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**Official Report
of Debates
(Hansard)**

Tuesday 16 June 2009

**Journal
des débats
(Hansard)**

Mardi 16 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

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LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS

Tuesday 16 June 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Mardi 16 juin 2009

The committee met at 0848 in the St. Thomas Timken Community Centre, St. Thomas.

SUBCOMMITTEE REPORT

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen. For those of you in the audience, the jam-packed seats there, thanks for coming today. We're going to spend the first few minutes just doing some small business items for the committee; then we should be kicking off on time, at 9 o'clock. If I can get someone to read the report. Maria, if you would read the report of the subcommittee decisions.

Mrs. Maria Van Bommel: I would move the adoption of the subcommittee report as follows:

Your subcommittee on committee business met on Wednesday, June 3, 2009, to consider how to proceed with site visits to First Nations communities and recommends the following:

(1) That the committee members, the committee clerk and legislative research participate in site visits of the following communities and institutions. (See Appendix A: Travel Itinerary: Select Committee on Mental Health and Addictions August 23, 2009-August 28, 2009)—which is on the back of the report: Wabaseemoong, Pikangikum or Kitchenuhmaykoosib Inninuwug (Big Trout Lake), Sioux Lookout health services, Kashechewan, Weeneebayko Health Ahtuskaywin.

(2) That legislative research provide background information on services and demographics in the communities that the select committee will visit.

(3) That the Schizophrenia Society of Ontario be invited to appear as an expert witness when the committee resumes public hearings in Toronto in the fall of 2009.

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

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

Susan is taking a look at the three options available: obviously, flying commercially, and getting some competitive prices on two charters as well. It's appearing that in order to accomplish what we want to accomplish,

perhaps the best way and the most economical way is to go by charter.

Are there any comments? Jeff?

Mr. Jeff Leal: The only comment the Ministry of Aboriginal Affairs made to me when we chatted about it—and they're very pleased we're doing a northern tour—maybe, time allowing, to visit a couple of First Nations communities in southern Ontario at some stage of our deliberations. It may be easier if we can look at a future calendar and look at a couple of areas where I think we should visit. That's the only commentary that they had.

The Chair (Mr. Kevin Daniel Flynn): I think what we did when we first set up the budget is we built some flexibility into the budget to allow that type of thing to happen. So I'd suspect we'd be able to accomplish that sometime in the fall, if the committee chose to go that route. It seems like the right route to go.

Mr. Jeff Leal: While First Nations communities in southern Ontario often are located in larger urban areas—they do have greater access, but there are still some barriers, and I think that's what they may want to talk about.

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

Mr. Jeff Leal: Thanks.

The Chair (Mr. Kevin Daniel Flynn): All those in favour? Those opposed? That's carried.

I just want to make note that today the Canadian Hearing Society will be joining us for the afternoon. Last week, they asked for committee approval for two interpreters for ASL for this afternoon at a cost of approximately \$1,000, so we need that covered. Would somebody like to move we approve that?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Moved by Liz. Okay, all those in favour? Those opposed? That is also carried.

That is the extent of the committee business, so let's go on to our first—I'm sorry. France?

M^{me} France Gélinas: Sorry. I know that I stepped out of the room for a sec, but did we decide if we were going to go to Kitchenuhmaykoosib Inninuwug or Pikangikum?

The Chair (Mr. Kevin Daniel Flynn): Susan is getting some prices on either a commercial flight or a charter. It appears that the charter is going to come in as the best option—to keep the plane for the week. If that happens, either one of those can happen. Potentially even

both, but at least either one—whichever one you think is best, perhaps.

M^{me} France Gélinas: I was just curious to know if we had made a decision, and I think we should, so that Susan can make travel arrangements.

The Chair (Mr. Kevin Daniel Flynn): Do you have any recommendation as to which one?

M^{me} France Gélinas: Either one is fine by me.

The Chair (Mr. Kevin Daniel Flynn): Perhaps we should leave that to the First Nations? Maybe we should get advice from the First Nations or from aboriginal affairs on, if we have to choose between the two, which one we would choose.

Ms. Sylvia Jones: Or what travel arrangements.

The Chair (Mr. Kevin Daniel Flynn): Right. KI is a lot farther than Pikangikum, isn't it?

M^{me} France Gélinas: No, they're both quite far. One is farther west; the other one is a little bit farther north.

The Chair (Mr. Kevin Daniel Flynn): I think the committee is open to go anywhere, basically, just as far as our—if you would leave it in the hands of me and Susan, unless there's any preference?

Mr. Jeff Leal: And MNA will fully—their resources are available to help us organize this at any stage?

The Chair (Mr. Kevin Daniel Flynn): Yes, and we'll make sure we get advice from aboriginal affairs. If anybody else has any comments on it, please let us know. I think what we want to do within the week is see as much as we possibly can, within the five days that we've allowed for the travel. But we don't want to just breeze in and out of places either.

M^{me} France Gélinas: I think, if I remember, Pikangikum has an innovative service model for aboriginal youth and suicide. I'm going by memory, but I think this is where the chiefs' sons—anyway, there were a number of suicides very close to one another, and they put together an innovative way to deal with teen suicide.

The Chair (Mr. Kevin Daniel Flynn): Okay. We'll certainly keep that in mind, then, when we do make the final travel arrangements.

Mrs. Liz Sandals: Which one was that?

M^{me} France Gélinas: Pikangikum. I know there's also a high rate of suicide in Kitchenuhmaykoosib Inninuwug, but I just don't know what kind of services they have.

The Chair (Mr. Kevin Daniel Flynn): Okay. We will make sure that we see as much as we can in the time that we've allowed and we visit what we think are the most appropriate places with the advice from people who know a lot more about these areas than we do—or than I do, certainly.

MENTAL HEALTH AND ADDICTIONS STRATEGY

ONTARIO ART THERAPY ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): We're close to 9 o'clock, so why don't we ask our first delegation to

come forward. Our first delegation this morning is the Ontario Art Therapy Association, and that's Evelyn Keep.

Ms. Evelyn Keep: Where do you want me to speak?

The Chair (Mr. Kevin Daniel Flynn): You can sit anywhere you like in those four chairs. The mic will be operated for you automatically, so you just relax. You've got 20 minutes for your delegation. You can use that any way you like. If you could leave a little bit of time at the end for any questions the committee might have of you, it would be nice. It's not necessary, but it usually works better that way. Other than that, the floor is all yours.

Ms. Evelyn Keep: Actually, I'm just going to pretty much present the script that you have in front of you, so if you have a better way to use my time, that's fine. There are some very important points in there that I do really want to leave with you.

I'd like to introduce myself. I'm Evelyn Keep and I'm a registered art therapist in Ontario and in the US. I'm a former registered nurse. In my private practice, I have seen psychiatric and mood disorder patients, sexual abuse recovery in adults and suicide prevention, which is also what I taught in the program. For four years, I worked in pediatric oncology and I've lectured and supervised students and internship clients in the program at UWO. I've been on the board of the Ontario Art Therapy Association, I served as the registrar for four years, and for the past five years I have been the ethics chair.

I am also co-chairing a task force comprised of eight psychiatrists and six art therapists. Our mandate is to initiate a clinical master's in psychotherapy and art therapy at the Schulich School of Medicine and Dentistry at the University of Western Ontario. Right now, our target date is in the air because the university is going through restructuring in its department, as is the psychiatric community here in London.

I'm very grateful for this opportunity to present to you on behalf of the Ontario Art Therapy Association, which is a member of the Ontario Coalition of Mental Health Professionals. Art therapists welcome the Legislature's efforts and time and energy to improve mental health services in Ontario. We are particularly enthusiastic that you have taken a comprehensive approach. We believe it is important for this committee to hear from practitioners across the spectrum of mental health care, taking into consideration the valuable contribution of self-regulated groups, such as art therapists who work both adjunctively and in private practice.

The Ontario Art Therapy Association is, as I say, a self-regulated organization. It is a government-chartered, non-profit organization. We are governed by our duly constructed constitution, a code of ethics, and standards of practice and conduct, and we enforce compliance with an ethics standards discipline process. This year we have reviewed, examined and resolved three cases. We have one case in process at this particular time.

0900

Our therapy training is based on a classical, theoretical study of psychology and fine art, and we utilize the

experience of art creation in the service of psychological clinical practice. The students are all taught widely accepted theoretical practice models. Some of us tend to specialize in humanism or behaviour or, you know, whatever along the way.

The practice of art therapy and the value of art therapy is that it goes beyond talk therapy. You don't have to be an artist to study art therapy or to have art therapy. Some people come in and are terrified by the blank piece of paper to begin with, but it doesn't matter what mark they put on there; it is their expression. Sometimes there are painful emotions and memory experiences that cannot be put into words, so we encourage—we are trained to work with them slowly. I have found that even the most resistant client will eventually put something on that paper.

Art therapists don't interpret; we just work with the client. The meaning is whatever the client says it is. However, we do have some techniques for drawing forth the information further, and we, of course, have studied the research on art therapy, so we know what certain symbols mean or a certain direction that it's going. The rate that we move at is established by the client, and it just unravels, layer by layer. If you have the art image out there, removed from just sitting in front of the client and eyeballing and saying, "Tell me your story," then you have this artwork out here. So it's a triangular relationship with the art.

The preparation to become an art therapist is rather rigorous; it's going to be more so in the master's program, but the master's level is the entry level in art therapy around the world and in the US, so that's why it is really imperative that we start that here. We start off with an undergraduate degree, then we have a didactic study of art psychotherapy for two years, and then we have—the total, before you can be registered, is actually 1,750 hours of practicum experience.

We train them across all ages and stages of development, both normal and abnormal. Practicum placements require experience with diverse societal groups and minority populations, including First Nations, new Canadian communities, child and adult illnesses receiving treatment, either physical or mental health care, either in hospital, out of hospital or outpatients. We also give them experience in rehabilitative services such as brain injury, palliative care and end-of-life care, which is where I have specialized, and it's just a wonderful practice, I feel.

In the First Nations in this area, we have art therapists. We have actually had First Nations students in the program who have graduated and registered and are now working back in their own communities. Of course, in the First Nations groups they have a lot of historical expression in their symbols and in their art. It's a very valuable practice there.

One of the examples that I would like to point out to you as to how art therapists serve and have been serving since 1978 is that at the Children's Hospital of Western Ontario, the first pediatric oncology program was begun in 1978, and it has continued without end up until present

day, where it runs five days a week, with three art therapists. They have even recently, in the last two years, expanded into other parts of the hospital, and they treat all children's illnesses within the hospital—dialysis, cystic fibrosis clinic, and the big issue right now seems to be eating disorders.

How's my time? You can interrupt with questions, or you can tell—

The Chair (Mr. Kevin Daniel Flynn): No, you're doing great.

Ms. Evelyn Keep: I'm talking fast.

The Chair (Mr. Kevin Daniel Flynn): No, actually, you're doing really well. You've used about eight minutes. If you could leave maybe eight minutes for questions, that would work out perfectly.

Ms. Evelyn Keep: Well, it's up to you. Do you want to read what I have in the last two paragraphs, or do you want me to keep talking?

The Chair (Mr. Kevin Daniel Flynn): Keep going.

Ms. Evelyn Keep: Okay.

Art therapists practise in a wide range of placements in Ontario. The list is endless as to possibilities. They're just popping up all the time. We are a creative group, and so we say, "Ah, we could work there," we go out, we start a practice, we struggle, and eventually it gets going. Some of these are really interesting. Veterans' affairs, here in London, at the veterans' hospital—they have a huge program, and it has been going for years; 20 that I know of. We work in schools, of course, hospitals, faith communities, and prisons, to mention a few. We had one very brilliant young woman who was working in Kingston Penitentiary for, all in all, about nine years, and then she moved to Toronto.

I have given you a copy of the student placements for the students out of the UWO art therapy program. There are other programs in Ontario and they may have placements other than ours, but most of our placements do develop into full-time employment. Of course, most art therapists maintain some level of fee-based private practice too.

Art therapists do, in many cases, fill the gap between the ministry-funded programs in mental health and the growing demand and the need for greater coverage to cut down on the wait times and that gap, and in exactly this fashion, we have been filling that gap and relieving the OHIP system of that expense. Not all mental health clients really require nor do they seek the medical model of care. I would like to mention in particular the grade school system in Ontario, which, for instance, may have one psychometrist per board. They, of course, manage test instruments. They don't see children. I personally haven't had experience with that, in trying to contact the psychologist connected with the school board—and there just wasn't one. He said, "Do what you're doing. I can't help you."

For the past number of years, the schools in London have been served extremely well by art therapists, who are supervised by registered people. We supervise everything that they do—their contact. We keep in touch with

the placement agencies. We keep in touch with the students' progress, what they're doing and what they're not doing.

We hope the creation of the college of psychotherapy and mental health professionals will soon become a reality. Public protection is the primary concern of the ministry and of psychotherapy. A governing college provides the public with clarification of the standards of its licensed practitioners, as well as an authoritative body to address if there's a complaint.

In summary, I would like to stress the point that mental health consumers would have more accessibility and would be better served if the college includes a broad range of regulated practitioners licensed to practise the controlled act of psychotherapy.

Thank you for your attention.

The Chair (Mr. Kevin Daniel Flynn): You've left exactly eight minutes for questions. That was impressive. Let's start with Sylvia.

Ms. Sylvia Jones: I wanted to get you to expand a bit. You mentioned that there's going to be a change in the education program in the United States and other countries in the world. They're at a master's level, and you're—

0910

Ms. Evelyn Keep: The change is going to take place here.

Ms. Sylvia Jones: Yes.

Ms. Evelyn Keep: Now, Concordia in Quebec does have a master's level.

Ms. Sylvia Jones: Do you have a timeline?

Ms. Evelyn Keep: We had a timeline for 2010, but as I say, the entire psychiatric community here has undergone department change, a head change—their whole construction is different. I think it's to economize—and also the departments at the university. We will rely on space to work our program in; we've already been operating there.

Does that answer your question?

Ms. Sylvia Jones: Yes. Is the program available only at UWO?

Ms. Evelyn Keep: Yes. Our particular program will be available only at UWO. This is ours at the Schulich School of Medicine and Dentistry, in the psychiatry department. It's a stand-alone. But it is not up and running, and I have e-mails all the time from people saying, "Oh, please start it," but, you know, it takes time.

Ms. Sylvia Jones: Thank you.

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

M^{me} France Gélinas: Good morning.

Ms. Evelyn Keep: Good morning.

M^{me} France Gélinas: If we look at the continuum of recovery for people who have a mental illness, where do you see art therapy fitting in?

Ms. Evelyn Keep: The continuum of care: Could you define—

M^{me} France Gélinas: No, of recovery; as in primary prevention, health promotion to prevent people from developing mental illness, people in an acute episode of

mental illness, people recovering and people needing support as the acute episode has gone but needing support in the community to keep their disease at bay. I'm calling this the whole spectrum of the recovery, from primary prevention to support. Where do you see your therapy fitting in?

Ms. Evelyn Keep: Art therapy would fit in probably after a diagnosis has been made or a problem has been defined. However, I have done some health teaching with people in depression who are not looking after themselves physically; then I would do dietary or thought reconstruction. Is that what you mean?

Actually, art therapists—I'm trying to think—would be in almost all of that continuum. Many times, psychiatrists come up against a problem—I treated a woman who had chronic and intractable back pain, and she had been treated for it for years. The doctor knew me and said, "Go try some art therapy." Does that answer your question?

M^{me} France Gélinas: Kind of. So basically, you're looking at people who have had an episode, who have got a diagnosis attached to whatever ails them, and you work with them in the acute stage as well as the support stage after.

Ms. Evelyn Keep: Some people self-refer. They know about art therapy in the community and they don't want to initiate talk therapy, so they will approach an art therapist. They don't necessarily have to be diagnosed; we don't always work to a diagnosis.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Evelyn. Jeff?

Mr. Jeff Leal: Evelyn, thanks very much for your presentation. It's fascinating, really. Could I just go back a step? You have an individual who comes in, and you give them the blank piece of paper. Could you just go through that? For want of a better term, what are you looking for? There have been great portraits painted in history, and the portraits clearly demonstrated mental illness on behalf of the painter.

Ms. Evelyn Keep: Yes. Okay. Where do you start?

Mr. Jeff Leal: Could we go to the blank page for a moment?

Ms. Evelyn Keep: Yes.

Mr. Jeff Leal: Just lead me through that.

