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**Official Report
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Tuesday 8 September 2009

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des débats
(Hansard)**

Mardi 8 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

Tuesday 8 September 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Mardi 8 septembre 2009

The committee met at 0906 in committee room 1.

SUBCOMMITTEE REPORTS

The Chair (Mr. Kevin Daniel Flynn): Okay, we can call to order. Welcome back, everybody.

We've got two orders of business to deal with before we start hearing from our delegations today. The first is a report of the subcommittee that was dated June 30 and one that's dated August 11 and August 19. Do they need to be read into the record? Would somebody like to read them into the record? Liz?

Mrs. Liz Sandals: So I am told.

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

Mrs. Liz Sandals: I move the adoption of the subcommittee report that is dated Tuesday, June 30, 2009.

The subcommittee met to consider how to proceed with site visits to First Nations communities and recommends the following:

(1) That the committee clerk find contacts in each community so that the select committee will have a local tour guide.

(2) That legislative research prepare a memorandum detailing what legislative research has done to date and what they are working on.

(3) That legislative research prepare a bare-bones summary of the committee's work to date. This summary is to be presented by the Chair of the select committee at the Minister of Health's advisory group on mental health and addictions summit July 13 to 14, 2009.

(4) That the select committee visit various First Nations communities in the south in the fall, including Mohawks of the Bay of Quinte, Oneida Nation of the Thames and Six Nations of the Grand River.

(5) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any comments on that? Water under the bridge.

All those in favour? Opposed? That's carried.

We have another one. Liz, are you doing that as well?

Mrs. Liz Sandals: Subsequently, I move the adoption of the summary of the subcommittee business conducted on Tuesday, August 11, and Wednesday, August 19.

The subcommittee met to consider how to proceed with site visits to First Nations communities and with public hearings in Toronto, Thunder Bay, North Bay, Sudbury and Ottawa, and recommends the following:

(1) That the committee travel to the First Nations of Wabaseemoong, Pikangikum, Sandy Lake, and possibly Attawapiskat and Kashechewan.

(2) That the committee meet with officials of law enforcement in Sioux Lookout.

(3) That the committee start its second round of public hearings in Toronto on September 8, 2009, followed by Ottawa on September 9, Sudbury on September 10 and Thunder Bay on September 11.

(4) That groups and individuals be offered 15 minutes for their presentations, including time for questions, in Toronto and Ottawa.

(5) That groups and individuals be offered 20 minutes for their presentations, including time for questions, in Sudbury and Thunder Bay.

(6) That the North Bay area groups that requested to appear be scheduled by conference call during the Sudbury hearings.

(7) That during the fall hearings in Toronto, groups and individuals be offered 15 minutes for their presentations, including time for questions, and that the committee meet on Wednesdays from 4 p.m. to 6 p.m. when the House is sitting.

(8) That OPSEU be offered a presentation time in Ottawa.

(9) That the Ontario Human Rights Commission be offered a presentation time in Toronto.

(10) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Liz. All those in favour? Those opposed? That is also carried.

Ms. Sylvia Jones: Chair, one question—it ties back to the First Nations community visits in the fall. Do we have a date on that?

The Chair (Mr. Kevin Daniel Flynn): No. We should establish one.

Ms. Sylvia Jones: Yes.

The Chair (Mr. Kevin Daniel Flynn): And we learned a lot from the last round.

Mrs. Liz Sandals: There are only a couple of constituency weeks, and there's a limit to how long you can hold those days. I'm getting all kinds of requests for things I need to do in those weeks.

The Chair (Mr. Kevin Daniel Flynn): If the subcommittee wants to meet over lunch today, or over lunch any time or during some free time this week, I'm sure we can establish a date pretty quickly.

Mrs. Liz Sandals: That would be really helpful.

MENTAL HEALTH
AND ADDICTIONS STRATEGY
CANADIAN PENSIONERS
CONCERNED—ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Let's get started, then. We have our first group here who's with us. It's Barbara Kilbourn and Christine Mounstevan. If you'd like to come forward; make yourself comfortable. There's some water there, if you need some. They're our first delegation of the day; that's probably why there's nobody in the audience yet.

As you've just heard, we've allowed 15 minutes for your delegation, and if you would leave a little bit of time at the end for some questions, that usually works out well. Having said that, the floor is all yours.

Ms. Barbara Kilbourn: My name is Barbara Kilbourn. I'm the current president of Canadian Pensioners Concerned. We're an organization founded in 1969—so it's our 40th year this year. It's a provincial and national, voluntary, membership-based, non-partisan organization of mature Canadians committed to preserving and enhancing a humanitarian vision of life for all citizens of all ages.

We would like to applaud the Ontario government, the Minister of Health and Long-Term Care and his advisory group for the development of a framework for a proposed 10-year mental health and addictions strategy for the province. This initiative reinforces the work of the Mental Health Commission of Canada and its work in developing a national strategy for Canadians' mental health, mental illness, recovery and well-being. We are supportive of the seven proposed directions and are especially supportive of the emphasis on person-directed services within an improved, transformed system. Now I'm going to turn it over to Christine.

Ms. Christine Mounstevan: I would like to start at the last page first: "Of the seven directions proposed, which do you think is the most important and why?" A 10-year strategy is ambitious in its intent and implementation. Transforming the system is the most important. What exists today in 2009 is inadequate. It's a patchwork of programs and priorities held together by ministry policy making mental health and addictions a central focus.

The first accountability is to increase the mental health budget significantly. Then, as the 10-year strategy is implemented, key performance indicators can be measured:

the existence and/or availability of community mental health and addiction services, wait times for services, how people use the services available as well as new or improved collaboration among service providers. But the public needs to know that Ontario is pledging to increase mental health spending significantly, and we believe that a goal of 10% in 10 years or less should be reached. The public also needs to know what percentage of mental health spending will be allocated to the needs of a growing, aging population.

Canadian Pensioners Concerned—Ontario would like to encourage the province to adopt, in all relevant ministries, the use of the Seniors' Mental Health Policy Lens Toolkit. It was developed in British Columbia in 2005 and has been evaluated at 15 sites across sectors throughout Canada. Its use would reinforce the mental health and addictions strategy to create healthy communities. The tool kit is intended to facilitate social environments, including health services, that promote and support the mental health of older adults, reducing the likelihood of mental health problems occurring.

What is most important about the tool kit is its inclusion of seniors' values, priorities and perspectives, highlighting seniors' strengths.

There is a shortage of geriatric specialists in Ontario. Positions in medical schools are not filled. The supply-demand difficulties of geriatric, psychogeriatric and neurobiological specialists must be addressed with the Ontario Medical Association and the Ministry of Health and Long-Term Care, specifically physicians' training and pay structures.

Family physicians are in demand throughout the province, especially in the north. In integrating mental health and addiction services with other health and social services, family health teams should have additional training and resources to help in the development of local mental health services or finding and expanding local services. Family health teams should not be penalized if patients are referred to family physicians outside the team who have psychiatric and mental health expertise.

Ageism related to housing or mental health or addiction issues exists and should be addressed as contributing to the stigma, the power imbalances or unavailable culturally competent services. Many older adults believe the prejudices and stigma related to their mental health issues are inevitable and they may not or do not seek help. Public attention and education for professionals and the general population are needed to reduce and eventually eliminate these beliefs.

Act early: Dementia and depression are seen as inevitable for older adults, but are not necessarily a normal part of aging. The strategy must differentiate between and provide for those who develop dementia and depression later in life and those who have struggled with mental health and/or addiction issues throughout their lives. In fact, dementia appears to be a normal physiological part of brain aging which drugs are so far able only to slow to some extent. The distinction must be made between dementia and depression which, late in life

and biologically based, is triggered by such issues as loss, chronic disease and isolation. The belief is that age-onset depression could be prevented or its symptoms mitigated by screening, early intervention, or appropriate treatment where necessary, including medication and/or taking therapy and/or social support. Also, the strategy notes state that 10% to 25% of seniors experience mental health disorders such as depression that are usually related to medical illness, disability, and social or emotional isolation. Coping with loss—of a loved one, of income security, of a home setting—can also trigger depression, the need for medical intervention or other health care professionals, or peer support or community services.

CPC strongly supports the important role of peer-based programs, not only in early identification but also in continuing community and social support networks, whether a senior is awaiting treatment, in a treatment program, or coping with a day-to-day mental health issue. CPC's new speakers' program continues the work of the Older Persons' Mental Health and Addictions Network, OPMHAN, and sends those with lived experience to raise awareness of those at risk of or dealing with depression. It is a prime example of a prevention program that is effective and cost-efficient.

The population of older persons with depression experiences a suicide rate which is five times higher than that of any other age group. Of all age groups in Canada, men over the age of 85 have the highest rate of completed suicides, yet very little attention is paid to addressing this. An indicator of improved services for older adults will be the suicide rate, especially that of men, and will be measurable and help the province and each LHIN in their accountability for community and health services. Thank you.

Ms. Barbara Kilbourn: Those are our comments.

0920

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. You've left all sorts of time for questions. You've used up about eight and a half minutes. We've got about six and a half minutes, so maybe two minutes for each party. Christine or Sylvia, would you like to start it off?

Mrs. Christine Elliott: I just had a question regarding the last comment that you made regarding the suicide rates. Who keeps those statistics?

Ms. Barbara Kilbourn: I think it's the mental health association.

Mrs. Christine Elliott: You hear about it more in the context of very young people, so I wasn't aware of that. That certainly will be a measure of success, to reduce those significantly.

Ms. Barbara Kilbourn: It's one of the shockers.

Ms. Christine Mounstevan: I think that's where we begin to look at statistics. Often, things are not measured in terms of the older person; it's just the general population. When you begin to look at younger and also older, you see where the marked difference is with the general population.

Mrs. Christine Elliott: Thank you.

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

M^{me} France Gélinas: I was also surprised to hear about men over 85. It's the first time I've heard these stats, and I'm certainly glad you brought it to our attention.

My question has to do with the peer support program, the new speakers' program that continues the work of the Older Persons' Mental Health and Addictions Network. I'm not familiar with this. Could you tell me how it works?

Ms. Barbara Kilbourn: Basically, it's a speakers' project. We're going to be training people who have either an interest in or a personal lived experience with depression, specifically. We have \$13,000 to do two places. It's money that was left from the Older Persons' Mental Health and Addictions Network, which has had to fold for lack of continuing funding. We're going to be starting in the Kawartha Lakes area and Toronto. There are about four speakers trained from the past. We'll be adding to that and then hoping to have materials reprinted if we can find some fairy godmothers who will give us materials, because there are some really good materials that the Older Persons' Mental Health and Addictions Network put together. So it could be used to raise awareness in the seniors population.

M^{me} France Gélinas: But it wouldn't lead, necessarily, to them supporting a self-help group. It would be a one-off—

Ms. Barbara Kilbourn: It could, because locally, if you're going to raise awareness and you have people isolated, and they get to their family doctor and the family doctor wants resources that perhaps the local Canadian Mental Health Association branch could help with, and continue to get a peer support group going—they're very inexpensive to run. I personally was with an organization for women that saw the success of peer support—magical; people were still in touch 11 years later.

M^{me} France Gélinas: So you're training speakers with the—

Ms. Barbara Kilbourn: To raise awareness only, and then what the community can do with that is up to the community, because we don't have any resources.

M^{me} France Gélinas: And with your \$13,000, how many people do you hope to train as speakers?

Ms. Barbara Kilbourn: We figure we'll do six to eight. Basically, if they are located either in Kawartha Lakes or Toronto, they'll cover their own travel, and we won't have to rent space because we'll be at the invitation of current groups.

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

Any questions from the government? Liz?

Mrs. Liz Sandals: Yes. You mentioned the issue of geriatric dementia. Certainly, that's a huge issue both for families and in long-term-care homes. I'm wondering if you've got any programs that you particularly recommend as being effective in dealing with geriatric dementia. What sort of programming have you seen that you would tell us about and recommend to us?

Ms. Barbara Kilbourn: It's not really our field of expertise. We're broader-based; we wouldn't specifically know of those. Both Christine and I have about 35 or 40 years of experience in and around mental health. I was in the corporate and private sector as a volunteer and then went into paid work in and around mental health issues,

Ms. Christine Mounstevan: I was, for 30 years, a mental health and addictions counsellor. I can tell you that in working with the population who are chronically mentally ill and also have addiction issues, at age 65 they had to move on from the program that I was managing. So what happens is we have a population of people who have grown up with mental illness who are now aging, and they're attempting to get into the system as an older person and there's very little that is available for them.

The other difficulty that we experience in what you see is that people begin to self-medicate. That self-medicating, of course, brings all sorts of other issues up. What is happening within the community as it is now is that if someone is self-medicating or is seen as an addict or abusing, it is often said that they have to stop using before they get into services. That's defeating of anything because the person needs help.

The only other thing I can say to you is that when we put in this about geriatricians, we know that there are very few geriatrics specialists who are graduating, and part of that is because of the way things are funded. We have people who get to a certain place, they're looking at specialties, and because of the cost of education today they do not go into geriatric medicine; they're going into internal medicine. The reason for that is that when you go to your doctor, the doctor has so many minutes to care for you. An older person needs more than 10 minutes, and that doctor does not get paid for the additional time that they take. So someone who has a practice of seeing—I don't know how many people doctors see today, but if they have a practice that's seeing 30 people in a day, we'll say, if you're seeing an older person you could cut that by half. Therefore, they're not going to get the funding.

Mrs. Liz Sandals: You said—

The Chair (Mr. Kevin Daniel Flynn): I'm afraid we're out of time, Liz, unfortunately. Sorry.

Thank you for attending today. Your presentation was appreciated.

CATHY DANDY

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Cathy Dandy. If you'd like to come forward, Cathy. Just make yourself comfortable. The same rules apply. You've got 15 minutes to use any way you see fit. If you could leave some time at the end for some questions, that always works better, it seems. If you're comfortable, the floor is all yours.

Ms. Cathy Dandy: Thank you. Good morning. I feel like I've been here a few times—not to this committee, obviously, but to others. As you know, my name is Cathy Dandy. My background is, for years I was a parent

activist. I was with the group People for Education, then I moved on to the Toronto Parent Network. I then was elected to the Toronto District School Board as trustee for Toronto-Danforth and—because that is not paid at a full-time salary, and I have three children—I also have a full-time job in the children's mental health sector. I work for a very large children's mental health agency and I've been there for the past three and a half years. That is not my background and I have learned an enormous amount while being there about mental health. I'm going to talk briefly about some of that work and some of the work I did while I was an activist and as a trustee, and then I'm going to just talk a little bit more personally.

I have spent the last three or four years researching the concept of integrated service delivery or hubs. I have given you a document that summarizes some of that research. I'm not going to review the statistics on children and youth mental health because I'm sure you're familiar with them—you're familiar with the outrageous rate of suicide, that anxiety and depression are huge issues for many children and youth in our schools, and also that 75% of mental illnesses begin between the ages of 12 and 25—but I am going to talk about the fact that much of the research around integration or hubs leads us to know that if we coordinate our efforts, whether through education, mental health or physical health, it leads to better outcomes.

In 1990, the Ontario Ministry of Community and Social Services said, "There must be a single major physical centre that operates as a hub of services for children within each community." So I'm talking about what we need to do to deliver properly to children and youth. "Where possible, the school should be this centre for service provision." What we know from studies out of the United States is that improved grade scores, improvements in personal or family situations, a reduced dropout rate, reduced behavioural and discipline problems, and a decrease in self-destructive behaviours, including irresponsible sexual activity and drug use, are all the result of coordinated activities.

0930

The 1983 Ontario Child Health Study shows that when we centred emotional and behavioural treatments in places where children and youth are, they showed a decrease in problem behaviours such as anxiety, depression and opposition, and an increase in positive behaviours such as self-control and co-operativeness. Families improved. Parents had a much better ability to cope because services were centred in those areas. The Highfield project also demonstrated that. The Highfield project is still going on, but people seem to pay little attention to it.

SchoolPlus in Saskatchewan also has moved into the area of coordinating, at the most senior level, policies and funding in order to integrate services in schools and around schools.

There are excellent attempts in Ontario to do this, but it is not supported by government. The Bluewater District School Board and the Halton Our Kids Network have done some remarkable things. But these excellent

attempts to promote learning and support students' complex needs are hampered because of silo-based funding and different definitions of outcomes. I think that's where we need to go. We need to think about what an outcome looks like.

Just briefly, I have had two personal experiences. One was, I was assaulted by someone who was mentally ill. She was already charged with another assault. My assault was dismissed because the crown attorney said they had to bargain in order to convict on the first, and the bargain was to let my assault charge go. So it was never followed through. My children witnessed that assault, and I had to tell them that nothing happened. The reason nothing happened was, as I was told by the crown attorney, that the court system can only deal with the most extreme cases and mandate mental health treatment. Once a person reaches adulthood, if they have not acknowledged or are unwilling to acknowledge a mental health problem, there is really little that can be done. The scatter fire that occurs from someone who is an adult living with mental illness among family, friends and community can be shocking.

My brother-in-law also experienced and is continuing to experience a bout of serious mental illness, leading to verbal abuse and the destruction of his marriage. He now too lives alone in the community and is barely receiving any treatment, partially because he lives in a community where there is little treatment available and partially because he is terrified and does not want to acknowledge that he has a mental illness.

I will repeat it: Once people reach adulthood and they have not received any intervention, there is a huge likelihood that they will cause untold damage in their families and in the community.

That leads us to children and youth. It makes so much sense to implant these services and to look at what we really define as outcomes in our community schools. I realize that the Ministry of Education has undertaken some initiatives such as the student support leadership initiative, but that does not even begin to get at the problem.

The most personal story is my daughter's. Last year, she started grade 9 at a high school in Toronto. Despite much talk at home, because her brother had struggled, we found her getting deeply involved in drugs, which culminated in May with her cutting herself. We have gone through a very difficult cycle. She has come out the other side. She was away at camp for a month and I think she realized a lot of things about herself. But in that process, what I found out was that that high school is just rife with girls cutting themselves. It has become the anorexia of the 2000s. Are there any resources there? Is there any way to get at those children? No. It's not my school, but as a trustee, I was able to ask for help, and we did get a social worker in. But we have school social workers who are working with seven schools each, our guidance counsellors are counselling on college and university, and our child and youth workers are barely on the ground. They were ripped from our schools and they were not really returned.

What I know as a trustee is that we have lots of space in our schools. That space is being touted as a liability, that we have declining enrolment. That space is an opportunity. Public institutions could be in those buildings, such as child and youth mental health agencies. They could reside in that space. They could own that space and they could operate in that space. I've talked to many EDs across the city, and they think it would be a fabulous idea. We can move to that, and there are efforts to move to that. As I said, the Our Kids Network has worked to do that. The Toronto District School Board is on the edge of creating a task force to look at how we can repurpose some of our school space. But one of the biggest obstacles to this is outcomes.

In education, an at-risk student is someone who fails to accumulate credits. In mental health, an at-risk person is someone whose life is falling apart. The reality is that unless we look at how we define an outcome—what do we want for our children and youth? Do we want them to lead healthy, emotionally successful lives, physically successful lives? We know so much about teaching pedagogy that we can teach. Teaching can be done. Our teachers are being trained in incredible ways now. We have a wonderful mentorship program, and the province has supported that. But until the government moves to support local initiatives to coordinate services on the ground, it will be disastrous for children and youth. We do not have even close to the resources, and even if those resources were—it is about coordination; it is also about funding, because children's mental health has not received even close to the amount of funding that's needed, even just to maintain services.

The government has a huge role to play in this. It is not enough to just look at how we can collaborate better. It is not enough to say—and this is what I have heard from government—"We can just go away and do it; there's nothing stopping us." There is lots stopping us. There's a funding formula that defines school space in a certain way. Nobody is mandating that children's mental health agencies move into these buildings and deliver service directly to these children and youth. Nobody is examining what exactly is happening to children and youth in our schools and what is causing their credit accumulation to not exist. It's because they are either hungry or ill or they're mentally ill. Once we support that, they will learn. We don't need to have more student success strategies around how we support their learning. We need to support their well-being. That is the outcome we should be looking for, and that is why we need coordinated policies at the most senior level and coordinated funding; we need cabinet-level coordination.

That is what goes on in other jurisdictions, and that is why I've provided you with my research and with some examples of it. Great Britain is moving, under Every Child Matters, to do exactly this. Why is it that this government cannot move to do senior-level coordination? This would not just benefit children, youth and families; this would benefit seniors. We have obviously—you heard from the last speaker—a huge problem with

seniors' mental health. We could centre these things in hubs. We could deliver in an efficient way, in buildings we already have, with services we already have, if they were coordinated and funded in a much more holistic manner.

The community is already doing its part. At the mental health agency I work for, we have instigated a peer navigator pilot project. We're going to be looking at working to support parents and families and children and youth in understanding how the system works and how to navigate it, how to navigate the interface between the mental health system and the education system. As I said, the Our Kids Network and the Bluewater board are doing their part. The Toronto District School Board is now moving to do its part. But we are hampered by poorly written and poorly coordinated policy, lack of funding and lack of coordinated funding. Although I've heard over and over again from people within government that it's really difficult, I would say that that is a poor excuse for allowing children in a high school to slash themselves.

0940

I have to insist that while it may appear difficult at the start, many, many jurisdictions have moved to do this and are doing it successfully. There are some excellent examples in the United States as well. There is a fabulous website—there are many of them, and one of them is around educational facilities and rebuilding them and renovating them expressly for the purpose of delivering to the whole community.

So I urge you to review what I've given you. I urge you to consider that this is not just about mental health but it is something that could capture all ministries that deal with children and youth within government. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Cathy. We've got time for probably only one very brief question, starting with France and probably ending with France.

M^{me} France Gélinas: One very brief one. There is lots to think about. Were you involved in developing the hubs, in your role as trustee, in the schools under your school board?

Ms. Cathy Dandy: I am involved in it now. We're looking at how we can do that more effectively and how we can take advantage of many of the community partnerships that already exist, many of the community tables—the First Duty Network, which is not about mental health but is an excellent example of how community and government came together and wrote up a model with very clear guidelines around alternative delivery of services in schools and coordination of services. We'll certainly be looking at that.

I think we're going to be moving to designating a fairly senior person within the board to coordinate that and to look at the various funding.

M^{me} France Gélinas: My question was, were you able to secure any funding to develop your hubs?

Ms. Cathy Dandy: Oh. No, not yet. We will be looking to do that. I know there are small pockets of

funding around the Ministry of Children and Youth Services, and we will be looking to do that.

Actually, I'm glad you've raised that. I think one of the biggest problems around funding is that we've moved to a project-based model, similar to what you would find with grants and foundations. That doesn't work. I mean, I'm sure we could secure some temporary project-based funding, but what we need is sustainable funding.

In Saskatchewan, the funding model will be co-ordinated from various ministries. Then people are hired on the ground to then coordinate it on the ground. That is sustained funding; that is not project-based funding. People are needed, and that's where the funding needs to go.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Cathy, for coming today.

FAIR SHARE TASK FORCE

The Chair (Mr. Kevin Daniel Flynn): Our next delegation this morning is from the Fair Share Task Force. John and Sandy, if you'd like to come forward and make yourselves comfortable. You have 15 minutes. You can use that in any way you see fit. If you would leave some time at the end for questions and answers, that works. The floor is all yours.

Ms. Sandy Milakovic: Mr. Chairman and members of the committee, I'm Sandy Milakovic, the CEO of the Canadian Mental Health Association, Peel branch. I am joined by John Huether, volunteer chair of the Fair Share Task Force. As representatives of the Fair Share Task Force, we thank you for this opportunity to speak to you.

Our presentation will be complemented by a more comprehensive written submission later this fall. It's being developed through a collaborative effort by the majority of the key mental health and addiction service providers and their partners in housing, justice, social and community services in Peel.

The Fair Share Task Force is a community coalition of social and health agency leaders and volunteers who are committed to advocating for equitable access to social and health services through funding equity across the province.

We are encouraged by the recent increased attention to mental health and addictions by the Legislature, by the Ministry of Health and Long-Term Care and by the Ministry of Children and Youth Services. We trust that this attention will result in specific action to combat the stigma associated with mental health and addictions, and increased accessibility to services and supports for all Ontarians.

Peel region is the second-largest regional municipality in Ontario, with over 10% of the population. As it has done since 1980, Peel continues to grow by about 30,000 people per year. Fifty per cent of Peel's population are immigrants and 50% are members of visible minorities. The Peel child poverty rate has grown at the rate of 1% per year since 2001, to a current estimate of 79,000 children. There is also an emerging geriatric population

and a growing level of youth violence. The need for mental health and addiction services is great, as demonstrated in our presentation of accepted prevalence rates applied to Peel region. So the availability of accessible mental health and addiction services is extremely important in ensuring that Peel is a healthy and safe community.

We recommend, as the previous speaker did, that the ministries responsible for mental health and addiction services mandate in legislation the provision of a full range of services, from prevention and early intervention to intensive interventions and ongoing community supports, that should be available to any Ontario resident in need of them. We also recommend that these ministries measure and monitor the access to these services for all Ontarians. The establishment of appropriate wait list targets for community-based and inpatient mental health and addiction services, similar to those in place for cancer treatments and knee surgeries, may provide a useful focus to create system improvement.

Our community benefits from the contributions of many immigrants with a broad mixture of culture and races. We understand the importance for service organizations of learning how to communicate with people from all cultures. Services that are sensitive to different cultures and provided in the appropriate language are especially crucial in the fields of mental health and addictions.

Research demonstrates the risks of failing to address mental health disorders, including psychosis, anxiety and depression, and addictions, among new and second-generation immigrants. We read the tragic consequences of this failure in the press. There is also considerable evidence that racial discrimination has a negative impact upon the mental health of individuals.

We would urge your committee to give full consideration to the work of the Honourable Alvin Curling and the Honourable Mr. Justice Roy McMurtry in their year-long study on the roots of youth violence. They provide substantial documentation about the relationships between youth violence, racism, poverty and mental health. This latter connection was so strong, and the lack of accessible, community-based mental health services so stark, that they recommended that the province invest an additional \$200 million for accessible community mental health and addiction services for children, youth and their families.

We view the implementation of an effective, accessible and comprehensive mental health and addiction strategy as an important component to support the province's praiseworthy commitment to reduce child poverty. We note that investment in affordable supportive housing is a significant source of support for persons suffering from addictions or who have mental health conditions, and a key factor in the prevention of recurrences.

The neighbourhood-strengthening strategies in the Breaking the Cycle report and in the Roots of Youth Violence will also be effective in supporting persons facing the challenges of mental illness and addictions. Peel's unique Families First project demonstrated the

value of developing partnerships to help social assistance clients address their mental health and addiction challenges.

Mr. John Huether: Funding policy must also be a fundamental component of an effective strategy for mental health and addictions in Ontario. Funding inequity is at the root of inaccessible services, long wait times, and low levels of utilization of local services in Peel and in other growth areas. We therefore support the commitment of the Ministry of Health and Long-Term Care to the implementation of a population- and needs-based formula for fund allocation to the LHINs, and urge its timely application.

0950

We recommend that the Ministry of Children and Youth Services and the Ministry of Community and Social Services also adopt a needs- and population-based approach to funding their services. The government also needs to redress the historical funding inequities for social and health services through a phased-in set of investments in order that high-growth areas are able to meet the needs of their residents.

As part of our handout, we have provided you with some documentation of the current funding inequities for your information: For Peel, the per capita funding for children's services is \$130.60, compared to the per capita provincial average of \$240.10 in 2007-08. The picture is \$10 worse for York region. In Peel, there are now over 360,000 children and youth between the ages of 0 and 19. The difference in per capita funding represents a gap of \$39 million if Peel were to be funded at the level of the provincial average per capita. This gap has been growing for Peel and the 905 GTA since 1990. It is not acceptable.

There are similar disparities between the provincial per capita funding levels for mental health and addiction services funded by the Ministry of Health and Long-Term Care. Peel is served by two LHINs: the Mississauga Halton LHIN and the Central West LHIN. For community mental health services, the per capita funding for the province is \$52 per resident; for the Central West LHIN it is \$36; and for the Mississauga Halton LHIN the per capita funding is \$21—the lowest in the province, and less than half the provincial average. For addiction services, the per resident funding for the Central West LHIN is \$2, the lowest in the province, while the funding for the Mississauga Halton LHIN is \$4, compared to the provincial average of \$13.

These funding inequities result in very limited access to service and deny many Peel residents the ability to obtain assistance for mental illnesses and/or addictions in a timely fashion within their local communities. The service providers behind every door within the Peel community and other growing communities are not and will not be able to be the right door for those in need of their services unless they are provided with funding support for the services that are appropriate to the populations they serve.

We would like to conclude our presentation by providing you with a series of examples of the consequences of this funding situation.

The 38,000 residents in Malton and 56,000 residents in Caledon do not have any local access to any community mental health services.

Parents seeking help for their child who is a victim of bullying or any other serious condition have to wait six to eight to 12 months for services for counselling.

When the police encounter a youth who is beginning to be involved in gang or criminal activity and who is clearly in need of mental health intervention, they cannot access services for him within a reasonable time.

A recently unemployed father of three who has a drinking problem cannot obtain support to help him deal with his addiction, and his family continues to suffer as a result.

An immigrant family having difficulty coping with their teenaged children who want to test their limits and cultural expectations is unable to obtain culturally competent support in a timely fashion.

The South Asian grandparent who is asked to look after her grandchildren and is having difficulty coping and is feeling depressed has limited sources for help in her own language.

The examples are endless. These are people with real problems whose needs we urge you to keep in mind as you undertake your important work.

We strongly urge your committee to make recommendations supporting the implementation of a funding formula that reflects population needs, size and growth on an ongoing basis, and of a strategy to address the current funding inequity which is denying access to many residents of Ontario's fastest-growing communities. We believe that the prevalence rates and the economic costs of mental illness and addictions, now well documented, warrant such an aggressive strategy and the investments required to support it.

We look forward to submitting to you a more comprehensive report in the coming months. Thank you for allowing us to make this presentation.

The Chair (Mr. Kevin Daniel Flynn): Thank you, John, and thank you, Sandy. We've got time for two quick questions, I think, starting with the government and then perhaps from Christine or Sylvia. Helena?

Ms. Helena Jaczek: Thank you very much for your presentation. I'm extremely familiar with the issues, coming from York region and being the former medical officer of health. I think our first report, York Needs Services!, was 1988.

If suddenly this funding formula were to be addressed and redressed—maybe more for Sandy, coming from Peel—where would you put additional funds, should they become available, as it relates to mental health? Where are your, say, top three priority areas?

Ms. Sandy Milakovic: Early intervention and prevention, stigma and psychosis.

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

Ms. Sylvia Jones: Yes. It's good to see you again, John. Thank you. I must say, part of the reason I'm sitting

on this committee is because of the many presentations I've heard and read with Fair Share, so well done.

My question relates somewhat back to Helena's in terms of point of first contact, assessment. Where do you see that most appropriately happening? Is that through the family physician or is there another scenario that you see playing out with mental health?

