
Legislative Assembly of Alberta

The 27th Legislature
First Session

# Standing Committee
# on
# Health

Monday, November 24, 2008
5:48 p.m.

Transcript No. 27-1-9

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## Standing Committee on Health

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Pastoor, Bridget Brennan, Lethbridge-East (L), Deputy Chair

Dallas, Cal, Red Deer-South (PC)
Denis, Jonathan, Calgary-Egmont (PC)
Fawcett, Kyle, Calgary-North Hill (PC)
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## Standing Committee on Health

### Participants

**5:48 p.m. Monday, November 24, 2008**

[Mr. Horne in the chair]

**The Chair:** Good evening, colleagues. I'd like to call this meeting of the Standing Committee on Health to order, please. Welcome, everyone. We'll begin just by going around the table and giving members and staff an opportunity to introduce themselves.

**Dr. Sherman:** Raj Sherman, Edmonton-Meadowlark.

**Mr. Dallas:** Good evening. Cal Dallas, Red Deer-South.

**Mr. Vandermeer:** Good evening. Tony Vandermeer, Edmonton-Beverly-Clareview.

**Mr. Denis:** Good evening. Jonathan Denis, Calgary-Egmont.

**Mr. Massolin:** Good evening. I'm Philip Massolin. I'm the committee research co-ordinator, Legislative Assembly Office.

**Mrs. Kamuchik:** Louise Kamuchik, Clerk Assistant, director of House services. Good evening.

**Mr. Quest:** Good evening. Dave Quest, MLA, Strathcona.

**Mr. Fawcett:** Hello. Kyle Fawcett, MLA for Calgary-North Hill.

**Ms Notley:** Hi, there. Rachel Notley, MLA for Edmonton-Strathcona.

**Ms Norton:** Erin Norton, committee clerk.

**Ms Pastoor:** Bridget Pastoor, Lethbridge-East.

**The Chair:** I'm Fred Horne, and I'm chair of the committee.

We'll move quickly. We have three presentations this evening, members, and we need to get everything done by 7:15. I think most of us are returning to the House this evening, so you'll forgive me if I move really quickly through the business part of the agenda.

Can I ask for a motion, please – this is item 2 – to approve the agenda as circulated. Moved by Ms Notley. Discussion? Those in favour? Carried. Thank you very much.

Item 3, adoption of the minutes of our meeting of November 18, 2008. Moved by Mr. Dallas. Any discussion, corrections, deletions? Those in favour? Opposed, if any? That's carried. Thank you very much.

We'll move on to item 4 now. This meeting is a public meeting under the provisions in the standing orders that we discussed last time. We're going to be hearing from three groups this evening on three different matters. Mrs. Ainsworth, I'll give you an opportunity to introduce yourself in just a moment.

We're going to follow the same procedure as we did at the last meeting. We've allocated up to 30 minutes per presentation. We'd like to ask that you divide that between up to 15 minutes for a presentation and then leave the committee members about 15 minutes to ask some questions and engage in some dialogue with you. The clerk will kind of help keep time and indicate when there are five minutes remaining in the presentation portion.

To begin, I'd like to welcome Mrs. Alison Ainsworth, on behalf of the Lethbridge Association for Community Living. It's very good to have you here. Thank you for making the trip from Lethbridge. Without any further ado, I'll just ask you to make any introductions you wish and then to proceed.

**Lethbridge Association for Community Living**

**Mrs. Ainsworth:** Sure. I thank you for inviting me to come. I appreciate it. I'm affiliated with our association as a parent, so a frequent flyer in the system and a user raising a child with disability myself, who is diagnosed as having both very severe, complex medical issues surrounding a very rare genetic mixup, compounded further by a diagnosis of autism spectrum disorder.

I come to you tonight to discuss with you details pertaining to my child's service dog, our assistance animal, the experiences that we have and the experiences that we'd like to see change within the system such that families affected by disability who have children with chronic and severe disability who can benefit from assistance dogs would have the advantage and the opportunity to achieve that greater quality of life and be able to be productive members of society.

I had intentions of bringing my child here so that you could actually witness first-hand exactly what it represents for my child to have an autism assistance guardian dog, but unfortunately, due to the nature of the beast surrounding autism, I couldn't guarantee that that wouldn't result potentially in greater hardship for her and lots of noise for you guys. So I thought I'd do you a favour.

I have to tell you something that's come into my mind very quickly. When we got into the hotel, I turned on the television, and some of you were on TV, so it's a little bit surreal. I feel like I should get your autographs.

Again, back to my purpose for coming. It's particularly to speak about assistance dogs in general, but I'd like to start, if possible, by demonstrating to you this very brief video that was featured on CityTV some time ago when my child was also featured on the Larry King Live show on World Autism Awareness Day. This is to provide you with that visual that perhaps we're missing just to get us going in the right direction but keeping in mind that this speaks to an autism assistance dog.

[A video was shown from 5:53 p.m. to 5:56 p.m.]

**The Chair:** Well, I think you got it wrong. I think it's we who should be asking for the autographs, including your dog. Please continue.

**Mrs. Ainsworth:** What can I say? We actually laughingly talked about how we should stamp his paw on some pieces of paper and circulate them afterwards. Lots of people like to stop us and get to know him.

In a moment if we can address a brief PowerPoint presentation that I have prepared if for nothing else than to keep my brain a little bit focused because Emily comes by some of her things a little bit honestly, I sometimes think.

The reality for those of us who have assistance dogs is that they're very expensive and that currently they're not funded by the province. We as a family are continuing to advocate very strongly and work very hard to recoup the $15,000 U.S. that it cost us to obtain our dog, which actually represented a discount savings compared to what some of the other organizations were prepared to offer and actually represented a lesser time frame for us to get the dog. For instance, some of the service clubs within Canada may have service animals or assistance dogs but may have a four-year wait-list.

With a child like Emily our fundamental, main priority of concern for her is safety. She runs away. She doesn't understand cause and effect. Danger is something that she can't possibly fathom or imagine. I would suggest that four years would be way too long to have to wait if there are options that are viable and available.

Obviously, producing $15,000 is not an easy feat, particularly in today's market, but even then the expense would be equatable to a low-end car, only you cannot mortgage your assistance dogs, and you can't take them to the bank although the results, I would suggest, we should be able to take all over the place, as we've been able to do, in that my child now has the opportunity to attend school. So the lack of an assistance dog has represented an inability for her to participate in a learning environment such that she would have the ability to develop and grow academically but also socially, so that she would have the opportunity to interact with her peers appropriately.

They use him on a regular basis such as when she has difficulties running away in the school. Unfortunately, we don't keep our schools on lockdown, and I don't think that's the real world for anybody. He's pivotal for her and necessary for her, so in consideration of other children who aren't on the autism spectrum, I would like to come to you with the proposed at least conversational initiative, if you will, to discuss with you the idea of funding service dogs for children within the province that, perhaps, meet the criteria of being critically dependent upon the assistance dog for life-sustaining support. Whether or not we're talking about a diabetic alert dog or epileptic response dog for seizures or an autism assistance dog for pivotal and fundamental safety, I would hope that at least we can start the process to think about: how do we make these dogs accessible to families like ours, who are already very taxed to begin with?