Ms. Evelyn Keep: The blank page: All right. If you want to know a technique, sometimes they say, "I can't draw; I've never drawn," and I'll say, "What do you think might be on the other side of that piece of paper?" If you know your patient, you pretty well learn everything about them in intake. You learn what their history is and what their problem is in your intake session, and so the piece of paper—you have materials out there, and you say, "Oh, well, just pick up a crayon and scribble. We do scribble drawings; we do line drawings. Scribble all over the page." Sometimes I would say, "Okay, this is my side, that's your side"—you work with the client. I say, "I'll start my side, and you can't come on my side unless you want to. I won't keep you out." So that might show a sort of anger. Those are techniques that are—does

that help? I really wish I could have brought in a case study for you today, but I didn't think the time allowed.

Mr. Jeff Leal: Quickly, the youngest patient who has worked through this, the youngest patient you ever had—a child?

Ms. Evelyn Keep: I worked with pediatric oncology, and I had a little girl who worked with two paintbrushes. I have her picture hanging at home; she painted me a garden. She was two and a half. That was just a distraction when she was in for cancer treatment.

Mr. Jeff Leal: Thanks.

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

Mrs. Liz Sandals: You mentioned that you would do an intake session. What sort of information would you be collecting generally during an intake session? Does some of that intake also sometimes involve information from other medical professions?

Ms. Evelyn Keep: Absolutely, yes. We have forms, forms, forms and more forms that are legally approved. For myself, being a former nurse, I cover everything. If they're taking medications, I want to know that, because many times it's the honeymoon stage, and they'll come in the second week and say, "I just dumped my meds down the toilet." At that point, I say, "I won't see you again until you go back to your doctor, because I'm not in charge of your meds." So the intake covers everything: It covers contacts, doctors, all associations that they are involved with, all their support systems, their history.

Mrs. Liz Sandals: I noticed that—

The Chair (Mr. Kevin Daniel Flynn): Unfortunately, that's the end of our questions and the end of our time. You used it really well. That was interesting. Thank you very much for coming today.

Ms. Evelyn Keep: Thank you.

The Chair (Mr. Kevin Daniel Flynn): For those of you in the audience, I know that old habits die hard, but you don't all have to sit in the back row. You can move up should you have any problems hearing.

ELGIN RESPITE NETWORK

The Chair (Mr. Kevin Daniel Flynn): The next group we're going to hear from is the Elgin Respite Network. We've got Lisa Boyd, Jenifer Deeley and Janice Fisher, if you'd like to come forward and make yourselves at home here. When each of you speak, you need to introduce yourself the first time for Hansard so we know who's saying what. Like all the other groups that are appearing before us on these tours, you've got 20 minutes, and you can use that any way you see fit. If you leave some time for questions, like Evelyn did, that would be great as well. The time is all yours.

Ms. Lisa Boyd: Good morning. My name is Lisa Boyd, and I'm the regional coordinator for respite services in the southwest region of Ontario. I'd like to introduce Janice Fisher, who's the respite coordinator for the Elgin Respite Network—

Ms. Janice Fisher: That's me.

Ms. Lisa Boyd:—and Jenifer Deeley, who's a family and child counsellor with the Oxford-Elgin Children and Youth Centre in Elgin county.

This morning, we're here to talk about respite services as part of the continuum of care for mental health and addictions. Our agenda for this morning will be what is respite, information about the Elgin Respite Network, respite as part of the mental health and addictions strategy, and then questions and comments.

Back in 2005, a group of respite service providers was convened by the Ministry of Children and Youth Services to discuss respite services and form a task group that created a document regarding respite services, which is in front of you, *An Ideal Model for Children and Youth—Respite Services and Supports: From Rest to Resilience*.

0920

As part of our work as a task group, we spent a lot of time talking about what respite is across the southwest region and, ideally, how respite could be delivered to families and children in the southwest. A lot of focus was on the eligibility criteria for respite services. At the time, it was decided that eligibility for respite would be determined by the child with a diagnosis of a mental health or developmental or physical disability or autism. However, in regard to providing support to children and families, we've learned that sometimes it's the caregiver who's incapacitated and needs support so that their child can remain at home.

As a group, we defined respite as a "flexible, periodic, short-term break from caregiving for the purpose of rest and renewal for the family." We also went further, to define respite options that could be made available to families. Within those respite options were in-home respite, which is, for the most part, hourly respite that can be provided in or out of the home with a family member so that the parent or caregiver can have a break. As well, there is out-of-home respite, which is based on overnight respite for 24-hour periods that can also take place in a host setting, or associated home or family care. In addition, there is centre-based respite care, which would be defined as a camp or daycare program. A child care centre setting could also provide hourly supports to families who require a break.

Ms. Janice Fisher: I'm Janice Fisher, the coordinator of the Elgin Respite Network. What is the Elgin Respite Network? We represent approximately a dozen agencies; you'll see some of the logos on our presentation. They are providers of respite; they are counselling agencies or other community support agencies. Some you will recognize, such as VON—we're all familiar with those. Others are the Talbot Teen Centre; they deal with programs for youth in the community. So we represent a broad section of agencies across the county.

What do we do? We administer funds that look at certain types of respite, primarily developmental disability, autism spectrum disorder, children's mental health, which includes those with social, emotional or behavioural needs, or medically fragile. Those are the

areas currently that we look at funding for. How we do that is, we receive applications. We meet on a monthly basis. Applications are received by the committee, normally presented to the committee through a social worker or public health nurse, someone who is working with the family and knows them well. We review those and then will allocate what funds we have available for respite services.

I'm sure I don't need to tell you that we never have enough money for the applications that we receive or what we want to do with them, but we try our best to meet the needs of the families. One of our criteria, though, is that we have to look at the child and the needs of the child: Do they have a functional loss in an area that meets the criteria for the funding? This is assessed through some professional documentation. It can be medical or clinical documentation, various other rating techniques—you'll see some different terminology here: the BCFPI scores, development disability as defined etc. So there has to be some criteria that meet the funds that we deal with in order for us to allocate funding and provide respite to those families.

Who qualifies for respite services? As it says here, "Families and/or caregivers with children or youth who have a functional loss or impairment (social, emotional, behavioural, developmental and physical) that limits ability on a day-to-day basis." These definitions are primarily taken from the document that Lisa referenced, An Ideal Model, that was put together by the ministry. What we find frequently in our committee, though, is that we deal with the needs of the child. The child will have a functional loss that creates a need for the parent to have respite, to have a break for rest and renewal. One of the reasons we're here today, and Jenifer is going to talk more about that, is the people that we aren't able to help, and perhaps how respite can play a part in the strategy on mental health and addictions.

Jenifer?

Ms. Jenifer Deeley: The benefits of respite: We put together a little bit of research, and we also pulled some research that comes right from An Ideal Model.

One of the things we found was a survey that indicated that 82% of the families who had accessed respite identified it as a critical component of their family support.

A lot of the research that I have here comes out of the States, because for most of it the ideas originated there. As well, what you'll see in some of this research is that a majority of it comes from families with children who have developmental problems. That is again because those were the first sources of respite, so a lot of the research emanates from there.

The research for how it helps with mental health and addictions is newer and it's coming; it hasn't been in place that long, for the most part, here in Ontario. It was in 2006 that we received funds for families caring for a child with a mental health diagnosis, so it's quite new and there is not a lot out there. So bear with us on some of this research.

An evaluation in Iowa found that respite care that was used was statistically significant in decreasing the need for foster care placements. "Not one of the 74 families who accessed..." out of hundreds of families in New Mexico, "entered the child protective services system." So as a benefit to respite, we're not accessing CAS as often.

One source of literature that we found had reasons why people accessed respite services. Now, if you'll see the numbers, they don't add up, because we didn't put all the reasons on the list. Some were just "Other" and some various reasons. But I put the ones that really pertain to what we're talking about today.

The reasons families accessed it were that they felt there was a risk of abuse or neglect if they didn't get a break from their child; some of the parents are struggling with alcohol and drug problems; employment; self care; domestic violence; mental health; and parenting difficulties. This is why the parents are saying they felt they needed the respite.

That same piece of literature also asked the parents what they would have done otherwise with their children, if they didn't receive the respite care services, to take care of some of those things on the list. Some of them would have missed work, school, or job interviews or opportunities. They would have delayed their own care or a family member's care for medical reasons. They would have kept the child in a situation that may have been inappropriate for them. They may have left the child with someone that they didn't feel comfortable with as a caregiver. They may have kept the child in an environment where they may have been exposed to danger. They may have left the child in the care of another child; it didn't specify in the survey the ages of those children, but in the work that we do, we know that the age and maturity level of some of the kids who are caring for others are not always adequate. And some of them may have actually requested a foster placement so that they could deal with what was going on personally.

That same study followed these families up later on regarding the reasons and the problems that they indicated. At one month, 56% of those families were able to resolve the reasons that were necessary for asking for respite, and 39% of them had partially addressed those reasons. At three months, 74% of the families reported that the referral issue was no longer a problem. So basically what we're trying to say is that respite can really help with an awful lot of these problems that the families are struggling with.

0930

Respite care studies out of New York found some beneficial outcomes. That research showed that it improved the family functioning overall, improved satisfaction with life, enhanced capacity to cope with stress, and improved attitudes. What they were referring to there was improved attitudes toward the children that they were caring for. This comes right out of the document in front of you.

These folks here, Bruns and Burchard, actually did a very comprehensive literature review, and the conclusions they drew were:

“Families who received respite care services were significantly less likely to need out-of-home placement for their child and reported less personal strain of caregiving than did families who did not receive respite care.

“Generally ... respite services is less costly than” other services like “residential care or treatment services.”

Again, it is recognized that one of the best ways of supporting children and youth is to protect families’ resiliency to care for their own children and youth. What we find in the work that we do is that all families want to look after their own family. It’s that sometimes they’re struggling to do that because they have a variety of stressors on them.

Current respite resources are only available to support families where the child has a functional loss or diagnosis. In the referrals that we’ve received as a committee, we recognize that respite resources should be available where the caregivers may have some functional loss associated, possibly, with mental health and addictions.

In the referrals we received, we actually had to say no to a variety of families because the children didn’t meet the functional loss criteria. In some of these families where the caregivers are struggling with mental health or addictions, they are actually doing a fantastic job of looking after their children and reducing the impacts of what they have personally going on. We recognize that respite may benefit them, but we haven’t been able to say yes because the criteria won’t allow us; the child doesn’t have a functional loss.

We put together some examples of families that may have been declined when they came to our table. One would be caregivers with mental health diagnoses such as depression, bipolar, or anxiety. The case scenario is: Grandmother is primary caregiver to children—and we’re finding more and more grandparents are taking care of the children—and both grandmother and mother have experienced mental health diagnoses over the years. CAS designated the grandmother as the primary guardian. The grandmother’s mental health status is approaching deterioration due to the additional stressors of caring for her daughter with a mental health issue and caring for her children, and the natural aging process itself. The grandmother believes that by accessing respite, this would prevent family breakdown, and as professionals we do recognize that as a good possibility.

Another scenario is caregivers with substance abuse problems who are approaching relapse. They are well cared for in terms of support and not using substances currently in their life. The scenario is a father and mother with an infant and a busy toddler, and they struggled with multiple addictions, primarily alcohol, cocaine and OxyContin. There were financial stresses due to job losses, which we don’t need to say much about at this time, in the economic climate we’re in. That’s a pretty big reality. Their natural supports didn’t exist, because their past friends were all into drugs and alcohol, so they

made a lifestyle change to distance themselves from those folks. And due to those past lifestyle choices, the families segregated them as well, so they didn’t have an awful lot of family support. The caregivers are feeling so stressed that they believe that relapse into their addiction is a possibility, but they believe that if they can get a break from the kids through respite, then they can attend to their own needs around prevention of relapse and job-hunting issues, those sorts of things.

Another scenario that we’ve seen an awful lot here in Elgin is teen mothers diagnosed with postpartum depression, or just teen moms themselves. A 15-year-old single mother to an infant, with limited natural supports: She left home because of family violence and substance issues going on in her own home of origin. The young mother is attempting to return to school, is diagnosed with postpartum depression, and she feels that a break from her baby would do some good for her—rest and renewal, and be able to carry on.

Just as an aside, I threw in this bit of research. We do know that children from birth to five are believed to be at the greatest risk of neglect and abuse. When you add that to the scenario we just provided, we as professionals truly recognize how respite can really benefit as a cost-efficient preventive to problems.

In summary, some of the benefits of respite: It promotes resiliency of caregivers and families; prevents parental mental health crises; prevents parental relapse of addictions; and prevents costly interventions such as residential care, CAS, specialized school interventions, and children’s mental health interventions. Respite can prevent children from experiencing emotional problems they wouldn’t otherwise have experienced. They can sometimes be traumatized by some of the things that they may witness in a home. They experience attachment and disruption and adjustment issues if they have to be taken out of the home and moved to foster supports. We feel that by enhancing the family’s ability, you can prevent some of these problems with the children directly. The research shows that it is cost-effective. As well, it’s quite time-effective. A few hours a week can go a very long way.

That’s the summary at the end there. A little bit of respite goes a long way for a family, so for us, what we’re hoping for is that a part of the strategy will include the fact that we need funds to help families where the caregiver may have some diagnoses or addictions and the child is actually quite insulated, as a preventive to problems coming up.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Janice, and thank you, Jenifer and Lisa. Unfortunately, we don’t have any time for questions, but that was a very comprehensive presentation. Thank you very much for coming today.

SELF HELP ALLIANCE

The Chair (Mr. Kevin Daniel Flynn): I’m going to call Allan Strong forward now. Allan is from the Self

Help Alliance. He's the recovery education coordinator. Allan, if you'd like to make yourself comfortable—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Yes. You sound different at each one of them.

Mr. Allan Strong: Oh, do I?

The Chair (Mr. Kevin Daniel Flynn): That's the really assertive one you're sitting at right now.

Mr. Allan Strong: This is the assertive one? I'll sit at this one then.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else, you've got 20 minutes. Use it any way you see fit. If there is a chance to leave time at the end, that would be a good idea as well.

Mr. Allan Strong: Okay. Thank you, Mr. Chair. Good morning. I'm pleased to have this opportunity to address the committee this morning. I will be referencing the brief that I prepared and that I believe all of you have a copy of. I will be drawing some attention—but I will try to keep my comments concise so we do have an opportunity for questions and conversations.

I am pleased to have the opportunity to come here and address the committee. By way of formal introduction, my name is Allan Strong. I am the recovery education coordinator for the Self Help Alliance. I'll explain more about that as I go through my presentation.

The lens that I view the mental health and addictions system through is primarily a lens that has been gained over 26 years of experience in the system as a care provider, as someone who has dealt with policy issues and who has been quite an active volunteer serving on a variety of boards and committees. I have, in the past, been a member of the Ontario division of the CMHA board of directors, the Ontario Federation of Community Mental Health and Addictions Programs, the Mood Disorders Association of Ontario and a variety of other committees.

I would like to say that this is not the first time I've sat before a committee such as this, looking at mental health and addictions in this province. My tenure in the system has seen four or maybe five significant reviews and examinations of the mental health system, starting with the Graham report, moving on to Putting People First, then Making It Happen, and then a variety of consultations by the Mental Health Commission of Canada. I was actively involved in the implementation task forces, and most recently, I've also been quite active in my community with the emerging discussions around the mental health strategy. So my lens comes as one with professional involvement.

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The other lens that I view the mental health system with, and this is the most intimate and personal lens, is one of a son of a woman who was quite actively engaged in receiving service. My mother was hospitalized a frequent number of times while I was growing up—several of those hospitalizations lasting several weeks. It is through that lens that I also look at the mental health system, realizing that my family life—that of myself and my

two sisters and brother—was coloured and determined by the experience of my mom's involvement with the system.

The final lens is the lens of someone who himself has received service. I've been hospitalized myself four times, and I've had the opportunity to see the mental health system, and to a lesser extent, the addictions systems, first-hand. It is primarily with those three lenses that I wish to make my comments this morning.

I started out by saying that I've been involved in previous reviews and examinations of the mental health system, and as I sit here, I'm somewhat cynically optimistic that the current process of this committee, and also Minister Caplan's initiative to look at the development of a 10-year mental health and addictions strategy, will bring forth some substantive fruit. I say that with full recognition that there has been a great deal of effort, and the desire and the intent of those who have gone before has always been to try to do the best that we can.

However, as I think about it, we often have focused on the how and the what we do, meaning services and programs. We are constantly looking at how we can either re-fund, develop more programs and more services or reconfigure the ones that currently exist to provide better care. Without sounding unduly harsh, my experience has been that it has been somewhat like rearranging the deck chairs on the Titanic: The view may be somewhat different, but the ship is still in trouble.

