solutions, but we wanted to flag it for the committee as it's something we hear about often.

So that represents what we heard from about 350 people across Ontario who are living with severe and persistent mental illness like schizophrenia, their family members and helping professionals. I'm now going to turn it over to Vani Jain, who is the manager of our policy and community relations program and the head of our justice and mental health program, to talk about criminalization and mental illness.

Ms. Vani Jain: Thank you for having us here today. SSO has been addressing issues related to justice and mental health for several years. However, work in this area began more formally about two years ago, when we established our justice and mental health program. This program has been designed to support families of people with mental illness who are in contact with the law, while promoting change in mental health and justice.

We initiated this program because there really was a high demand from families who had a loved one whom they were supporting through the criminal justice system and needed assistance and system navigation and information on how to advocate and support their loved one through the process.

We also have a strong background in policy work in this area, addressing issues such as taser use on people with mental illness, police record checks and how they affect people with mental illness specifically, as well as, most recently, the issue of deportations of people with mental illness. This deportations project examines the immigration consequences of criminalization—and it's quite complex to get into, so we've included a description of that in your package as well.

What our experience has shown us is that, while there have been many improvements in the area of mental health and justice over the past several years, such as the implementation of mental health court diversion programs, mental health courts and safe beds, for example, these have made a huge difference, but we really do still have a long way to go.

When we use the term "criminalization," what we're talking about is a criminal justice or legal response to behaviour related to mental illness. This is evidenced clearly by the disproportionately high number of people with mental illness in our jails as well as people who come into contact with the police on a daily basis.

In our view, there are two key causal factors behind criminalization. One is deinstitutionalization and the

resulting lack of access to treatment. Over the past 40 years, people have been moved from psychiatric hospitals into the community, which is a great policy and it's great for people with mental illness. However, the community sector was not developed at the rate that it needed to be and people are still unable to access treatment and supports in the community. So in our view, the plan for deinstitutionalization was really never completed, leading to poor access to treatment. Because many people are not able to access treatment and supports in the community, their symptoms often are exacerbated and they are at higher risk of going into psychosocial crisis.

Our civil commitment laws are also an issue, because the criterion for civil commitment is "an imminent risk of harm to self or others." Oftentimes, when people reach the point of dangerousness, they're actually coming into contact with the police rather than the mental health system. The result is a revolving door where people cycle in and out of the system without having their issues meaningfully addressed.

There are a few key issues that I'll touch on briefly. The first and most important is probably that, while we have had all of these great new programs and policies developed in the area of mental health and justice, they have not really addressed the root cause of the problem, which is access to treatment. Our efforts in this area should not only be reactive; we must also look at how to improve access to treatment so that people don't come into contact with the law in the first place.

Another issue is the people who are not diverted out of the criminal justice system and end up in jail. There's basically a category of people whose offences are probably too serious to make them eligible for diversion, but they don't meet the criteria to render them not criminally responsible, which is the inability to understand the nature and consequences of your actions. So, this middle ground of people often ends up in jail.

For these individuals, access to treatment in correctional facilities is a major, major issue, and we know that our correctional facilities in Ontario do not have the capacity to address some of the serious mental health issues that the inmates present with. When these individuals are ready to be released, discharge planning is often not sufficient, leaving them without proper arrangements for community support. This can increase the risk of relapse and reoffending. Sometimes individuals are not accepted into community services because they have complex criminal records, and I'll go into that in a little bit more detail later.

In terms of our recommendations, we have some concrete recommendations for the committee on how to improve access to treatment services and supports specifically, as well as some recommendations on how to solidify the mental health strategy and improve mental health policy over the long term. We've tried to prioritize our recommendations in the interests of time. I'm sure we could sit here for an entire day and talk to you about all the things that could be changed to improve the system.

In terms of improving access to treatment, our number one suggestion is to increase access to psychiatrists in the province. One of the things we're looking at is how to increase the number of psychiatrists who are practising in the province. In 2004, which is the latest statistic we could find, there were only 13.1 practising psychiatrists per 100,000 people, and that number is highly concentrated in urban areas. I'm sure you've heard through your travels that when you're looking at non-urban, rural northern communities, there are sometimes one or two psychiatrists practising if you're lucky.

Currently, only 5% of medical graduates choose psychiatry as their first choice for residency, and that's due partly to the stigma of practising psychiatry. Also, what needs to be recognized is the compensation levels. Psychiatrists earn 15% to 50% less than other specialty areas, and obviously that is a disincentive for practice in the area. We need to increase incentives for practising psychiatry in the first place as well as practising in northern and rural communities specifically.

Another way to increase access to psychiatrists in non-urban areas is to make better use of telemedicine, specifically telepsychiatry. I know you've already heard from the Ontario Telemedicine Network, so I won't repeat those recommendations. However, we do support the suggestion to expand telemedicine for mental health across the province as a way of increasing access to psychiatry.