Raising a child with a disability at the level of my child's – and I'm certainly not downplaying any other family who has a child who is more or less severe – I would say that we do categorically and statistically fit in a realm where there are significant and substantial resources and supports in dollars and cents that are coming out of parents' pockets regularly just for them to be able to participate in what we would consider to be normal life opportunities and experiences. For instance, the fact that my daughter had a feeding tube for six and a half years didn't remove the responsibility for me to endeavour to put food on the table for her. It didn't mean that she would eat it, but it did mean that it was part of the learning process. Not only did she have that, but then she was getting her PediaSure formula in her feeding tube. If I can relate that to other families with disability, it's not to say that a child isn't worth the investment in trying to entertain the notion of putting them into a program or being able to give them opportunities; it's saying that we need to do that, and if we're not successful, we need to do this, too.

This PowerPoint presentation, I'm sorry to say, has a couple of typos in it. Hopefully you won't fault me; you'll fault the organization I'm representing. They did it. I'm just kidding. If you had a chance to look at this ahead of time, I thought it necessary to just define assistance dogs to be able to offer clarity, again, speaking to the fact that service dogs within the province are currently not funded by the province. Right now the expectation is that service dogs are funded within the community by the community at large or from the individual users. I know, certainly in our case, where we were experiencing a move to a new community, to Medicine Hat, our contacts there were new and not yet at a level where we felt comfortable or confident.

Also, too, we're that family who years ago had to go to the Mayo Clinic in the States. It wasn't funded by the province, so we went out and fund raised $100,000 to be able to make a trip for my child that literally saved her life. It felt hard to go back to the same public and say: you know, I continue to wind up at your feet. The end result for us was that we raised $2,000, and I'm grateful for every moment. Surprisingly, it took a lot of work and time and energy that I'm glad resulted in what it did, but it was certainly very difficult for us.

This piece is written in a bunch of literature on their websites if anybody is interested. Assistance Dogs International, National Service Dogs of Canada, and, in our case, All Purpose Canines are wonderful resources that define the roles and responsibilities of service dogs, service dog handlers, and service dog users. Essentially, the bottom line for service dogs, be it assistance dogs for autism or assistance dogs for other related disabilities – persons with visual impairment, hearing impairment, epilepsy, diabetes – is that all dogs have access to all places. That's part of the law that I believe Alberta is working hard to pave the way, to make sure is upheld and recognized. We appreciate that. The good thing is that if we're willing to recognize that these dogs have that access, then they must have value to be able to substantiate that, because they're not pets; they're life saving, life sustaining for our kiddies.

The requirements to obtain the service dog clearly include a battery of, I guess, standards in order to even have your service dog able to go into a public place. To get the service dog in the first place, you have to be able to demonstrate a clear need for this service animal. You do absolutely have to demonstrate that there is a medical condition that is documented by the medical community, who are certified and recognized. Then that works in conjunction with the screening process, which in our experience took a very long time. It took a couple of months, actually, to collect the data to be able to support without pause that there was, in fact, a genuine, real need. Otherwise, I don't know why people would do it, truthfully, because service dogs and assistance dogs, while they're really wonderful – we literally could not live without him – are a lot of work, too. That said, I don't see everybody putting out their hand for nothing.

***6:05***

I put this together. This is certainly not a universal standard that I was pulling off the Internet but, rather, something I thought perhaps might be helpful in, again, promoting a conversation about this such that I could come to you with a clear conscience to say that, you know, not every child who has a severe disability needs a dog. To make sure that we're not having to pay for dogs at random, how can we control that? In my experience and opinion the one common thread is that those of us in the assistance community have a genuine need for, it seems to be, the life-sustaining, life-saving part. I do have to say that while the dog is pivotal in saving the life of my child, he gives me that third arm that I am missing.

Again, I have spoken about these types of service animals and assistance dogs. Some of the things that I didn't put in here under safety are alert tracking guidance, support, and assistance. There's obviously the element of retrieval for some individuals. There's the element of tethering. In the instance of my daughter you saw in the video that she actually wears a waist belt and will be attached to him periodically in times where there would be a prospective road hazard or something, when they cross intersections or they're out in the parking lot, where she would bolt and has done a thousand times, where we've had cars within an inch. In the instance at Candle Lake, we had to bring in a search party for her. Her service assistance dog is a tracker and actually was pivotal in helping us find her. You can imagine a six-year-old, going on size 3, with no understanding of danger but so much determination, you can't even imagine. She was about a kilometre away by the time we caught up with her, I would say about 12 minutes later, and she was operating on a broken foot with a cast. Anyway, she was just booting it through all the shrubbery.

They also have significant benefit, naturally, for communication, socialization, and other areas. The thing that I would like to instill is obviously not as life and death but, rather, that I think assistance

dogs are genuinely helpful in a world in a time that doesn't always understand children with disability. We're working hard to create education in the classrooms and so on, but it's certainly wonderful to know that there is somebody around that's going to graciously take her back in and take her under his wing and give her unconditional love and affection and confidence to get up and keep going.

Again, the costs aren't just contingent on the purchasing of the service animal but that many of the places require training, and that training often will happen at the actual place where you secure your assistance dog from. In our case we actually located an assistance group that's recognized throughout North America, and they brought their assistance dog to us and placed the dog in our own home, which was excellent for us. It represented less of a burden, more appropriate support, in our opinion, as far as integrating the service and assistance dog into our life and our community to address questions for us.

Certainly, that's an expense for families. The yearly ongoing everything else that comes with them, I would say again, is certainly a deterrent for some families who would be questioning getting an assistance dog for the fun of it because there's a lot more to invest in it than just initially. Certainly, if we had the support in the initial acquisition, then the rest wouldn't seem so overbearing, if that makes any sense.

We talked about this, that one of the things that statistically is appropriate, at least in the autism community, is that divorce rates are greater than 85 per cent according to much of the literature that you'll see out there. That is a true statistic, give or take, relative to the entire disability community's families, if you will. The challenge, I would say, to put forward, at least in conversation, would be that if an assistance dog is going to help the well-being and welfare of the child and, thus, the family and decrease the stress, you know, perhaps we're saving marriages, too.

If we're saving marriages, then look at what else we're saving, essentially, if we look at the giant picture, you know, instead of having single families on welfare. I myself had a job, being that my background is marketing, public relations, and communications. I had my own company. It was successful. I was proud. Then I had a daughter with a one-in-a-billion genetic mix-up, six months in hospital, feeding tubes, brain surgery, and an autism assistance dog. If it weren't for my husband, I'm not sure if anybody would let me open up a bank account because according to them, I am just a mom. I would say that I'm justified to be a mom, but unfortunately on the books if I was not with my husband, I would be dependent on the system.

I would say that having an assistance dog has certainly improved that because, again, speaking to the role that he's playing for her, which is freeing me up, not entirely but at least in some of the responsibilities, I'm able to adjust and adapt better such that I can feel better about my circumstance and feel more productive.

Qualified personnel are obviously a problem, regionally for us especially, so that places a further toll. What I would say is that the assistance dog would help the personnel to be more successful in their jobs as well, which would lighten the burden for them, too, and lighten the burden for the regions to be able to find adequate care for people who are severe.