It is with that experience that I sit here today. I look forward, and I ask that we challenge ourselves, perhaps, to think differently and to think outside the box of our approach toward how we want to structure, look at developing and creating a system of care that allows individuals at all levels to be able to engage fully and participate fully in the communities of their choice as full and active citizens.

I often like to think about Albert Einstein and say, "We cannot solve the problems of today with the same thinking that has created them." So it is that challenge that I put forward to the committee, and essentially all of us, because it's not an "either-or" and it's not an "us and them"; mental health and addictions and the issues that surround them are something that affect us all.

I would hazard a guess that there isn't one member of this committee sitting before me today who has not been either directly or indirectly affected by a family member, a friend, a work colleague or somebody you know who has experienced first-hand a mental health or addictions problem. I would also hazard a guess that it's the same for the audience. Mental health and addiction is not a problem of us and them; it's a problem that we all have to face together. It is a challenge that we all have to undertake if we are to create a community that accepts, appreciates and honours the skills and abilities that each and every of its individuals offer.

What I would like to see, and what I am challenged to think about, is how we can go forward and create a system of care that provides opportunities for all of its citizens to be fully engaged and to participate. What we

have done in the past, and unfortunately what we seem to be bent on continuing to do, is to recreate the dynamics that really haven't worked for us in the past.

My experience as a family member, a professional and as an individual who has used service is that we have created systems of care that often make the person fit the system. We often try to make people fit into boxes that are predetermined and defined by those who may not know what it's like to have to walk through an emergency room at 2 o'clock in the morning not knowing whether your loved one will live or die the next day. We define these boxes based on arbitrarily defined systems of efficiencies, cost reduction, and what works best and what suits the system of care, as opposed to those who are seeking care.

My dream and my vision are that we would shift our focus and our way of providing care and service to really look at what it is that people need in order to live a life. Because essentially, that's what we're here to do: to try to create opportunities for people to live their lives—to live a life in the community that appreciates, honours and makes use of all the skills and abilities that people have to offer; to live a life that is free of discrimination, prejudice, fear and ignorance of the issues that they themselves may be facing; to live a life that offers opportunities that, as someone who has used or is using services, I may engage fully and optimize my dreams, goals, hopes and aspirations; and to live a life where I'm fully engaged as a citizen and I have all the rights and responsibilities that go along with citizenship. I really feel that is the challenge that is facing us today, and I hope that as the outcome or the product of these conversations that we are having here today and across the province—and, I would also deeply desire, the conversations and consultations that are about to begin as part of Minister Caplan's design to develop a 10-year strategy for mental health and addictions services—we can come to an agreement and to a collective commitment to creating a system of care that sees individuals fundamentally differently than they have often been seen.

We need to create a system of care that sees individuals not as diseased, broken or damaged people who are in need of being fixed, changed or even made normal—because, really, isn't normal a setting on a dryer? We need to create a system where we provide a continuum of care for all individuals so they can seek the supports, services and opportunities that meet them where they are, not where we think they should be, and where we provide them with the opportunities to develop skills and knowledge, and to access the opportunities that will allow them to have the life of their dreams, not just to dream about having a life.

As I reflect upon past reform initiatives, we have often spent more time focusing on how we can do things and what we need to do, as opposed to why. It is that I offer up as a challenge to all of us this morning: What is our vision and our statement of purpose for a mental health and care system here in Ontario? What is it we want for our brothers, sisters, mothers, fathers, sons and daugh-

ters, because aren't those really the people who are most directly affected? It's not some bogeyman, it's not the image that appears in movies, advertising and our popular culture of deranged individuals waiting to commit heinous acts of violence. Because if we are really able and if we really are desiring of moving forward, we also have to deal with the profound discrimination and prejudice that exist in our communities towards individuals with mental health and addictions.

I'll give you an example. During the course of my career, I've had the opportunity to travel across this province and this country giving lectures, workshops and presenting to a wide variety of groups. Unfortunately, quite often, people come to me and say, "It's funny, you don't look like somebody with bipolar disorder." My question then is, "Well, what precisely does somebody with bipolar disorder look like?" Often, people say, "Well, you're articulate, you're bright, you're smart, you're witty, you dress well and you've got nice hair." I can't compete with the Chair, unfortunately, in that regard. But really, fundamentally, what am I supposed to say to that? Really, when you think about it, mental health and addictions can strike any of us at any time.

My challenge to all of you today and to all of us is that we need to create and we need to move towards a vision of care for mental health and addictions that is rooted in the values and principles of recovery.

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As part of my brief, I have attached a document that was developed by my organization, the Self Help Alliance. The Self Help Alliance is a consumer-survivor organization situated in the Waterloo Wellington LHIN area of the province. We have program sites in Kitchener, Cambridge, Guelph and Dufferin. What we did is we developed a vision of what we thought the system could and should look like. A few years ago, the Ministry of Health invested some funding into the case management services in our area, and there was a conscious decision by our system to say we need to provide service that is recovery-oriented. As those who are most directly affected by service, we said, "If that's the case, then this is what it's got to look like."

A recovery-oriented mental health and addictions system will value empowerment, value and instill hope, value self-determination, work towards the elimination of prejudice and discrimination, and value meaningful choice. To that end, we also said that the system will embrace and focus upon the principles of promoting the development of skills through personal development, the development of the system, and the ongoing involvement of those who use service in the implementation, planning, development, governance and evaluation of the service. We also said that the community will value each and all of its citizens and provide supports and opportunities for engagement. The most critical thing is that we have to create a system that instills and promotes hope, that encourages people to see a life beyond the system. It is not something like the Hotel California, where you move in and you never check out. We must provide oppor-

tunities for people to be able to dream, to aspire and to have a life as a full and active citizen.

I'll leave you with a quote by George Bernard Shaw, that being, "Some men see things the way they are and ask, 'Why?' I dream of things that never were and ask, 'Why not?'" It really is the challenge of, "Why not?" What do we hold as possible and what do we believe is possible?

It is with that end in mind that I would challenge us all to spend less time, perhaps, figuring out what we need to do and how we do it, and perhaps more time saying, "Why are we doing what we do?"

I look forward to your comments and questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Allan. You have left some time for questions, which is wonderful. We'll start with France and then go to the government side.

M^{me} France Gélinas: It was a pleasure to hear your presentation, Mr. Strong. I tried to follow as best I could.

When you talk about wanting a new system that helps everybody be engaged in the community, but you also recognize the profound discrimination and prejudice against people with mental illness, do you really see this as part of one, as part of the mental health system?

Maybe I'll talk for myself. I had this preconceived idea that society needs an attitude adjustment on how to deal with the discrimination and prejudice, and then we need to work on our mental health system so that we can support people through their recovery no matter where they are at. You seemed to put the two together, and I was wondering if I heard that wrong, or did you say that?

Mr. Allan Strong: No, the two definitely go hand in hand. Not only do our society and culture need an attitude adjustment, but unfortunately the system itself needs an adjustment.

The Schizophrenia Society of Canada did a study a few years ago which indicated that some of the most profound discriminatory attitudes that exist towards individuals in mental health actually exist with the workers in the system itself. I think we really have to look at challenging values, beliefs, and the mythology of what people with mental illness not only are capable of but what they're not capable of. I really think that it goes hand in hand. It's not an either-or; we really have to look at tackling the issue of discrimination at all its levels, wherever it exists, both in the system and outside.

M^{me} France Gélinas: Do you have any direction for us as to best practices or other jurisdictions that have made some significant strides toward tackling the prejudice and the discrimination that we find?

Mr. Allan Strong: One of the most interesting documents I read was some research that was done in the United States. It's often assumed that by education alone we can address discrimination, but unfortunately, what they found was that over the long haul we may have more information and better information about mental health, but still, people's attitudes and beliefs don't change. They find that the most significant way to change people's attitudes and beliefs is through personal

contact. So then it becomes somewhat of a paradoxical situation: If we have an environment which doesn't encourage people to come forward, how do we get people to come forward?

So it's through research that we find that personal contact and education is often the best way to change attitudes. The challenge is, how do we create the environment to allow that to happen?

The Chair (Mr. Kevin Daniel Flynn): Thank you, Allan. Helena's next.

Ms. Helena Jaczek: Thank you very much for your overview. I agree with you totally in terms of this idea of an overarching vision and a system of care that fosters hope, that type of an approach, and has the primacy of consumer choice at its centre. I suppose, from the perspective of a self-help alliance, there would be an acknowledgement from yourself of a need somehow for those who are experiencing mental ill health, to put it in some sort of frame that perhaps you could accept, that there's a need for assistance in navigating the system—or non-system, such as it is—in terms of allowing you that kind of choice.

I suppose what I really am trying to get at is, have you seen any models that, with your vision, assist an individual in navigating the non-system that we have that work really well? We've heard a little bit about intensive case management; that sounds very intrusive. Is there something that you've seen out there that sort of meets the needs of a self-help alliance within this vision of consumer choice?

Mr. Allan Strong: Well, it's interesting. We have a proposal and a suggestion to our local LHIN to do what you're talking about with the establishment of peer navigators, which would be people with the lived experience to provide support, education and an opportunity to walk beside somebody.

There's a model in Maine. There's a consumer organization in Maine that has peer support people in the emergency department of the state hospital, and they see over 50% of everyone who walks in the door. There are also examples of peer navigators in various pockets in the States, in Connecticut, I believe. There are also peer advocates in every hospital in Ireland. These are, essentially, people who have the lived experience and provide that context.

I also work part-time for the mobile crisis team in our area, and I recognize—and having been through the system myself—that there are times when you do experience distress and you do need support. That's a given. It's not an either-or. How do we create and how do we provide a continuum that provides people service where they're at?

The limited research that has been done on the idea of having peer navigators says that that's one model and one way we can approach that, that we have somebody who's been there, who can say, "I know what you're going through, and perhaps I can provide you with some information or a different way of looking at things that can help you come to a better understanding of what it is you're going through."

Sherry Meade, who is an MSW, a writer and a consultant on peer, says that peer support is trauma-informed. Understanding the trauma is a way of providing a different context for your experience and providing opportunities for you to emerge from that experience, perhaps with a better understanding and a different way of approaching things.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Allan. We really appreciate your presentation today. Unfortunately, the time is up. You used your time perfectly; it just turned 10 o'clock. I have a very public clock here today.

Thank you very much for coming today.

GABY WASS

The Chair (Mr. Kevin Daniel Flynn): If we can call up the next delegation, Gaby Wass. Come on forward. Choose any microphone you're comfortable at. Like all the other delegations today, you've got 20 minutes. You can use that any way you see fit. If there's any time left over at the end, perhaps we can ask you some questions. Welcome.

Ms. Gaby Wass: My name is Gaby Wass, and I'm here to share my story in the hopes that together we can move forward in making Ontario a better place for our children and youth.

My journey begins with a birth announcement that reads as follows: "The day was cloudy and rainy, yet ours was filled with sunshine, having been blessed with the birth of our daughter Amanda Iris." Amanda enjoyed almost four fantastic years in life. She walked at nine months, was toilet trained by her first birthday, was reading early reader books and speaking in full sentences by the age of two. At three years old, she was singing Céline Dion songs better than Céline herself.

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Each June, before her birthday, we had portraits taken of the kids so that I could give them to friends and family at her birthday party. The portrait in 1997 shows her happy smile, her bright eyes and her sweet personality shining right through the photograph. That would be the last photograph of my little girl lost. By September 1997, her school pictures begin to show the haunting tale—the smile is gone, the dark circles under her eyes and the genuine sorrow which we can only see in hindsight. In November 1997, Amanda discloses to her father that she is being abused by a close family friend.

Our first involvement with an agency is CAS, as part of the police investigation of the crimes committed against my children. After a thorough investigation, I am found to be negligent for over-bathing my children, and my husband is questioned at length for loving his daughter too much. If only love alone could have saved her.

CAS protocol at the time is simple: The child must now attend a crisis intervention program with other child victims of the same such crimes. My daughter, at barely four years old, is the youngest participant, and I see the

horror in her eyes after each session. These much older children are sharing some pretty graphic details about their own abuse. Not one to question authority, I assume they are the experts and they know what is best for my child.

By 1998, the school is calling to ask me to send a change of clothes to school with Amanda, as she is at times showing up with soiled pants. I was later able to determine that being on the bus with a male bus driver is what caused her to urinate in her pants. Incidentally, at this time, she is also beginning to withdraw from her father, with whom she had been very close. The school is also reporting that Amanda hides under her desk when a man enters the classroom. Amanda will not sleep unless her father and I are in bed with her. We purchase a king-size bed to accommodate our new nightly guest.

Her teacher finally suggests that perhaps I take Amanda to a therapist. The fact that the therapist is a man further exacerbates her anxiety, and it is only in hindsight that I realize I further contributed to her trauma. After repeated sessions in silence, I decide I cannot afford to spend the money with no gains, and Amanda certainly is not being engaged.

In 1999, I seek out an art therapist and, after only one session, am told that Amanda is not ready for this type of work.

In early 2000, Amanda's teacher calls to address some concerns she's having about her—namely, Amanda's daily routine of throwing out her lunch as soon as she walked into the classroom; the strange animal noises she made in class, which often frightened the other children; and the fact that she was hearing and seeing things that others could not see or hear. In a barely audible whisper, she says, "Mrs. Wass, I think your daughter is suffering from some sort of mental illness, and she needs help."

I make arrangements to have my daughter begin play therapy. My initial appointment with the therapist I attend alone, and share with her the details I had learned at trial about Amanda's abuse. I advise that my daughter gave her father very surface information which led to the arrest of the perpetrator, but Amanda never told us the details about the horror herself. Several visits later, the therapist tells me that she just can't seem to get through to Amanda and asks me to attend the next session with my daughter. We arrive at the appointment, and the therapist has two anatomically correct dolls and asks Amanda to tell her about what happened to her. To my complete shock, the therapist begins to relay, in detail, her own abuse as a child, and says, "See, it's okay. I'm okay. We can talk about it." With silence hanging heavy in the room, the therapist begins to re-enact the details I had shared with her about Amanda's abuse. Amanda unleashes a guttural scream and runs out of the office. We get into the car, and as I am putting on my seat belt, Amanda tells me, with a very blank look on her face, "Mommy, I hate you, and I wish I was dead." Sobbing the entire way home, Amanda attempts to jump out of my car while it's in motion. I pull over and ask my husband to pick us up. Amanda enters her room, I give her a few

minutes to herself, and am appalled to walk in on her banging her head on the floor and two fistfuls of her own hair. She repeats over and over, "I wish I was dead. I wish I was dead." At six years old, my daughter wants to die.

Incidentally, my son is diagnosed with neurofibromatosis, and a family support worker from the Elgin Association for Community Living is assigned to our family. Darlene Siddall becomes our rock during the toughest of times. By this point, Amanda's mental health is in such a decline that we cannot go out in public. People stop and stare or make rude comments as Amanda bites herself, bangs her head against the walls or displays other alarming behaviours. We have effectively become prisoners in our own home.

Darlene tells me about CPRI, and I call in a self-referral. Amanda is assessed, and the initial findings determine that Amanda has PTSD, early onset anorexia and possible dissociative disorder. The recommendation made is a treatment placement. My husband and I agree that Amanda would likely benefit from an intensive-type intervention. Amanda is placed in a program at CPRI.

Amanda thrives in this artificial environment and within weeks, the initial diagnoses are kiboshed and replaced with conduct disorder and ADHD. The cause: poor parenting. My husband and I are sent to parenting classes. We are thoroughly confused. We have two children being parented the same way. One is thriving; the other child is languishing. However, the problem is determined to be our parenting. We rely on the expert opinions and do as we're told. Amanda is discharged 90 days later. Her first night home, she climbs on our roof and threatens to jump. Within days she is back to head-banging, biting herself and pulling out her hair. Darlene assures us that we are great parents and that Amanda needs professional help. We seek out services within our local children's mental health agency and are told that Amanda does not have mental health issues. In fact, if we would just put her on Ritalin, we would be able to better control her. Once again we do as we're told. A local pediatrician prescribes the medication. The medication has no effect on Amanda.

In 2001, Amanda begins to see her school social worker, but no gains are being made. We don't know what to do; we don't know where to turn. Darlene remains our pillar of strength and encourages us to be hopeful. My strength is fading by the day and I wonder how we'll make it through another minute. Darlene says to me one day, "Gaby, find your strength. Your daughter's future depends on it."

In 2002, Darlene tells us about Madame Vanier, and once again we reach out for help to yet another agency. The supervisor, a kind man, tells me that he has been in the field for many years. He relays that a small percentage of the population is untreatable. Based on Amanda's case file, he believes Amanda to be in that small percentile. She has been left to languish far too long.