Another approach to be examined is shared care. Again, the gentleman from the Ontario Telemedicine Network discussed this. Basically, you would have a health care practitioner, such as a nurse practitioner, doing the face-to-face client work with the individual with a mental illness but with guidance from a psychiatrist from afar. That allows the individual to receive access to treatment in a more timely manner and closer to home.

These are just some of the examples of innovative approaches or models that should be examined when we're trying to improve access to psychiatric care.

Our suggested priority for improving access to community-based care is to focus on the most at-risk, high-needs individuals. In our experience, people with really complex cases—that is, people who are dealing not only with serious mental illness but also issues of poverty, homelessness, addiction and sometimes criminal histories—are the individuals who have the most difficulty accessing services. Part of this is due to the capacity of community agencies to address the needs of these complex clients, but we can't ignore the stigma and discrimination that occur even within our sector as well.

In cases where a particular agency does not feel equipped to provide service to a high-needs, at-risk client, we need to ensure that a system is in place to refer that individual to another agency for service. People should not simply be turned away because they can't be helped by that particular agency without an alternative.

In terms of funding as well, a priority should be put on this population. Models such as assertive community

treatment, intensive case management and highly supportive housing should be expanded and prioritized for those who need them the most, those with the most complex needs.

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Another way to improve service provision for at-risk, high-needs individuals is to improve the links between community services and institutions such as hospitals and jails. In times of limited resources, priority should be put on those who are most at risk of relapse or reoffending due to lack of community supports, and intensive supports must be provided to these individuals during their transition into the community—so really, eliminating that gap, those cracks that people fall through.

As mentioned earlier, the social determinants of health play a crucial role in mental health recovery. Eighty per cent of people with schizophrenia face barriers in entering the workforce and are dependent on ODSP. That's a huge, huge number of our population. Unfortunately, this program actually works against recovery in practice. If we are to improve access, we really need to see major reforms to ODSP. One of our first recommendations is, as stated in the poverty reduction strategy, that a social assistance review must be conducted, and this review must go beyond minor changes and really make substantive changes to the program.

Some of our suggestions, based on the demands of the ODSP Action Coalition, which is a group that we are a member of, are to:

- raise ODSP levels to cover the real cost of living;
- index ODSP rates to inflation;
- simplify the application process;
- provide sufficient staff to support people with mental illness and other disabilities through this process;
- eliminate barriers to employment supports; and
- increase access to education and training.

We need to change this from a program that keeps people in the depths of poverty to one that really helps and supports people in their recovery.

I'll turn the presentation back over to Mary for our last two recommendations.

Ms. Mary Alberti: There are a couple of recommendations we have around infrastructure development and how you ensure that a mental health strategy will have longevity in Ontario and that a strategy will actually be carried out and can be implemented. The first is to restructure the government responsibility for mental health. As Michael Kirby from the Mental Health Commission of Canada has mentioned to you and stated in his presentation, one of the major impediments to strategic planning and delivery of mental health services is the lack of a single-point person or body responsible for mental health.

Currently, as we know, the Ministry of Health and Long-Term Care takes on most of the responsibility for this area. We know that mental health is not the only health issue that we face, but we do know that mental health cuts across all government departments and it impacts many people. Coordination and buy-in from

different ministries can only go so far. What we need is a minister responsible for mental health and a distinct body within the government whose sole responsibility is mental health. We are proposing a secretariat to deal with mental health and a body that would deal with that.

A model you would be familiar with that we have examined is the Ontario Seniors' Secretariat, which you've already heard of in your consultation process. Here you have a minister responsible for the issue and an assistant deputy minister who reports to them. You have dedicated staff who develop policies and programs and meet the needs of a target population and who advise in policy across government. The creation of a specialized department responsible for mental health issues in Ontario that could coordinate the efforts of all the ministries that are involved in this issue is vital.

Our second recommendation for you to consider is to enshrine mental health strategy into legislation. While past governments have shown interest in mental health and have commissioned report after report to provide recommendations for system improvement, none of these recommendations were adhered to when a new government came in. What is needed is long-term, ongoing commitment that will extend beyond one government's mandate.

We would like to use the Poverty Reduction Act as an example for you. In May, the provincial government showed its commitment to poverty reduction by passing Bill 152, the Poverty Reduction Act. We recommend that a similar act be created based on a mental health strategy. This act would include specific targets and indicators and measure how well the province is doing in addressing mental health issues in Ontario. It would also ensure that subsequent governments are required to re-examine the mental health strategy and provide a report on progress, to engage in consultations with key stakeholders during this review process and report publicly on the results.