Of course, I think all these things that I have spoken about are a given, but I would speak to my son as well. He's happily in the back right now. Having an assistance dog in his life has been a really positive experience for him because one of the things that we don't often realize is the impact that severe disabilities have on siblings. Sometimes that whole notion of creating a monster can happen just simply by being distracted or overlooked by a sister who is very, very busy and has lots of extraordinary needs and is now modelling for him, as has happened in the past, behaviour surrounding safety and danger such that he becomes a risk as well. So the assistance dog is improving that.

Again, if assistance dogs are going to help a mother feel better about doing her job and feel more adequate and maybe free her up, too, so that she can get back to work – because the more the assistance dog is around, the more stability we have; the more stability we have, the better time and better chance we have at freeing ourselves. If we can help the siblings and help the marriage and help the children to become productive, then I would suggest and submit as an application that assistance dogs be considered a priority and be constituted as a necessary medical, life sustaining, life supporting – I don't want to call them a device, but I would certainly say, well, just that they're necessary, whatever the verbiage that would be helpful.

I remain in a position where I'm not even able to get in front of some of the local committees affiliated with government, such as the complex disability board, to be able to make my application because there is no verbiage currently written either way. If we were to be bold and actually make a definitive statement about assistance dogs for children with chronic severe disability, then I would be grateful, and I really think the families in the province would be really grateful to you, too.

Thank you.

***6:15***

**The Chair:** Thank you very much for the presentation. We have time, maybe, for one question. It's unfortunate we don't have time for more. We'll go to Ms Notley on this one.

**Ms Notley:** Thank you. Okay. Sort of two questions but I'll frame them as one. You might have started to answer that question. I know that for services for children with disabilities where you do have a severely disabled child, there's a pot of money that you can go to for therapy-type stuff; for instance, with autism, the IBI kind of stuff, individual education program. I think that's called IBI. Then also there's money for respite. My first question is whether you've tried that route and what the response was. Then my second question is: could you give us an example of what your daughter can do now that she couldn't do before and how the dog actually makes the difference?

**Mrs. Ainsworth:** Sorry. Can I just clarify if you're asking me whether or not going through FSCD, family support for children with disabilities, and accessing respite – do you mean respite for us as a family just to have? Yes? Okay.

**Ms Notley:** Well, that and also the IBI funding. I'm just wondering if there's been consideration of this as a therapy.

**Mrs. Ainsworth:** Our experience with FSCD, truthfully, has been very challenging unto itself. We have a lot of documentation. We currently have a team panel of more than 15 specialists and associated documentation coming out the wazoo, literally, that will tell you that my child is so severe that they're contemplating a six-week hospital admission, in-patient, just to get some of the associated anxiety and related sleep disorders under control, which are costing our family.

It has taken us more than six months to get an increase in five hours per week of respite, and we had to go through appeal. We had to degrade ourselves and fight like crazy, where it got so personal that the CEO in our region – and this is very documented, so I'm not slandering or defaming anything. It went well beyond and over and

above to ensure that not only were we not receiving adequate behavioural supports to receive IBI, but we were not receiving the respite that our family needed either.

It hasn't been until recently when we have attempted and reattempted – and if anybody would like to see any of this, I'd certainly be glad to put forward even the courtroom transcripts from an appeal where there are demonstrated and documented incidents whereby we were told that the service dog was not funded by FSCD and that the reason we weren't allowed to discuss it anymore or to continue the appeal was because we hadn't appealed it in time. The reason why we didn't appeal it in time was because we were never informed that this was an appealable issue. We were always told that it was a policy within the government not to fund assistance dogs. The director went on record, and I have this transcript that says that nobody in the department, including the highest up people at FSCD, would have ever advised our family to appeal. So we lost the appeal because we didn't appeal in time, yet the department said that they would have never told us to appeal. Our only course of action to follow is to go to the Court of Queen's Bench, which we don't have the time or resources to do.

So, yes, back to the other issue – sorry – with respite and IBI therapy and so on. It's a very complicated process to even get approved. You're dealing with personal issues, but you're also dealing with a complicated MDT process which takes the responsibility and involvement away from professionals who do know your children and places it outside that scope and realm to give it sort of one more step. Then if you are successful, what you end up with is a region with severe, severe staffing shortages and limitations.

**The Chair:** Mrs. Ainsworth, I'm sorry, but I'm going to have to call it there just in fairness to the other presenters that are going to follow you. Thank you very much for coming, and thank you to the association that you're representing.

**Mrs. Ainsworth:** Thank you for having me.

**The Chair:** Our next presenter is Dr. John Huang, clinical associate professor of ophthalmology at the Faculty of Medicine at the University of Calgary and director of undergraduate medical education for ophthalmology. Dr. Huang, thank you very much for coming and on behalf of the committee, welcome. Just in the interests of time, I'm going to dispense with the introduction of members.

**Dr. Huang:** Understood.

**The Chair:** Our names are here on the cards.

I'd like to thank you for being here. We have no more than 30 minutes, I'm afraid, this evening. We'd like to try to divide that between about 15 minutes for your presentation, and then we'll have some questions and discussion with the committee. Without anything further, I'd just like to invite you to proceed.

### Improving Vision Care in Southern Alberta

**Dr. Huang:** I'd like to thank Chairman Horne for inviting me to present to this committee, and I want to thank the hon. members for taking time out tonight to listen to the concern that's being expressed. I wasn't aware of the ability to provide PowerPoint presentations, so I did submit the presentation in print form. I have made some slight changes based on more current data, but the gist of what I'm here to present should be available to you. I want to present the overview first. I will adhere strictly to your time limits, starting the count at 6:22.

Why am I here? The reason I am here tonight is to explain that there has been an ongoing, unacceptable, and chronic imbalance in support given by government for sight-restoration cataract surgery. The effect is an ongoing, markedly negative impact on the eye health of patients of the Calgary region that is both disproportionate and unfair.

The prevalence of cataracts is such that I would be surprised if most, if not all, of the members on the committee and, indeed, most of the people in this room did not know someone who is or has been affected by this problem. Those who do know of such a person know that impaired vision is and can be significant not only for the patients themselves, who are typically elderly and have other illnesses to contend with, but also for the families of these patients who have to care for their loved ones, care that is made more difficult by their loved ones not being able to see properly, care that is made more difficult for primary care physicians who cannot obtain proper eye care for their patients due to severe chronic wait-lists. Patients, typically, who have these illnesses and whose active and preventative medical care is indeed impaired are not able to do things like properly see their medications, see instruction sheets given to them, self-administer insulin shots, or use health care appliances necessary for their self-care.

The impact is not only in personal but real economic terms. As you will hear, in 2007 the impact from cataract wait-lists was estimated in Alberta to have an economic impact of approximately $47 million, with Calgary disproportionately shouldering much of that impact.

As I realize that not all of you may be aware of all the subspecialties in ophthalmology, I should first explain what ophthalmology is. We are specialist physicians who treat medical and surgical diseases of the eye. In addition to comprehensive general ophthalmology, there are eight subspecialties: cornea/ external disease, pediatric, retina/vitreous, glaucoma, ocular oncology, immunology, oculoplastics, and neuro-ophthalmology.

Now, the division I come from, who do we take care of? We take care of the people of the Calgary health region and its surrounding areas. As of March 31, 2008, the Calgary census of the metropolitan area has a population of just under 1.3 million people. This, in fact, increases if you include the immediate surrounding towns of the Alberta census division 6. The Alberta health care insurance registry is the source of that information.