My heart refuses to believe him, and after four months of treatment, the supervisor tells us he has never met two more committed parents who have gone above and beyond in an effort to seek appropriate treatment for their child. My husband and I voluntarily take parenting classes in an effort to gain insight into how to deal with the new behaviours. He commends us on the work we do as parents and recommends that Amanda be placed in a long-term residential treatment program if there is to be any hope. Amanda leaves this agency in August 2002 with confirmation of PTSD.

By December 2002, my husband is calling children's aid for assistance. Efforts are made to have respite services for Amanda. However, that placement does not work out, and we are left with no open doors and continue to suffer in shame and silence. In May 2003, CAS advises that they have found a long-term treatment program for Amanda that truly believes they can help her. The only catch is that in order to access the treatment bed, Amanda must become a crown ward. On June 10, 2003, my husband and I appear before the courts and abandon our parental rights. We later learn that this was the first time a child was turned into a crown ward to access this mental health treatment. Days later, CAS apprehends Amanda from our home and transfers her to this program, three hours away from home. I contemplate suicide that day, feeling like I have failed my daughter terribly.

I show up on the doorstep of the agency supervisor, who tells me that there is little hope of recovery for Amanda. He listens as I sob and he assures me that my husband and I have done everything humanly possible, and what we did by abandoning our rights was clearly a sign of tremendous love for our child. I return home and spend days unable to get out of bed. Contact with our daughter has been severed and the battle to reinstate our right to access is exhausting.

The treatment home is in a dilapidated neighborhood in a poor state of repair. Within months, Amanda's condition is worsening. Her hygiene is appalling, she is frequently assaulted by other residents, her clothing and shoes are stolen, and she begins cutting and running away. On one of her escapades, she jumped out her second-storey window and broke her foot. Three days after complaining of terrible pain they finally take Amanda to the hospital, but only after my lawyer sends them a letter. I am appalled; I wouldn't leave a dog to limp on a broken foot for three days, let alone a child. Eighteen months into her placement, there has still not been a psychiatric evaluation, nor have counselling or treatment commenced.

In 2004, I decide to quit my full-time job to become a full-time advocate for my daughter. I begin having conversations with the Office of the Provincial Advocate for Children and Youth and the Ombudsman's office. In 2005, the Ombudsman releases a report entitled *Between a Rock and a Hard Place*, and that document results in the immediate restoration of our parental rights. We immediately begin the process to transfer Amanda back to

Madame Vanier. Incidentally, that report ceases the forcing of families to give up their rights of access for treatment of any kind for their children.

1010

In August 2005, Amanda returns home. The recommendation at this time is that Amanda be placed into long-term-treatment foster care. We have promised Amanda to never place her outside the home again. I am baffled as to why the ministry would pay exorbitant amounts of money to keep Amanda out of her home but will not wrap services around her to keep her at home, which she so desperately wants. The effects of the separation have been hard on the entire family. Amanda has become so disengaged that she won't even eat meals with us. She just doesn't feel like she fits in. She spends a lot of time alone in her room listening to music and reading. She has become isolated and ostracized in her community. She refuses to engage in therapy, and life at home is a living hell.

In 2007, Amanda enters high school, and I suspect that she is self-medicating with drugs and alcohol. My family doctor sends her for a psychiatric evaluation, and once again she is diagnosed with PTSD, and this time also depression. She is put on antidepressants and seems to fall into a black hole that we can't get her out of. She talks constantly about killing herself, is cutting, binge-eating and purging, writing dark poetry and becoming physically combative with me.

In January 2008, I call a crisis line of the agency for Amanda's last psychiatric evaluation and tell them that something is terribly wrong. I have taken her countless times to the local hospital begging to help me save my daughter's life. Amanda does not meet the criteria to be put on a Form 1, and we are sent home over and over again. The crisis line agrees to present Amanda's case at the morning meeting to see if she can access an urgent response bed in their secure lockdown facility to undergo an intensive psychiatric evaluation. Within 24 hours, I have a return call that a bed will become available for Amanda the following morning. I am instructed to appear before a judge to get a Form 1. The judge hears my story, signs the form, states he wishes there was something more that he could do to help and wishes me well on my journey. My husband and I transport Amanda to the facility against her will, and she is placed in an isolation unit as she is unmanageable even by their highly trained staff. They wonder how we ever managed her at home, and I relay that it has not been easy.

One of the hardest parts was living a double life. To the community at large, we appeared to be living the Canadian dream. We were living in what one reporter called "an affluent neighbourhood in an immaculate home." Financially, we appeared to be doing well. We drove nice cars, had a boy and a girl, and seemed so happy. Even our closest friends didn't know what was happening behind closed doors.

The facility diagnoses Amanda with PTSD, reactive attachment disorder and bipolar. The psychiatrist explains that a traumatic experience can trigger an onset of

bipolar, and that RAD has likely developed due to the multiple placements beginning at such an early age. The psychiatrist advises that if Amanda is to have any success, the community must be prepared to act in a timely fashion. He recommends that Amanda be returned home, that supports be placed in the home for 59 hours a week, full-time support at school, ongoing psychiatric care and therapy. The only recommendation that our community is able to pull together is the full-time support at school.

Amanda's discharged in February and rapidly begins to fall apart without the services to support her. It is exactly what the psychiatrist predicted. Amanda runs away from home in March and somehow bulletins appear on the radio 24 hours later: "Amanda Wass of St. Thomas, age 14, last seen wearing ..." Our friends think there has been some sort of mistake; after all, we have the perfect life and are the envy of many. Slowly our secret life is exposed, and in anguish we share our story. My friend Marianne Watson contacts the London Free Press, and I agree to allow our story to go public.

My shame is not mine alone to shoulder. The province of Ontario has neglected my daughter, and I'm tired of my secret life. My daughter is eventually found after our family, friends and police conduct a door-to-door search. Amanda is taken to an adolescent psychiatric unit at a hospital in London, and two days later we're asked to come pick her up as she is unmanageable and they don't know how to help her. She returns home with a confirmed diagnosis of PTSD and bipolar. A referral is made to the WrapAround program and CPRI. A few weeks later, Amanda runs away again. Police don't know what to do with her. The hospital doesn't know what to do with her. Ambulance attendants refuse to take her in their ambulance. My husband and I don't know what to do with her, and CAS cannot technically become involved, as she is not a child in need of protection.

I Google "children's mental health," "youth mental health" and "mental health in Ontario." I develop a list of 432 people who are somehow connected to mental health. I have stationery made up with a picture of my daughter on the left-hand side of the envelope and a picture of my daughter as the letterhead. I beg somebody to help me save my daughter's life. I receive calls from Ian Manion, Simon Davidson, Gordon Floyd and Barry Evans, to name a few. They applaud the extraordinary lengths I am going through to access service and share the dismay in the current crisis of children's mental health in Ontario.

In the meantime, our first WrapAround meeting occurs. Our initial team is about 40 people. I candidly share that one of the options I have considered is murder-suicide. I cannot stand to watch my daughter continue to suffer and I have exhausted all our resources. I beg the team for help. The initial meeting occurs on April 21, 2008.

My parents got to hear from the professionals involved with our family, from our friends who had witnessed the cruelty of the last few months, the educators who had

done everything humanly possible, the therapists who just didn't know what to do. My stepdad went to work the next day, quit a supervisor's job he'd had for 14 years and called to tell me he was leaving Toronto and coming to help me. He left his friends, his job and even my mother. He apologized profusely for not having seen through my charade and allowing us to suffer in silence. He said, "Gaby, it will be a shared responsibility. I'm here to help you now."

With help from many people, we were able to access 20 hours a week of in-home support. Sadly, it was not enough time to stabilize Amanda in the home and the help had come too late. Amanda was re-hospitalized in May 2008, transferred to an urgent response bed at CPRI in June 2008, and transferred to Anago Girls' Home in Parkhill in September 2008, and continues to reside there. CPRI has confirmed the diagnosis of PTSD and bipolar. A psychiatrist recently told me that Amanda will likely spend the rest of her life institutionalized. Her story did not need to end like this. There were 11 years of missed opportunity.

I may be too late to help my own daughter, but not too late to help others coming behind her. I now spend my time sitting on various committees pertaining to children's mental health in my community. I sit on the provincial board of Parents for Children's Mental Health, I help families and children navigate the system, I attend conferences in an effort to better educate myself, and I speak to the media and will do whatever it takes to bring this matter out of the shadows forever.

My recommendations:

—Don't be so quick to point the finger at the parents. We are the experts in our children.

—Create navigator positions so we can help other parents navigate the maze of services.

—When we reach out for help, don't slam the door in our face. Help guide us in the right direction to do right by our children.

—Wrap services around the child and not the child around the service.

—Stop taking kids out of their home for treatment. Bring the treatment to the child's home and allow them to have the inherent benefits of loving and stable families.

—Find creative ways to collaborate with other agencies already involved in our life.

—Connect us to peer support groups, as someone with lived experience can often help us best in times of despair. They know best; they have walked in our shoes.

—Don't turn things into a power struggle. We are all in this together.

—Most importantly, hear our voices and allow us to help you through consultation and implementation phases. We have lived experience, which is very valuable.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Gaby. Unfortunately, you haven't left very much time, but perhaps I could ask one question. What should have

happened? What was the very first thing that should have happened?

Ms. Gaby Wass: When I was explaining to the therapists what the behaviours were that Amanda was exhibiting, perhaps they should have taken a closer look at the behaviours as opposed to our poor parenting, which at the end of the day was not the cause of her mental health issues.

The Chair (Mr. Kevin Daniel Flynn): So how old was Amanda then?

Ms. Gaby Wass: Four.

The Chair (Mr. Kevin Daniel Flynn): She was four. Okay. Thank you very much for coming forward today. It's really appreciated.

DONNA BOWERING

The Chair (Mr. Kevin Daniel Flynn): Our 10:20 appointment is Donna Bowering. Is Donna in the audience yet? Donna, please come forward, then. Make yourself comfortable.

Ms. Donna Bowering: Like a lot of these people, this is the first time for me in front of a committee.

The Chair (Mr. Kevin Daniel Flynn): We're all friendly people.

Ms. Donna Bowering: I know you're friendly.

The Chair (Mr. Kevin Daniel Flynn): If you'd like any water, I'm sure we can arrange to bring some water for you. We're just talking about that; we don't have any there, but I'm sure we could arrange it.

Ms. Donna Bowering: It's okay, I brought some in my purse. And can you hear me okay?

The Chair (Mr. Kevin Daniel Flynn): Oh, yes, we can hear you fine.

Like everybody else, like Gaby before you, you've got 20 minutes. You can use that any way you like. If there's any time at the end, maybe we can ask some questions.

1020

Ms. Donna Bowering: Okay. I'd like to begin. This is my story: My name's Donna Bowering. I picked up my first drink when I was 13 years old and I put down my last drink at 38. One drink did something to me that, within one year, I had no control over. I believed I was the perfect image of a wife and mother. Before too long, I crossed what was an invisible line from social drinking to full-blown alcoholism.

I have three daughters, a wonderful husband and six grandchildren. None of this would have been possible if I hadn't gotten honest with myself. I vowed I wouldn't drink every day or drink in the morning, but eventually I did. My girls would come home from school and wouldn't know which mom was at home: the drunk mom or the sober mom. I tried every day not to drink, praying to God, "Not today, not today," but each time I lost the battle and I picked up the drink, usually to take away the guilt and remorse from the night before.

I learned later in my recovery that an alcoholic's willpower alone, however strong in other respects, was not enough to keep me sober. I remember one day my

oldest daughter was in her room packing a suitcase. She was leaving home. I was upset and hung over from the night before. She said, "I can't do this anymore, Mom." I told her that I loved her; she didn't say it back. I told her again, and nothing. Her friend said to her, "Tell her you love her." My daughter cried and said, "I can't," and she left.

A few months later, my middle daughter left also. My youngest daughter was too young to leave; however, she told me years later that she asked her sisters to take her with them. My husband and I fought all the time about the drinking. You see, I lived in a beautiful home with five people, but I felt I lived alone, all because of the abuse of alcohol.

Six months prior to arriving in recovery, I had a doctor's appointment. My doctor wanted me to go with him, so I followed him into a large room. In this room were my husband, daughters, parents, sisters and brothers. It was an intervention. I was so angry I folded my arms in disbelief. The doctor said to me, "Donna, your family is here because they're concerned about your drinking." My father was the first to speak. Tears rolled down his face. He said, "Donna Marie, we love you. Please get some help for your drinking." I never saw my father cry before. Tears rolled down my face and I unfolded my arms. Everyone in that room shared with me that day about my drinking. The doctor asked them to leave so he could speak to me and my husband, but as each one left, each one of them told me that they loved me, even the two daughters who had left home, who couldn't find it in their hearts to say those words the day they left.

Within six months, I was a patient at the Homewood Health Centre in Guelph. I stayed there for eight weeks, learning the guidelines to my recovery. I learned how it happened and what I could do about my addiction. November 25, 1994, was the first day of the rest of my life. The first thing I learned about alcoholism is that it is one of the oldest problems in history, described as a physical compulsion coupled with a mental obsession. Dr. Bob Smith and Bill Wilson were the two co-founders of AA, Alcoholics Anonymous, and the 12-step program back in 1935—two alcoholics helping each other. There are 78,000 local groups in 114 countries.

Alcoholism is a worldwide problem, but most importantly, it is here in our own city of St. Thomas. I moved to St. Thomas three and a half years ago from a small town called Mount Brydges. I started an AA meeting in Mount Brydges eight years ago. This meeting is packed every Friday night with alcoholics wanting to get well. Not everyone succeeds, but if I hadn't gotten honest with myself, this small town would not have an AA meeting for men and women to share their experiences and hopes of recovery.

When you stand inside an AA meeting, you hear laughter. That is the basis of recovery. Outside these meetings, the recovering alcoholic/addict feels fear and loneliness.

Today, I live life on life's terms: clean and sober. I sponsor seven women who are all mothers. I'll share with you one of these stories of one of these moms who called one night, crying and drunk, who wanted to quit drinking. She replied, "I'm not a welfare mom. I have my kids. I have a nice home." I told her, "You keep drinking like you are and you will be a welfare mom." Sure enough, she did go on welfare and is losing her home because of her drinking. Eventually she surrendered, and she has been sober for one and a half years. You see, when you help a mom or dad, you help the whole family, my own family being a prime example. A judge once commented in the St. Thomas Times-Journal, "You poison people, you poison families." How true that is.

Alcoholics are everywhere. If you haven't been touched by someone's drinking or drug use, ask yourself, what would you like to be available for your son or daughter, parent, friend, husband or wife etc., if it happened to you? When I was in Homewood Health Centre, there were moms, dads, judges, psychologists, teachers, police officers and even a Catholic nun. This disease can affect any profession and any age group.

In my sobriety, I try to go beyond sobriety. Just not drinking—that was only the symptom to a bigger problem. Recovery is an inside healing job.

Anything that works toward recovery for the alcoholic and the addict is good, and this includes hospitals, rehabilitation centres and detox or recovery houses. St. Thomas has daily AA meetings and two NA meetings. Twelve steps and aftercare are the tools they need to live a sober life. Doctors provide prescriptions; recovering alcoholics provide the help.

Presently, there are no accommodations for these individuals to attend. Only church basements are accommodating the alcoholics for AA meetings. A lot of alcoholics and addicts have to detox in our hospital emergency areas before entering a recovery facility.

I believe that with the introduction and co-operation of the aftercare treatment facilities, it will serve to the benefit of the community of St. Thomas with resources to help the alcoholic and the addict. With education, counselling and rehabilitative treatment, it will help the community to be aware of people still suffering from the deadly disease that AA has helped us arrest.

This is my story of what alcohol has done in my life and where recovery has taken me. I know I've played an important role in the lives of others, and I wish to continue to do so. An older gentleman from Texas who I met in AA told me once, "We are the chosen few."

I have recommendations I'd like to address to the committee.

- (1) Provide a drop-in centre where information can be provided, as well as counselling.

- (2) An increase in rehabilitation centre space.

- (3) Easier access to rehabilitation centres.

- (4) A recovery house after leaving a rehab centre. The gap between recovery which I experienced when I left Homewood—I remember my husband taking me home, and he said, "Why are you so quiet?" I said, "I'm

scared,” because in that place I felt safe, but what I learned is I had to take it out there and I had to start walking it and talking it.

(5) Provide a detox centre with medical supervision.

(6) A safe environment to teach life skills through agencies, professions and recovering alcoholics.

In closing, I'd like to thank you for your time and invite you to take a prepared copy of my submission from today. If you have any further questions, please feel free to contact me at any time. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming forward today, Donna. You have left some time for questions. Anybody over there? Liz?