Mr. John Huether: My sense is that there isn't one point of first contact. In the earlier presentation, you heard from Cathy Dandy about how schools and hubs for kids are an excellent place to start for many youth, and we would echo their efforts within Peel to build some of the kinds of hubs that Cathy was referring to. We would echo her comments about the kinds of changes that need to happen. Family physicians are important sources, but also social services, child care centres, seniors' centres, the whole range of resources. I think we need to build changes in the system by paying attention to a number of capacities to deal with first contact.

The Chair (Mr. Kevin Daniel Flynn): John and Sandy, thank you for coming today.

LOFT COMMUNITY SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our 9:55 presentation is not here yet, but our 10:10 is here a little bit ahead of time and is prepared to come forward. Terry, if you'd like to come forward and make yourself comfortable. Thank you for agreeing to move ahead a little bit. It will keep us all on track.

Mr. Terry McCullum: No problem.

The Chair (Mr. Kevin Daniel Flynn): You've got 15 minutes like everybody else. If you'd leave a little bit of time at the end, that would be great.

Mr. Terry McCullum: Yes, I'll try to speak in a way that, maybe if you have questions, allows that. Congratulations to all of you for doing this work. It's so important, and I'm so encouraged that the Legislature has an all-party committee. It's an extremely important topic that's often been hidden and needs to be talked about more.

I'm presenting on behalf of LOFT Community Services. It's one of the largest community mental health and addiction agencies in the province, although we may not be a household name by any means. We serve about 3,000 people each year in Toronto and York region in a variety of ways. Through an extensive supportive housing program in over 70 sites, we're serving 880 people in properties we own, lease, or rent, and in other people's buildings, like public housing. We also do individual case management support, individual services to 600 people throughout the community, and we do outreach in Toronto and York region: in Toronto through a program for street youth involved in the sex trade, of which 70% have some serious addiction issues, and in York region through a homeless outreach network, which is a partnership project I'll talk about.

LOFT is committed to supporting health and recovery for people with mental health and addiction challenges, especially marginalized populations, people who fall into

the gaps in service and people for whom there are no services.

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LOFT is a transfer payment agency, but we are also a charity. Each year we're putting in a million dollars—a million dollars—for unfunded areas, and they come right now in two big areas: transitional-age youth and seniors. I'll talk about those as we go along.

My presentation is, we have some great things going on that are newer, we have some special needs, and I believe we have a profound need for a paradigm shift in how we do services altogether, so I'll talk about that—just that; that's all. It's all in my paper, if you have questions.

Positively, with the LHINs coming in, I think some really good things have happened. It's been an occasion to bring people together in the community. We always had that, but the LHINs have made it more formal. I'm personally co-chair of the mental health and addictions steering committee for Toronto, and we're highly involved in York region. It's great when community partners can formally come together and not just informally, which we always did. This is more formal. There's a direct link into the LHIN structure, so that's good.

There has been positive work around stigma, and around social policy, through the Mental Health Commission of Canada, even through the discussion paper that's out, and the history of policy in the province.

There has been widespread acceptance of recovery thinking, which is broader than medical model thinking in mental health.

There have been a lot of integration activities. You're going to hear lots about that. LOFT is involved in a number of them. The homeless outreach thing in York region is a partnership of 11 agencies, both mental health and non-mental health. Last year we started a program in the Jane-Finch community for seniors and mental health, right in public housing, in a partnership model with three other agencies.

We're involved in a mental health project with homeless and HIV people. We're also involved, most significantly, as the lead agency for a coordinated access project for 29 supportive housing agencies in Toronto to link their services, have common waiting lists and transparency of admission. I think it's fabulous.

I could go on. I think some of the electronic stuff that's possible for us is fabulous because it will make it known to everybody, not secretive to look up in a manual somewhere. Okay, that's great stuff.

Moving along: special needs. You'll hear many. I'll just pick three: transitional-age youth; seniors with mental health challenges; and the method of supportive housing.

There is a big gap area for transitional-age youth. Everyone will tell you we need more money, and we do, of course. But the children's sector is well funded—I shouldn't say that, maybe. It's funded, whatever, up to the age of 18. There's a gap area between 16 and 18. But

after 18, boy, everything drops. That's why we call them transitional-age youth, because they're transitioning between the children's and adult systems. There are some things going on, for sure, but this is a big gap area.

We work with some of the children's agencies, and you talk with children's aid societies and other agencies. They're really concerned about this group. In our street program for kids in the sex trade, we see about 800 kids, and that's just in one area of Toronto, the downtown. Half of them come from child welfare, many have serious issues, and they're not connecting to services, okay? They will be the adults of the adult mental health system—certain of them, anyway. We need to really look at that area. We house about 60 transitional-age youth, at any given time, in 10 sites.

One of our programs is for women and addictions. Things can happen for that group that are positive. I just point it out as a need area.

The other is seniors. You're hearing a lot about seniors these days, but not seniors with mental health challenges. Often when they think about seniors with mental health challenges, they think Alzheimer's or dementia. But you know, there are other people too who have mental health challenges, including people now who will be becoming seniors. We haven't planned for them. Traditional seniors' services have a nervousness around this group. They're seen as disruptive and hard to deal with and they don't want them, so they fall back into agencies like us who run with skeleton crews to serve them.

If you were a board member, you might think, "Where's the risk management in all this?" We had a fire this last summer. Fifty seniors, including some with wheelchairs, or walkers, rather—two staff on duty. That's all we could afford. Thank God, everyone was out in four minutes because we had everyone fire-drilled. But no one would take those people, right? Someone has to take them, so they go to hostels, the street or back into hospital.

Supportive housing is a wonderful way of creating a normalized environment for people to live in the community, and we have many fine examples through the province. LOFT has a range of support options, from our higher support—we can do 24-hour, especially with the seniors' groups—down to no on-site at all. That's the majority of ours, but we have support options for them. So LOFT is an integrated service provider. We're not siloed into one area; we do many things. We integrate that. LOFT actually supports about 14 different programs which could all have their own boards and be agencies, but they're not. They're part of one integrated effort and we have a management system to support that. We could add new programs because of it.

Those are some special needs areas I'd highlight and one solution area: supportive housing. We have only one way of funding supportive housing today, called rent supps. It doesn't fit for some parts of the province, especially around places like Sudbury or York region where you don't have a lot of single units to rent, even if you have the rental support money. Plus, when the federal

government comes in with capital monies to build new housing, we can't apply for those grants because we don't have the support dollars to go with it or the rent supps aren't available. The city of Toronto did a housing proposal call recently and there were only two non-profits out of 48 applicants because nobody can afford to apply. So we need to look at that stuff. Sometimes the devil's in the details.

My last point—last but not least—is we need a profound system change. For over 20 years, the province has been committed to switching from an institutionalized-based kind of funding for mental health and addictions to a community-based. In its policy documents—I quoted one in here. Back to even 1999, they talked about 60% community funding, 40% more institutional. That's never happened, and it isn't happening now. Just as a statistic, 85% of the Toronto Central LHIN's funding is institutional and only 15% community. In the Central LHIN, it's 90% institutional and 10% community. Everyone says the community is the answer, right? Hey, people need services in their local community, person-to-person and on their streets, and yet the funding doesn't support that.

Other constituencies, like the UK and New Zealand, have done some really dramatic things. They haven't saved any money. It's the same amount of money, but they reallocated it; they did it differently. You have to believe it can be done, and it can.

In the LHIN structure right now, the role of policy is with the province. It's really a provincial responsibility to set policy and direct the LHINs around this. How could a LHIN take the risk on their own if that wasn't the policy, even though it's been the policy for 20 years?

The current document about "the right door" says that the system has to be funded within its own capacity right now. There will be no new money. That means the status quo must continue. You can make incremental little changes, but basically the paradigm you have now will exist. And I would say to you, Ontario loves institutions. They just love institutions. The answers are in institutions, and that's where all the cost is too, by the way.

For seniors, we put all our eggs into the basket of hospitals, long-term care and nursing home facilities and then we found out—surveys showed that up to 53% of the people on the waiting lists for nursing homes could actually be served in the community.

CAMH did a study years ago that showed that up to 90% of the people in psychiatric hospitals wouldn't need to be there if there were community resources. You've probably seen the Auditor General's report in Ontario on mental health and addictions. Well, it's true. Everything in that report mostly is true. You have an unbalanced system. You hear about children's mental health. At least with children's mental health, they have a community system. It's hardly institutional at all. It's mostly all in the community. We don't have that in adult mental health. When people like Peel come to you, York region and others, and say they need more of a share, they do, but we need to put it in the community. So it's how you think about the thing. It can work.

People have an inner strength. If they have the right supports, they can live their lives. That's what recovery thinking is all about, that even though you have mental health and addiction challenges, you can live a successful life in the community with the proper supports and orientation. It is a lifelong process, though.

1010

One other point; I haven't got it in the paper. I think you're going to see from your hearings here that there are so many fabulous people working in the system. I think you will probably conclude that. I certainly feel that way about everyone I've met across the province and here.

The Ontario Federation of Community Mental Health and Addiction Programs: If you look at their budgets, most of the agencies in that organization have their budgets under \$1 million, or even under \$500,000, so how is that community care? Those are tiny operations, if you're really trying to be comprehensive.

I'll stop at this point, and I wish you well with your tasks. But I hope you will think about the big picture and a policy about affecting the big picture. At least get us back on that course of shifting the paradigm. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Terry. I appreciate the presentation. We've probably got time for two quick questions, starting with Sylvia and Christine.

Mrs. Christine Elliott: You've touched on so many things that I hardly know where to start. But I would like to ask you one question about working with homeless people and with youth. We certainly hear anecdotally that a lot of people who are homeless have mental health problems. First of all, is that your experience? Secondly, how do you get people to get into your homes if they're people who are chronically mentally ill and maybe don't want to initially? Do you just keep up the relationship with them or how do you get them, I suppose, to want to come into one of your homes?

Mr. Terry McCullum: First you have to have a home to get into. We took over a building for seniors that was falling apart, and we took in 110 people. It had a lot of vacancy because it hadn't been going so well for years. We took in 40 women from the women's shelters right away. You have to give people choice, but if they have a choice, they will come. To live in a hostel is not where you want to be. There is a significant percentage of people who have some mental health and addiction challenges, and that was not always talked about. It seemed politically incorrect but it's there. It doesn't mean all the homeless have mental health problems, certainly. But there is a group in there, and if we give them options and allow them to choose, a number will choose, for sure.

And then you asked about youth?

Mrs. Christine Elliott: Well, it's the same thing with youth. They're looking for a place, and if you have a home for them to live in, they will come.

Mr. Terry McCullum: Yes. You have to be a bit creative. If you think of your own teenagers, they're going to resist authority, right? So you've got to do this in the right way. I just made a joke, but in a way it's true.

You've got to allow them to live their lives with some freedom too. We have a house we started with women and addictions committed to abstinence. We said, "If we give you a house"—because they were saying, "Where are we going to live after this more intensive program?"—"would you run it?" They said, "Sure." So we call it peer support. They're committed to continuing in that, and they're doing well.

We have seven houses for transitional-age youth that have no staff in them, and we've been doing it since the 1980s. It seems to defy logic but it works if you do it the right way.

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

Mr. Terry McCullum: Did someone else have a question?

The Chair (Mr. Kevin Daniel Flynn): No, that's it, and unfortunately your time is up. You did a wonderful job. Thanks for coming today.

Mr. Terry McCullum: Thank you for your work.

MRS. X

The Chair (Mr. Kevin Daniel Flynn): Our next presentation is at 10:15 a.m., if that person would like to come forward and make themselves comfortable. Sorry, 10:25—even though it is 10:15. Make yourself comfortable. There's some water there. Like everybody else, you have 15 minutes to use any way you see fit. It works a little better if you leave some time at the end for any questions, maybe.

Mrs. X: Thank you for the opportunity to speak to you today.

The previous speaker said something very important, and that was that you can lead a successful life with mental illness.

When I was growing up, mental illness was the lady down the street whom our parents told us to stay away from. Looking back, I'd guess she suffered from paranoid schizophrenia. As kids, we didn't understand, didn't want to, and skipped her house at Halloween. Twenty years later, I'm an ultra Type A Bay Street lawyer. I work ridiculous hours and I love every minute of it. I've been married to a wonderful man for more than a decade. I have a five-year-old son, which makes me an expert in dinosaurs, Star Wars and Harry Potter.

Two years ago I woke up in the intensive care unit of a psychiatric ward. I was there for six weeks. Since then I've been back four times. I've spent six months in that hospital.

Since I was diagnosed with bipolar disorder, I've learned a lot about the misunderstandings and stigma that surround mental illness. Too many of my friends and colleagues, who are intelligent, open-minded, compassionate people, had to really readjust their views in light of my illness.

I found that mental illness is often seen as something other than a "real" illness. There seem to be three aspects of this fundamental error. First, in most cases, when

someone is seriously ill, there are specific medical tests that produce concrete results. There are numbers and images and tracings and outcomes that are positive or negative or abnormal or not. Mental illness doesn't fit into that framework.

Second, abnormal changes in emotions or behaviour may be so gradual that they go unnoticed or they may be dismissed as unfortunate overreactions to life's ups and downs. If you care about somebody who is behaving oddly, almost anything, any explanation, is more comfortable to you than that they have a mental illness.

Third, there's a perception that mental illness isn't all that serious, especially when you compare it to other serious medical conditions. On that, I can only speak to my experiences with bipolar disorder.

To avoid killing myself, I have lived months of my life in three-minute increments, one to the next, telling myself that my family needed me. At the other extreme, I've stayed awake for four days straight, absolutely enraged that the rest of the world can't keep up with me. That level of involuntary sleep deprivation causes me to hallucinate.

I used to run from any room that had even the tiniest little spider in it. Recently, I went to a zoo. It had a tarantula called Rosie, of all things. The staff there recognize phobias: You're pale green; you're shaking; you're standing 20 feet away. It's pretty obvious. It took me 10 minutes to go that 20 feet. I finally touched Rosie, just so that the next time I have tarantulas swarming out of my walls and over my bed, it might not be so bad.

Some bipolar patients have intrusive thoughts which they can't ignore, no matter how hard they try. I know that what I hear isn't real and I know it never will be. If you have a child you love, you know what your worst fears are. That's what I hear, for hours.

Despite all this, for someone with my diagnosis, I'm lucky. I have a spectacularly good medical team. My primary psychiatrist is world-class, as is one of the sub-discipline specialists that I see.

I have tried so many medications in attempts to find the right combination that my pharmacist thinks I'm fascinating. I currently take at least five different medications a day. I have a rheumatologist to deal with one of the worst side effects, which is swollen joints which stop me from being able to pick up a coffee.

The psych ward nurses that I know are the kind of people who stop me in the street to introduce my family to theirs.

I also have a very wise and experienced social worker. Once, she looked at me and said, very calmly, "This illness nearly killed you. Your family is traumatized. You can't wait to get back to work but you can't go. You want control and you don't have it." And I felt better because she was right, and I was mad with myself for feeling sorry for myself at that particular moment.

Then she asked the question that really, really resonated with me. She said, "What happens if you know someone who is in hospital with cancer or a heart attack?" I said something about visitors and cards and

balloons and flowers and their co-workers signing up for the next 10K run. She just looked at me. In psych wards, there aren't balloons or cards or flowers and there are barely any visitors, because most people are too ashamed to admit they even have mental illness.

Whether you're aware of it or not, you probably know somebody with a mental illness. It might be family or a friend or a co-worker or the guy who orders his double-double at Timmy's at the same time you do.

1020

Mental illness can be terrifying, not just if you suffer from it but if you see it. Before I went to law school, I had a volunteer job. Late one night, I was out with an ambulance crew and they were trying to save a 60-year-old man who had tried to commit suicide. He had horrific injuries. They were a good crew. They were working on him, and I was kneeling on the floor and cradling him, and he was calling me Mommy. He started to fade. They got him to hospital, they treated his injuries, and he got psychiatric treatment. I saw him a year later. He was walking around and smiling.

So what do we need to do? Why are you here? Why am I here? We need to make the public understand that mental illness takes many forms and it can attack anyone at any time through no fault of their own. We need mental illness to be recognized as a physical condition that simply happens to manifest in a patient's moods, emotions and behaviour. We need our civic and political leaders to ensure universal access to treatment, to fund research, perhaps in hope of a cure, and to improve on the resources that we have now. CAMH itself is cause for optimism, but facilities for the mentally ill are still woefully inadequate—not just the inadequacies described by the previous speaker, but even for those who have access to our best mental health services. Even in downtown Toronto there are emergency departments holding patients for up to a week because they don't have psychiatric beds and they don't have psychiatric nurses. In one of Toronto's largest and best-funded hospitals, which I am all too familiar with, I'm told that there isn't actually enough to repaint this dismal, Dickensian ward.

Finally, we need to give people hope. Every fund-raising ribbon that you see, whether it's pink or yellow or purple or blue, is a symbol of hope that a particular disease can be beaten. People donate because they care enough to invest in the hope of finding a cure. Two years out, I'm starting to have hope. My life is fundamentally different. I now live day to day. I have wonderful moments and I have awful ones, and I go to the hospital every 10 days for appointments. But it doesn't matter how uncertain my future is; right now, my treatment means that I can kiss my husband, hug my kid, and look forward to being a productive member of society again, whether that's working or volunteering or helping somebody else through the same problems.

You probably know that ad for the Princess Margaret Hospital—you know, that one where they all hold up the blue cards and then turn them over? The woman who holds up that sign saying "Given months to live ... four

years ago" is my son's teacher. For three years, she's talked to these little kids about dying and about chemo and about having the time to spend with the kids you love, doing the things you most want to do. Literally thousands of people who know her or know of her get a little jolt of hope and faith in the human spirit every time they see that ad. Unfortunately, there aren't clever and uplifting ads about mental illness. People can't even openly admit to having a mental illness and expect understanding and compassion.

It might sound trivial, but think about how we speak or how others speak from day to day. In our everyday conversation, "He's insane." "She's got crazy ideas." If you're neat, you are "obsessive." If you're depressed by trivial things, you are "depressed." If you are energetic, you're "manic." If you are worried about when your kids miss curfew, you're "paranoid." If you listen, you'll hear that language. It doesn't mean much, but it tells you about the way people think about mental illness.

There isn't a cure yet, but one day there will be, and if our leaders get behind a significant public education program, they'll have fired the first shots in the war to defeat mental illness.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for that presentation. You have left a little bit of time for questions, if you're prepared to take some.

Mrs. X: Of course.

The Chair (Mr. Kevin Daniel Flynn): Let's start with France.

M^{me} France Gélinas: I liked how you summed up your last sentence with how a public education program will be the first shot at winning the war. You've mentioned what Princess Margaret has done. Have you come across any positive messages or any ideas as to other jurisdictions where that have been successful in changing people's minds through a public education program?

Mrs. X: I haven't. I wish that I had. I've seen a very successful program in a hospital that seems to be addressing mental health issues in youth very well. But in terms of a broader, more successful education campaign, I haven't seen that and I've been looking for one for two and a half years.

M^{me} France Gélinas: The next question is personal, and you don't have to answer it. What was your first point of access to the mental health system?

Mrs. X: An emergency ward.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any further questions?

Mrs. Liz Sandals: You spoke about a number of different mental health professionals that you work with in one way or another, so you seem to be working now with quite a comprehensive team. I'm wondering how you got connected to that team, because my sense is that in many cases people are much less successful in getting connected to that medical and social support team.

Mrs. X: They absolutely are. From my experiences working with people living on the street and in various other circumstances, there is a huge number of people who aren't getting that kind of care.

I was fortunate, probably for a number of reasons that are unacceptable reasons to be fortunate. I have ferocious advocates. I'm articulate enough to be able to explain what my problem is so that it can be specifically treated. I'm medically interesting, according to a couple of doctors. My treatments have been atypical, so there is a certain amount of sharing of, "You've got to see this one." I'm also stubborn, and if somebody trivializes the situation and says, "You're not within 20 minutes of killing yourself. You need to go home," originally I would have taken that and I would have gone home. I've now learned that you have to say, "That's not going to work." Sometimes I'll do it at home; sometimes I need to be here.

Mrs. Liz Sandals: So you've got a lot of interpersonal skills that don't come with the average patient.

Mrs. X: I'm also—unless you love me, I'm not frightening. When I'm hallucinating, I retreat into myself. I don't start lashing out at people physically or verbally. I don't suffer from paranoia or delusions. I come from a well-to-do background, so at a certain level I'm not somebody whom people want to get out the doors, and I've worked with, for example, homeless people. I would go with them to the hospital and I was the one arguing that this is a person who is just as entitled to treatment as the next bed over.

1030

Mrs. Liz Sandals: So perhaps our challenge is to figure out how to get everyone the level of treatment that you have received, and also to deal with the stigma.

Mrs. X: That's absolutely critical, and I think that until the public understands that mental illness is beyond someone's control, that it's not a weakness and it's not a failing, and they stop seeing it as a fault, then they'll start seeing it in people who they know, people will admit to it, and they'll start realizing it's a widespread problem, and then they'll realize that it's entirely unacceptable that all Ontarians don't have access to the same kind of treatment.

Mrs. Liz Sandals: Thank you very much for sharing.

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

NEASA MARTIN

The Chair (Mr. Kevin Daniel Flynn): Members of the committee, our 9:55 a.m. has arrived now, so I'm going to ask Neasa to come forward. We had somebody else step into your spot, so we're still not too far off schedule.

Ms. Neasa Martin: Thank you very much, and I can only express my deep apologies for the delay in arriving.

The Chair (Mr. Kevin Daniel Flynn): That's fine. You're here, and as I've explained to everybody so far, everybody's got 15 minutes. You can use that any way you see fit. If you leave a little bit of time near the end for some questions, that works out well usually. The floor is all yours. Make yourself comfortable.

Ms. Neasa Martin: Thank you. I'd like to just mention that your question about, "Are there any examples of

campaigns that have been effective in addressing stigma and discrimination and enhancing social inclusion?"—that's what I'm here to talk to you about today.

I'd like to thank you for taking the time to meet with me. My original request came through a protest around the imminent closure of the *mindyourmind.ca* program, which is an award-winning, internationally acclaimed, anti-stigma education awareness program targeted at teens. It was incredulous to me that such an example of excellence was at the risk of being lost to our community, and I thought, "How is it possible?" I'd like to thank the Honourable Deb Matthews for giving a reprieve to the program of one year so that it could demonstrate its effectiveness. The thing that made me want to speak to you is that I think this is an example of where public policy and funding are reflective of the broad-based discrimination that people living with mental health problems experience on a day-to-day basis.

On the issue of mental illness, I am not a neutral observer. Mental illness has been an active and continuous part of my life as a daughter, as a sibling and from a personal perspective; I also suffer from a mental illness. I know only too well the negative and harmful impact an untreated mental illness complicated by substance abuse can cause in a person's life and the long shadow it casts. I understand how easy it is to see yourself as broken and fear the risk of becoming one's genetic destiny.

For over 25 years I've also worked as a mental health care professional, and I've worked in every area of the system: in-patients, outpatients, community case management, rehabilitation, community consultations, capacity building. I've learned from this experience and seen first-hand how supports and services fail to foster hope, optimism and a belief that recovery is indeed possible, and are frequently misaligned to help people maintain friendships, kinships and a foothold in the world of work.

For the last seven years I've been working as an independent consultant at both the provincial and federal level with an eye to trying to find those critical points of influence where we can achieve transformative change, because transformative change is what is needed.

I've worked with the OLCG, when it was known as such, on developing a responsible gaming strategy, and it remains today clear to me that profit continues to trump social responsibility on this gambling issue. I've researched the connection between mental health and problem gambling, and in fact, the connection is very strong that people with mental illness are more vulnerable to developing problems.

I've recently consulted with the Mental Health Commission of Canada in helping it develop its national stigma and discrimination reduction strategy, and helped them frame recovery from a consumer perspective in the creation of a discussion document.

I've just completed a research study on quality of life for the Schizophrenia Society of Canada, trying to find out what "quality of life" means for people living with mental illness and their families. I've just finished a

project up in North Bay with the North Bay General Hospital and the Northeast Mental Health Centre, helping them to reduce the stigma and discrimination as these two enterprises come together in a new location. I've just returned from Australia, where I delivered a keynote address on social inclusion, and I'm working right now with the Queensland alliance to develop an evidence-based stigma reduction strategy with a mind to social inclusion. So I come with a fair bit of experience and knowledge.

I see in the provincial strategy that there is a desire to address stigma as a priority. To do this, you will need a strategy. Good intentions won't be enough. The emerging research is very clear that having a comprehensive strategy does work. There is economic modelling that shows that it is also cost-effective and that it is far more expensive not to undertake this kind of approach.

Stigma and discrimination and social exclusion, as you well know, are critical. It's widely acknowledged as a problem. There's a high degree of agreement that we should be doing something, but there is no agreement on what that something is. There are many programs that are under way right now; many are based on intuitive understanding, not on evidence-based research. Hardly any of them are being evaluated, although the Mental Health Commission is developing strategies to increase the research on what's being done.

It's thought that any activity that is focused on stigma and mental illness is inherently stigma-reducing, and that is not true. Stigma, as you know, impacts on every area of life. I'm sure you've heard from people that it's worse than the illness itself and, in fact, continues long after successful treatment. So enhancing treatment is not going to be enough to remove the discrimination that people feel.

It affects your self-image, your self-esteem, your mood. In the worst cases, it causes people to end their lives. It prevents people from seeking help, from staying in treatment and, as a result, not getting access to good-quality care. Self-stigma is when people absorb the negative feelings around them and make them their own. This is highly corrosive and contributes to the way in which people will not approach the health care system. It starts when people feel different and "other," and that's reflective of the way in which the world sees people with mental illness as abhorrent and different. It's reinforced in people's contact with the health care system through the process of receiving a diagnosis and starting medication. It's pernicious, it's pervasive and it's all-enduring.

Having a diagnosis of mental illness also leads to overt discrimination and the denial of people's rights. People will not get employed, they won't get life insurance, they can't get disability insurance; mortgages are denied. Even the right to travel is restricted when you have a diagnosis. It's critical that we start to shift our thinking away from seeing this as an illness-based issue and into a social rights and human rights issue.

Let's talk about what works and what doesn't. I have spent the last couple of weeks researching thousands of

literature papers. What really is clear to me when you start to look at the research is that consumers are the critical experts on this issue and that the research has followed their insights, whether it's on the importance of recovery, the need to focus on having a friend, a home, a job, purpose, meaning, value, and the value of peer support. I used to run a peer support program in Ontario. It was extremely difficult in the early days for people not to see this as something dangerous and not to be supported, where in fact the research now is showing that the most effective way of reducing self-stigma is through peer support, group identification, participating in advocacy efforts and that sort of thing.

We've never been in a time when there has been more information about what mental illness is, what its treatment is, what its signs and symptoms are, because the most prominent approach that we've used is around mental health literacy. The assumption is that if everybody understands what these illnesses are and sees them as not a character weakness, not your fault, but as an illness like any other; if we teach about signs and symptoms; if we emphasize the potential risks of morbidity and mortality; if we emphasize the science around the illness, that that will in fact help.

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Despite these efforts, stigma and discrimination are actually increasing. The work by prominent researchers who map public-attitude surveys are noticing that now the public is more aware of what mental illness is, and its signs and symptoms, and accept that it's a genetically based and biologically driven illness. They're more supportive of funding for research but they also hold much more stigmatizing attitudes. There's this paradox that the more you know, the less you want to have to do with people with mental illness. So it's critical that we get the framing of this approach right.

There's also an increased belief that people with mental illness are dangerous and incompetent, and people want more social distance. There's also a decreasing belief that recovery is possible.

Where is less stigma? When the public understands that mental health problems are a response to social stresses, to a history of loss, and to experiences of trauma and abuse, that they are illnesses but that they are normal reactions to life and that they are part of our shared humanity.

People are more accepting when they see mental illness as part of a continuum, much like "normal" with the volume turned up. We understand now that depression and anxiety are acceptable because they feel as if they're part of our human experience.

People are more accepting when we use descriptors rather than diagnoses in our education and if treatment is perceived to be successful. There is also less stigma in societies where services are being provided, particularly at a community base. The policy neglect of government plays a critical role in contributing to stigma and discrimination.

Mental health care providers—professionals like myself—have played a major role in defining what reform

should look like. But the research is also very clear that mental health professionals hold much more discriminatory attitudes, also want more social distance from people living with mental illness and tend to take a paternalistic approach to treatment and routinely deny people basic rights and freedoms; that the over-focus on medication and medication compliance is part of that; and that, as a result, we do not see the development of services which are recovery-focused because many mental health care providers continue to hold the belief that recovery is indeed not possible.

The focus has been on disabilities and not strengths, and that when people refuse involvement with treatment services, it's more of a symptom of the illness than a protest against the quality of care that they receive.

It also is felt, through health care providers, that when you have a diagnosis of mental illness you are less likely to be investigated for other physical illnesses, although people with mental illnesses have more chronic illness. People have much poorer health care, shorter lifespans, suffer from more chronic illness and they're less likely to be investigated and treated.

Research with consumers about what their experience is: They say, "What's important to me is I want to participate in the community. I want to work. I want to enjoy a meaningful, purposeful life and be accepted by family and friends. I want to be able to access recovery-focused supports in my community."

Research shows that quality of life, and medications and treatments, are really critically linked, but when they support independence; that there's too much attention paid to medication and treatment compliance; that people are seen as a diagnosis and not as real people; that they're looking to be treated with trust and respect, not judged and criticized. They're looking for partnerships with care providers where they feel in partnership with, and not a sense of having power over, their decision-making.

As I mentioned, there are five international jurisdictions right now that have comprehensive social inclusion strategies, and one of the three most effective strategies that they have used is education—not education about illness, because that brings its own problems, but education that challenges the myths of what a person with a mental illness looks like, and that's best accomplished through personal contact. Having the experience of meeting with people with mental illness is the most consistently effective way of shifting attitudes and behaviours. And protest: Protest is an important one. The consumer movement has been actively involved in protest, and in fact new research is starting to say that that very act has protected them from the self-stigma, has helped them to reframe their illness as something meaningful and important to them rather than something broken that needs to be fixed.

The Chair (Mr. Kevin Daniel Flynn): I've got to tell you that your time's up.

Ms. Neasa Martin: Okay.

The Chair (Mr. Kevin Daniel Flynn): But if you want to wrap up, you've got about 20 seconds left.

Ms. Neasa Martin: My apologies. My recommendations to you are that if you want to reduce stigma and discrimination, make it an active campaign, with strategy that partners with key stakeholders; that consumers and leaders take a leadership role in that; that you focus not on education about mental illness but education about rights; and that you look at policy changes as well. One of the critical things is work. Remove the barriers to work. The Ontario disability support program still represents a huge barrier for people—that is within your domain to change—and make recovery outcomes and social inclusion goals as the measure of whether the supports and services that you're funding are being successful.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Neasa. That was very good. We got your point.

KINARK CHILD AND FAMILY SERVICES

The Chair (Mr. Kevin Daniel Flynn): Let's go on to Kinark Child and Family Services. We have Peter and Tracy with us. If you'd like to make yourselves comfortable. I'm assuming we still have some clean glasses there if you need any water. Like everybody else, you've got 15 minutes. Thank you very much for coming today. Use that time any way you see fit, but if you want to leave time for some discussion at the end, that seems to work well as well. It's all yours.