***6:25***

As a referral centre we also see urgent, emergent, and elective referrals from all of southern Alberta and southeastern British Columbia and parts of Saskatchewan. From 1996 to 2006, as you can see in your tab B, there has been a 36 per cent increase in the population of this region. This doesn't include the last two years. Now, while it's still a relatively young population by Canadian standards, Alberta is aging, like everywhere else in Canada, and will thus experience a concurrent increase in the prevalence and incidence of all eye diseases.

By contrast, the former Capital health region as of March 31, 2008, had a smaller population, as you can see in tab A, of just under 1.1 million people. Now, the demographic breakdown that's illustrated in tab A shows that as of March 31, 2008, in the 50 to 90-plus age group Calgary had a total of just under 350,000 people. Capital health had just under 318,000. There is thus a dramatic difference in the population base that may develop cataracts.

I want to just note for one moment that in this age group, which is the one that is likely to develop cataracts, there's a beginning prevalence of approximately 10 per cent of the population. This increases to 50 per cent in patients aged 65 to 74 and to 70 per cent

in persons aged over 75. These patients, of course, are also more likely to be affected by multiple medical problems and their care affected by being unable to see properly; for example, as I mentioned before, being unable to see things such as their medications or instruction sheets.

Now, to let you know: what is cataract surgery? Cataract surgery is the removal of a cataract, or a clouded lens, from one or both eyes and replacement with an artificial implant lens. Cataract surgery is performed by ophthalmologists, or eye physicians and surgeons. It should be noted that cataracts are a leading cause of visual disability in Alberta and North America.

Now I need to explain who the members of my division are. We are 42 specialists responsible for the medical and surgical eye care of the people of the former Calgary health region; 33 are operating surgeons, and two are dedicated basic scientists. Where do we typically work? We work in private offices, nonhospital surgical facilities, Alberta Children's hospital eye clinic, and the Rockyview general hospital eye clinic.

Why am I here? What is the problem? The problem is that there is a discrepancy in the support given by the government to eye care in Calgary vis-à-vis other regions. In 1996 in the Calgary health region 7,000 cataract surgeries were funded by the government of Alberta. In 2008 that number has merely risen to 8,500. This is an increase of only 18 per cent over 12 years. This does not even begin to match the population growth. Now, the most comparable region is here in the former Capital health region. Edmonton as of 2008, as I mentioned earlier, has a population base of just under 1.1 million people but has been funded for 13,500 cataract surgeries. This is fully 37 per cent more funding for a smaller population.

Another example of disproportionate support is that the eye clinic at the Rockyview general hospital, which is the main diagnostic centre for our division, remains at the size of half a ward. This has not changed since 1996. However, in contrast, the present 4,000-square-foot eye facility at the Royal Alex hospital in Edmonton is now planned and funded to be expanded to a new building four storeys in height exclusive to ophthalmology.

What's also of note is that as a corollary there remains virtually no support for the administrative educational heads of ophthalmology in Calgary. This is a situation that simply does not exist anywhere in Canada.

What's the result? As some of you may recollect, in 2004 the federal-provincial 10-year health accord was signed between the government of Canada and the provinces. Alberta was a signatory. This accord targeted five key areas that had to be improved in order to strengthen health care. That's referred to in tab C. Sight restoration – that is, specifically, cataract surgery – was one of these areas. The Wait Time Alliance of Canada has rated the current Alberta provincial support at an A for timely access to health care; however, this is based on disproportionate funding to regions other than Calgary.

The government of Alberta's own wait-list registry indicates that cataract surgery is 90th percentile wait time; that is, the point at which 90 per cent of the individuals waiting for surgery received cataract surgery is at 17 to 19 weeks. It is a constant figure in the former Capital health region. That can be seen in tab D. By contrast, the government of Alberta's own wait-list registry indicates that the cataract surgery 90th percentile wait time in the former Calgary health region is at 26 to 30 weeks. This is a dramatic difference. Sixteen weeks is the maximum wait time recommended by both the Wait Time Alliance of Canada and the Canadian Ophthalmological Society. If the chair should so desire, I have a copy of our guidelines to submit to the committee for review. This is a standard set by all jurisdictions in Canada, not just specific to Alberta.

What is the actual number of people waiting? The number of patients waiting for cataract surgery in the Calgary health region has been chronically at 6,000 to 7,000 patients or more, which is the experience that I've had for my entire professional career. As of September 30, 2008, that number has risen now to 7,825 persons. That's referred to in tab G. Again, this is from the Alberta government's own wait-list registry.

By contrast, as of September 30, 2008, the Capital health region has a total of 2,564 persons waiting, a very dramatic difference. In Calgary the number of patients who are waiting for cataract surgery is, in fact, equivalent to the total number of all persons waiting for all forms of surgery in Calgary.

Now, I've referred earlier to the economic impact of each patient waiting for cataract surgery. It is estimated by the Wait Time Alliance to be approximately $2,900 per patient waiting, which you can see referred to in tab H. As I mentioned earlier, the total economic impact on Alberta from patients waiting for cataract surgery was estimated in 2007 at $46 million. Because of the obvious disproportionate impact on Calgary in terms of the number of persons waiting, the majority of this economic impact is shouldered by the Calgary area.

Now, why am I here? Well, it comes under the heading: what can you, a standing committee of the Legislative Assembly, do? We would hope as a division that you will support our efforts in achieving parity. We don't seek special treatment. We merely seek fair treatment in supporting our patients in their sight restoration/eye care vis-à-vis other regions of Alberta. As a division we feel this is a viable goal given the intent of the May 2008 reorganization of the health boards to a single health board. I quote:

> The new governance model is intended to strengthen a provincial approach to managing health services, including surgical access, long-term care, chronic disease management and addictions and mental health services as well as health workforce and access to primary care.

Given the intent that this is a province-wide approach to the delivery of health services, it is only reasonable to ask government and committees of government that such services, including surgical access, be similarly and uniformly accessible across the province. All of Calgary's eye physicians and specialists intend to work with the government to make sure that the changes that occur on an ongoing basis in health care delivery are a success, but we need the resources to do so. Access to sight restoration surgery is an important start. Our estimate of the additional cost of supporting cataract surgery in southern Alberta and the Calgary health region is about $5 million per year.

It is important to note – and this is a point I need to emphasize – that the infrastructure is already in place in the form of nonhospital surgical facilities. No new bricks and mortar are needed. The capital investments have already been made. We're looking for additional funding support. Indeed, that additional funding support would actually utilize more fully the capacity of these facilities, which at times are quite idle.

It is also very important to us as a division that if government should choose to provide proper and adequate support for sight restoration surgery, this not be done at the expense of corneal, glaucoma, surgical retina services. That is merely transferring support from these services in order to provide cataract surgery. I should note to you that while I'm not presenting on those services, there is already an approximate six-month waiting list for those surgeries, where the recommended wait time is approximately four months.