In closing, in our recommendations for infrastructure, what we are looking for is that a strategy actually come to life, and that implementation is key, that in Ontario the issue be taken very seriously and that we do see some change, because mental illness impacts many people in Ontario.

We thank you for the opportunity to present to you, and we'll be open for questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left us about six minutes, so we'll get about two from each of the parties. Christine or Sylvia?

Ms. Sylvia Jones: I'm glad to see that you've raised the privacy issue because, as you can imagine, many families have talked to this committee about how that's a frustration for them. I obviously haven't had a chance to look at the recommendations, but I wonder if you could highlight some of the solutions you see, because so far we haven't had anybody come forward with solutions.

Ms. Vani Jain: Again, the legal aspects of this are very complex. We looked at, first of all, very minor changes. One of the issues that families face is in sharing information with the health care provider and being

concerned about what the repercussions of that would be should their family member find out. So we looked at strengthening the wording around when a health care provider should share that information with a patient and when they may take the safety concerns of the family into consideration when making that decision.

Another thing that we looked at was clarifying the privacy act and how it's used by health care providers. We found that there are a lot of people who provide health services who actually go beyond the requirements of the privacy act, when it comes to sharing information with family members. So one of the things we recommended was doing more education with health care providers around what the actual limitations are versus the perceived limitations.

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

M^{me} France Gélinas: I was interested in that question, but I'll try to pick a quick one. You've talked about stigma and discrimination. We've heard lots of people pointing to health professionals as being the worst culprits—and the examples of people with severe mental illness having a tough time finding a family physician and the consequences of that. There are new models out there of interdisciplinary care, whether we talk about family health teams or we talk about community health centres. Is there something out there in primary care that works better for your members, for people with schizophrenia?

Ms. Mary Alberti: Maybe I can start with that and then Vani can add. Yes, I think when we look at health teams where individuals with schizophrenia feel comfortable and feel that they can trust the team they're working with—the primary care program at a place like Mount Sinai is an example that might work very well.

I think the other component of it, education of primary care practitioners, is key. Schizophrenia is not something that a primary care practitioner would deal with on a day-to-day basis or have real knowledge of, but we feel there is very limited knowledge about the illness and the health-related consequences of schizophrenia. As an example, a lot of people with schizophrenia would have diabetes, would suffer from metabolic disorder, a lot of the effects of medications.

I think we speak more on how we can educate people about social inclusion and how we can have good health practice for people affected by schizophrenia, so looking at models where—I think the trust factor for many of our people is very important. The ability to go to one location to have a lot of their health needs met is very important; that they're not travelling or going to different parts of a city is also very important.

The Chair (Mr. Kevin Daniel Flynn): You have about 20 seconds left to do the other half, Vani.

Ms. Vani Jain: Oh, no, it's okay. We can go on to the next question.

The Chair (Mr. Kevin Daniel Flynn): Are you sure? You want to move on?

Ms. Vani Jain: Yes.

The Chair (Mr. Kevin Daniel Flynn): David or Bas.

Mr. David Zimmer: Just last week, the very distinguished psychiatrist Oliver Sacks wrote an article in the New York Review of Books entitled “The Lost Virtues of the Asylum.” He uses the word “asylum” in its Oxford Dictionary meaning; that is, a place of refuge, a place of protection and a place of sanctuary.

He makes this statement: “The last 15 years or so have seen a new generation of antipsychotic drugs, with better therapeutic effects and fewer side effects, but the too exclusive an emphasis on ‘chemical’ models of schizophrenia, and on purely pharmacological approaches ... may leave the central human and social experience of being mentally ill untouched.”

He makes the point that the pharmacological treatment of it is not enough. There also have to be places of refuge, sanctuary and protection where people can live out their lives, because although the drugs may control it, there’s no real protection, no real humanity. Would you agree with his statement?

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Ms. Mary Alberti: That fits very nicely into our access-to-treatment campaign and identifying the three pillars of treatment, and what we would identify as that. I think we can’t negate that certainly anti-psychotic medication is very important, as well as other medications, but community and social supports are also very important.

Mr. David Zimmer: Then he goes on to make the point—I just want to get this in—that one of the difficulties is that the legal community, or the legal world—I’m a lawyer—has stepped in and has all sorts of barriers in place that really prevent the hospitalization or institutionalization of people who really need that kind of sanctuary and protection. What would you do about all the legal types who are causing difficulties?

Ms. Vani Jain: I’ll address that—another legal question. It is a challenge, and our mental health laws are really meant to balance individual rights and freedoms with public safety. I think we’ve made great strides in trying to achieve that balance, but yes, there are ways in which our mental health laws actually prevent people from getting treatment, especially when they’re in a situation where they may not know they need help at the time. As Mary mentioned, lack of insight is an issue that people face.