Mr. Peter Moore: Thank you. Good morning. My name is Peter Moore, and I'm the executive director of Kinark Child and Family Services. This is Tracy Folkes Hanson, who's our director of communications at Kinark.

Today marks the first day of the school year in many Ontario jurisdictions. Several of our clients, including a girl I'll name Emily, will be joining classrooms across the province thanks to treatment and services they've received. Emily had a difficult path in her early school career. She had trouble concentrating, had difficulty with anger management and was the brunt of bullying in the schoolyard. She is now a success because of the counselling, intensive family therapy and specialized school supports she received. It's important that we celebrate her success, but we also need to shine a light on the kids we don't see.

We're pleased to be here presenting to you, and commend the Legislature for supporting the establishment of a Select Committee on Mental Health and Addictions for Ontario. It is certainly time to talk about the importance of mental well-being as well as the urgent needs facing individuals with mental health problems, particularly, in our opinion, children and youth. I know you've heard from many of my colleagues about the chronic underfunding of mental health and addiction services for children and youth.

In my time with you I'd like to give you an overview of children's mental health, but I'd also like to focus on three issues which may not have been addressed previously: (1) the need for a population-based approach

to mental health and children's mental health; (2) the urgent need to address the mental health issues of our youth justice population in Ontario; and (3) the plight of our First Nations children in southern Ontario, and most particularly in the far north.

1050

To begin with, and by way of background, I'd like to tell you a little bit about children's mental health and Kinark services. Hospital-based services provide a small percentage of specialized children's mental health programs. The majority of services for children and youth are provided in community-based centres. These are not-for-profit organizations like Kinark that offer a range of treatment programs in their offices, in family homes, at community centres and in schools for children and youth, ages zero to 18, and their families. Children's mental health centres are located throughout the province and are funded principally by the Ministry of Children and Youth Services. Services range from prevention and early intervention to intensive treatment services.

Let me speak briefly about cost. The average cost of treating children's mental health problems in community-based agencies is less than \$2,500 per child per year. The cost of incarcerating a youth through the juvenile justice system in Ontario is over \$90,000 per year, and the cost of a pediatric hospital bed is more than \$900,000 a year. If I can just take you through that again: \$2,500 per child, per year in community-based care; \$90,000 per year for a youth in the youth justice system; \$900,000 for a pediatric hospital bed.

Kinark is the largest children's mental health organization in Ontario and provides professional help to over 10,000 children and youth with chronic and multiple mental health issues every year. I know some of you are familiar with us as we have programs in your constituencies. We partner to deliver services with child welfare agencies, schools, child care centres and community organizations. Our services are divided roughly into three main areas: child and youth mental health, autism, and youth justice. We run the Syl Apps Youth Centre in Oakville as well as a number of community-based justice programs.

The number of children and youth in Ontario who need our assistance is staggering. We know that one in five children in Ontario currently struggles with mental health issues. Only one in six of these children receives treatment. Each of these children and their families needs help, and each of these children is surrounded by a classroom and a neighbourhood that are affected by these problems. So, statistically, most of us in this room are personally impacted, directly or indirectly, by the issues of child and youth mental health.

Hand-in-hand with the volume of need is wait time. Families often wait weeks, and in some cases months, to receive treatment and service. If parents had to wait days, let alone months, to fix their child's broken arm or leg, the public outcry would be deafening. The wait time suffered by parents and their children is compounded by stigma and discrimination—and I know you've heard

something about that this morning. A national study conducted by Kinark in 2007 resulted in 38% of Canadian parents acknowledging that they would be embarrassed and ashamed to admit that their child suffers from anxiety or depression.

It's time we recognized that mental health is as important as physical health. Untreated mental health issues often become more severe, increasing the likelihood of school failure, family breakdown and involvement in youth crime. We know that we all deal with mental well-being at different points in our lives. These are often minor issues. We know that for serious mental health issues, treatment does work. We also know that evidence-based prevention and early intervention programs for children are effective, leading to all kinds of improvements: academic progress, social development, behaviour and mental well-being.

So what are we to do? In these turbulent economic times, we need cost-effective programs that can intervene early, a population-based approach providing the right amount of support at the right time in the most cost-effective manner possible. At Kinark, we are investing in evidence-based programs with proven track records. One example of a population-based service, which we have introduced in some regions in the province, is Triple P, which stands for the positive parenting program. Developed in Australia, it has been implemented in a number of countries and has been tested by a myriad of independent studies. Documented in more than 70 published studies, the Triple P approach has been shown to prevent or reduce social, emotional and behavioural problems in children, freeing them from reliance on medications or costly therapies. I'm pleased that its founder, Dr. Matt Sanders, has been invited to speak at a conference sponsored by the public agency of Canada next week, and I encourage members of your committee to investigate the merits of a broad, population-based approach to mental well-being.

In the Senate report *Out of the Shadows at Last*, tabled in May 2006, Senator Michael Kirby wrote that if mental health is the orphan of the Canadian health care system, then children's mental health is the orphan of the orphan: "We have neglected an entire population of youth struggling with mental health issues."

We know that 80% of youth in our youth criminal justice system have a mental health disorder. Senator Kirby has called these institutions "the asylums of the 21st century."

In his *Roots of Violence* report, the Honourable Roy McMurtry recommends that funding be targeted to the mental health issues of our youth. This is the only recommendation in his report with specific dollars attached.

In your examination of the mental health needs of Ontarians, I urge you to look at the neglected population of youth in conflict with the law. For the economy and the well-being of all of our communities, we need to deal with these kids' underlying mental health issues.

Finally, I appeal to you to take a leadership role with the marginalized population of aboriginal children and

youth—that we in Ontario become an example for all of Canada.

Kinark has been asked to intervene in a number of fly-in communities in the far north. These requests have come from the First Nations leaders in those communities. I am pleased to report that we have had some success by introducing western mental health expertise to traditional healing measures and looking to local communities to build on their own strengths and develop their own solutions, including giving youth a voice in the process. We are now being asked to replicate this work in other fly-in communities in the north as well as First Nations communities in southern Ontario. This is not a panacea for the complex social and economic issues facing our First Nations people. Rather, it can be an important first step to significantly reduce or even eliminate child suicides and give youth a voice, which is in and of itself an important step for mental health.

Summarizing, then, change starts with children and youth, where preventive measures and early intervention are most effective. We need to examine how these changes will have an impact on our service delivery and how we can work together to give youth their own voice and empower them to speak about their struggles, finding solutions that work best for them; recognize that Ontario's youth population is shifting; discover ways to build multi-faceted, community-based programs for the whole province, including our First Nations communities; and support the development of population-based, evidence-based programs and services to meet the ever-changing needs of the children, youth and families of our communities.

We need to create awareness of the issues, eliminate stigma, and champion the rights of children and youth with mental health challenges by delivering effective programs and treatments that meet the needs of our population. There are half a million children and youth in Ontario with mental health problems who deserve and need our help—half a million children who live, play and go to school in our communities. I urge you to give these issues serious consideration in your deliberations.

Thank you for your time.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Peter. You've left a little bit of time for questions, just over five minutes. Let's start with the government side. Helena? I think I saw you first.

Ms. Helena Jaczek: Thank you. Lots of questions. Specifically, I'd like to hear a little bit more about the Triple P, positive parenting program. I presume you involve the child as well as the parents. It's not entirely clear from the brochure.

Mr. Peter Moore: Absolutely, but it really is focused mostly on the parents. There are five levels. It goes from kind of a media blitz to let people know about how important parenting is for children, and then there are more intense levels. A second level has tear-off sheets to give to parents if they have problems, say, with bed-wetting or some minor kind of problems that they're worried about, so they don't have to get involved in something that's intrusive.

They go on the basis of minimal sufficiency, so whatever level of need the parent has, they tailor the intervention to that need. In York region, for example, we have involved the school boards, public health nurses, all of the children's mental health centres and the teachers so everybody is speaking the same language about parenting. If a parent goes to a parent interview in a school, the teachers can talk the same kind of language as therapists would talk.

As I say, it's population-based. It is mostly focused on parents, but it has a huge impact in terms of effect and also cost savings.

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Ms. Helena Jaczek: Just as a follow-up, suppose that during the process one of the counsellors realizes that there is in fact a really serious issue. I presume that you would continue on and make that kind of referral—

Mr. Peter Moore: Oh, absolutely.

Ms. Helena Jaczek: —because we've heard about early intervention over and over. So it's sort of a continuum that would—

Mr. Peter Moore: Absolutely. This isn't a panacea for all mental health problems for children and youth, but really, if you focus on parenting, that's a huge step to eliminate mental health problems—and you intervene early. So at Kinark, for example, we have a program at the front door. We've been able to reduce our wait time from 51 days to 19 days, and we've done that by using Triple P and using brief therapy. But if the therapists pick up that there are deeper problems, then they'll route them over to more intensive services.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Let's move on. Christine or Sylvia?

Mrs. Christine Elliott: Thank you. I'm interested in the issues of youth in conflict with the law. It's something that we haven't heard that much about yet and I'm wondering if you could tell us where you normally would get involved, what your involvement would be. And I believe there is one youth mental health court that we now have in operation; I wonder if you've had any experience with that.

Mr. Peter Moore: Our clinical director, Dr. Dick Meen, has had some involvement with that—it's in Ottawa, I believe—but no more than that.

Dr. Meen has a saying that children would rather be bad than mad, so it's more acceptable to have behaviour problems that relate to youth justice than to have mental health problems. I think these kids go through a different door—if they slide one way, then they'll get involved with the youth justice system; if they slide another way, then they may come to us through their family doctor. There's a range of services for youth justice clients. Our experience is that behaviour control is much more important than the underlying issues of mental illness—our psychiatrist again says that behaviour is the language of children, so if we get underneath what the behaviour is and look at what the causes of the behaviour are.

We have some non-residential programs. Multi-systemic therapy would be one example which we

operate in Durham region and York region and Simcoe, and that's an intensive, community-based program for kids in conflict with the law. Then you go from that to open custody to secure custody. I'm not sure if I'm answering your question. There are diversion programs, but I guess my point in my presentation is that it's more often the behavioural control than the underlying mental health issues. So if that's not dealt with, these problems, I think, will recur. That's been our experience.

The Chair (Mr. Kevin Daniel Flynn): Time for one very brief question and answer, France.

M^{me} France Gélinas: Sure. You mentioned that you have gone into First Nations communities and have been able to bring white people medicine with traditional—does this program have a name, and where was it and could we know a little bit more?

Mr. Peter Moore: It was in Wunnumin Lake. It was at the First Nations children's aid society. Tikinagan had a rash of suicides of 12- and 13-year-olds in this very small fly-in community. We were with one of the supervisors at a conference and she stood up and spoke eloquently about how, "You think you have problems down here? Let me tell you what it's like up north." So, with permission from my board of directors, we were able to send a couple of clinicians up to talk to the mental health professionals in the community, the paraprofessionals, and got them involved in speaking about their issues. Our psychiatrist who went up there got a list of 40 children who the community thought had mental health issues. In fact, when he did his assessments, only one of those 40 children had a diagnosable mental illness, but there were lots of complex social problems—difficulty parenting in terms of the residential school experience, drug and alcohol abuse. So it's getting the community to work on those problems, to be available by videoconferencing, and to be consistent, to come back and have relationships with them and to be able to do very targeted interventions when they are needed.

The Chair (Mr. Kevin Daniel Flynn): Peter, thank you very much for coming today.

GRIFFIN CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our 10:55 appointment is not coming today, but we have the folks here from the Griffin Centre ahead of time, I think. Laurie, if you'd like to come forward and introduce yourself. Make yourself comfortable. Welcome. Like everybody else, you've got 15 minutes. You can use that any way you see fit. If you can leave some time at the end for discussion, that always works better. If you'd introduce your colleague this morning, that would be great.

Ms. Laurie Dart: Good morning. We're very appreciative to be here this morning to meet with you. I will start by introducing my colleague. This is Zack Marshall. Zack is a supervisor at Griffin Centre, where I'm the executive director. We're going to whip through our presentation as quickly as possible so you have a chance to ask questions. I'll do my best at that and so will Zack.

We've reviewed the work of the committee and the various presentations to date. We're very impressed by the focus on this very important issue, the commitment of the committee members and the quality and diversity of the presentations that you've received. You've heard a great deal about how and why the mental health system isn't working, but we would like to take a bit of your time today to tell you some of our ideas about how it might be improved.

I've been the director at Griffin Centre for over 20 years and, prior to that, worked in mental health as a social worker and in senior management roles in various service sectors: children's mental health, youth justice and secure treatment and developmental services. All these experiences have shaped my learning and my strong commitment to building a system of mental health care that includes strategies and service models that create real accessibility for individuals who do not otherwise seek help from traditional services or for those whose needs are so great that one sector can't meet them. Many of the individuals with mental health challenges whom we see at Griffin Centre need significant outreach and ongoing support to make use of our services.

Zack and I will focus our attention today on three core issues that, if addressed properly, can make a huge difference in the lives of people with mental health and other concerns. The first one is improving access to supports and services. The second is developing partnerships, and the third is coordinating services across organizations and sectors.

First, I'll just give you a quick overview of what we do at the Griffin Centre. Griffin is unique in that it's a children's mental health centre for youth with a range of mental health needs, often exacerbated by other issues or challenges. For instance, many of our youth have learning and school problems, developmental disability, substance use issues, conflict with the law, newcomer challenges and many more. The centre is also a multi-service mental health organization for adults with a dual diagnosis.

We provide community counselling, in-home and in-school support, day and residential treatment programs and crisis supports via various access points and program sites across the city of Toronto. Our clinical staff seek to create every opportunity for our clients to make use of what we have to offer. We have a long history of creating new services that respond to emerging community needs. As well, we offer training and consultation via various partnership arrangements both locally and in other parts of the province.

We serve about 1,000 clients with complex mental health needs per year. As you've learned from previous presentations, an individual with a dual diagnosis has mental health needs compounded by a developmental disability. I know that you had Dr. Philip Burge here and he provided you with an excellent overview of the statistics related to dual diagnosis and the limited number of services that exist across all age ranges.

First, accessibility, or what we like to call barrier-free services: A typical barrier to service that Griffin staff hear

about frequently from our clients is the fact that individuals who have more than one diagnosis or mental health challenge don't fit into many of the programs being offered. For instance, a youth with a diagnosed anxiety disorder and a developmental disability and substance use issues may be excluded from another service because of his or her cognitive level of functioning and/or the substance use. People with more than one problem need services that can accommodate their unique situations and complexity.

Improving access has been a core value of the centre since its inception 34 years ago. However, talking about barrier-free services and providing them are two different things. At the Griffin Centre we've learned that this work needs constant attention. We know that people with serious mental health concerns also face a myriad of other problems as young people and on into adulthood: lack of success in school, aggressive outbursts, being bullied or bullying others, isolation, unemployment and homelessness. It's these circumstances and behaviours that often indicate underlying mental health problems. I think you heard a similar story from Peter previously. It is individuals in these circumstances who need prompt and flexible services and access to those services.

1110

Unfortunately, these issues are often addressed in isolation without recognizing or understanding what else might be going on. For instance, the youth who continually skips school and becomes verbally aggressive with teachers when asked to do something may in fact have a mild developmental disability that's been undiagnosed, a significant learning disability that may be undiagnosed, or may be struggling with issues of poverty, racism and/or other issues related to gender identity or sexual orientation. It's our job as professionals in that youth's life to find creative ways to get to know them and to engage them in a mental health support plan which will meet their needs.

If we really believe in the positive impact that mental health services can have on people's lives, it's our job as organizations to provide flexible services which can be put in place and adjusted as the needs change, to support clients through crisis, to help them with the critical issues in their lives, like housing, employment, money management and medication, and to help them to learn new skills. This takes time and patience, and a commitment to progress being made in small steps.

Individuals needing mental health services come from many different ethnoracial and cultural backgrounds and will not always see the benefit in services that are grounded in a western cultural approach. Griffin has continually reviewed its policies, practices and service models to improve accessibility and ensure that our programs are relevant to the lives of our clients and their families. Hiring staff from various communities; situating services within priority neighbourhoods—for instance, our Y-Connect program in the Jane-Finch community; creating safe and accepting program environments for our LGBT youth—which are lesbian, gay, bisexual,

transgender; providing evening and weekend access to crisis supports; seeking client input into their service plans and to the centre's program development; and continuous staff development related to diversity: All of these strategies contribute to barrier-free access.

Partnership development and service coordination: At Griffin, because we serve individuals with a variety of mental health concerns and other challenges, we know that to be most effective other organizations need to be part of the service model. It isn't all about us. To this end, the centre has built formal service networks that create coordinated access and service navigation assistance to a range of linked programs from various sectors.

It is these networks that form a system of care for the individual and family. Each organization commits specific services to the overall network of service and can access, on behalf of its own client base, all the other network components. This model enhances services and supports for the individual while also creating a support system for the partner organizations. The stronger and more diverse the partnership network, the more complex the needs of the individuals receiving service can be. The individual who needs a made-to-order and highly individualized treatment and support plan from services funded by different ministries benefits from this kind of network design and specialized service coordination. Instead of shopping around for a program that the individual will fit into, the services are organized to fit the individual and family, and ongoing support and coordination are provided.

In essence, our staff form the glue that integrates the services needed to create this individualized program. Based on our experience after many years of providing a service coordination function, which is called case management in some of the sectors, we know that there is a great need for more specialized service coordination for both youth and adults with complex mental health needs. A service coordinator with strong clinical and facilitation skills can make all the difference to the individual's success. Conversely, the lack of this support often leaves people confused and angry, struggling with mental health challenges while trying to get help, and facing rejection or inadequate supports. This leaves people with complex needs in crisis, bouncing between hospitals, shelters and the justice system. Increased service coordination efforts need to both address the immediate crisis and develop long-term stabilization plans for these clients.

Finally, to make the service network a truly effective strategy to support individuals with mental health needs and other challenges, there need to be strong inter-ministerial linkages which will support or encourage organizations to work together in providing a network of care.

Current government funding streams are based on specific needs and/or age groups: The Ministry of Health funds adult mental health, the Ministry of Community and Social Services funds developmental disability services, the Ministry of Children and Youth Services funds children and youth mental health services and the

Ministry of Education funds education. But mental health needs don't fit into life stages or lifestyle activities. They are, instead, all-pervasive and can be long-standing, requiring flexible, individualized and persistent responses. Formal interministerial agreements, like the dual-diagnosis guidelines that outline how cross-ministerial services should work together, are essential to encourage seamless services across age ranges and diverse needs.

Mental health is the essence of a person's sense of well-being and ability to cope. It can make the difference between children staying with their parents or requiring alternate care. It's the strength that underlies a child with a severe learning disability being able to succeed in school, and it creates a more stable workforce. It deserves everybody's attention.

Zack is just going to provide you with an example of one of our programs, and the clients in it, that illustrates what I've been trying to talk to you about.

Mr. Zack Marshall: Thanks, Laurie.

The Chair (Mr. Kevin Daniel Flynn): Zack, you've got about five minutes left.

Mr. Zack Marshall: Excellent. I will try to talk for about three, at maximum.

Good morning. Thank you for this opportunity to speak with you. I'm the supervisor of ReachOUT, which is our program for lesbian, gay, bisexual and transgender youth at the Griffin Centre. In the past five years, we've worked with over 400 youth, attempting to provide what Laurie has talked about as barrier-free services or accessible services for all LGBT people in our communities.

The youth who attend our programs typically tell me they don't fit into other agencies, and sometimes, to be honest, I feel like I can tell why. They may be experiencing a number of barriers, whether that's related to mental health issues, intellectual disabilities, homelessness, poverty—just a range of pieces of challenges that are confronting them at different points in their lives. They often are dealing with, as I said, mental health issues and substance use concerns and struggling with basic needs such as housing, employment and transportation.

They also are often dealing with what we call intersecting oppressions, such as racism, homophobia, transphobia, ableism—the list goes on. So we're working to try to help support them around those and to gain their own skills to deal with them in their lives.

To respond effectively, we've tried to combine a clinical model with a model that has more of a community development focus. A lot of programs do one or the other. We've tried to have both. This has meant offering more drop-in groups, increasing our youth engagement and holding community events in an effort to strengthen and build our communities.

As we have developed more of an awareness of the social determinants of health and their impact on well-being and mental health well-being, we've worked to offer a more holistic program which recognizes people's full range of strengths but also the needs that they have over time.

I wanted to talk to you about a couple of examples. One young person we work with was rejected by his family after they found out he was gay. We supported him over the past four years as he entered the shelter system, experienced hospitalization for mental health concerns and struggled with substance abuse. However, we were also there when he attended our weekly drop-in groups, for his graduation from a job training program and when he found stable housing. Providing holistic and accessible programming requires strong partnerships as well as advocacy and self-advocacy. As one of our young leaders, this client has continued to successfully gain facilitation and self-advocacy skills.

I have to be honest and tell you that very often I hear questions from the staff I supervise that I do not know the answers to, and I wanted to mention a few of them here, just because it might help you to see some of our struggles. Recently I had a question from a staff saying, "How do I support a client who has a \$9,000 cellphone bill?" I was quite mind-boggled. Thinking about this in the context of someone who's also on ODSP and doesn't do so well with their finances, obviously, but was really interested in talking every day to their girlfriend in the United States, we were trying to figure out, "Okay. How can we support this person?"

Another question was, "What is the best way to help a transgender youth who is experiencing harassment in the shelter system? How can we work with the system to support that youth better?"

Another staff came to me last week and said, "Zack, I just got back from vacation and found out that one of our clients is being evicted after a series of misunderstandings and miscommunications with the landlord. What can I do?"

I won't go on, but one other was, "A client we're working with does not have enough money to pay for her prescription antidepressants. How can we help her?" I know that we have many programs in the province and in the city that can respond to clients if this was maybe the one problem they were trying to deal with, but what's often happening with us is that there are multiple layers. So to respond even to the question of how to address the prescription medication costs takes a fair amount of work and service coordination on behalf of the staff.

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As I mentioned, I don't always know the answers to these questions, but we are working on figuring them out. The youth we work with are certainly an inspiring, amazing group of people. They also frequently experience significant difficulties with mental health, precarious housing, poverty and substance use concerns. While as service providers we face challenges in responding to their needs through accessible programming and these strong partnerships with other community organizations, we're able to support them and build and strengthen our communities.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Zack. You're about eight seconds over 15 minutes, so unfortunately there's no time for any questions, but you made a great presentation. Thank you very much.

GLENN BROWN

The Chair (Mr. Kevin Daniel Flynn): I understand that Reverend Brown is with us. I can pick you out in the crowd.

Rev. Glenn Brown: That's deliberate.

The Chair (Mr. Kevin Daniel Flynn): Come on forward and make yourself comfortable. Like everybody else, you have 15 minutes. You can use that any way you see fit.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Oh yes, absolutely; anywhere you're comfortable.

Rev. Glenn Brown: First let me explain the paper I distributed to you. I had explained to my congregation over several weeks that I was going to be making this presentation. With a medium-sized Protestant congregation in a suburb, I serve people who deal with a variety of problems, so I expected some intelligent comment from them that I might bring as part of this presentation. Many offered to write; only one did. This is the result of that one person's writing, so I'm not going to repeat what is in that paper. It's simply there for you to read.

I would only say to you that this is a person who continues to experience mental illness, and I'm told this person continues to have hallucinations, times of detachment from reality, and yet is fully employed and is a university graduate. I ask you to keep that in mind when you read this person's paper because it illustrates quite well this person's point that, although generally considered symptom-free, which in this person's opinion is really all that the system cares about, the fact is that this person experiences internally a lot of the frustrations and fears of being mentally ill and finds that, because this person is so successful otherwise, it is difficult, if not impossible, to have serious attention paid to the fact of the feelings and the experience of life that comes with mental illness.

The point of this person's paper is that there needs to be a way for people who seem to be making it to nonetheless have available to them some attention to their mental health issues even if they no longer present as symptoms that ought to be modifiable by some kind of medication; or, to put it another way, success in the world's general terms doesn't necessarily mean that you have a person who feels whole. Indeed, you may have a person who feels continual, not continuous but episodic, need for some attention that doesn't necessarily mean just a review of medication but may mean sitting down and saying, "So how's it going? What's it feel like? What is it we need to talk about?" If you'd keep that in mind when you read the person's paper, I would appreciate it.

I'm a clinically trained mental health chaplain. I currently serve on the Durham Advisory Committee on Homelessness. I chaired the Niagara District Health Council's plan to redevelop and redeploy mental health services in the Niagara Peninsula. So I come from a background which perhaps makes me unusually comfortable in dealing with people and mental health issues. I

also have a clinical understanding of much, but not all, of what I encounter not only among parishioners, but my church is along a route that is frequently visited by itinerant people, not necessarily homeless but frequently between one place and another. It often happens that among them there are mental health issues too, and it's sometimes difficult to know whether the mental health issues they face are largely a result of the itinerant lifestyle or whether the itinerant lifestyle is the result of the mental health issues, and how those things impact.

So I come to you with the familiarity of a clinical background of what goes on among families where adults, children and teenagers as well experience diagnosed mental health difficulties, and I also encounter the homelessness as a regular part of what I do.

That's why I thought my coming to you might be particularly useful to you, because what I'd like to stress most keenly is that from a pastoral standpoint, trying to help people find appropriate services can sometimes be very difficult. There are two primary reasons for this. One is the regulations regarding confidentiality. I understand them all; I don't argue with the need to have good systems of confidentiality. But the simple fact is that sometimes it gets in the way of providing effective help on a timely basis. It just does.

The second is that because the presumed model of mental health delivery in this area is still medical, it's sometimes very difficult to find an appropriate referral. Perhaps that's because of bias against clergy and religion or perhaps it's because of the presumption of the medical model, but again, coming to matters with a clinical background, sometimes I can hear in what people are telling me and know exactly what kind of therapist they need, and I also know of what therapeutic biases I would rather this particular person didn't have to deal with. But it's difficult to find out who possesses those biases, what kinds of treatment modalities a person will experience and what the reception will be at a given institution. I say that not because I expect a legislative committee to be able to solve that problem, but simply because I think it's useful for you to know that for somebody who is in the community system but who is not, myself, a medical provider, yet who nonetheless is expected by a considerable number of people to be able to offer some kind of intelligent help, this makes it difficult. It would be nice if there were a way for—well, you know how if you go online, it is possible to know what the expertise and the technical and academic backgrounds are of physicians and things like this? Maybe this will sound silly, but it would be nice if somebody would just write an essay on what they do and don't like in mental health patients.

It's a serious fact, for example, among GPs, that there are those who, as they set up a new practice, interview patients, and are stating quite explicitly that they are less interested in dealing with the elderly with chronic problems and even less interested in dealing with mental health patients, on the assumption that there's someplace else for them to go, and that's not necessarily true.

From my parishioners, specifically, aside from my own observations, I want to bring to you the following

things—and I want to close by offering some praise in four or five directions. One is, the least expensive treatment on an individual basis is to refer somebody to something that's paid for by OHIP. Generally, that means a psychiatrist. A psychiatrist generally means attention to medication; it's less likely to mean attention to the wholeness of the person, talk therapy, that kind of thing. What a lot of people need is the talk therapy, and they don't necessarily need to have the medications reviewed. There needs to be some kind of a way to make talk therapy more affordable to the general person, with or without regard to whether they have group health insurance or private health insurance. Getting talk therapy if you're on private health insurance is just a laugh. And by talk therapy, I mean the Ph.D. level. Yes, you have CSWs and MSWs, but not all of them are actually trained in talk therapy. OISE doesn't train a lot of people in talk therapy even if they're Ph.D.s in psychology. I think there needs to be a re-examination of the usefulness of talk therapy, and I say that coming out of 30 years of clinical background.

The second thing I'd like to bring to your attention is that there's great confusion among people who deal with suicidal loved ones. When they try to bring them into hospital to get them held for a while, when they look desperately for some assurance that the person is not going to come home tomorrow and try again, that kind of assurance is absent. Again, I've worked within the system on the wards and I understand the difficulty in interpreting and making decisions about this, but there has to be a way to help families get a better understanding immediately as to what it is they're dealing with with a loved one who has attempted suicide. If the person is going to be discharged tomorrow because, in the opinion of the psychiatrist, the person does not really represent a potential harm to himself or others, there's got to be a way to explain that. And if it isn't something the psychiatrist has time for, then maybe there's somebody else within the psychiatric system who can have that responsibility. But honestly, to listen to families who live in permanent terror about loved ones who have tried suicide is very, very difficult. While I believe profoundly in the power of prayer, it's not always adequate to people for their comfort and their assurance of the future to say, "I'm praying for you." There needs to be something more concrete in addition to that and it needs to come from the system.

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The third is confidentiality. Again, I understand the need for it; I do. I've worked with enough abused people that I understand the reticence to let parents know about what their kids are doing and why. But you know, sometimes even people who are adult children will go into hospitals for emergencies and it's not just that the families will not be notified but when the families eventually find out and come to find their loved ones in hospital, they leave with the impression that they were really rather stupid for having expected that somebody might want to notify them that an adult child has gone

into some kind of crisis. There really needs to be more sensitivity to that. Everybody who does this stuff is intelligent. Surely there's a way to get around rigid confidentiality rules, isn't there?

The fourth has to do with bureaucratic parameters. Compassion and mercy can be overridden by catchment areas, age criteria, programs for limited varieties of diagnoses, and simple funding limitations. I run into this all the time in trying to find appropriate referrals to people: Yes, they qualify because they meet these standards but they don't qualify because they don't meet those standards. There needs to be a way to give intake clinicians a way to have more latitude. At the very least, I would like to see intake offices in our institutions required to keep track of who they turn down and why. By "who," I don't mean personal identity; I mean, what was the presenting crisis and why was that person turned down, and some information about where the person was referred to instead.

I've asked this question many times of the different helping services with which I deal, and they don't know who they turn down and they don't know what happens to them. I suggest to you that there's not a comprehensive way to understand what our mental health delivery services should be if we don't know that information.

Fifth has to do with lack of communication among institutions. CAMH does wonderful programs. So does Centenary. They don't know about each other. Nobody knows what Whitby is doing since its reincarnation. They just don't talk. And for a person who's trying to refer, because I deal with parishioners at CAMH, Whitby, Centenary and St. Mike's on a frequent basis, it's going to drive me nuts, and it's really hard on them.

I have experienced with parishioners a lack of professional understanding and tolerance of mental illness by ER staff and EMS staff. It's surprising to me. I have been with parishioners who have had to wait five or six hours at a major hospital downtown for a "psych consult," and the psych consult usually has had more to do with the medication than with the person. I know that there are efforts, particularly out of St. Mike's, to try to address that. I know they have a chair of suicidology that is providing lectures and grand rounds and things, but the people I go with are not necessarily experiencing that.

