



**Legislative Assembly
of Ontario**

First Session, 39th Parliament

**Assemblée législative
de l'Ontario**

Première session, 39^e législature

**Official Report
of Debates
(Hansard)**

Monday 15 June 2009

**Journal
des débats
(Hansard)**

Lundi 15 juin 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

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

<http://www.ontla.on.ca/>

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-3708.

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7410 ou le 325-3708.

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

**SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS**

Monday 15 June 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

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

Lundi 15 juin 2009

The committee met at 0902 in the Hilton Hotel, Windsor.

**MENTAL HEALTH AND ADDICTIONS
STRATEGY**

The Chair (Mr. Kevin Daniel Flynn): Ladies and gentlemen, thank you very much for your patience, those of you who arrived a few minutes early. One side of the committee is here, and I know the other half of the committee is just coming in the door. Some other people have been held up—unfortunately, their planes are late—but we're going to kick it off.

HOUSE OF SOPHROSYNE

The Chair (Mr. Kevin Daniel Flynn): Maybe we can ask the first delegation to come forward: the House of—Sophrosyne?

Ms. Deborah Gatenby: Sophrosyne.

The Chair (Mr. Kevin Daniel Flynn): I knew I'd get that wrong. Whichever one I said, it would be the other one.

Thank you very much for coming forward, Deborah. If you'd like to just make yourself comfortable. What we've been doing with the delegations is that everybody has been getting 30 minutes—

The Clerk of the Committee (Ms. Susan Sourial): Twenty minutes.

The Chair (Mr. Kevin Daniel Flynn): Oh, 20 minutes; I'm sorry, yes. You can use that any way you see fit. If you could leave a little bit of time near the end, that would be great. If you would introduce yourself for Hansard at the start of your presentation, and other than that, the floor is all yours. Welcome.

Ms. Deborah Gatenby: Does everybody have a copy of my handout? Because I'm going to take you through it.

The Chair (Mr. Kevin Daniel Flynn): I'm sure we do.

Ms. Deborah Gatenby: Good morning, everyone. It's such a pleasure to be here and meet with you this morning.

House of Sophrosyne: I'll start out by telling you where the name comes from. Sophrosyne was the Greek goddess of moderation. It means a wise and balanced life, and Plato speaks of her in his work *The Republic*. That

philosophy of knowing yourself underpins everything that we do. We're a women's alcohol and drug treatment facility. We've existed in this community—we celebrated 30 years last year, and a woman doesn't know herself till she's 30, so we're very proud of that.

I'm going to take you very quickly through a little foundational piece: how women are different from men in terms of becoming addicted; consequences; shame and stigma; physical and sexual abuse equalling trauma experience for women; and treatment and systemic issues. That takes you to page 3.

Women metabolize alcohol and drugs differently than men because their bodies contain less water and more fatty tissue, so substances are less diluted in our bloodstream and we keep them in our bodies longer. We also have decreased activity of an enzyme that breaks down alcohol. Estrogen affects our metabolism. We become dependent on substances more quickly and use less of a substance before becoming dependent. On average, women abuse alcohol and drugs three times longer than men before they come to treatment, so they are much more ill when they arrive for us to treat them. Women are five times more likely to have been sexually abused as a child. Women suffer greater physical, interpersonal and legal—especially child welfare involvement—consequences and financial stigma as a result of their substance abuse. And pregnant and parenting women—you know, the notion of motherhood or being expectant and also being dependent is quite stigmatized.

The entire addiction treatment system was designed over 50 years ago for the male alcoholic. In fact, our own centre was designed for the sort of stereotypical kitchen drunk, the housewife with the bottle of vodka tucked into the ironing basket. We don't see her anymore. She doesn't exist. The women we treat are much more complex, and, by and large, predominantly are addicted to pharmaceuticals. Pain relievers and benzodiazepines are the most common things that we're seeing.

Over the past three decades, the treatment of women has evolved, and we categorize these into three evolutionary periods.

The first is gender-specific—and some coeducational treatment providers haven't even made this leap. That means that women represent at least one third of the client population in a coeducational facility, they're treated separately from the men, and special groups and

services are added on to the treatment program that was originally designed for the male alcoholic.

Page 5 is the second evolution, and this is gender-informed. You'll see the shocking photograph, which my next colleague, I'm sure, will speak to a little bit more. This is one of the fashion models who was banned at the Rio show. The program is designed to recognize the distinct differences in women's treatment and health needs. It's a feminist/empowerment model: all-female staff; flexible length of stay—best practices are up to 35 days; child care is made available, because women come with children; integrated eating disorder programming, family systems, and harm reduction.

The third evolution, which is the evolution that I'm dwelling in right now as a service provider, is trauma-informed and integrated treatment: relational theory; strengths-based leadership development for women; holistic approaches; adjunctive programming; hormonal mapping; mothers and children treated together; smoking cessation; poverty reduction and supported housing.

Everything we know about treating women applies to the treatment of young women as well. We know that we need to keep our young people in their home communities when we provide treatment to them. It seems that the very families who can least afford the expenses that go along with long-distance phone calls and travelling out of town to visit their children who are in treatment in places like North Bay are the families who are impacted by this. How can a service provider in a community hundreds of miles away, with shrinking resources, be expected to connect those young people back to the community from which they originated? We want to keep our children in this community and treat them here.

As service providers, we have, or could develop, the capacity to realize best practices in treatment, including being able to bring women and their children to treatment together and being able to run some dedicated cycles of treatment for youth that keep them in our home community. It's not money that stands in our way to do this; it's the lack of interministerial collaboration. The Ministry of Children and Youth Services came together with the Ministry of Health and Long-Term Care and developed the best practices in women's and youths' treatment collaboratively, and those are the practices that we operate under, yet the ministries stopped there and didn't create a framework or protocols that would allow me, as a provider who receives money from the Ministry of Health and Long-Term Care, to enable the women I treat, particularly women with young children, to come to treatment with those children. This is a model that has tremendous success, and it's evidence-based, yet I can't get there from here because nobody has developed the framework for me to do it. So that's one of the things that I'm here to ask for today on behalf of women and on behalf of young people. I urge the ministries to come together at the political level and create the framework where these best practices, these evidence-based prac-

tices, could be realized within the capacity of the existing sector, because it's a major barrier.

0910

Page 10, one more issue: It's called "Popsicles and Crack Pipes." Despite our involvement in recovery, whether personally, professionally or both, we need to protect freedom and support the values of harm reduction when it comes to drug paraphernalia. We believe that an adult who wants to go into a so-called head shop and make a purchase of merchandise that is being sold legally should have that right. Anyone who patronizes one of these establishments knows exactly what they're getting into.

As an organization that is for women, by women, our commitment to freedom and harm reduction needs to be balanced against the need for supporting those in recovery and, perhaps even more importantly, prevention work for our children. The honourable member from Whitby-Oshawa introduced a private member's bill that will lead this province into developing a drug strategy, and one of the pillars will be prevention as part of that strategy, so I think the timing is really good to take a look at this issue.

This forces us to draw the line on having these items on display at our neighbourhood stores where we go in to buy our bread, milk and a summertime Popsicle treat for our children. This has been a real problem for the clients of our facility who are new in recovery and want to avoid being triggered by the sight of these drug-related items. While they know to stay out of head shops and liquor stores, how do they stay out of variety stores? You know, the little shop on the corner, down the street from our community programs, has crack pipes for sale in a display case where women go to get their bus tickets and buy a Popsicle. When we talk to the store owners, they say, "Everybody's doing it; why should we stop?"

The province made an excellent decision when it put a ban on the display of tobacco in Ontario. Three main factors influenced this decision:

(1) We determined that tobacco has become the anti-thesis to the health of Ontarians and, as such, should no longer be visibly promoted in our communities.

(2) We didn't want to pique the curiosity of children and endorse tobacco products as a normal and expected part of transitioning to adulthood. We want to prevent early experimentation with this gateway drug. Science shows that these displays are effective at enticing children toward these products. The health promotion minister, Margaret Best, said, "It's time convenience stores stopped selling cigarettes right behind the Twizzlers and hockey cards."

(3) We wanted to support those who are quitting or who have quit using tobacco products by removing the trigger that's caused by viewing these addictive substances.

While the display ban moved the tobacco out of sight, the paraphernalia stayed in plain view—those items that are commonly associated with drug use but remain

legally for sale due to their specious connection to tobacco products.

We implore the government of Ontario to include these products in the display ban for all the same reasons that apply to tobacco. These are even more compelling when these items are associated with illicit substances.

To critics that claim that these items are not the same as tobacco products because they don't contain either the illicit drugs that they're connected to or the tobacco, we say that vibrators and other adult toys don't contain the genitalia of the adults, but they're not on the countertop at Mac's Milk.

We've already made a conscious and concerted decision regarding the message that we want to convey. That involves eliminating tobacco from what is acceptable for our children's futures. While we continue to hope that our children will grow into an adulthood that includes healthy sexuality, we still insist that exposure to sexually related merchandise be restricted to them until they're 18 years old. What is it that we hope for our children in adulthood that has us subject them to normalized, routine, early exposure to drug paraphernalia at every corner convenience store in our neighbourhoods?

Let's work together to shape a public policy and community standard that keeps the Popsicles and crack pipes separate so that our kids don't get confused about what is a normal and expected part of their childhood.

The Chair (Mr. Kevin Daniel Flynn): Deborah, thank you very much. You've left a little bit of time for questions, and that was nice. We've got about six or seven minutes. Gilles, do you have anything to kick off?

Mr. Gilles Bisson: Yes. Some of the ideas are the simplest ones in regard to your suggestion of banning crack pipes, and I think that's something somebody might just pick up on in a private member's bill. It sounds like a good idea.

I want to go to the funding issue in regards to the monies that—you're funded from?

Ms. Deborah Gatenby: We receive money from the Ministry of Health and Long-Term Care through the Erie St. Clair LHIN.

Mr. Gilles Bisson: Do you find that, given the work that you have to do, the amount of funding that you get is sufficient? And if you had to change how we fund, what would you do—not so much how much, but how?

Ms. Deborah Gatenby: Obviously, I don't think the funding formula works, but I think that you're going to hear that ad nauseam: "There's not enough money, there's not enough money." What I'm saying is, it's not money that stands between the realization of some of these best practices. If the ministry told me tomorrow that I could run two dedicated treatment cycles of 35 days, where I could bring in a client group of women and their children, it would reduce my bed occupancy, because now I've got kids in some of the beds that I've got patients in right now. But I wouldn't need new money to do that. New money would be nice, but I wouldn't need new money to do that.

The women who are dying because they don't want to reveal the fact that they're struggling with these pills they're taking, because they don't want the CAS involved with their children or they don't want their partner to bring it up as a custody battle issue down the line—by the time I do get them, their kids are going away to college, and they've been taking this stuff for 15, 20 years. If they could come to treatment with their kids—especially women who have younger children and are on their own—we could treat them earlier. We'd have much better outcomes.

It's the same thing with our young people. I could fill my 14 beds with girls who are 12 to 15, whose parents call me on the phone, sobbing, begging for a treatment option. There's no reason my facility couldn't run a cycle of treatment. I'd like to treat them separately from the older client group—

Mr. Gilles Bisson: But what prevents that from happening?

Ms. Deborah Gatenby: One, we're funded by the Ministry of Health and Long-Term Care, which funds patients over 16, and when they're under 16 or when you're going to house their children conjointly and treat them conjointly, it's the Ministry of Children and Youth Services.

Mr. Gilles Bisson: That's why I was asking specifically about how you're funded, because it's a bit of a common problem. So what would you suggest? How should the funding flow in order to make sure that we deal with people generally, so that we have the ability to move from one to the other? Do you have any suggestions?

Ms. Deborah Gatenby: I think it has to happen at a much higher level. That's what we're frustrated about. We say we could make it happen, but how do we make it happen? We're really stretched thin doing what it is that we do, and we're not, quite frankly, that politically savvy. I would say, strike a working group that includes representation from children and youth services and the Ministry of Health and Long-Term Care to do a review of the best practices in treatment of families and youth and women, and talk to service providers on what stands in the way of you making these a reality, and start to get something in terms of a protocol going.

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

Ms. Helena Jaczek: I lived in Windsor 25 years ago, and I remember hearing of your agency then, because it has such an unusual name.

Just to follow up a little bit, I was really interested in this issue that you've raised about not being able to care for those aged 12 to 15. Could you describe a little bit more how many beds you have for 16 and over, and what geographic area they come from? And is North Bay really the next closest place for the 12-year-olds to 15-year-olds from Windsor to go for treatment? I'm just not clear on exactly how this works.

Ms. Deborah Gatenby: Most of them actually go to Sister Margaret, which is in North Bay, so it's a tremendous problem.

We have 11 beds that are funded by the Ministry of Health and Long-Term Care—the Erie St. Clair LHIN—and we have three private beds. Being a border town, as well as with a really strong CAW presence—some of them have them within their contracts, so those beds are accessible. Right now, we're booking beds for October, because all of our beds are filled, and we're running a waiting list of about 16 women. If a bed becomes available, we'll put them in. Pregnant women do jump the queue and come in right away. We treat them—16 and over. The 12-year-olds to 15-year-olds—that's the problem. There's that cut-off age.

We serve the province. Because we're an integrated trauma treatment and residential treatment model—we do first-stage trauma treatment—we've really become a provincial destination for women to come to.

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

Mrs. Liz Sandals: I'm still trying to figure out the 16-year-old bar. Do you know if that's true of all adult health services: that you can only go down to 16? I had always thought that addiction, even youth addiction, was funded by health, unlike mental health, where it's clear that health doesn't fund youth mental health—MCYS. But what you're saying is that that's not really quite true; that Health only funds down to 16-year-olds and MCYS would have to pick up anything under 16 on the addiction front as well.

0920

Ms. Deborah Gatenby: Correct, yes. A lot of treatment centres won't take them until they're over 18, but the mandate does dip down to 16 and over.

Mrs. Liz Sandals: Okay. I come from Guelph, so I can remember a time when Homewood, in Guelph, used to do both adolescent and adult treatment. It seemed that the Ministry of Health at some point stepped in and said, "No, you can't mix these age groups together." Have you—

Ms. Deborah Gatenby: Well, Homewood is a bit of a unique environment—

Mrs. Liz Sandals: I know, it's different—

Ms. Deborah Gatenby: —because it's a hospital, so it is a little bit different. We get long-term care, which is mental health and addictions funding, and Homewood gets some actual capital-H health care funding as well, as a hospital.

Mrs. Liz Sandals: Okay, so because you're a treatment program, you can take down to 16 as opposed to a hospital that can only take down to 18?

Ms. Deborah Gatenby: Well, I think a hospital would be able to take them even younger, but no, they can't—well, that might be why they're 18.

Mrs. Liz Sandals: It's quite weird. Okay. But you're beginning to at least describe to us the weird questions we need to get answers to. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Deborah, thank you very much for coming this morning. Excellent presentation.

BULIMIA ANOREXIA NERVOSA ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): Our next delegation is the Bulimia Anorexia Nervosa Association. Mary Kaye Lucier is with us today.

Mary Kaye, if you'd like to make yourself comfortable; pour yourself some water if you'd like. Like everybody else, you've got 20 minutes to use any way you like. If you leave some time at the end, that would be great.

Ms. Mary Kaye Lucier: Okay. Thank you for hosting this hearing.

The Bulimia Anorexia Nervosa Association, or easily referred to as BANA, is a registered charity membership association, incorporated in 1985, with approximately 500 active members to date. Active members are consumers of our service, staff, volunteers and community partners. We are one of the original founding members of the Ontario provincial network of eating disorder specialty services, which comprises 32 funded specialized eating disorder services from Thunder Bay to Windsor. BANA is also a member in good standing of the Academy for Eating Disorders, the National Eating Disorder Information Centre, the Ontario Federation of Community Mental Health and Addiction Programs and the World Wide Charter for Action on Eating Disorders committee.

BANA is leading a delegation of eating disorder experts to China as part of the People to People ambassador cultural and professional exchange program, an official committee of the President of the United States. We're bringing greetings from the Ontario Premier's office as well while we're in China, and we'll be meeting with the Canadian ambassador to China, formerly the federal director of the Health Canada agency.