From our perspective, we don’t have the answers right here and right now, but one thing we would recommend is doing a review of our mental health laws and looking at how well they are actually serving people with mental illness, and looking toward perhaps other ways of designing those laws.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Vani and David. Bas, if you’ve got a very, very short one and then Christine. We’re just going to extend this a little bit.

Mr. Bas Balkissoon: Okay. I have a very quick one, and if you can’t answer it today and could send us input, that would be really great. You basically said that the system for dealing with mental health is uncoordinated. I’m wondering, if you look across the province, do you

have an idea for the committee as to how we would restructure it? If you don’t have the answer today, I’d be willing to get your input later on in writing.

Ms. Mary Alberti: We’d be pleased. We can send something with our thoughts about that, absolutely.

The Chair (Mr. Kevin Daniel Flynn): That’s wonderful. Thank you. Christine?

Ms. Christine Elliott: I don’t have a question but rather just a comment. I’d like to thank you both very much, Mary and Vani, for your presentation today but also for your very early support of the creation of this committee. In many ways, you’re partly responsible for us being here today, so I’d really like to thank you very much for your ongoing efforts and all of the wonderful work you’re doing, especially, as David mentioned, with respect to the issue of mental health laws. We have heard from a significant number of families in our hearings across the province, and it is something we are looking for more input on. So if you can point us in a direction that will help us make a determination and some recommendations, that will be helpful. We would really appreciate that.

Ms. Vani Jain: Absolutely.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Christine. Thank you very much, Mary and Vani, for coming today. Great presentation.

ONTARIO COLLEGE OF FAMILY PHYSICIANS

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is Dr. Jan Kasperski, CEO of the Ontario College of Family Physicians. It’s wonderful to see you again, Jan. You always hit the good issues.

Ms. Jan Kasperski: It’s Ms. Kasperski, because Ms. Kasperski is a registered nurse.

The Chair (Mr. Kevin Daniel Flynn): That’s right. I’m sorry.

Ms. Jan Kasperski: The Ontario College of Family Physicians is run by a nurse.

The Chair (Mr. Kevin Daniel Flynn): That’s right. I knew that, and I blew it.

Ms. Jan Kasperski: Just for everybody’s information, the Ontario College of Family Physicians is a chapter of the College of Family Physicians of Canada. Our college has received a federal charter in order to develop the standards of practice for both the practising family physician and for the education of family medicine residents, so we work really, really closely with all 17 medical universities across Canada to accredit their programs, and family medicine residents sit the exam in order to be licensed in the province of Ontario. We are truly the educational body.

In Ontario, the Ontario College of Family Physicians works really closely with all six medical universities to ensure that our residents here in Ontario receive a really superb education, but our college spends a great deal of its time and effort in continuing professional develop-

ment to ensure that family physicians stay as current as our residents.

I think it's really important for the select committee to recognize the fact that 80% of medical care in this province is delivered by family physicians, and that includes 80% of the mental health care that is delivered in this province. Thirty per cent of the patients presenting to a family physician are in that office because of mental health and addiction issues.

Family physicians deal with patients through their whole lifespan, and we're not just talking in the mental health arena of patients who have severe persistent mental disorders. People have emotional, social and mental health and addiction problems throughout the whole of their lifespan.

Our patients become very distressed when they can't be parents. They worry terribly during the first trimester of their pregnancy, and they suffer tremendously when their fetus is lost. The sleepless nights and anxiety during the last trimester lead to an overwhelming happiness at the beauty of the world's most precious baby being born. But it can quickly turn to maternal blues or to postpartum depression. Did you know that there is not one setting in this province in which a mother who is in a crisis postpartum can be bonded with her child? We separate them. We send the baby home; we bring the mother into hospital.

Family doctors are there when our parents are worried about autism or childhood mental disorders or learning problems or behavioural problems. We deal with childhood obesity, acne, bullying and all the trials and tribulations that lead to adolescent angst, eating disorders, alcohol and drug use, promiscuous behaviours, and arguments and violent episodes, which we're seeing in this city in spades.

We support couples when they're having marital difficulties, and we're the first to know when there's violence in the home. We help them through midlife crises, and we're there when they're experiencing empty nest syndrome, which I'm experiencing myself.

We're identifying and intervening very early when Alzheimer's disease is suspected. We care for our patients with dementia in their homes and in long-term-care facilities, and we do it as best we can. We support their loved ones. We try very hard to ensure that the patients have the best quality of life, as long as possible.

We comfort our patients when they've lost their spouse, parent or precious child. We are the doctors who are working in the emerg departments when a patient is brought in by police after a call from a family member who fears their loved one is suicidal or homicidal.

When the diagnosis is severe persistent mental disorder or they are addicted to drugs or alcohol, or they're doubly diagnosed with both, which is often the case, we are frequently left on our own to deal with the patient and the family members without the support we need from the system. This is especially true for those of us who practise in the far remote north, trying desperately to meet the needs of our First Nations people.