An interesting contrast: Having sat with parishioners waiting in the ER at St. Mike's—here's one of the praises—I've been absolutely astonished at the skill and carefulness with which some of the security staff at that hospital have dealt with the mentally ill whom they've encountered. It's just really astonishing to watch the gentleness and the kindness and the lack of physical aggressiveness that I've seen. I know about the stories early on. I just want to say, I've sat there; there's some good stuff that goes on.

By the same token, it's astonishing how unpreoccupied with physical security your downtown hospitals are, and again I'll point to St. Mike's. You walk into any of those doors that you get into and you're very seldom going to encounter looming, large people who

look like they're there for providing security. You know you're being watched from somewhere but it's not threatening—the second point of praise.

Back to the complaints. I was at a conference that was offered for families of loved ones who had made at least four attempts to commit suicide. I was invited along with the family at St. Mike's. One of the things I was told—we did a rotating of tables to talk with different people in the conference—one of the things that I heard most consistently from them was the frustration they experience at having to act crazy in order to get the levels of support they need when they're not quite ready to break out of the support system and on into the economy, particularly in regard to ODSP. The impression of these people was that they're being watched very carefully, and if they look like they're improving an iota, they know they're going to be tossed out of the system, and they know that their own bouts of depression are so episodic that they can't count on being able to take care of themselves next time. To have to fake an act in order to get financial support so that they can otherwise keep on improving on themselves is terribly denigrating. That's just something I've been hearing consistently.

The final one is the lack of appropriate supervised or mentored living environments for people who are okay sometimes. Again, these are folks who recognize within themselves that they'll probably never be able to be consistently independent, and they need to be able to live in an environment where somebody knows them well enough that when they watch them go out the door, they can tell the difference between the depressed state and the "I'm okay, Jack" state and can inquire, "Have you been staying on your meds? Has there been a crisis? Has there been a death in the family?"—a death will knock your wheels out from under you no matter what your mental state otherwise—and can kind of help the person reflect on whether everything that that person is planning to do for the day is really going to be adequate for the needs of living independently.

I have a parishioner in such a situation. It took me two years to get him there. He had great difficulty in other kinds of environments, and I'm just profoundly appreciative of the fact that there was anything that was willing to take him in.

The Chair (Mr. Kevin Daniel Flynn): Could you summarize, Reverend Brown? We're getting right near—

Rev. Glenn Brown: I'm on my last two compliments, okay?

The Chair (Mr. Kevin Daniel Flynn): You're doing great.

M^{me} France Gélinas: End on a positive note.

Rev. Glenn Brown: Well, yes, ending on a positive note.

I have noticed the new ACT teams; I've encountered them with two parishioners in the past year. While you'll notice in the written paper I circulated that particular person is not appreciative of ACT, I've been very impressed because I can compare it with what was going on earlier. I have found the ACT teams to be as quick and

responsive as they promise. I have found them to listen as well as one could hope as to what is really going on. The two parishioners with whom they've dealt, of whom I speak, felt that they were being taken seriously, that their needs were being regarded, and this is probably miraculous: In both cases, the ACT teams were actually able to get adequate attention from psychiatrists at the appropriate hospitals on a timely basis. That's just really, really impressive.

I guess I did do the other compliments earlier, so I'm done.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. That was a great presentation. Unfortunately we have no time for questions, but we do appreciate your attendance here today.

Rev. Glenn Brown: Thank you.

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

GORSKI CENTRE FOR APPLIED SCIENCES

The Chair (Mr. Kevin Daniel Flynn): Our final presenter of the morning is from the Gorski Centre for Applied Sciences. Wayne and Greg, if you'd like to come forward.

Mr. Wayne Blampied: Greg will be helping me today.

The Chair (Mr. Kevin Daniel Flynn): Great. We'll give you a few seconds to get set up, then.

Mr. Wayne Blampied: I'll just start by reading the first page.

We provide web-based educational and self-awareness tools that are accessible anywhere, any time for clients as well as their support network—their family, their peers—and support workers as well. It's not treatment that we provide. What we're looking at is trying to augment treatment and to provide a continuum of care for people in mental health and addictions.

We believe very strongly in peer support. Our tools are available for peer support. We think that the educational component is what's missing from some of the peer support programs, that without consistent education there can be some misunderstanding, or some information could be misconstrued. So we're looking at a peer support education program but also with self-awareness tools, which are a way to communicate a client's well-being between himself, his peer support network and the counsellors.

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We strongly believe that what we offer is not treatment, the reason being that we believe that a trained professional needs to be involved before it can be called treatment.

The head of our company, Terry Gorski, has written 130 books on mental health, mostly focused on addiction, though. He is recognized as a leader in relapse prevention. Dr. Grinstead has a program that is focused on addiction-free pain management. We are combining the two. We're also looking at trying to integrate more mental health programs into our offering.

Again, we do not provide treatment. There are some programs online that can represent themselves as treatment. We feel that, again, if there is no professional involved, there is no treatment.

Again, because it's web-based, it's available anywhere there is computer access.

We believe in providing support, educational and self-awareness tools, not just to the client but to their peer support and especially their families. Their families are often confused, lost. They're looking for information. They may not be willing, unfortunately, in some cases, especially in addictions, to seek the help from the addiction treatment centre, but we can provide them something online so they can start understanding the disease of addiction and also look at the roles they play in the addiction and perhaps in their own behaviours towards that person that could be making it worse or causing problems within the family.

We look at expanding current programs, not changing what is already there. What is already there is working well, in our opinion, but we want to enhance it, especially in the area of pre- and post-treatment. With recovery being a five-year period at least, for addiction, and treatment being limited to one to three months, there is a large amount of time where we feel that education and self-awareness would be appropriate. So we're looking at offering this in a continuum of care.

We also look at pre- and post-treatment, especially pre-treatment, as a time in which the person is struggling. They want help, and unfortunately, they may be wait-listed and it could be weeks to months before they're actually going to make it to treatment. We see this as a golden opportunity to start the educational and self-awareness program, reducing the amount of education required then in treatment and enhancing the therapeutic content that would be available during treatment.

Again, we're looking at trying to convert wait times into an education, into an opportunity, because they really are. It is a period where these people are ready, they want help and we can bring them into, I believe, an educational and self-awareness program which would also involve peer support, which would, I think, enhance that greatly. So they're actually doing a lot before they're going into treatment.

The moment of crisis is the biggest opportunity, at least for addiction, so we're looking at offering our programs right from home, homeless shelters, hospitals, chemical withdrawal centres. Anywhere there's a crisis, if there's a computer with web access, they can access our programs and start learning, at least, about addiction.

We have mental health and addictions programs under the single, one umbrella, so we are truly concurrent.

Often in an addictions setting, a person will go in for treatment and receive some concurrent treatment, but perhaps not at the level they require. We can augment that treatment, while they're in there, with an educational process specific to the individual. So somebody with a high level of anxiety, that may be something they can actually start learning about through an educational

process and self-awareness tools, and work with their counsellor on their anxiety at the same time that they're in for addiction. The same is true for any other disorder—perhaps depression as well.

We also give the tools to the client so they're doing their own assessment. That empowers them to look at their behaviour and the results of that assessment, and by repeatedly doing the assessments over and over they start to take ownership of the results of those assessments and start taking ownership for their treatment, and they start looking at it differently. Rather than, "Fix me," they start to take the attitude of, "I want to be fixed. How can you help me?" Then they start looking out through these programs, because we have a myriad of programs. We're looking at eventually having 60 small programs so that they can actually go shopping and augment their own treatment. The core treatment would remain the same, but they could get their special needs met.

The self-awareness program is based on cognitive behavioural therapy. By having them ask themselves the same questions over and over again, they start breaking through their denial and start seeing the reality, but they also take ownership. The most powerful question we had in one of the inventories was, "Are you an addict?" Most people would put a number from zero to 10. When that number was written down and they had to put the number in and click it down, they took ownership of that number. The same with anxiety: We found that people who would answer the question, "I can manage my own anxiety," or "I can do things to manage my own anxiety," when they put a number beside that, they took ownership. So we're looking at trying to put the client in charge of their own treatment and, through the use of this tool, integrate it to the existing services.

Our programs are extremely extensive. We want a client to be able to come to us and be able to pick up everything they need, but also, if they realize that their needs are beyond what this tool can do, because education and self-awareness is only going to help somebody with a mild problem, it's going to empower them to look for solutions. If there is a problem that is beyond what education and self-awareness can do, then there will be a way to get further treatment through recognized treatment centres that already exist.

We would love to provide early intervention programs on addiction education. I think this is where education could be the most powerful, in schools. When someone gets in trouble with drugs or alcohol or behavioural problems, an educational intervention could be the first phase, and a self-awareness process.

Also family programs: Many of the families struggle with a lack of knowledge around their children's behaviours, their children's addictions. They suffer almost as much as the person themselves, sometimes more, because the child, especially an addict, is medicated. The parents aren't medicated, and if we can educate them and bring them into the understanding, they can start doing things to protect themselves but also to understand what's going on.

Judicial programs: We believe that our programs could be used in court diversion. Some of our programs are in line with programs that are being used in California right now. Rather than have people doing community work, they could possibly be instructed to take an addiction education program in a supervised site and have to graduate from that as part of a judicial program, perhaps.

We'd like to see this available through community centres, Ontario Works centres, children's aid societies, as well as shelters. We have talked with the Salvation Army about perhaps putting it into Gateway, so that would at least be available to people who are homeless so they can start the educational process.

There are many programs I think that this could actually be integrated with, and the education will become the forefront of the process.

Our programs are written at a grade 5 level. We anticipate a lot of cognitive difficulties. Generally most content on the Internet is written at a grade 5 level, so we've simplified the programs. Some of the programs we evaluated, it would take a college level to understand them, and that's not going to help our people.

We can also translate into other languages. Of course, we would love to be able to adapt it appropriately to different cultures within Canada.

We provide remote education and self-awareness. Along with some of the tools that are available now—online counselling, for instance—treatment could be provided into the most remote areas of Ontario. We extend the reach of existing services. Quite often, somebody will go to a very good treatment centre, spend three months there and then leave and have to go home, miles and miles away, and they've kind of lost contact. With this tool, by taking it before treatment, during treatment and then taking it home with them, they feel like they're still connected. Especially through the self-awareness inventories, they could be remotely monitored by their counsellors to see if they're at risk of relapse. By their completing the self-awareness inventories on a daily basis, those inventories can be used to determine the wellness of the person who has completed treatment for an extended period after treatment and proactively call them back in, if need be.

We're writing programs currently for the military, so we adapted their motto: Leave no one behind. The military program we're developing is based on "train the trainer," where we're going to go through, and everyone in the military will be taking the post-traumatic stress disorder program. It destigmatizes because everyone has to take it. At the same time, once we get one class through, that class will take the next class through. We've developed a program that is very easy to run. They can take it with a limited amount of background. Then the self-awareness inventories will be monitored by the counselling services in the military to determine if further action is appropriate. If not, then the peer support will be effective enough.

I have a few more minutes, I guess?

The Chair (Mr. Kevin Daniel Flynn): You have about two minutes.

Mr. Wayne Blampied: Are there any questions?

The Chair (Mr. Kevin Daniel Flynn): Perfect. I think we were going to start with this side first. Christine or Sylvia? We probably have time for one question.

Mrs. Christine Elliott: You were talking about the possibility for remote learning. I was wondering if you have any programs operating right now in northern Ontario, in any of the fly-in communities, for example.

Mr. Wayne Blampied: We had a program running for a few months, a very small trial, in South Cochrane Addictions Services. We've had our first graduate, who did very well. Actually, the results were forwarded to the Ministry of Transportation and her licence has been renewed. What they like about it is the flexibility—this is a working woman who has a family—to be able to take it during their own time.

Mrs. Christine Elliott: Is that a contractual arrangement, then, through the federal government?

Mr. Wayne Blampied: No, it wasn't. It was a free trial we offered to her, so there was no responsibility on the ministry to accept it, but they did accept it.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): We have about a minute left. France, did you have a question?

M^{me} France Gélinas: Yes. I'm just curious to see, right now, how do people gain access to your program? How does it work?

Mr. Wayne Blampied: Actually, people are sent an activation code, and then they set up an anonymous ID. So the whole system is anonymous. We don't know who is who. The only person who will know who that client is is their counsellor or perhaps their peer support worker. It's sent through e-mail, they activate the account and then they simply log on. There is no software that they have to download or anything like that.

M^{me} France Gélinas: I come from northern Ontario, and I'm guessing that you need high-speed Internet.

Mr. Wayne Blampied: It does work on dial-up, but it's relatively slow and a lot of people have not been happy with it, honestly.

M^{me} France Gélinas: Who pays for the service?

Mr. Wayne Blampied: Currently, we're looking at a subscription to the individual, the client themselves.

M^{me} France Gélinas: And what is the price?

Mr. Wayne Blampied: Currently, we're running at around \$50 a year.

M^{me} France Gélinas: To subscribe? And if they're being followed by a counsellor, then the counsellor has access to their account?

Mr. Wayne Blampied: What happens is, the counsellor has to contact us and we have to get something in writing from the client allowing the counsellor access. Then we will grant the counsellor access.

M^{me} France Gélinas: Okay. Where do your clients come from, mainly?

Mr. Wayne Blampied: A lot of them are people who are in recovery already who realize that they've come in through a 12-step fellowship and they never got the educational process. The other area is referrals through

counsellors that we've been in contact with. We have some down in California who are ex-offenders, and it's part of their parole program. So a variety of referrals, actually.

M^{me} France Gélinas: And has it been translated into French already?

Mr. Wayne Blampied: No, it has not. We're still under development. French will be our next language.

M^{me} France Gélinas: And you offer your services in the States?

Mr. Wayne Blampied: Yes, as well as in Britain.

M^{me} France Gélinas: As well as where?

Mr. Wayne Blampied: In Britain. Right now our major focus is the military, and that will support the affordability for the addiction treatment providers, because we know that funds are rather limited in the market.

The Chair (Mr. Kevin Daniel Flynn): Our time is up. Thank you very much for your presentation. Thanks for coming today.

We're recessed until 1 o'clock. Enjoy your lunch.

The committee recessed from 1154 to 1302.

GARY ROBINSON

The Chair (Mr. Kevin Daniel Flynn): Okay, let's call to order. Thank you very much, those people who are waiting for us to get going.

Our first speaker of the afternoon is Gary Robinson. Gary, if you'd like to come forward. You have a choice of seats. If you want to grab some water, I'll go over the rules for the benefit of those other people who perhaps are in the audience and who will be speaking later.

Everyone has been assigned 15 minutes. You can use that any way you see fit. If you want to leave a little bit of time at the end for any sort of a discussion, question and answer, that would be good too. Other than that, it's all yours. Have a seat; make yourself comfortable.

Mr. Gary Robinson: Good afternoon, and thanks for taking your time to spend with me. It's an honour to be in a room with such luminaries.

My name is Gary Robinson. I struggle with severe mental health challenges. I've been involved with the mental health system for over 35 years. I'm considered a consumer-survivor and have recovered from my illnesses. I believe I'm a consumer surviving, and not recovered but recovering from them.

I must admit I'm the exception, not the rule. I take my medication, which of course is the golden rule. I take handfuls of medication. I have a phenomenal support system, meaningful relationships and meaningful activities.

That's not to say it's been without a lot of struggle. I've had very dark days in my life. I've had physicians who were detrimental to my well-being. I have been poked and prodded, and I have tried wild cures and medications with horrible side effects. I do get admitted to hospital once or twice a year, and I kind of feel, well,

you've got to make hay while the sun shines so you do your best in those times out of hospital.

I'm a firm believer in first-episode psychosis interventions and, in particular, peer support. I would have benefited tremendously from those interventions.

That's all I have scripted.

Wait times in a hospital's emergency room: awful. Not the time you spend before you see the crisis nurse—because you have to be medically cleared by a doctor before you can see the crisis nurse, and the crisis nurse will then speak to the psychiatrist on call. But when you're put in a cell—that's the only way I can describe it—it can make you, pardon the expression, go nuts even more. A camera's staring at you sitting in one chair in a room the size of anybody's bathroom. It's intimidating, and some people cannot handle it. Then it becomes an issue and they have a violent patient on their hands. That's one thing.

I don't believe you should be—how can I put this? I think you need to be supported when you walk into that emergency room. I think you need peer support, someone who can say, "I've been there, done it; I know what you're going to go through."

It breaks my heart to see 19-year-olds being escorted up to the psych ward, because I was them. Like, by the grace of God go I.

Every mental illness is very particular and unique to each person, so you can't really put people in pigeon-holes. You can't use a tool to decide what this person is going to do or benefit from or whatever.

As you probably know, medications are only a treatment; they're not a cure. There's no blood test to determine which medication is going to work for you. No one can say. It takes years.

I've been extremely fortunate. I'm married; I have two great kids. They've been the best support I've ever had. I consider myself extremely—well, it's a dream come true for me, because there was a time when I thought I wouldn't make it past the age of 21. My teenage years were a total washout. It was a time when no one talked about mental illness. I missed most of high school but, thankfully, graduated from high school.

Stigma? Huge, because when you see a person, you see how they are around you, how they react to you. No one knows what's going on inside someone else's head. Sure, you can have experience as a doctor or psychiatric nurse that, "Okay, this is generally what happens," but it is so individual. Nurses in the ER—just horrible things they say. Because I work in the hospital that I spend time in once or twice a year, it's rather difficult for me, but that's where I got my start.

At any rate, as I say, I am the exception. I believe in peer support wholeheartedly. I think, for myself, I have so much to offer. It just hasn't been coming to me, so to speak.

My medication is extremely expensive. Hospital stays, as you know, cost thousands of dollars a day.

The ACT model is a good model. It's expensive, I know. It's sort of like, as you probably know, a hospital without walls. That's a very popular thing to say.

I know people from 30 years ago, when I was in the system earlier, who haven't changed at all. They still have concurrent disorders that beat alcohol or drug abuse. That is something I can't speak to. I've never had any experience with addiction or concurrent disorders.

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But one thing that I did have, and that I think has carried me through, is hope. I know I'll get better after that stay in the hospital. I know I'll get out of the doldrums. I know that things will get better. But I've been through a lot, and I think the opportunity to speak here is phenomenal. I just speak for myself. I don't have any charts or graphs, I don't have statistics, I don't have models, I don't have anything like that. I just wanted to come here to let you know that things do need to change, definitely—the budget's always a problem or an issue—but I think things can be done with early episode psychosis. I was 15 when I was diagnosed and nobody knew what was going on. They really didn't. I said and did and thought awful, awful things.

I'd like you to ask questions, actually, so have I got time for questions?

The Chair (Mr. Kevin Daniel Flynn): The time is yours.

Mr. Gary Robinson: Thank you again for listening to me and I hope we have time for questions. That's me.

The Chair (Mr. Kevin Daniel Flynn): You've left a lot of time for questions. I forget where we left off. Why don't you start, France?

M^{me} France Gélinas: Thank you for coming, Mr. Robinson. If you feel the questions are too personal, feel free to say, "I don't want to share this," and we'll move on. The first one is, you mentioned that you'd like early episode, first episode intervention—I forgot how you called it.

Mr. Gary Robinson: Psychosis.

M^{me} France Gélinas: Yes. What is it in this program that you like?

Mr. Gary Robinson: Early intervention psychosis: If you have someone like myself, who hasn't had any treatment—because you don't know what to do. You haven't had any treatment, you haven't had any experience, so you tend to lift away, become accustomed, if you're psychotic—you kind of do that—and you will pick up mannerisms and things, especially for parents who don't know what they're going through. So first episode psychosis is to catch these people and their families and support them, and it has been proven. Early episode psychosis programs are popping up all over the place. It's where you nip it in the bud, so to speak.

M^{me} France Gélinas: Okay. You mentioned that you have to take a lot of medication and it's very expensive. Who pays for your medication?

Mr. Gary Robinson: My insurance company through work.

M^{me} France Gélinas: You have private insurance?

Mr. Gary Robinson: Mm-hmm. And that's another thing: I know these insurance companies say that they

don't have a lot of money, but I've cost Sun Life quite a few dollars.

M^{me} France Gélinas: It's what they're there for, I guess.

You talked about some of your personal experience when you needed to go to the emergency room, and the wait and the environment in which you had to wait. Is there a better place to access the health care system than the emergency room? Or is the emergency room where it should be, just in a different environment within it?

Mr. Gary Robinson: For me, I go to a medication clinic once a month to get refills on my scripts, but maybe that's a good place for the psychiatrists—just a clinic atmosphere, just a drop-in kind of thing. I think you can keep tabs on people. They've got a community support team. I've never been involved in that, but they keep a close eye on people. I, because of my experience, know when I need to be in hospital. As I say, the support network includes everyone from my wife, my kids, my friends, my doctor—

M^{me} France Gélinas: But you're at the point where you know that you need more help than you can get at home, that you need hospitalization. There's no way for you to get admitted without going through an ER?

Mr. Gary Robinson: I haven't—

M^{me} France Gélinas: That's the way the system works, so that's—

Mr. Gary Robinson: They prefer you to see the psychiatrist, and hopefully he can assess you over a couple of weeks and say, "Look, Gary, you need to be in," but—

The Chair (Mr. Kevin Daniel Flynn): Okay. Let's move on to the next questions. Maybe you can answer that at the same time. Liz?

Mrs. Liz Sandals: Actually, I wanted to follow up with your comments on peer support, because you talked about the value of peer support and getting support and understanding from someone who's already been through it. How would you organize that? How would you manage linking someone like yourself up with someone who is having a first episode or needs some understanding?

Mr. Gary Robinson: I think the Canadian Mental Health Association in Oakville does some of that, and the society for schizophrenics. I have personal experience with being a mentor, if you want, to a young man who was very ill. I don't want to blow my horn, but now he's in third year law at Queen's, and he has said many times that I saved his life. Obviously I don't believe that, but that's what he says. We're still in contact. I just met with him again last week. Just the fact that you can say, "I've been there. I know it," says more than an education. Statistics say that a peer can connect with a mentee, if you will, more so than it would take six months for a doctor or a nurse to do the same. Just to be able to say, "You're not alone," that's the biggest thing, because mental health is still a stigma. Unfortunately, the people who care for you probably have the biggest stigma.

I've heard and read some of the transcripts from these meetings and I see a lot of people complaining—no, I shouldn't say that; that's not right. It's a lot of people struggling and butting heads and not getting this and not getting that. I think you have to co-operate with the system to get anything out of it. People who don't take their medications—well, I'm sorry, but taking the medications is going to help no matter how bad the side effects are. But you've got to get the person to take their meds—

Mrs. Liz Sandals: And that's maybe something that you can help people understand, what are wise courses of action or not from the perspective of someone who has been through the experience.

Thank you very much for coming and sharing your story with us today.

Mr. Gary Robinson: Thank you very much.

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

Ms. Sylvia Jones: Mr. Robinson, thanks for appearing. I wanted to go back to you—you mentioned that you were diagnosed at 15. So I'm assuming there were some family supports at that stage.

Mr. Gary Robinson: No.

Ms. Sylvia Jones: Okay.

Mr. Gary Robinson: My parents had no idea what was going on. They never had any experience with mental health in my extended family.

Ms. Sylvia Jones: Were you living with your family at the time?

Mr. Gary Robinson: Yeah.

Ms. Sylvia Jones: The reason I'm asking is, we've had a couple of presenters talk about the challenges that they were dealing with with privacy issues. I'm wondering if that ever came up in your—

Mr. Gary Robinson: Well, it depends what you want it to be when you talk about privacy. At work and in my general experiences in life, it's not a secret that I have a mental challenge, but no, I don't—

Ms. Sylvia Jones: I'm thinking more in terms of your family being included in the diagnosis treatment plan, any of that.

Mr. Gary Robinson: They weren't, not at all. And it caused some rifts in my family, for sure.

Ms. Sylvia Jones: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. I know we've spoken before.

Mr. Gary Robinson: Yeah, at your constituency office.

The Chair (Mr. Kevin Daniel Flynn): That's right. I knew your story and I was trying to think where we talked before now.

Mr. Gary Robinson: That's right. Thank you all very much.

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

Mr. Gary Robinson: Is it okay if I sit and listen?

The Chair (Mr. Kevin Daniel Flynn): You spend all the time you want. We're staying till 4. You can stay as long as you want.

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416 COMMUNITY SUPPORT FOR WOMEN

The Chair (Mr. Kevin Daniel Flynn): Our next presenters this afternoon are from the 416 Community Support for Women group. We've got Rosie Smythe, Alex Branston and Rajini Potechin. If you'd like to come forward and make yourselves comfortable. There are a number of microphones there.

Ms. Rosie Smythe: Thanks so much for having us today.

The Chair (Mr. Kevin Daniel Flynn): No problem at all. Make yourself comfortable.

Ms. Rosie Smythe: Okay, I guess I'll get started. My name is Rosie Smythe, and I have with me Alex and Rajini. Alex and I work at 416 Community Support for Women. It's a daytime shelter for women in Regent Park. Rajini is a medical student from St. Mike's hospital and she did a study with our women. It looked at their level of satisfaction with medical services, both in our agency and outside. Alex talked to many women who come to our centre just to get a voice of theirs here today and to get their suggestions, so she'll talk to you about that.

In order to give you some context, I'll briefly tell you what we do at 416. We offer an array of services to marginalized women dealing with mental health and addiction problems. We offer breakfast and lunch for up to 100 women a day. We have showers, laundry facilities and a weekly food bank. Most of our women live in the area and they are aging; most of the women are over 45. Our staff help the women manage their money, and we run an ID clinic.

We also happen to have a medical component, which includes two family physicians. They run clinics twice a week in our centre. We have a registered nurse on staff. We offer one-to-one mental health and addiction counselling as well. We do this all in partnership with numerous community agencies and services.

That's just very brief. I didn't want to take too much time to go over our services, but I think you have a bit of an understanding there of what we do.

Our women are pretty marginalized and aren't women who usually get to have their voices heard, and that's what we wanted to do today: bring forward some of their thoughts. Alex, did you want to talk about what you found out?

Ms. Alex Branston: Our clients like the idea of accessing walk-in clinics; then they don't have to go to the ER. They like having medical staff in the drop-ins in the community. They'd like to receive more respect and compassion from health care professionals. They would like to be treated with dignity and understanding.

Some women suggested that the system needs to be sure there are advocates for vulnerable individuals. They feel that they are being treated unfairly due to their housing status. One woman asked for equal access to service: They feel that they are waiting too long for services with lengthy wait lists. This woman was actually talking about

having to wait 90 days to get into an addiction treatment program.

I'd like to now read some quotes that I took in talking with some of our women:

"When you are poor and a woman, the medical system often considers mental health before health issues." That is, health care staff often see a poor, dishevelled woman and assume she's there because of her mental health issues instead of medical issues.

"I just lost my husband three months ago from cancer. We had to wait five to six weeks to get him a bed on a palliative care unit. The staff were very kind to me and my husband. But it seems ridiculous to have to wait so long just to go somewhere to die."

"I like that 416 offers a psychiatrist, a foot doctor, two medical doctors and a nurse. It makes me feel the same as everyone else and that we are being treated equally."

"I live alone and sometimes I have really horrible anxiety attacks. I don't want to go to Gerstein or the hospital. It would be nice to have more mobile crisis teams that could come to my apartment and help me through my anxiety."

"I feel that we had a better health care service 10 years ago, but due to budget cuts our health care service has declined."

"I like that I can connect with addiction counsellors who will support me before going into treatment, help me get into treatment and then work with me when I've finished treatment."

"I went to the ER once and was treated like dirt. I think it's because they thought I was homeless."

"I have hep C stage 2. I need treatment, but cannot receive treatment until it's at stage 3 hep C. What are you supposed to do, just wait until it gets worse?"

"I think because I'm homeless and living in a shelter, it makes people think they can treat me like garbage because I don't look that good."

"I want to get clean, but waiting to get a bed at a withdrawal management centre is hard. I can't stay clean long enough."

"I have been given five different mental health diagnoses from different doctors over the years. Everyone wants to give me new meds to try. Thank God, I am covered by ODSP or else I wouldn't be able to have the medication. But I still don't know which doctor was right about my diagnoses."

I'd like to turn it over to Rajini.

Ms. Rajini Potechin: While I was at 416, I really wanted to understand the advantages of providing a regular source of care to homeless women within the centres like they do, because it's been found previously that this will result in less unmet health care needs. These women are more likely to seek preventive health care services, and more likely to express satisfaction. In my mind, these were particularly important in these cases because there were mental health and addiction concerns.

My research question was comparing the satisfaction and accessibility associated with health care services

within and external to the 416 drop-in centre. My population was homeless adult women.

I had a small sample size and interviewed 17 women. I measured satisfaction with care using the homeless—a satisfaction-with-care scale—and accessibility by asking questions such as, "How many times have you used these services in the past? Would you use it in the future if you had concerns?" I compared the services that Rosie mentioned that are within the centre to their responses with the services outside, including hospital visits, outpatient visits, ER visits and government-funded home care.

I wasn't expecting a statistically significant difference because of the small sample size. There was greater accessibility—again, not statistically significant. But I was very surprised to see that there was enormous difference in the satisfaction and that this was significant despite the extremely small sample size.

The scale is broken up into various themes, and this is particularly seen in themes such as trust, as in they trusted their provider and felt the provider trusted them; inclusionary care—there were fewer barriers to them in accessing the care; respect; and assumption-free care.

I then wanted to understand a little bit more about what's worked for 416 and why the clients are so much more satisfied with this care. I think there are two big reasons. One is, as I mentioned, that barriers were broken: The medical clinic is on-site; there is an ID clinic there, which is a big barrier—often these women lose their ID or it's stolen; the clinic offers flexible schedules, so the women can come at any time within the time frame that the doctors are there; blood work is done on-site; for prescriptions, the costs are covered and the staff will pick them up and hold on to them, so the barriers with mental illness that are involved with drugs are eliminated as well; and there are escorts for hospital and clinic visits.

The other big reason is that it fits into this multiple-access care. This overlaps with the barrier reason because there are often daily pressures that take priority for this population. So the centre helps clients cope with their symptoms and solve their practical daily problems by teaching cooking and offering laundry services. The centre also has interventions to help their clients' social environment, such as helping them solve their housing problems and helping them with money management.

I think these are a big part of the reasons why these women find these services much more accessible and are much more satisfied with them.

The other thing that I think is important with this population is to encourage these individuals to vocalize their concerns and feel like a part of the process.

I think that's all from me.

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Ms. Rosie Smythe: We just wanted to finish with some suggestions and, as staff who work at 416, we have a few points we want to present.

The first one is that we wanted to suggest that the system look at securing affordable and supportive housing. This is essential for this group. Without this, they

really don't have a chance to overcome their addictions and/or their mental health problems.

Ms. Alex Branston: I had a client who I was referring to treatment. She desperately wanted to get clean. She was homeless and living at Fred Victor, but due to her housing status, she had a terrible time following through with the pre-treatment requirements and, ultimately, sobriety.

Ms. Rosie Smythe: For our women who are housed, most live in terrible conditions in city-owned buildings with all sorts of other people dealing with mental health and addiction problems. This can make it very difficult for them to remain sober following treatment, or to even maintain a goal of harm reduction. They need safe, clean housing, dispersed throughout the city.