As the primary resource for eating disorder treatment, prevention and research services in the Erie St. Clair LHIN, which services Windsor, Chatham and Sarnia, we're honoured to present this brief to comment on the need for expanded specialized treatment and prevention services for eating disorders in this LHIN. The brief has been prepared in consultation with the Ontario outreach coordinator for eating disorders, Dr. Gail McVey, at the Hospital for Sick Children, and is presented by myself, the executive director of BANA. The specialized treatment, prevention and research programs for eating disorders referred to in this brief are based on best practices as recommended by the provincial network, the Academy for Eating Disorders, and the World Wide Charter for Action on Eating Disorders, which I've included in your handout.

BANA is qualified to speak on the issues of eating disorders, given that we're an active member of the network and that we embody a professional commitment to best practices. We engage in forums and advocacy initiatives related to persons affected by eating disorders and we take positions on important related issues. We are the voice of persons with eating disorders in our region.

It is imperative that this public hearing on mental health and addictions hear accurate information based on scientific data and clinical specialists regarding the status of mental health and addictions.

Eating for emotion regulation reasons has been extensively empirically researched and is now well understood within eating disorder diagnoses. Eating disorders are serious mental illnesses characterized as under- or over-eating, followed by methods of unhealthy weight control such as extreme dieting, purging and obsessive exercising. Eating disorders are diagnosed as anorexia nervosa, bulimia nervosa, binge eating disorder or eating disorder not otherwise specified. Motivations for eating disorders vary, including emotion regulation and poor body image, all of which impair decision-making and emotion regulation, especially during the acute phase of the illness. These deficits leave the person feeling hopeless and alienated in their interpersonal relationships. The death rate for these debilitating conditions is the highest for all the psychiatric conditions and can be as high as 15%. Cause of death is usually attributed to cardiac arrest, organ malfunction and suicide. Persons with eating disorders often complete suicide after many years of unsuccessful attempts to recover. The social and systemic costs of these disorders are tremendous.

According to the Erie St. Clair LHIN report of 2005, suicide and suicide attempts are indicators of mental health. The suicide rate for the Windsor-Essex/Chatham-Kent community is higher than the provincial average. For persons with eating disorders, the suicide rate is not calculated, but it's estimated, from the records kept at BANA over the past 25 years, that of the people who have died from their disorder, suicide can be attributed to 50%. The average age of persons who die from complications due to their eating disorder is 26, after a 10-year struggle.

The Ontario provincial network of eating disorder specialty services was established to coordinate and oversee the assessment and treatment of eating disorders in the province. It was created in 1994. The network established a web of specialty hubs and sub-hubs across the province in recognition that the location of services should not determine availability of services. The network is responsible for planning, coordinating and collaborating with eating disorder specialty services, and it conducts annual training and research opportunities, which assists with advocacy initiatives as well.

Existing services in the Erie St. Clair LHIN: BANA is the lead agency in this LHIN that offers specialized treatment. The programs are offered on a continuum, beginning with a specialized diagnostic assessment, followed by psychoeducation, cognitive behavioural therapy and support services. Support services such as nutrition, family education and follow-up are offered, and they are considered an integral component of the treatment continuum. The specialized diagnostic assessment is standardized and was created by BANA in consultation with the network.

Thorough specialized diagnostic assessment for eating disorders is essential to guide referrals for appropriate treatment. The specialized diagnostic assessment sometimes establishes an eating disorder diagnosis when the patient's personal assessment was to the contrary, and vice versa. In either case, the diagnosis allows for referral to the appropriate treatment.

The specialized diagnostic assessment consists of two components: a standardized structured interview, followed by the administration of eight psychometric tests conducted by specially trained social workers. Following the specialized diagnostic assessment, the social workers present the results to our consulting psychologist and physician at the weekly clinical rounds. An individualized treatment plan is formulated, and the treatment plan is discussed with the consumer. Treatment options include psychoeducation, cognitive behavioural therapy, nutrition therapy and follow-up support. These services are conducted pre/post for each treatment option.

All of the data collected from the specialized diagnostic assessment is stored in a research database for the purposes of creating a snapshot of our consumer base for program evaluation and conducting multi-site outcome research. We've been collecting data on the outcomes of our programs for nine years. There are supportive organizations in Windsor, Chatham and Sarnia that offer adjunct complementary services to the specialized eating disorder service in Windsor.

BANA is the lead provider of preventive strategies for eating disorders which focus on health promotion. These strategies include puppet shows on body-based harassment, self-esteem workshops and developing media savvy. Prevention and early intervention are the best forms of treatment, according to our founder, Dr. Richard Moriarty.

0930

BANA's research strategy is a three-pronged approach designed to evaluate our own programs, to build capacity for more rigorous scientific research, and to conduct multi-site research within the provincial network. Three of BANA's most recent in-house studies are: comparing the outcomes of group participants diagnosed with an eating disorder for psychoeducation with assertiveness training; program evaluation of that psychoeducational group; and third, looking at attachment in adolescents with eating disorders.

The assertiveness training research project demonstrated equal effectiveness in decreasing eating disorder behaviours as traditional psychoeducation. The program evaluation research indicated that there was a high comorbidity of suicidality and attachment problems for teens with eating disorders. This led to our third study, the attachment study, which indicated that teens with eating disorders had fearful and insecure attachments, suggesting that they were more resistant to treatment.

Gaps in services in the Erie St. Clair LHIN:

According to the Erie St. Clair LHIN report, standardized rates for hospitalization for any mental illness are higher in this area than the provincial rate. The

significant medical complications that accompany eating disorders, namely hair loss, tooth erosion, growth retardation, osteoporosis, gastrointestinal bleeding, bowel paralysis, dehydration, electrolyte abnormalities, hypokalemia, hyponatremia and cardiac arrest, lead to eventual death if left untreated, or become chronic.

Hospital stays for persons with eating disorders are significantly longer and occur more often when compared to all other psychiatric illnesses, according to recent data in the UK. The average length of stay for an adolescent in the UK was 90 days. In the US, about 20% more of all in-patient admissions for any psychiatric illness were for children and adolescents with eating disorders.

Intensive in-patient and residential specialized eating disorder services are non-existent in our LHIN. The nearest in-patient pediatric specialized unit is in London, and for adults it's even further, in the greater Toronto area. It's not surprising that the highest referral pattern for out-of-province and out-of-country for eating disorders is from southern Ontario, the Windsor-to-London corridor.

Due to the lack of adequate in-patient programs across the province, there's a pressure for eating disorder programs to find ways to assist clients who are the most needy in accessing the required service. For Windsor-Essex/Chatham-Kent, a designated underserved area, this has meant increased waiting lists for children and adults diagnosed with eating disorders. Many families travel to the US and jurisdictions outside of our LHIN for specialized treatment.

Best practices require residential services after discharge from hospital, which is non-existent in the province. Community-based residential care is a step down from hospitalization before reintegration back into home life, and has been shown to reduce relapse of the disorders and reduce multiple hospital admissions.

Our recommendations to the public hearing on mental health and addictions for best practices service delivery to persons with eating disorders:

Our first recommendation is to recognize that eating disorders are a serious mental illness. The position paper entitled *Eating Disorders Are Serious Mental Illnesses*, crafted for the Academy for Eating Disorders, states that eating disorders "are biologically based ... mental illnesses that warrant the same level and breadth of health care coverage as categorized in this way (e.g., schizophrenia, bipolar, depression, obsessive-compulsive disorder).... [W]e advocate this position unequivocally based on an emerging science that affirms with a reasonable degree of medical and scientific certainty that eating disorders are significantly heritable; influenced by alterations of brain function; significantly impair cognitive function, judgment and emotional stability; and restrict the life activities of persons afflicted with these illnesses.... [T]he denial or restriction of equitable and sufficient treatment necessary to avert serious health consequences and risk of death is untenable and should be vigorously protested."

Our second recommendation is the best practice that treatment is offered on a continuum and within a multi-disciplinary setting. The Provincial Network of Specialized Eating Disorder Services, the Academy for Eating Disorders, the World Wide Charter for Action for Eating Disorders and BANA all endorse this concept. Treatment that is provided on a continuum, that is voluntary and that includes families shows the most promise—treatment that recognizes personal choice and control over one's life as more effective, but also recognizes that institutionalized care must be part of the continuum. Hospitalization, partial hospitalization, day treatment and residential care are some of the continuum options. Funded residential care for eating disorders is, to date, non-existent in Ontario, but in the for-profit sector it shows promise both in Canada and in the US. Private for-profit programs are largely unaffordable for most Canadians.

A continuum of treatment is shown to be more successful in the long term, but because eating disorders have the highest death rate—around 15%—there need to be resources available in every community to adequately and appropriately handle re-feeding and medical monitoring of patients in the acute state of starvation within the specialized treatment hub.

Dr. deGroot states:

"At mid-life, weight dissatisfaction is also ubiquitous, as it is endorsed by 80% of women and over half of women who are 'normal' weight. Further, women with poor body esteem are more likely to avoid everyday activities...."

"The remainder either have persistent eating disorders or mortality. Women with" anorexia "are reported to have 1.5 to 18 times the standard mortality rate ... In British Columbia, the standardized mortality rate (SMR) was 10.5 among adult women with" anorexia "treated on average seven years previously at a tertiary care centre, with death most commonly due to suicide ... Further, 35% of women with" anorexia "were reported to be on disability at a cost of \$2.5 million to \$101.7 million to British Columbia annually...."

The third recommendation is the best practice that requires standardized treatment that is evidence-based. As mentioned earlier, residential treatment facilities for eating disorders are non-existent in Ontario, but should be considered an alternative to in-patient beds for individuals who would otherwise be placed in hospitals and need a highly structured environment with supervised independence. Residential treatment facilities may provide 24-hour staffing and the capacity to handle more chronic clients and facilitate transition to home life. Residential treatment facilities work to normalize and restore eating patterns. The emphasis would be on reintegrating the individual into the community. The specialized diagnostic assessment would lead to the determination of the need for residential treatment facility, and length of stay would be gauged according to individual consumer need.

The fourth recommendation is the best practice to use standardized specialized diagnostic assessment to ensure an accurate diagnosis. Research indicates that this specialized diagnostic assessment is the first step toward developing a treatment plan, which includes a plan for recovery. Although eating disorders are chronic, persons who suffer from them need hope for the future. The specialized diagnostic assessment tracks the onset and the course of the condition, and thereby provides data on the level of severity. Just as persons undergoing other specialized diagnostic assessments for other medical conditions, people with eating disorders feel validated and hopeful that this condition can be treated if accurately assessed. Analysis of the data collected over the past nine years at BANA has indicated that 9% of the referrals that come into our program do not fit criteria for an eating disorder. In particular, there were a number of seven-year-old children who were referred who displayed eating and food-related problems, but the diagnosis was depression or some other mental illness. The treatment plan included reducing fear and anxiety around eating, and referral to a more appropriate children's mental health centre. In particular, these seven-year-old children were in a state of acute food refusal, and their parents were deathly afraid that they were going to lose their child. They didn't have an eating disorder, but they did have problems with food and eating.

The fifth recommendation is the best practice of formulating an individualized treatment plan based on well-researched treatment options. Although treatment should be standardized, individuals need to be treated as unique individuals with a range of options for recovery.

The sixth recommendation is that prevention is the best form of treatment. Although many persons have recovered in generic mental health programs, the rate of relapse is high, and therefore the conditions become chronic over time. Chronicity is best treated within the framework of prevention or early intervention.

0940

Dr. deGroot, who is associate professor at the department of psychiatry, University of Calgary, responded to the Kirby report, and she cited two large-scale Canadian studies which found that weight concerns begin at an early age and progress to disordered eating attitudes and behaviour with increasing age. She noted that "nearly a third (29.3%) of girls, most of whom were of normal weight and aged 10-14 endorse attempting to lose weight and 10% were ... dieting or using other extreme weight-loss methods, both of which are risk factors for eating disorders. Over 27% of girls aged 12-18 report disordered eating attitudes and behaviours. Of note, only 4% of girls reporting binge episodes and 6% who endorsed purging had ever been evaluated or treated for the behaviours. Such behaviours are of additional concern as they are often associated with additional health-compromising behaviours, such as smoking, alcohol and drug use, depression and suicide. As well, dietary restraint, binge eating, and diet pill use is often associated with an increased risk of obesity."

The Chair (Mr. Kevin Daniel Flynn): Mary Kaye, if I could just stop you there, you've got about a minute left. You might want to go to your recommendations.

Ms. Mary Kaye Lucier: The recommendations—okay.

The Chair (Mr. Kevin Daniel Flynn): Yes. I think you have some at the end. I just read ahead a little bit, and I think that would be a good way to summarize.

Ms. Mary Kaye Lucier: Okay. Our recommendations:

- policies that address workplace wellness programs that focus on healthy living, because everyone is affected by mental health;

- adequate funding for hubs/sub-hubs of eating disorder specialty treatment on a continuum, across the province, especially in Ontario's urban areas, where there's a higher proportion of children who have eating disorder risk factors;

- public education campaigns that integrate healthy eating and healthy activity messaging with the modifiable risk factors to chronic diseases across all sectors;

- school curricula that address healthy lifestyle choices while accepting cultural diversity;

- strategically inform the media on the latest statistical reports that support best practices for prevention of chronic mental illnesses such as eating disorders;

- specialized diagnostic assessment centres that offer a continuum of treatment in the community;

- increase research funding that investigates the high rates of death and disability secondary to anorexia;

- that the National Eating Disorder Information Centre become a truly national program with national funding;

- address the idea of boys and men in ways that increase empathy but don't provide or reinforce sexist/prejudicial behaviours;

- prevention strategies should focus on health promotion rather than on the illness;

- include body-based harassment in anti-bullying policies; and

- reduce screen time for children and increase unstructured play/activity.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you very much for coming today. All members have a printed copy of your presentation, so they'll be able to review it at their leisure. Thank you for the time you spent. You've made your point very clearly.

EDDI CHITTARO

The Chair (Mr. Kevin Daniel Flynn): If I could call forward the next presenter, Eddi Chittaro. Mr. Chittaro, am I pronouncing your name right?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Like everybody else, Eddi, you have 20 minutes. You can use that any way you see fit. If you could leave some time at the end for questions, that would be great, but if not, it's entirely up to you.

Mr. Eddi Chittaro: Thank you. Mr. Chairman, committee members and support staff, I appreciate the opportunity to be here. My presentation will be somewhat brief, but you may have some questions. I'm relating personal experiences regarding a family member. If you'll bear with me, I'll try not to be too detailed, but I'd like to give you enough background so you'll understand why I gave a lot of thought to being here. In fact, I called Susan and e-mailed her on two occasions; I was going to back out on making this presentation, and I thought, well, it's worthwhile that I be here, in my opinion.

I'm a retired secondary school counsellor/teacher, with about 40 years in that career. Let me give you the background that I wish to explain, and then really get to the reasons why I'm here.

A family member suffered from paranoid schizophrenia for approximately 40 years and was hospitalized at several psychiatric facilities from 1965 to 2004. She admitted herself voluntarily on two occasions, and involuntarily, by my initiative, on two occasions—and the other times are unknown. She didn't live in the community; she lived elsewhere.

One justice of the peace refused to authorize a psychiatric order for examination, and one month later the order was approved by another justice of the peace. Identical information was provided to both justices of the peace. So I have a little concern about justices of the peace.

Let me briefly give you a little history of her hospitalization. In 1965—in the 1970s, in either Paris or Ottawa; in 1984, locally, 116 days in hospital; in 2000, locally, 87 days in hospital; in 2003, locally, 55 days in hospital; and in 2004, 53 days in hospital.

My purpose initially, the issues I had and recommendations to this committee, had to do with involuntary hospitalization by a psychiatric examination order authorized by a justice of the peace. However, since the publication of the notice that was in the Windsor Star on April 22, I spent time reading the Ontario Mental Health Act. What I discovered was that section 33.1 in Bill 68, introduced in 2000—referred to as Brian's Law, which I'm sure you all know is named after Brian Smith, who was murdered by an individual who had paranoid schizophrenia—refers to the community treatment order, CTO, which contained guidelines similar to what I intended to recommend. Believe it or not, I was five years late. Again, I didn't know that that article was in the Mental Health Act; no one told me.