We do all of this and much more in a system that is fragmented and hard to access, and that lacks the people with the knowledge and skills to provide evidence-based care.

What has the Ontario College of Family Physicians done to help our members? We established the Collaborative Mental Health Care Network. This is a province-wide program that pairs psychiatrists with GP psychotherapists to mentor family physicians, who receive just-in-time advice as well as formal education to increase their knowledge, skills and, just as importantly, their confidence in being able to provide excellent mental health and addiction care. It has proven to be such a successful model that it has been established as a permanent program, funded by the Ministry of Health. We have been invited all over the world to help other ministries of health set up similar programs, but I bet none of you know about it.

The Alzheimer's physician education strategy has been modelled after the collaborative mental health network, but it pairs geriatric medicine and psychiatry specialists with family physicians who have taken our third-year residency program in care of the elderly. It supports family physicians to care for patients with dementia and their families from that first stage, when they begin to show signs of mild cognitive behaviour, right through to end of life.

1650

The medical mentorship for addictions and pain has teamed pain specialists with addiction specialists and methadone prescribers. They assist family doctors in dealing with the care of patients with intractable pain and the sequelae of the use of opioids, such as addiction. This project has led us into the realm of drug diversion. We're working closely with the police, with pharmacists. We now know that opiates are the street drug of choice, and we have a great social issue to deal with in that realm.

Lastly, we have worked hard on developing family health teams, with social workers and mental health workers embedded in the teams, to assist with the 30% to 35% of the patients in our practices who need mental health services. With practice supports in place, with guidance and advice from our specialists, family doctors are much more willing to take hard-to-serve patients into their practice. These patients may receive care in the mental health service arena, but they lack primary care, so their physical health is neglected. They are ripe and ready for chronic disorders. Their eating behaviours, their lack of exercise, their smoking like chimneys and their medications all lead to early onset of major chronic disorders. We want them in primary care.

What are our recommendations to you? By the end of the term of office of this government, we will have 200 family health teams in place, but that's not enough. Every person in this province deserves to have their care needs met in a family practice with inter-professional team members to really meet their needs. We need to invest, and invest heavily, in the primary care sector. Patients do not want to be seen in an environment labelled "psychia-

tric hospital” or “clinic,” “addiction outpatient clinic” or “methadone clinic.” They want to be cared for where they’re comfortable: their medical home. We want to bring the expertise to those family practices rather than sending the patients to the black box of psychiatric care. We suggest you support shared care in mental health programs and bring psychiatrists and social workers to our practices. We certainly hope you support our collaborative care model.

We need to create a single entry point into an integrated mental health and addiction program. It is just too hard to find all of the services that are out there, and patients deserve to have easy access. When a family doctor can’t find them, they can’t. We need to create a Cancer Care Ontario for the mental health sector, one that undertakes research to identify best practices and evidence-based care and measures every service provider to ensure that they’re providing high-quality care. We are often uncomfortable referring because we just don’t know the quality of care, the methodologies and the philosophies in the programs that are out there. We need to do a better job of measuring and ending up at the end of the day convinced that we’re able to give the best care possible.

We need to invest, and invest very heavily, in the early years, zero to six, when the resilience to all kinds of chronic disorders, especially mental health, can actually prevent them. We need to put public health nurses back into our schools to give better access to our children and adolescents during their formative years.

We need to address childhood poverty and, indeed, poverty in general. At a minimum, we need to ensure that everyone has a roof over their head and sufficient food to eat.

We need to shore up employee assistance programs by making every employer responsible for creating a healthy workplace. It should be a priority in Ontario.

Our health care system was built on the principle of equity; that is, the most care for those most in need. It is not equal care; it is equitable care—most care for those in need. Patients with mental health and addiction problems are some of the most needy people in this province, but instead of providing them with equitable access, we don’t even provide them with equal access. That great Canadian philosopher Rex Murphy once said that the Canadian health care system is cherished by the public because it is the best expression of Canadian values. He went on to say that nowhere in the health care system do we see these values translated into action more fully than in the family doctor’s office.

Thank you so much for inviting me to meet with you today. I’d be happy to answer any of your questions.

The Chair (Mr. Kevin Daniel Flynn): Jan, thank you very much for coming. It was a great presentation. We’re going to start with France. Unfortunately, we’ve got about a minute and a half each, so if we could make these brief.

M^{me} France Gélinas: Thank you very much for an excellent presentation. I value the work that the Ontario College of Family Physicians has done in mental health.

I would be interested, if you could share with us a little bit more, in who you see being part of the shared-care model in mental health.

Ms. Jan Kasperski: The shared-care model actually got its start here in Ontario, and we should be very proud of the successes. It has rippled all across Canada.

