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Mercredi 28 octobre 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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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS**

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

Wednesday 28 October 2009

Mercredi 28 octobre 2009

The committee met at 1604 in committee room 1.

**MENTAL HEALTH
AND ADDICTIONS STRATEGY
HALTON REGION OUR KIDS NETWORK**

The Chair (Mr. Kevin Daniel Flynn): Our first presenters today, if we can call to order, are from an area I'm really familiar with, Halton Region Our Kids Network. We've got Mary Beth Jonz and Joyce See with us today. If you'd like to come forward, make yourselves comfortable. There's some fresh water there and some clean glasses, I hope. Mary Beth and Joyce, you've got 15 minutes, you can use that any way you see fit. If you would like to leave some time at the end for any questions or discussion, that would be good, but it's entirely up to you. It's all yours.

Ms. Mary Beth Jonz: Joyce is going to begin.

Ms. Joyce See: I'm going to start. You have a package of information in front of you that we'll refer to as we go through. We're going to talk about some issues about mental health that you will know something about. We're going to talk about some local successes and then, at the end, make some suggestions for things that might change.

The issue of children's mental health obviously—you're delving into this issue you know of. One of the issues we wanted to talk about was the issue of parental mental health and its impact on the ability of service providers to deal with child's mental health. You can't engage the child without engaging the parents, and closer links are required with the adult mental health sector; it's needed to be acknowledged in some ways.

Just to give you some examples, with our HBHC, our Healthy Babies, Healthy Children program in Halton, our high-risk families, of those high-risk families, about 40% of them had one parent who had an undiagnosed mental health problem or that the service provider would have seen, that there were mental health issues that hadn't been addressed and it was impacting on the family's achieving its objectives.

Our mental health provider in Halton, which is called ROCK, Reach Out Centre for Kids, talks about 47% to 50% of the children they treat having a parent with a mental health problem. Before they can get to treating the child's mental health, they have to work with the parent. The psychiatrist at ROCK also talks about 100% of the

families who are in the compass program, and our compass program is for the very highest-risk families, in 100% of those families, one of the parents would have a mental health problem.

Continuing with some of the issues, we have siloed services, which you'll know about, which I think is one of the purposes of this committee. There are a number of ministries who mandate mental health services but there are few bridges between those systems, and the lack of those bridges makes it difficult for families to receive service.

The other piece for Halton which is a huge issue is our population growth. To give you a bit of a sense of that, we have had a 25% increase in children zero to 18 between 1996 and 2006. In our Healthy Babies, Healthy Children program, we've gone from 3,900 births in 2000, and we're anticipating 5,300 births this year. For Healthy Babies, Healthy Children, without any increase in the funding of that program, the early intervention, which is the purpose of those programs, becomes more difficult to deal with.

1610

The next slide just talks about the four areas that we want to talk about. I know you don't want to just hear about the issues. You've gone across the province and the world. We also want to talk to you about some of the solutions and some of the things we're doing locally that we think could have an impact across the province.

I'd like to talk about the Our Kids Network. In the package that we've provided you with today, there is a structure which I'd like to look at a little bit with you. I think the two areas that I'd like to focus on in this structure are the children's mental health and developmental services, and the research and evaluation.

But before I get to that, the Our Kids Network actually started 12 years ago, and the key was the Early Years at that point. We've grown and evolved since then, and in the last five years, we actually have signed protocol and financial partners to support this, but our main function is to look at service integration for those children, youth and families who are most at risk but provide it for whole communities. So Halton region health and social services, our police services, all our school boards, our children's aid society and our children's mental health are our key financial protocol partners for this model.

As I said before on the structure, one of the things we feel we can make a difference in, and see what difference

we've made, is with our report card, so we've provided you with a report card. It's a large document. We've also given you the executive summary that's attached to that, which breaks it down. But when we move forward, what we looked at in integration, and when we talk about silos and some of the issues, is an ecological model, which is also in your package, that looks at the ministries that you're most familiar with as well as all the local pieces. But the core is the child and the youth and how we all have to integrate together and focus on what the core is, which is the child and youth, and mental health is one of those key areas.

With our report card this year, we've identified seven population results and indicators, which we will be evaluating through results-based accountability. If you go to pages 58 to 60 in the report card, it really talks about the results-based accountability and how we want to turn the curve.

Kevin was able to come to one of the local community forums, which was great. We held five of those to introduce the report card to the community and to help communities identify their key issues. In all five of our communities, they identified children's mental health as their prime key issue. So we know with the report card, and what we have to do locally is to turn the curve on how we're working with children and youth with children's mental health.

We feel this is one of our key models of early intervention and prevention—to work with families at risk, to look at health issues, mental health issues, poverty and the determinants of health. So this is a key driver for us in our local community.

The next integration example we wanted to talk to you about is the North Halton Child and Youth Psychiatry program. It's a collaboration between public health; the North Halton Mental Health Clinic, which is administered by the region of Halton but is a psychiatric outpatients for adult programming; and Reach Out Centre for Kids. On our advisory committee, we also have the addictions programs within Halton as well as our educational partners. The North Halton Child and Youth Psychiatry program is 100% funded through the region of Halton. We receive referrals through family physicians and other professionals, and it provides services to children from four to 18 years of age.

We started the program on November 1, 2008, and we're just at the end of our first year. We will have had about 210 families referred through the program. It's a psychiatrist, a social worker, a nurse and then two family therapists that are provided through the Reach Out Centre for Kids.

An example of a young woman who was a client of the clinic: a 15-year-old who was becoming increasingly aggressive at school, and it had come to the point where the school had determined that she was not safe to be allowed back in school. Through some outreach, she was connected with the clinic, and the social worker working with her mom, and the nurse working with the young woman convinced her to talk to the psychiatrist who

diagnosed her with ADHD and some beginning conduct disorder signs. Through some therapy, medication etc. she's now back in school and she's better-connected with her mum and her mum feels that she's got her daughter back. That's an example of one of the children.

In your package you will see—I'm afraid it's a little dry—a logic model that tells you the different components of the program. It's an example of that bridge that we talked about in the first slide. It's bridging the children's mental health sector, the Ministry of Health and Long-Term Care-funded North Halton Mental Health Clinic and then the public health programs, as well as education.

Ms. Mary Beth Jonz: Due to the essence of time, service coordination is the next one, and it's one that we believe in as a key component for any family that has multiple service providers, and most of our children and adults who have mental health problems have multiple service providers or they have no one. That seems to be the distinction. Service coordination is something that we developed 13 years ago now, I believe. Healthy Babies, Healthy Children was the first to move this forward, but the key component of this was to ensure that families had the opportunity to work with all their service providers for one plan. What we hear repeatedly from our families with mental health issues is that they tell their story over and over again. I have provided an example; I could provide you probably about 400 examples of how this is working in our community because as you can see we've trained over 200 service providers in this model of service. This is something that we require to be offered to all families who need that extra support and who have more than one service provider that they're working with. In the essence of time, I'm not going to give you the actual example I was going to use, but it's here and we will take questions at the end.

The other piece is the infant/child mental health program that we're offering, and it's really an integration of services and collaboration. What I want to reiterate is that the early years represent the first and the most critical stage of the entire life course. The things that happen to us early on, the environments and events to which we are exposed can have immediate, delayed and long-term impacts on our overall health, particularly our mental health.

With the Our Kids Network in the Halton region, we have put a lot of resources and collaboration in those early years. But in saying that, I do want to reiterate that our children's mental health facility, ROCK, has a 380 working days'—almost two years—wait list for psychological assessment for the earliest child around attachment. We know there can be no treatment plan if there hasn't been any assessment. So with our demographics, which we reinforced in the beginning, we still struggle, even with integration, to meet the needs of these children. There is a handout as well that details the levels of intervention for infant and child mental health.

Ms. Joyce See: The last example that we're going to talk about is our Youth Net program. Youth Net is a

mental health promotion program that we provide to young people in high school. It's a mechanism for identifying young people early who have a mental health problem. It's provided through a classroom setting. There is a survey that's done, and about 5% of the young people who participate in the Youth Net program are identified as needing clinical support. So those are just kids—you have 30 children in a classroom and you divide them in half and in 5% of those 30 children, one of them will need a mental health clinical follow-up because of suicidal ideation etc. Those are the unfound ones. It's a partnership between the Canadian Mental Health Association, CAMH, the Centre for Addiction and Mental Health, the local YMCAs and our school boards. It incorporates a program called TAMI, Talking About Mental Illness, that CMHA provides.

Then our last slide, really, is looking at some of what we think might be solutions. You can read some of those details. The one we wanted to highlight, again in the interest of time, is one that we think is an easy one, and we've had lots of discussion about this: the use of health care resources differently. We know that we have six child and adolescent psychiatrists in Halton, some who work only a day a week, some maybe two days a week. So there are six physicians, but they don't work very much.