It is also important to recognize that simply telling us and our patients to go somewhere else for cataract surgery is unacceptable

and is not a solution for three reasons. One, it is a burden for patients and their families to pack up their often elderly loved ones to travel long distances to obtain care that they could get locally if there was adequate funding. Also, each surgery is accompanied by multiple visits, and the impracticality of merely travelling long distances for something that is available locally does not seem either fair or practical. Two, many of these patients have a long-standing patient-physician relationship, which is the cornerstone and the basis of good care. It is the trust that develops through patient-physician relationships. By merely parachuting patients into another region, you don't have that sort of trust. Finally, we don't seek in Calgary to merely transfer our problem from one city to another. It is not reasonable, and it is simply unnecessary given the fact there are underutilized surgical facilities in Calgary.

Finally, we would ask as a division that you support our efforts in achieving parity of support for our research, educational, and administrative activities. These activities are critical to the training of future physicians and the ongoing operation of our organization. We recently established an ophthalmology residency in Calgary, and it simply cannot be successful in the continuing situation, where we're simply improperly funded. Supporting our efforts to provide better vision care for the patients of southern Alberta is, we feel, both fair and sustainable health care. We certainly hope that your committee will give it due thought and perhaps at some point, if possible, give us assistance in this matter.

Thank you. I'll open the floor for questions if you wish.

*6:35*

**The Chair:** Thank you very much, Dr. Huang.

I've got a few questions lined up for you. Mr. Denis, please, followed by Mr. Fawcett.

**Mr. Denis:** Thanks very much, Mr. Chair. Dr. Huang, thank you for appearing before the committee this evening. Just in the material you've handed out, on page 4 it indicated that in '96 there were 7,000 cataract surgeries funded, that in 2008 there were 8,500. Can you tell the committee how many were not funded in each instance just so we have comparison?

**Dr. Huang:** When you say not funded, in terms of patients waiting? With the chronic wait-list, as I mentioned earlier, every year from 1996 to 2008 there's a set number funded. Then all the other people who are on the wait-list simply just wait their turn. They just don't get done.

**Mr. Denis:** Okay. Do you have a figure? If you can't provide it now, maybe you could get it later.

**Dr. Huang:** Well, as I mentioned later on in the presentation, the entire length of my career, since 1994, there has chronically been between 6,000 to 7,000 people on these wait-lists, and they simply wait their turn, whether it's six months, eight months, whatever.

**Mr. Denis:** I guess what I was getting at, if I could, Mr. Chair, is that just between '96 and 2008 you listed the amount of persons on wait-lists. Would they have been about the same?

**Dr. Huang:** It would have been chronically at least that amount. Some years it's been higher.

**Mr. Denis:** Okay. Thank you.

**The Chair:** Thank you.

Mr. Fawcett, followed by Mr. Olson.

**Mr. Fawcett:** Actually, Mr. Chair, that was my question as well.

**Mr. Olson:** Thank you very much for the information, Doctor. Forgive me if this is a naive question, but it just occurs to me that there may be a question, at least in my mind, of economy of scale. What would be your observation in terms of providing the same services in both Edmonton and Calgary? Given a population of 3 and a half million people, how would we compare to other jurisdictions? You know, would it make more sense to centralize it in one spot? I know that there's extra travel. You've already kind of anticipated my question, I think. Kind of coupled with that question, though, is the issue of education and doing training and so on. It's just a question that occurs to me, and it makes me wonder if this would be better done in one spot.

I'll just ask one more kind of a supplemental, I guess, and that is: if there is a much longer waiting list in Calgary than Edmonton, is there ever any collaboration between the two places? Does it make any sense to ask people if they would like to maybe get bumped up by going onto the Edmonton list, or is that not practical?

**Dr. Huang:** I'll start from the education point of view. As the director of undergraduate medical education in Calgary I trained at the University of Alberta, and I've now been on faculty for a long time at the University of Calgary. There are two faculties of medicine. Each has almost parallel programs in terms of specialities and training in family practice. For that reason it only makes sense to utilize the preceptors that are available, and preceptors are not easy to come by. At the University of Calgary the great majority of the preceptors are simply volunteer, unpaid teachers. Given the fact that the government of Alberta has chosen to dramatically increase the medical school class in both universities, it would simply be, from my point of view, impossible to train the entire school class of 300-plus students per year in one facility. It simply wouldn't happen. As well, you're ignoring the expertise available in each centre.

Secondly, have patients had the availability to go elsewhere? Absolutely. The government of Alberta established a wait-list registry. I don't know exactly when, but it's been around for a few years. Patients are aware of it. But as I mentioned earlier, the cornerstone of good patient-physician care is trust. When a patient comes to you to do microsurgery, they develop a relationship. As a comprehensive ophthalmologist I see these patients for years and years and years. To merely tell them, "Well, time to parachute you up to Edmonton," they resist, and patients have a right to choose their surgeons.

Now, economy of scale. The five nonhospital surgical facilities simply cannot be replaced presently in Calgary because there are simply no bricks and mortar available. The size and volume and expertise that have developed since 1994 in these facilities say that they're pretty darn efficient and they're pretty darn economical. I'd challenge any mass facility, including our friends at the Royal Alex, to beat us in terms of economy of scale. You know, should we have one centralized warehouse in one central location? I would say for multiple reasons that that would not be accepted by patients and, with due respect, would not be the best type of care.

**Mr. Olson:** Thank you.

**The Chair:** Thank you, Mr. Olson.

**Mr. Dallas:** Thank you, Dr. Huang, for your presentation here this evening. I was born in Calgary, I've lived in Edmonton, and I'm now from Red Deer, so I have no vested interest in the outcome of

the question other than trying to assess the facts here. You mentioned earlier in your presentation the age groups of patients that would be most likely recipients of the services that you offer. In looking at tab A and making a comparison between Calgary and what was known as the Capital health region, when you start looking at the demographic of the over-60 population, it would appear to me that the numbers are very, very close in terms of total numbers.

Another observation. I'd like to ask if you factored into this that while the population throughout Alberta has been growing at a rapid rate, there certainly are an awful lot more Albertans that live north of Calgary than there are south of Calgary. I wonder if there's a factor in terms of the way these funds are allocated, not based on the population in what were the Calgary health region and Capital health region but really on those provincial population numbers?

**Dr. Huang:** I appreciate the question. First of all, the reason I specifically chose to compare the former Capital health region and the former Calgary health region is that these are directly comparable populations. You're absolutely correct in that if you isolate out the 65-plus age group, they're similar numbers, and that merely reinforces our division's argument that the inequities in terms of funding are not justifiable, that 13,500 procedures are funded in Edmonton and 8,500 are funded in Calgary for almost the same size of population if you merely isolate out the 65-plus population.

The other question you had was that if you draw a line through Red Deer, the population is different, right? But I need to point out that the reason I didn't include Red Deer and Grande Prairie and Lethbridge and Medicine Hat is that under the previous system they were considered separate divisions and, therefore, had separate funding. I don't want to disparage my friends in those smaller regions, but, as an example, in Lethbridge there is essentially no cap on their cataract surgery volume. That is an historical thing, but it exists. I thought that on behalf of my division it would only be fair, rather than picking on smaller centres, to say: well, you know, we know that there's due diligence in Grande Prairie, Red Deer, Medicine Hat, and Lethbridge, and they're taking care of their population. So then what we do is we isolate out the two big centres and compare them and see what the discrepancy is.

**The Chair:** Thank you.

Dr. Sherman.