Mrs. Liz Sandals: I'm just curious. I happen to be the MPP for Guelph, so I know the Homewood very well. Were you there as a private patient or a public patient?

Ms. Donna Bowering: I had insurance through my husband's company. It made it a lot quicker for me to get in. That was almost 15 years ago, and I don't know what the changes are now, but OHIP will still—

Mrs. Liz Sandals: It's still the same situation, which is why I'm asking.

Ms. Donna Bowering: Yes. It just takes a lot longer to get in, and I know at that time there were 80 beds, and those 80 beds were full.

Mrs. Liz Sandals: Yes, and that was the reason I was asking: Did you have to wait a long time, which is true in a public bed—

Ms. Donna Bowering: Not with insurance.

Mrs. Liz Sandals: You got in quickly. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Anybody else?

Let me jump in. Just so I understand the 12-step program, there are people who talk about a harm-reduction model, and there are people who talk about an abstinence model. The AA program, the 12-step program, is an abstinence model. Is that right?

1030

Ms. Donna Bowering: Yes.

The Chair (Mr. Kevin Daniel Flynn): Do you find that there's any conflict within the profession about which way is better or do you find that one is in style for a while and one is not in style? Do you run up against that?

Ms. Donna Bowering: I'm not sure if I understood your question, but I'm going to explain something to you. Prior to getting into Homewood in Guelph, after the intervention, I had gone to a centre to be evaluated for my alcoholism. The counsellor I had—you have to understand, when you're an addict and an alcoholic and you have to give up something that has been so strong in your life—this counsellor said to me, “I don't think you're a full-blown alcoholic, so I'm going to teach you how to drink socially.” That was the best news I heard. Believe me, I wanted to quit, because those people who were sitting in that room, just like a table like this—you know, they say no human power can restore you from your alcoholism. Those people in that room tried, but when that counsellor told me that he would teach me how

to drink, I thought, “Oh my, I'm going to make everyone I love happy, I'll make me happy and I'll be able to drink socially.”

The Chair (Mr. Kevin Daniel Flynn): It doesn't work that way.

Ms. Donna Bowering: It can't happen. When I ended up in Homewood—I pay no disrespect to that counsellor, but I called him and I said to him, “Hi, I'm Donna Bowering. You counselled me prior to getting into Homewood in Guelph, and you cannot teach an alcoholic how to drink.” He said, “Well, I'm sorry,” and I said, “I just had to tell you that.” Abstinence is the key. Even last night at the meeting, when you substitute alcohol for a drug or a drug for alcohol, they're both the same. It's abstinence.

The Chair (Mr. Kevin Daniel Flynn): Okay, that answers my question. Thank you, Donna. Sylvia?

Ms. Sylvia Jones: Thank you for coming, Donna. I noticed that you have used your life experience, and you're now sponsoring seven people?

Ms. Donna Bowering: Yes, I am.

Ms. Sylvia Jones: Is that, for you, a critical part of your rehabilitation? Tell me more about why that's so important to you.

Ms. Donna Bowering: It's like I said: A doctor will prescribe prescriptions, an alcoholic will help an alcoholic. The two gentlemen who started it back in 1935 were two men, two alcoholics. Drinking has been a problem, but these two men helped each other. From that, it continued.

When I sponsor women and they're calling me or I'm counselling them, I always say to them afterwards, “Thank you.” I had one lady say, “Why do you say thank you?” and I said, “You do not know how much you are helping me.” I don't want to get complacent in my recovery; I want to remember where I came from so I don't go back there. They give me a gift, and that's why only an alcoholic can help another alcoholic.

A mother I sponsored for one year got her one-year medallion with all her family there, and her older daughter came up and she said, “Donna, we tried so hard; we tried so hard. Why did she listen to you?” I said, “Sweetie, her heart listened to you, but I'm an alcoholic, and I help your mother because she's an alcoholic. I know how she thinks; I know what she feels.”

Ms. Sylvia Jones: Thank you.

Ms. Donna Bowering: Thank you.

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

M^{me} France Gélinas: Thanks, Donna, for sharing your story. I was a little bit puzzled as to why it took so long. How come when your daughters left, there wasn't an intervention then? Basically, you're talking about 25 years. There are a lot of days there; there's a lot of opportunity for change. How come it didn't happen when your daughters were born? How come it didn't happen when they left?

Ms. Donna Bowering: That's a good question. Do you know what? That's why it took me so long to get into recovery. Alcoholism and drug addiction is a

physical, mental and emotional obsession. I pay no disrespect to the panel, but unless you've walked it, you don't know. I think Mr. Strong was saying too that you don't know what you're dealing with unless you've been inside that box and you know what they're feeling and thinking. That's why for me, as a mom, I tried so hard to fight, to not drink today, and I thought it was willpower and I thought I was weak. But the physical, mental and emotional obsession of this disease just festered inside of me, and—I think about this daily—when it came to my family and it came to the drink, the drink won every time.

For me, when I hit my bottom—my children are my life; my family is my life. When it came to me at the bottom and I hit my bottom, I was very depressed, and I tried to kill myself because I thought, "I'm a bad person. I'm not a good person." Something so powerful as alcohol was controlling my life, and I couldn't understand why. I looked into the eyes of those children and I thought to myself, "No. I can't do this anymore." And that's the power of the disease of alcoholism and addiction. It is hard to understand if you're not an alcoholic or an addict, but it is an overpowering compulsion.

So I guess my meaning here today is just to explain to people that this destroys families. When I said this in my presentation—when you help a mom or someone's helping a dad, you're helping those families.

M^{me} France Gélinas: I'll ask you a personal question, and you certainly don't have to answer. When you were pregnant, didn't anybody talk to you about your alcoholism? Didn't they offer treatment then?

Ms. Donna Bowering: No. I always say this, and everybody says, "But why do you say this?" Because people do drink when they're pregnant. I was pregnant three times, and I had this life inside of me, and I did not drink.

I was, at one time, a social drinker. My first husband was a full-blown alcoholic. When I went back home to Quebec to visit his family and friends, I was offered a beer, and I said, "No, I'm a member of Alcoholics Anonymous and I don't drink anymore," and they said to me, "When did you start?" There's a line that you cross, as an alcoholic and an addict—as I always say, the invisible line. You have control over something, and all of a sudden you cross over and it's got control over you. So when I was pregnant, no. As God is my witness, those children were my life and I would never have jeopardized them. But the disease, when I crossed over, took over my life and my family.

That's why I'm here today: to tell you that getting into recovery is great and it saved my life, but when I got out, I didn't know what to do. And this is what I'm trying to teach these moms: that there's more to life than just going to the meetings—which I'm 100% on board with—and to teach them how to live life on life's terms, to start to be a mom again.

M^{me} France Gélinas: I guess what I'm trying to get at is, because of the 25 years it took, were there opportunities missed there? Were there other times when you would have been ready to go into recovery, but those

opportunities were missed? You said you had a family physician; I'm sure at some point he or she must have asked you if you drank, and didn't that trigger some action? Twenty-five years is a long time.

Ms. Donna Bowering: I know it is. And you're right: The physician did ask me, "How much do you drink?" And you know what? It's a cunning, baffling disease. Trust me, when you're sitting in a seat like this across from your doctor, you're not going to tell him what he wants to hear. You're going to tell him what you want him to hear.

One of the things I did when I went into recovery was meet with that doctor, and I said to him, "I owe you an apology." And you know what he said to me? "No. You taught me a lesson. When I'm sitting there and I've got somebody as smart as you who thinks that they're getting away with it"—so I fooled the doctor. For all those years, I fooled the doctor.

My husband said to my own mother, "I didn't even know it was going on in the house," because he—you know, it's a sneaky, secretive thing that goes on. He said, "She had it down underneath her lacy, curtained table there." We try so hard to hide it. It's cunning and baffling and powerful, and we will—it sounds horrible, and it breaks my heart every time, but we choose it over what we need. So they didn't know.

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

Ms. Donna Bowering: Thank you.

ALZHEIMER SOCIETY OF ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next scheduled presenters are the London Health Sciences Centre and St. Joseph's Health Care. I understand that only two of the three presenters are here, but the Alzheimer Society is prepared to go ahead. David, if you'd like to come forward. It's good to see you again. Why don't you find a comfortable place to sit? Like everybody else, you have 20 minutes, and you can choose to use that time as you see fit. If you'd introduce your colleagues for Hansard, that would be great.

1040

Dr. Jane Rylett: I'm Dr. Jane Rylett. I'm a professor at the University of Western Ontario and the chair of the department of physiology and pharmacology in the medical school. I'm also an Alzheimer's disease researcher, and have been for more than 25 years. I'm a member of the board of directors of the Alzheimer Society of Ontario, and previously the Alzheimer Society of Canada. So I'm here as a representative of the board of the Alzheimer Society of Ontario and as a researcher.

Mr. David Harvey: I'm David Harvey. I work with the Alzheimer Society of Ontario, serving as the interim CEO at the moment.

Ms. Shelly McCorkell: I'm Shelly McCorkell, and I'm the executive director of the Alzheimer Society of Elgin-St. Thomas. I'm very pleased to be here today.

Mr. David Harvey: Dr. Rylett is going to start our presentation.

Dr. Jane Rylett: Thanks very much, David. It's a large privilege for us to be able to speak to you today on behalf of Ontarians affected by dementia—those individuals affected today and those individuals who will be affected in the future.

We'd like to deliver a very simple message to you. First, the demographics of dementia can overwhelm the health care system unless we're prepared to deal with it. Second, the essentials for preparedness are already in place; it's just a matter of making use of them and expanding upon them. Third, a comprehensive response to dementia involves all of us, and in particular, the mental health care sector.

I'd like to tell you just a little bit about the Alzheimer Society. The Alzheimer Society of Ontario is one of the provincial members of the Alzheimer Society of Canada. It was founded in 1983 and supports a province-wide network of 39 chapters. These chapters and members are committed to improving service and care of individuals with dementia; funding and advancing research into the causes, cures and treatment of Alzheimer's disease and dementia; education in the community that is served by the Alzheimer Society; and finally, creating awareness and mobilizing support for the disease and related dementias.

Our society's vision is a world without Alzheimer's disease and related dementias. We're affiliated with the Alzheimer Society of Canada, as I mentioned, and also with Alzheimer's Disease International. In the spring of 2011, the Alzheimer Society will proudly welcome people from 71 countries to the 26th Alzheimer's Disease International conference in Toronto.

Alzheimer Society chapters provide a range of services, including group support, counselling, information and education, public awareness and dementia-specific education for front-line health service providers. Some also provide day programs and respite care for caregivers.

The Alzheimer Society of Ontario and its chapters work in partnership with a variety of groups. These include health service providers, primary care practitioners and clients. We have a long history of working together to improve access to services for our clients, promoting best practices in dementia care, and raising the profile of dementia-related issues.

So what is dementia? Dementia is a syndrome with symptoms that include loss of memory, loss of judgment and reasoning, and changes in mood, behaviour and communication abilities. These symptoms may affect a person's ability to function at work, in social relationships or in day-to-day activities.

Alzheimer's disease is the most common form of dementia. It's a progressive, degenerative neurological disease of the brain, and causes thinking and memory to become seriously impaired to a point where it is lost. Next to Alzheimer's disease, vascular dementia is the second-leading cause of dementia in the world.

I'll talk a moment about the prevalence and impact of dementia and Alzheimer's disease. At present, more than 180,000 people in Ontario have dementia, and in less than 25 years, this number will double. Within relatively few years, this will reach about half a million people.

Dementia is the leading cause of disability in Ontarians over the age of 60 years, causing them to live more years with disability than stroke, cardiovascular disease and all forms of cancer together. These are statistics from the World Health Organization, as recently as 2007. Most Ontarians with dementia today are supported outside of institutions. They're supported in their homes, with their families as caregivers.

Care partners of people with dementia report stress levels three times greater than those individuals caring for persons with other chronic diseases, and depression amongst these caregivers is nearly twice as common.

Dementia has a dramatic impact on the health care system as well. Persons with dementia use one third of all alternate-level-of-care bed days. Dementia is highly correlated with hip fractures, and persons with dementia occupy 60% of our long-term-care homes. Also, 57% of older persons presenting at emergency rooms have cognitive impairment and dementia. Today, in 2009, there is no cure for Alzheimer's disease and related dementias. Moreover, there is no effective treatment. Dementia is fatal.

Mr. David Harvey: I'd like to talk for a moment about the dementia-mental health interface. Progress in dementia care is tied to progress in mental health, in four areas in particular, the first being stigma. Persons with dementia face a double stigma: one associated with mental illness, the other associated with ageism. Often, older people feel excluded, diminished and marginal because of our fast-paced society. Add to this the experience of gradual cognitive decline and the accompanying self-doubt, and you have a potion that inhibits self-disclosure and leads to isolation. Unfortunately, our health system often reinforces these feelings.

Prevention is another area of connection to mental health. While age is the most significant risk factor, researchers think that the disease starts much earlier in our lives. A healthy lifestyle will reduce the risk for developing dementia.

A third area is in primary care. The strengthening of primary care is the key to adequate treatment of dementia, as it is in mental health. Differential diagnosis is central to dementia identification, as depression and delirium, among other conditions, can appear as dementia. The type of dementia also drives treatment responses. As well, in a family practice setting, the health of the care partner is monitored as closely as that of the person. In one study at the Trenton health centre, of the 15 people who were examined who appeared at the emergency department with dementia, eight of them were there because of issues related to caregiving, not because of issues related to the person with dementia themselves.

Specialized geriatric services is another area. A multi-skilled, flexible primary care service working in col-

laboration with specialized geriatric mental health offers a powerful team approach to supporting persons with dementia. In the late stages of the disease, responsive behaviours may emerge that can cause harm to the person or to others. Specialized geriatric mental health services provide added expertise and diagnosis, behavioural strategies and pharmacological treatment. As well, pre-existing serious mental illness can present exceptional challenges when combined with dementia. It's encouraging that in our audience today two of our partners in the southwest providing these services, at the Stratford hospital and London Health Sciences, St. Joseph's, are key partners in specialized geriatric services in our community here.

Dementia-specific supports are also provided by the Alzheimer Society, which offers a range of support services, including counselling and support groups. Counselling offers people the opportunity to understand and cope with dementia, plan for the future, discuss needs and issues and learn about community resources. Support groups offer an opportunity to meet, learn and share with others who are going through the same experience.

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There are confusing issues in the area of policy related to mental health and long-term care. Until persons with dementia are unequivocally identified as people who may benefit from the involvement of mental health practitioners, the struggle for adequate and well-planned supports for people with dementia will continue. Policy workers in government and planners in local health integration networks are cognizant of these policy issues but must wrestle with the history of indecisive policy within government that confuses all concerned. Initiatives to redesign mental health often overlook the potential partnerships of an enriched long-term-care system, and strategies to promote aging at home are inhibited by debates around whether or not the client should be served by long-term care or by mental health. We need to overcome that policy obstacle.

There are solutions and strategies that are in place, and we'd like to comment on a couple of these. Each of our chapters in Ontario has a public education coordinator who works in disseminating information about dementia to address the issue of stigma. As well, we are working in partnership with the Murray Alzheimer research program at the University of Waterloo to finalize an approach to age-friendly communities that will help communities become supportive of all persons with an impairment, but especially persons with a cognitive impairment. We recognize that it takes a whole village to support a vulnerable person.

As well, the risk reduction activities that are identified for dementia are the same as those for chronic diseases such as heart disease and diabetes. Dr. Rylett mentioned that vascular dementia is the second-leading cause of dementia. For this reason, the Alzheimer Society of Ontario is a partner with the Ontario Chronic Disease Prevention Alliance, which recently sponsored a symposium on mental health and health promotion.

There are some emerging opportunities in support services. Our First Link program, which began in Ottawa in 2002, has now expanded through the aging at home strategy to 25 communities across the province. At the moment, most of the GTA is not yet covered by the First Link program, but we hope that that will change in the next round of the aging at home strategy. First Link offers primary care practitioners the assurance that their efforts in diagnosing and treating Alzheimer's disease will be augmented by a direct referral to community agencies skilled in this area. Their patients will be provided with education, self-management tools, and will have an ongoing contact. Our commitment to a person who presents themselves to us at the First Link program is to keep in touch with them across the span of the disease.

Behavioural support services: I'm going to divert from the text here simply to say that in April, there were 70 organizations, including many LHINs, that met together to explore how behavioural support services can be developed in Ontario. We're meeting with the assistant deputy minister on June 25 to put forward some proposals. These proposals have been languishing—they're not new ideas—in this province for 10 years or more. In 2005, there was a coroner's inquest into a double homicide at a nursing home. Still, these proposals are not moving forward, primarily because of money. A recommendation from your committee could tilt the balance in this particular issue. I would urge you, as you move forward, to keep in mind the issues of dementia in the later stages of life in particular.