If my understanding of the CTO is correct, for a person with a severe mental disorder who has been in a psychiatric facility for a period of 30 days or more during that three-year period and his or her condition is stabilized, a community treatment order may be established by a committee—a doctor, nurse, social worker, caregiver etc.—prior to discharge. If the patient does not maintain the community treatment plan—medication, follow-up, doctors' appointments etc.—they may be involuntarily readmitted to a psychiatric facility by a doctor's author-

ity. If this is so, then I, who had power of attorney and was the caregiver, was never informed that there was such a thing as a community treatment order in 2000, in 2003, in 2004.

I believed that to involuntarily admit my family member, it was required to obtain a psychiatric examination order and justice of the peace authorization. Obviously, no one told me of the community treatment order. Why was I not informed? My family member certainly met the criteria for the order. The CTO procedures would have been less stressful, more efficient, less time-consuming and much easier to relate to the medical personnel with whom previous contact had been made, rather than some medical person telling me, "If you don't behave"—referring to my family member—"you're going to end up in the psychiatric facility in St. Thomas"—a threat which wasn't needed.

Were the local medical facilities aware of the community treatment order in 2000, in 2003, in 2004 and ensuing years? How are changes to the Mental Health Act conveyed to hospitals and doctors? What follow-up is there that changes to the Ontario Mental Health Act are implemented? What percentage of serious mental patients are re-hospitalized in Ontario for refusal to take medications and allow support? Is it possible that many street/homeless people would not be there if a community treatment order had been initiated? I'm just speculating; I have no idea.

0950

Another suggestion or question that I have is, why not have the psychiatric order be authorized by not just a justice of the peace but a medical person? And why does it have to be in a court? Why can't it be in a hospital setting? It's an illness. It's a legal matter, certainly; I'm not trying to split hairs here, but to me, anyway, it seems that we're treating an individual legally rather than mentally or physically—we're treating them legally rather than as having an illness is what I'm trying to say.

Tied to my recommendations and conclusions, I wish to refer to the Ontario Mental Health Act, section 33.9, which has to do with review. It reads:

"33.9(1) The minister shall establish a process to review the following matters:

"1. The reasons that community treatment orders were or were not used during the review period.

"2. The effectiveness of community treatment orders during the review period.

"3. Methods used to evaluate the outcome of any treatment used under community treatment orders."

The first review was to take place three years after the article was introduced in 2003. The subsequent review was to take place five years after the three years, so in 2008. I'm assuming it's been done.

Here are my recommendations, very briefly: I strongly recommend that patients and caregivers of seriously ill mental patients be clearly advised by medical psychiatric personnel throughout the province of the community treatment order. Perhaps it's done elsewhere already; I don't know. I'm only speaking from my experience in

my particular locale. Perhaps a pamphlet, a brochure or a handout on the criteria needed and actions available should be developed. Nothing was given to me, nothing was ever told to me by a doctor, nurse, social worker etc.

Conclusion: Except for not being advised of section 33.1 of the Ontario Mental Health Act, the medical care provided for my family member was never an issue or a problem. However, involuntary admission was a problem for me and my family. If a person meets the criteria set forth in section 33.1 of the Ontario Mental Health Act, then it should be implemented without exception.

I hope my presentation will help current and future family caregivers to be better advised and to cope better with a person with a serious mental illness, which is usually difficult and very, very stressful.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. You have left a little bit of time for questions, which is great. Is there anybody from this side with a question? Christine or Sylvia? Christine?

Mrs. Christine Elliott: I'd just like to thank you very much for your presentation, sir. The involuntary hospitalization issue is something that we are struggling with and an issue that we want to take a look at—and community treatment orders, because there are some issues around those as well; they are voluntary as well, so they may not apply in every circumstance. But I'm glad that you told us about the fact that you weren't informed of them. I think that's really important. I believe that there is a whole issue with the homelessness aspect of it that we do want to explore, so your thoughts and your being here today have been very valuable. Thank you very much for being here.

Mr. Eddi Chittaro: Thank you very much. I appreciate that.

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

Mr. Gilles Bisson: I didn't catch the beginning: Is it a son or a daughter who was in—

Mr. Eddi Chittaro: Sister.

Mr. Gilles Bisson: And you're the primary caregiver at this point?

Mr. Eddi Chittaro: Correct. By the way, she passed away last December.

Mr. Gilles Bisson: My condolences.

Mr. Eddi Chittaro: Thank you. Like I mentioned earlier, I really wasn't going to do anything about it until I saw this notice. That was the issue I had. I really had a problem going back to the justice of the peace. It's not the easiest thing to do. I don't know if you've had the experience. Your motivation is being questioned, obviously, your knowledge, your experience, and believe me—and by the way, I didn't live with my sister. She lived on her own—never married. She lived in an apartment. I would go there occasionally with my wife and so on, and we'd take her out for lunch or breakfast. I could see things. I mean, you don't necessarily have to be a doctor to see a person not acting normally. For example, had I known in 2004 that the CTO existed, had they done

this for me, I would have had her back in the hospital. Unfortunately, she got sicker and sicker, and I was hoping that I'd have time to get her to emergency like I did one or two other times, but anyway.

Mr. Gilles Bisson: I have two questions. I have a sister who's schizophrenic, and I've had to Form 1 my sister three or four times, where she's been a pretty big danger to herself. She's doing well today, knock on wood. She's living on her own and functioning well.

My question is in two parts. The first part: What I've realized over the years is that, unfortunately, most people don't have families to take care of them. Either their family has abandoned them, or they themselves abandoned the family. The community treatment order helps to a degree, but I take it that you still think where the family is there, the family should have some ability and take the responsibility towards that individual.

Mr. Eddi Chittaro: Definitely. Following up your—excuse me; I interrupted you. Go ahead.

Mr. Gilles Bisson: The second part is what really troubles me now. My mother passed away last year and she was the primary caregiver; now I am. What I'm finding is that the mental health system takes care of my sister's mental health, but they don't deal with her physical health, which in the end adds to her mental health problems. I'm wondering if you had the same experience, where your sister may have had difficulty bathing or shopping or whatever it might be—now there are ACT teams for shopping. Do you find that it's not a whole system, that in fact mental health people take care of the mental health problem and the twain never meet?

Mr. Eddi Chittaro: To follow up, my sister also had a hyperthyroidism condition. She refused to take medication after a while. The hospital did a good job, stabilized her and dismissed her. She had some follow-up with a social worker, then refused to see the social worker: "I don't need that. I'm okay." You've heard that story: "Nothing wrong with me. I'm normal." Consequently, her health deteriorated. I knew it. I saw it. I kind of blame myself in a way. I didn't go back to the justice of the peace. I'm sure—I'm not sure; I'm not going to play God here. Perhaps, had I done it, she could still be alive today. The point is you're right.

Not only did she refuse to take the medication for her mental condition, but she also refused to take the medication for her thyroid condition, and that compounded. She became very, very overweight. She wasn't taking care of herself. She was very argumentative. She was rude to people. When we took her to a restaurant, the waitress would be very kind to her, and she'd make some remark that was offhand—that type of thing.

The other frustrating thing is you feel abandoned. You have a social worker come in and say, "She doesn't want to see me." Now what do I do? The social worker obviously can't force herself—what do you do? You know that the consequence is that the medication will not be taken, and she will revert back to where she was. I recorded the many days she was in the hospital. Not to make fun of it, but she certainly took advantage of our

hospitalization time. That's the only thing. Again, I don't know what hospitals do around the country or around the province, and I don't know why this wasn't done here. I don't know whether they knew and they didn't tell me, or they didn't know because no one told them about the act. There was no follow-up.

That's why I'm asking if people can be helped throughout the province with this issue, and it's a really serious issue. They are ill. I don't think it's a legal—I know there are people who perhaps want to take advantage of someone with illness. I realize that, but I think most people who are family members are concerned about getting the person healthy again, maintaining some kind of normality.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Eddi. If there was any question whether you should have come forward, we're all glad you did.

Mr. Eddi Chittaro: Well, thank you very much. I appreciate the opportunity.

CONSUMER COUNCIL, CANADIAN MENTAL HEALTH ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): Our next presenters will be from the Consumer Council. We've got two women, I believe, Sherry and Diane, if you would come forward and make yourselves comfortable. Have a seat. There's some water there if you need a glass of water before you begin. Make yourself as comfortable as you want.

Ms. Diane Middleton: Thank you.

1000

The Chair (Mr. Kevin Daniel Flynn): Welcome, Sherry and Diane. Like all the other presenters, you've got 20 minutes. You can use that any way you see fit. If you can leave some time at the end for some questions and a discussion, that would be great, but it's not necessary; it's entirely up to you. The floor is all yours.

Ms. Diane Middleton: Great. I'm going to start. We've given you kind of an outline of where we're going to go.

The Chair (Mr. Kevin Daniel Flynn): Could you identify yourself for Hansard so we can get it in the official recording?

Ms. Diane Middleton: Sure, that would be great. My name's Diane Middleton. I'm a staff liaison with the Consumer Council, a staff member of the Canadian Mental Health Association, Windsor-Essex County Branch, but I'm also a family member. My oldest brother has schizophrenia.

The information that we've compiled for you is the result of input from the Consumer Council, so those are all consumers of programs in our agency and people who have been involved with the mental health system at large coming together to provide some input regarding some of the areas that you've been focusing on in terms of this committee. I've also included some comments, as part of my work—my title is mental health advocate. I do short-term support with consumers, family members, the

community at large and social services agencies, so I've had many years of working with family members seeking help.

I apologize. Both Sherry and I are dealing with throat—with colds and things.

The first comment that was very resounding in the group was talking about the need for counselling. What's currently available is very short-term and solution-focused. The comments that were made were that consumers felt that they could not bring up a lot of past experiences or deal with traumatic life experiences, that they were talking about staying in the moment and focusing on the future. There were some examples in the group where they had been able to deal with past issues through venues like AA—Alcoholics Anonymous—and Brentwood, which is a recovery program for addictions in Windsor. Council members noted that they felt a sense of release when they were able to deal with these past issues. The suggestion was made that OHIP could fund counselling services. That was a suggestion in the group.

There is currently very limited access to a psychologist for the purpose of counselling. Formerly, there was a psychologist attached to the mental health outpatient clinic at Hôtel-Dieu hospital that was available for counselling. That has been discontinued. I would assume the funding was redirected.

Number two: We spoke briefly about alternative therapies. The council identified the need for access and funding for alternative types of therapy—for example, art, music, massage, acupuncture—to assist in recovery. Art therapy is available through Mental Health Connections. They spoke about being able to expand and have more opportunities. But access to massage, acupuncture, as the family member who was here before—I heard at the end you were talking about how for physical health issues, even things like chiropractic and other medical needs, other types of therapy, are not available to folks who don't have the funding for such a need.

Number three, advocacy for service complaints: Certainly, our agency has a complaint process, but one of the members of the council spoke about actually a service within the community at another agency. But they all resounded in talking about the fact that there was some fear in terms of complaining about any kind of service, that they might lose their services. The comment was, when you're mentally ill, you need someone to help you through the steps in terms of bringing a complaint forward. That could be for any kinds of services dealing with financial appeals, any kind of legal process. Certainly, there are law clinics that assist with this, but often the advocacy or the service complaint process is quite long and tiring, and it's very emotionally draining for the person dealing with it, so they spoke about needing someone to help them walk through that.

Number four, peer support and after-hours support: Although at Canadian Mental Health, we do offer some peer support—and I will speak about that briefly later—it's not set up formally as a peer support program or as peer support workers as they do in other areas with ACT

teams. With some mobile crisis teams, they have peer supports available. The council was discussing the benefits of peer supports and how consumers feel more comfortable speaking with a peer about an issue. They also discussed the fact that there are limited after-hours services. Several folks acknowledged that the crisis service that's available out of Hôtel-Dieu hospital, including the mobile crisis service, has been very helpful.

Number five, consumer survivor initiatives programming: The council identified the need for more options for consumers who are further along in their recovery. When the restructuring was done before the LHINs came in—this was several years ago, the mental health restructuring of the different agencies—there was a view to, obviously, not having different agencies overlap or offer the same services.

All the consumer survivor initiatives or programming came under one umbrella or one agency, so what the council members were commenting on is that they felt that they were all being put in one basket, that they only had this one option and if they didn't fit in with the one option, it didn't give them any other venues. They found that the current programming available through Mental Health Connections—they needed more, different programs and something that was more challenging. They all identified that there are excellent programs through the local consumer survivor initiatives, but they noted the need for more.

Number six: It alludes to some of the comments that the family member mentioned in the last presentation, folks with mental health issues needing practical help in terms of homemaking. In Windsor, previously, through the city of Windsor, there was a homemaking program that was accessed through other consumers that was very practical in terms of being able to get housework done, light housework, as well as even yard work for folks who actually owned their own home. Just some practical things in that, when the person was not doing well, they were able to access that, and it was really helpful in terms of just being able to function and work on their recovery. As I've noted here, it used to be available for folks with physical limitations as well as mental health issues.

There is currently, through the VON home help program, some help of this kind, but there is a fee attached. As well, I don't believe it fits the criteria. It does not fit for folks with mental health issues who are physically able to do the work themselves. I'm talking about when a person's symptoms are just to the point where they're not able to do some of those basic household things.

Number seven, integration: The comment was, there is no community life. People need to be incorporated back into community. People need to be helped to get back into other areas of society beyond the mental health system. I think that kind of speaks for itself.

Number eight, and I didn't elaborate—

Ms. Sherry Harder: I'm sorry.

Ms. Diane Middleton: That's all right. Could we just get—

Mr. Gilles Bisson: Are you okay?

Ms. Sherry Harder: Yes. I have bronchitis. I just found out.

The Chair (Mr. Kevin Daniel Flynn): So does my wife, so you're not alone.

Ms. Sherry Harder: Thanks.

Ms. Diane Middleton: Are you all right?

Ms. Sherry Harder: Sorry for the interruption, everybody.

1010

The Chair (Mr. Kevin Daniel Flynn): No problem. I know how it feels.

Take your time—no rush.

Ms. Diane Middleton: I know you guys are on a bit of a clip here.

Okay, number eight—I'll get back to that. This has been an ongoing discussion with the Consumer Council over quite a long period of time about accessing education and employment and some of the difficulty in doing that. Certainly there are programs available to help people access those things. It's fairly limited in terms of the resources. We have two staff at our agency who help people to look for employment. It's very limited at the ODSP office, so as much as those programs are helpful, their comments were that it needs to be expanded.

Number nine, the need for residential treatment for concurrent disorders: Certainly there are places in the province, but there is currently no residential treatment for concurrent disorders in the Windsor-Essex county area. The closest option is in Guelph, Ontario. As well, some residential programs do not accept consumers who are prescribed benzodiazepines, even if the medication is taken as prescribed by their psychiatrist. This presents a barrier for concurrent clients. Later on—I actually forgot to give you this; this will be another handout. This is a community program called the STAGES program, which the Canadian Mental Health Association has been offering for some time now. It's for concurrent consumers. Those are folks with mental health issues and an addiction issue. The description of the group is pretty self-explanatory, but it's been very, very busy. They're having new referrals every week for folks who have gone into addiction treatment and who need some follow-up in the community, but with a specialty regarding mental health as well as addictions. So it's been very successful.

There are two staff attached to this program at our agency. The addiction specialist provides one-on-one support to individuals with concurrent disorders. They meet with individuals who are not yet in the maintenance stage and are trying to stop using substances—and these folks are not eligible to join this community group—refer individuals to appropriate treatment programs if still using substance, and meet with individuals with concurrent disorders who require support and education and do not want to participate in groups. Once again, they facilitate the STAGES group. So that's been something that has been very helpful in terms of the folks who are needing those kinds of services in our area. I'm almost finished.

Number 10, emergency room wait: Consumer Council members identify the difficulty of waiting sometimes up to eight hours in emergency while experiencing a mental health crisis. The quote is, "I needed someone to talk to while I was waiting." Family members have also noted the need for a quiet place in the emergency department for their family member with a mental illness while awaiting service.