**Dr. Sherman:** Thank you, Mr. Chair, and thank you, Dr. Huang, for appearing before the committee today. The fact that there are these disparities is one of the reasons behind going to a provincial region. We represent everybody in the province, and everybody deserves equal access and equal care. How do the wait time ranges in Alberta compare to across the country? How do Edmonton and Calgary compare across the country for cataract surgery?

**Dr. Huang:** Well, the reason I referred specifically to the recommended reference point of 16 weeks is that that was established on the basis of national consultation. Now, your specific question is: for example, what's the wait time in, say, Toronto or Vancouver? Unfortunately, I don't have that specific data in front of me at this point, but as it compares in terms of the nationally recommended wait times, I would say that it's well above the recommended level. But I could get that information to you. I mean, that's easy enough for me to find and send to you.

**Dr. Sherman:** Just to follow up, what is the cost to do a cataract? Between the facility fee, physicians' fees, and so on what's the total cost per eye?

*6:45*

**Dr. Huang:** Well, again, I don't wish to disparage my colleagues here in Edmonton, but because a majority of the procedures, 11,500 procedures, are done at the Royal Alex hospital, it's very difficult to know exactly what their facility fee is because they're basing out of a hospital. An exact amount is really not known at this point. It's done through an institutional system. In Calgary, because we have nonhospital surgical facility funding, we have a much more defined number. If you add the professional fee plus the facility fee that's paid, it would come out to approximately $1,400 per case.

**Dr. Sherman:** Thank you.

**The Chair:** Okay. Thank you.

I think I'm going to call it there, Dr. Huang, just in the interests of time and the group that's following you. I'd like to thank you very, very much on behalf of the committee for appearing this evening.

**Dr. Huang:** Thank you very much.

**The Chair:** The information is very helpful. Thank you.

Okay. We'll come back to order, then, please. I'd like to welcome representatives of the Alberta Alliance on Mental Illness and Mental Health and recognize Sharon Sutherland, the chair. I know you have a number of representatives with you. Just in the interests of time – we have no more than 30 minutes, and we've asked to divide that between about 15 minutes for your presentation and then leave some time for questions and dialogue with the committee – I think I'll just dispense with the committee member introductions if that's okay. We all have placards in front of us. Just on behalf of the committee thank you very much for appearing, and over to you.

### Alberta Alliance on Mental Illness and Mental Health

**Ms Sutherland:** Now that I've had my cataract surgery, I can read all the signs, so that's good.

Good evening, and thank you very much for the opportunity to present to the committee. I'd like to introduce Mr. Pierre Berube to my right, the executive director of the Psychologists' Association of Alberta and vice-chair of the alliance, and Mr. Tom Shand to my left, executive director, Canadian Mental Health Association, our host agency.

Like many members of this committee I am not a health care professional. I have, however, been an advocate in this area for more than two decades, and like many members of this committee I know someone with mental illness. That someone is my son. As you know, there is a very real stigma about mental illness. People with mental illness do not want others to know, especially their employer, prospective employer, fellow workers, colleagues, insurance companies, and, I can assure you, even family and close friends.

During the past few years leaders in government and in business have begun to try to remove this stigma: the federal government with the establishment of the Mental Health Commission; the Kirby report, Out of the Shadows at Last; and imagine the post office introducing a mental health stamp. There are other initiatives. Still, mental illness and mental health remain the true orphan of all health care systems not only in Alberta but globally.

The Alliance on Mental Illness and Mental Health is a diverse coalition of 10 provincial organizations created in 1999 and representing thousands of Albertans: patients, families of patients, health care professionals, and service providers. We have been a

credible and powerful agent of change and have provided important feedback to the Alberta Mental Health Board and other government departments, ensuring that the voice for mental health service providers and clients is clearly heard. Now, we've provided you with the names of our members in the materials that were provided to you earlier. The current work of the Alberta alliance is made possible by a three-year government grant, and our appreciation to the Ministry of Health and Wellness.

In my remarks this evening I would like to provide you with a brief snapshot of the major concerns that we in the mental health and mental illness community have. I'd like to outline our expectations and hopes for the new central health authority, Alberta Health Services, and share our concerns around community services, effective and accessible treatment, housing, and other social determinants.

In Alberta today there are or will be approximately 600,000 Albertans suffering from mental illness and mental health problems during their lifetime. That's 1 in 5 Albertans. Mental illness does not discriminate. It's found in all ages, in all cultures, in all occupations and professions, and in all levels of society.

In May of 2004 Alberta released its provincial mental health plan. It reflected a true collaboration of many players in mental health as well as compromise and consensus. It was a truly significant achievement, and the Alberta plan was the only one in Canada. Members of the alliance felt the plan was an appropriate response to the state of mental health in Alberta and that it provided a road map for a much better future.

Today our concern is: where does mental health fit into the government's agenda for the health care system? We are deeply concerned that mental health will fall through the cracks that often come with major restructuring. We are concerned that funding for mental health will be siphoned off to other services that have more political mileage, and we're very concerned about the face of mental health in any new governance structure.

The Alberta Mental Health Board has been abolished. It would be only too easy to disenfranchise advocates for mental health, and we could become invisible. The promise of an advisory council has not alleviated these concerns, and I will speak more to that later. The members of the alliance are concerned that decisions as to the future of mental health will be made without meaningful input from the health care professionals on the front line. The consumers, caregivers, families, psychiatrists, family physicians, psychologists, psychiatric nurses, social workers, occupational therapists: these are the experts.

The government is proceeding with an electronic health record, and decisions will be made in the coming months as to what information will be contained in that record and who will be able to look at it. For mental health patients and their families both decisions raise many red flags, particularly with the proposed changes to the Alberta Mental Health Act. I do hope we'll be consulted before any final decisions are made.

In 1996 a report on best practices was funded by Alberta Health and Wellness and strongly supported the concept of consumer and stakeholder participation at the most senior levels of planning. This finding was reinforced in a 2003 report by the World Health Organization and since then in many other credible reports.

I would ask the members of the committee to be mindful that for many mental health services the essential ingredient in successful treatment is the relationship between the patient and her or his mental health professional. In mental health each patient has unique needs. Treatment options are much more personal and variable than in other areas of health care. The one-size-fits-all approach simply does not work. The best treatment must be patient focused.

*6:55*

It is our hope that Alberta Health Services will re-establish strong and effective communication links so that the needs of the community and the patients are understood by those making the decisions. It is hoped they will empower a board or advisory council – and I do mean empower – to oversee the direction of mental health in Alberta and to ensure that the goals set out in 2004 are met. I'd like them to ensure that funds earmarked for mental health are spent on mental health, and stakeholders want to be involved and listened to.

There have been a number of positive developments in recent months: the $50 million over the next three years for the children's mental health plan for Alberta, Bill 31 with its amendments to the Alberta Mental Health Act. Of course, the challenge there will be to invest the resources that are necessary for community treatment orders and enhanced community services for all. This was promised and directed by this provincial government in the spring of 2008, and the alliance's going along with the proposed changes to the legislation was contingent on enhanced community services. We agree with the move to integrate addictions and mental health. We strongly support the primary care initiatives, which include mental health as part of a comprehensive service package. Alberta must fully embrace this unique opportunity by including all professions best trained for the job.

The three concerns mentioned earlier offer many opportunities to improve mental health for all. Under community services we can do a better job of the sharing of knowledge. We can ensure or provide resources to private and nonprofit service providers and strong antistigma campaigns, expand the delivery of school programs, and tailor services to meet the needs of clients and families.