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One of the issues that happens a lot is that the children are medicated, prescribed medication, and then the psychiatrist is the only one who can monitor that medication. Family physicians are very leery of psychiatric drugs in children, and so they aren't happy taking the children back. By creating some kind of role for the nurse practitioner, public health nurses or other nurses and the creation of medical directives under the jurisdiction of the psychiatrist, there are ways, I think, of taking that psychiatric time and using it in a much more efficient way, so that you can spread it more.

Some of the other things we've talked about are the funding issues, which you've talked about, and looking at one-stop shopping for families so that they don't have to keep being assessed over and over again, which is, I think, what happens with a lot of services. Making Services Work for People started along this path but never required service providers to integrate and have a common definition for integration. It allowed people to do what they want with only minor changes and tweaking to their existing systems, and that continues today.

Ms. Mary Beth Jonz: So our last word is that we want you to do what works best for children, youth and families and not for systems, governments and organizations. We're a part of that—we both work for a regional government—but I think one of our mantras with our kids has been, "The child is first." We need to make our systems work for the child instead of working for us.

So that's our message to you that we want to reiterate. We're passionate about our kids and service integration locally, and on a daily basis try to drive this message

home in the work that we're doing with our own staff and the community.

So, any questions?

The Chair (Mr. Kevin Daniel Flynn): Well, unfortunately, you didn't leave any time for questions.

Ms. Mary Beth Jonz: Oh, I'm sorry.

The Chair (Mr. Kevin Daniel Flynn): But you made an excellent presentation, and thank you for that presentation. I know what wonderful work you do, and now everybody at the table knows what wonderful work you do. I think there's something to be learned from what you do in Halton on a daily basis. So I really do want to thank you for coming today and making your presentation.

Ms. Mary Beth Jonz: Thank you for providing this time for us.

NATIONAL ASSOCIATION FOR THE DUALY DIAGNOSED

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this afternoon is from the National Association for the Dually Diagnosed: Susan Morris, the clinical director. You must be Susan.

Ms. Susan Morris: Yes. I was going to introduce—

The Chair (Mr. Kevin Daniel Flynn): Good guess?

Ms. Susan Morris: I'll clarify.

The Chair (Mr. Kevin Daniel Flynn): If you'd introduce your colleague.

Ms. Susan Morris: Yes, I will.

The Chair (Mr. Kevin Daniel Flynn): You were probably here at the start. Everybody gets 15 minutes; you use that any way you see fit. If there's any time at the end, we'll just share that amongst the parties.

Ms. Susan Morris: Okay. So I am Susan Morris, but I'm actually the president of the national association of dual diagnosis in Ontario. My colleague is Mr. Jim Johnston, who sits on the board of NADD Ontario and will also be speaking.

I believe you have a package with some slides. We're talking about children, youth and adults with developmental disabilities and mental health needs, and in that regard I'm talking about mild, moderate and severe disorders of intellectual disability, including fetal alcohol spectrum disorders and autism. We're not going to go through each slide. I'm going to highlight some things and point to the slide, and then I'll turn it over to Jim, who has a much more compelling story to tell than I do.

NADD Ontario is a chapter of an international association, and we provide information resources on practice, services and supports. We also advocate for excellence in education and training.

Turning to slide 5 to give you a sense about who we're talking about, I want to point to the first bullet, which says that 38% have mental health difficulties. Overall, first of all, this slide really gives you a sense of both the health and mental health issues that are experienced by individuals with developmental disabilities. If you turn that 38% into numbers, we're talking, at a conservative rate, 100,000 Ontarians, which in fact is quite similar to

the prevalence of individuals with schizophrenia and also is two to four times more frequent than for the general population.

In thinking about our presentation today, on slide 6 we organized our thinking conceptually based on service and system-level integration, with “integration” obviously being the key word.

Slides 7 to 9 provide you existing examples of integration in those two categories and also provide some references for you.

Turning to slide 10, this is where we get to our recommendations for today. Really, the point here is that individuals with a dual diagnosis must be incorporated into any reformed mental health and addictions system. But unfortunately, they also provide the best example of the worst that can happen when you have complex, more than one need.

With that in mind, we have some recommendations, the first being a flexible system structure, starting not just at a service level but at an interministerial level, so that there is a culture of integration and working together across the various ministries.

Secondly, of course, it requires the ability to move flexibly between systems, like moving from children to adults and so on. I think it’s notable that although this is being sponsored by the Ministry of Health and Long-Term Care, the trajectory of an individual’s illness and recovery means that their involvement with the Ministry of Health is rather limited and in fact periodic, as opposed to housing, ODSP and primary care services. We have to really think about the structure of the system in that regard.

Then, of course, resources for service and system-level integration: There’s a history, particularly within health but within other ministries, that system navigators and case management is not funded or supported.

Turning to page 11, I talk a bit here about the funding formula, particularly with regard to treatment—the focus on funding is more around hospital beds than it is around community support—and of course the need for a competent workforce and career paths.

Training in mental health is not a priority for nurses. Training in developmental disabilities and dual diagnosis only recently became an elective, but not a requirement, for psychiatry residents.

And then, finally, the notion of a continuum of services: Just like for health care and diabetes, individuals with developmental disabilities should have access to specialized and knowledgeable services so that the system is tiered and people move through as necessary.

I’m going to turn it over to the last slide and to my colleague, Jim.

Mr. Jim Johnston: Thank you for the opportunity to talk about what the challenges are for families who have a family member with dual diagnosis, which includes myself.

As our children with intellectual disabilities age, mental health issues become more apparent. Our family’s

issues really started in the teen years and became worse as appropriate services were difficult to find.

I’m sure you’ll understand how rejection, teasing, loneliness and isolation for someone with an intellectual disability can lead to depression and anxiety, emotional outbursts, anger and aggression.

Having a child with a dual diagnosis creates great pressures in the family. As the mental health issues manifest themselves, the family is unsure of how to help the individual. Are the behaviours the result of the intellectual disability or are there other factors involved? Stress and frustration affect all members, often leading to physical or psychological symptoms in family members. Help seems fragmented and remote. When a professional or team has the knowledge and training to really help the family as a whole, the difference can really be profound.

Abuse, and particularly sexual abuse, has a significant impact on those with an intellectual disability; it’s four to five times more likely in this population. Many can’t communicate. They make poor witnesses in court and they become easy targets. If you can imagine the impact on a normal person’s life when they are sexually abused, you can barely imagine what a person goes through who can’t talk about it and can’t express their anguish. If there are mental health problems, they are worsened; if there are not, they may be triggered. Many families, including ours, have gone through this trauma.

A friend’s son, who was sexually assaulted by a priest, is now labelled a difficult case, with severe behavioural problems. Medication has meant a weight gain of 125 pounds, with accompanying health problems. The family can find no agency which will support him, so he lives at home with his family, who are also in crisis. How can our system fail these individuals so badly?

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Many consumers are undiagnosed or diagnosed in one aspect only. Some are identified with intellectual disabilities as children but may never have had their mental health needs identified or been reassessed as they aged and experienced stress at various stages in their lives. These mental health issues often show up as behavioural problems, and social workers, the police and others treat the behavioural problem without identifying or treating the mental health need, which can be very unproductive. If there is an undiagnosed mental health issue, a crisis will almost invariably result.

I wonder why we don’t have a system where health and developmental sectors co-operate to determine the best for each consumer, which would then drive required changes to the system. I know there’s a joint policy guideline between health and MCSS for the provision of community mental health and developmental services for adults with a dual diagnosis, but from my perspective, I’ve seen little implementation of that policy.

It can be complex to understand how intellectual disabilities and mental health problems interact. Mental health problems can be mistakenly seen as part of the intellectual disability. If a person is impulsive, withdrawn or irritable, this may be attributed to the intellectual

disability, and many are improperly diagnosed and overly medicated.

Parents need flexibility. Some parents with children with a dual diagnosis are willing to design a program themselves to fit their children's needs. Individualized funding is a way of providing this flexibility, but funding is scarce and most parents are unable to access adequate funding of this type.

But each individual is unique. Each case needs an effective assessment so proper supports can be developed. Unfortunately, there are few professionals in the field knowledgeable in assessing and treating those with a dual diagnosis. Training of medical professionals and workers is key.

Developmental agencies often do not have the capability of dealing with someone with a dual diagnosis since there is little training on mental health matters, yet the staff are expected to deal with some of the most difficult issues and behaviours.

Some agencies are unwilling to accept those who have mental health needs with the accompanying behavioural issues. They are disruptive to the day program or group home and take more staffing. Government funding must be flexible enough to recognize this and step up to those issues quickly.