In the shared-care model, psychiatrists, social workers and mental health workers go into a family practice, and with the family doctor they assess, in conjunction with the patient and family, the patient’s needs; develop a care plan; and then leave that care plan for the family doctor to oversee, along with the support of a social worker. That model works really, really well.

The Collaborative Mental Health Care Network has modelled that type of support, but at a distance. Our psychiatrists tend to be really well established in the larger cities. Throughout the rest of the province, access to psychiatry is very, very limited. Getting in to see a psychiatrist here in Toronto is hard enough, but trying to get in to see one in the rest of the province is difficult. So we have paired GP psychotherapists with psychiatrists to mentor family doctors at a distance—so by e-mail, by teleconferencing. They get just-in-time guidance and advice so patients don’t wait to get care. As soon as the problem is identified, the knowledge and the skills to be able to look after that patient are delivered to the family physician.

The Chair (Mr. Kevin Daniel Flynn): I’m going to have to cut it off there. Jeff?

Mr. Jeff Leal: Thank you, Ms. Kasperski, for a very good presentation. I’m from Peterborough, so we have great experience with family health teams in my community, which has been the model for the rest of the province.

Ms. Jan Kasperski: I was part of your steering committee.

Mr. Jeff Leal: Absolutely. I thought I’d get that plug in today.

We have a family health team model that was developed for many communities, particularly in southern Ontario. I’m wondering if you’ve given some thought to developing a family health team model and the various components of that to serve our First Nations in particular. We have geographic challenges. We had the opportunity to visit Sandy Lake a couple of weeks ago. It’s very isolated. Have you given some thought to the components of a family health team model that may work directly and in partnership with our First Nations community, bearing in mind that the traditional healing methods have to be part of that family health team, along with our traditional approaches to medicine delivery?

The Chair (Mr. Kevin Daniel Flynn): Jan, this is going to have to be almost a yes or no.

Mr. Jeff Leal: I’m sorry. My preamble was a bit long, but I wanted to set the table on this one.

The Chair (Mr. Kevin Daniel Flynn): Take your time, but we do have to be brief.

Ms. Jan Kasperski: We have been working with the chiefs in order to address some of the issues around

mental health and addiction—opiate use—in our First Nations communities. Again, the only medical supports tend to be our family physicians flying in. So shoring up, on site, in professional teams is where we should go.

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

Mrs. Christine Elliott: Thank you for your presentation. We have not heard about the Collaborative Mental Health Care Network in committee before. You were right when you said we probably had not. Can you tell me when it was established and whether it's fully rolled out across the province?

Ms. Jan Kasperski: It was established in 2000. It was evaluated in 2004. It demonstrated that family physicians who are part of the network tend to keep their patients within practice, so it has been really cost-saving. They don't end up being just shipped off to emergency or sent to psychiatric services. It has built communities. The family physicians start to really know what community services are out there and reach out to them.

When I said there will be only 200 family health teams by the end of the next couple of years—in actual fact, there are lots of virtual teams out there, where smart people have been able to find ways of building virtual teams. That's probably the model that we're going to end up being able to use: most cost-effective in using the services that are already there, but bringing them into practices rather than out.

1700

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Jan. Great presentation, as always.

Ms. Jan Kasperski: No problem.

DIANE DE CAMPS MESCHINO

The Chair (Mr. Kevin Daniel Flynn): Our next and final presenter today is in perinatal mental health, Diane de Camps Meschino, provincial liaison. If you'd come forward, Diane, make yourself comfortable.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): That's the first hug ever in Hansard, I think.

Like everybody else, you get 15 minutes. You can use that any way you see fit. If you could leave a little bit of time at the end for any questions, that's entirely up to you, but it seems to work well when that happens.

Dr. Diane de Camps Meschino: That's my plan. Thanks very much.

I'm Diane de Camps Meschino. I am a psychiatrist. I currently work at Women's College Hospital as the leader of a program called the reproductive life stages, which is reproductive mental health. I cannot tell you how thrilled I am to learn about this committee and how thrilled I am to be here, and I first of all want to thank you for that. In terms of who I am, I'm extremely committed to our health care system, I'm extremely committed to improving our health care system, and as such, I do an awful lot of volunteer work in terms of team building and program building.

I'm here to tell you not that the population I serve is more important, but really to bring it to your attention. The population we serve and our program is across the lifespan. We deal largely with mood, anxiety and psychotic disorders which present primarily during reproductive life changes; that could be premenstrual, pregnancy, postpartum, pregnancy loss and the menopausal transition. The bulk of our patients are perinatal, pregnant or postpartum or loss. The reason for that is these patients have the greatest urgent need. They are undoubtedly the sickest, they get sick very quickly and they need urgent services, so they fill most of our spots.