Effective and accessible treatment. We need to reduce the waiting time for Albertans seeking psychiatric treatment. Right now, I believe, the Canadian median is 10.5 weeks. Alberta's is 17.5 weeks, and that's after seeing a GP. We need to ensure access to the best possible medications, increase research, adopt the successful practices from cancer and the hip and joint project, and introduce navigators for mental health patients and their families. Imagine having only to tell your story once.

Housing and other social determinants. That's a huge challenge but absolutely necessary to improve access to an appropriate range of supportive housing and living options, to expand criminal justice diversion programs, ensure that social policies take into consideration those living with mental illness. The Alberta Alliance on Mental Illness and Mental Health has an obligation to advocate strongly for the mental health of all Albertans, and we look forward to continued collaboration with government towards that end. I do truly believe that together we can do the right thing.

Thank you.

**The Chair:** Thank you very much.

I've a list started here for some questions. Mr. Fawcett, followed by Ms Pastoor, please.

**Mr. Fawcett:** Yeah. Thank you, Mr. Chair. The question that I had was that you just mentioned right at the end there – and I didn't catch the numbers; I'm sorry – about the wait times, that are significantly above what I believe was the national average.

**Ms Sutherland:** Yes. The Fraser Institute has just released a document within the last month, and I have it here. The Canadian wait time is 10.4 weeks. Alberta's is one of the longer times, 17.4, I believe, but that is after seeing a GP. I'm sure you're all aware that with our community a lot of our people don't even have a family physician.

**Mr. Fawcett:** My question is, I guess, more of a general nature. We obviously have a lot of groups that come before us. We just had one saying that our wait times for cataract surgery are above the national standard, yet we spend more per capita on health than anybody in the country. There are a number of examples where groups will come in and say: we're waiting longer. Can you tell me why? In your opinion, what's causing us to have those delays on our wait-lists?

**Ms Sutherland:** If I may. I appreciate the question. Mental health and mental illness are truly underfunded, not talking just simply about money but the human resources. We're short of psychiatrists. We're not utilizing the other mental health care workers that we have in an efficient fashion. I think all of that plays into it. Cataracts and cancer and all of those other very noteworthy illnesses have a following, have champions. Mental health does not have a champion, and because of that, it's my opinion that our wait times are longer than they need to be.

**The Chair:** Thank you.

The deputy chair, please.

**Ms Pastoor:** Thank you very much, Mr. Chair. I'm not sure this is a question so much as I would appreciate a comment from you. I'm looking at the 10 member organizations, and I don't actually see, with the exception of perhaps social workers and a couple of others, where they would actually be working with addictions. Now that AADAC and the Cancer Board and mental health have come under one large board and addictions are now going to be considered mental illness, I'm wondering if you have concerns about dollars going to, I think you said: more politically correct or politically visible than perhaps a mental illness. I'm just querying which will get the most money when, in fact, mental illness is already underfunded.

**Ms Sutherland:** Well, if I could be rude and blunt . . .

**Ms Pastoor:** Good.

**Ms Sutherland:** They have the duct tape with them for me.

. . . I think it's wonderful that addictions and mental health are going to merge. My personal feeling, being a mom anyway, is that addictions have always had the ear and the government's political will to move along. I'm thinking: oh boy, maybe we're tying ourselves up to something that's going to share the public relations that are necessary, the marketing, maybe ease a healthier budget through Treasury that will enhance services both for addictions and mental illness. We're the poor cousin, and I'm grateful to be invited to the table of the bigger family, the rich family.

I'm deeply concerned, though. We are marrying these two things. The alliance had the pleasure of being on a three-day workshop and retreat. Dr. Sherman was there. It think it was – what? – syntegration. That was it. I, too, am concerned. We have had no formal announcement that this is happening. None of us, our organizations that are listed and others out in the community, have had an opportunity to share and ask questions about how our mandates will change. We need to be all inclusive. We're in little silos. We're breaking that down. If it's the government's will to have this done by March 31, I'm hoping that means 2010 because it's not going to happen in 2009.

***7:05***

**Mr. Berube:** If I may comment, though. Agreeing with all of that, I think it still is and certainly our position is that it is a very, very good thing that they're merging both of them. Our clients, our patients are the same people, and the notion of keeping them separate and that you have to go see one department or the other department because you have a different label just does not make sense. I think this is a very positive move, and certainly that's the point of view of the alliance. We support that.

**The Chair:** Mr. Shand, did you want to add something?

**Mr. Shand:** If I may. I think, certainly in support of both those comments, that it's quite interesting, though, when you talk to people that have gone through with their children and others a situation where they don't know what's happening and they wonder which has the greatest stigma attached, they'll be quite relieved when something is diagnosed to be an addiction as opposed to a mental illness. It's a curious thing, and you wouldn't think that, but that's how heavy the stigma is relating to mental illness. It's hard to believe.

From what we've seen, we have advocated from the Canadian Mental Health Association for certainly the two working more closely together, too. There's much to be learned from each other. Their styles of treatment and dealing with things are quite different. Provided that the budgets are adequate for both and put together so that they're not decreased to less than they are now, there should be something net gained from the combination of the skills and the energies in both areas, and it may actually assist mental illness to be involved with the addictions end of things, too. It strikes me as strange that the stigma would be less for something that, really, you can't help as opposed to most addictions, which are more self-inflicted probably, but it's not the case. It's a curious situation and curious partners to be brought together even though it seems to be a natural thing.

**Ms Pastoor:** Thank you very much for all three answers.

**The Chair:** Thank you.

We have time for probably two more very brief questions. Ms Notley will ask the first brief question. Then I'd like to ask one as well.

**Ms Notley:** Okay. You know, I read with interest through your presentation, and there's a point in it where you do a good job of outlining report after report after report after study after report that was produced, typically, every three or four years for the last 25 years or so. It seems to me that we often get to this point where, particularly as we moved away from institutionalization, there's always this outcome: we need more community services. I see that in terms of your recommendations, that's number one. You talk about more community services, and you also talked about how that's necessary for Bill 31. I might be putting you on the spot here – and if I am, then just pass – but my question to you is: if you could wave a magic wand, what percentage increase in resources for community mental health services do you think we need to see in this province?

**Ms Sutherland:** Thank you for the question. I'm not sure that we need any more money. We went through an exercise for a long period of time called the provincial bed review. We met, and people travelled outside the province, in Canada, and met with all of us, and we were attempting to put together the beds, the cost efficiencies, the projects that are working across the province that no one else seems to know about or there isn't sustained funding for. We still don't have the results of the provincial bed review, which is a shame

because it could be a newer listing on the reports. I really do think that if we had an opportunity or if government had an opportunity to look at the inventories and what is out there and to somehow bring it all together in a much easier fashion, maybe that might help alleviate some of the problems.

**Mr. Shand:** Fifty per cent would be good.

**Mr. Berube:** I also want to say that part of the issue is accessing the resources that are there, and now I speak as a psychologist. In our field about half of our 2,000 psychologists in the province are in private practice, and therefore the issue is access to them. The funding structures are such that our psychologists primarily become available to people who can afford the fees. At least for those people who don't have the financial ability to access these psychologists' fees, that's a major issue. It's not that the resources aren't there.