Families that we deal with continue to ask for:

- co-ordinated assessments, where developmental, mental health and physical health factors are all assessed and integrated so that an effective plan can be created;

- accreditation or some other measure of quality that allows families to assess which agencies meet or exceed standards of excellence in their programs;

- recognition by government that workers in this field must be highly skilled and paid. Current salaries are not enough to attract and keep good staff;

- access to case management support that can help the family navigate both sectors and receive general support to keep the family unit strong;

- assurances that services will be there when families can no longer support their children;

- better education for medical and support staff in the field of dual diagnosis;

- flexibility, including individualized funding; and finally and perhaps most importantly,

- respect for our children, seeing them as valued members of society.

To conclude, I believe we have a moral obligation to work together to change the system so that our children can live a life that has meaning and gives them a feeling of worth and acceptance in the community.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Jim. Thank you, Susan. You did leave some time for questions; that's great. We've got about a minute each. Christine, if you want to—

Mrs. Christine Elliott: Thank you very much for coming to present today. You've highlighted really effectively some of the challenges that are faced by people who have a dual diagnosis. Some of the housing issues, I think, are particularly relevant. I come from

Durham region. I've met with many families where they're trying to find a place for their family member to live safely and comfortably, and there are just very few facilities available. That's certainly on our radar as we consider this. I thank you.

I also appreciate the inclusion aspect of it. I think we still have a lot to learn about how we can be truly socially inclusive. Thank you very much for bringing that forward.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Christine. Any comments, Howard, or questions?

Mr. Howard Hampton: I have several questions, but the housing issue is one that constantly jumps out at me. I wonder if you have any suggestions. It doesn't matter if you come from large communities in Ontario or small communities in Ontario; the need for supportive housing, housing that has services attached to it, is huge. Do you have any ideas?

Mr. Jim Johnston: Well, I think that if there's an integrated assessment in the first place, you realize how much support the person needs. The tendency now is to say, "Well, an adult can move into semi-independent living," and with people with a mental health need and an intellectual disability that just doesn't work. So you have to assess the person.

When you realize the need after that assessment, you realize that you have to have a supported group home, and then it's—you pass the ball over. You need money. You need to buy the home and you need to staff it, and that becomes the issue.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Jim. Anything from this side? Maria?

Ms. Susan Morris: Can I make a comment?

The Chair (Mr. Kevin Daniel Flynn): If it's really brief.

Ms. Susan Morris: Really brief. If we had 2,000 people on a waiting list for some kind of heart care, we wouldn't stand it. We have 2,000 people or more in Toronto waiting for housing. We withstand that.

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

Mrs. Maria Van Bommel: I just wanted to ask Jim: You talked about the point where you realized your child has more than just developmental challenges. What age was your child when you realized that this was beyond just developmental?

Mr. Jim Johnston: I think when we really began to realize it was when they were in their early teens. I have two children who have intellectual disabilities, and when they were children we just thought it must be part of this intellectual disability. It was confusing and difficult and hard to find services, so the outbursts and everything, it was just, that's the way they were. It was only a little later that we began to get some advice about, "This may go beyond this."

Mrs. Maria Van Bommel: So do you think that it actually started well before their teen years, then? When they were still really small children?

Mr. Jim Johnston: I don't know. I wish I knew. I wish I could give you an answer to that. It may well have. I mean, my daughter went into a severe depression and we realized that was a mental health problem, and we began to deal with depression now as opposed to an issue of an intellectual disability.

In their early years, you know, it was hard to say. If we had had a good assessment it might have been better.

The Chair (Mr. Kevin Daniel Flynn): Thank you for a wonderful presentation. You did a wonderful job of getting your point across, and thank you very much for joining us here today.

CHRISTINA JABALEE

JENNIFER TAKACS

CAROL FARKAS

The Chair (Mr. Kevin Daniel Flynn): Okay, if you look to your agenda for the day, two of our delegations, the one at 4:30 and the one at 4:45, are not coming today. However, Christina Jabalee is going to move up on the list, so if you'd like to come forward, Christina, and whoever you've brought with you. Make yourselves comfortable. There are probably some clean glasses there and some fresh water. There's even a microphone for the baby, if—

Ms. Christina Jabalee: He has a lot to say.

The Chair (Mr. Kevin Daniel Flynn): It looks like he's got something to say.

Make yourselves comfortable. Like everybody else in the presentations, you get 15 minutes. You can use that any way you see fit. If there's a chance you can leave some time at the end for any sort of questions and discussions, we'll try and split that evenly amongst the group, but it's all yours. Relax.

Ms. Christina Jabalee: I think we're going to divide it, half and half. So can we just turn this on so that she's ready to go?

The Chair (Mr. Kevin Daniel Flynn): That will turn on itself, and if you stay about a foot away from them, they work perfectly.

Ms. Christina Jabalee: Okay, wonderful.

The Chair (Mr. Kevin Daniel Flynn): And if each of you would introduce yourselves as you speak so the people from Hansard who know who's speaking.

Ms. Christina Jabalee: Sure. My name is Christina Jabalee; I'll start first. I've kind of written in here who we are, but we'll try to follow along.

We're here to share the story of how our family has been impacted by mental illness and the mental health system. Our brother Michael suffered with mental illness from the time he was 15. Since then, he had times where he was buried in the depths and darkness of depression and, during others, tortured by the paranoia, fear and confusion of psychosis. He lived the agitation, sleep deprivation and chaos of mania. It is with tremendous sadness that I share that Michael is not here to tell his story.

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Michael took his own life last year on July 24 at the age of 25. We are Michael's family. Carol is his mother. She's a mother of three and resides in Oakville. She journeyed with Michael throughout his life and illness, attempting to navigate our system of fragmented mental health care. We are Michael's sisters. My name is Christina and I live in Burlington. I have completed my bachelor of social work and now work as an early intervention family worker for the Schizophrenia Society of Ontario. Jennifer is the mother of my two beautiful nieces and an adorable nephew. They live in Waterloo and she is a family doctor.

We quickly lost confidence in a mental health care system that was unable to provide Michael with the treatment and us with the support that we all so desperately needed. We have come here today equipped with our family's experiences to help you improve our current system. We want to learn from Michael's life and suffering and our suffering so that others will find the help that we did not.

When Michael first displayed symptoms of a potential mental illness at the age of 15, he saw our family doctor. He was exhibiting classic signs of depression. He was sleeping 16 hours a day, not eating, crying a lot and unable to function. There was a six-month waitlist for him to see a psychiatrist so he left that day with no referral, no medication and no further support. His symptoms worsened. He struggled to go to school and dropped out without completing grade nine.

His second attempt to access treatment came at age 17, when Michael had his first manic episode. He was not sleeping. He began working as a roofer, engaging in risky behaviour. His thoughts were racing; he was disorganized and frantic. He fell off a roof and presented to hospital for the first time. But it wasn't until he climbed to the top of the hospital's four-storey parking garage and threatened to jump that he was eventually admitted. Looking back, we are pained with the thought that if he had received early treatment, his illness would not have prevented all the attempts he made to try to have a quality life.

Over the next several years, Michael was in and out of the system, repeatedly treated for brief periods and then discharged without any plan to keep him well. When he was discharged after that first hospitalization he was diagnosed with bipolar disorder, but was provided no psychiatric follow-up. Having been untreated for two years, Michael's mental state continued to worsen. He moved rapidly between depression and mania and first began to experience psychosis. Michael was then hospitalized because he was a risk to himself and others.

After several months in hospital he was discharged with a prescription for an antipsychotic, a mood stabilizer, but no follow-up appointment. The social worker actually copied names from the Yellow Pages and told Michael to find his own doctor. The plan was for my mother to take him to the YMCA. She had to pay his weekly rent for the next two months because Michael had

yet to receive his approved ODSP. Throughout the journey, clothes, food, accommodations were always provided by my mother, even though it was a financial and emotional struggle for her to do so. This became a recurring theme. We are now aware of the significant shortage of psychiatrists and family doctors; however, it is unacceptable for someone to be discharged from hospital without any medical follow-up or community supports. There is a need for improved coordination between mental health services and medical practitioners in order to close this critical gap between in-patient and outpatient care.

As a family, we were constantly at the whim of Michael's symptoms. Our family life revolved around the distress of the illness. We never knew what would be happening next and we lived with a learned helplessness that we couldn't prevent the next crisis. We never received any education about his diagnosis or prognosis. We were left on our own to interpret and cope with Michael's bizarre and at times frustrating behaviours and a system that we did not understand.

Looking back, I am filled with guilt. My patience was worn thin with the symptoms of the illness. I never knew there were other ways for families to cope and respond. I know now, because I facilitate support and education groups for families and see the positive impact it has on their mental health and their relationships. Where was this for us? It is extremely painful to be aware that it wasn't for a lack of medical understanding about mental illness, but a lack of appropriate dissemination of that information that added to our family suffering.

Ms. Jennifer Takacs: I'm Jennifer Takacs; I'll take over from here.