Number 11, support to the family unit: As much as through our agency and through the ACT team—certainly, the ACT team has a smaller caseload and sees their folks more often—the family unit is often the 24-hour case manager for folks. The need to provide supports for children of parents living with mental illness, increase collaboration with family supports, inform them of decisions and welcome their input—consumers have identified that. If their family members had more education and supports, it would in turn benefit them in their recovery.

A final comment: The Consumer Council spoke about what it's like to access service and get an answering machine or have to call back or come back to emerg and on and on, and the having to tell people the story repeatedly, and how frustrating that was for them.

I'm going to introduce Sherry. I've gotten to know Sherry over quite a while. She's going to be presenting her personal experience in the mental health and addictions system. She is part of our speaker's bureau at Canadian Mental Health, she has been involved with our staff orientation, and she has also gone out with us in making presentations to social service agencies and the general public. So she has really been doing a lot of work over the last couple of years and educating folks about mental health.

Ms. Sherry Harder: Hello. My name is Sherry. I will be presenting, in chronological order, different things that have happened in my life.

The first one is that I was eight years old when my parents divorced. It was very hard for me. I blamed myself for their divorce.

When I was 11 years old, I had my first drink. My grandparents had crème de menthe at their house, and I thought that stuff was great. I kept drinking it and drinking it, and I felt better all the time. I found that I finally fit into groups—family groups at first, and other groups later—if I drank first.

Also, when I was 11 years old, I had a behavioural problem. I wouldn't listen to my mother. She tried to discipline me in a good fashion, but I just would have nothing to do with it. I rebelled, and my stepfather and I started incest, which didn't help me at all.

When I was 15 years old, I quit school. I had been going to Western Secondary School. It's a school for trades out in Amherstburg. I was only there for about three months, because I was drinking in the back and I was causing trouble in classes all the time so they didn't want me there anymore. They said, "Quit or you're going to get expelled," so I had a great choice there.

I ended up at Maryvale. Now, I know, it's for boys and girls, but when I was going it was just for girls. It was a treatment centre. I was considered disturbed, so I stayed in their cottage for disturbed girls for seven or eight months. Then I ended up going to London Psychiatric Hospital because I was angry and was a threat to myself and to others. While I was still at Maryvale, I got diagnosed with bipolar disorder, and when I went to London Psychiatric Hospital I had been diagnosed with schizophrenia, so I had a tough thing to carry. I used to drink on the grounds outside of Maryvale with my friends—I had some friends who drank with me.

When I was 17 years old, I was discharged from London Psychiatric Hospital to a group home in London. That group home did me a whole lot of good. It helped me get some confidence in myself. It helped me do better in school, because I had gone back to school. It was just, on the whole, a great experience for me. I was there for about two years.

Then I moved back with my father, and there I started drinking heavily again. I didn't remember what I had done or where I went. It was a big mess. I was drinking in bars instead of just on my own, and I tried other drugs when I was 17.

1020

When I was 19, I moved to Windsor with my father and I mixed alcohol with marijuana, which wasn't a very good idea, but I thought it made me feel better. Any time I got depressed or anything, it was like, "Let's have some more marijuana" or "Let's have something to drink. It'll make me feel better." For a long time, that worked for me.

When I was 20, I went to Riverside Secondary School, but I quit Riverside in grade 13 because the work was just too hard and I was too busy drinking. I went to Fanshawe College in London. I stayed there for three months, but they asked me to leave because I was drinking. I was spending more time in their pub than I was in their classes, so that wasn't very good.

At 21 years of age, I started going to psychiatric wards in general hospitals for lack of self-confidence, lack of self-esteem. I took medication but I was still suicidal, and I spent a lot of time trying to get therapy to help me to feel better about myself. But I was still drinking at that time too, so that didn't help.

At 25 years old, I got married and my addiction and mental illness were closer together. My first son, Jason, was born. He's 20 now; he's going to be 21 in September. He goes to St. Clair College, where he takes advertising. He's got one year left, and then he's thinking about taking marketing or something after that.

At 30 years old, my other son, Matthew, was born. I was still drinking in excess, except I did not drink when I was pregnant because I thought that it would not be good for them—the alcohol and the drugs and things—that it wouldn't be good for my pregnancy, so I didn't do it during pregnancy. And I smoked less marijuana at the time.

At 36 years old, I started CMHA treatment. Case management really helped, although not so much with addictions, because at that time they didn't have the STAGES group yet.

At 39 years old, I was fed up with alcohol. My husband said, "Either change or you will not like the changes around here." I started a recovery program and I went to Connaught Clinic for four months. The program was for addictions—alcohol and drugs—and it helped with self-awareness. The program was called concurrent disorders. There I learned a lot about how I responded to things and how I thought about things, and like I said, a lot of self-awareness.

When I was 40 years old, I had admitted to drug addiction. I had taken Tylenol 3s for a toothache I had, and later on the toothache went away but I still kept taking more Tylenol 3s because I felt so good with them. They made me feel like I was better as a person than I was without them. I went to a psychiatric ward and my medications were stabilized.

At 41 years old, I started volunteering at the Canadian Mental Health Association.

At 42 years old, addiction and mental illness were brought together in treatment through STAGES—sobriety through accessing group education and support—at CMHA. That's the group that Diane passed out the flyers about.

In the present, I am six years sober and five years clean, which is without street drugs or drugs that aren't prescribed. I take medication to stabilize my mental illness and I have a family: a husband and two sons.

I was introduced to CMHA through the psychiatric ward at Hôtel-Dieu hospital. Help for my addictions came when my husband said that he was going to make changes at home and I would not like them. The next day, I called a recovery program for alcohol.

In February 2004, I tried to go to the House of Sophrosyne for help with alcoholism. They would not take me because of my mental illness and because I was hearing voices. There is no local in-patient or residential concurrent disorder treatment program. The closest place is Homewood in Guelph, which has a waiting list of four years if you cannot get it paid for through work.

What helps me now in my recovery is partially attendance at recovery meetings. I have a home group and go to three meetings a week. Also, I have literature on alcohol and other drugs. When I was starting to get help, phone calls from peers, other alcoholics, really helped. This still works today. I also have a sponsor, like peer counselling.

In day-to-day life, a constant struggle is finances. The cost of food is rising more quickly than the amount of my disability cheque. Prices are climbing for the same amount of food. If this keeps up, we may have to go to a food bank.

I am happy to give back what was so freely given to me. Help is still needed to expand addictions and mental health services. I will keep putting my foot forward to try

to help the community get what we need. Thank you for listening to my story.

The Chair (Mr. Kevin Daniel Flynn): Sherry, thank you very much. It takes a lot of courage to come forward and say what you did, and we're really pleased you did. Unfortunately, you haven't left any time for questions, which—

Ms. Sherry Harder: Oh, sorry.

The Chair (Mr. Kevin Daniel Flynn): No, hey, that's not your fault. I'm sure there would be interesting questions if we had the time, but unfortunately we have to move on. Thank you very much for doing what you just did. Thanks for the presentation. Diane, thank you for your presentation as well.

CHATHAM-KENT CONSUMER AND FAMILY NETWORK

The Chair (Mr. Kevin Daniel Flynn): Our next presenters this morning are from the Chatham-Kent Consumer and Family Network. Kelly Gottschling and David Hutchinson, if you'd come forward. Good morning. Make yourselves comfortable. There are probably some clean glasses there if you need some water yourselves. Like everybody else, you have 20 minutes. If you could leave some time at the end for some questions, that would be great, but it's entirely up to you. If you'd identify yourselves for Hansard when you speak, that would be great.

Ms. Kelly Gottschling: Certainly. Good morning. My name is Kelly Gottschling. I am the executive director of the Chatham-Kent Consumer and Family Network.

My goal today is to discuss the value of consumer initiatives in Chatham-Kent and in the province of Ontario. What is a consumer initiative? For those of you who do not know, a consumer survivor organization is run by, and often for, persons who live with a mental illness. They are unique in that their strength comes from utilizing the skills of persons who have shared experience within the mental health system. Although medical interventions are often necessary and valued by persons living with a mental illness, there is so much more that adds quality and purpose to our lives.

The people we spend our days with are 16 years of age and older. Ninety-nine per cent of them live well below the poverty level. Their experiences with the mental health system vary. Some of the people we support have been ill for more than 50 years; many of the young folks just in the last few. What they need from the Chatham-Kent Consumer and Family Network is the same: to be respected, safe, encouraged, and to have educational opportunities, personal interactions, the opportunity to volunteer and to be actively and productively engaged in their own communities.

1030

When speaking to the people we support, they say the piece of their lives they miss the most is the opportunity to develop strong bonds with other adults. They wish to become a friend, to nurture that friendship and slowly

leave the isolated world that they were in for many years. The ability to create natural networks of friends, in my mind, is one of the most important things that will assist in long-term recovery for persons living with a mental illness. The thing we recognize most is that after all the service providers close our doors at 4:30 every afternoon, there is nothing left in Chatham-Kent for persons with mental illness. There are crisis staff available, but most of the time people don't need crisis workers; they need someone to have a coffee with, talk on the phone to, to problem-solve, laugh, have fun, or just be heard. The difference between consumer organizations and medical models is that we are proactive and not reactive. When people have a group of their peers that they can count on, as many of us do, they are less likely to become unwell.

Many of the people we support lived for years in long-term mental health facilities. They were released and now, for the most part, live on their own. Most of these folks lost connections with family members. They are often isolated and lonely. When they come to us, most have few or no friends at all. Many have poor life skills because they became ill during the years that they would have learned these skills, or they did not develop them. In the institutions, they did not need them. The skills that they did have at the time were lost years ago. One of our primary goals is to work one-on-one or in small groups to restore these vital skills that people need to live successfully on their own.

Every day, we have new young people enter our building. They are referred by local hospitals and CMHA. These kids are struggling because they are quite ill. Many have lost their friends due to the misunderstanding of their symptoms and, of course, the stigma attached to mental illness. I do not know what it is like to be 16 years old and living with schizophrenia. Being 16 is difficult enough without the symptoms of psychosis. Medical intervention is crucial. Once that has been implemented and working well, then what? Young people need something very special and unique. Because they are already so fragile due to their age and complexity of their symptoms, we must be prepared to offer them what they need specifically. The best way we have found to do so is through education regarding their illnesses, strategies to stay well, a social recreational program that allows them to be young and have fun in a group of their peers who "get them." We participate in formal and informal activities and events in the community together.

The strength of this group comes not from me, as executive director, but from two young people who came to me with the idea that young persons needed a place that was just theirs in which to grow, learn and be accepted. We took a leap of faith, with no funding, and created the Young Minds group for persons aged 16 to 32. Two young men who live with serious mental illness facilitate this group. They are now strong, happy and living well in spite of their symptoms. They go forward and set an example of what it is like to live with a life-altering illness but still have control and hope that their

lives will be productive and happy. They are wonderful role models and wonderful people.

Last year, we provided 5,005 face-to-face visits to 250 persons living with mental illness. We have four staff, two of us full-time and two of us part-time, all chosen very carefully for their education, their life experience and, most importantly, their ability to engage people of all ages and abilities. Our yearly budget is \$177,000.

Our request to you today is to consider the important role that consumer survivor organizations play in the mental health system. We want to be funded in a way that allows our staff to receive health care benefits, which almost none of the consumer survivor initiatives have—and to fund us fairly. We need you to see that our role in the mental health system is valuable, unique and necessary.

I would like, at this time, to introduce Dave Hutchinson. Dave is representing the 250 members of our organization, and he has quite a remarkable story and is a wonderful man. I would like to introduce him on behalf of CKCFN.

Mr. David Hutchinson: Hello. My name is Dave Hutchinson. I represent more than 250 consumers who are members of Chatham-Kent Consumer and Family Network.

A consumer is anyone who uses the mental health system. Examples might be anyone who sees a psychiatrist, psychologist or social worker. I have been a consumer for more than 55 years.

I want to speak of a better approach than waiting until a person is in crisis before coming to his or her aid. The reactive approach just mentioned is necessary but flawed. How can we expect a person unable to cope with personal problems to have those problems solved in a few days in hospital? The likelihood of having to return to hospital again and again is very high.

Now to my main message: I wish to speak of a proactive approach, an attempt to support and prevent return to hospital. Recovery from mental illness takes time.

Consumer initiatives may be new to you. The best way to describe initiatives is to let you look at my life and the difference that CKCFN has made to me. A year and a half ago, I separated from my wife of 40 years and moved to Chatham. I didn't know anyone and was mourning the death of my marriage. As well, I had never been totally responsible for myself and my finances. I was seeking personal autonomy and health. My well-being is greatly improved, physically, mentally and socially, as a direct result of being a member at CKCFN. In what ways? My self-esteem and self-confidence have been enhanced because of my friends at CKCFN. They believe in me. Many friendships, a sense of belonging and getting respect by respecting others are invaluable. I'm growing and more fully realizing my potential. With the encouragement of friends, I have returned to the University of Windsor, which is my alma mater, and I'm in my third year of studies for a second degree. A third degree is also in my plans. I go to university not only for

the pleasure of learning, but some of my studies may help me assist my fellow consumers.

I am a social activist and believe that one person can make a difference. This implies that all of us here today can make a difference.

1040

In conclusion, I am not advocating for more psychiatric beds, nor more psychiatrists, but more consumer initiatives in Ontario. Your ideal model is in Chatham.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David, for your presentation, as well as Kelly.

Let's start with Christine or Sylvia?

Ms. Sylvia Jones: David, I wanted to expand on your comments about your circle of friends—peer support—that you discovered when you went through Chatham-Kent. Was that in a formalized way or was that a network that happened just by virtue of you being part of the organization?

Mr. David Hutchinson: I happen to live across the street and I discovered it after a couple of months and began going. More and more, the persons who attended there became my friends.

Ms. Sylvia Jones: So informal?

Mr. David Hutchinson: I would call it informal, yes. We go voluntarily. None of us are compelled to go in any way. We are not patients, we are not clients; we are members.

Ms. Sylvia Jones: And Kelly, are there opportunities that you make available to encourage those informal networks and peer support?

Ms. Kelly Gottschling: Absolutely. We also have at least four programs per day, so we have educational opportunities as well as social, recreational and rehabilitation programs. We also have things like a men's group, a women's group, our Young Minds group. All those are peer-led. We do pay our peer support staff, which is very unique in the province of Ontario. Most persons who are in a peer support model are not paid, they are there to volunteer, which is too bad, because what they have to offer the mental health system is in many ways far more valuable than—they are people sharing their experiences, triumphs, strategies or skills. But yes, it is available formally and informally.

The luxury that we have is that most of the people whom we meet come almost every day, so we get to learn and we get to see what they like and what they dislike, so we know sort of that this guy likes to play the guitar and this young man who just came in likes to play the guitar, so we could help mould those—in fact, many of our instructors are peers, people who just happen to live with symptoms of a mental illness but have fabulous skills and go forward and teach those. Over half of our programs are taught by peers.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Time to move on. Gilles?

Mr. Gilles Bisson: Just following up on your presentation and the ones before, you're part of what is necessary in order to deal with the ensemble of what is

necessary to allow people to live in a community. It seems to me, from my perspective and from what I'm hearing, that it's not necessarily true that various agencies sort of complement each other. You do complement each other, but there's no mechanism to make that happen.

My question to you is, in a community, what is needed in order to be able to make sure that consumers—people suffering with mental illness—are able to get the various types of services that are necessary, because it's clear to me that one agency doesn't provide that, and what would you suggest as a mechanism to make that happen?

Ms. Kelly Gottschling: I think the most important thing is communication. Because, of course, we don't have any kind of marketing pot of money to use to get the word out there, we have to work really closely with our community partners. They have to be aware of what we do, so we go out to services, go to their staff meetings, work with psychiatrists, psychologists, social workers, counsellors. We want to make sure that everyone new coming on board to CMHA has a chance to come out to our building and see what we do. We're really passionate about that and we have excellent, excellent, community partners. Most of the referrals that come to us are word-of-mouth.

There is one thing that I do want to say, if I can, and it's that when a person is diagnosed with a mental illness, if indeed they qualify for services, they often go on a waiting list for up to a year or longer, which is—it's the way it is. It's not great. We wish it was different, but they sit. They may have a piece of paper or a doctor telling them that they have a diagnosis, but then what?