Dr. Jane Rylett: I'd like to advance to you a call to action. Your committee has an important role in urging our government, health care providers and our communities to action. We ask you to include, in your call to action, the following points: first, that Ontario's mental health policy and service framework include the needs of persons with dementia and their caregiving partners, especially at stages of diagnosis and early intervention, very early in the course of the disease when they're just learning about the disease and when responsive behaviours may emerge; second, that efforts to address the stigmas encompassing dementia and ageism be addressed; and third, that service capacity keeps pace with the growing numbers of persons with dementia and care partners throughout the continuum of the condition, which can span many years.

Mr. Chair and members of this committee, we need to work together to address dementia, consistent with our social values and traditions. The impact of dementia is immense and will only increase in the coming years as our society ages. If unprepared, we are at risk of being overwhelmed. If prepared, we are confident that our communities will be able to cope, Ontarians with dementia will live with dignity and their care partners will be supported. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David. Thank you, Shelly and Dr. Rylett.

We've probably got time for one question, so let's start with Sylvia, I think. Is it your turn?

Ms. Sylvia Jones: I actually don't have any questions. Thank you for your excellent presentation.

The Chair (Mr. Kevin Daniel Flynn): Oh, good. Okay. France, anything?

M^{me} France Gélinas: I just wanted to be clear that David—am I calling you by the right name? Yes. Mr. Harvey. You said a recommendation from us could help you. That was specifically to behavioural support services?

Mr. David Harvey: Yes.

M^{me} France Gélinas: Okay.

Mr. David Harvey: Or specialized geriatric mental health.

M^{me} France Gélinas: Okay, just expand a little bit as to what you would like us to do.

Mr. David Harvey: Oh, okay. There are services; geriatric psychiatrists, specialized neuropsychologists and nurses who are trained in providing support to people with responsive behaviours. Often these services are generally underfunded. They are sitting in the mental health sector; the clients are sitting in the long-term-care sector. There's always a resource debate between these sectors, and we would like to see a closer connection in those areas in particular.

M^{me} France Gélinas: Okay. This could be a clinical question, so if I'm out of order, just let me know. I'm certainly not very familiar with behavioural support services, but would some of those services and therapies have an impact as to the type of behaviour that developed as the disease progressed, or is it to teach people how to cope with the behaviour?

Mr. David Harvey: No, it would be to help with behaviours that are as a result of the progression of the disease. We already, through our chapters, do teaching toward caregivers. This is more of a clinical need.

M^{me} France Gélinas: So we could actually have an impact as to some of the behaviour not developing or developing differently?

Mr. David Harvey: That's correct.

M^{me} France Gélinas: Oh, okay.

Mr. David Harvey: If you've seen on TV Ontario or the articles in the Toronto Star a few years ago, many of those issues are related to responsive behaviours and can be avoided if consulting services from the specialized geriatric field are available to long-term-care providers.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your answers, and thank you very much for being here today. It is appreciated.

LONDON HEALTH SCIENCES CENTRE ST. JOSEPH'S HEALTH CARE

The Chair (Mr. Kevin Daniel Flynn): Okay, if we can call forward now the London Health Sciences Centre and St. Joseph's Health Care. Make yourselves comfortable. It's good to see you again.

Like all the other presentations, you have 20 minutes. You can use that any way you see fit. If you could leave some time at the end, we'll be starting with this side for any questions this time.

Ms. Kristine Diaz: Well, thank you very much for giving us an opportunity to speak on behalf of the academic centres in the southwest: St. Joseph's Health Care and London Health Sciences Centre.

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The presentation you have before you will provide you with an overview of London Health Sciences Centre as the acute care mental health site, Regional Mental Health Care attached to St. Joseph's Health Care, and then move on into some further detail.

Dr. Beth Mitchell will start with the overview of London Health Sciences Centre. She is the director of the acute care mental health program.

Dr. Beth Mitchell: Good morning. I'll just give you a bit of an overview about London Health Sciences Centre. We are the schedule 1 hospital for London-Middlesex, and that's our primary area of focus. We provide acute care services across the lifespan, so from early childhood through geriatrics and everything in between.

The Chair (Mr. Kevin Daniel Flynn): I'm sorry. I should have asked each of you to identify yourselves as you speak. Everything's being taken in by Hansard, and they don't know when one voice changes to the next. So just the first time is fine, if you'll just introduce yourself.

Dr. Beth Mitchell: Sure. I'm Beth Mitchell.

Further to the kinds of services we provide, we have an emergency psychiatry team located in the Victoria Hospital emergency room 24-7. That's a team of nurses and psychiatrists that are available to provide assessment and consultation there. We have 68 in-patient beds for adults and 11 in-patient beds for children and adolescents, and that includes an eating disorders program that serves the region. We have ambulatory services, which include both general services and also specific services with early intervention, which I can speak to later, as well as trauma services and services for affective disorders. We offer consultation liaison services, which is a bit of a jargon word, but those are services where we provide consultation to the medical surgical units at London Health Sciences Centre—so those patients who have come in for medical reasons but also have psychiatric disorders.

To come into our service as an outpatient, we have a coordinated intake; that's one number to call and you can be triaged to whatever outpatient services you need, both at LHSC and some services at Regional Mental Health Care. We offer assessment and consultation, and in that consultation we do have an urgent service for adults as well as children, so that we can offer an appointment for a psychiatric consultation within 72 hours as an alternative to a visit to the emergency room, but also a more immediate service rather than a wait for a longer assessment. We provide crisis stabilization, both on an outpatient and in-patient basis, as well as ongoing acute treatment services.

We work closely with our partner at Regional, and I'm going to let Kristine provide the overview there.

Ms. Kristine Diaz: At Regional Mental Health Care, as you heard last evening when we met, we have two sites: one in London and one in St. Thomas. Our services are defined by mental health reform documents, such as *Making It Happen*, which identify the role for specialized mental health services. We work with those individuals who have the most severe and persistent serious mental illnesses and who aren't able to receive the level of care or services that they require in their home communities and their general hospitals. Currently, we have in-patient, ambulatory and outreach services serving the southwest—11 counties stretching north from Grey-Bruce, as far south as Elgin county, west to Essex and east to Waterloo-Wellington.

Our programs are built along diagnostic lines that include an assessment program; an adolescent program; dual diagnosis, which serves those individuals with a serious mental illness and a developmental delay; a mood and anxiety disorders program; concurrent disorders, which works with individuals who have a mental illness as well as an addictions issue; psychosis; geriatrics; and forensics. A key piece of our ambulatory services includes the 11 assertive community treatment teams that we sponsor through the southwest.

We currently are serving 441 in-patient beds and have approximately 3,500 registered outpatients across our various programs. So it's a large base of clientele that we currently work with.

Both organizations work in partnership with the University of Western Ontario to fulfill our academic and education mission. We continue to ensure that we use evidence-informed care as we plan for the care across our various programs at both sites, London Health Sciences and Regional Mental Health Care. We have a number of professionals from all disciplines who are involved in research and evaluation at all points of care, starting with our early intervention programs, moving right through to our geriatric programs, where I'm proud to say that we've been able to inform the field significantly in the last few years. We provide a huge role with respect to the education of all health care disciplines in an inter-professional team manner, and work in partnership with both the University of Western Ontario and Fanshawe College to fulfill that mandate.

You heard a little bit about the HSRC directives last evening. Just to highlight for you what those mean for us going forward, for London Health Sciences it meant the consolidation of acute care mental health at what is now the South Street campus in 1998. We will complete the final piece of those HSRC directives for London Health Sciences in 2011: opening a new mental health program at the Victoria campus on Commissioners, which will have 74 acute care adult beds and 16 child and adolescent beds. This will be the first time that both adult and child and adolescent mental health programs are on one campus, so we're very excited about that piece.

On Regional Mental Health Care, you heard about the tier 2 directives and the work we are continuing to do with that piece, which will mean that 55 beds will open in Grand River for specialized mental health care; 50 beds at Windsor Regional Hospital; 14 beds will be transferred to St. Joseph's Healthcare in Hamilton, and there will be a 15-bed acute care mental health unit at St. Thomas Elgin General, which will be opening sometime in the future. What that means for the southwest is a net loss of 67 beds.

We are also currently working with Infrastructure Ontario and the Ministry of Health to finalize our functional plan for Regional Mental Health Care, which will see us opening 156 beds in London; 89 beds in St. Thomas for forensics—and shelled-in space in London, to take us to 168—based on our population growth needs.

Dr. Beth Mitchell: Just to talk about some of the challenges and needs from the acute care perspective, I've broken these into three components: early intervention, ambulatory care development, and then strengthening community linkages.

In terms of early intervention, really we're talking about two types. One is during the lifespan, so trying to reach clients earlier, before they develop more chronic types of problems: working with children and adolescents, transitional-age youth, pre-geriatric or early geriatric clients so that we're trying to intervene, assess and set people on a course where they are able to recover and continue with more of a normal life ahead. This is also important in terms of the course of illness. It's very difficult, I think, in a system that's geared to look after people who have already been diagnosed and have already developed problems, sometimes of a long-term nature, to think about it in the same way we think about health promotion: think about early intervention, look for early signs. Early signs of psychosis—our early-intervention-in-psychosis program at LHSC has both a strong clinical record but also a very strong research record in terms of intervening with usually late teens/young adults who are presenting with signs of early psychosis, often schizophrenia and affective disorders, and intervening at that time. We've had up to an 80% success rate of return to school or return to job. Many of those clients are treated without ever coming into hospital, which is pretty amazing.

We also have begun a program in first-episode mood and anxiety disorders with the same intent: that young people, particularly who have never had an episode and are presenting with depression and anxiety, can be treated early, with the hope of avoiding a lifetime of more chronic kinds of problems. It's a dilemma in our system as to whether or not we support those clients who are already part of our system and obviously need care and treatment, but we also want to change the whole system in the way that we are providing people with a chance for recovery early on in their illness.

We hope to do most of that on an ambulatory care basis. We have a number of ambulatory care programs. Albeit small in number in terms of staff and physicians,

we serve probably 40,000 or 50,000 visits a year between all of our ambulatory programs. We're looking to partner more strongly with community agencies. We have a number of pilot projects with the Canadian Mental Health Association in London, as well as others, to look at how we partner and provide services through them or with them so that it doesn't mean a trip to hospital always; there are other ways of providing those kinds of services. We hope to grow and develop those as well with other health agencies, including long-term care and the CCAC.

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Ms. Kristine Diaz: For Regional Mental Health Care, our projected needs are somewhat different, given the patient population we serve. For both London and St. Thomas, we have a number of what we call legacy clients or patients who have been institutionalized for a number of years, and who, despite best efforts using the current interventions we have, including our assertive community treatment teams, will not be successful in the community given the risk, either to themselves or the community. The need for residential treatment facilities, we believe, is clear. Making It Happen does speak for facilities such as these to be linked to academic centres. Unfortunately, at this time, policy is silent on the development of residential treatment facilities in Ontario.

We would see the need for enhancing our outreach services as a projected need moving forward as community capacity is built. We've had some very significant success with our discharge liaison teams attached to the geriatrics program, as they support clients transitioning to long-term-care facilities, and using that model across the spectrum of care that we provide would be important. We feel we have a great need to link with our schedule 1 partners, which include London Health Sciences, in the development of an ambulatory service that is virtual in how we provide care, and that includes community partners like CMHA and other community agencies—the Alzheimer Society was one that you heard from earlier today.

The ability to link with the CCAC in a meaningful way that has some policy attached to it would be an issue that we would also support having some further dialogue on with the ministry and with your committee. The absence of actual directives for the CCAC to work with the seriously mentally ill means that there is some confusion around who works in collaboration in providing care for these clients, who have both physical as well as psychiatric needs.

Elgin county, specifically, is facing some challenges that we would like to bring to your attention. The delivery of acute care services within the St. Thomas-Elgin General Hospital will be a new avenue for this institution. There will be requirements that will need to be made at the Legislature with respect to the Mental Health Act around enhancing that role for Elgin General, as well as new learning for all areas within that organization in providing acute care mental health ser-

vices. We are working in collaboration with Elgin General as they start their functional planning process.

The economic downturn in the southwest is obvious to all, and we are starting to feel those effects across both community service providers and the hospitals with respect to the increased stress that families are under and the diminishment of privatized EAPs as they relate to employment and employers. As unemployment rises, we have individuals who now have no safety net with respect to those resources.

I would echo the challenges that many of our community partners have echoed—and that various planning documents such as the South West implementation task force document identified—around regional resource disparity. There are areas and pockets within the southwest that have limited resources and access to specialized psychiatric services such as psychiatrists, specifically, trained into professional teams. The need to continue to have and request for investment in housing, long-term care and treatment in the community is essential.

In conclusion, we would advocate that your committee work strongly with key stakeholders and the Ministry of Health in looking at how we can determine the needs of this population across a variety of ministries as well as ensuring that there is investment in the community. That investment in mental health and the community will allow the most expensive resource, the hospitals, to do our work effectively and efficiently.

I'll turn the table over to Dr. Sandra Fisman, the chair/chief for UWO and LHSC Regional Mental Health Care.

Dr. Sandra Fisman: I'm here as somewhat of a resource, to answer any questions. I'm the chair of the department of psychiatry at the Schulich School and the chief of the mental hospital services, which would be St. Joe's and LHSC. I'd like to just briefly comment on some of the things that I heard sitting in the audience, if that's permissible.

One of the very passionate comments about addictions and mental health really resonated for me, and I think an important area that we're finding is amongst youth often presenting with a mood disorder or with an anxiety disorder and concurrent use of substances, with very little in the way of resources to manage the addiction component. I think Beth was mentioning that in our early-intervention mood and anxiety disorder program, which is sort of built on a shoestring or less, we've finally been able to cobble together, through a special opportunity fund, a day a week of an addiction counsellor to work in that program. But I couldn't agree more with the comments that these are undiagnosed, the comorbid addiction problems, and absolutely need to be addressed. Perhaps this is an opportunity to drive the message home.

The other important piece that I heard was the link between geriatric psychiatry and geriatric medicine in long-term-care facilities as I listened to the Alzheimer presentation. I think the consultation/liaison team that Kristine described, which provides support to people being discharged from Regional Mental Health Care,

geriatric psychiatry, into long-term care, and being able to access back readily is something that is a model that we should look at, not only in tertiary care but on the acute care side as well.

One of our perhaps large gobblers of emergency services in mental health and in medicine is people who can't be managed in long-term-care facilities, and it becomes the path of least resistance to simply bring these people to the emergency room and to leave them. I think that if we could develop a similar system on the acute care side, we'd be able to prevent those emergency room visits and maintain people in long-term-care facilities with those behavioural interventions that the previous group were describing. We're not able to do that because we are unfunded on the acute care side to do that. I don't know whether Beth wants to add anything to that—

Dr. Beth Mitchell: Yes, we are.

Dr. Sandra Fisman: —but we really see a great need for that.

Finally, in terms of the role for the academic hospitals, we see ourselves as very much needing to be sort of at the hub, developing effective models of care, doing the research, educating and training people to practise in the community and of course the whole southwest, and wanting to be part of a continuum of care, but as I think Kristine was saying, really supporting that community services be developed so that there's not a total reliance on hospital services.

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

We probably have time for one very short question and one very short answer. Liz?

Mrs. Liz Sandals: Kristine, you mentioned that policy was needed for residential treatment facilities. I just want to make sure I understand what you mean. What I think you mean would be the equivalent on the medical side to complex and continuing care, that you've got someone with a chronic condition and you need residential facilities for people with chronic mental health. Is that what you're saying?

Ms. Kristine Diaz: Residential treatment facilities are a model of care which in other jurisdictions, in other provinces, fall under their mental health act with respect to ability to have someone under a mental health certificate in those facilities, to have them secure. So that's the piece.

It really speaks to some policy around two things: one, some reform of the Mental Health Act; two, a shift or an opening of policy around what services would be available outside an acute care setting for individuals such as this.

Mrs. Liz Sandals: But it could in fact be fairly secure, sort of what I would think of as closed custody when you're doing youth corrections.

Ms. Kristine Diaz: Exactly.

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The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your answer, and thanks for coming today.

CAMH CENTRE FOR PREVENTION SCIENCE

The Chair (Mr. Kevin Daniel Flynn): If we can move on to the CAMH Centre for Prevention Science, is Dr. Claire Crooks in the audience?

Dr. Claire Crooks: Yes, right here.