Eventually, Michael's agitated and impulsive behaviours led to run-ins with the justice system. We suffered to see him spend one year in a correctional facility, where he remained untreated and deteriorated. He was targeted by other inmates; once almost suffocated by being rolled in a rug, another time needing stitches for a facial wound, and then protected by being placed in isolation for days to weeks at a time. I would visit Michael with my daughters because it was so important to support Michael and have a relationship with him; he absolutely adored his nieces. These visits were not at all easy. Jail and forensic institutions are not for children, and they should not be for the mentally ill either: They are often equally vulnerable.

When he was released after that year, he was acutely ill. He was paranoid, delusional and hearing voices. He didn't sleep for days. Within three weeks, he succumbed to his psychosis and assaulted a family member and then attempted suicide.

As a family, we were desperate to get him the help he needed. We were advised that he would be best treated in a forensic facility, which meant we had to press charges. Michael was eventually found not criminally responsible and spent the next four years, the last of his life, under the Ontario Review Board.

We were all very close to Michael. We spoke often, sometimes at 4 in the morning. We were always acutely

aware of his mental state. We needed a means to communicate this with his treatment team. However, due to very strict interpretation of the privacy laws, any information that we provided to his treatment team was communicated directly to Michael. Michael was often very paranoid. This pattern made it impossible for us to communicate our concerns about Michael's mental state without worsening his paranoia and causing him to mistrust us.

Paranoia is not a symptom which is unique to Michael. In fact, it is often a prominent feature of psychosis. A mechanism needs to exist for caregivers to give information to treatment teams without these repercussions.

We felt sandwiched between wanting to protect our relationship with Michael and wanting to protect and help Michael. In his last months, we had become so crippled by the poor lines of communication that we could not safely express our intense fear for Michael's safety. Michael took his own life, and we felt powerless to prevent it.

We are left feeling sad, feeling guilty, feeling there was so much more that could have been done, yet feeling exhausted from the years of struggling and now knowing that we didn't have the tools to do more. It hurt to watch Michael suffer, it hurts to live our tragic story, and it hurts even more to go on without him. There is much to learn.

That is why we have come here today. We want to help change a system that made appropriate treatment for mental illness practically unattainable and good mental health for all of us very difficult to achieve.

We are asking you to consider three things: a focus on earlier intervention, more public and family education and better lines of communication.

Early intervention can improve prognosis, lower the burden of disease and, most importantly, improve the quality of life for all those affected. Early intervention is only possible when we are able to recognize the onset of disease and immediately access appropriate treatment and resources. Often that first presentation is to a family doctor, and not only do we have a shortage of family doctors in Ontario, but the resources available to those doctors are severely limited. I require far more than my prescription pad to effectively treat mental illness, and other mental health care workers play a vital role in treatment and recovery.

Family health teams are one such model, where social workers, psychiatrists, family doctors and psychologists can work together. I had the privilege of training in this environment and have seen first-hand the benefits of this model. More family health teams would increase to appropriate primary care, allow for earlier intervention and improve continuity of care upon discharge from hospital. But even more importantly, access to these services needs to be readily available to all family doctors and their patients, regardless of practice model.

In recent years, multidisciplinary early intervention programs for psychosis have become available. They are run as outpatient teams, of which Christina is a partner.

We would like to see these programs expand beyond the diagnosis of psychosis as, in our case, Michael only developed psychosis three years after his first presentation. We need to continue to support these initiatives and increase awareness of their existence.

Secondly, we believe that education of the public and caregivers will work to reduce stigma, increase knowledge and promote a positive environment for early intervention. One such program, for which Christina is also a presenter, reaches into schools and youth groups; it's titled TAMI, Talking About Mental Illness, and is run by the Halton region.

Organizations such as the Schizophrenia Society of Ontario are also equipped to provide numerous resources, including education sessions to assist families. We need to increase the public's and health professionals' awareness of organizations and programs such as these. We should look to these programs as examples of what can be accomplished, and strive to increase their resources and their reach.

Finally, we ask you to strongly consider how we could increase primary caregiver and family involvement in the mental health care system. Families are the private-sector caretakers for people with severe and persistent mental illness. Their involvement is often significantly dismissed.

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Family workers who focus on the specific needs of families are desperately needed. Caregivers and family members are at greater risk of developing mental illness themselves. Supporting families has many benefits.

We thank you very much for giving us the opportunity to share our experience and we very much appreciate your efforts.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We really appreciate you being here today.

You've left some time for questions, which is great. Howard, I think it's your turn to kick off first. We've got about a minute or so each.

Mr. Howard Hampton: It's hard to know where to start, but the overwhelming impression I got is that services were there, but the services were hardly ever coordinated or integrated to work together, and your brother, over and over again, was simply slipping through the cracks. Is that a fair assessment?

Ms. Christina Jabalee: Absolutely.

Ms. Jennifer Takacs: For sure, and I think that would be a fair assessment for a lot of people, not just our brother. I think that's the saddest part of how the system functions. I think Christina said it well also: The services are there, but as you said, they're not integrated, they're not coordinated, and a lot of times, we working in the profession don't even know how to access them.

Mr. Howard Hampton: Do you have a theory as to how this could happen?

Ms. Jennifer Takacs: That's a good question.

Ms. Christina Jabalee: I think often, the services don't know about each other. Now that I'm working in the field, it's amazing to find out who doesn't know

about each other and that even similar programs can be occurring and they don't even know about each other. I think there's just such a disconnect about what's actually going on there. There's no central hub where we all can find this information, and if there is, we don't know about it.

Ms. Carol Farkas: And there's no sharing of the information. You can go from one civic hospital to the next civic hospital; they won't share their records. There is no continuity. They're totally isolated silos.

The Chair (Mr. Kevin Daniel Flynn): Does anybody from this side have a question? Maria?

Mrs. Maria Van Bommel: I just want to go a little bit further from where Mr. Hampton went when you talk about coordination of services. Do you find that in a lot of situations, everybody seems to have a little piece of this and nobody has it all? You know, it's sort of scattered, and part of the problem, like you say, is that you don't even know about each other. But everybody has some sort of a claim to—

Ms. Jennifer Takacs: Every patient or every—

Mrs. Maria Van Bommel: No, no; every agency that has claims that they're delivering some mental health services—but nobody is coordinating that. Even in terms of government funding, we're funding a little bit here, a little bit there, and there's no coordination between any of it so you don't know who's delivering primary types of services and who's delivering more acute or advanced services, or everybody's doing primary, nobody's doing advanced and nobody knows who's doing what.

Ms. Christina Jabalee: Everybody's focused on their area, and it came out clearly with all of Michael's discharges from hospital. There's a social worker, someone who's willing to talk to my mom while he's in hospital, but he's there for maybe three days, a couple of weeks, however long that is. When he gets out, they don't try to link you to a similar service or support. So then you're just dropped because they only know about when he's in hospital. They're not thinking of that continued care afterwards, which is what you would think would happen.

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

Mrs. Christine Elliott: Thank you very much for joining us today. My question relates a little bit more to your brother's situation. I'm sort of gathering that he wasn't really amenable, necessarily, to treatment, that it was more the family who was trying to get help for him. Is that fair to say?

Ms. Jennifer Takacs: Well, I think it would have fluctuated because his illness fluctuated a lot. Definitely someone who's depressed is often more willing to seek help than someone who's very manic and grandiose and thinking that they've got everything under control. So for sure, I think his illness in general was difficult to treat. At times he would have been harder, so yes, sometimes we were seeking treatment on his behalf. But even when he was willing to take his medication—his mood stabilizer and his anti-psychotic—there was no physician for him

to see. There was no one to renew his prescription. There was no one to support him in his endeavour, to help him find a job, maintain employment or maintain housing. There was a big lack. They would get him stabilized in hospital, he'd go to the community, and then you're basically left waiting for the next crisis.

Ms. Christina Jabalee: One example that we left out of the speech was that three weeks before he died, Michael was so stressed out with his symptoms and hallucinations that he actually took himself to a crisis centre to check himself in, which he never did. He packed a bag and everything. They were so uncoordinated. They had no idea who he was, even though that was his emergency care; he was supposed to go there. Basically, they gave him medication and sent him home. Three weeks later, he dies.

He was so unwell, so that kind of stuff was happening. Even when he was reaching out, the coordination wasn't there. It was both.

Mrs. Christine Elliott: It points to the need for someone to sort of be almost a navigator for—

Ms. Jennifer Takacs: Well, I think mental illness is really a chronic illness. We wouldn't let somebody with diabetes have absolutely no medical care or support. To just treat someone acutely in hospital with a mental illness—and if they need to be there for several months, to just send them out into the community and say, “Find your own doctor with the Yellow Pages”—it's not appropriate. We wouldn't treat people with other medical illnesses that way, and we shouldn't treat the mentally ill like that either.

The Chair (Mr. Kevin Daniel Flynn): Thank you. One final question I had—it just intrigued me out of the whole presentation—is that Michael spent a year incarcerated, you said—

Ms. Jennifer Takacs: Yeah.