**The Chair:** My question is in a similar vein, but rather than just talk about the dollar increase – we spoke earlier about Bill 31 last year, the Mental Health Amendment Act, which provides for community treatment orders. My understanding is that work continues on a regulation which will allow CTOs to be implemented. You referred to community-based services that would be required to support the implementation of CTOs. I was wondering if you could be very specific for us as to what the nature of those services would be and what the benefit would be that would be offered to the individual suffering from a chronic mental illness that will receive those services.

**Ms Sutherland:** Well, having sat on the steering committee and the community services task force, I think one of the major issues is the housing options. If you're talking about people under a community treatment order and assuming that this will be implemented sometime in the future, there needs to be appropriate housing. There need to be co-ordinators put in place to take the services to the client. There need to be navigators for these people to make sure they get to their appointments, to make sure they get referred to the appropriate physician, to make sure they're taking their medication. But out of all those things, it's the housing. As you know, we have people in Alberta Hospital Edmonton and Alberta Hospital Ponoka. If we had transitional housing, we could free up some of those beds, but it's a difficult subject in trying to get the inventory and the political will to move ahead.

Now, having said that, I know that there was a recent announcement. The government has the Homeward Trust thing, and they're looking to take 80 homeless people and house them. That's wonderful, but we need more of that.

I don't know if that answers the question.

**The Chair:** It does. If I could, the part I was hoping we'd get to, as well, is how those services actually help an individual avoid beginning that slope into deterioration of their condition whereby they're forced to go back to the hospital. It seems to me that a lot of this is about providing services that help catch people at the brink. Assertive community treatment is one form of the services.

**Ms Sutherland:** Exactly. That's the big one.

**The Chair:** Mr. Shand.

**Mr. Shand:** Yeah. In addition to that, there was reference made here to the social determinants of health. Unfortunately, when you go to the ministry of health, usually the answer you get is: this doesn't fall within the boundaries of what our parameters are or our budget is. Justice doesn't fall there; education doesn't fall there; housing doesn't fall there; employment doesn't fall there. It's not an easy thing, I'm sure, for government to look across those boundaries, but mental health does cross it. It doesn't stop there. It's not just a clinical application, and it's not even just the social supports that are provided directly through mental health counselling and others. It does cross into all those things, and they have a huge impact on the ability of a person to be resilient and to recover.

I don't know whether it means having somebody – it's one of the reasons why we emphasize the importance of empowering a council or a board to have some ability to look and see whether the changes being made overall are effective, not just those within the ministry of health and within that budget but that overall things are being looked at, that AISH is being looked at properly and other things to make sure that people aren't being left behind just because it doesn't fit within the boundaries.

**The Chair:** Thank you.

If you can be really brief, Dr. Sherman, if I could ask, we have time for one more.

**Dr. Sherman:** Thank you, Mr. Chair. Thank you so much for presenting on this very important issue. I'll start off with a couple of comments. Approximately one-third of Albertans or Canadians at any one time suffer some sort of mental health issue. Half of adult mental health issues start by age 14, and suicide is the number one nonaccidental cause of death under the age of 44.

Now, having worked on the front lines in the emergency department at the Royal Alex, having seen a lot in adult and child mental health, I will comment. Part of the reason behind making that decision is that we had a lot of patients that if it was a mental health issue, the addictions people didn't want to deal with it, and if it was an addiction issue, the mental health people didn't want to deal with it. Then you actually have the medical issues. With this decision there are people who have medical problems who end up having mental health issues. We have an ability to improve the efficiency and provide more comprehensive care to patients who fit all of those areas. On the prevention side of child mental health a lot of that is in the transition from age 18 to 24, when a lot of the young people fall through the cracks. Then they end up homeless. Then the adult mental health agencies are more severely affected.

My question to you is with respect to homelessness. I wonder if you can comment on the model that they're using in Oregon on Housing First because 40 to 50 per cent of homeless people have mental health issues.

***7:15***

**Ms Sutherland:** Actually, my understanding from inner-city advocates is that it's probably a low figure, but I can't give you an accurate. Hope Hunter used to say that it's at least 80 per cent of her clientele.

**Mr. Shand:** The Housing First philosophy, Dr. Sherman, is certainly one that most CMHAs – we're heavily involved in housing, as I think you're aware – have adopted. For those that aren't familiar with it, it means that people that normally wouldn't be given the opportunity to get into or stay in a place are given that opportunity because they are allowed some supports. So if there are two or three weeks that they're in hospital or something, there is somebody looking after them to make sure that the landlord doesn't just dump them out.

If they come in with an addiction, the first thing is to get them off the street. The first thing is not to say: well, you can't come in if you have an addiction or if you have a straight mental health problem. We believe that it's an important philosophy, and we're actually encouraged by the acceptance of that philosophy across Alberta. Some of the efforts to end homelessness are taking on that strategy of not judging the person and making it so that they can have an ongoing situation with their landlord, take some of the stress off the landlord as well. Often even after they find housing, they end up being evicted, so this is a way of managing that so that the tenant and the landlord better understand their rights and responsibilities in that regard.

**The Chair:** Thank you very much. I'm sorry to cut you off there, but there will be some really loud bells ringing in about five minutes.

Just before you leave, first of all, thank you very much for the time and trouble you took to appear before the committee. I wanted to recognize, as well, the hon. Dennis Anderson, a former Member of the Legislative Assembly and member of cabinet, who is with us this evening.

**Ms Sutherland:** I might add that he's the founder of the Alberta alliance.

**The Chair:** Okay. Thank you. Well, you'll forgive me if I talk while you're leaving. We just have a couple of items of business to finish up. So thank you again.

Ladies and gentlemen, I'll be really quick here before the bell rings. Sort of by way of background, we've held two public meetings now, and we've heard from a total of, I think, nine organizations. First of all, thank you for the excellent questions and for co-operating with the time limits. I think we made very good use of the time that we had available. We certainly heard from people on a broad range of subjects. Thank you for your help in making it a success, and thank you to the staff.

There is a provision in the standing orders in various sections for the committee to initiate action either based on something that we've heard in a presentation or through an idea of our own for a course of inquiry. I won't go through sort of chapter and verse what those are. We designed this series of meetings to give people an opportunity to speak directly to us as a committee on issues that they chose to come and talk with us about.

What I'd like to propose: if you're in agreement, I'd like to table a brief report in the Assembly and simply provide the names of the organizations that we met with and a very brief description of the subject so that there is some formal record in the House of how we used the time. Then at a future meeting we can discuss anything else we might want to contemplate.

Would someone be so kind as to move that? Mr. Quest. Any discussion? Those in favour? Opposed, if any? Carried. Thank you. I'll undertake to do that.

**Ms Notley:** I'm sorry. Can I just ask something? I think you implied, but just to be clear, that we set a meeting relatively soon before we forget all this and set aside a bit of time to, you know, consider resolutions or discussions that arise from what we've heard.

**The Chair:** Agreed. I was just going to speak to that. The clerk will poll the committee for some future meeting days. We'll try to get some in place. That's certainly something that we can discuss at that time.

**Mr. Denis:** I move we adjourn.

**The Chair:** Adjournment has been moved. The bell has rung. Those in favour? Thank you.

[The committee adjourned at 7:20 p.m.]

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