We support moms and dads and kids, women who are 45 years old, just diagnosed, women my age who finally have a title, a name to something, and they want to talk to somebody about it. They want to know what their future is going to hold. They want to know how medications are going to impact their life, their marriage—so many things. We offer that with peer support and education. We have a fabulous resource library.

I think it's really important that when people are diagnosed, they have a next step—not waiting on a waiting list for a year. To access us, you simply walk in the door.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Kelly. Thank you both for being here today. Unfortunately, your time is up.

Ms. Kelly Gottschling: Thank you.

HEATHER LINDSEY

The Chair (Mr. Kevin Daniel Flynn): Our next presenter here today is an individual, Heather Lindsey. Heather, make yourself comfortable. I think we're getting you some clean glasses; I see you brought your own water. You've sat through a few of the presentations now, so you know that everybody's getting 20 minutes. Use that as you see fit. If you'd like to leave some time at the end for questions, that would be even better.

Ms. Heather Lindsey: Yes, definitely. I've practised a little bit; hopefully I can keep it to a minimum and have time for questions.

I'm really glad to be here and glad to meet all of you. I think it's a great initiative, to have this committee going across the province and getting input from consumers, how consumers perceive our current system and our past systems, and what we can do to go forward to support consumers.

My story is just a typical story. It's not extraordinary. As I said, my name's Heather Lindsey, and I'm a 48-year-old woman who has been managing episodes of major depression, anxiety and post-traumatic stress disorder for the last 15 years. I have a university degree from Western, and at the pinnacle of my career I managed a \$3-million-a-year provincial capital grants program which assisted private non-profit organizations from across the province to retrofit their existing buildings so that persons with disabilities and seniors could access their community programs and services. So it's interesting, working with the office for disability issues back in the late 1980s and early 1990s, that things have kind of come full circle.

You know, I had it all. I was 33, I loved my job, I had an office at Queen's Park, the power centre of the province, and I was making a difference in people's lives, people's everyday lives. I had a beautiful home in the suburbs and I'd been in a long-term relationship and was planning my wedding when I was diagnosed with my first episode of major depression.

Back then, I was a high-energy person. I worked; I was focused and driven. I was the first one in the office and the last one to leave, and I always met my deadline dates. There were times I even stayed all night. I'm proud to say, again, that I never missed a deadline even while I was suffering through crippling anxiety attacks and couldn't get out of bed for days. I still micromanaged things from home.

What started off as crashing on the weekends, sleeping a lot, isolating, not going out or participating in social activities, over time turned into having major anxiety attacks on the platforms of the GO trains in the morning, especially Monday mornings—standing there, not able to move, with one train after another rolling to downtown Toronto. Then, slowly but surely, it went from Mondays—I couldn't get out of my bed and go to work until Wednesday. And then a whole week would go by. I was out of control; my life was out of control and my depression was in control.

1050

Fortunately, working in the field of disabilities and being around people who managed their disabilities, who were productive, high-functioning people, I did reach out for help. I was one of the fortunate ones: I knew where to go to get help. Not everybody does.

But I don't share this story so that you'll feel sorry for me or say how brave I am to be here today, because there are more horrific stories and more courageous people than me. I share this story to show you that any of us—

you, me, your sister, your daughter, your colleague—can succumb to the debilitating effects of mental illness. In our society of ever-increasing pressures to do more with less, to be all things to all people, to manage our households on less money, there are increasing numbers of people struggling, fighting to keep their heads above water. It has created a demand on our mental health system like no other time, and in the foreseeable future, this will just continue to grow. So I applaud you again for taking on this issue.

I have three key messages. Mental illness is an illness; it's not a character flaw, and people should be given the same level of access to care as any other person needing medical attention in this province. We talk about reducing waiting times in emergency rooms. If you think that's long, try to find a psychiatrist here in Windsor-Essex county.

I'll tell you a funny story—and that's the way I've dealt with most things: I kind of deflect depression and mental illness with humour. It's a scary thing for most people and, heck, it's scary for me, and I have to live with it. So I find humour is a more palatable way to bring it forward.

Here's my funny story. I grew up in Windsor. I moved to Toronto, and when I came back from Toronto to Windsor, I was on long-term disability—and it's definitely more affordable here to have a car and live on your own, plus I have family here. When my well-intentioned general practitioner referred me to a new psychiatrist in town, the only hitch was that I was going to be on a one-year waiting list. You've heard about some of those one-year waiting lists. After two years on this one-year waiting list, I said, "There's got to be a plan B because plan A's not working." He put me on another one-year waiting list, and actually, I got in in another year. So the moral of the story is, or the joke of the story is, it took me three years to see a psychiatrist, who spends 10 minutes every few months reviewing my medications. So that one-year waiting list turned into three.

I don't have anything against psychiatrists, and they're hard-working professionals doing the best they can with the time they have. There are only so many hours in the day, and the need is so great. But I challenge you to show me where else in the medical system this would be acceptable. Would a cancer patient be left to wait three years to receive chemotherapy or radiation therapy? No. We'd be outraged. People would be calling your offices; they would be organizing rallies. There would be media campaigns. They would be camping out in front of the legislative buildings until something was done to rectify the situation.

I call on you: It's time for action. We don't need another study; we need real, measurable action with goals, objectives, timetables, implementation and follow-up. We need a paradigm shift or a systematic change in the way people with mental illness are treated. We must raise mental illness to the same level of status as the rest of the health issues facing us, with funding, account-

ability, and emphasis on creating a system that meets the needs of a broad range of disabilities.

As you've heard, today our system is basically more reactive and deals in crisis. I'm not going to talk so much about that because you've already got that speech, so I'll go to my third point.

The great news is that most mental illnesses are treatable. But we can't just rely on medications to manage symptoms. We need to take a holistic, patient-centred approach to care. We need to give people access to affordable, ongoing care. What does this look like? It takes many forms, shapes and sizes. We don't have to reinvent the wheel or go back to the old paternalistic, medical model. There is a very low percentage that do need ongoing institutional care, and, heck, that's okay, but the majority of us just need access to medications, talk therapy and some counselling for us to recover and maintain our recovery and get back to being productive citizens.

In my 15-year travels with mental illness, I'll give you one of the examples that I found was most instrumental in me getting back to work. There was a clinic in Markham Stouffville that was overseen by a psychiatrist and had different personnel—board-certified clinical psychologists, psychologists who were doing their practicums and getting their clinical hours in. They were specializing in a range of fields, from children and adolescents—I'm just going to take some water; my medication is giving me a dry mouth, and my talking, too. They had different specialities. There were a couple of people who specialized in working with children and adolescents, some people who worked with marriage and couples therapy, some who did cognitive behavioural therapy, others who assisted people with post-traumatic stress disorder.

What was so special to me about this clinic was that it worked on a sliding-scale basis. I did have limited insurance coverage through my employer, but I was one of the lucky ones. We're not here to tackle insurance reform, but should there ever be a conference on that, sign me up—but then you'd have to extend it past 20 minutes. What was really great about these folks is it's like—you've probably heard of co-op condos in downtown Toronto, on the Esplanade, and there are people there of all levels of financial ability, those who can afford the highest rate and those who can afford very little. Everybody puts money in the pool, and I think it makes everyone better, because you're all together in the same community. They use this type of effect with the sliding scale. So those who could afford the full rate paid the full rate, and then so on and so on. Those who could not afford it, who were on social assistance, maybe paid \$5, where the person who could afford it paid \$85—because, as you know, psychologists are not covered under any medical plan. Psychologists and social workers are the folks who do the talk therapy that helps you through issues.

I know there are other programs like CMHA that provide educational types of information, and those are

great, but I think the greatest need is to have access to ongoing, affordable services, because, unfortunately, although it's treatable, there are times, just like leukemia, when you have recurrences of episodes.

1100

Closing remarks: I think it's imperative that we move forward developing a sustainable mental health system that not only treats the most severe among us—we deserve to be treated with the same dignity and to the same level of care as anyone else struggling with a medical condition. The key is developing access to a patient-centred, affordable mental health system that supports people throughout their lifetime, not just when they're in crisis.

In closing, I'm an eternal optimist, although I'm slightly depressed some of the time, and it brings me hope that committees such as yours are going across the province talking to consumers. It's an important step, and I wish you all every success in this venture. It's an important initiative.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Heather, and thank you for your sense of humour. You've still got a lot of Queen's Park in you. I notice you gave us three key messages.

Ms. Heather Lindsey: That's right. You see how I put them in bold, a little highlighting for the stuff in between. I must admit I still have a little Queen's Park in me.

The Chair (Mr. Kevin Daniel Flynn): I have a question. In the business world, from an operations management point of view, there are two ways of assigning the operation to a business. There's finite loading and there's infinite loading. Infinite loading means you just get it; you go there and you get it, whatever it is. Finite loading, obviously, has got to be scheduled. Why do you think the one side of the health care system, those people with broken legs and bleeding and traffic accidents, they get the infinite loading; they get treated right away, but somehow, you can wait three years to see a psychiatrist? How has that evolved?

Ms. Heather Lindsey: Yes, I think it's overwhelming, the broad spectrum. I'm not sure how familiar you are with the history of the mental health system, but it went from a very paternalistic type of system, where those people weren't talked about. There was mention earlier about the stigma. Unfortunately, the stigma is still present even though we're making inroads. Most people, on the news media, who do they see? They see a person who's in crisis, they had a psychotic break and pushed somebody into the subway system. So it scares the heck out of the general public. It's not a warm and fuzzy issue.

You can't solve it by having a surgeon mend your bone. It's more to do with a combination of things from biomedical—to a certain extent, the medications do help to stabilize, but they only treat a basic symptom. They don't take care of the person, the issues, what got you there. I truly believe that you can't just take medication and fix the problem, the old story about "Oh yeah, take a Prozac, and you'll feel happy." Heck, I took a lot of

Prozac, and I still had days where I still suffered with depression—so that type of thing. I am always of the opinion that in conjunction with the medication and that guidance, you need talk therapy. You can't have one without the other. Sometimes you can have the talk therapy without the medication if you have a mild form of depression. You may only need medication for a short time, but some of us need it for the rest of our lives. But you can't make the recovery inroads without some talk therapy.

Right now, that's unaffordable to the average person. Being on long-term disability, I'm seeing a new counsellor. I'm going to take mental health as a priority for me. I don't have coverage anymore. Fortunately, I was over-insured, but I'm taking a portion out of my income and I'm applying it to see a psychologist, and I've done that for many years because it's important for me. If it was more affordable, then there would be better access for people.

I think it goes in conjunction with what Chatham-Kent and CMHA will tell you. They can provide peer support and that kind of thing, but they don't have the resources to provide the in-depth treatment, talk therapy.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Heather. Thank you very much for coming today. It was appreciated. Thanks for your optimism; I share it.

Ms. Heather Lindsey: A long-winded answer; I should be a politician. What was that question again? So that's the long way to the short question.

Mr. Gilles Bisson: That's like being in question period.

The Chair (Mr. Kevin Daniel Flynn): That's right. Thank you very much for joining us today.

Ms. Heather Lindsey: With a little less fighting or animosity. I'm an all-party kind of person.

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

WINDSOR-ESSEX COUNTY DRUG STRATEGY IMPLEMENTATION GROUP

The Chair (Mr. Kevin Daniel Flynn): Colleen Mitchell is with the Windsor-Essex County Drug Strategy Implementation Group. She's our next presenter. You too have 20 minutes, Colleen. Use it any way you see fit. If you'd like to leave some time at the end, that would be great.

Ms. Colleen Mitchell: That's my plan. Dear members of provincial Parliament, the Windsor-Essex County Drug Strategy Implementation Group is comprised of 25 citizens and organization representatives committed to reducing the harms of substance misuse in our community. We came together in response to community consultations that began in February 2008 and have resulted in the identification of a series of priorities to address substance misuse. This consultation has involved over 200 people and is ongoing.

We would like to commend the provincial government on its efforts to improve the mental health and addiction

system. We thank you for coming to Windsor-Essex county and for the opportunity to share with you some of our findings from this process.

We recognize that when someone is addicted, it is a disease, an illness, with significant physiological, physical and psychological effects. We have also come to understand that people are seeking out and misusing substances for a variety of underlying causes. We have been talking to people in recovery and also to people who are actively misusing substances, and they tell us that they have experienced significant trauma such as sexual, emotional and physical abuse. They have often experienced family conflict, and in the case of youth, they have left the home early and do not have the level of supports needed to make a smooth transition to adulthood.

Many families experience financial stress that ripples through all dimensions of family life. When asked what would have prevented them from turning to substances, many said "family support," and a group of youth told me, "having a positive relationship with my parents." So although we believe that treatment services will always be necessary, our community is committed to shifting the dynamic from a reliance on treating people once they are already addicted to preventing them from ever seeking out substances in the first place. Furthermore, we understand there are many people who have both mental illness and addiction, who require an integrated approach for the treatment.

The balance of my comments will relate to some of the objectives that were articulated for your committee, specifically the mental health and addiction needs of children and youth. By far, the most consistent feedback was the necessity to have strategies that will impact youth. We know our children's mental health system has been experiencing significant demand compared to other centres, and particularly since economic stress has increased for our community. However, even more concerning is the lack of youth-specific addiction services across Windsor-Essex county. Many of our organizations that provide supports to adults have shifted their age criteria to 16 years in response to this need. However, we would also agree that this is not necessarily the best approach. Our community has identified the need to develop a comprehensive strategy for youth, and we have commitment across sectors, including police, educators, youth providers and addiction providers.

Although we have excellent co-operation taking place, one of the top priorities was to talk with youth and find out their concerns and solutions with respect to using drugs. In order for youth to believe changes can occur, they need to be engaged in the solutions.

A primary component of our strategy is a prevention strategy that goes beyond substance prevention and extends to addressing some of the reasons why youth are using or misusing substances. The greatest challenge to developing a comprehensive strategy is that often funding does not recognize prevention. Some very good prevention programs get started; however, they do not continue. Prevention cannot be accomplished with one-

off approaches; it needs to be ongoing and consistent to have any long-term community impact.

1110

In addition, to develop a comprehensive strategy it is necessary to have a designated resource person whose purpose is to pull the community together and establish the partnerships necessary to ensure everyone's role is defined. Your recently announced healthy communities fund has the potential to demonstrate how sectors can work together to strengthen youth. We were most pleased to see that mental health and substance abuse were considered factors to be addressed within this approach.

A second component is a mechanism to identify youth who are at risk of seeking out substances. When youth are identified in the community, the community needs an immediate response to have the greatest impact and to shift the potential to move towards greater dependence on substances. We currently do not have a coordinated mechanism to address this issue.

Previously I mentioned that youth who become dependent or addicted require youth-specific treatment services that have been designed according to their needs and not to those of the predominant adult population of our current treatment system in Windsor-Essex county. We currently have one youth-specific substance abuse outpatient service with a significant waiting time and we have no youth-specific substance withdrawal management, day treatment or residential beds. We are estimating a minimum investment of \$15 million to look at some of these needs.

You also asked us to address innovative approaches. There are current, innovative models that exist within the mental health system that, if enhanced with the expertise of addiction counsellors, could encourage an integrated approach. These models include the mobile crisis team and COAST, which is a collaboration between the Windsor Police Service and the crisis centre. The COAST program is currently a pilot, and early results suggest that it should be funded ongoing as an integral mechanism to prevent people from unnecessarily accessing emergency room services.

We also have a mental health court that has been in existence for almost two years. This model has proved beneficial to ensuring that people receive mental health treatment and support rather than enter the justice system. A similar model for people who are addicted is one of the priorities in our drug strategy. This model requires collaboration across sectors, including mental health and addictions and the Ministry of the Attorney General.