The Chair (Mr. Kevin Daniel Flynn): Even during that period he received no treatment?

Ms. Jennifer Takacs: No. He received some—

Ms. Carol Farkas: Epival. A little bit of Epival.

Ms. Jennifer Takacs: He did receive a little bit of a mood stabilizer—

The Chair (Mr. Kevin Daniel Flynn): Just medication—

Ms. Jennifer Takacs: He was given a sedative, but he definitely was not appropriately treated.

Ms. Carol Farkas: Can I say something? At the very, very end of—actually, it sounds like he was a year in one spot; but that's not how it works. They were working him up to Rideau for correction, but he was too paranoid and not able to co-operate. He ended up at the St. Lawrence Valley, which is the psychiatric ward of the jail system. And like they said to me, he doesn't belong in jail.

But basically, again, they don't go to the hospitals; they don't get any prior records. They just deal with the immediate thing in front of them. They gave him, like I said, a little bit of Epival, and when they went to release him, I did get to talk to some social worker, and she said,

“Okay, a little bit of Risperdal.” I think it was two milligrams.

Anyway, that's what happened.

Ms. Jennifer Takacs: So he was undertreated, and his illness was under-recognized. I think, at some point, people recognized that he was ill, but he wasn't treated as a patient; he was treated as an inmate, and so he just deteriorated. The whole environment, you could imagine, would increase someone's paranoia and psychosis. He was much, much worse when he left.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today and telling Michael's story. I know that all the committee members really appreciated it. Hopefully some good comes from what you did today.

Ms. Jennifer Takacs: Thank you very much.

NICKEL-A-DRINK FOR ADDICTIONS AND MENTAL HEALTH RESEARCH FOUNDATION

The Chair (Mr. Kevin Daniel Flynn): Our next presenters this afternoon are from the Nickel-a-Drink for Addictions and Mental Health Research Foundation: Lembi Buchanan and Wayne Skinner. Are they here yet? There we go. Thank you for moving up a little bit in the agenda for us today.

Ms. Lembi Buchanan: No problem.

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 left over, we'll share it like we just did. Thanks for coming.

Ms. Lembi Buchanan: Well, thank you very much for the opportunity. I'm the president of the Nickel-a-Drink for Addictions and Mental Health Research Foundation, and Wayne Skinner is the deputy director for addictions programs at the Centre for Addiction and Mental Health.

Nickel-a-Drink for Addictions and Mental Health Research Foundation was incorporated in July 2007. Our foundation is the only family- and consumer-driven national organization whose mission is to support research activities into the causes of addictions and mental illnesses.

The inspiration for the Nickel-a-Drink initiative is credited to the former US Surgeon General Everett Koop. He asked the question, “Who could quarrel with a nickel-a-drink user fee?” to help pay for alcohol abuse prevention programs and related medical services.

In 2006, the Senate of Canada also recommended that the excise tax on alcohol be increased by a nickel a drink to raise the money to pay for the programs outlined in its report *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. According to the report, such an extraordinary measure was necessary because, “Canadians living with a mental illness or substance abuse problem have been neglected, or at best, substantially underserved for so long.”

Our provincial government, not unlike the federal government, has a disproportionate dependency on revenues

obtained from the most vulnerable and high-risk consumers of alcohol to pay its bills. Residents of Ontario consume over four billion standard drinks each year, producing \$1.4 billion in dividends from sales of the Liquor Control Board of Ontario and another \$398 million in PST. Not a nickel was spent on research related to the causes and cures of addictive behaviours.

1700

Some 10% of the population consumes more than half of the wine, beer and spirits sold in the province; 20% of the population consumes approximately 75%, contributing \$1.35 billion to the government coffers—and I'm sure you all know what \$1 billion means. These are the people who are the most vulnerable to the harms related to alcohol. Just about all of them would qualify for treatment; however, we do not have an adequate strategy to better understand, prevent and treat problems associated with alcohol abuse. Young people aged 18 to 25, who have the highest alcohol consumption of any group, are especially at risk.

No one denies that drinking is a risky behaviour. It persists even with the knowledge of negative health and social consequences, because alcoholism is a chronic and relapsing brain disease. Despite its profound effect on our society, less than \$10 per person is spent on substance abuse treatment programs.

In December 2008, Auditor General Jim McCarter highlighted how the province is failing some of its most vulnerable citizens. He suggested that up to 90% of those needing addiction treatment might not be getting it, even though the annual economic burden of alcohol and substance abuse in Canada exceeds \$14 billion—that's \$1,185 per person—considerably higher than any of the other disease groups. But there has been no political will to treat addictive behaviours with the same urgency as physical medical conditions. Instead, the revenue from the sale of alcohol is allocated to pay for education, health care and other important government programs and services. The key health priorities in our society include chronic diseases such as cancer, heart disease and diabetes, and we have to remember that alcoholism is a chronic disease as well.

In fact, the slice of the pie spent on addictions and mental health in our province is getting smaller each year. In 1996, 6.9% of the health care budget went to mental health and addictions. In 2006, only 3.3% of the overall health care budget went to mental health and addictions.

Interjection.

Ms. Lembi Buchanan: We're trying to get coordinated here. I just want to talk briefly about the harms of alcohol consumption before Wayne continues this presentation.

Although a glass of wine may be good for the heart, excessive alcohol consumption has a detrimental effect on a number of medical conditions, contributing significantly to the high cost of our health care. Research has already established the complexities of the relationship of alcohol consumption and health outcomes: As many as

60 diseases are adversely affected by heavy drinking, since alcohol affects many organs of the body. Prenatal abuse of alcohol is the leading cause of birth defects, including fetal alcohol syndrome.

Long-term alcohol abuse puts you at risk for developing the following conditions: certain forms of cancer, especially cancer of the mouth, esophagus and the throat, liver disease and heart disease. Alcohol is a central nervous system depressant, leading to reduced work performance, impaired concentration and memory and impaired driving. Every single day, four Canadians are killed on the highways and 200 are injured because of impaired driving. Alcohol also alters brain receptors and neurotransmitters, increasing the probability of aggressive behaviour. Alcohol is often associated with domestic abuse, crime and violence, including homicide and suicide. Nearly 25% of the people consuming alcohol have indicated that they have caused harm to themselves or others when they have been drinking.

Now, Wayne is going to continue on and talk about the current provincial approach to alcohol problems.

Mr. Wayne Skinner: Thank you again for the opportunity to be here, and it's an honour to participate with Lembi, whose work in this area I admire greatly and I'm happy to support.

I just want to talk about Ontario's current approach to alcohol and substance use problems in general. The Ministry of Health and Long-Term Care is the lead in this area. Over \$120 million is spent every year for specialized substance use treatment services in Ontario: a wide range of services, from withdrawal management through community to residential services.

There's a bit of money that is spent on the prevention side, and, actually, the government's investment in research is pretty hard to find. There are places like CAMH, where I work, and other institutions that do research, but our research is funded from other sources, either provincially, nationally or internationally. The balance in Ontario, then, is very much towards treatment funding, but even that, one can argue strongly, is underfunded.

There's a dilemma here, because generally health care costs are increasing. There are priorities that we all recognize and typically they do tend to trump alcohol and drug problems when investments are made. So the issue becomes how to deal with funding alcohol and substance use treatment services, and mental health as well, when you have these other priorities. The solution that we think needs to be considered is looking toward the behaviour itself.

Just generally, it's worth noting that the funding and investment that is being made in this area hasn't kept up with inflation over the past while—Ms. Buchanan mentioned this in some comments—and generally, this tends to be an area that can go to the backburner very easily, even though it insinuates itself into many health problems that we are trying to deal with, some of them ones that we give urgent status to.

Really, the issue, in our view, is that we need to start dealing with this imbalance between the revenues that

society takes from consumers of alcohol—in terms of what the government is getting out of it, and corporate profits as well—and our investment in preventing and reducing alcohol-related harms. That's the dilemma right now.

Essentially, this is, in our view, kind of a key issue, and there is a remedy for this. Rather than having to compete with other health care priorities from general tax revenues, our view is that monies from the consumption of alcohol should be applied to education, prevention, treatment and research of alcohol and related substance use and other problems that apply.

The nickel-a-drink movement is something that this foundation that Ms. Buchanan has set up deals with. If we were to apply across the board a nickel-a-drink surcharge to every standard drink consumed in Ontario—and I don't know if you know what a standard drink is, but we can maybe talk about that later, if you want—it would produce an annual fund in excess of \$200 million. The idea would be not to put it into general revenues but to direct it toward addressing problems related to substance use and abuse in Ontario. That would virtually double the current investment without having to find other sources of government revenue to do it.