The Chair (Mr. Kevin Daniel Flynn): Oh, how are you doing? Okay. Would you like us to go on to the next one or are you all set to go?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): No, no, that's fine. If it's only going to take a second, then we can wait. Welcome.

Dr. Claire Crooks: Are you ready?

The Chair (Mr. Kevin Daniel Flynn): We're ready. Like everybody else, you've got 20 minutes. You can use that any way you see fit. If there is any time at the end for any questions and answers, it's always best, but it's not absolutely necessary. The floor is yours.

Dr. Claire Crooks: Good morning. Thank you very much for the opportunity to present today, along with my colleague Charlene Camillo. We're going to talk today about meeting the unique needs of aboriginal youth and making a case for strength-based programming and explaining what that means.

I'm Claire Crooks. I'm a clinical psychologist and the associate director of the CAMH Centre for Prevention Science in London. For the last 10 years, I've been working with my colleagues David Wolfe, Ray Hughes and Peter Jaffe on violence prevention programming and other related risk behaviours through a program called the Fourth R.

About five years ago, I started to work more specifically with aboriginal youth, trying to understand how our programs needed to be a bit different or why they seem to be missing or not accessed the same way and with the same effect for aboriginal youth as for their non-aboriginal peers. What I want to talk about today is how our thinking has emerged about what aboriginal youth really need to develop the skills, mental health and competencies that are going to make them successful citizens.

I'm going to give you a really brief snapshot of aboriginal youth—and I don't want to belabour this because I trust, as the Select Committee on Mental Health and Addictions, that you're familiar with these numbers. The overall view is that aboriginal youth, families and communities experience almost every negative health outcome at a disproportionate rate compared to other Canadians. When you look at individual adjustment, you see higher rates of alcohol and other drug-related problems, unemployment, suicide, depression and other risk behaviours. That doesn't come as a surprise. You can pick up the newspaper and see that.

Similarly, high school achievement and academic achievement is disproportionately low. The last time I saw these numbers calculated—one way to think about it is that aboriginal youth in Canada actually have a higher

likelihood of being incarcerated than they do of graduating from high school. That's a really important thing to wrap your head around because it says a lot about what the norms are for a particular group. What it means when you do choose and become successful in graduating from high school is that you've actually gone against what's happening with the majority of your peers.

Once aboriginal youth do graduate, interestingly, they tend to proceed to post-secondary education at equivalent rates to their non-aboriginal peers, even though there are some differences between college and university in terms of where they go.

When you look at families, you see similar rates of problems: Stats Canada data would suggest five times the rate of family violence and a disproportionate number of kids in foster care.

At the community level, it's interesting, because we know that suicide rates are higher, but there has been some really important work done out in British Columbia looking at the range across communities. What these researchers, Chandler and Lalonde, found is that when you look across all the different reserves in BC, there's a range from communities that haven't had a single suicide in five years to communities that have 800 times the national average. That's a really important thing to think about, because if you can understand a little about what's different in those communities, that's a really important lesson for us and an opportunity moving forward. What's different about those communities is the context in terms of the extent to which aboriginal communities have regained a sense of cultural identity, autonomy and self-governance. I'm going to explain a little bit about why that's important.

Those are just numbers. They really don't tell the story. Those are the numbers that are easy for people to throw around or easy for the media to throw around, but they really don't paint a picture of why. I think all too often we accept those numbers around suicide and substance abuse without stepping back and thinking, "How does this make sense? Why is there an identifiable group of youth and adults in this country who experience such disproportionate outcomes? Is it something inherent about them being aboriginal?" Because if we accept that, that's a very negative and biased kind of hypothesis. You need to look beyond that. I would argue, and a lot of people have argued, that what we need to look at is the context, and by that I mean looking a little bit at the history and the contact between aboriginal and non-aboriginal peoples in Canada.

I'm going to talk specifically about residential schools for a few minutes and why it matters. It's important to remember that residential schools are just one symptom of the whole colonization process, but in some ways it's the easiest for us to understand. I think there has been a lot of understanding developing around residential schools, in part because of the leadership of the federal government in putting together an apology just over a year ago, but there are still a lot of myths and misconceptions. Even people who understand residential schools

still kind of have this, "Why does it matter now and why isn't it something that people can just get over? A lot of these people who have trouble didn't even attend or their families didn't attend." Trying to understand that link is still a challenge.

I've identified some myths that I tend to run into doing training about residential schools. I just want to debunk each of these really briefly and then move on to what we're proposing as a solution.

The first myth is that residential schools were benevolent boarding schools or that they were somehow about education. That's a really easy one to debunk because you just have to go to the federal government record itself. What becomes clear is that residential schools were part of an aggressive assimilation policy. It's not cloaked in anything more subtle than that. The idea was to solve the Indian problem, take the Indian out of the children or to kill them trying, and either outcome would have suited some of the policy-makers of the time. Really, very little education attainment occurred in general. Obviously, there's a range, and there are adults who speak positively about their experience, but they're in a great minority.

The second thing which I think there's been a little bit more visibility about is that people still associate residential schools with the churches—the Catholic Church, the Anglican Church, the United Church. Although all the churches were partners, this again was a federal government strategy. It was funded by the federal government and subcontracted out. Sometimes people are confused about how long residential schools lasted or when they ended. The reality is that they lasted in some form or other for over 150 years, which is generation after generation of being taken away from your family and community at a very young age and being punished for speaking your language or acknowledging any siblings or cousins or kin. The last one closed in Saskatchewan in 1996, so they're a very, very recent part of our history.

The last myth, which is a little more complicated to understand, is this idea that when we think of residential schools now, we immediately think of all these reported cases of physical and sexual abuse. Obviously, those are terrible things for children to experience, but sometimes people take the next step and think, "If they didn't actually experience that, then it probably wasn't so bad." The reality is that there's a cultural or spiritual abuse that is there even if you weren't physically or sexually abused or neglected. That cultural or spiritual abuse is really what we talk about as the legacy or the intergenerational trauma that we see. You have these children who get removed from their homes for up to 10 years and are often shuttled across the province, so they're not put into a residential school close to home because then there's a chance they can run away and still connect with their families. They're punished for speaking their language—everything that makes them who they are is stripped away from them, so it's very different from a traveller in a foreign land where you don't speak the language but

you're aware that you're there by choice and you're going to go home. It's being ripped out of everything that makes you who you are and being told that that's somehow shameful or dirty or subhuman and that these people are going to save you by making you something other than what you are.

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When you come home, you don't fit in there either. So now you have these kids—and this is generation after generation—who come home and now don't really fit in either world. They still don't have the legal rights of a Canadian citizen off the reserve, but they come home and don't speak the language, don't know the traditions. You have these children then becoming parents, having had no model of parenting, so replicating what they've learned about abuse and power in residential schools. Again, over the generations it actually has accelerated, so we see higher rates of problems now, further away from the residential schools, than were initially witnessed.

There is low education and career attainment, poverty, high rates of substance use and interpersonal violence and a big mistrust of the school system, which is, again, not surprising. I have a quote here from a young woman who lives on Chippewa, and I just love the way she put this. She said, "It's where our parents are coming from. It's where our grandparents are coming from. By the time you get to my generation, we have all the baggage and we don't know where it comes from."

I think that's a really important piece too, that just as the average Canadian doesn't have this context, the average aboriginal youth doesn't either. They don't think, "Well, I look around and my friends are sniffing inhalants and dropping out of school, but hey, I'm part of a post-colonial history and we need to overcome this." It's just this internalizing of somehow not being as good as or as successful as non-aboriginal youth.

So if that's the history and the backdrop, I think where we are right now, there are reasons to be hopeful and there are reasons to be disheartened. Looking at the education system specifically, because that's where I do most of my work, there are some really promising things being set forward and some real leadership by the government, looking at policy directives. There's a new Aboriginal Education Office, and they have this directive about incorporating aboriginal perspectives, closing the gap in achievement, raising confidence—lots of funding. So that's a really positive framework, and I think this committee has the same opportunity to sort of set that framework. The reality is that there's a huge capacity issue and a really long way to go in terms of what that actually means in day-to-day practice.

I'm just going to give you an example: something I saw in December that really, to me, speaks to the acceptability of discrimination that's still here, even though Canadians hate to think of themselves being discriminatory. The Ontario College of Teachers is the official regulating body of teachers. If you have a complaint against a teacher, that's who you complain to. They have an adjudication process. I'm just going to show you a

complaint that was written up in their December journal, because I think the complaint and the college's response are very informative.

So the complaint is: "A parent complained to the college about a grade 3 teacher's alleged racist comments, made to the class during a unit on aboriginal Canadians, as reported to the parent by the parent's child. According to the student, the teacher stated that aboriginal Canadians begin smoking at age 8, sit around drinking alcohol all day, don't work and permit their children to 'run around wild' until late at night." So that's the report; the child comes home and says, "Hey, this is what my teacher said." The parent is concerned and writes in. Obviously that's very troubling, but you don't let one teacher spoil the bunch for the whole group.

What's more concerning to me is the college's response, which is this: "After a full investigation, the investigation committee panel reviewing the complaint sent a written caution to the member to be cognizant of the age and level of the students being addressed when dealing with sensitive subject matter." So the way it's framed is that it's the wrong age. You don't tell kids the real truth about aboriginal Canadians at grade 3; they're too young then. You know, wait until grade 9 or 10.

What I would submit to you is that if you put any other identifiable group in there for aboriginal Canadians—if you put Jewish Canadians, Muslim Canadians, homosexual Canadians—there would be such an uproar, and yet this is such a part of our post-colonial history that I think people would read it and think, "Oh, that sounds like kind of a crummy teacher." But even the institutional response is really disappointing, in my mind.

So that's the history. We get to this point, then, of: What do aboriginal youth actually need to be successful? This is a question we've spent quite a bit of time researching, both with youth themselves—we've done a number of videos and projects looking at that—and looking at other people's research. Really, what you need are intentional engagement strategies. Within most institutions, be it community programming, be it schools, they don't feel like they fit in. They don't see themselves reflected there. They need intentional engagement strategies to be made to feel that they belong in these institutions. They need an environment that feels comfortable and welcoming and educators who connect with them at a personal level. They need access to role models with whom they can relate, educators who understand their realities and set high standards for them. This is something youth tell us again and again: "We want teachers, we want social workers, who understand where we're coming from, who've been out to the reserve, who know what my life looks like but don't lower their standards for me because of that." They don't want the message, "Well that's pretty good work for a native kid." That's what they feel they often get. Parents have told us that too. They'll call in and say, "My child got 79% on a test. What can we do to improve that?" And the teacher will say, "Well, 79% is pretty good," and there's that unspoken "for an aboriginal kid from the reserve."

Finally, they really need an opportunity to develop and use leadership skills. No individual always wants to feel like they're on the receiving end of a program. They don't want to feel that they always need the help. They want a chance, like every person needs, to be part of something positive and something where they're part of the leadership for change.

Over the last four years, along with a couple of colleagues, we've developed a tool kit that looks at principles, strategies and case studies for effective programming with aboriginal youth. I brought one copy of it for the committee.

What we did is we organized our thinking around some guiding principles: that effective programs, first of all, understand and integrate cultural identity; they increase youth engagement; they foster youth empowerment; and they develop and maintain effective partnerships with community partners and family. I'm just going to talk about the first three, and then Charlene's going to talk specifically, as an example, about a peer mentoring program that we've developed and have been running.

The first principle, and it should flow logically from where I started with this, is that if loss of cultural identity or theft of cultural identity, if you will, is a major risk factor at both the individual and community level, then really we need to rebuild and give opportunities for communities to rebuild what's been taken away. That's a very different picture than saying, "There's something about aboriginal Canadians that makes them use drugs at higher rates." That's saying that there's this process, this place in time where we are now, historically, where something that was taken away needs to be rebuilt. The communities themselves have the best ideas about how to do that, but there are lots of ways that we can be good partners and support them.

Therefore, connecting youth to culture and teaching non-aboriginal students and adults about the culture and contribution of aboriginal peoples should be an underlying goal of virtually all programming. That's the thing that, again, I think the Ministry of Education really got right. It's not just about having better programming for aboriginal youth, it's also about all Canadians learning about the contributions of aboriginal people so that they're not always seen as the problem or a public health concern. But I would submit that the average educator or service provider has no clue how to do this, even when they want to. So you can go and learn about residential schools, as a teacher or a community worker, and think, "All right. I need to do something." But without really clear guidance and structures and resources, sometimes you can make things worse because you try to do something that ends up being very tokenistic or that somehow still misses the mark.

Again, if you look at this historical context, you realize there are lots of reasons for low engagement: previous experiences, the fact that they don't see themselves reflected in the school or in community programs, the logistics of getting to school or other programs, low academic attainment starting high school—we've done a

lot of work looking at the transition from elementary to high school, so there are all kinds of other problems by that point. If you're already behind in reading, in math, it's hard to then transition into a large, inner-city school and feel successful. So, really, we need to develop specific intentional strategies.

Finally, this idea of fostering youth empowerment, which is that all youth need to develop skills and need to be able to use them for change: Especially with marginalized youth, the opportunity to be a leader and to be a positive influence in your school and in your community can really be a life-changing and transformative experience. When we talk about our experience with the peer mentoring, we've seen that very clearly in a number of cases. But these leadership opportunities need to be built into the structure of schools and programs because, again, these kids don't just self-identify. So you can have a great student action committee at a school or youth centre, and you can put up a flyer that says, "If you're interested in being a youth leader on this committee, come on out." In general, the aboriginal youth are not going to be the ones who come out and self-identify that way, so that's where you need the engagement strategies and you need to think about the skill-building and empowerment.

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At this point I'm going to turn it over to my colleague, who's going to hopefully—

The Chair (Mr. Kevin Daniel Flynn): It's going to have to be a really brief hand-off. Are you good at summarizing, Charlene?

Ms. Charlene Camillo: Sure.

Dr. Claire Crooks: What time are we—

The Chair (Mr. Kevin Daniel Flynn): You've got maybe two minutes left.

Dr. Claire Crooks: Okay, shoot.

The Chair (Mr. Kevin Daniel Flynn): That's okay. No problem. And I don't want to dismiss the importance of the end of your presentation; I'm just trying to be fair to everyone who's sort of confined themselves to the time limit. If you could go through it fairly quickly and then maybe summarize at the end, that would be great.

Ms. Charlene Camillo: Sure. For about the past four years now, we've run a peer mentoring program for aboriginal students in three of the schools in Thames Valley. We feel that a mentoring program fits well culturally with aboriginal people, because in most communities, it's not just the parents' job to raise children; it's the whole community's: aunts and uncles—it's really a whole family and community bringing up the children together.

In our program, for the peer mentoring, there's a lot of emphasis on oral traditions that we use. We use sharing circles, and it's the youth together. It's a chance for them to have a leadership role and mentor a younger First Nations student.

Who's involved? We have mentors who are selected as good role models in their schools, who are attending their classes and putting forth all their efforts. We have

mentees who are younger aboriginal students, usually in grade 9, where it's been identified that it would be helpful to have an older student there to help guide them, someone they can turn to and talk to. The First Nations counsellors at each of these schools are very involved in the programs of helping us select the students and organizing the date and time that the students are going to meet. We also have a community mentor who's selected through a process of referral from the community, and First Nations counsellors might recommend them to come in and speak to the students.

We'll just go on to the manual and training—

Dr. Claire Crooks: The successes.

Ms. Charlene Camillo: All the successes; okay.

Just a quick breakdown: Each semester, the students would meet for lunch once a week. The successes of the program: We have shown that involvement in this program increases engagement of the students in their own school and in other clubs and programs in their school.

The program has grown each year, and there's been a change in the referral patterns, so it's not just the First Nations counsellor identifying now; students are seeing their friends being involved, and they're more willing to become involved in this program. There's a huge retention, and the number of youth who are moving from mentee to mentor increases each year. It's often a goal of the mentees to stick with the program. They enjoy it and see it as a goal for them to become a mentor to other students.

There have been many youth who have graduated who have been involved in our programs and have continued with their education and career opportunities, and we have many great individual stories that we obtain from the program—success stories of students becoming more involved in their school and how this program itself was the stepping stone for that.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you very much for your presentation.

Dr. Claire Crooks: We have other materials about the specific programs that I can send in, if that would be helpful.

The Chair (Mr. Kevin Daniel Flynn): If you would send it in to the committee, that would be great.

I noticed your background, Charlene. The committee, before you arrived today, agreed to visit a certain amount of First Nations communities. One of those was Moose Factory, I think—Moosonee. Maybe you can give us a little bit of advice as to what we might expect and maybe what we should see up there as well.

Ms. Charlene Camillo: When are you heading out?

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

Ms. Charlene Camillo: August: I might be up there.