In terms of the overview of what I'm going to tell you today, I'm going to go over some statistics to tell you why this population is important to know about and to look at; the impact of these illnesses on mothers, fetuses, children and families; I'm going to tell you a little bit about what a coordinated systems model would look like and identify some gaps in the current system. I am here, in fact, representing the province. When I received the invitation on Monday to present today at 5 o'clock, I e-mailed my colleagues across the province and said, "How do you feel about me acting as your liaison at this meeting?" I got responses immediately from my colleagues all across the province saying, "Yes, please," so I'm here representing this whole group of us that do this work.

Why am I here pitching the pregnant and postpartum population? For women, this is the highest time in a woman's life where they would get a severe mental illness. So if they already have depression, then depression recurs very typically in pregnancy or postpartum, but not mildly; it occurs in a severe form. It is a very high time for relapse of bipolar; 75% chance of relapse of bipolar in the first two weeks postpartum—untreated bipolar. Same with anxiety and obsessive-compulsive disorder. You will probably be most familiar with the media—can you hear me?

The Chair (Mr. Kevin Daniel Flynn): That's the problem: We can hear you almost too well. These are great mikes, and you can sit back a little bit. What happens is they pop if you get too close, so you can relax and you can almost walk around and talk, they're so good.

Dr. Diane de Camps Meschino: That's great. So, is that better, then?

The Chair (Mr. Kevin Daniel Flynn): That's great.

Dr. Diane de Camps Meschino: Thank you. Just getting back to my slides here: Of the women who become ill during the pregnancy and postpartum period, about a third are a first onset of mental illness and about two thirds are a recurrence. It's an ideal time for intervention, prevention and promotion. The reason for that is that mothers or mothers-to-be are amongst the most receptive patients I have ever encountered. I've worked in family practice and I've worked in many areas of psychiatry, and there's nothing that's gotten me as fired up as working in this particular area. Moms want help and they will seek help on behalf of themselves and of

their children. They're receptive and they're highly motivated. They will do whatever it takes to get well and keep their children well.

Just in terms of who I'm here representing, I work with the Ontario college of family practice, as you could see by my reconnecting with Jan. I work with Best Start Hubs, public health, Hamilton, and I was instrumental in helping set up the perinatal psychiatry programs in Sudbury and the North Network, Ottawa, London, the Niagara region and Toronto. I led the setup of the program here. I represent clinicians, researchers and educators.

The trouble with our current system is that we are swamped. I'm sure you have heard that from everyone who has sat in this spot. Waiting lists are clearly an issue; you don't need to hear more than that. But the impact that this has on our patients is that we triage according to priority, so only the very sickest patients get seen and only the sickest patients get service. That means we're not intervening early for the other patients. We have to wait until they actually get very sick before we can treat them.

I'm sorry the graph is small; I can send you the PowerPoint electronically if it's helpful. This is just a slide on depression; it doesn't include bipolar, anxiety or OCD. Just depression alone, we're looking at 13,000 to 26,000 women per year who get the most severe form of postpartum or prenatal depression and another 46,000 to 80,000 women who get moderately severe depression; 70% to 80% of women with depression who are treated recover. The remainder require ongoing care.

How's my time?

The Chair (Mr. Kevin Daniel Flynn): I'm using the BlackBerry to do it. You've got about eight minutes left.

Dr. Diane de Camps Meschino: Okay. I'm going to have to fly.

The next slide I've got here regards maternal deaths. Mental illness is the most common complication of pregnancy and the most common complication of postpartum, bar none. If you look at this graph—this data is from the UK—it accounts for the greatest number of maternal deaths up to one year postpartum.

I was introduced once by, "Now that we've solved all the difficult things in terms of complications of obstetrics and labour and delivery, we can deal with the soft things." I responded with, "Since when is suicide soft?" And I would say that here. This is something that is not properly dealt with or known. We don't have stats in Canada on this.

In terms of the impact on untreated mothers, if they're pregnant, they become sicker. We're dealing with frequent substance abuse. There are labour and delivery complications. There's evidence that untreated illness has an impact on the brain of the fetus, with long-term consequences including mental illness and cognitive and language development. This is fairly new evidence, but the evidence is mounting in study after study after study; it's convincing.

In terms of the infant and the child, we also know that with postpartum depression, even if the mother is not

depressed in pregnancy, there are frequent long-term implications for language development, cognition and mental illness and also increased physical illness.

1710

I'm not going to go over all of my slides. I'll leave them to you, but I want to say that mild symptoms and moderate symptoms can be dealt with very well in the community as long as there's expert care to back them up. We don't have enough experts. There's a very small number of us, and we're trying to handle the problems for the whole province. The severe symptoms need to be dealt with by experts in reproductive mental health because the data and research on the subject change so rapidly that there is no possibility that one could be a specialist in another area and keep up with the material in this field.