The question becomes, can we tolerate adding five cents a drink to the cost of every standard drink? The US Surgeon General quote from a while ago suggests that even then, when a nickel was probably more than it is today, it was not a bad idea. This would be a modest amount to a standard drink. Anybody drinking in a public establishment and giving a tip will give more than that. Probably the cheapest standard drink you could buy would be a 24-pack of beer and that's probably a dollar a bottle.

The idea that this money would be invested back into the prevention, treatment and research of these problems is what we think is the selling point in making a policy initiative like this. The brewing industry didn't face any objections in 2008, when it lobbied for an increase in the floor price of beer. The whole idea of doing this, in our view, is not—there doesn't need to be a barrier. There needs to be some will to act decisively in this area.

There is one area, actually, where there is a policy framework that is worth emulating and that's in the gambling area. The government dedicates 2% of new slot machine revenues and that's how it funds its problem gambling strategy in Ontario. And guess what? That's a much more robust strategy than we have for substance abuse. In Ontario, we pay for treatment; we don't pay for prevention or research. In the gambling area, we have a strategy that pays for a treatment system and prevention, and it also pays for research. That is the direction, we think, that can allow for an innovative response to what I think everybody would agree is an important social problem.

Ms. Lembi Buchanan: So in conclusion, as it stands now, the real winners, from my understanding of the harmonization tax process, are consumers of alcohol. The agreement with the federal government requires the

province to lower taxes on alcohol to a standardized 8% from 12% for LCBO purchases and 10% for beverages consumed in licensed establishments. This is a perfect opportunity for our government to exercise social responsibility by proposing new legislation not only to protect its existing revenue with adjustments to various fees, but also create a dedicated tax levy to close the gap between the cost of the disease burden to our society and the dollars earmarked for addiction prevention, treatment and research, including mental co-morbidities.

1710

People who are most vulnerable to the harms related to alcohol are already providing most of the revenues obtained from the sale of wine, beer and spirits in our province. Therefore, investing a portion of these revenues to address alcohol-related problems makes sense, both intuitively and ethically. The provincial government has already created a similar program, as Wayne indicated, so the precedent has already been set by this government. I understand that it's probably the best program in the world as such in terms of taking an allocation of the revenues from gambling and apportioning it out to various areas.

By adopting this nickel-a-drink initiative, we can make a real difference, not only for the people who are abusing alcohol and drugs but also their families. We will also reduce the economic and disease burden in our society. In your folder you have a copy of an article that André Picard wrote over a year ago about our foundation. He said that if we can adopt this kind of initiative, the end result would be priceless.

The Chair (Mr. Kevin Daniel Flynn): Good time management. Did you hear the beep? That was a wonderful presentation. Unfortunately, we have no time left for questions but I believe the members got your point very clearly. Thank you very much for coming here today.

Ms. Lembi Buchanan: I appreciate that. I didn't really time it with a stopwatch, but—

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

Ms. Lembi Buchanan: Thank you again.

CHILD DEVELOPMENT INSTITUTE

The Chair (Mr. Kevin Daniel Flynn): Our 5:30 appointment has also agreed to move up. Tony, are you in the audience? If you'd like to come forward, Tony Diniz, executive director of the Child Development Institute. Like everybody else, Tony, you get 15 minutes. Use that any way you see fit. Make yourself comfortable, and if there's any time left at the end, we'll use that for questions.

Mr. Tony Diniz: Thank you, and I hope I don't hear that little beep before I reach my time, because that would be the worst.

Good afternoon. I'm Tony Diniz and I'm here as executive director of the Child Development Institute, which is located in downtown Toronto. I'm also a board

member of Children's Mental Health Ontario and a board member and president of the Child Welfare League of Canada, which has a national focus on vulnerable children and youth.

The Child Development Institute serves the needs of children under the age of 12 and reaches more than 4,000 families and children annually through a range of programs, including healthy child development, early intervention and family violence. Most importantly, I'm really proud of the fact that this year we're celebrating our 100th anniversary and we're looking forward to our second century of service to Ontarians and Torontonians.

I welcome the work of your committee and the opportunity to provide input. There's so much that I'd like to say on the subject of children's mental health, but with the limits of time and the fact that I suspect you'll hear from many others on this key subject, I'm really going to limit my remarks to one area.

The Child Development Institute has a strong emphasis on evidence-based programs and practices. While our programs serve some of the most difficult children and challenged communities in Toronto, we have a core commitment to a scientist/practitioner model where science informs practice and practice informs science. The whole point of this is to increase the effectiveness of our work. Just as we have service partnerships with the boards of education, child welfare and other providers, we have research partnerships here in Toronto with the University of Toronto, Sick Kids, OISE and York University. Further afield, we have partnerships with the Karolinska Institutet in Sweden, the University of Pittsburgh and University of Cambridge, and I'll just mention that Pittsburgh and Cambridge house two of the most important world scientists in children's mental health.

I'm going to speak about SNAP. SNAP stands for Stop Now and Plan. It's an award-winning Canadian model designed by a child development institute to help young children with aggression and conduct disorder who are in conflict with the law. These children are under the age of 12, but well on a trajectory toward serious criminality and violence. The program strategies uniquely marry the education community, children's mental health and police services.

SNAP begins with a protocol to get kids into service; so while they can't be charged under the age of 12, they can't be ignored either. We want them into programs that are going to hopefully improve their lives and their life chances. We have also developed assessment tools to help us understand and measure particular kids. In the third stage, the SNAP program actually helps kids and parents deal with anger. It really teaches kids to stop now and think before you act. I'm sure there are days when all of us could benefit from that, and with a little snap we could make better decisions consistently.

This evidence-based program has proven effective because at its heart, it's simple. It's easy to learn. Kids like it. They can practise it. They can practise their real-life situations that happen on the playground and under-

stand how to manage them in a better way. At the same time, brain research is showing, through imaging at Sick Kids, that SNAP actually alters the brain pattern of the kids who participate in our programs. They start using a different part of their brain, which is factored with control and reason, rather than with impulse and outrage. That's actually showing up on brain imaging. SNAP works through the most rigorous research studies and research is showing us that results stick and are long-lasting.

Now, I'm not here just to tout SNAP. I'm here to talk about evidence-based programs, and not all evidence-based programs are created equal. Because of the strength of the research and the extent of change, SNAP has the highest endorsements. It's achieved exemplary status from the Office of Juvenile Justice and Delinquency Prevention in the United States and exemplary status from the White House's Helping America's Youth. In Canada, SNAP has been endorsed as an exemplary program by the National Crime Prevention Council. Because of this rating, the National Crime Prevention Council is actively funding the rollout of SNAP sites across Canada. This past month alone, we've seen SNAP programs being established in Calgary and in Niagara and, most recently, Minister Peter van Loan announced major SNAP programs in Toronto schools in partnership with Safe School Network. Many other sites and announcements are in the wings.

We have about 100 sites across Ontario and Canada, the US, in Europe and now in Australia. We have two large SNAP sites in Dade county—which is Miami, which has serious juvenile issues—and Pittsburgh, and both are under very close third party evaluation. I have to tell you, we're very proud that a made-in-Ontario solution is being selected as a children's mental health program in many other communities globally and that the replication results are showing the same strong outcome globally as we've demonstrated locally.

In the course of our work, we deal with many jurisdictions that are looking for solutions. We are actively visited by lawmakers—recently from Norway and England; we'll be hosting the minister from Brussels very shortly—and they're looking for solutions. We're on their port of call. They recognize now that science is a key factor in program selection and that the Internet has dramatically sped up access to this information. We see policy- and lawmakers looking for the world's best programs in the same manner that they would look for the world's best-proven medical procedures. We see jurisdictions boldly rolling out children's mental health evidence-based programs at scale, because they know that they have to get the best outcome for their investment. For example, Norway has implemented three leading evidence-based programs, including SNAP, right across their country, with consistency and purpose.

1720

In Ontario, we have recognized in policy documents the importance of evidence-based programs, but I have to say that we're stalled at that point. Language to that

effect appeared in the document *A Shared Responsibility* several years ago, and there has really been no further movement there. It seems to me that we don't have a strategy in Ontario to move this forward.

We can't afford to work this way anymore. We just can't afford to do it. It's the difference between effort and intentions—however well-intended—and results and outcomes. I have to say that trying is no longer good enough when we know we have hard facts and science with which to choose programs.

Ontario is behind other jurisdictions in ensuring that Ontario's children, youth and families have access to proven and best programs. I urge you to include in your report a recommendation that within six months after consultation with stakeholders, Ontario adopt a strategy to transform its funded children's mental health services toward a system of programs that are evidence-based or at least that can demonstrate a level of a promising practice.

Finally, if I may, I'd like to make one other point. Over the course of our research work in childhood aggression, we began to understand some years ago the extent of girlhood aggression and that this aggression looked and was different in some ways from boy aggression. In particular, without intervention, these girls are at high risk for teenage pregnancy, and because of their self-control problems, at high risk for very problematic parenting.