Overall, the Windsor-Essex county substance abuse system has a strong framework. However, there are components that require strengthening for it to be most effective and to effect change at earlier stages of substance misuse. These areas include additional resources for concurrent disorder programs—that is, mental health and addictions; community-based withdrawal management services with a central phone line and a system of trained peer support volunteers; enhanced outpatient counselling—our community continues to have the

lowest per capita spending on this type of treatment; enhanced methadone services, including capital dollars for an appropriate facility—we know that we have over 400 individuals currently in our methadone program, but we still have individuals leaving the community to go to places like Hamilton and Sarnia to receive weekly methadone supports; drug treatment courts similar to the mental health courts; enhanced crisis supports; a system of accessible family support; and a system of after-care that is free and accessible in every community. This is particularly important in our county area, where transportation can be a major barrier for individuals and families to access supports. We estimate a minimum investment of \$10 million to establish the above required components of our addiction system.

Another factor that the community agreed on was that people with substance misuse issues are presenting for help at the door of many other organizations while not identifying a substance misuse problem. Research indicates that primary care is often where people, especially those with addiction issues, will access services. Primary care models such as the family health teams and community health centres have great potential to assist in early intervention and health promotion addressing substance issues if the professional team were to include mental health/addiction specialists.

Therefore, it becomes essential that staff in organizations across our community have the tools to identify possible substance misuse issues. Training for professionals in these fields is a solution; however, resources are needed.

Our community also identified that they want to develop brief intervention resources that can be used by the person, families, physicians, and other service providers. We will be working together to achieve this goal.

We estimate a minimum investment of \$100,000 to establish a coordinated training program across our community.

Finally, you asked about mental health and addiction needs of francophone and ethnic groups. Windsor-Essex county is one community in the southwestern Ontario region with some identified cultural and linguistic needs. We have the highest proportion of mother tongue/French-only population among counties in the southwestern Ontario region. We also have the fifth-highest proportion of foreign-born population across Canada, and the fourth-highest in Ontario, based on the last census. The greatest barrier to accessing services and appropriate treatment is language/English proficiency. We encourage a similar approach as the United States, where provision of interpretation within the health system is required and funded through legislation. Interpretation support is particularly important for mental health and addiction treatment, as much of the assessment and treatment processes rely on verbal communication between the professional and the person. As well, when addressing the sensitivity of health issues, most people prefer to speak to the issues in the language they are most comfortable with. This ensures accurate diagnosis and treatment.

Recent immigrants are coming from geographic areas where there has been significant war, torture, trauma and extreme poverty. The mental health needs of recent immigrants are not being addressed because of the lack of designated resources for the intensive supports that are necessary to address post-traumatic stress disorder. This is an example—oops, I didn't turn to the right page here; I know I have another page, but I've lost it somewhere—that addresses the interaction between sectors: between mental health, addictions, and the Ministry of Citizenship and Immigration.

To close, I would just like to say that our community is poised to take action. We are working together, we are trying to bring people across sectors around one table, and we have identified many priorities that we will move on. We recognize that not everything needs resources and that we can make a lot of changes in our system without them, but there are some that will definitely require additional resources.

Thank you very much for your time.

The Chair (Mr. Kevin Daniel Flynn): You have left us a little time for some questions. I think we'll start this time around with Gilles. Was it you?

Mr. Gilles Bisson: Jeff didn't get a chance last time.

The Chair (Mr. Kevin Daniel Flynn): I'm sorry, Jeff, then.

Mr. Jeff Leal: I'll be quick. You talked about providing services or potentially providing services to francophone Canadians. In this area, to provide services for urban aboriginals, are you seeing that as an area where—because the urban aboriginal population is increasing significantly throughout Ontario.

Ms. Colleen Mitchell: Yes. In fact, we have seen that increase in our community as well. Overall, it's maybe not as high a proportion in terms of our total population, but we're seeing the increase. We do have some resources locally that are aboriginal-specific, but in fact I know we only have one mental health and addictions counsellor in that system. So we definitely see the needs, and we see them coming up in some of the other organizations, but, again, we don't always have the skills or the knowledge to be treating within the aboriginal health model.

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

Mrs. Maria Van Bommel: In your presentation, you talk about how there's a shift from providing services to adults to 16-year-olds. Earlier today we heard from Sherry, whose issues actually started, she said, when her parents divorced and she, by 11, was involved in substance abuse. Are you seeing that shift, even younger than the 16-year-olds—or was that just sort of one isolated event?

1120

Ms. Colleen Mitchell: No, we are absolutely seeing a shift. I think some of the statistics for the Ontario student drug use survey bear that out for our region of Erie St. Clair, that youth in our community are definitely using substances at younger ages and using at higher rates than other areas. So it's not an anomaly, what she was talking

about, and that's why we're saying we need the youth-specific—you know, we have children's mental health centres in our community. They're great, and I'm sure that they're seeing some substance misuse issues, but essentially their model is more around mental health and not so much the addiction issues. That's why we're saying that we definitely need that level of support if we're going to shift the dynamic.

The Chair (Mr. Kevin Daniel Flynn): Okay, time for a really short question, Liz.

Mrs. Liz Sandals: So am I hearing you properly, then, that if you have a youth under the age of 16, while they might get mental health services, there actually are no addiction services available?

Ms. Colleen Mitchell: We have one youth outpatient assessment service: combined assessment and outpatient, youth-specific. When I say youth-specific addiction, that's meaning that their mandate clearly states substance abuse.

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

Ms. Sylvia Jones: Yes, thank you. You mentioned the COAST program. It's a pilot project. When did it start and who's currently funding that pilot?

Ms. Colleen Mitchell: It started in January 2009, formally. The police officer is funded through the police department resources and the mental health worker is funded through the adult mental health crisis service.

Ms. Sylvia Jones: So the individual agencies came together and saw the need?

Ms. Colleen Mitchell: Yes.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): You're good?

Thank you very much for coming today. Your presentation was really well-received; it generated some questions. Thanks for taking the time.

Ms. Colleen Mitchell: Thank you very much.

VICTORIA SHEARON

The Chair (Mr. Kevin Daniel Flynn): Just some brief announcements while Victoria Shearon comes forward from the Schizophrenia Society of Ontario. The bus is going to pick up those of us who travelled in on the bus yesterday, at the back of the hotel where we came in, that beautiful door we came in yesterday. We go back to there.

They'd like us to check out of the hotel before lunch; that'll be around 12:30 or 1, whatever. Lunch is going to be in the Windsor Star room, which is downstairs, right at the bottom of the stairs.

Tomorrow morning they want you to check out of the hotel before boarding the bus for the community centre, because we're not returning to the hotel from the community centre. We're going right to Hamilton tomorrow after St. Thomas.

You probably didn't need to hear all that, but we did. Victoria, the floor is all yours. You've got 20 minutes, and you can use that any way you like.

Ms. Victoria Shearon: Okay. I want to start by thanking the members of the Select Committee on Mental Health and Addictions for the opportunity to share my experience with the mental health system and to offer my ideas to improve that system and provide greater hope and help to those directly affected by persistent, serious mental illness, and their families.

My name is Victoria Shearon, and I'm a lifelong resident of Windsor. I would like to share a little of my background as it relates to mental health. I have a family history of schizophrenia. Aunt Harriet, my dad's sister, was diagnosed with schizophrenia in 1947, at the age of 21. She had started nurse's training, but within months her mental health deteriorated rapidly. She was forced to abandon her studies and return home. Her illness eventually progressed to the point where she had to be admitted to the regional mental health centre at St. Thomas. This became her permanent home for over 27 years.

Although my dad was close to Aunt Harriet—we would visit her every summer, but because of family and financial commitments we weren't able to keep in touch more often. My dad did keep in touch with her by mail and the occasional phone call. So the news of the transfer of the long-term-care beds from St. Thomas to Windsor in 2011 will be a huge benefit for Windsor families, because it remains a burden, travelling back and forth to visit loved ones at the regional mental health centre.

My aunt eventually moved to Windsor in 1975 and lived in area rest homes for the remainder of her life. My parents had frequent contact with her; she was always invited over for Sunday dinner and was included at family celebrations and holiday get-togethers.

Personally, I remember her as a very quiet, private person; somewhat difficult to engage in conversation but very pleasant. My dad tells me that she was always very sharp and kept up on current events. We also know she was a hard worker who regularly helped in the kitchen at her rest home and worked at Goodwill Industries here in Windsor for many years. She also loved the freedom of being able to go shopping in downtown Windsor or for long walks whenever she wanted.

Unfortunately, Aunt Harriet's story ended with tragedy. On October 31, 1992, she took her own life. Her body was found floating in the Detroit River after she had been absent from her home for many hours. After struggling with mental illness for over 40 years, we believe she lost all hope. She saw no purpose to her life and no end to her torment. To this day, my dad lives with the guilt that he didn't see signs of her illness, of her intentions. He regrets that he didn't take action when she said that she wanted to walk in front of a car and die. At that time, my dad dissuaded her by reminding her of the trauma that would cause the driver of the car. Being such a kind person, she understood this and never mentioned suicide to him again. But the tragedy remains, and to this day, 10% of people with schizophrenia commit suicide and many, many more attempt it.

I also have a sister with schizophrenia. She was diagnosed with the illness in 1987. We know her husband and two children struggled to deal with her mental deterioration long before that. They had no idea what they were dealing with until her first psychotic break and hospitalization. Because of her illness, her marriage ended and she was alienated from her children for a number of years.

Today, thankfully, although she doesn't have a psychiatrist, she does take her meds faithfully, and hasn't needed hospitalization for over 15 years. She's one of the lucky ones. She has re-established her relationship with her children and has remarried. She and her husband, who also has a mental illness, have their own apartment and are able to manage their lives fairly well, but they always struggle financially and use area food banks regularly. Family members, including myself, help whenever possible with groceries, rides to appointments and sometimes just being a good listener when she's having difficulties.

In 1996, I joined the Schizophrenia Society of Ontario to educate myself about the illness so I'd be better able to help my sister and understand what she's going through. People in the local chapter provided excellent support and a wealth of information, and many of them have become wonderful friends in the process and remain an important part of my support network, as does the Schizophrenia Society.

Unfortunately, I see that it looks like I'm representing the Schizophrenia Society today. Although I am an active member, that's not my direct message. Maybe that misled people. I apologize for that.

The Chair (Mr. Kevin Daniel Flynn): That's okay. As we travel around the province, we expect to hear from your group on a number of occasions.

Ms. Victoria Shearon: I would like to share my experience working at a residential inn for people with persistent, serious mental illness. I have worked at IRIS House since September 2006, and during that time I've learned a tremendous amount about people with the illness and what supports they need to have the best quality of life. To me, one of the most basic needs for someone with persistent, serious mental illness is having a psychiatrist, a specialist. Yet I've learned that while 70% of people in rest homes suffer from mental illness, only 40% have psychiatric care. Compare this to people with heart disease or cancer. Can you imagine if only 40% of those people had a specialist to treat them? How well would they do, and how many would die needlessly from lack of care?

In Windsor-Essex county, for our population, we need 35 psychiatrists. We have only 17, and one of them treats older adults exclusively. Only a few psychiatrists accept new patients, and you can hear from Heather's presentation the difficulty people have with finding a psychiatrist. This huge deficit places many people with persistent, serious mental illness at great risk for homelessness, repeated hospitalizations and even death. Without a doctor who can take care of this most basic need—a

proper diagnosis and appropriate medication—what hope do they have for the best quality of life?

At IRIS, all of our residents have a psychiatrist. This provides them with a doctor who knows them personally, is aware of the history of their illness, knows about their unique symptoms and their unique reactions to medications, who has a trusting relationship with them. I believe a psychiatrist is essential for optimal recovery.

1130

Yet often this support isn't enough. In May 2008 we had a resident with bipolar disorder who became increasingly manic. He changed from a pleasant, cheerful and polite man to someone who was aggressive, agitated and argued frequently with other residents. Staff often had to intervene to prevent a situation from getting out of hand. Additional meds to manage his symptoms had little effect. As a staff member, I care about all the residents and their well-being. It was very frustrating for me to watch this man's health deteriorate so drastically. All IRIS staff felt that hospitalization was necessary to stabilize him and return his life to normal. But there is the rub: His psychiatrist indicated there were no beds available. This is the second area where the health care system fails to meet the needs of those with persistent serious mental illness: There are not enough beds for psychiatric patients.

At Hôtel-Dieu Grace Hospital, on average eight to 10 people arrive at ER with psychiatric complaints, but only one or two are admitted. In fact, senior staff at IRIS have told me that they find there is less availability of hospital beds for psychiatric problems since 2002, when IRIS first opened, and thus our resident continued to deteriorate until late in June, when he disappeared one afternoon. Although residents do come and go during the day, after several hours of absence and contact with his family, staff decided to file a missing person report. Police were unable to locate him in the downtown area, but he showed up very late that night at his brother's house out in the county. He had walked part way and then when he got tired, he hailed a cab, and his brother, obviously, paid for the cab. In that event, he was brought to ER because it was a crisis situation and was provided with medication to reduce his mania. The next day, he was finally admitted to hospital.

He stayed in the hospital for one month and returned to IRIS House with a great deal of medication changes. He can now enjoy his life at IRIS and his regular outings with his family. I enjoy talking to him each morning and it is such a relief for me to see him doing well. But it took a crisis for him to get well. What if there had been a bed early in May when he started to deteriorate? His life wouldn't have been completely disrupted. His family wouldn't have had to deal with the constant worry and distress during those two months. His hospital stay would most likely have been shortened and his fellow residents wouldn't have had to deal with the constant stressful and upsetting situations that developed, stress that could put their mental health at risk.

Waiting for a crisis is no way to treat an illness. Prevention is far more practical, less disruptive to the person and his family and far less expensive to the health care system. Prompt admission to hospital when deemed necessary by a psychiatrist is another essential need for those with persistent serious mental illness.

Another example is a resident who started to deteriorate in January 2008. He became progressively more argumentative, confrontational and paranoid with residents and staff. He became very unkempt, often refusing to change his soiled shirt or urine-soaked pants. It was very painful for me to watch his decline because he'd been such a pleasant person before and I wasn't able to help, because we repeatedly tried to help. We asked that he be admitted to hospital, and the answer was always the same: "There are no beds right now."

Finally, in mid-November 2008, 10 months after the first signs of his deterioration, the resident confronted another resident who was holding a glass coffee pot. There was a brief struggle and the resident with the coffee pot fell to the ground. The pot shattered, he cut his hand and was sent to ER and received several stitches. Because of that incident, the resident whose mental health had deteriorated was finally admitted to hospital, but again it took a crisis and someone getting hurt this time. Early admission to the hospital would have prevented all of that, and I find it extremely frustrating that people with persistent serious mental illness do not receive timely treatment. I'm angry that this very vulnerable population is not being treated fairly. Mental health is often referred to as the orphan child of the health care system, and I clearly see why that statement has been made.

That resident spent three weeks in hospital. His condition was stabilized and he was discharged in early December. He was somewhat improved but still not himself, and after much encouragement by his family, his psychiatrist and all of IRIS staff, he agreed to start a new medication. This medication has made a huge difference in his outlook on life and his behaviour. He now takes care of himself. He sleeps through the night in his own room instead of wandering all night. He wears clean clothes every day. When he gets up in the morning, his hair is combed and he has brushed his teeth. He is generally calm and pleasant, and it's wonderful to see him well. You may think these are tiny things, but for someone like this man, these are terribly important things, that he is able to live a normal life again.

Again, hospitalization allowed him to be stabilized, and our support at IRIS and his long-term relationship with a psychiatrist enabled him to receive new medication to manage his illness effectively.

I could go on for hours, probably, with more examples, but I know I have limited time, so I want to address a third area where the system fails those with persistent serious mental illness. This is supportive housing. Even if a person had a good psychiatrist to provide effective meds and access to a hospital when needed, what happens if he has no place to live? Many people with

serious mental illness are homeless or in substandard or inappropriate housing. Many people share a room with several people and they share a communal bathroom. One facility in this city has no doors on the toilet stalls. This is considered a minimum standard of care: You have a toilet but you don't need a door. Do you want your loved one to live like this, without the most basic of privacy? I know I don't.