Necessary components of a system would include screening, identification, creating care pathways, and community treatment, including public health, home visitors and family health teams. Within specialist care we need out-patient programs, which is the one thing that we have. An intensive day treatment program would be very helpful to keep patients out of hospital. We need an in-patient program where we cannot separate mothers and babies—that's a bit of a luxury that's well-developed in other countries. We desperately need a database. We do not have a Canadian database. We're relying on countries around the world—Australia, the UK and the United States. We need policy and we need standards.

The next slides really illustrate what an integrated continuum of care would look like, but I don't want to go over that in detail for you. Let me just stress that some of our major gaps include that illnesses during this period are underdiagnosed and undertreated—that's both addiction and other mental health problems. We do not have a coordinated system for screening, identification and treatment. We don't have preventive programs for high-risk women and teens. We do not have services that well accommodate the needs of diverse, marginalized, refugee or new immigrant families—and teens and immigrant families are at particularly high risk. We have inadequate expertise. Those who are expert are really expert, but there aren't enough of us.

We do not have a parenting program for mentally ill parents that deals with both the child and the parent. Led by Jean Wittenberg, we have rolled out an excellent program that helps mentally ill parents parent, but it does not deal with the mental illness of the parent. The international movement in this area now recognizes that these programs, while they're fantastic, have paid inadequate attention to the parent's mental illness, in this case maternal mental illness.

Barriers to care and access include language, culture and distance to travel. Many of our moms come from great distances, through ice storms and snow storms, with multiple children. It's a crazy way to deliver care to these poor women who are also mentally ill.

Child advocacy problems: People are terrified of their children being taken away. I just met with children's aid

today. I want to reinforce that the program that has family meetings with transparency, where we are seen as helpful, not punitive, is going to be very important in terms of women who are pregnant and post-partum accessing care.

I'll stop there, and I welcome your questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. That was a great presentation. As we've travelled the province, we've learned a lot about fetal alcohol syndrome and also touched on the issue of post-partum depression, but this is probably the most thorough presentation we've had on the perinatal population.

We've got a very short time for questions but probably time for one from each of the sides. Is there anybody on this side? There isn't? We can go right to Christine and Sylvia.

Ms. Sylvia Jones: Just really quickly, thank you for your presentation. Jan previously mentioned—I'm not sure if you were in the room—

Dr. Diane de Camps Meschino: I was.

Ms. Sylvia Jones: —how there was currently no access for mothers to be treated with their children. You've also highlighted it as one of your issues. Is there any access to that program where a mother could be treated without having the child either stay at home or be elsewhere?

Dr. Diane de Camps Meschino: The reason I know Jan is that I put a proposal together with a steering group that you will find in your package here as an outline. It's really a comprehensive program for the entire province. Getting it to the government has been very difficult. It has been reviewed by the Toronto Central LHIN favourably, but of course money is the issue.

Included in that proposal were a couple of in-patient beds for mother and baby. Mount Sinai did volunteer two of their in-patient beds where mom and baby can be admitted together, but there are a lot of issues around liability, and at this point they do not have the staffing to take care of the baby. That would have to be provided by the family.

Ms. Sylvia Jones: Thank you. Two beds.

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

M^{me} France Gélinas: You mentioned that you did basically a screening of your waiting list and provided treatment only to the most severe cases. Is there anything out there you can offer for early intervention and for people that don't meet the "very sick"—to get care with you?

Dr. Diane de Camps Meschino: We prioritize because we have to, because these patients are often suicidal and have homicidal thoughts regarding their infant, so we have to respond to that. I've spent a lot of time putting educational programs together and have travelled the province with the Ontario College of Family Physicians. Unfortunately, we get small numbers of people out. So, we're trying to build expertise in family practitioners and the family health teams, and that would be enormously helpful. Other than that, I've also worked with Toronto public health, trying to enhance their expertise so that they can do as much monitoring for us in the community as possible. You've asked me a question about the beds. I think that's an issue, but I think a much greater issue is the community. If you don't have all tiers of your system together, it's going to fail, and ours is failing because we do not have community resources. We don't have enough people to transfer our patients to once they get well enough to leave our program. We need family doctors; we need public health; we need home visitors who have enough expertise that they could manage these patients. We're delighted to provide the backup.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you, Diane. Thank you very much for coming today and speaking on behalf of your colleagues—and yourself, of course.

Dr. Diane de Camps Meschino: Thanks very much. If you want this in an electronic format so you can see the slides more easily, I can send it.

The Chair (Mr. Kevin Daniel Flynn): If you would e-mail it to the clerk, that would be wonderful.

Dr. Diane de Camps Meschino: That's great; will do.

The Chair (Mr. Kevin Daniel Flynn): Thank you, members of the committee, for attending today. This meeting is adjourned.

The committee adjourned at 1715.

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