Girls did not respond well to treatment within the same programs as boys, and in fact did worse. For that reason, we formed a separate treatment program called the SNAP Girls Connection program. This program is highly lauded and one of the experts, Dr. James Garbarino from Cornell, calls it the only documented treatment program that works for girlhood aggression.

SNAP Girls Connection has been studied closely and shown to achieve strong treatment outcomes, and has been fully replicated in Hamilton and base-funded by the Ministry of Children and Youth Services. Other replications are now under way in other communities.

Last spring, the ministry convened a conference to draw attention to the issue of girlhood aggression and we laud them for that effort. Our program was in fact showcased at this conference. And yet I have to tell you we have not received a positive response to our request for funding. This is clearly a world-class program, and we have to fundraise annually about \$300,000—plus to operate this program, to the extreme gratitude of about 90 families per year—even though the program is being replicated and lauded across the world. It is confounding for us to achieve any provincial funding, and confounding for us when we talk about the evidence-based programs that we have that are a reality.

I'm pleased to take any questions that are available within the time. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Okay, Tony, that's great. You've left about four or five minutes, which is great. We'll start with Christine.

Mrs. Christine Elliott: Thank you very much. I wonder if I could just ask a question, just to clarify: You don't currently receive any governmental funding, or do you receive some but not enough?

Mr. Tony Diniz: The government funding is for the SNAP boys' program. The girls' program is not funded. The SNAP research has been funded for the last 25 years entirely on foundation dollars.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Howard, any questions or comments?

Mr. Howard Hampton: I'm given to ask how a program that has been very successful for boys could just be totally ignored when it comes to girls who manifest the same sort of behaviours. How bizarre. What are you told when you—I mean, you're funding one with foundation money, but you've applied for funding for the other and been constantly turned down.

Mr. Tony Diniz: The response is that the ministry now recognizes the importance of girlhood aggression, but there are no dollars and there haven't been dollars for the four years that we've been asking, even though other programs, including the replications, seem to get funded. So that's what we're told. We've met with different ministers; ministers have come and gone, and we're still left with this situation.

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

Mrs. Liz Sandals: A very interesting presentation. I'm curious as to what you find the difference is between boy aggression and girl aggression.

Mr. Tony Diniz: There's a common sense that girlhood aggression is passive-aggressive. People understand that in high school, through exclusion and so on—

Mrs. Liz Sandals: It's often social.

Mr. Tony Diniz: Yes. But with the girls we're seeing, it's not the case. The girls we're seeing are assaulting other girls, are beating up girls and teachers, are using pens as knives and actively aggressing. One of the big issues that we find is, with boys, aggression is aggression and it's impulse control. We have discovered that with every girl we've seen, there's a co-morbidity of depression. It's a very different understanding, and what we're finding, too, is that the girls have a very strained, conflictual relationship with their mother. We're not blaming mothers, but we really focus on repairing that relationship because without it, we almost certainly see the teen pregnancy.

Mrs. Liz Sandals: Fascinating, and it's interesting that—I don't want to put words in your mouth, but the more conventional, social aggression that you often identify in girls is in some ways more like physical aggression in boys.

Mr. Tony Diniz: That's right, but we're now seeing the physical aggression in girls as well, though.

Mrs. Liz Sandals: But the physical aggression in girls is a different can of worms than the physical aggression in boys.

Mr. Tony Diniz: Yes it is. When you unpeel it, it is different.

Mrs. Liz Sandals: Fascinating.

Mr. Tony Diniz: And if we don't pay attention to the depression, for example, we're missing half of the issue.

Mrs. Liz Sandals: What we're hearing in so many contexts is that you often have more than one thing going on at the same time.

Mr. Tony Diniz: That's correct.

The Chair (Mr. Kevin Daniel Flynn): Which begs the question: If you treat the depression, does the aggression go away automatically or does that need to be treated as well?

Mr. Tony Diniz: We treat them both. Aggression has to be treated with self-control. The girls have to learn that there are better ways to express anger. Many girls see family violence and believe that physical aggression is a way of expressing interest, handling conflict, many other things, so they have to learn different solutions. It doesn't work in school; they have to learn to find other ways.

The Chair (Mr. Kevin Daniel Flynn): Tony, thank you very much for coming today—a very interesting presentation. As with the previous presentation, hopefully you did some good for yourself today as well.

DIANE SACKS

The Chair (Mr. Kevin Daniel Flynn): Diane Sacks has joined us early. If you'd like to come join us at the table here—there should be some clean glasses left there, and some water. Make yourself comfortable. Everybody gets 15 minutes. You can use that time any way you see fit. If there's any time left at the end, we'll just get into a discussion with the three groups.

Ms. Diane Sacks: Good. Thank you very much. My name is Diane Sacks. For over 35 years now, I've practised pediatrics and adolescent medicine, both at the Hospital for Sick Children and, more recently, at North York General Hospital. I have a private practice in pediatrics in North York.

I'm wearing a number of hats. One is the Canadian Paediatric Society's; I'm chair of their mental health task force. I'm a member of the child and youth advisory committee of the federal mental health commission. I'm also, of course, wearing a hat as a community pediatrician and other primary health care providers who see and try to help in the valiant and never-ending battles fought by our patients and their families as they try to get services, both health and educational, for these children over the young years.

It's important, when the government is trying to organize a health care project, that we start with some of the facts we know. We just heard about science and mental health, and it has gone leaps and bounds in the last 10 years. I hope I'm not repeating what other people have said. What we know is that more than two thirds of mental health disorders begin under the age of 25. We know that one in five youth in Ontario—and that's under the age of 18—has a diagnosable mental health disorder, whether it's anxiety, depression, eating disorders, ADHD, autistic spectrum disorders. And we know that, of this group, less than one in five ever get to see a health

care professional. Those are firm numbers, replicated many times.

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We also know that whether you get help or not is determined largely on whether you can pay. I would like to tell you that nowhere is the two-tier system of health care more alive and well than in the area of pediatric mental health. We know that early diagnosis and treatment may substantially improve outcomes because, just like in cancer and diabetes and other medical problems, delay in diagnosis and treatment can result in terrible secondary consequences. This is more than true of children with mental health disorders.

For these children, having mental disorders stops them in their tracks and keeps them from the normal developmental parameters of successful adolescence into adulthood. They're isolated. They lack social skills to form peer relationships. Often, if they have peers at all—and this relates directly to Tony's comments—they are forming toxic relationships with kids estranged like themselves. For men, we call these "gangs." For the girls, I guess they're still groups, but they are girl gangs.

Many of these young children with undiagnosed mental health disorders are so anxious or depressed that they can't concentrate, they cannot attend school regularly, they fail and even drop out. Schools don't have to look any further for reasons for failure or drop-out than the mental health situations of these patients who are leaving.

Another, secondary consequence of an untreated mental disorder is substance abuse. Substance abuse is not necessarily a problem, but, in fact, it's a teen solution to a problem. Mental health is not being addressed, so they self-medicate. Substance abuse is the solution, not the problem, for many of these teens.

We have learned through neurophysiology that critical brain growth does not stop at age three. In fact, adolescents show tremendous brain plasticity, so treatment at this stage is particularly crucial. These disorders keep children and youth, as I said, from progressing to be healthy adults. Some—too many—don't make it to adulthood. They are affected by these secondary consequences of untreated mental health, and depression becomes comorbid.

What happens is, depression is the leading underlying factor of suicide in Canada, and suicide is the number two killer of adolescents. Having worked with adolescents for 35 years, I can tell you it's probably number one. Kids who are depressed take alcohol and get in a motor vehicle—which is number one—specifically for the purpose of killing themselves. It's listed as a motor vehicle accident, but in fact, it's a suicide.

What can we do? We know now that there are well-validated, well-researched assessment tools to diagnose mental health disorders in children and youth. We know how to identify children and youth who are at risk for mental health disorders. Primary health care providers are very well placed to educate and monitor these disorders that run in families. The number one underlying risk factor for having depression or anxiety is having one

parent with depression and anxiety. So the family doctor knows or the pediatrician takes a history and finds out: “This is a kid who needs to be followed and watched.” Thirdly, and most importantly, we know that there are effective treatments—up to 85% in such cases—both non-pharmacologic and pharmacologic, to help these children and youth to continue their paths to successful adulthood.

We know that there are a number of college-regulated professional groups who can treat children and youth with mental health conditions but are not accessible because their counselling is not covered. We know that publicly funded services for these conditions are seriously underfunded and leave families scrambling for the few spaces available. We’re not even close to the number of child and adolescent psychiatrists in Ontario to assess or offer continuing care to those who need treatment. Presently, primary care doctors are not properly prepared or remunerated for counselling these patients and their family. The total number of child and adolescent psychiatrists in Canada is under 500. I tried to find the number for Ontario; I really couldn’t.