It was reported in the Star on September 1 that the Dundas-Sherbourne corridor, where 416 is located, ranks number one in the city for violent offences. It makes it a very unsafe environment for our women to live in.

I'd also like to suggest that hospitals and community agencies really need to collaborate in order to provide holistic supports and services to people. As a community agency, we have put effort into trying to form partnerships and alliances with hospitals, but it has proven somewhat difficult. I think community agencies work fairly well together, but it would make the system more streamlined if efforts were put into promoting and supporting collaboration between hospitals and community organizations.

Ms. Alex Branston: We would like to suggest the importance of including front-line staff in the planning of the future health care system. We are the people dealing directly with the clients, and therefore feel that we are in a better position of creating dialogue with consumers about their needs from the health care system.

Now, 416 is fortunate enough to have medical services for our clients and other local individuals on-site. This allows our clients to have regular contact with a family physician, no matter what their housing status is. We would like to suggest that you provide leadership in setting up this type of model of multiple access points in the community. We feel that this would provide for a more coordinated system.

Ms. Rosie Smythe: We feel strongly and want to urge you to put forward an effort and/or funding into educating the general population regarding addictions and mental health. Our clients continue to be subjected to discrimination, including the criminalization of their behaviours associated with these disorders.

Ms. Alex Branston: We would also like to suggest that you invest in a mental health and addiction promotion approach to strengthen public perception that freedom from addiction and mental health are integral to their overall health. We certainly work hard at putting this forth in the work that we do, but think that a government effort would be worthwhile as well.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left, I think, time probably for one question. Somebody from the government side: Helena?

Ms. Helena Jaczek: Thank you. Well, you've certainly showed us—we've heard quite a bit about multiple access points, depending on the population, and obviously you are fulfilling a real need for the women that you're looking after.

Are you funded by any particular government ministry? Were you a pilot project? How did you get started?

Ms. Rosie Smythe: The agency was started 25 years ago by a woman named Joy Reid. She was the founder. She was able to access salary dollars, so all of our staff are funded through the Ministry of Health, through the LHIN. But our operating funds we get through fundraising, and it's a really difficult task for us. It's not easy because women with mental health and addiction problems are often very misunderstood and not really a favourite charity. It's a very specific person with a background and understanding about addictions and mental health who has been able to help us.

Ms. Helena Jaczek: And are the physicians billing OHIP?

Ms. Rosie Smythe: Initially, the physicians came in and they actually ran these clinics for free. They weren't paid. Now they can get paid through an inner-city fund through—I think it's the city of Toronto which has set this up, so if any inner-city doctor is connected with a hospital and runs these clinics, now they can get paid. But it's a more recent thing. Also, in terms of the medications we talked about, the doctors donate money for our clients to get medications. For most of them, that's where the money comes from.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Excellent presentation. Thanks for taking the time.

Ms. Rosie Smythe: Thanks so much.

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is from—

Ms. Silvia Kendall: May I just approach for a minute? I just want to say that this group here is amazing and they show within their program the nurturing that is needed. I would also like to mention that it's not just for women. It's for the men out there as well.

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

Ms. Silvia Kendall: And I thank you for your time.

DAVID HEATH

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is Dr. David Heath. Dr. Heath, if you'd like to come forward and get comfortable. There should still be some clean glasses there if you need any water or anything. I think you were here at the start when I was talking with Gary and was saying everybody gets 15 minutes and you may use that any way you see fit.

Dr. David Heath: Good afternoon, ladies and gentlemen. Thanks for the opportunity to present my ideas. Believe it or not, this is the first time, after knocking on the doors of the provincial and federal governments, I've been able to talk to anybody about what I'm talking about today.

My name is David Heath and I'm a psychiatrist in the Waterloo region. I'm going to talk for 10 minutes and leave five minutes for questions. I did have a previously written submission which I trust you all have. I also brought some other material which I think Ms. Sourial has distributed. You don't need to look at it. It's background except for the top two figures of the material I brought today. I'm going to be referring to those, so I hope you have those.

My submission relates to number two of your terms of reference, which is to explore innovative approaches to delivering services in the community. In particular, I'm going to focus on a service that's an alternative to hospital admission, and the innovative approach I will talk about is what I call mobile crisis home treatment.

Today, I want to leave you all with one idea: The Ontario mental health system needs to develop a community-based alternative to the practice of admitting patients to a hospital psychiatric ward when they are in a crisis. This would be best accomplished by short-term, intensive treatment in the patient's own home. By "home," I mean their home, but it also includes temporary homes. We've treated homeless people in shelters very successfully. This short-term, intensive treatment is mobile crisis home treatment. For short, today I'll just call it home treatment.

My credentials today for talking to you about this are two. One is, I started the first home treatment service in Canada 20 years ago this fall in Kitchener at Grand River Hospital. Secondly, I wrote the first book on home treatment, called *Home Treatment for Acute Mental Disorders: An Alternative to Hospitalization*. This was published by Routledge in New York in 2005. I've left you with some information about the book. Now, I'm certainly not here to try to sell you folks my book, but I do get asked about it. Also, quite frankly, I hope it adds some credibility—the book and the reviews—to what I'm talking to you about today, which is why I gave you the information.

So why do we need an alternative to hospitalization? The reasons fall into four broad groups.

The cost of hospitalization: Mental disorders are no slouch when it comes to driving up hospital costs. If you look at table 1—this is from the Canadian Institute for Health Information, CIHI; the 2004-05 figures. Of the 15 medical conditions, not just psychiatric, that cost the most in a year to treat in hospital, mood disorders ranked number 6 out of 15. Schizophrenia and delusional disorders ranked number 12.

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Table 2 comes at it a different way. It divides expenditures into what are called clinical chapters. This means groups of diseases of each organ system, like respiratory diseases etc. You can see that of the 20 chapters, mental and behavioural disorders ranked sixth out of 20.

The second group of reasons is patient and family preference. My experience and studies indicate that most people prefer to keep their normal life on the go as much as possible, even when they're in a crisis. You've likely

been hearing about the influence of the recovery movement on mental health services in this committee, and avoiding hospital is consistent with those principles.

The third group of reasons is that hospital is just not a good fit for numerous groups of patients. These are many. They include recent immigrants who don't speak English, senior citizens, mothers who've just had a baby and have a postpartum disorder, first episode psychosis, as mentioned by the previous speaker. Some patients, like those with borderline personality disorders, actually get clinically worse in hospital. At the other end of the spectrum, local doctors, nurses and VIPS like yourselves often feel acutely uncomfortable on a psychiatric ward.

Fourthly, in some parts of Ontario there are insufficient beds. The last page is a comparison of the Ontario recommended ratio of beds to various cities in the world.

How does home treatment work? There's a patient in crisis in a psychiatrist's office, a family doctor's office, an emergency room or a mental health clinic. The clinician considers that they need hospitalization. Normal procedure, as we've heard discussed earlier, is to send them to the ER. Sometimes you can bypass that by calling the psychiatrist on call to arrange admission.

With home treatment, a proportion of those patients—and I'll say how much later—can be diverted to home treatment and bypass the ER. The same clinician, instead of phoning the ER, phones the home treatment team, who will go to the patient's home that day or the next day, depending on circumstances. The team sends a worker or two workers who visit daily. They can even visit up to three times a day if necessary. That's very rarely needed. There's some kind of 24-hour emergency coverage supplied and psychiatrists regularly make home visits. Psychiatry is not high-tech, so any treatment you can get on a psychiatric ward you can get at home, except for locked doors, physical restraint and close observation.

The treatment in home treatment is the same as hospital. It's usually a combination of medication, practical help with the many social problems that these patients have, and counselling. There's a very large emphasis on recruiting the natural supports of the patient. There's a huge emphasis on working with families. They don't need to live with the patient and the natural supports can include other people such as friends, college roommates, neighbours, a landlord. Length of stay varies. Four weeks is common, but it can be shorter or longer.

Home treatment can also be used to drastically shorten hospitalization. Let's face it, many times you cannot avoid hospitalizing a patient, but some patients settle down after just one or two days on the psychiatric ward, settle down enough to be transferred to home treatment.

What about the research evidence for home treatment? There are about 14 studies over 40 years in five countries on four continents—the last one, and the best one, was in 2005—all showing the same thing: that about 37% to 50% of patients destined for hospital can be treated in home treatment. The results are the same in terms of symptoms, functioning, risk of suicide, harm to others. Usually patients and families prefer this, and it's about

40% cheaper. Some cases of involuntary hospital admission can be avoided. Just because you refuse to go to hospital doesn't mean you can't be persuaded by a skilled professional to accept treatment in your own home.

What's the international experience with home treatment? Australia was the first to adopt this nationwide in the late 1990s, mainly in the states of New South Wales and Victoria, where it's part of the routine mental health system.

England is unique, though. I have never seen this with any other model of treatment, in which a country decrees, as the English did in 2001, that there should be nationwide adoption of this home treatment model, where it's called crisis resolution teams. They decreed that there should be 335 services created throughout Britain—there were already some services leading up to that—with an expected 30% reduction of pressure on hospital. Since then, naturalistic studies have shown reduction of admission in the northeast of Britain—Yorkshire, Newcastle region and Birmingham—of 37%, 45% and 50%. Some wards have been closed.

So how about Canada? There are four home treatment services in Canada. To my great surprise, when I read the Romanow report on the future of health care in Canada—I don't know if you're familiar with that, the federal Romanow report, from 2002—there was a highly specific mention of home treatment. There was no reference, and I've not been able to speak anybody in the federal government as to how it got there or what they want to do with it. It doesn't seem to have had any influence.

There are four services. The first one is called the Hazelglen Service, at Grand River Hospital in Kitchener, established by myself in 1989. Then we opened a branch in Cambridge across the 401 in 1998; in 1993, at the University of Alberta Hospital in Edmonton; and in 2001, at the Royal Jubilee Hospital in Victoria. In 2006, the Fraser Health Authority in the communities of Langley and White Rock/South Surrey had two pilot programs. They've been using my book for their steering committee and staff, and I included an e-mail from those people.

In conclusion, I'm suggesting that the Ministry of Health adopt a policy in which clinicians are encouraged to avoid thinking of hospital automatically when faced with a patient in a crisis, and instead consider whether the patient before them can be treated in the community, and that home treatment be the principal model to use. They should take a leaf out of Fraser Health's book, start two or three pilot studies, one in a rural area, one in a medium-sized town or one in Toronto, relate it to one of the terms of reference, leverage—I think it may be possible to leverage some of the mobile crisis teams in the province, which are quite different, into home treatment teams, where they would be more useful.

I have some time for questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you. I'm going to start with one. I haven't asked a question all day today, so I'm going to start with one question.

Dr. David Heath: Okay.

The Chair (Mr. Kevin Daniel Flynn): When the committee was in Kingston, I think we heard from the

former chief of psychiatry at Kingston General Hospital and he said that everybody talks about a shortage of psychiatrists in the community. He used his own city as an example. He said, "In the city of Kingston, we've got over 40 psychiatrists, but less than 10 of them will see patients." The other 30 of them are doing research work at Queen's, presumably. If it's hard enough to get psychiatrists to see patients in the first place, how could you convince a psychiatrist to get into what I understand you're proposing, which is sort of a mobile method of treatment, if they won't even see people in their own offices these days?

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Dr. David Heath: As I say, our program and the one in Cambridge—our program has been there 20 years. We've had no trouble getting psychiatrists. I'm semi-retired, so we've been able to find other psychiatrists. You have to pay them sessional money; you can't just bill OHIP, because there is a lot of non-face-to-face work. So there has to be adequate sessional money or a salary. Fee-for-service will not fly, but you can combine it, which is what they do in Kitchener.

The Chair (Mr. Kevin Daniel Flynn): Okay, the idea sounds great. The idea sounds wonderful.

Dr. David Heath: And it's actually very fascinating work. If you provide them with an adequate team and a rationale, I think you can get them to do that.

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

Let's go on to either Christine or Sylvia. Do you have questions? We've got time for probably two questions.

Ms. Sylvia Jones: Just to follow up with what the Chair was referencing, with your program in Cambridge, have you been doing sessional money through OHIP or how are you doing—

Dr. David Heath: Both, for 18 years: sessional money plus OHIP.

Ms. Sylvia Jones: And that was a special arrangement that you were able to work out with OHIP when you set up?

Dr. David Heath: Oh, no. Most psychiatrists now who work in hospitals get what's called sessional money for the non-OHIP work they do. There's nothing unusual about that; it's been there for years. It's no different.

Ms. Sylvia Jones: Thank you.

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

M^{me} France Gélinas: I saw that Hazelglen has been evaluated, and certainly with flying colours in the review. Were you involved with this review? I was curious to see how many patients had been evaluated to give—

Dr. David Heath: It wasn't an academic—the hospital had a program evaluator and she evaluated it. The people you treat, would they really end up in hospital if you weren't there? You never really know. So we measured how sick they were, and there's a measurement where you can compare your patients with patients in a psychiatric hospital in the US, a famous one, McLean Hospital. So 85% of our patients scored severe; 61% of McLean Hospital in-patients scored severe. It was a high

level of improvement and satisfaction. There was that kind of evaluation.

M^{me} France Gélinas: So when you were first setting up, and I guess even to this day—how does the primary physician in his or her office decide they are a candidate for the at-home service versus no, they really need to go to the hospital? How was this knowledge—

Dr. David Heath: You have to do a lot of education, but also it's frankly trial—I wouldn't say trial and error, but people have to get to know the program and you develop what I call a brand image, because at first the ER physicians weren't too happy about sending patients, but now they just love us. But you have to sort of show them by experience and education, repeatedly.

M^{me} France Gélinas: Where would you say your clients come from right now? Are they mainly the ER physicians who refer or are they family physicians who refer, or where else?

Dr. David Heath: It's changed a lot. When we first opened, we actually couldn't get referrals in the hospital even though there was a desperate bed shortage. It's hard to believe. We got self-referrals, and from various people—teachers, home care nurses. Now they tell me—I haven't worked there for two years—it's mainly from the ER and from some family doctors.

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

DOWNTOWN GUELPH FASD SUPPORT GROUP

The Chair (Mr. Kevin Daniel Flynn): Our next presenters today are from the Downtown Guelph Fetal Alcohol Spectrum Disorders Support Group, Mary Cunningham and Shiona Watson.

Ms. Shiona Watson: Hi. Good afternoon, everyone. I'm Shiona. We're here today because we want to talk about the importance of including a large population of people with fetal alcohol spectrum disorders in this initiative and to tell you about why that's so important. I facilitate the caregiver support group in Guelph for those living with people with fetal alcohol spectrum disorder. I also do education and advocacy around this. I'm also the mother of a 14-year-old boy who has fetal alcohol syndrome and is profoundly deaf. We're people who live the experience of mental health issues in the community.

My husband and I adopted Mikey when he was 18 months old. We knew that he had fetal alcohol syndrome and we read all the books and we talked to people already living the experience. I always say that we kind of went into it with our eyes wide shut, because really, we knew nothing at all.

My son's birth mother, just to let you know how this played out, was abandoned by her own mother when she was three years old. She was physically and mentally abused by her father. She was left at the age of 12 to live with her next door neighbour, who sexually abused her. The social workers who worked with this lady were pretty certain that she also had fetal alcohol spectrum

disorder, according to her behaviour. There was no doubt that she loved her son, but she couldn't look after him. She had four other children before my son and she didn't have custody of any of them because of all the issues that she lived with. His birth father also—both of them were alcoholics, and he had other mental health issues too, including ADHD, and spends a lot of time at the Maplehurst corrections institute.

Ms. Mary Cunningham: I'm Mary Cunningham, and I'm a colleague of Shiona's from the downtown support group. I'm also a fetal alcohol spectrum disorder advocate and educator. I became this after we experienced FASD in our family. We adopted our second child when she was 13 weeks old and we knew absolutely nothing about FASD until she was 18. When she was 18, we discovered FASD for the first time and it was just like walking face first into that wall over there. It was stunning. It totally incapacitated us. We knew there was something terribly wrong, but we had no idea what it was. So after I more or less recovered from that, that's when I—I'm a retired teacher and I just kept on teaching. So I present in various provinces and was in the UK this spring doing this.

FASD has huge implications for the success of this Every Door is the Right Door initiative, because there are thousands and thousands of people with FASD in Ontario. It represents a reservoir of mental health issues because almost every single person with FASD will develop mental health issues. They are costing, on average, at least \$2 million each over their lifetime in extra social costs—you're basically hemorrhaging money here—and they're not getting the kind of treatment they need to keep them from developing addictions, to keep them from developing homelessness and so on and so forth.

Shiona and I are going to pass this back and forth to make it a little more interesting. Everything we're more or less saying is in the handout you have; all these children on the front have FASD. You also have a little book from the Public Health Agency of Canada, because we could spend all day talking about this and we'd only get started.

Shiona's going to lead off.

Ms. Shiona Watson: First of all, why is the recognition and understanding of fetal alcohol spectrum disorder so crucial to the mental health and addictions initiative? Fetal alcohol spectrum disorder is the most common birth defect in Canada, bar none. That's according to Health Canada. This is almost twice as many as have autistic spectrum disorder and between seven and eight times as many as those born with Down's syndrome.

Ms. Mary Cunningham: It affects at least 1% of all live births in Canada. That's what Health Canada's actually saying now. We know that's a very conservative estimate. At 1%, there are 130,000 Ontarians living with it, but in the field, it is suspected that it's probably 2% or 3%. So multiply 130,000 by two or three times \$2 million and you know why we have to do something about

this, plus the fact that it's really going to affect this initiative. If you understand it, it's going to work a lot better.

Ms. Shiona Watson: Although experts in the field currently say that there's roughly 1%, we do need an awful lot more research in the area, more studies and definitely more diagnosis. Trying to get a diagnosis in Ontario is extremely difficult and very frustrating for parents. There was a recent study, which has not yet been published, I believe, in Grey county, where they were isolating in utero alcohol exposure by—well, I'm going to say meconium, so they were guddling about in babies' diapers, basically. They reckoned that 4.17% of all the infants in their sample were alcohol-exposed. Now, this study only identified exposure after the 13th week of pregnancy. For all the women here, you know how long it takes before many of us know that we're pregnant, especially if we're young or we're not counting periods or we're on the pill or other birth controls that may not be effective at that time. So, many of the infants would be missed by this crucial time.

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FASD is usually misdiagnosed. Frequent misdiagnoses are ADHD and autism spectrum disorders. One clinical psychiatrist and FASD researcher from Northern Ireland, Dr. Kieran O'Malley, says, and I'm quoting him, "FASDs are the greatest clinical masqueraders, and their most common disguise is ADHD." That's from 2007.

Ms. Shiona Watson: So the same psychiatrist, Dr. O'Malley, says that FASD is often mistaken for ADHD because it looks like ADHD. However, the big problem with getting those two things mixed up is that the treatments would be very, very different. When we treat people with ADHD, we make an assumption that they can learn from consequences. This is something that is very difficult, if not impossible, for many people with FASD to do. This means that their mental health outcomes are very poor. It's very nice for families to think that their child only has ADHD, but the reality is that it's going to lead to very poor mental health outcomes.

Ms. Mary Cunningham: Noted FASD expert Dan Dubovsky, from the States, notes that often women who have mental health disorders—and we know that a lot of these are genetic, including depression and bipolar—drink to self-medicate and they become pregnant and they are still drinking in the pregnancy because it's self-medication. Consequently they are likely to have babies who have FASD and mental health disorders. It becomes a very vicious cycle.

Ms. Shiona Watson: Most people with FASD—that's between 90% and 95% of all of them—have no recognizable facial features or any other medical anomalies to let you see who they are. All they have are the dysfunctional behaviours, which we tend, as a society, to see as just bad people. FASD becomes an invisible disorder.

As Mary indicated, all the photographs on here, including that of my son, are of people living with FASD. Some of them have features and some of them do not.

Ms. Mary Cunningham: It also shows an awful lot of individuality. You can't go through a population and say,

"I know, I know, I know." There's a laundry list of symptoms. Consequently you can have very, very individual manifestations of it, but you almost always have dysfunctional behaviour.

Ms. Shiona Watson: Almost all adults with FASD, diagnosed or otherwise, will develop mental health problems, according to a study that Dr. Ann Streissguth, one of the leading researchers in FASD, did in 1996.

Ms. Mary Cunningham: These mental health problems tend to be very complex and frequently feature drug and alcohol addictions. In the field we have traditionally called both of these conditions secondary effects of FASD but now—I've been in this for about 10 years and now we're starting to see research showing that basically the mental health disorders are probably caused by the alcohol in utero. There's a lot more to go here. This is early times.

Ms. Shiona Watson: Dr. Kieran O'Malley again refers to this constellation of FASD, mental health disorders and addictions occurring together as "the triple threat of FASD." What he means is that a majority of people in this population, many of whom will be undiagnosed, are going to develop the mental health problems and addictions, and will be very difficult to treat.

Ms. Mary Cunningham: Common secondary effects with this are disrupted school experience; early dropout; sexually inappropriate behaviours; trouble with the law, often featuring recidivism; trouble staying in relationships; and trouble staying employed. You'll see these are our big, serious social problems. That's where the \$2 million is coming from.

That \$2 million, by the way, was a Dr. Sterling Clarren study and it didn't include legal costs for incarceration, so it's actually higher than that.

Ms. Shiona Watson: There's a very high rate of completed and attempted suicidal behaviour within this community. This appears to be related to an inability to cognitively understand the finality of completing suicide. It's also combined with the FASD impulsivity and high rates of self-injurious behaviour, which may unintentionally cross the line and result in accidental suicide.

Ms. Mary Cunningham: The secondary effects, as I just mentioned, are all recognizable as the biggest, most expensive and intractable social problems. Mental health is very often at the root of an awful lot of this. If we could understand how to intervene successfully in the life of a child who has FASD, we could prevent most of these.

Ms. Shiona Watson: And many of the adults with FASD have experienced physical, emotional and sexual abuse as children and may also suffer from post-traumatic stress disorders in addition to the FASD.

Ms. Mary Cunningham: Children in foster and residential care often have an FASD. One study in Ontario found that 31% had an FASD. One social worker from Alberta who often does work in Ontario estimates 80%. One young woman in care went through approximately 75 placements before her FASD was recognized. She is

now in a much more supportive environment, but consider the mental health ramifications of that.

Ms. Shiona Watson: Co-occurring mental health diagnoses are common with FASD. Dr. Kathryn Page from California calls this an “alphabet soup of diagnoses”. She lists the following as common diagnoses given in addition to or in place of FASD: There is ADD or ADHD, various forms of depression, reactive attachment disorders, conduct disorder, borderline personality disorder, obsessive compulsive disorder and oppositional defiant disorder.

Ms. Mary Cunningham: Some of the above are real, co-occurring disorders and some we consider misdiagnoses. Dr. Page theorizes that as a person, usually the caregiver, goes from clinician to clinician basically saying, “You’ve got to do something about this child. Give me something because their behaviour is really difficult to deal with,” that’s where we accumulate this huge list, this alphabet soup.

Ms. Shiona Watson: Many people with FASD would qualify for what’s called a dual diagnosis if in fact they actually had a correct FASD diagnosis. The National Coalition on Dual Diagnosis in Canada notes, “Those with dual diagnoses”—that is, developmental disorders and mental illness—“are often denied services because they are too complicated to treat.”

Ms. Mary Cunningham: As Shiona mentioned previously, getting a diagnosis of FASD is very, very difficult. It’s very difficult in Ontario. It’s very difficult across Canada. It’s a complicated diagnosis. It needs a multi-disciplinary team of medical and psycho-social professionals.

Ms. Shiona Watson: The research shows that children with FASD who are diagnosed prior to the age of six—there we go. We were just telling you how difficult it is for anybody to get a diagnosis and now we’re saying that we need them to have a diagnosis before they get to age six. Then, if they do not have that diagnosis and they are not supported, they tend to develop many, if not all, of the secondary effects of FASD. This seems to be related to the fact that these children received services that supported their needs much earlier, that is, if they were diagnosed before age six.

Ms. Mary Cunningham: Changing the topic slightly here, what you have to understand is that all people who have FASD have permanent brain damage and it usually affects the following areas, any one or all of them: cognition and effective decision-making, adaptation—that’s probably the most complicated effect—attention, reasoning, memory and language development. The language development is odd in that people with FASD are often extremely good talkers. They’re able to talk the bark off trees basically, but receptively, they’re not getting the message. We have teachers who say to us, “Listen to them. How can anything be possibly be wrong with them? Listen to them talking.” But it’s not getting it.

Ms. Shiona Watson: The majority of people with FASD show only dysfunctional behaviours in the five areas noted above and they receive no support or

understanding that it’s permanent brain damage caused by alcohol, that that’s what’s causing their behaviour. There’s a tendency in society to believe that behaviour is something that we always have control over, but for people with brain damage, that simply is not true. They look instead as non-compliant, uncooperative, resistant, manipulative and unmotivated.

Ms. Mary Cunningham: As I said, most people with FASD can talk the talk brilliantly, sound like they know what they’re talking about, but because of the brain damage, receptively, if you ask questions, they’re not going to understand what they said. This gets them in trouble all the time. They sound a lot more functional than they actually are.

Ms. Shiona Watson: Another huge issue with this population is that mostly the IQs are above 70, which is the cut-off for many, many services that they could have been eligible for. So although these people have an IQ above 70, they often are not very good at being able to make any kind of use of that. Ninety-one per cent of children with ARND—that’s alcohol-related neuro-developmental disorder; essentially, that’s FASD without any identifiable features—have IQs of between 70 and 130. Without these services, obviously these children, and later when they become adults, are at greater risk of depression and other mental health issues and addictions because their self-esteem and confidence in their own abilities are so low.

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Ms. Mary Cunningham: Most people with FASD would like to be able to behave properly and fit in. That’s probably their greatest wish: “I just want to fit in.” It is not that they won’t do something; they can’t. They simply can’t do it. Changing this paradigm is one of the critical things we have to do, to understand that they can’t do it, it’s not won’t, and that comes from Diane Malbin, who is an acknowledged expert in this area.

Ms. Shiona Watson: When the brain damage of FASD is not recognized or understood, the standard psychiatric and psychosocial attempts to support a person with it tend to fail miserably. For example, behaviour modification is really useless with this population. Reward systems, relying on learning theory and learning from one’s mistakes: These are all cognitive activities that require good use of the frontal lobes, which is something that people with the brain damage of FASD cannot do.

Ms. Mary Cunningham: Psychiatrists and other mental health care professionals generally do not understand our people, and these apparently non-compliant behaviours of people with FASD tend to get them fired from treatment. They are told to come back when they can comply. Well, they can’t comply, so they’re out of that treatment program and looking for another treatment program. But—

The Chair (Mr. Kevin Daniel Flynn): I’m going to have to jump in there, Mary. We’re a little bit over time, but we do have your last page and we do have all the recommendations you make from 29 to 34. So if you could just maybe summarize really quickly.

Ms. Shiona Watson: We were actually going to finish there, so that's very clever of you.

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

Ms. Mary Cunningham: We were just going to say that we've presented all these negative stereotypes—well, they're not stereotypes; these are all researched. But I have never, ever yet met a person with FASD, and I've met hundreds of them, who did not have an aptitude or a really strong case. So if we could get to supporting that and providing support for the brain damage, then we would be able to do something positive here.

Ms. Shiona Watson: And if we could get everyone in the government to understand what FASD is, that would be a huge start.

The Chair (Mr. Kevin Daniel Flynn): Well, I think you just got eight or nine of them here, so it's a start.

Ms. Shiona Watson: Thank you very much for listening.

The Chair (Mr. Kevin Daniel Flynn): Actually, if you could explain maybe one thing for the whole committee. You talked about a link between FASD and autism. Were you saying that FASD causes autism, or you're saying that FASD is—

Ms. Mary Cunningham: It's mistaken for.

The Chair (Mr. Kevin Daniel Flynn): So we could be treating kids for autism who actually have FASD?

Ms. Mary Cunningham: We can tell you for sure you are.

Ms. Shiona Watson: Lots of them. Because they can get services if they're diagnosed with autism, but not for FASD.

Ms. Mary Cunningham: And frequently, autism is a more socially acceptable disorder to have.

The Chair (Mr. Kevin Daniel Flynn): Yes, we were talking about that before. Thank you very much for coming today. It was good to see you both.

Ms. Mary Cunningham: Thank you for having us.

KEVIN TREGUNNO

The Chair (Mr. Kevin Daniel Flynn): Thank you. Okay, after Mary and Shiona, our next speaker is Kevin Tregunno. Kevin?

Make yourself at home. We've still got some clean glasses if you need some water. Everybody gets 15 minutes, Kevin, so you can use that time any way you like.

Mr. Kevin Tregunno: I've actually prepared a short speech and left lots of room for questions.

The Chair (Mr. Kevin Daniel Flynn): Perfect. Well, I'll let you just handle your own time, then.

Mr. Kevin Tregunno: Okay. I'll begin now.

At the age of 17, I remember reading about schizophrenia in a psychology textbook. It seemed like the absolute worst kind of illness you could get, in my mind. I made the connection due to my own stigma that these were the people who you only ever saw in mental hospitals and didn't see in public. To me, it was the pinnacle of insanity. It seemed so far removed from anything that

could happen to me that it occurred to me at the time that this could never happen to me.

Boy, was I wrong. At the age of 19, I would learn what it meant to be a person with the label of schizophrenia and a recipient of psychiatric services.

I would also learn that this very thing, though bitter, would transform my life into something tremendously meaningful: a life with purpose and promise. Though it took me years to accept this illness due to stigma, internal and external, I eventually found hidden strengths and determination which have, in ways, carved my character and life into this outstanding person who stands before you. I've risen up in the face of poverty, homelessness and despair. I have bounced back from the deep chasms of psychosis, from delusional to inspirational, from thought disorder to enlightened, from isolated to engaged and engaging.

My story, though unique, is testament to other unsung heroes alike who have faced tremendous obstacles and barriers, adversity and strife, yet still have risen up to recreate and recover. My story isn't so much important as is the underlying meaning: that we do recover, and we have a lot more to offer than what was previously imagined.

Right now I work as a peer support worker at the Halton safe beds program. I see the tremendous qualities in my fellow consumers who are not only struggling to discover what life is about; they're discovering what it means to live with a serious mental illness in all its various manifestations. It's not a welcoming feeling.

I believe we need to do more to combat stigma. Part of that could be reaching people in their school years, as early as elementary school. Early intervention is key. There needs to be early detection and intervention in all realms of mental health, not just psychosis but depression, anxiety and addiction. Early detection should start in the schools.

More needs to be done for the youth at risk in these areas: homelessness, addictions and mental illness.

I look forward to the day when the young child who is at risk is supported throughout so that he or she never has to live through what I've been through. No one should slip through the cracks, not in a day like today. There needs to be more support and education for and about mental illness at a younger age so that we grow up knowing at a younger age more about the realities of mental health and addiction.

Combating stigma should be part of early intervention for addiction and mental illness. It involves all of us. I've lived as a person with schizophrenia for 10 years. I've worked in mental health for close to five years as a peer with an education and a purpose. It took me many hardships to get here, and I stand before you now as a witness and a survivor.