I ask you: Is this the best we can do for people with persistent serious mental illness? I say no. I know there is a better way. If the committee is looking for innovative models that provide real help and real hope to people with persistent serious mental illness, look at IRIS House. IRIS House is a great example of supportive housing that treats residents with respect and responds to their individual needs. Only five rooms are shared by two people, and everyone else has a separate room with a private bath. Our residents have a full program of activities, with two outings planned every week. There is a vocational work program, a fitness program and nutritious, healthy meals and snacks based on Canada's Food Guide. All of our residents have a family doctor they visit regularly. We provide ongoing support and guidance to residents, and we direct them to outside resources depending on their needs. Thus, they have a safe, secure and supportive environment where they can take time to decide what they want and need to move forward with their lives.

Since 2002, IRIS has helped 158 individuals with persistent serious mental illness, 61 current residents and 97 former residents. On average, the 97 transitional residents stayed 14 months. The majority, 81 of them, came from hospital, another rest home or were homeless. After leaving IRIS, all but eight people went to their own apartment, another rest home or to their family home. What a tremendous positive change for these people.

In addition to the excellent quality of life enjoyed by residents at IRIS House, our facility is very cost-effective. I'm told that a day at Regional Mental Health Care in St. Thomas costs \$480, while a day at IRIS House only costs \$47.50—a real deal. A study by IRIS management in 2004-05 found that we had saved the health care system approximately \$1 million in hospital days because we keep people out of hospital. We strive to keep our residents healthy in mind and body. We work with the ACT teams; W-PEP, which is the Wellness Program for Extended Psychosis; the Canadian Mental Health Association; the YMCA; Mental Health Connections, which is a consumer support network; and many other programs, to ensure our residents have all the support they need throughout their stay, whether they are with us for a few months or for the long term.

But we are only one facility. We always have a waiting list of 20 to 30 people and sometimes more. Many wait months and months for a room, and some of them eventually give up and move on to other housing options. But I see the difference in people's lives when they have appropriate supportive housing, and I feel there is an

urgent need for another IRIS House and other facilities like IRIS House.

I would like to conclude with three points regarding access to care for people with persistent serious mental illness. A psychiatrist is an absolute essential for optimal recovery, and we desperately need more psychiatrists in our community. Prompt psychiatric care in hospital, when necessary, is a must. We need to be more proactive, and we need more psychiatric beds. Supportive housing allows people to live with dignity in a safe environment. We need far more supportive housing, such as IRIS House provides.

I want to thank all of you for listening to me, and I would be happy to answer your questions you might have.

The Chair (Mr. Kevin Daniel Flynn): Thank you. You've left time for one brief question, so let's start with Christine or Sylvia.

1140

Mrs. Christine Elliott: Thank you very much, Victoria. IRIS House sounds exactly like the kind of model that we're looking at across the province.

My question was really related to the situation where you have a resident who's deteriorating. Let's just say there was a hospital bed available, but they didn't want to go. How do you deal with that?

Ms. Victoria Shearon: At IRIS House, if the person has deteriorated to the point where they are, perhaps, suicidal or violent or very aggressive, we would call the police and an ambulance. There has never been a time when the person hasn't ultimately agreed to go, because I think, even at their sickest, they realize that they need help. Sometimes they might be against going in the ambulance, but in our experience the ambulance drivers are pretty good at talking to them and explaining their options and how this will help them. They've all had to go, but it's not like they've had to be dragged to the hospital.

So that would be the final solution if things get really out of hand. We're not there to intervene if they're violent, but we do have the resources of the police and the ambulance, who take them to the hospital when they're needed, and that has happened on occasion, yes.

The Chair (Mr. Kevin Daniel Flynn): Victoria, thank you very much for coming today. It really was appreciated.

ANNETTE DUFRESNE

The Chair (Mr. Kevin Daniel Flynn): We have two more delegations for the morning.

The next speaker is Dr. Annette Dufresne. Come forward and make yourself comfortable. There may be some water left. There are some clean glasses, I think.

Doctor, like everybody else, you've got 20 minutes. You can use that any way you see fit, and if you could leave some time at the end, that would be nice. Please introduce yourself for Hansard, as well.

Dr. Annette Dufresne: My name is Dr. Annette Dufresne. I'm a psychologist in the local community. Thank you for your efforts in developing a mental health strategy for the province and for the opportunity to present to you today.

I come before you today as an individual with a passionate concern for the well-being of individuals in our society. I expended considerable time and effort to complete a PhD in clinical psychology so that I could be of assistance to individuals suffering from mental health issues. I have trained and worked in a variety of sectors: community corrections; community mental health, working with adults with serious mental illness; in-patient psychiatry; and part-time private practice psychology.

In my talk today, I would like to focus on three issues: first, the importance of psychotherapy as a treatment for mental disorders; second, the importance of family and community in healing and recovery from mental illness and addictions; and third, the value of psychologists in a publicly funded mental health system.

Psychotherapy includes a broad range of interventions: cognitive behavioural, interpersonal therapy, brief psychodynamic therapy, relapse prevention. It can be conducted using a range of modalities: individual, family, and group. A wealth of research exists that demonstrates the effectiveness of psychotherapy. We can look to clinical practice guidelines for various mental health disorders, where they review the current evidence base for the treatment of disorders, as confirmation of the importance of psychotherapy or psychological treatments.

For example, the clinical guidelines for the treatment of depression developed by the Canadian Network for Mood and Anxiety Treatments, in collaboration with the Canadian Psychiatric Association, recommend cognitive therapy, cognitive behavioural therapy, interpersonal therapy or pharmacotherapy as first-line treatments for depression. Such recommendations are not restricted to the Canadian context; similar recommendations for cognitive behavioural therapy or interpersonal therapy for the treatment of moderate to severe depression are contained in National Institute for Health and Clinical Excellence guidelines from the United Kingdom.

Clinical practice guidelines for the treatment of anxiety disorders by the Canadian Psychiatric Association state, "Psychological treatments play an important role in the management of anxiety disorders." They recommend CBT and pharmacotherapy as first-line treatments for generalized anxiety disorder, panic disorder, social anxiety disorder, obsessive-compulsive disorder and for post-traumatic stress disorder, and exposure-based therapies for specific phobias.

In addition to demonstrated effectiveness for depression and a variety of anxiety disorders, psychotherapy also has demonstrated effectiveness for eating disorders, borderline personality disorder, addictions and as adjunctive treatment in bipolar disorder and schizophrenia. Psychiatric clinical practice guidelines recommend that cognitive behaviour therapy should be offered to individuals with treatment-resistant schizophrenia. In

addition to its effectiveness for mental health disorders, psychotherapy is also beneficial for adjustment difficulties and relationship difficulties and for health conditions such as chronic pain, tension headaches, irritable bowel and obesity.

To take this to a more personal level, I would like to mention some of the difficulties typically faced by individuals who might present for psychotherapy. One of my professional responsibilities is to lead a women's psychotherapy group. If I can present somewhat of a composite picture of a group client, they often grew up in a home where there was some type of abuse, perhaps due to parental addictions, being the victim of sexual abuse or witnessing and being affected by domestic violence. For some, it was horrendous, ongoing abuse. Often, they were not exposed to healthy modelling and teaching around relationships and healthy emotion regulation and emotional expression skills. Often, they had a history of fairly competent functioning in work settings at some point in their lives, but difficulties with mental illness, perhaps depression, bipolar disorder, psychosis or concurrent addiction and mental health issues, disrupted their level of functioning, and they are currently unable to manage work. They are trying to work on their recovery from mental illness, given additional stresses they face with poverty, family dysfunction and social stigma.

One of the strengths of Senator Kirby's report, *Out of the Shadows*, is that it brought the issue of mental illness to a real, human level. It is my hope that you, too, remember that mental illness and addictions affect real people as you face this difficult task of devising a mental health strategy.

In addition to the benefits of psychotherapy for treatment of mental illness, there is also some research showing effectiveness of therapeutic interventions for prevention of the onset of depression. A recent meta-analysis that included 19 studies concluded that preventive interventions can significantly reduce the incidence of depressive disorders. They also concluded that prevention based on interpersonal psychotherapy might be more effective than prevention based on cognitive behavioural therapy. So we can say, therefore, that psychotherapy also holds promise as a preventive approach.

1150

Not only is psychotherapy treatment an effective treatment, but research also shows a demonstrated need. A 2002 mental health and well-being survey of Canadians showed the 12-month prevalence rates for any measured mood disorder, anxiety disorder or substance dependence was 11%. One in five participants met the criteria for a mood or anxiety disorder or substance dependence at some point during their lifetime. In 2003, mental illness accounted for 30% of disability claims. In the 2002 mental health and well-being survey of Canadians, 21% of individuals whose reported symptoms met the criteria for anxiety or mood disorder or substance dependence in the previous 12 months reported that they wanted help for mental health problems but could not get it. Among

those who had unmet needs, the type of care most commonly felt to be required was therapy or counselling, help for relationships, and information on mental illness and treatment.

Research has also shown that, given a choice, many primary care patients with major depression would prefer to be treated with psychotherapy rather than with medication. Despite psychotherapy being well recognized as a recommended form of treatment for mental disorders, the availability of this treatment in the publicly funded mental health system is very limited. Currently, funding from the Ministry of Health and Long-Term Care for psychotherapy treatment is quite limited. Previously, hospitals had outpatient psychiatry/psychology departments that provided psychotherapy treatment, but the majority of these departments have been cut and there are limited services for psychotherapy in community agencies. For individuals with serious mental illness, the ministry funds community agencies for intensive case management and ACT teams, but not psychotherapy. Psychiatrists are funded under OHIP and some are trained to provide psychotherapy, but there's a shortage of psychiatrists in this community and many others, therefore provision of psychotherapy is generally not a regular part of their practice. In the Windsor-Essex county community, ministry-funded services for psychotherapy would include short-term treatment at the mood and anxiety treatment program that is part of Windsor Regional Hospital, and treatment is available for a select population served by a few family health teams and community health clinics that employ social work therapists.

To illustrate the limited availability of this type of service in this community, I heard from a client recently who called the mood and anxiety treatment program that there is currently a one-year wait list to be seen there. The net result of the lack of funding for psychotherapy is that an effective treatment for disorders that are leading causes of disability are not available to a significant number of individuals affected.

Psychotherapy is not only an effective treatment, but it is also cost-effective. A 2006 meta-analysis, where they reviewed 22 studies from a variety of countries that included an economic analysis of CBT, found that CBT is a cost-effective treatment. A large-scale investigation in Australia, looking at the cost-effectiveness of interventions to help guide policy-makers in planning for health services in Australia, concluded that cognitive behaviour therapy by publicly funded psychologists was a cost-effective treatment for generalized anxiety disorder, panic disorder and major depression.

A variety of options exist or have been proposed in other jurisdictions for how psychotherapy could be publicly funded. I'll briefly describe some of these options here.

The first option is a program called volunteers for psychotherapy. This model sets up a system where psychotherapy is provided by mental health professionals who agree to work at a somewhat reduced fee, with fees being covered by public funding, and in exchange for the

psychotherapy that is provided, clients must perform volunteer work in the community for a non-profit, charitable or government organization of their choice.

The second model, currently being conducted in Australia, is better access to psychiatrists, psychologists and general practitioners. Under this model, general practitioners are able to refer persons with an assessed mental health disorder for subsidized psychological therapy.

The third option is psychological treatment centres. This is an option that has been proposed by the Centre for Economic Performance's mental health policy group from the UK. Psychological treatment centres would involve therapists working in teams, with senior therapists making the initial diagnosis and training, supervising and supporting junior therapists. The senior therapists for one geographic area would be based in one building, but the bulk of therapy would be delivered in GP practices, job centres and so on.

Two other countries that cover the provision of psychotherapy are Italy and the Netherlands.

Finally, in Ontario one possibility for funding psychotherapy would be to redistribute OHIP funding for GPs providing psychotherapy and move the funds to psychological treatment centres or mental health professionals in family practice offices.

The second point I would like to focus on is the importance of moving away from solely an individualistic model of services to treat mental health and addictions to one where we recognize the essential role of families and of building a healthy sense of community. Building stronger families, where the roots for building resiliency can be developed, should be an emphasis in prevention efforts. The importance of considering the family system in accessing mental health services should also be considered.

When we look at individuals with serious mental illness, the importance of family and community support is well recognized as an important factor in recovery. We can consider research that has shown there are better outcomes for individuals with schizophrenia in Third World countries, despite the higher amounts spent on health care in developed countries. The presumption is that these results are seen because individuals have better family and community supports in developing countries.

One area of need that I regularly see in my work is for children who have a parent with a mental illness or problems with addiction. We know that when children grow up in a household where one or both parents have a mental illness or addiction, they will be impacted in terms of greater hereditary susceptibility to mental health/addiction issues, but also they'll be impacted because of the effects of mental illness on the parent-child relationship during a period of illness and the general stress mental illness will put on the family. Such children should be prime targets for prevention efforts. Yet often such children receive no outside supports. In extreme cases, children are removed from the home into the custody of a children's aid society and receive no

intervention, other than being provided with a more stable foster family.

The importance of family and healing in community is also vital when we consider services to individuals from diverse communities such as First Nations and new Canadians. We cannot assume that our model of individualistic services, often based primarily on a medical model, will fit for all individuals in all cultures. We might consider the concept of healing circles that are used in First Nations communities and how we might support such initiatives, and also what we might learn from them that may be useful for the treatment of other individuals.

Finally, I'd like to address the importance of the profession of psychology as an integral part of multidisciplinary teams in public mental health systems. Psychologists have extensive post-graduate training in a variety of models of healthy psychological development and functioning, and psychopathology. And yet, I would argue that psychologists are being eradicated from our public health care system. As many general hospitals have faced budget challenges, what are viewed as ancillary services, such as psychology, are generally the first to be cut.

1200

It used to be quite common for hospitals to support psychology departments that often provided psychological treatment in in-patient and outpatient psychiatry. There has been a shift in the mental health system to move from hospital-based services to community-based services, but the inclusion of psychologists has not been a part of this shift. Community agencies have not traditionally employed psychologists and are not being funded to hire any.

There is now a focus on having primary care practitioners play a bigger role in the treatment of mental health disorders. There has been funding for multidisciplinary family health teams, and yet, few have psychologists. There is the view that social workers can do the same work and social workers can be hired at a less expensive rate, and this view is never challenged, even though some masters in social work programs include no specific coursework or supervised practice in psychotherapy. I do not say this to discount the value of the profession of social work, but rather to emphasize the importance of having psychologists be part of a publicly funded mental health system.

To me, the current status in our mental health system shows an underlying bias for mental health care—that it is acceptable to shift to lesser-trained individuals: from psychologists to MSWs to BSWs, to perhaps people with a one- or two-year college diploma. If it was the case of a person who has been diagnosed with cancer, I don't think as a society we would accept that treatment should be provided by the least costly personnel that has some training in the area. Yet in the case of psychotherapy treatment for mental illness, I increasingly see this type of logic being used.

I think I'll stop there and give an opportunity for quick questions.

The Chair (Mr. Kevin Daniel Flynn): Well, that was a great place to stop because you'd used up your entire 20 minutes at that point. That was excellent time management. Unfortunately, we're not going to be able to continue the discussion, but I did want to thank you for your presentation. It was well received, and we all have a copy of it. Thank you, Doctor.

LEONARDO CORTESE

The Chair (Mr. Kevin Daniel Flynn): Our last speaker for the morning is Dr. Cortese. Thank you very much for coming today, Doctor. Have a seat. There's a clean glass down there, if you're going to need any water for your presentation. If not, you've got 20 minutes like everybody else, and you can use that any way you see fit. If you would like to leave some time at the end, that's always appreciated, but not necessary. It's entirely up to you.

Dr. Leonardo Cortese: Thank you very much. First of all, good afternoon. I think we've just hit the 12 o'clock hour, so it is formally the afternoon.

Let me begin by just telling you a little bit about myself. My name's Dr. Leonardo Cortese. I grew up here in Windsor, but spent about 20 years in London, Ontario, and then made my way back to Windsor when the medical school was started about five years ago. I was asked, as well, to come to Windsor to develop a schizophrenia program. I'm sure you probably all had heard of or knew about the tragedy with the Dr. Demers issue a number of years ago. I was asked to come to Windsor and set up a program to help.