We know that there are huge silos that have separated mental health providers, both educationally and geographically, from the rest of the medical system. This isolation of mental health services does not bode well for patients, their families or providers because, “I’m not familiar with who’s doing what. They’re over in a different area and I can’t reach them. I don’t know about them, and I can’t reach them.”

We know that children’s mental health services are even more fragmented than those for adults. Case managers and organizations arbitrarily make decisions about when to transition these patients on, a decision which is often, by the way, made and which makes no sense. Although the majority of mental illness begins before age 25 and needs to be effectively and intensively treated during this time, there’s an abrupt interruption of child services between the ages of 17 and 19. Therefore, the services are interrupted at a crucial time. We need these services to go through those adolescent years to at least age 25.

Don’t forget, most of these youngsters are developmentally and socially delayed because of lack of schooling and lack of a peer group. Although they may be 20, that’s not where they are developmentally, and yet—boom—their services are cut off because they’re 18.

We know the case management system—important for patient and family support—needs to be majorly improved for these children. It’s no wonder patients and their parents are exhausted under the current system, as they have to reapply year after year after year for the same services, even though it’s apparent that the condition is unchanged. These applications really become a full-time job for families. They can’t work and do these applications.

So what can we do with it, and how can we address some of these problems?

I recommend targeted, province-wide screening in schools for high-risk groups. In this vein, there will be

appropriate tools and programs, mostly web-based and community-dependent; the community will choose what’s appropriate for them. It will be available in less than two years, as we’re working on that in the child and youth advisory committee for the mental health commission. There’s a school-based mental health project. It’s going nationwide; there’s a lot of contribution from Ontario. We will have programs where some school may say, “Hey, that looks good for us; it fits,” and so maybe they will try it. This is going to be available, but we have to fit it into the school system.

I recommend expanding health coverage to college-regulated professionals who treat children and youth with mental health disorders. We have found, especially with the new treatments—cognitive behavioural therapy, it’s a non-drug treatment that everybody loves. It can be used by doctors, psychiatrists, psychologists, social workers, teachers, nurses and, unfortunately, even a computer. When they test them, the success rates are quite good. I knew I was going to be replaced sooner or later by that thing, but it’s sooner.

I really recommend physically moving mental health services into more primary care settings, where a lot of the assessing and educating of families can actually be done by the primary providers. Mental health monitoring should be an incorporated, even a required part of the Well Baby Well Child visit. As the medical profession, we need to encourage primary health care providers to establish ways—and, yes, be compensated—for dealing with mental health disorders. It’s easier to treat a sore ear or a throat than to sit down and wait for a teenager who barely talks to try and tell you what’s wrong with them and what’s hurting.

I think by increasing competencies of different professionals here, some primary providers could really treat many mental health issues. With close interaction and education with mental health professionals for backup and consultation, the line for children and youth with complex or serious mental health disorders would shorten dramatically. That means we need to compensate child and youth psychiatrists for advisory positions with these professionals and other health care professionals, and it must be enhanced, whether that’s by computer or telephone; we need to really spread that program.

I recommend completely revamping case management systems for these patients and families and using modern technology. Waiting for a face-to-face meeting with some of these people can take months, during which time a child can definitely spiral downward enormously.

The status quo—and I’m just repeating what David said—is really not an option. Continuing to identify and trying to treat these patients as adults is not a viable option. The loss to our society of thousands of these children and youth is unacceptable, both ethically and financially.

Thank you.

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The Chair (Mr. Kevin Daniel Flynn): Thank you, Diane. You have left some time. Let’s start with Howard.

Mr. Howard Hampton: You actually strike a few tones of optimism there.

Ms. Diane Sacks: I hope so, otherwise I would have given up a long time ago.

Mr. Howard Hampton: Let me ask you this: Given the array of services that are there—and those services are not perfect; I think we heard you there. There is an array of services, but I think what I hear you saying most of all is that they're not used appropriately. So what's the single biggest thing you think needs to be done that would make the single biggest difference?

Ms. Diane Sacks: The services are not necessarily not used properly, but, in fact, they're not initiated properly. We have learned—it took medicine a long time—these services need to be patient-directed if they're going to have any appropriate impact for families and youth. That means there has to be somebody who knows—a case manager; as I said, whether it's a history that's on a computer that continues and follows with this family, but I think if we got case management directed by the patient and family—what works for them. What works for someone in Toronto won't work for someone in another part of Ontario, so we need to listen more carefully.

There are very few areas where we have great histories on these children and youth, and so we need to pick these kids up early and we need to support the families early. Then we need to transition so these youngsters know how to support themselves. They can be more resilient than those who don't have mental health disorders because they've gone through this and they know how to cope. These can be amazing individuals, but they really need support to learn how to cope through these various stages. So I think patient-directed and one-on-one case management, at some level.

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

Mrs. Liz Sandals: So if a child or youth comes into your office and you start to work with them—albeit not that you have a whole lot of time—and you realize there's a mental health issue, what would you be doing in your practice? What steps would you go through to try to figure out the service and to connect them to service?

Ms. Diane Sacks: The first thing you do is you need to assess. Primary care people can do this very well. Then we need to diagnose, and you can do that very well. Then you need to establish how sick that individual is. If they are mild, there is nothing stopping, except time, a primary care practitioner from instituting very basic, cookbook cognitive behavioural therapy, which works 65% to 85% of the time for these mild individuals. I wrote guidelines along with the University of Toronto and Columbia University for the taking of primary care treatment for kids with depression called GLAD-PC. Step by step, it says this is what you do in the first visit, this is what you do in the second visit. It explains specifically when you refer to a secondary psychiatrist or psychologist for further evaluation. That can be done after. GLAD-PC says, "Okay. You've had two or three weeks. Nothing's happening or the youngster's getting

worse—more suicidal—on your questionnaires, which are included in this program, but they need time." Right now, when I present this—and I've gone all over the country presenting these programs; we have one for anxiety, we have one for depression—the doctors say they don't have time. They don't have half-hour or 45-minute slots. They would if they were paid for it. I know that's—

Mrs. Liz Sandals: I understand what you're saying.

Ms. Diana Sacks: I'm one of the fortunate doctors who has a working husband and he supports me. I'm just not supposed to charge him for anything I do in medicine. But the truth is, I have time, but a lot of family doctors don't. I've tried to convince them to take an afternoon and see three or four of these kids, but if the mental health professional was in proximity to the primary care provider, they would learn how to do this quickly. When you do something over and over you can be more efficient with your time, and it could only take a half hour. Many of these kids can be helped with supportive counselling, as well as some cognitive work, with a minimum of time.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Diane. Christine, a brief question?

Mrs. Christine Elliott: Just a brief question. I'd like to thank you very much. You've left us with a lot to think about here.

One thing I was interested in—because you're the second person today who has commented about the high relationship between children with mental health problems and parents with mental health problems, how do you approach that with the parent, when the parent might not necessarily realize that they have a mental health problem too?

Ms. Diane Sacks: Of course, that's where the primary health care practitioner comes in. It's also where the hat I'm wearing with the mental health commission will come in. They are going to have a very large anti-stigma campaign, which we hope will let people know that mental health disorders must come out of the closet. I think there are a lot of reasons—there are a lot of barriers to that. I think the main one is that people don't think that there's help, or that the help will come in the range of a medication that will zombie you. So there's a lot of education that needs to be done.

I think we have a captive audience, because parents will do an awful lot if they know their children can be helped. So although they say, "I don't want you to write on my chart that I have depression, because my employer might ask you for my records or something," if you tell them this is essential for their kids—so you need to know that so-and-so was an alcoholic or you need to know that someone in the family dropped out of school and he really had great potential so we don't know what happened. That's a very important piece of history. These kids can be picked up and followed so we can catch them early or give them tools before they get sick.

I don't know if you know a lot about cognitive behaviour therapy. It's wonderful for everybody. Everybody should do it.

The Chair (Mr. Kevin Daniel Flynn): Thank you. I wonder if you could briefly answer one question that just entered my mind and that is, from a clinical perspective, why are “anxiety” and “depression” almost always used in the same sentence?

Ms. Diane Sacks: They’re co-morbid in about 30%, and you could put down anxiety, depression and ADHD. If you have anxiety, you have a 30% chance of getting depressed. If you have depression, you have a 30% chance of having diagnosable—on questionnaires— anxiety, and the same is true with ADHD, for some reason. We know the reason: They’re actually very close genetically. We have the genetic outline for a lot of these disorders. They seem to be in the same place.

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

Ms. Diane Sacks: I’m sorry I’m so long-winded.

The Chair (Mr. Kevin Daniel Flynn): No, that was wonderful. You gave us some wonderful—

Ms. Diane Sacks: I’ve left an H1N1 office, so I’m so happy to be here.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming. It was really appreciated.

And we’re adjourned. I understand there will be a vote shortly.

The committee adjourned at 1744.

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