I want it to be easier for people just like me who might be overwhelmed with school due to symptoms of their illness. There needs to be more done to help people with serious mental illness meet their goals and dreams, whether that be school or work. Whatever it is, if we're

going to attempt to live on disability and have the incentive of part-time work, then we need better options. We need better opportunities for us to go to school and meet our goals.

I've also worked as a recovery support worker for the early intervention program in Hamilton. I see many people dealing with psychosis who have big dreams but are stuck in some ways with what's offered to help, and it's not good enough. I propose we offer more opportunities for people to work through funding programs that offer a more extensive plan than what employment supports offer, a program with more avenues and more financial support.

I also propose that peer support be made mandatory for every mental health program in the system, from clinical outpatient care down the line to early intervention, from hospital settings to community programs. The help of our peers can mean more than any mental health worker.

Being on disability doesn't offer much promise of an education. It offers just barely enough to get by, and in many cases not enough. Right now, I'm working at CMHA Halton safe beds. I see the people on ODSP, and a lot of them have slim options.

I believe we, as consumer-survivors and those of us witness to this, have so much potential and so much promise despite our illness and the obstacles we face. We have so much to offer, so much to give. We need to be able to have the chance to give and have the help we deserve to get there. I believe that we as people with serious mental illness can do anything we aspire to with the right help and supports.

Being diagnosed with a serious mental illness can act like a wall between you and others in society. We need to break down those walls and build a community where we are respected and appreciated. In my early years, I felt the weight of those walls and it took me years to feel empowered.

My experience as a recipient of mental health services does not end as a consumer and a peer support worker; it's also as a family member. My mother worked as a psychiatric nurse for 30 years. At the age of 57, in March 2009—this year—she lost her job, she lost her house, she lost her car, and she became homeless. She was suddenly a consumer of mental health services—not just any, but the one I work at. As a son with schizophrenia, I reached out to places and I told my story. How did this happen to my mom? Why wasn't she connected with services earlier? It's complicated, I'm sure, but these are the questions we need to look at.

You can bet stigma played a role in preventing my mom from seeking help. She was supposed to be the helper, not the one who needed help. She often talked about never wanting to go to the hospital for this reason. How can homelessness be the deciding factor in whether or not a person gets the help they need? How did her alcoholism and mental health issues and isolation go on for so long? Why aren't services reaching out to people more? Early intervention and detection are key to this,

along with combating stigma and offering more opportunities for consumers to reach their potential.

I believe we live in a society where people with mental illness should not only be understood and accepted in society, but should be appreciated, not just within the segmented mental health system but in all of Canada.

I'll now answer any questions anybody has.

The Chair (Mr. Kevin Daniel Flynn): Thank you. You've left about three minutes for each party. I'm not sure who's first. Is it you, France?

M^{me} France Gélinas: Sure. I'm not keeping track, but I'm happy to go first.

The Chair (Mr. Kevin Daniel Flynn): You're all getting three minutes anyway.

M^{me} France Gélinas: All right.

You mentioned a number of times about how early intervention certainly would have changed the atrocity that your mother went through, and you talked about it for yourself also. Where do you see this happening? Who should be the people doing the early intervention? How should it be rolled out?

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Mr. Kevin Tregunno: I think it needs to happen as early as school years, like elementary school. If, by some kind of campaign, through advertising, reaching kids at a younger age through some kind of activity that the elementary school students could do to learn about people with mental illness, to learn about the realities of mental illness, the statistics about how many are likely to have it and everything—they could make it something fun and entertaining but still learning about it, and then, from there, continue to get educated about it as they grow up. But it needs to become a reality for people, because people are becoming so struck by it that they don't see it coming and they don't expect it and they're not prepared. If we can intervene at an early age, you can ensure that people will have a better outcome.

M^{me} France Gélinas: You certainly speak very positively about peer support. You're not the only one. A lot of people have come forward. Do you have ideas as to how it should be rolled out province-wide, how it should or should not be structured and organized?

Mr. Kevin Tregunno: I don't really have too many ideas around that. I think there should be more opportunities for full-time work, because a lot of the opportunities are part-time or casual. But I think there needs to be more opportunities for full-time. In some ways, I think it might be better if it's standardized and there's training that's standardized throughout the province. I haven't really put all that much thought into it, but yes, I think—

M^{me} France Gélinas: The peer support that you're offering: It's part of your job, or do you do this—

Mr. Kevin Tregunno: Yes, it's part of my job.

M^{me} France Gélinas: It's part of your job. It's not volunteer work.

Mr. Kevin Tregunno: No.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you, France. Let's go on. Who's speaking? Helena?

Ms. Helena Jaczek: I wanted to pick up on the peer support issue as well. We've certainly heard a lot about it. Could you just describe, even for us, how you were trained to be a peer support worker? Obviously, you've got your personal experience, but what sort of training did you go through?

Mr. Kevin Tregunno: I started off with a diploma in recreation and leisure services at Mohawk College, and through that, I volunteered at the disability office at Mohawk College. I was a peer mentor for students with learning disabilities. From there, I volunteered quite a bit. I received training from the Ontario Peer Development Initiative around peer support in Burlington. From there, I volunteered and I got an initial job working at the Cleghorn program in Hamilton, an early intervention program. From there, we worked to develop the role. That's where I really got my know-how and everything to do peer support.

Ms. Helena Jaczek: We heard this morning from the Gorski Centre for Applied Sciences. Are you aware of that particular program?

Mr. Kevin Tregunno: No, I'm not. I'm not sure. Is that in Toronto?

Ms. Helena Jaczek: It's web-based.

Mr. Kevin Tregunno: No. I've heard of it, but I'm not very familiar with it.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Anybody else from that side? We've probably got about a minute left. No? Okay. Christine?

Mrs. Christine Elliott: Just one question: I'm interested in some of the issues concerning the barriers to employment, and I think it's probably fair to say that there's a lot of employer education that needs to happen, but also with the way—we've heard from other people that it's the way that the ODSP payments are set up. Do you have comments that you'd like to make on that?

Mr. Kevin Tregunno: Yes, actually, the one thing that bothers me the most is that if I make over a certain amount of money, I won't get benefits. For instance, if I get a job—when I was working at the Cleghorn, I was part-time, but I was above the limit for ODSP, so that meant I had to pay for my medication, which is a huge barrier because it's not easy. Even with Trillium, it's not easy to pay for your medication. To not have the support of that drug card means that my health is compromised and I can't do my job as well. You know, I ended up leaving for that reason, partly. I mean, that's a major issue, too.

Mrs. Christine Elliott: You'd recommend that's something we should take a look at, then, in terms of the system itself.

Mr. Kevin Tregunno: Yes, for sure.

Mrs. Christine Elliott: Thank you.

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

Mr. Kevin Tregunno: No problem.

MARGARET FRAZER HOUSE

The Chair (Mr. Kevin Daniel Flynn): Our next two speakers today are from Margaret Frazer House: Diane Walter and Elaine Flis, if you'd come forward. Those mics move pretty easily, I think, if you need to pull it closer.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you very much. If you'd introduce yourselves, because obviously there's more than two of you. You've got 15 minutes, like everybody else. Use that any way you see fit. If you can leave some time at the end for questions, that would be great.

Ms. Elaine Flis: Great. Thank you very much. We do have one more person with us today. I hope that it's not too much of an inconvenience, but we did want to bring someone with lived experience with us to share her story.

My name is Elaine Flis and I'm the volunteer chair of the board for the Margaret Frazer House. I'd like to begin by thanking the committee for providing us with the opportunity to make our presentation today. With me is Diane Walter, our executive director, who's to my far right, and Tina Swift, who has lived at Margaret Frazer House and now lives independently.

Margaret Frazer House is a transitional shelter for women with severe mental illness, and we provide a continuum of care for our residents. Diane will speak more specifically about Margaret's itself.

We are putting forward three recommendations to the committee today. Firstly, we recommend that the Margaret Frazer House model be rolled out across the province. As you will hear, our model is unique and successful in helping women with mental illness. Secondly, we recommend that psychotherapy be covered under the Ontario health insurance plan, since we know this is crucial to one's health care and leads to success when used in combination with other medical and pharmaceutical supports. Thirdly, we would like to see mental health parity in Ontario with the United States with respect to insurance companies, so that no one person with mental illness is rejected and goes without. Many therapies can be expensive and out of reach for individuals who cannot afford their prescription medication.

At this time, I'd like to turn it over to Diane to speak specifically about Margaret's and our unique model, which offers women with mental illness a continuum of services. Diane?

Ms. Diane Walter: Hi. Good afternoon, everyone. My name is Diane Walter, and I'm the executive director of Margaret Frazer House, a mental health agency which provides a continuum of housing and supports to women who are living with mental illness and addiction to a lesser degree.

I'd like to give a brief history of the agency. It was started by a group of women which included the late Margaret Frazer and the late, renowned journalist June Callwood. The agency will celebrate its 25th year in

operation. It came out of the shelter—they created a shelter called Nellie’s and they observed that a subgroup of women had presented with different issues than women who were fleeing abusive relationships. The staff and Margaret and June sort of lobbied the then-Conservative government. The then-minister was Larry Grossman. They lobbied really aggressively for funding for an agency. Larry Grossman, in his wisdom, funded 10 transitional beds for women with serious and persistent mental illness. We have grown since then.

We advocate for safe, affordable housing for women that is women-centred and which operates from a culturally sensitive place. This is not only ideal for some, but is recommended for a group of women who are living with mental illness and addiction. We understand that women’s housing needs are distinct from those of men and are embedded within the context of poverty, social, racial and gender inequalities and violence against women.

I’d like to talk about our services. Our model of service is based on a woman-centred care and recovery model. It is an approach to housing and support that emphasizes a client’s potential for recovery. Recovery is seen as an individual journey, a personal journey, requiring hope, a safe and secure base, supportive relationships, empowerment, social inclusion, coping skills and finding meaning. Client-centred refers to a joint participation of the client and the service provider. It requires consumer participation at many levels with a professional and supportive organizational structure and a clear understanding of the population we serve.

We currently have 14 transitional beds, two crisis beds, 20 aging-at-home units in the community and 18 scattered units in the community. All of the above housing and supports are staffed 24 hours to support as needed. Our staff are culturally sensitive. We have a psychiatrist and we work in collaboration with community agencies and the hospitals.

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Our governance model is one that meets the criteria for best practice, but additionally, our board of directors must have at least two consumer-survivors on the board, thus keeping the service accountable and, at minimum, some degree of authenticity in its programming. Our programming includes social recreation, art therapy, a peer support program, French classes that are taught by consumers and a community dining program. Management of the housing and its program is done in a collaborative fashion. Consumer and client voices are heard and integrated into service delivery.

How do we measure success? Well, I suppose, just in tangible ways: cost-benefit analysis. We do exit interviews and the women tell us that we are doing a great job. And we have a waiting list that we—as a matter of fact, we just dissuade waiting lists because we can never meet that demand.

There’s still a dire need for housing and supports for women with mental illness provided like what Margaret’s provides, yet there isn’t enough. I also think women’s

housing was not recognized by the commission and I think that can only be an oversight.

I thank you for listening to me this afternoon. This is one of the forums that will give us an opportunity to talk about the issues of mental illness and addiction in Ontario. I urge us to continue to listen and learn, and then act. Thank you.

Ms. Tina Swift: I guess that leaves me. Hi, my name is Tina Swift and yes, I’m a consumer-survivor at Margaret’s. I’ll give you a little bit of my history and what led me into Margaret’s. I have really severe mental illness and at times have been unable to work. Um, there was one job that I had to leave and I didn’t have any benefits, so here I was living on CPP money—that was \$721; rent was \$500—and I couldn’t afford my drugs. Yes, that was a bit too much. So I ended up in a shelter, and I was so, so ashamed.

As you see, I have a really good education. I’ve had great jobs. Um, to have, first of all, a mental illness take me where it’s taken me and to be in this group that I was in at the shelter was terrifying—it was terrifying. I was introduced to Margaret Frazer House then and I kept on refusing because they, um—I’m sorry there are so many “ums”; I’m nervous.

The Chair (Mr. Kevin Daniel Flynn): We’re all nervous. You should see the job we have.

Laughter.

The Chair (Mr. Kevin Daniel Flynn): You’re doing a great job.

Ms. Tina Swift: Thank you.

I kept on refusing Margaret’s, hoping that I could save up the money again for first and last and be independent again. It never worked. The finances were just the same. So I went to Margaret’s and I literally kissed the floor of the bedroom that I got, because I had a bedroom, I had safety. I got addicted to painkillers a long time ago and I was in recovery in the shelter. It was hard—I had five years, then—and here was a safe place. I didn’t have to keep all my guards up and it was a lifesaver.

Being there was interesting. It challenged all of my preconceptions of mental illness, it challenged me to change my patience level, but it also did give me two lifelong friends and it’s given me a home. I can’t be around my family, so Margaret’s is my family. There’s always somebody there for me. I’ve been away from Margaret’s for a lot of years now and I’m living in one of their independent units with the aging-at-home project.

Margaret’s put a registered nurse back into society and employment. Without Margaret’s, I would have just kept on stumbling along and my good skills would have been lost.

I’m thriving. I know I have the support. I really believe that there have to be more Margaret’s, because there are a lot of women out there who are falling through the system who are professionals, who are mothers, who are just a full range.

Without Margaret’s service, I’d be totally lost. So, yes, it’s a really necessary thing and, hopefully, I’ve made a bit of a difference. Thank you.

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

Ms. Elaine Flis: Just in closing, very briefly, if I may?

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

Ms. Elaine Flis: In closing, I'd like to briefly share my experience with Ontario's health care and insurance systems.

Last September, I was diagnosed with bipolar disorder, after years of misdiagnosis. I'm fortunate to have an excellent health care team that supports me, although there are many gaps in our system. Specifically, I'm a sole proprietor, and as such, I'm denied medical insurance by all companies I approach.

My pharmaceutical bill is approximately \$600 per month out of pocket. My weekly psychotherapy treatment costs \$85. My group therapy is approximately \$200 per month. My total health care bill, in a society that claims to have universal health care, is approximately \$1,200 per month. This is out of reach for most people and why we make the recommendations we do, stated at the beginning of our presentation. If it weren't for family and friends and their support, I would be homeless or worse.

Thank you again for the opportunity, and if time does permit, we'd love to take some questions.

The Chair (Mr. Kevin Daniel Flynn): Well, time does permit.

Ms. Elaine Flis: Perfect.

The Chair (Mr. Kevin Daniel Flynn): It doesn't permit a lot, but it permits some. Why don't we start on this side? Anybody? Liz.

Mrs. Liz Sandals: What you're describing is supportive housing plus treatment. Is there a treatment component at Margaret Frazer House?

Ms. Diane Walter: We have a visiting psychiatrist who comes to the house twice monthly.

Mrs. Liz Sandals: Okay. So in terms of putting together that model, then, which seems to be really successful, of supportive housing and a psychiatrist who's available, where do the pieces of funding come from, what is fundraising and how do you pull this very successful model together?

Ms. Diane Walter: It's a very interesting dance. We're funded by the Ministry of Health. Now the Toronto Central LHIN manages that funding.

The psychiatrist is actually done through a partnership with St. Mike's, through the inner city medical team. The Ministry of Health pays them directly. That came out of sort of a—

Mrs. Liz Sandals: It's a community treatment bucket of some sort and you're on the visitation route?

Ms. Diane Walter: Yes. It was a creative way of having a psychiatrist visit, because we have women who absolutely flatly refuse to go to a psychiatrist or to see any doctors at all. We have a brilliant psychiatrist. She's just wonderful for the job. She comes in and she sees them, and she'll see them anywhere. She actually goes out into the community and sees women in our satellite housing as well.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We'll go on to Sylvia.

Ms. Sylvia Jones: Thank you for coming. I'm not from Toronto so I'm going to ask some questions because I'm not familiar with Margaret Frazer House. You mentioned that there is a waiting list but you didn't really explain that.

Ms. Diane Walter: Well, I guess, why get someone's hope up? In the transitional program, you can stay for two years. The permanent housing, obviously—

Ms. Sylvia Jones: Okay, so your average stay is two years?

Ms. Diane Walter: It's two years, but the reality is, some people do stay longer because you discharge someone and they're going to end up in hospital. You've got to wait until folks are really stabilized before you discharge.

Ms. Sylvia Jones: So you would be encouraging people to look elsewhere for other programs while that list is happening.

Ms. Diane Walter: Absolutely, yes.

Ms. Sylvia Jones: A last, really quick question: Where are your referrals coming from at this point?

Ms. Diane Walter: Primarily, 80% come from hospitals. Some come from shelters and family members, but I would say that between 80% and 85% come from hospitals.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France, you've got about a minute.

M^{me} France Gélinas: Continuing on what Sylvia was talking about, the average length of stay is two years?

Ms. Diane Walter: For the transitional housing.

M^{me} France Gélinas: For the transitional housing, it's two years. Do most of the tenants in your other housing complex come from the transitional housing?

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Ms. Diane Walter: Most of them do. As a matter of fact, that model is really quite lovely because there's a fluidity. If a woman is not doing well in the permanent housing, she can come back to the crisis bed and avoid a hospital stay. I can tell you, hospitals are not fun places to be. So they can come to the crisis bed and stabilize and when they get better, they go back, and there will be staff to visit them in the community.

M^{me} France Gélinas: So how many different levels of support do you offer? I take it that in your transitional stage, it's 24/7?

Ms. Diane Walter: It's 24/7.

M^{me} France Gélinas: And then it goes to nothing at all?

Ms. Diane Walter: And then as needed. With the aging-at-home, that's a very different project. That just started a year ago. It's as needed.

M^{me} France Gélinas: As needed, and the money to pay for the staff comes from the Ministry of Health?

Ms. Diane Walter: That's correct.

M^{me} France Gélinas: Okay, all of it either through the aging-at-home strategy or through the transitional beds?

Ms. Diane Walter: Yes.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for presenting today. You didn't look nervous at all, Tina.

Ms. Tina Swift: I wing it good.

The Chair (Mr. Kevin Daniel Flynn): You did a good job. Thank you for coming.

MARVIN ROSS

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this afternoon is Marvin Ross. Is Marvin here?

Mr. Marvin Ross: Yes, I am.

The Chair (Mr. Kevin Daniel Flynn): Please come forward, pick a comfortable seat and make yourself at home.

Mr. Marvin Ross: My first task is to pull the chair out.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else, you get 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll split that among the parties.

Mr. Marvin Ross: Okay.

The Chair (Mr. Kevin Daniel Flynn): The floor is all yours.

Mr. Marvin Ross: Thank you for the opportunity to present to you today. I'm going to focus on schizophrenia, a topic that I am far too familiar with as a parent. In addition, as a medical writer, I have used my expertise to research the disease and I wrote the book *Schizophrenia: Medicine's Mystery—Society's Shame*. The book has received excellent reviews and I will leave you a copy at the end of my presentation.

The subtitle of my book says "Society's Shame" and it is if we look at some facts about our treatment of the victims of this disease. The World Health Organization states that 44% to 70% of people with schizophrenia receive no care at all.

Dr. David Dawson, a former professor of psychiatry at McMaster and chief psychiatrist at what was the Hamilton Psychiatric Hospital, stated in the preface to my book that "the mentally ill of many western countries are not faring as well as they might have in 1960 or 1970 despite our advances in knowledge, treatment, and our nations' wealth." Michael Wilson stated that only about 25% of those who need treatment actually get proper treatment. There would be a public outrage if these same statistics applied to those with heart disease or cancer.

Wilson also stated that the system in Ontario is based on 30 years of neglect that had led to staff shortages and little evidence-based treatment. And by the way, Wilson co-chaired a series of 11 reports on mental health in this province commissioned by the former Conservative government that was presented just before the McGuinty government took office. I would suggest that you take a look at them, if you haven't already, as part of your deliberations.

A 2005 report by Canada's correctional investigator found that between 1998 and 2004, the number of prisoners with psychiatric illnesses doubled. It went up

50% while the total number of prisoners declined by 12%. This does not mean the criminals are developing mental illnesses; it means the mentally ill are being criminalized. Instead of spending weeks and sometimes months in an underfunded, neglected but otherwise humane treatment facility—a mental hospital—they are being cycled through the courts to jails, hostels and street corners, and back through the courts at far greater expense than good treatment facilities would cost. A Canadian Mental Health Association official, Penny Marrett, said, "Our prisons have become warehouses for the mentally ill due to funding cuts and closures...."

A 2005-06 report by the Canadian Institute for Health Information found that there are significant numbers of homeless people with psychiatric disorders. Many of the people who you see sleeping on sidewalk grates and begging for change not far from this Legislature have untreated psychiatric disorders. They deserve to be treated. Some estimates go as high as 70% of long-term homelessness is caused by mental illness.

A study reported in the Archives of General Psychiatry in 2007 that combined data from 37 other studies in numerous countries found that people with schizophrenia have a death rate two and a half times that of the general population. Another study, in the Journal of the American Medical Association, found that people with serious mental illness lose 25 years of life expectancy compared to the general population. The conclusion from these studies by one of the authors is that this is a "tragic reflection on how sub-optimal our current treatments are."

But none of this has to be. These problems do not exist in the Netherlands or Norway. Yale psychiatry professor Thomas McGlashan said of Norway that any mentally ill person found on the streets would be connected with an outpatient clinic and provided with a doctor and a nurse to ensure his or her well-being. I would strongly suggest that this committee look at what is being done in those two countries.

My friend Ian Chovil, who I have written about, is an interesting case: He spent over 10 years living on the streets with undiagnosed schizophrenia, addicted to drugs and alcohol. In 1985 he was living in his car in Toronto when he was arrested. The court sentenced him to three years' probation and required him to see a psychiatrist. This he did in Guelph. He improved sufficiently that he was able to eventually get a job at the Homewood, a world-famous psychiatric facility in Guelph, and set up and maintain a very good, informative website on schizophrenia. He is now retired, but his website is still on the Internet, and that is chovil.com.

He once commented to me, "It is only too self-evident to me that I have permanent damage that I must live with because I was not treated in the first six months. It is something that I think about every day, something that I have to re-accept every morning."

The longer that schizophrenia goes untreated, the more brain damage there is. The more frequently one has severe relapses, the longer it takes to recover, and that

recovery is not back to the same state the person was in before the relapse.

One of the reasons for this state of affairs is that many in society still do not recognize psychiatric illnesses as real diseases. Look at the recent report called *Every Door is the Right Door*: a commendable attempt to improve conditions, but they talk about prevention. If they truly recognized psychiatric illnesses as diseases, they would not talk about prevention. After all, how can you prevent something when you don't know what causes it? We can prevent a lot of heart disease, skin cancer and type 2 diabetes through lifestyle changes because research has uncovered some of the factors causing those diseases.

Medicine cannot prevent diseases like Alzheimer's, MS or ALS because it does not know the cause. Similarly, medicine cannot prevent schizophrenia, bipolar or depression because no one knows what causes them. We have theories and ideas, but as of now we do not have any understanding that could lead to primary prevention, and secondary prevention is just what I talked about a few moments ago: early diagnosis, early and adequate treatment, rehabilitation and health maintenance.

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Schizophrenia is a disease of the brain that just happens. It is not a "mental health issue," a term that is often used. We don't talk about people with insulin-dependent diabetes as people with pancreas issues. They have a disease. Schizophrenia is a disease that causes, or is caused by, significant changes in the brain. There are well-documented structural abnormalities, neurological abnormalities, neuropsychological abnormalities, electrophysiological abnormalities and cerebral metabolic abnormalities. These changes have been documented in people who have never been treated, although the opponents of drug treatment would argue that the changes are the result of prescribed medicines and nothing else.

Imaging studies of the brains of untreated people with schizophrenia have shown that there are significant differences when compared to the brains of matched healthy people. The effect of antipsychotic drug treatment on these sick patients results in their brains gradually starting to resemble the brains of the normal healthy controls.

The people you see pushing a shopping cart with all their worldly possessions in it while mumbling incoherently to themselves or shouting rhetoric on the street corner, or living in a cardboard carton, are sick. They deserve humane care, humane consideration and treatment, so why aren't we giving them treatment?

A large part of the reason is that we allow them to make their own treatment decisions, something they do not have the capacity to do. Part of their illness is their inability to understand. This is a condition called anosognosia. They are so sick and delusional that they do not know they are sick and refuse treatment, and our society thinks that this is okay.

Most opponents of compulsory treatment cite John Stuart Mill's *On Liberty*. Mill said, "That the only purpose for which power can be rightfully exercised over

any member of a civilized community, against his will, is to prevent harm to others." When Mill wrote that, there were very few medical treatments for anything, let alone psychiatric disorders.

But Dr. Richard O'Reilly, a psychiatrist in London, Ontario, and the former president of the Ontario Psychiatric Association, points out that Mill also said in the very next paragraph: "Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against" personal "injury."

We do that for the elderly with severe dementia and Alzheimer's. We do not allow granny to refuse treatment for her dementia and to live in a refrigerator box outside, so why do we do that for young people with schizophrenia? It is cruel and inhumane for any caring society such as ours to allow people who are sick to remain sick.

In fact, the most effective anti-stigma strategy is not to try to educate the public, but to provide treatment for those who need it. Tragedies like the Virginia Tech shooting or the Greyhound bus beheading only fuel negative views about mental illness. Preventing these events by providing treatment for those who commit them, or who are likely to commit them, does much better.

Psychiatrist Dr. Sally Satel said in the *New York Times* recently, "No matter how sympathetic the public may be, attitudes about people with mental illness will inevitably rest upon how much or how little their symptoms set them apart."

In the western world, with growing affluence and increasing attention to civil liberties, in the 1970s mental health laws changed. They were rewritten to protect individual rights. I am told that the authors of Ontario's Mental Health Act did not expect the results that have become so obvious over the past twenty years. They thought the mentally ill would still get good treatment, but that within that right to receive treatment their other rights would be protected. At the time, cynical psychiatrists often joked about the mentally ill now being allowed to die in back alleys with their rights intact. The laws created due process and caused a careful examination of forced treatment, but were ultimately based on a fantasy that those without insight into their illness could make sound treatment decisions. The result has been that many seriously mentally ill have lost their right to treatment.

In several European countries, the same countries that have excellent social welfare systems, excellent systems for the care of the mentally handicapped, and countries that are renowned for their approach to civil liberties, it has been recognized that we threw away the right to treatment when our laws overemphasized the civil rights of the mentally ill. It is the attitudes, resources, rules, practices and laws of these countries that we should study and emulate.

In conclusion, I would like to pass on some comments from my family.

My wife would like me to tell you that if our health system cannot do a better job of providing treatment for

people with schizophrenia, then we, the families of those individuals, should all be given free antidepressants.

My son works for a psychiatric rehabilitation program in Hamilton as a peer counsellor. A previous speaker talked about peer counselling. The LHIN that is responsible for that program has just cut off their funding. As a result, the clients—and, since you're writing, I'll mention that it's the Wellington Psychiatric Outreach Program—some of them, will lose their support. And the peer support workers, for whom this job helps with their self-esteem and feelings of self-worth, will be unemployed.

As I promised, I will leave you a copy of my book. There is no test, so don't worry when you read it. I'm also going to give you a DVD of a feature film on developing schizophrenia that's going into release in the US in October. It was written and directed by a psychiatrist. It was shot in Hamilton, and it is probably the most accurate depiction of what it's like to develop schizophrenia that I've ever seen. In addition to the 90-minute feature film, there are also three extra scenes that were added to the DVD as little extras that are very, very informative, in my humble opinion.

Thank you for your time. I'd be happy to answer any questions.

The Chair (Mr. Kevin Daniel Flynn): We'd be happy to hear your answers, but we have no time. That was a wonderful presentation, though. I thought it was very thorough. Thank you very much for coming here today. If we can get those books and DVDs from you.

Mr. Marvin Ross: I will leave a copy of the book and the DVD. If you want any more, just let me know. I'd be happy to speak about schizophrenia, the DVD or any other aspect that I'm familiar with. Thank you very much for your time.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Marvin. We really appreciate you coming today.

HOPE PLACE CENTRES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is somebody I know very well, John Challinor from Hope Place Centres, accompanied by a member of the staff. Maybe you can introduce your colleague, John, because we only have your name on the program today. Like everybody else, you've got 15 minutes. You may use it any way you see fit.

Mr. John Challinor II: Thank you, Mr. Chairman. I'd first like to introduce our executive director, Jacque Shartier, who, in addition to managing our business, will be my subject matter expert this afternoon.

Thank you for the opportunity to appear before you this afternoon to offer our insights related to the development of a comprehensive mental health and addictions strategy in Ontario. As Haldimand-Peel's only residential drug and alcohol treatment facilities, Hope Place Centres and its predecessor organizations have given thousands of Ontarians the chance to get their lives back through their significant presence in the community for more than 34 years.

Despite that considerable effort, one in five Ontarians at some point in their lives will experience a level of alcohol and drug abuse that requires treatment. For 2% to 3% of the province's population, it becomes a chronic problem. Some eventually come into contact with the criminal justice system. Almost all fail to achieve their true potential as contributing members of their communities. Because of alcohol and drug addiction, Ontario is spending billions of dollars annually to address lost productivity, involvement in the legal system, extensive medical care and social services.

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Hope Place Centres fully supports the four goals and seven directions found in *Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy*, a discussion paper published in July of this year by the minister's advisory group. However, what follows are seven directions from the board of directors and staff of Hope Place Centres that we also believe are required to help more Ontarians get their lives back:

(1) The government of Ontario should give consideration to developing and delivering ongoing education directed towards students at both the primary and secondary levels of education related to alcohol and drug use. Only through such teaching will young Ontarians come to fully comprehend the consequences of their choice to use drugs and alcohol.

(2) The government of Ontario should give consideration to developing and delivering consistent, ongoing mass communications directed towards all Ontarians regarding the implications of alcohol and drug use. Only through consistent, ongoing messaging will all Ontarians be effectively reminded of the impact of choosing to use drugs and alcohol.

(3) The government of Ontario should give consideration to developing and delivering comprehensive post-secondary education to medical students, including physicians, pharmacists and psychiatrists, regarding alcohol and drug use. Such education should place particular emphasis on providing a level of care that minimizes the prescribing of mood-altering addictive drugs. This training should be complemented by consistent, ongoing communications directed at all practising medical professionals about alcohol and drug use and the life-altering consequences to patients.

(4) The government of Ontario should give consideration to funding ongoing, independent, third party research into drug and alcohol addiction and its relationship to mental health so that more is known about both to inform innovative treatment best practice. Revenues from alcohol and tobacco taxes should be directed away from general revenues and towards alcohol- and drug-related research funding.

(5) The government of Ontario should give consideration to balancing treatment funding of mental health and alcohol and drug addiction, as mental health treatment centres receive more funding today than do alcohol and drug addiction treatment centres. Addiction is a mental health matter. Revenues from alcohol and tobacco taxes

should be directed away from general revenues and towards alcohol- and drug-related treatment funding.

(6) Client treatment: The government of Ontario should give consideration to the following measures, and they are many. You have a copy of them.

(a) Provide base funding for residential treatment service that typically extends beyond 24 days to a minimum of 30 days and a maximum of 90 days.