I'm an associate professor at the University of Western Ontario. I also have cross-appointments in family medicine, pharmacology and neurology, so that keeps me fairly busy. Here in Windsor, I am chief of psychiatry at Windsor Regional Hospital. I am, as well, the director of the W-PEP program, which essentially is the Wellness Program for Extended Psychosis. Notice that we don't—it's essentially schizophrenia, but we've tried to avoid that terrible name that has so much stigma attached to it. That is essentially who I am and what I'm doing.

I don't have any handouts and I'm not going to read to you because I find that sometimes, just reading from a piece of paper, we lose eye-and-eye contact, and I don't find it very helpful. So I'm going to speak from the heart. I don't think I'll need my 20 minutes, but hopefully I'll leave enough time for you to ask any questions that you have.

I wanted to talk about two points this afternoon, one being the issue of schizophrenia and the second being the issue of psychiatry and family practice. Those are the two issues for which I'm hoping I can clarify some of the needs and some of the important issues.

I'll start with schizophrenia. I know that a representative from the Schizophrenia Society was here, and I'm sure they mentioned all the important issues about

schizophrenia, but I'd just like to reiterate a couple of main points. The World Health Organization recently stated that schizophrenia is probably one of the most disastrous illnesses to affect our young adults, more than cancer, more than heart disease, more than suicide, more than depression, more than anything. Essentially, that statement was made because our young adults who are afflicted by schizophrenia have their hopes and dreams, their life, pretty well taken away from them at a time when major decisions are being made.

I'm sure you know that it's very common but not so popular: One in 100 individuals is at risk for developing schizophrenia. However, when you look at the research and the funding for schizophrenia, it's way below what would be expected for an illness that is so high in terms of incidence. In fact, there's more research in tooth decay—and certainly, my respect to tooth decay—than there is in schizophrenia.

I think what has been an issue here in Windsor is that when I was asked to come down and recruited to build a program in schizophrenia, the funding really was not here. In fact, I can get into all sorts of issues about promises that if I came to Windsor, then this would be offered, and we'd be able to do this, that and the other thing. But I think you all know what often happens to those promises. Anyhow, I was determined to get this program together, and we had very, very minimal funding. In fact, most of the funding that has kept our program going has been by private and industry donations. Pretty well, that has been the majority of the funding that we've actually had. One of the hospitals did help us with one nurse, and one of the other hospitals helped us with a physical location, but essentially we are not funded by any government agency at all.

We certainly see the importance of the first episode. I'm not sure if you heard anything about that this morning, but there certainly is a large momentum, actually internationally as well as nationally, that a lot of emphasis should be put on individuals who are at their first break of psychosis, in other words, the typical 16-, 17-, 18- or 19-year-old woman or man who develops their first episode of psychosis. There have been wonderful programs.

I was involved 10 years ago with the London program, helped establish that, then came here to Windsor and helped establish that. The funding is wonderful, and it should be because we are trying to be preventive. All the evidence certainly identifies that if we jump in quickly and treat these young kids—let me call them kids, relatively speaking, because I'm an older guy—if we get in there and intervene at an early age, we can turn around the process of schizophrenia.

Unfortunately those programs are only about two years long, so after they finish up in two years, they come to our program. The research showing how they do within their first two years is fabulous. The data is amazing: They do well in terms of their symptoms, they do well in terms of their quality of life, they do well in terms

of decreasing suicide, and they do well in terms of decreased burden on the family. It is wonderful.

But as soon as you hit that third year, their outcome is a disaster. The outcome is a disaster because the funding for a chronic program—and about 75% of these youngsters in a first episode program will go on to develop a chronic schizophrenia—has really not been there.

1210

We have certain reasons why we've had difficulties in Windsor in terms of establishing good programs. First of all, I'm sure you know we are extremely resource-limited as psychiatrists in this city. There presently are 12 psychiatrists, and if I can compare it to London—same population: 400,000—London has 125. Windsor has 12. We are expected to do all the work, but unfortunately, we're expected to do that work without the proper team around us, and you heard from Dr. Dufresne, who I think did a wonderful presentation.

We, in fact, lack psychologists; we lack social workers; we lack OT workers; we lack everything that the international guidelines on the treatment of schizophrenia state that we should have. We need social workers to help us with family intervention; we need psychologists to do psychotherapy with our patients; we need neuropsychologists to help us assess when individuals are ready to go back to school or go back to independent living or able to be a part of the family and so on and so forth. Without that team around a psychiatrist, it is very limited what he or she can actually do.

Our case managers are nurses, and it has been difficult for some agencies and government committees to see the importance of nurses in the role of case managers. This is essentially because they are able to give medication. They go to the home and they give injections, because individuals with schizophrenia are probably among the most challenged at coming to their appointments. Often, when they don't come to their appointments, the only way that we can assure them having medication is for our nurses to go there and do home visits. In fact, 50% to 75% of individuals with schizophrenia are non-compliant with medication, and when they do not take their medication, tragedies occur.

Unfortunately, we've heard a number of tragic episodes where individuals with schizophrenia have been involved with terrible situations of murder and killings and so on, and unfortunately, that's the only time we hear about schizophrenia in the news.

As well, they represent the highest proportion of the homeless. They have a high rate of HIV. They have a high rate of suicide: 50% of people with schizophrenia will attempt suicide; about 20% will be successful at suicide. Substance abuse becomes a major issue, and often they become victims of crime in cities, so they are hurt, they are stolen from, and so on and so forth. Without treatment, the complications of that become very tragic for them and, obviously, their families.

We have been able in our program, in the W-PEP program, to continue on with, really, almost a negligible budget. Again, as I mentioned, I've done research pro-

jects and have been able to bring some money in, and we've had some wonderful support from the community in terms of private funding. We have, actually, a yearly gala for W-PEP. Some of you may have actually heard about it. We've been able to raise from \$50,000 to \$120,000 per year that goes, essentially, to pay for our staff so that we can keep them going. My worries are that if that funding stops, we have these patients who are essentially, then, in the community without any care, and that certainly presents a terrible, terrible challenge.

The second thing I'd like to talk about is family practice and psychiatry. If you actually look at the research, about 45% of family practice is composed of mental health. So when you go see your family doctor and you look around the waiting room, about half of the individuals there are there because of psychological, mental health issues. Unfortunately, for family doctors—and my full respect to them, and they need to know a lot about a lot of things—mental health is certainly an area where they are challenged.

In fact, when I was at Western, we did a study. We sent a survey to all family doctors in terms of what we could do better for them and so on and so forth, and essentially what they stated was, "We have almost had zero instruction and teachings in medical school." So when you look at the totem pole of priorities, psychiatry and mental health are not among the top. Heart disease, cancer and diabetes—certainly we need to respect them in the fullest, but mental health is not one of them.

So essentially, what is occurring with family doctors in the city—they are desperate to have psychiatric/mental health interventions to help them out. Unfortunately, what is occurring is, if a family doctor is looking to have someone see a psychiatrist, it's a minimum six-month wait. Many psychiatrists are so busy that they have to close their practices—they can't see anyone—which puts the family doctors in a terrible, terrible mess. In fact, I always say that if somebody has to wait for six months when they're depressed or they're suicidal or they're having terrible emotional difficulties, either they will get better on their own or they'll be dead by suicide.

One of the things that has been an initiative is shared care, where there have been family doctors and psychiatrists identified to work together. Unfortunately, that really has not been occurring. There has not been any funding for that. There have not been resources established in the community, what I would call urgent consultation care, where a family doctor could see a psychiatrist within one day, two, three, or certainly within a week, to be able to have some sort of direction. As it is now, that is not occurring, and I think that would be well accepted and well seen by family doctors as an incredible help to their practice and to their patients.

As well, what I believe is that psychiatrists should be able to go to a family doctor's office. It's something that I do sporadically when I have the time, and that is very, very difficult, but often what I try to do is go to the various family doctor clinics in the city and see their patients with mental health difficulties in their office,

which is very rewarding. Family doctors see that as a tremendous help so that they can get the patients who are in grand need seen in their office, and it's certainly most gratifying for the patients.

Many patients, as you can probably identify, do not want to come to see psychiatrists. But when they see them on their home base with their family doctor, it certainly makes a grand difference. I've been so pleasantly surprised at what a difference there is when I go to a clinic with a family doctor and help them to see these patients together. As well, I think it's a nice educational experience for the family doctors.

There is no funding whatsoever for individuals to do that. We had a discussion with some of our psychiatrists so that we would be able to do that on a rotational basis, but many psychiatrists are seeing that there are no resources for that, and therefore, no time as well to do that. But they're willing to put some time aside to help out in that respect.

My sympathies go out tremendously to family doctors and certainly their patients who need to be seen but don't want to be seen at a psychiatrist's office, but who really have important needs.

Those are the two main issues that I want to bring to your attention. I'm sure it's nothing new that you haven't already heard, but I wanted to make sure that you had, again, a chance to hear that situation.

I don't think I've taken that much time—

The Chair (Mr. Kevin Daniel Flynn): No, you did a great job. Thank you, Dr. Cortese. Is there anybody from the government side? Liz?

Mrs. Liz Sandals: Thank you very much for your presentation. This isn't something that you mentioned, but you seem to be in charge of creative solutions. One of the things that I will frequently hear from folks in my constituent office is about families of schizophrenia or other serious mental issues, where the family hasn't burned their bridges totally with the patient, but the family is extraordinarily frustrated because they can see that the patient is off meds, that they're deteriorating, but they can't seem to get a foot in the door with the medical system. If they go to the police, they're told, "Well, they haven't started a knife fight on the street yet. We'll pick them up when they do that." There doesn't seem to be any way to kick-start the relationship. Often, it will be the doc who's saying, "No, no, I don't see that." The family will often pick it up before the doc does. Is there any way we can break this logjam?

1220

Dr. Leonardo Cortese: Yes, and I agree with you 100%. It has certainly been, I think, one of the most frustrating issues for me and, obviously, families as well as patients.

When someone is referred to our program and we sit down and we have our first consultation, we essentially try to educate the client, the patient, that their family is an integral part of their treatment; that all the literature has shown that once you get families involved, patients do better. We actually have them sign a consent sheet when

they come into our program that says they will have the gold standard treatment, everything that we can give them we will give them, we'll bend over backwards to help them and so on and so forth, but they also need to consent that their families will be part of the program. If they say no, then we ask, "Why is that a problem? What is the major issue?" Many of them will say, "I don't want my family to know about private issues." So then we sort of have a compromise: "The private issues about sex or religion or whatever, we'll keep among ourselves, but let's agree to what may be the issues where families can really be helpful." Families see the warning signs before they do and before their family doctor does, and so on and so forth.

While I'm talking about family doctors, on average, somebody who becomes psychotic sees a medical professional five times before they actually are referred on or identified as having a mental health problem. Family doctors, as much as I love them—and I work with them in my cross-appointment with family medicine—do not have that ability to see that. Families do.

As well, we state that as soon as we finish with our first appointment, their families will come in with us, and we will talk about the illness; we'll educate them about things not to do, things to do, and so on and so forth. I think that's extremely helpful.

In fact, I hear from many families that they're often told—this is one thing that I, being a psychiatrist, have stated has been a terrible burden on us and has made us look terrible. Often, historically, we've said, "We only want to see you. We don't want to see the family." The families get a sense of, "My gosh, there must be something I did wrong. Maybe I should have given them a warmer coat in the winter or spoke to them about this or that when they were growing up, and I didn't, so maybe it's my fault." So we did a terrible injustice there.

The other thing that we do to get families connected with us is we have a family workshop on Saturdays. It's only for family members, their loved ones. We do this every few months or so. We get families to come in, and we spend a whole day together. It's not funded, so we fund it ourselves; we put bits and pieces here and there. The family members come in, and we limit it to about 30 so we can have some good interaction. In the first part, the morning, we teach them everything we know about the illness. In the second part of the day, which is the afternoon, we have videotaped scenarios of what not to do as a family and what to do as a family. We show the pre- and the post-. So they begin to talk with each other, they identify with each other. In fact, from there has grown a family support system. We have a family support group that has helped us in fundraising, that has helped us certainly in London when they were going to cut our positions. They actually went to the CEO and threatened to burn down the hospital. I hope that's not recorded.

The Chair (Mr. Kevin Daniel Flynn): That's a pretty good note to close on, though.

Dr. Leonardo Cortese: So we've brought families in, and they've been a part of the program, and clients have seen how important that has been. But you have to certainly maintain some form of agreement in terms of what we won't discuss with family members. Generally, that has worked out really quite well. So that has to occur. Families have to—

Mrs. Liz Sandals: With that prior consent, if you do get a call from the family member saying, "I've noticed this," then you actually have the prior consent to take some action, as opposed to my experience, which is, "Well, I haven't noticed yet, so there's nothing I can do."

Dr. Leonardo Cortese: That's right. We as well inform them that there are things families can do. The most frustrating thing for families is, they see that their loved one is deteriorating, they bring them to the emergency room, and he or she does not want to come into the hospital. They say, "I don't want to come into the hospital." Then the question is, "Do you want to kill yourself or somebody else?" They say, "No." "Well, then you can go home."

The Chair (Mr. Kevin Daniel Flynn): We've got time for one very, very brief question and one brief answer, and then we're through for the day, because we're doing St. Thomas ourselves this afternoon. Christine?

Mrs. Christine Elliott: It was just a quick follow-up: If a family contacts you and says that the family member's deteriorating, would you then call them and ask them to come in and see you?

Dr. Leonardo Cortese: Yes, absolutely, or the case manager would go right to the home.

Mrs. Christine Elliott: What if they say no? How do you deal with that? Is it just through more persuasion that—

Dr. Leonardo Cortese: Yes. We bring them in, the case manager goes over. Essentially, the case manager has formed a trusting bond, and I think that's been the key issue with case managers. If I say, "We need to put you on medication or change your medication," they kind of look at me, saying, "Hmm, I'm not sure," but if the case manager, who essentially becomes their best friend, says, "Do you know what, Johnny? I think maybe this is a good idea. Maybe we need to speak to the family. Maybe you might consider a change in medication," all of a sudden, it's a different response.

Mrs. Christine Elliott: Okay, thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for being here today and for your wonderful presentation. We're glad you came.

Dr. Leonardo Cortese: You're welcome. Thank you for your time.

The Chair (Mr. Kevin Daniel Flynn): That's it. We're adjourned.

The committee adjourned at 1226.

CONTENTS

Monday 15 June 2009

| | |
|--|--------|
| Mental health and addictions strategy | MH-115 |
| House of Sophrosyne | MH-115 |
| Ms. Deborah Gatenby | |
| Bulimia Anorexia Nervosa Association | MH-118 |
| Ms. Mary Kaye Lucier | |
| Mr. Eddi Chittaro | MH-121 |
| Consumer Council, Canadian Mental Health Association..... | MH-124 |
| Ms. Diane Middleton; Ms. Sherry Harder | |
| Chatham-Kent Consumer and Family Network | MH-127 |
| Ms. Kelly Gottschling; Mr. David Hutchinson | |
| Ms. Heather Lindsey | MH-129 |
| Windsor-Essex County Drug Strategy Implementation Group..... | MH-132 |
| Ms. Colleen Mitchell | |
| Ms. Victoria Shearon..... | MH-134 |
| Dr. Annette Dufresne..... | MH-137 |
| Dr. Leonardo Cortese | MH-140 |

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

Chair / Président

Mr. Kevin Daniel Flynn (Oakville L)

Vice-Chair / Vice-Présidente

Mrs. Christine Elliott (Whitby–Oshawa PC)

Mr. Bas Balkissoon (Scarborough–Rouge River L)

Mrs. Christine Elliott (Whitby–Oshawa PC)

Mr. Kevin Daniel Flynn (Oakville L)

M^{me} France Gélinas (Nickel Belt ND)

Ms. Helena Jaczek (Oak Ridges–Markham L)

Ms. Sylvia Jones (Dufferin–Caledon PC)

Mr. Jeff Leal (Peterborough L)

Mrs. Liz Sandals (Guelph L)

Mrs. Maria Van Bommel (Lambton–Kent–Middlesex L)

Substitutions / Membres remplaçants

Mr. Gilles Bisson (Timmins–James Bay / Timmins–Baie James ND)

Clerk / Greffière

Ms. Susan Sourial

Staff / Personnel

Ms. Elaine Campbell, research officer,
Research and Information Services