(b) Provide operating funding for alcohol and drug treatment services within prisons and mental health facilities.

(c) Provide operating funding that enables more timely and frequent drug and alcohol pre- and post-assessment and counselling of clients which addresses both physical and mental health. Such assessment and counselling activity should be expanded so that mental health and addictions workers can visit in homes and institutions to reduce hospital wait times.

(d) Provide full capital funding to residential treatment facilities that wish to expand because they are experiencing growth pressures due to increased substance abuse linked to current socio-economic conditions.

(e) Fund pre- and post-treatment beds in safe and supportive residential environments, such as a withdrawal management centre, which of course Halton doesn't have at this point.

(f) Fund second-stage or post-care housing and beds for recovering clients who are vulnerable because their existing home and/or neighbourhood and/or community environment places them at high risk for relapse.

(g) Fund second-stage or post-care housing for recovering mothers that permits them to care for their children as they progress through their recovery.

(h) Fund recovering mothers and mothers in treatment who require child care support, employment skills training, life skills training, job placement and volunteering opportunities.

(i) Fund day or evening drop-in treatment programs for working Ontarians who are at risk of losing their employment and/or families because of increasingly harmful levels of alcohol and drug abuse.

(7) The government of Ontario should give consideration to providing funding to programs that educate and support families in coping with and/or assisting their loved ones when they are abusing substances, as well as after they have participated in treatment programs.

In closing, the solution isn't just a matter of making a larger financial investment, although more funding is needed. Hope Place Centres believes the long-term solution lies in preventative education, promotion of active individual and family engagement in the treatment process, and support with practical means to make one's way back into mainstream society—a hand up rather than a handout. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, John. You've left a lot of time for questions, which is wonderful. We're going to start with either Christine or Sylvia, if you have questions.

Mrs. Christine Elliott: I just have one, just the inter-connection of the mental health aspect with the problems of addiction to drug and alcohol, the kinds of counselling that you provide. A lot of people say that people self-medicate and so on. Do you delve into the underlying mental health issues as well?

Ms. Jacqie Shartier: We have two residential programs, a women-only residential program and a men-only residential program. We have a medical doctor from Credit Valley Hospital who specializes in mental health and addictions, who comes one day a week. We do a pre-assessment of each client who comes in with him to see what their drug use is. He assesses what medication they're on, if they're on the right medication or how long they've been on the medication, consults with their own doctor, if they've had a family doctor, for a history, and works with that family doctor to balance their medication while they're in treatment and to stabilize them.

Mrs. Christine Elliott: Thank you.

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

M^{me} France Gélinas: I was happy to see that in your recommendation to be more proactive there is a lot of education. You recommend education for schoolchildren, education for the family, mass media education etc. Are there any best practices or are there any examples out there of which you think, "This is really the way we should do things," or "There's a health unit that really has a good message for kids"?

Mr. John Challinor II: Let me answer that first, France.

M^{me} France Gélinas: Sure.

Mr. John Challinor II: I can't use an example in this particular industry but let me use another one. At one point in this province's history—and some of you may have heard this speech before—Ontario had the best mass recycling education in North America; it was in the 1970s. It reached into the schools, it reached the public in their cars, it reached them when they were at home through television, there was newspaper advertising etc. It extended for about 10 years. The province made a considerable investment in it, and I think that is the kind of structure, from a marketing standpoint, that the government of Ontario needs to consider in drug and alcohol education—mass communications.

Ms. Jacqie Shartier: An example I would like to use is smoking. If you look at 30 years ago and you look at today, the impact of the smoking education on children—children today are telling adults it isn't good to smoke. So children are learning about smoking at a very young age when they go to school. If they learn the impact of what alcohol and drugs have on driving from MADD, I think that is a great example as well.

M^{me} France Gélinas: You also made two recommendations that have to do specifically with mothers and women; that is, to be allowed to mother their children, to care for their children, as well as to broaden outside of addiction counselling to employment skills, life skills, job placement. Is this because of a need or—

Ms. Jacqie Shartier: Yes, it's a need. When you have a woman who is coming to treatment, a lot of women coming to treatment are mandated through CAS and sometimes they have the children, sometimes they don't or they're on the verge of losing their children, so if the treatment programs had access to child care support so the children would be able to have access to their mother while the mother is clean and getting healthy and being well—also, if there was more financial support to provide more of resumé writing, clinical skills, where they could get ongoing support after treatment so that they are not coming from a hostel and going back to a hostel. In a 24-day program, when you take a woman from a hostel and send her back to a hostel, her chances of recovery are very slim.

M^{me} France Gélinas: Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. Anybody on this side? If not, I have a question, and maybe we can go back to that side.

People talk about a genetic predisposition to addictions. First of all, from your experience, is that true? If your grandfather was an alcoholic and your dad was a drug addict, chances are you're going to be something or you're going to have a predisposition?

Ms. Jacqie Shartier: There is a lot of research on the predisposition to alcoholism and drug addiction. Dr. Gabor Maté has written a lot about this. There are several other doctors who have done the research on this; I could get the links for you. I believe the apple doesn't fall far from the tree. If you look at anyone who has an addiction and go back three generations in their family, usually there is somebody in their family who has an addiction, and if it isn't an addiction, it is usually sexual or physical abuse that has happened at a very young age, and they have masked that pain to deal with it when it happened to them, when they were very young up until they were adults.

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The Chair (Mr. Kevin Daniel Flynn): Okay, then the question I have, before I go back to Liz, is, as part of the treatment for the clients at Hope Place, do you ask them to speak to their kids? Do they tell them, "Look, I had a drug problem, I had an alcohol problem, and you've got a good chance of getting one as well."

Ms. Jacqie Shartier: Well, not only to their children. We have a family worker who's supported by the United Way—and without that support of the United Way funding that family worker, we couldn't help the family. So it is not only to help the children, but it's to help the parents, because the possibility of the addiction has come from the family. So we bring the family in for a full-day education on addiction and what addiction is, and support the children as well, if the children—we don't have a full program for children, which would be an ideal thing to have in place with CAS, to provide that for the children, because I think it is needed for the children as well. Good question.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you. Liz or Maria?

Mrs. Maria Van Bommel: I just want to carry on a little further with where you started, Kevin, and that is, you talked about—and France talked about it too—your program for mothers in treatment and the idea of having child care and that. What about a program, not just child care in the sense that it's babysitting of the children, but an opportunity to have the children discuss what's happening to them in living in those situations, having them understand what's happening to their mothers and to try and make sure that the family situation changes enough so it's not just mom who gets the treatment, but the whole family has an opportunity to get through this and survive it?

Ms. Jacqie Shartier: That's a perfect example of what is needed in the treatment centres, and I think you won't find that in Ontario, because we're not funded. If we had the funding to support the family, to bring the family in, that is who needs the education to help the whole family.

Mr. John Challinor II: It's recommendation number 7.

The Chair (Mr. Kevin Daniel Flynn): Any other questions? We've got about two or three minutes left, if it has prompted any—let's go to Liz or Helena, whichever.

Mrs. Liz Sandals: I was going to ask about, I guess it's recommendation 6(f) where you're talking about post-treatment care—well, post-treatment housing or beds for recovering clients, because if you send them back into their home environment they're quite likely to fail at their recovery. Is that an issue simply of affordable housing or is that supportive housing? Because there's a difference.

Ms. Jacqie Shartier: I appreciate that question. I know we haven't much time, but if you look at a model in Toronto, the St. Vincent de Paul Society has six post-treatments and they have Ozanam House, which is pre-treatment. You look at the model of that and the success they have with that, that the person waits for up to three months to get into treatment because that's how long we have to wait—three to five months to get into treatment—and then after treatment they go back there and live two years. There's nowhere else in the province that has that model. In the Halton region there is no supportive housing at all for any client waiting to get into treatment or after they leave treatment.

Mrs. Liz Sandals: So it is supportive housing, not simply affordable housing that you're—

Ms. Jacqie Shartier: Yes, supportive housing.

Mrs. Liz Sandals: Okay, thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Helena, we've got about a minute.

Ms. Helena Jaczek: Okay. It's somewhat related. You have a very specific recommendation in 6(a), extending the residential treatment from 24 days minimum to a minimum of 30 etc. If you had this sort of post-recovery or second-stage housing, would you also need that extension in the residential treatment program?

Ms. Jacqie Shartier: How we look at this is, from the 24 days for women and the 90 days for men, if somebody

has had a chronic addiction for 10 years, 24 days is a very short time to be able to deal with that person. The advantage we have with the men's program is that we have 90 days for that person to change their life, to get them volunteering in the community, being part of the community. Twenty-four days is very hard to be able to even get housing or supportive housing, any kind of housing, to send that woman back to.

Ms. Helena Jaczek: Do you know the origin of that difference between male and female?

Ms. Jacqie Shartier: I think what happens is in our situation, the government changed the 28-day treatment program several years ago to 21 days. Hope Place kept theirs to 24 days. So all short-term residential treatment programs in the province of Ontario are 21 days. Halton Recovery House, which is the men's program, is funded as a recovery house, not a treatment centre. However, we've changed it to a treatment centre and sold beds to be able to fund it as residential treatment and kept it for 90 days under the recovery model.

Mr. John Challinor II: To further explain, part of our business is funded by the taxpayers of Ontario and part is funded by EAP, so the private sector as well.

Ms. Helena Jaczek: Employee assistance programs? *Interjection.*

Mr. John Challinor II: And that's how we're able to fully function. That's how we were able to expand recently.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, John.

Mr. John Challinor II: Thank you for your time. I very much appreciate it.

The Chair (Mr. Kevin Daniel Flynn): I knew you'd make a wonderful presentation, and you did. Thank you.

JAMES WEBER

The Chair (Mr. Kevin Daniel Flynn): James Weber is our next speaker. James, if you'd come forward and make yourself comfortable. You know the spiel. You've got 15 minutes—

Mr. James Weber: Fifteen minutes—

The Chair (Mr. Kevin Daniel Flynn): Do anything you want with it.

Mr. James Weber: If you can do me a favour, just flag me at 10, in case I'm going too long, and I'll get straight to the point then and we'll leave some time for questions.

The Chair (Mr. Kevin Daniel Flynn): I will do that.

Mr. James Weber: Thank you very much. My name is James Weber. I'm a project manager within wealth management services at RBC, Royal Bank. I currently reside at 115 Omni Drive, Apartment 1202, Toronto, Ontario, near Scarborough Town Centre. The major intersection is Ellesmere Avenue and Brimley Road.

I'd like to thank everyone for allowing me to share my story today. My story starts 22 years ago, when I met my first wife. Approximately six months after we met, we

were engaged. Soon after that she developed her first episode and I discovered that she had a mental illness called schizophrenia. She recovered within a few weeks, after being stabilized on medication. She was fine for the next two years. We were married. She graduated from the early childhood education program at the University of Toronto as a teacher, and all seemed well.

Over the summer that she graduated, it was suggested that she reduce her medication by taking a vacation from the medication, as advised by her psychiatrist, to avoid any buildup and future side effects, so she did. However, as the medication left her body over the next several weeks, the symptoms of the illness started to return. She became paranoid and finally had a full-blown episode. It was fortunate that I was able to obtain medication fairly quickly and have her stabilized.

Once she started to receive medication again, the improvement was evident. However, this time it was not quite as easy. Unfortunately, she had to leave her first job as a teacher within the first week because she was not fully recovered.

The recovery this time was not the same. She was depressed. On Tuesday, October 24, 1989, she called me at work. She wanted permission to kill herself. Her voice had a strange sadness that was not there before. I went home. She was depressed in a way that I had not seen before. She felt hopeless, struggling with the dark vacuum of thoughts that typically race through the minds of people who have schizophrenia.

While I was in the kitchen, she got up from the couch. She said, "Jim, I have to do it," opened the balcony door and rolled over the edge. That was it.

But actually, it was just the beginning. Two days after her passing away, I received an information package from the Schizophrenia Society of Ontario, which was formerly known as the Ontario Friends of Schizophrenics, that I had mailed away for just a few weeks earlier after seeing one of their advertisements in the subway. I opened the package. Inside the package there was a fact sheet and a recommended book list. I read the fact sheet. Three quarters of the way down the page it identified that 40% of people with schizophrenia attempt suicide, and 10% to 15% succeed. Until that moment, no one, including her doctor or psychiatrist, had identified the risk or provided a book list to help me educate myself about the illness. I do ask myself whether events would have been different if I had been more aware.

However, in life you learn that sometimes you cannot change the past but you can impact the present and shape the future, so that's what I did. I ordered the book list recommended by the Schizophrenia Society of Ontario. I contacted the Schizophrenia Society of Ontario. I joined the local East York chapter. I became involved because I wanted to prevent my experience from being repeated. I wanted to educate families so that they could be better prepared.

I quickly learned that the knowledge about the illness was not only in the books or in the brochures but in the people who are part of the organization and who have

seen and experienced it all, some with over 30 years of experience coping with schizophrenia in their families, and not only with one member but sometimes two or three.

Today we're focused on the future. In the past 19 years that I have been involved with the Schizophrenia Society of Ontario, a lot has changed: medications, treatments and information that is much more readily available. However, we still have a way to go.

Some facts: Schizophrenia is a brain disease. Schizophrenia affects one in 100 people. That translates to about 120,000 people here in Toronto and 300,000 in Ontario. The onset for schizophrenia usually is between the ages of 15 and 25. Therefore, the illness has been called "youth's greatest disabler." More hospital beds in Canada are occupied by people with schizophrenia than by people with any other medical illness; schizophrenia represents 8% of the hospital beds in Canada, more than any other diagnosis.

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So it's frustrating to hear family members come into our chapters sharing similar stories of how treatments for mental illness were not there, how the person they finally had admitted into the hospital was released after 72 hours, and the process starts all over again. It's frustrating to hear families say they have to wait until their son reaches rock bottom before they get treatment or are picked up by the police, and how family members were ignored by health care professionals.

I get frustrated reading the newspaper headlines whenever a person with a mental illness, such as schizophrenia, reaches the front page, knowing that if the person had received treatment, the situation may not have occurred. I get frustrated when I walk by people lying on the street at Wellington and York, knowing full well that they probably are there because they have a mental illness and refused to be treated because they are too ill to realize that they are ill. We need to take responsibility for people who can't take care of themselves, yet we seem to continually find an excuse not to do so.

But it's not all gloom and doom. As I mentioned, treatments and services have improved over the past years, and there are some fantastic success stories that I have seen. Here are a few.

Bill MacPhee and the Schizophrenia Digest: In the package I've given you, I've given you a copy of a magazine called Schizophrenia Digest. Bill MacPhee has the illness, and he's more than willing to share his story, so please contact him and ask. He was the editor and founder of that magazine, and it now reaches not only Canada but the US. And he's started a new magazine about depression.

The Bloor Street viaduct suicide barrier: one person every 22 day was jumping off the Bloor Street viaduct, second in North America only to the Golden Gate Bridge in San Francisco, not particularly something you want to see advertised in a tourist brochure for Toronto. However, it took seven years until the proper approvals were received and the financial issues were resolved. Today,

no suicides have since occurred that I'm aware of from the viaduct, and the rate of suicide has declined overall. Contrary to popular belief, people will not always find another place to commit suicide. The act itself can tend to be impulsive. The Bloor Street viaduct has succeeded in removing this risk. However, it took seven years to get everyone to work together. I sometimes wonder, if we had an intersection in the city of Toronto where one person was being killed every 22 days, whether our reaction would have been different.

The Moving Lives Forward Scholarship program: This program is offered by Eli Lilly through their foundation. It is, in my opinion, a wonderful success. The program provides small scholarships within the range of \$500 to \$1,000 to selected applicants who are suffering from a mental illness such as schizophrenia to continue their education. The logistics of the program are done through a charitable organization, like the Schizophrenia Society of Ontario and their volunteers. The success of the scholarship program is not that the money is offered, but it's the fact that receiving the scholarship offers a person with a mental illness a second chance. It shows them that somebody cares and is willing to believe in them. The feedback that I have received has been very positive.

Now, I have three asks for the committee to consider:

(1) We need to find a champion for mental illness. As a project manager, you quickly learn that if a project's going to succeed, a project needs a champion who's going to stand up for the project and protect it from other competing priorities. Projects that don't have a champion fail. Mental illness needs a champion at the provincial level and federal level of government. The champion needs to be supported by all political parties and have the authority to make the changes that are required, and I do believe it can be done.

(2) We stop the revolving door when it comes to treatment of the mentally ill. When a person is sick, we need to treat them as best as we possibly can. We need to stop discharging people after 72 hours. Treatment of a mental illness takes four to six months. We need to improve the handover that takes place once a person is released from hospital and ensure that follow-ups occur—not for a few weeks, but for a few months and possibly a few years afterwards. We need to actively involve families, who are the true 24/7 caregivers.

(3) I would like to see the funding for the Moving Lives Forward Scholarship program, or a similar program, increased. My preference would be \$100,000 per year, either through the Ontario government or other foundations. The scholarship program would be able to offer 100 people a scholarship of \$1,000 to return to school and to help them to start rebuilding their lives. It's amazing how having a second chance can sometimes make the difference to them. The structure of the scholarship program already exists, and only additional funding is required.

Thank you very much for your time today. I did provide some handouts, but I will provide some more, as I understand I didn't bring sufficient. Within the package,

I gave you a copy of the Schizophrenia Digest and a PowerPoint presentation that I present to other groups. Do take a look at the slides at the beginning that provide a 10-question true-and-false quiz.

On a final note, you'll notice in the package I did put a copy of a slide in there where "hope" is in "scHizOPhrEnia." Though we don't particularly like the word, it is nice that you can actually spell "hope" out of the word "schizophrenia."

As for myself, I'm going to continue to be an active member of the Schizophrenia Society of Ontario, providing families a reason to hope and the means to cope. If by chance you are in the neighbourhood of Metro Hall on Sunday, May 30, 2010, I invite you to drop by for the Walk of Hope for Schizophrenia and come and meet some of the families who are working together to make change happen.

The Chair (Mr. Kevin Daniel Flynn): That was pretty good. You didn't even hit 10 minutes—9:52.

Mr. James Weber: There we go. Toastmasters does work.

The Chair (Mr. Kevin Daniel Flynn): Let's start with France. We've got about six minutes.

M^{me} France Gélinas: Thank you for your presentation. I'm sorry about what happened to your wife.

The idea that we should do more for people who refuse treatment is one that we have heard a number of times. Have you thought this thing out, and can you elaborate as to what would be the trigger from now on as to, "We will treat you whether you want us to or not"?

Mr. James Weber: Let me put this in the context of what I had to deal with with my wife. One, she reacted very well to her medication. Typically, if she was on her medication, you would not be able to tell that she was actually ill. I'm sure to this day that several of her friends don't even realize that she had a mental illness such as schizophrenia. But when she became ill, she actually refused her medication. It would reach the point where she could not eat or sleep or settle down. We'd literally have to corner her in such a way as to make sure we could get an injection into her to get the medication straight into her bloodstream. Once that was done, she started to realize what was going on. She would actually realize that she had fallen into another episode and she'd start to recover.

Now, a lot of people aren't that fortunate. She was good on the medication. Other people don't react the same way. Once a person is unable to feed themselves, can't take care of themselves—and it's not fair to point out, but with people on the street, typically you can tell they haven't been able to take care of themselves in a while. Then you've got to ask the question of whether or not they are mentally ill and whether or not they really need to be treated. I understand it comes to the point of rights, but then again we have to look at the other side: Do they truly understand how sick they are in that respect?

I can only tell you from my experience that once I got the medication into my wife, she realized she was ill, she

recovered, and she became much better. In the time that I knew her, she went on to get a degree in early childhood education, and if all things had worked out, she possibly could have been a teacher, but that's the way it goes.

I get frustrated by the fact that we have a tendency of leaving people on the street, hoping they're going to fend for themselves. They're going to survive, but it's not a life that I would particularly want to lead.

The Chair (Mr. Kevin Daniel Flynn): Thank you, James. Let's move on. Liz?

Mrs. Liz Sandals: Thank you very much for sharing your experience with your wife. From what you've just said, in the case of your wife you obviously had access to the drug to try and get the drug into her. What I often hear from families of schizophrenics in my office is possibly one more step removed, where the person isn't necessarily living with the family but has close contact with the family. The family begins to see the signs that they're off medications. They know, but nobody will pay any attention to them. Either the police will say, "But they're not a harm to anybody. They're not a danger yet," or the medical profession will say, "But we can't talk to you," the family. It's confidentiality. In both of those cases there's tremendous frustration. The family knows what's going on but has no capacity to do anything about it.

Do you have suggestions about what you would change to deal with that situation?

1530

Mr. James Weber: I know it's difficult to put in legislation, but common sense has to prevail. When you do see somebody who's unable to feed themselves and the family is indicating to you that they are not helping themselves, that they are heading towards the bottom, then we should allow ourselves the right to step in. I understand that we need to protect the rights of people, but at a certain point, too, we're actually abdicating our responsibility to treat people who do need treatment.

Typically, family members—and you can tell, if a family's fairly stable. If they see somebody with a mental illness degrading, if we could simply apply the common sense that goes with it and step in, figure out what the situation is like and try to determine what's going on, then I think we'd start to see that the family is correct in terms of the person being seriously ill.

When I say step in, I'm not talking a one-hour interview, because typically people with a mental illness like schizophrenia—my wife could hide it for an hour. It's more in being with the person 24 hours a day, seven days a week, that you start to see the symptoms come out. They can't hide it forever, and that's where you see the problems.

The Chair (Mr. Kevin Daniel Flynn): Thank you, James. We have to move on. We've just got one short question, perhaps, from Sylvia.

Ms. Sylvia Jones: Hi, Mr. Weber. Thank you for your presentation. I wanted to continue on the compulsory treatment theme.

In your work with the Schizophrenia Society, are you familiar with jurisdictions where they have dealt well, in

your opinion, on involving the family and on treatment when it's being refused?

Mr. James Weber: To be honest, I'm not aware of it myself. I hear of programs; I hear people coming into our chapter talking about various programs that seem to work, but I can't point out a specific area or region that's doing it extremely well at this point in time. It seems to be pockets of success without integration that's sort of linking them all together.

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

Mr. James Weber: Thank you very much.

ALLIANCE OF PSYCHOTHERAPY TRAINING INSTITUTIONS

The Chair (Mr. Kevin Daniel Flynn): Our next presenters today are from the Alliance of Psychotherapy Training Institutions: Linda Page and Sharon MacIsaac McKenna. If you'd like to come forward and make yourselves comfortable.

Ms. Linda Page: Good afternoon.

The Chair (Mr. Kevin Daniel Flynn): Good afternoon.

Ms. Linda Page: We appreciate the chance to come and talk with you. Sharon and I are both involved in the Alliance of Psychotherapy Training Institutions. We each work in our own institution. In general, I want to talk with you today about what we teach, which is psychotherapy, so it's kind of a different level of discussion that I'll be talking about.

I have given you a written report that will be different from what I'm saying to you. The points are pretty much the same, but I'll describe it in a different order.

The alliance is made up of 21 psychotherapy training institutions that have existed in the province of Ontario for many, many years. Altogether, we probably have thousands of hours of teaching and have touched the lives of nearly every psychotherapist in Ontario in one way or another, whether they are practising as doctors, social workers, independent psychotherapists, in the ministry or whatever, because so many of the professionals come and train with us.

I want to start off by talking about my own experience and that of other psychotherapists when we're at a dinner party or a family gathering—actually, when I'm someplace where people don't know me very well. They'll say, "So, what do you do, Linda?" and I'll say, "Oh, I'm a psychotherapist," and there's a pall that comes; there's a silence, and, "Um, um..." I think part of that is—

The Chair (Mr. Kevin Daniel Flynn): Try telling them you're a politician.

Laughter.

Ms. Linda Page: Is that even worse? My condolences.

I think the reason for this kind of stop in conversation is—several reasons. One is that people are embarrassed if they themselves suffer from the stigma of mental illness

or if some of the people they are close to do. However, I think another reason is that people don't know what psychotherapy is. For most people, psychotherapy, psychiatry, psychology, and anything else that starts with a p-s-y is pretty much all the same thing, so they're not quite sure what it is you do.

I think that's a big reason for the silence, that people don't know what to say. They don't know what to ask you. I mean, if you're a plumber, they say, "Well, gee, can you come fix my pipes?" but they're a little bit more reluctant to say, "Can you come and treat my schizophrenia?" or whatever.

So what I'd like to do today is explore the advantage of the fact that there is so much variation in psychotherapy, talk about the challenge that comes from that variation and give you an example of APTI, which I believe shows a collaborative example for both extracting the strengths and overcoming the weaknesses of the great variability that we find in psychotherapy. Basically, I hope this will prove useful to you as you consider how to apply resources so that the people of Ontario can receive better mental health services.

As I say, psychotherapy is very variable. If you are a client of a therapist—and when I say "psychotherapist," I mean clinical counsellor, psychiatrist, anyone who provides what is defined in the new Psychotherapy Act as psychotherapy. Clients may say, "Well, I'm in psychotherapy and what I do is I sit and I talk with my therapist." Somebody else says, "Well, all we do is draw pictures," and somebody else says, "Well, I dance," and somebody else says, "Well, we sit and meditate." So the experience of clients is very different. Therapists might be trained as medical doctors, as pastors, as social workers, as counsellors or addictions counsellors. Until recently in Ontario, of course, there was no single standard for psychotherapy, so that there was nothing in legislation that you could point to say that says, "Okay, here's a definition of psychotherapy." In fact, even the scientific community around us has questioned what is psychotherapy and does it work. For a while there was an argument that you're better off leaving people alone than giving them psychotherapy; they'll recover just as well. We now know that's not the case, but there was that argument. And for whom does it work and, if it works, what is it that does the working? So all kinds of variations and arguments and contention have been the case in psychotherapy.

This can be a strength. There are many modalities of psychotherapy and that is a strength. If you think of Tolstoy, there's a phrase in *Anna Karenina* about happy families being pretty much the same but unhappy families are different in many ways. But the fact is that unhappiness, the suffering that comes from mental illness and addictions, comes in very many flavours. So it's important to protect the variability within psychotherapy services so that the different kinds of suffering can be treated in ways that suit those many different needs.

However, this variability, I think, contributes to things like dinner party confusion, which is not the biggest

problem, of course, but confusion about what psychotherapy is and what it can do. We in APTI have sought to look at what is an underlying connection, a commonality among the different forms of psychotherapy. Science has aided us in this search. Over the last three decades some very rigorous research has been done—you've probably heard about it—that has identified that no matter what kind of psychotherapy is being offered, there are basically underlying it four things that account for effectiveness or efficacy in psychotherapy. One of them is the psychotherapy relationship, which is part of the definition of psychotherapy in the Psychotherapy Act, that that's treatment provided through a relationship. About something like 30% of the variability in improvement in psychotherapy comes from the quality of the relationship, only 15% from the kind of technique you use and 15% from placebo effect. The other 40% has to do with the characteristics of the client or the patient. So that again underlines how important it is to have a variety of treatment modalities available, given the variety of issues that exist and types of individual issues that exist in mental illness and addictions.

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Science says that underneath all these different variations there is a commonality, but right here in Ontario we have another example, and that's APTI itself. In the lead-up to the change in the health act that produced the Psychotherapy Act, we in the various organizations that have come to form APTI looked at each other and said, "You know something? We know what psychotherapy is. We teach it to people all the time. When we speak to each other, there is a commonality, so surely we can arrive at a curriculum that we all agree on as a kind of common basis." Then you can go off from that and study the specific modalities, whether it's psychoanalysis, emotion-based therapy, cognitive-behavioural or relation-based therapy—right?—a relational system, self-psychology, all those different approaches.

Surprisingly, given the contentious history of psychotherapy, these 21 institutions came up with a common curriculum where we all said, "Yes, this is what we agree on is necessary as a foundation for a psychotherapist to be able to practise." Then we did something else which I think is very notable, and that is that we said, "And there are guidelines that we can follow for our own individual types of psychotherapy." For example, in my school we teach Adlerian therapy, and in that approach I need to follow the guideline of providing a history of how that developed, an explanation for how people become mentally ill from that perspective, what treatment means and how it occurs and all those things. So those guidelines I think are very important.

I'm offering this to you as a sign of hope in the potential for the psychotherapy community to come together and collaborate and work across professions, because this is one area where there's one profession which is practised by many professions; that is to say doctors, social workers, people who identify primarily as psychotherapists, psychiatric nurses, occupational therapists and

psychologists. These are the people who are allowed to practise psychotherapy under the new Psychotherapy Act. We stand as examples that it is possible for us to collaborate across those professions, and we see as a next step then to invite academic institutions to examine what it is that we see as the common basis, the common foundation to provide psychotherapy education for incoming psychotherapists.

As I say, psychotherapy is variable. That's a strength that must be preserved, and yet there's also a need to identify the underlying unity within a profession that has been quite disintegrated over the years.

I think in order to be more efficient in providing services to the people of Ontario, we need to come together. I'm glad to say I didn't believe that this was possible when we first started talking at APTI, but the collaboration that we have achieved I think is really quite remarkable. We offer that not only as an example of what's possible within the psychotherapy community, but we also offer APTI as a place that pulls together much of the knowledge about what psychotherapy is and what it can do. So we offer that as a resource to this committee. Of course, as we understand better what the commonalities are within psychotherapy, perhaps that will not only improve mental health and addictions counselling and therapy in Ontario but might even improve dinner conversations.

There are several discussion points that we mention in the paper that I've provided for you. I think my colleague Sharon MacIsaac McKenna has a couple of comments to make about that.

The Chair (Mr. Kevin Daniel Flynn): We've got about a minute left.

Ms. Linda Page: Oh my God, I took that long. I'm so sorry.

The Chair (Mr. Kevin Daniel Flynn): How good are you at summarizing?

Ms. Sharon MacIsaac McKenna: I would suggest that you really study this and absorb it, because psychotherapy is new on the health services scene. It's actually a health service and it's outside of health service; it's in the spiritual realm if you look at the institutions involved. Those are what the forms of psychotherapy are in the province and internationally; these are all international. You might be surprised to find that something like the sand play therapy is very, very congenial to the native community. They're asking for it. Hincks-Dellcrest institute is involved in working with dreams with them.

Psychotherapy is about human life. It's indicated in here that states like anxiety and depression are normal. They're often realistic. They follow loss of jobs, loss of income and they follow divorce—the tendency in the health service is to talk about them as pathological. Where pathology will then have them hit medical records, there's going to be a problem, and I've indicated this here.

One of the big problems is that people avoid diagnosis because they know that they're going to pull through or they've got to find other means. I can only invite you to

have us talk to you. It's so big a field; it's over 100 years old. As Linda said, it brings together such disparate streams, so many disciplines. There is a Buddhist outreach, there are all kinds of body therapy, there's yoga and meditation, and it sounds like just a bag of tricks, but it's actually a profound presence to one's own life and it's restoring to each person the capacities to live their own life. Whether they're on medication, whether they're addicted, that's the psychotherapy presence. That's what distinguishes it. It's basically relational but it needs lots of training and lots of modality.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. The report is very thorough. I'm sure that all members will pay some attention to it.

Ms. Linda Page: Thanks a lot.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. It was really appreciated.

PATRICIA TESKEY

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Patricia Teskey; Patricia, if you'd like to come forward and make yourself comfortable. You have 15 minutes, like everybody else. Use it any way you see fit. At the end, maybe there will be some time for questions.

Ms. Patricia Teskey: Thank you for this opportunity to speak to you today. I'm a mom. My son became ill with schizophrenia and experienced his first psychotic break in 1996 at the age of 23. I have some recommendations about early intervention, but I would like to begin by sharing some reflections and observations.

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A few years ago, I attended an event where the guest speaker was Heather Stuart, a researcher at Queen's University, I think. She said that when agencies receive funding with a mandate to meet the needs of the very seriously ill, it's common to find, before too long, that they have given up on the difficult people and have gravitated to people who are easier to serve. We need to protect money targeted for people with serious mental illnesses. We need to promote healthy approaches to life's challenges, such as being laid off from your job, but new money should be found for that. The money should not come by cutting psychiatric beds to the acute care mental health units of our community hospitals.

Both the Mental Health Commission of Canada and the Schizophrenia Society of Canada are asking us to reject the so-called biomedical model or message and to embrace the so-called recovery model or message. With all due respect, neither of these organizations needs you or I to be their cheerleaders. They need our honest evaluation and feedback. Both the recovery and biological models have inspiring contributions; however, both have serious flaws, and choosing one over the other will only add to the grief and suffering of people with serious mental illness and their families.

Family caregivers, imperfect as we are, are the default mental health system for both models. We need to be free to cherry-pick the best of any model, concept or idea that comes along.

The recovery model inspires us to envision even the most ill as having the potential to recover a meaningful life, and that is truly wonderful. However, the recovery model seriously fails the many people who are like my son was when he was floridly psychotic and not well enough to make an informed choice.

For most people in a psychotic state, the part of the brain that enables the person to have insight or self-awareness is not functioning. The person has anosognosia, a Greek medical term. In English it means "to not know that you are ill." Yet the recovery model insists that our highest value must always be the ill person's right to choice. How can that be the highest, most compassionate or ethical value when the person is suffering from mental impairment and can't make an informed choice? Some people argue for letting a person go ahead and make a poor choice: That's okay, because they will learn from the consequences and maybe make a better choice next time. But that is playing Russian roulette with the person's life. There might not be a next time.

A mom and dad that I know sought to have their 25-year-old daughter found incapable at a consent and capacity review hearing. They wanted her to be involuntarily detained in hospital because she was suicidal. The patients' advocacy office defended her choice to leave the hospital, and won. So she left, jumped off a bridge and died. The patients' advocacy office didn't even send a card. It was the family that was left to literally pick up the pieces.

As long as a person thinks they're not ill, they won't ask for help. Why would they? And if they don't seek help, they will continue to be ill. This dilemma is so common, it is called the Catch-22 of schizophrenia. The longer a person remains in a psychotic state, the more cognitive damage occurs, and the longer it takes to stabilize once medications are started. So the recovery model, or message, becomes relevant only after a person is stabilized and their insight is restored. They now need choices and opportunities for recovering a meaningful life.

I believe the most efficient and humane path through this psychosis to readiness for recovery is through early intervention. However, early intervention is still largely unavailable. Even in the greater Toronto area, population about four million, there are only a handful of first-episode clinics.

We're told to get help early, but what happens when you go for help early to your family doctor or your local community hospital? I invite you to look through a parent's eyes at what happened to my boy. He was 23 years old and just six credits shy of graduation from university when he had his first psychotic break. Initially, he had insight into what was happening to him. When I asked him to explain his sudden bizarre behaviour, he said, "I have paranoid schizophrenia." This would have

been the optimal time for early intervention, but it was to be four years before he was stabilized on medications.

I phoned his family doctor, who said, “I don’t do psychiatry.” He didn’t refer him to a psychiatrist. He said, “If he’s psychotic, take him to emergency.” My son and I went together to our community hospital. The psychiatrist there gave him old medications and sent us home. My son stopped taking the medications. Within four months, he was so psychotic that the hospital finally admitted him. He went willingly. He wanted help. But after four weeks, the newer medication still hadn’t stabilized him. He was discharged in a psychotic state.

That was the first of eight hospital admissions in less than four years. My son became a revolving-door patient because the hospital kept discharging him too early—when he had just started to stabilize, but before he had reached a fully stable state. He deteriorated, dropped out of university. He lost his friends, and he now didn’t know that he was sick. He thought people were poisoning his medication, so he was afraid to take them. He was terrorized by constant threatening voices and begged me to help him. I tried to help him.

There were three involuntary hospital admissions, all requiring a form 2 from the justice of the peace and a police escort. There was a consent and capacity hearing that found him incapable and allowed for him to be given medications involuntarily. However, the hospital still discharged him before he was stabilized and without support for staying on the meds.

Finally, in 2000, a psychiatrist agreed to detain my son in hospital until he was stabilized. My son came out of the psychotic state and his insight was restored. It took nine weeks. Fortunately, this hospital had just acquired an assertive community treatment team. As part of my son’s discharge plan, he agreed to work with the ACT team to stay on the medications.

But the real miracle came two weeks after discharge: 11 weeks after starting the medications, they finally clicked in. The delusions and paranoia disappeared like night and day. I came home from work to find him phoning his cousins and friends. He got his relationships back. Then he phoned his former employer and got his part-time job back. That was nine years ago. He has never had to go back to the hospital. He returned to university and graduated in 2006. He is now working part-time.

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And, I want to add, after he was stabilized my son did not resent me or the doctor who detained him in hospital and treated him involuntarily. On my next birthday he gave me a beautiful card. It said, “To mom, with gratitude. Thank you for everything you have done for me.”

I’m grateful too, but I wish that he had received early intervention at the time of his first psychotic break. He would have been spared years of suffering and torment. And for those who care about the cost, the mental health system would have been spared huge expense.

In our community hospital I believe there are plans for an early intervention program, but it will be restricted to

adolescents up to age 17. But what about the many young people who have their first psychotic break between ages 18 and 30? My son had his first episode at age 23. Age cut-offs for early intervention should be recognized as discrimination on the basis of age. Can you imagine telling someone with the first signs of cancer that they can’t receive early intervention because they’re over the age of 17, or 34, or 46? It is double discrimination against females, who often have their first psychotic break at a later age, in their late 20s or 30s.

So my recommendations to the select committee are:

(1) That the mental health units of every community hospital in Ontario be mandated, funded and required to follow the best practices of early intervention as the norm with every patient, with no age or gender restrictions;

(2) That instead of a discharge plan, mental health units in community hospitals design a wellness or recovery plan with each individual, where discharge from hospital is just one point on a continuum of support and opportunity in the community; and

(3) That funding be allocated for more ACT teams to support people after discharge from hospital.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): That’s wonderful. You’ve left us about a minute and a half for maybe one question. I think we’re on this side now. Lorenzo.

Mr. Lorenzo Berardinetti: First of all, it’s very brave of you to come forward with your story, so I want to thank you for sharing that with us.

More than a question: This issue about—and I’m only subbing for today, so I’m only here for today’s session, but I wanted to know, and maybe the researcher could find out for us, what the rights of an individual are and at what point a doctor or a health care provider can step in to help someone or intervene, because I think the problem that we see again and again, and we’ve seen with this deputant today, is that people who have episodes are allowed to continue to make decisions. I think there has to be some—I guess the doctors out there are aware of some kind of law that doesn’t allow them to hold these people—

Ms. Patricia Teskey: The Mental Health Act does allow for somebody to be treated involuntarily if they are in danger or a danger to someone else or—I think in Ontario; I know in BC, maybe in Ontario—if they are markedly deteriorating.

Mr. Lorenzo Berardinetti: Who makes that decision?

Ms. Patricia Teskey: I had to go to a Consent and Capacity Review Board; I went to two of them. And it’s very important that the family member be allowed to be there. Some other people—the lawyer for the client doesn’t often want that because the family has essential information that the review board needs to hear. But most people don’t make it that far through the system because access to get into the hospital in the first place, to get a doctor—anybody who makes it all the way through to a Consent and Capacity Board is really sick. People complain that in only 3% of cases the client wins. Well,

that's because most people who really should be at a Consent and Capacity Review Board never make it anywhere near there. You have to be pretty sick—and the doctors, it's no fun for them and they're busy.

Mr. Lorenzo Berardinetti: Yes. So I guess the question would be, how do we make it easier without creating more bureaucracy? Nobody wants more bureaucracy, but how do we make it easier to get to that point where intervention can take place?

The Chair (Mr. Kevin Daniel Flynn): The next presentation may shed a little more light on this issue as well. So thank you for your answers and for your presentation today. Thank you very much for coming.

Ms. Patricia Teskey: You're welcome.

PSYCHIATRIC PATIENT ADVOCATE OFFICE

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is the Psychiatric Patient Advocate Office, Vahe Kehyayan and Ryan Fritsch. Was that last presentation a good segue for your presentation?

Mr. Vahe Kehyayan: It is indeed.

The Chair (Mr. Kevin Daniel Flynn): That's what I thought.

Mr. Vahe Kehyayan: Can I take my jacket off?

The Chair (Mr. Kevin Daniel Flynn): Oh, yeah; I've had mine off all day. It's a little hot in here. It was freezing this morning.

You've been here for a few of the presentations, so it's exactly the same. You get 15 minutes. Use it any way you like, and maybe leave some time at the end for some questions and answers, if possible.

Mr. Vahe Kehyayan: Before I begin, I'd like to acknowledge the passionate message of the previous speaker. I think, coming from the heart of a mom, it's very important, so it really makes my own presentation, in terms of importance, relative to that message.

Good afternoon, Mr. Chairman and committee members. I'm Vahe Kehyayan, director of the Psychiatric Patient Advocate Office. With me is Ryan Fritsch, our legal counsel. We are very pleased to appear before the committee and thank you for your invitation.

The PPAO began more than 25 years ago to protect and uphold the legal and civil rights of inpatients of the provincial psychiatric hospitals in Ontario. We are here today in support of a formally established and provincially coordinated mental health advocacy mechanism as an essential and integral component of a comprehensive mental health system.

Last year, our 12 patient advocates responded to over 3,700 individual issues. One third of these issues related to quality of care and quality of life. Over half of the issues were related to legal matters, especially access to justice. The remaining 15% of our advocacy services related to social entitlements and programs. We also provided mandatory rights advice under the Mental Health Act in over 22,000 cases within the community and provincial psychiatric facilities. More information

about our office and our activities is detailed in our 2008-09 annual report, which we sent to the committee members last month.

Our activities represent just a fraction of the need for mental health advocacy across Ontario. While we currently provide advocacy in 10 specialty psychiatric facilities, there are more than 55 psychiatric units in general hospitals across Ontario where consumers have no access to advocacy services. In addition, many treatment, rehabilitation and support services have now migrated from hospital to community, and the vast majority of those individuals who live with mental illness reside in the community and receive services there. However, for these individuals, access to advocacy services is limited or non-existent. In our view, advocacy services should be available to all Ontarians with mental illness, regardless of where they live or where they receive their services or treatment.

Our focus since the inception of our program in 1983 has been to strengthen the voices of those we serve and to support their ability to make decisions about their own care, treatment and lives. The ability to make decisions about the things which most affect us is fundamental to our rights as human beings and our membership in a democratic society. Because of stigma and discrimination, persons with mental illness may never fully enjoy the benefits and opportunities to which most citizens are entitled.

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In our 25 years of experience, we have developed a much deeper understanding of what it means to be socially marginalized, stigmatized, and economically disadvantaged as the result of mental illness. We now know how living in poverty, joblessness, homelessness, substandard housing and the absence of equitable access to resources and opportunities—and early intervention, as a previous speaker talked about—can directly and negatively impact physical and mental health. These are not only the potential social consequences of mental illness, but often determine its course and outcome.

Advocacy has the power to mitigate the negative social impacts of mental illness through its work with individual consumers and the service delivery and support systems at large. In this way, advocacy is both a front-line resource and a fulcrum for social change at the systems level. Our ambition as advocates is to put people in control of their own mental health care and lives. We may be striving to create a client-centred system of care, but our greatest challenge is how to harness the expertise of the client as a source of change. Advocates help foster a collaborative approach to care that respects rights while facilitating self-defined recovery. This creates a more responsive, effective and comprehensive mental health system.

These considerations respecting the role and importance of advocacy lead us to believe that formal, independent advocacy services must be strengthened. As the mental health system continues to undergo modernization and refinement, so too must the delivery of mental health advocacy services.

In order to achieve effective advocacy in Ontario, we believe that we must take the following steps:

(1) We must ensure that advocacy has both the mandate and the resources to be fully independent. It must be provided free of any interference from institutions or service providers and from any perception of bias or conflict of interest. Effective advocacy also requires the ability to work across systems like health, law and social services. Advocates cannot provide such services if they are tied to a particular institution or program or clinical service that may be mandated to work from the standpoint of best interests.

(2) We must ensure that advocates have a formally established and fully recognized role throughout the mental health system. When the PPAO was established in 1983, we were the first patient advocacy program in Canada. Today, Ontario is falling behind other jurisdictions like the United Kingdom, where legislation mandates the availability of advocacy services at any point in the mental health system. These jurisdictions have recognized the importance and value of professionalized advocacy services provided by formally trained advocates. A legislative mandate would give advocates the authority to do their job more effectively and would allow for the creation of coordinated province-wide advocacy services. Such oversight is a particularly important role in a fractured mental health system delivered through a variety of health and social support providers.

(3) We must ensure that provincial advocacy services have a modern governance model that supports stronger accountability, transparency, and more responsive service delivery. We believe that formal advocacy services are just one in a plurality of consumer advocacy opportunities that includes peer support, family members and public interest groups. Governance of a provincial advocacy service should represent that diversity. It should be a way to enhance and improve coordination to identify common issues, incorporate consumer and stakeholder feedback, and evaluate remedies and strategies. It should also help foster the development of local community resources where none exist or resources are limited.

(4) The final point: We must develop advocacy resources that keep pace with the migration of services into the community and that are fully accessible across facility-based and community settings throughout Ontario.

In summary, our vision of a comprehensive mental health system hinges on the inclusion of advocacy as an integral component to assist consumers in taking greater charge of their own mental health care and lives. Advocacy services that are provided seamlessly throughout the mental health system are of benefit to individuals, service providers and policy-makers. For individuals, advocacy provides a means to realize a truly client-centred mental health system that maximizes the consumer voice in matters that affect their care, treatment and quality of life. For service providers, advocates provide early identification and resolution of consumer concerns and are a professional resource on mental health

law and rights. For policy-makers, advocates provide a province-wide perspective on systemic barriers and service delivery from the consumer perspective, improving risk management and balancing operational needs against the rights of the vulnerable. The further development of a fully accessible, province-wide, independent advocacy service will pay substantial dividends in consumer recovery and wellness and the overall effectiveness of our mental health system.

In closing, we wish to thank you for the opportunity to appear before you, and we hope that you will give serious consideration to the realization of our vision. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We do have some time, then, for questions. Let's start with either Christine or Sylvia.

Mrs. Christine Elliott: Thank you very much for coming forward with your presentation today, because I think it really is critical that we hear from your organization. Some presenters—you may have heard some of them today—take the position that the Psychiatric Patient Advocate Office is sort of furthering the rights of people who may not have the ability to make their own decisions. But I think it's a question of balancing the roles and responsibilities, and I certainly see your office as an important part of that balance, because there are many situations where people's rights do need to be brought forward.

But I would just be interested in your comments as to what you would say to the parents who are saying, "There's no way for us to get help." What would you see as a necessary change in order to achieve that balance between civil liberties and the rights of parents and families and of the individual where they may not have the capacity to make their own decisions in a careful, thoughtful way?

Mr. Vahe Kehyayan: That's a good question, a very good question indeed. It's difficult to answer, though. We do agree on the balance in the system.

Our program really brings forward the voice of the consumer and client. We bring that concern or voice to the treatment team, and we raise the issues from the client's perspective. Sometimes the quality-of-care issue could be that the medication that they are receiving is not helpful, and the patient is complaining about the side effects and whatever, yet that treatment approach is not being changed, so the client comes to the patient advocate and says, "Could you help me with this issue?" Really, the patient advocate becomes the facilitator in that dialogue with the treatment team so that the treatment team sees a different perspective. Many times, the treatment approach—the medication, for example—is changed, and the patient benefits from that.

We also appreciate sometimes that there's a conflict between a family's perspective and the client's, as our previous speaker raised, and we also appreciate that concern. But, again, in our society, we respect people's choices and the need to make decisions about their own lives, to self-determine what happens to them. Within the

framework of the mental health legislation, the advocate brings that voice forward.

The Chair (Mr. Kevin Daniel Flynn): Thank you. It's time to move on. France?

M^{me} France Gélinas: I guess we've heard enough people come and talk to us, especially with schizophrenia and severe mental illness, where it comes to a point that it's almost part of their disease that they refuse treatment and suffer horrendous consequences for it, to the point where one is left to believe that all of the seriously ill that we see as homeless have lost their right to treatment. We've kind of lost the balance, where the right to treatment lost out to the right to civil liberty. The fact that you lost your right to treatment means horrible consequences for those people. If your vision was to be realized, would it have an impact on what we see?

Mr. Vahe Kehyayan: Well, part of our vision is that our advocacy, which right now is restricted to the 10 former provincial psych hospitals, is available to all patients in all settings, including in the community. If we feel that patients have some sense of protection within the walls of a hospital, you can imagine that those who are out there in the community, and that's the majority of them, do not have those protections—the homeless, etc.

On early intervention, which our previous speaker spoke about, many of our clients, or those who are in the community, have difficulty navigating the health care system or the health and social service system.

I don't know about you, but sometimes, I, as someone working in the ministry—many of our extended families come to me as their advocate and say, "Help us connect to the right service." I have difficulty helping them, so imagine the vulnerable individual who has a mental illness and who's out there in the community and is unable to navigate. One of the roles that we see for advocates in the community is to help these individuals connect to the right source at the right time before some serious harm comes to them.

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Again, your question is related to the earlier question in terms of how we balance that. The advocates really do not have any authority or power about the treatment. All they do is bring forward the issue to the treatment team's attention so that they reconsider the decision that they have made.

The Chair (Mr. Kevin Daniel Flynn): Okay. We're going to have to move on. We've got about a minute and a half left. Does anybody have a question on the government side? Liz or Maria, whoever.

Mrs. Maria Van Bommel: I'd just like to carry on with the whole idea. You talked about the need to be able to make decisions and to have choices and make those for the client. I think we've heard repeatedly in the number of hearings that we've had that there are very often consequences, and France talked about horrific consequences for the patients themselves, but for the families, too, who are essentially going along and trying to do remediation for things that have happened that their family member has done in the community, and that sort

of thing. They're constantly going along and they're asking to have some opportunity to have treatment and medications essentially enforced. You're saying as an advocate your job is to allow the choice and to allow the patient to make their own decisions and to make their own choices. How do you reconcile the needs of society and the family and the needs of the patient?

Mr. Vahe Kehyayan: We think that our Mental Health Act, the mental health legislation, is very well thought out and was debated before committees many years ago, and it does provide a framework. It does have a balance, and people do exercise their choice. Again, there is a framework: Where there is a risk to the individual, whether it is self-harm or harm to society or to others, there are mechanisms in the act itself so that the person receives treatment at the right time so that harm does not occur.

Just to clarify, when you say what the advocate's actions are, we only take the voice of our client to the treatment team. Our value system is that we respect choice, yet we help the individual to bring that concern to the treatment team—it could be the physician, or it could be the multidisciplinary team—so that the decision is made.

Many times, the reality is also that many of our patients who are in the provincial psych hospitals or the divested ones do not have family members, or they may have family but they are in other cities, towns or provinces or even out of the country, and it is very difficult. In our rights advice situation, we come across family members who are away from Ontario, and we have difficulty connecting with them when there is rights advice to be provided.

The Chair (Mr. Kevin Daniel Flynn): Thank you. I'm going to have to jump in there, unfortunately. We did want to hear the answer, but we're starting to run out of time. Thank you very much for your presentation. It was really appreciated.

Mr. Vahe Kehyayan: Thank you.

PAUL CASOLA

ADRIANNE SEQUEIRA

The Chair (Mr. Kevin Daniel Flynn): Our last presenter of the day before we head off to Ottawa is Dr. Paul Casola.

Ms. Adrienne Sequeira: I'm afraid he's not here yet.

The Chair (Mr. Kevin Daniel Flynn): You must be Adrienne.

Ms. Adrienne Sequeira: I am.

The Chair (Mr. Kevin Daniel Flynn): You don't look like a Paul. Make yourself comfortable then, Adrienne, and we're all yours for the next 15 minutes.

Ms. Adrienne Sequeira: I think Dr. Casola must still be on the road. Oh, he's right here. Great. Good timing.

The Chair (Mr. Kevin Daniel Flynn): Okay, we're all yours.

Dr. Paul Casola: Thank you for having us. Actually, I was sitting in the other room, just waiting. I wasn't sure where my colleague was.

I hope that the committee got a copy of our presentation. It was a PowerPoint presentation that we'd submitted. We're going to work off those, given that we don't have AV abilities here.

I'll start by way of background. I'm a psychiatrist by training, but my practice has been solely in the area of addiction medicine. I was trained through the Addiction Research Foundation, which is now CAMH. I've worked in various facilities, including St. Michael's Hospital. I consult to regulatory bodies with respect to dual diagnosis or concurrent-disorder patients. My current practice includes work with individuals at the Salvation Army Harbour Light, to which I consult.

Adrienne Sequeira is a nurse who has worked since 1996 in the area of concurrent disorders. She and I hooked up around the year 2000, during the beginnings of what was at that time the substance abusing mentally ill program at St. Michael's Hospital. We have maintained a connection in terms of our professional pursuits since that time. Adrienne currently works at the Humber regional hospital.

What I'm going to do is let Adrienne present the first part of our message here, and I'll continue with the last segment.

Ms. Adrienne Sequeira: I wanted to start with the Auditor General's report, which was on a slide, which we don't have, obviously. It shows that 90% of the people evaluated by the province to need addiction treatment are not in fact getting it. This was released in December 2008.

Today there are two areas pertaining to concurrent-disorder services which we would wish to address: access to the substance abuse treatment system, and the organization of the treatment programs for the concurrent-disorders population within the treatment system.

The current means of self-directed treatment system access, or self-referral, other than by word of mouth, is via the DART and CONNEX databases—DART being the drug and alcohol registry of treatment—or an in-person telephone consultation with a member of DART personnel. From the patient and front-line clinician perspectives, this system is not effective in connecting—

The Chair (Mr. Kevin Daniel Flynn): Can I just jump in there? You're a little bit too close to the microphone. Apparently the mic is really sensitive. You don't have to get really close to it.

Ms. Adrienne Sequeira: Okay, sorry.

The Chair (Mr. Kevin Daniel Flynn): Everybody makes the same mistake.

Ms. Adrienne Sequeira: Thanks.

From the patient and front-line clinician perspectives, this system is not effective in connecting individuals with a concurrent disorder with the right treatment. The DART database, while comprehensive, is not user-friendly. Attempting to sort out which treatment resource best matches the needs of the patient is extremely difficult.

We did a search of the DART website for concurrent-disorders programs and got 70 hits. A data and information specialist from DART generated this list from the DART database: Ontario supposedly has 954 drug and/or alcohol treatment programs; 889 programs indicate that they will provide services to clients with mental health issues; 214 programs indicate that they offer services specific—restricted and/or specialized—to concurrent-disorder clients.

The DART database is supposed to generate a shortlist of possible treatment programs that may be suitable for the individual. An individual or clinician may also be able to shortlist treatment programs by telephoning a DART staff member. Once one narrows down one's options, the application process for entering a treatment program is onerous, involving a lengthy assessment tool package with 10 different assessment tools. This tool package, when initially introduced, was supposed to be a single tool to access all Ontario treatment facilities. However, this has not been monitored, and many treatment programs have added their own application forms to the package. Going through the package itself often takes two to two and a half hours. Most often, after going through this lengthy process, an applicant or the clinician acting on behalf of the patient is told that the patient is not eligible because of medications they are on, specific diagnoses or symptoms they might be exhibiting.

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There is inconsistency in the criteria, and front-line clinicians are often vague about their exclusion criteria. For example, individuals are told that the centre does not accept anyone on sleep medications, regardless of what these medications are. More recently, patients waiting for medical withdrawal management admission and attempting to line up post-discharge treatment are told they will have to be clean for three weeks before they can apply and be assessed. The treatment centre's rationale is that patients are likely to have seizures up to three weeks following detox.

Patients without skills to stay clean cannot be kept in an expensive hospital bed while waiting to be assessed for treatment, displaying a need for education of front-line addiction treatment centre staff about withdrawal management. The individual or clinician has wasted valuable time applying to a centre that has declined to assess the patient, and they have to go through the entire process again once the patient has relapsed. Better access to treatment would entail a database which provides upfront information on the exclusion and inclusion criteria for each centre to enable clinicians to be more efficient and effective at assisting their patients to find treatment. The current barriers to the system make it onerous, if not impossible, for an individual with a mental health disorder to match their needs with the appropriate service in a timely manner.

Another important factor in improving the current access would be to ensure that addiction programs that access funding to provide services to individuals with

complex problems, medical complications of withdrawal and/or psychiatric issues receive adequate education on these issues to provide good-quality care.

I'd like to hand over now to Dr. Casola.

Dr. Paul Casola: I want to briefly address the issue of the organization of treatment programs for concurrent disorders. I have a very simple model I want to describe, which is basically lifted and/or borrowed from the American Society of Addiction Medicine's protocols or patient placement criteria. I want to caution you that, as I've been told previously, for every complex problem there is usually a very simple solution, but that simple solution is usually wrong. However, I will say that there has to be a basis or a place from which we start, and we believe the simple solution that I am suggesting is a valid and reasonable way of starting to sort out the mess that we see in the addiction and mental health fields at the present time.

The suggestion we are making is that the treatment system in Ontario should be divided into three groups: addictions-only programs, concurrent-disorder capable programs, and concurrent-disorder enhanced programs. The definitions and the criteria for these specific programs are all listed with the American Society of Addiction Medicine's protocols. They're very much detailed, and I'm not going to elaborate on those at the present time.

In order to implement this rather simple concept, the suggestion would be that existing treatment facilities within the province of Ontario be delegated to provide these services. I don't know how you want to divide them up. You could divide them up by LHINs, you could divide them up by geographical areas, but the idea would be that certain existing treatment programs would be designated to provide the services based on the three levels which I just mentioned above. As I see it, there really is no need to reinvent the wheel here. There are existing treatment programs. Treatment for addictions as well as mental health for concurrent-disorder patients involves treating the substance use issue. It's a case of adding specific treatment modalities for individuals with concurrent disorders.

That's the essence of our presentation. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you to you both. You've left a few minutes for some final questions for the day, starting with Christine or Sylvia.

Mrs. Christine Elliott: I just need time to consider this, but thank you.

The Chair (Mr. Kevin Daniel Flynn): That's fine. France?

M^{me} France Gélinas: No, no. Go ahead.

Ms. Sylvia Jones: My question falls with your, I guess, frustration—I don't want to put words in your mouth—as you try to find available treatments, as you go through this two-and-a-half-hour application process only to be blocked. Are you finding that there are beds available but they don't fit into the parameters of what you're looking for for your patients, or are there not

enough beds for the types of patients you're trying to serve?

Ms. Adrienne Sequeira: That's a tricky question, because when you look at the numbers of treatment programs that claim to be offering services for concurrent disorders, there seems to be no dearth of them. However, when you actually try to access those beds or those spaces, the treatment centre has a lot of exclusion criteria. They don't seem to be clear on what they will accept and won't accept, although on some things, like medications or certain symptoms, they are quite clear. But on other things, they wait until they get the application form before they decide whether they're going to accept this patient or not. It's very frustrating for the patient because, as we know, with addictions, there's a slight window of opportunity which, if you lose it, the patient goes out again for a period of time, and there are many more losses that go with each cycle of using.

In one of our slides here, it does mention that there's a dog's breakfast of services. That's basically, in essence, what we're saying. Someone needs to go in there and take a look at what's being offered and categorize it effectively so that those of us who are trying to access these beds know exactly where to go and it's provided for the patient in a timely way.

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

M^{me} France Gélinas: I have a whole bunch of issues. I'll put them all out, and you get to pick which one you want to answer. How's that?

The first one is, it's atypical that we usually try to link the clients, the patient, to the closest caregiver. In your field, clients often choose to go out of region. If we were to move through these three—you actually mentioned four in your paper, one being for specialized—would that mean we wouldn't need DART anymore, or would we still need it but under a user-friendly type of way? I'm thinking that for heart disease, you call it critical, and they let you know where there's a bed and then this is where you go. How come we don't have that in mental health and addictions? I don't know too much about your field, so maybe you can fill me in.

Ms. Adrienne Sequeira: I think with DART, way back in the 1990s, when setting the course happened, which was where they integrated all the addiction treatment programs in the province, the idea was that wherever there was a bed available, the patient would go. So it wasn't going to be regionalized. With the LHINs now, we're looking at catchment areas and that kind of thing, so a lot of times, some of the new monies are going towards programs which are regionalized based on the LHINs, and often people from outside the LHINs—certain treatment centres etc. or agencies that have developed relationships—are now having to turn people away because they're not in the catchment or whatever. However, DART was initially put in place so that every single treatment centre, supposedly, would phone in their availability, and the clinician who's trying to access the bed would just find out where the bed was available.

So in theory, it's a really good system. It's just that it's not user-friendly and it's just become a mishmash of services.

Dr. Paul Casola: Each region of Ontario, we believe, should have all three of these services available to them. We don't think people should be shipped from Kenora down to Toronto or wherever. We believe that within the region in which they live, treatment should be provided. The experiment of the 1990s of patients going to the USA for treatment was an abysmal failure and it should not be repeated. The idea is that there should be regional treatment with each of these types of services provided.

The DART provides a valuable clearing house or resource for patient placement. It's really a case of DART cleaning up its act so that the patients are clearer on whether they meet the criteria or not for any given program.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. Unfortunately, that's the end of our time allotment today. Transportation leaves for the airport in about seven minutes.

Mrs. Christine Elliott: Before we adjourn, Chair, can we just discuss a couple of issues about follow-up that I'd like to ask Ms. Hull to do?

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

Mrs. Christine Elliott: Thank you very much. Today's presenters did great presentations, but I think there's certainly a theme that seems to have gone through—Lorenzo, you picked up on it in some of your questions—and that is, some of the issues to the involuntary treatment issue. I think it was Mr. Ross who mentioned that the Netherlands and Norway had some good experiences that perhaps we could take a look at and draw from to see how they're dealing with that particular issue. I'm wondering if you would be able to take a look at that, to provide us with information about how they're dealing with it, and then we can maybe have a further discussion about it.

The Chair (Mr. Kevin Daniel Flynn): Absolutely. Any other points? No? Okay, we're adjourned to Ottawa.

The committee adjourned at 1638.

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