The Chair (Mr. Kevin Daniel Flynn): There we go. Maybe you can meet us up there; we can spend a little bit of time.

Ms. Charlene Camillo: Yes. When in August?

The Chair (Mr. Kevin Daniel Flynn): We'll be in Moosonee on the 26th and 27th.

Ms. Charlene Camillo: If you're there for the long weekend in August, they have an annual gathering, so I'll be there. I'm playing in a basketball tournament and helping to run a basketball camp for youth. But later on, there'll definitely be blackflies. It'll probably be a little chillier than usual.

To get to Moose Factory, you'll have to take a boat taxi across to the island. Be sure to walk around: There are a lot of historical sites. Say hi to quite a few people because I'm probably related to about half of them.

The Chair (Mr. Kevin Daniel Flynn): We will do that, and thank you very much for coming today. That was a great presentation.

Ms. Charlene Camillo: Thank you.

HURON PERTH HEALTHCARE ALLIANCE

The Chair (Mr. Kevin Daniel Flynn): Our last presenters before lunch are from the Huron Perth Healthcare Alliance. Andrew Williams, Penny Cardno and Terri Sparling, if you would like to come forward and make yourselves comfortable.

For the other members as well, this afternoon, we're having ASL interpreters from the Canadian Hearing Society, and they've asked that as we speak and as the presentations are made, people be very, very clear and precise in their comments and identify themselves. We'll go over that again after the recess at lunch, but if you would like to identify yourselves as you present so that Hansard knows who's talking at what time, that would be great. Like all other presentations, you have 20 minutes. Use that any way you like, and if there's any time at the end, I'm sure we'll have questions for you.

Mr. Andrew Williams: Thank you very much, Mr. Chair, committee members and guests. It's a pleasure to be here this morning. My name is Andrew Williams. I'm the chief executive officer of the Huron Perth Healthcare Alliance. We are here today to discuss a gap in our local mental health system, specifically as it relates to children and youth and their access to acute care beds.

It has been really interesting sitting and listening to the stories this morning, some very personal, some at the system level, but I think they all boil down to the fact that we have cracks in the system, and that's where we get into trouble. So what we are really here to talk about is a crack in our Huron-Perth health care system that we feel needs to be fixed.

I'm going to pass it over to my colleagues, who will introduce themselves and take you through our presentation. I do expect we'll have some time for questions. We're not going to take the full 20 minutes in our talk, but hopefully there'll be some good opportunity for dialogue at the end of it.

Ms. Terri Sparling: My name is Terri Sparling, and I'm the chief executive officer of the Huron-Perth Centre. We're a children's mental health centre that is funded by the Ministry of Children and Youth Services, and we're accredited through Children's Mental Health Ontario.

Ms. Penny Cardno: My name is Penny Cardno and I'm the program director for mental health services with the Huron Perth Healthcare Alliance. Good morning.

We understand that the Select Committee on Mental Health and Addictions has been mandated to examine access-to-care issues for persons with mental health and addiction issues, including primary care and emergency care. As representatives of Huron and Perth counties, we thank you for giving us the opportunity to present the gap on lack of access to acute care mental health beds for children and youth in Huron and Perth counties and the impact that this has on the children and their families, to present our collaborative efforts to respond to the gap in Huron and Perth, and to present a more permanent response for seriously mentally ill children and youth in Huron and Perth counties.

To help you understand the significance of this issue, I've presented a case scenario. This involves a young man who's eight years old who presented to one of our emergency departments in Huron county. He was brought to the emergency department by his mom and his stepdad, and the family had identified that this young man was becoming increasingly aggressive at home. A situation involved him being brought to the emergency department one evening after his mother reported that he'd become more aggressive with the three other children in the home. Johnny, which is what I'm going to call him, has a history of sexual abuse as well.

On this evening that he presented to the emergency department, the family indicated that he took a knife from the kitchen and stabbed a pillow repeatedly. When the emergency department physician saw him and questioned him, Johnny referenced the fact that he was hearing voices and that the voice actually told him to cut off the head of his sister's doll. The emergency room physician spoke to him further and Johnny alluded to the fact that there was a horse and buggy outside of the emergency department that were waiting for him to run away. There was no horse and buggy outside the emergency department.

The emergency room physician really felt that admission to an acute care institution was the most appropriate, given the severity of his symptoms, but in Huron and Perth we have no access to any acute care beds for children and youth. So the process that we have established in Huron and Perth is one where, in partnership with children's mental health services, the Huron-Perth crisis intervention program links with the Huron-Perth Centre for children and youth and a request for an emergency consultation is arranged.

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Some statistics that we have are that last year in Huron and Perth counties, 400 children required admission to an acute care bed that wasn't provided. We have no access to any acute care beds in this province, and, as a result, we've worked very hard, together with our community partners, to come up with an alternative method of managing these situations.

Ms. Terri Sparling: Before I talk about the efforts that we've made over the last 10 years to try and resolve this issue, I'd like to put a bit of provincial context.

It's important to recognize that, historically, children's mental health has been underfunded across the province. There was a 12-year period of time where, provincially, there was no increase in base funding to manage increased costs; in fact, there was a reduction in that period. I mention that because prior to 1999, we as a centre would have actually just sent families to hospital thinking that the hospital would respond and having no idea what would happen after that. We would have said we were not positioned to provide a crisis response. However, in 1999 we received initially \$45,000 to create a 24-7 crisis response, and it was recognized that \$45,000, even at that time, was not going to be able to create a 24-7, 365-day-a-year service, so we partnered with the Huron-Perth crisis intervention program. They're funded by the adult system to provide crisis response and, on courtesy, they provide the front door to our service. We use our limited funding to actually allow us to pick up cases in a priority way. Again, \$45,000 in 1999 was not a lot. We've had it increased so it's now about \$80,000. But in total that's how the system works.

We have no after-hours capacity, so I carry a cell-phone on courtesy to my community partner, because we have access to psychiatric consultation, again, through the Ministry of Children and Youth Services, but the only way I can offer that to my partner is through me. So after hours they link to me if they need a psychiatrist and that's how I would have a child seen. That's just a little bit of context.

Specifically, then, in Huron and Perth we have two significant gaps that impact on our most seriously ill children, and frankly impact on our entire system. We have no access to acute care beds—we've mentioned that—and we have really no ongoing child psychiatry, with the exception of this emergency psychiatric consultation service, and in the last two years they've added telepsychiatry. So we have no child psychiatrist practising in our community.

The impact and burden this places on local hospitals, family physicians and community-based services and on families is enormous. The services that get drawn in to support families in crisis—really, that becomes at the expense of families who may be waiting for service but are not presenting in those more urgent states. Our current system, as I mentioned, has been created, really, in collaboration, and I describe it as a bit of a courtesy service. On courtesy, the Huron-Perth crisis intervention program, with no money from health, provides our front-door response, and, on courtesy, we respond after-hours to link them to limited things. At the end of the day, though, if a child needs to be hospitalized, we have no ability to hospitalize. We have to create safety with those family members; we have to draw in additional supports. Oftentimes we're sending families home with a little bit of medication through emerg doctors just to get through the night, and then our services are being required

intensively to manage cases that really would be more appropriately managed in an acute care situation.

I am aware that since 1999 and the Health Services Restructuring Commission—that's when we were formally designated as outside the catchment of London, and therefore formally without access to acute care beds for kids under 16. The gap has been identified. Through various health structures we have worked to identify the gap and bring resolution over the last 10 years, and that fact sheet in your package outlines our efforts since 1999 to have this issue addressed. We've worked with the district health councils, the Ministry of Health, more locally with the southwest LHINs, and my own ministry, the Ministry of Children and Youth Services.

I think it's important to know that in this province there are only four counties that have no formal access to acute care, and that would include ourselves—Huron-Perth—and Bruce-Grey. What that means is that every time there is a child who presents at an agency, in a school or, ultimately, at the emergency department in our two-county area and that child is deemed to be in need of acute care treatment, we really have two crises: We have the crisis of the child and how we are going to respond, and we have a systems crisis.

The kind of pressure that this gap places on our community is enormous. I've mentioned that the Huron-Perth crisis intervention program continues to respond without any funding in order to develop a plan to support that child and family until our agency can pick them up the next day. When we pick up those cases the next day, that will usually mean that a family on the waiting list will wait longer. It puts pressure on emergency departments, which continue to be required to see these children without having access to a child psychiatrist on-site, having to link into our service, which then offers them access to a psychiatrist in London, which means we then have to transport the child who is in crisis to London to be seen, and if that child needs to be hospitalized, we're stuck.

Family doctors see these children and youth in their practices all the time, with the same lack of real local options when acute care may be needed. Our service, as the children's mental health centre, attempts to manage those situations, the child and their needs and their family, and that means that these cases take priority over the other, non-urgent cases. Currently I have 256 children on the waiting list for outpatient service. Just because there are more clients—families identified in need of service—doesn't change the funding level.

The Huron-Perth centre, as an outpatient service with day and evening hours only, gets placed in a role 24-7 to link local hospitals to our emergency psychiatric consultation service, and that's the only real way we ever have access to acute care from regional resources. Fortunately, we've had a positive relationship with the Children's Hospital of Western Ontario, specifically the in-patient unit. It's those psychiatrists who also work on this emergency psychiatric consultation service who, if they have space, sometimes find us a bed. But we never have

any sense at the time of a call that we have access to a bed, and I can't tell you the number of times that my staff have needed to provide more intensive services to families just to get them through the period of crisis. There was one case where we actually had the child report to our outpatient service three days in a row in order to allow her mother, a single mom, to continue to work, because she didn't have enough of a social net to actually step up and provide supervision to a child who would not agree to stop hurting herself.

Mr. Andrew Williams: To be candid with the committee, I think you would all agree that we haven't given the attention to mental health and addictions that we should have. It's very comforting to us to see your efforts, and we're very confident that they are going to truly elevate. I've worked in health care for about 22 years, and I've really never seen this important area get the attention that it does deserve.

We have a very visible and public health care system and are making a lot of efforts to improve it. I think health care is front of mind with a lot of people, whether it's addressing emergency department waits, reducing hip and knee surgery wait times, access to MRI—you can go down the list. What we haven't yet done, though, is prioritized adolescent and mental health care in this province to the degree that it should be.

In our particular situation, and it's been alluded to already, we are one of only four counties—geographically, in case you're not aware, Perth and Huron counties are directly above London-Middlesex. So St. Marys is one of the southern towns in our region, and Goderich would be one of the northern towns. We're very close to London. But we are two of only four counties in the entire province that have no access to adolescent beds for our youth. It's a huge gap in the system. I cannot think of—and I've tried to—another single service where I could say there's no access. We may not have an MRI in Huron-Perth, but our patients can get on the waiting list and can get seen. Our children and youth who need to be admitted to a bed can't be, and it really is a challenge for us.

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The need for beds specific for children and youth—it's been an acknowledged need for over 10 years. The Health Services Restructuring Commission was mentioned. For those of you who may remember that group, it came through urban centres with a lot of vim and vigour, made a lot of pronouncements and a lot of investment recommendations, including mental health, and then came to rural Ontario and was basically silent. So we had the recommendation in London-Middlesex that they should focus on only London-Middlesex for child and adolescent mental health bed needs. They came to our area and made no follow-up recommendation that said we should have beds in our region as well. So we have been advocating, over the last 10 years, to try and get those beds to fill that need.

Now, we have cobbled together local solutions by working in partnership with our community providers,

and I commend Terri and her leadership to work closely with Penny and our team. We have a fantastic team on the ground, really trying to provide safe solutions for our children. But trust me: It's not adequate. As you've heard through the sessions today, where we run into trouble is when people fall through the cracks, and our children and youth are.

We're not here today asking the committee to consider a new program. We're not here asking the committee to deal with a major system issue. We're really asking you to advocate on behalf of the children and youth who live in Huron and Perth—and in Grey-Bruce, because those are the other two counties that don't have these beds—for equitable access to beds when they need it. Because if we're not looking after our children in a timely fashion, then we are creating not only problems in the moment, but we're certainly undermining their future and a large part of our society's future.

So our request today is simply that you put this on the agenda; that you join us in advocating for what we think is a very serious gap for the children and youth of Huron and Perth counties.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Andrew, Penny and Terri. You have left some time for some questions. We're going to start with Sylvia and then get around.

Ms. Sylvia Jones: Thank you. So based on your location, would I be correct in assuming that the beds that you would like to see for youth and adolescents would be based out of London?

Mr. Andrew Williams: No. We have a schedule 1 mental health facility at our Stratford hospital, and the proposal that we have in front of the LHIN and the ministry is to locate a unit in Stratford.

Ms. Sylvia Jones: Those are only—is that four beds, did I read that?

Mr. Andrew Williams: Three beds. There were two proposals put in: one in Owen Sound for Grey-Bruce and one in Stratford for Huron-Perth. All of the providers, hospitals and communities support the locations where they are, so we're hoping to locate it with our existing mental health services at our Stratford hospital.

Ms. Terri Sparling: Sorry, I would just add that certainly the best solution for families is closest to home, but if in fact that wasn't possible, we're asking for access.

Ms. Sylvia Jones: So today, when you are looking for that acute bed, what are you doing? You're calling around?

Ms. Terri Sparling: No. First of all, we're assessing at the local level, and we're putting together whatever resources happen to be available in that moment, depending on the time of day. If we can stabilize the situation, we'll do that; if by picking up the case immediately, we'll do that. If the child needs to be seen by a child psychiatrist, I call London. I queue up a psychiatrist, and they confirm a time for the child to be seen. We try and problem-solve how we're going to get the child safely to London, whether that's family,

emergency, my staff, whatever. The child is seen, and I still don't have any sense that I'm going to have access to a bed, but I go to the next step, which is at least to have the child seen by a psychiatrist. And it's been that psychiatrist's connections, where, from time to time, they've pulled strings and had a child hospitalized in London, but otherwise they're sent home with meds.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Let's hear from France and Liz, then lunch.

M^{me} France Gélinas: Continuing on the same path, I can't fathom what you're telling me, that for the last 10 years we haven't been able to find funding for three beds in Stratford? This is—it took 10 years and we're still there?

Ms. Terri Sparling: That's right.

M^{me} France Gélinas: How could that be?

Mr. Andrew Williams: That's a very good question. I would say that it's probably because, again, it has fallen through the cracks. When the restructuring commission was going across the province, any new proposals were not reviewed. We were told, "Wait until the restructuring commission comes through." Once they finished their work, we were told, "Well, we've got to implement the restructuring committee recommendations before we can look at new capital." So there are a number of reasons, and we are where we are and we are really trying now—and again, as I mentioned earlier, with the visibility that the province is now giving this issue, we think it's timely to get this back on the agenda.

M^{me} France Gélinas: Are we talking capital costs, are we talking operating costs or are we talking both are not there?

Mr. Andrew Williams: Both.

M^{me} France Gélinas: So—

The Chair (Mr. Kevin Daniel Flynn): Sorry, France. We're actually over time already. Let's hear from Liz.

Mrs. Liz Sandals: I'm just struggling—and I'm not trying to be argumentative—to get what you mean by no access, because I think there's probably half of us here on the committee who would say, "There are no acute care beds for children's mental health in my community. There is no child psychiatrist in my community." The majority of the committee would be in the same situation. However, there are certainly kids from my community who might go to a residential treatment centre in Waterloo or might end up in a children's psych bed in London. Are you telling me that you are not allowed to refer kids to the children's psychiatric unit in London?

Ms. Penny Cardno: In Huron-Perth-Grey-Bruce, we are not one of the identified counties for which they must provide service.

Mr. Andrew Williams: Just to clarify, most communities in the province do not have child and youth beds in their communities, but they will have and they will be part of a region that accesses beds in Kitchener, in Hamilton, in Ottawa, in Kingston. Our regions have been specifically identified as not having that access. That's the point.

Mrs. Liz Sandals: Then I guess my follow-up question would be—

The Chair (Mr. Kevin Daniel Flynn): I'm not sure we have time for a follow-up unfortunately, but thank you—

Mrs. Liz Sandals: But what I don't get is, why didn't you redraw the boundaries?

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Your point was well made, and I think the committee would have loved to explore it further—and perhaps we can after we break a little bit—but I do want to be fair to everybody else, and everybody else kept to the 20 minutes. I know it's painful sometimes.

Mr. Andrew Williams: I'd like you to chair our meetings.

The Chair (Mr. Kevin Daniel Flynn): We've got to travel the province, unfortunately. We could spend the whole week here, I know that, but we did get your point very clearly. Thank you.

We're adjourned until 1:30.

The committee recessed from 1207 to 1330.

CANADIAN MENTAL HEALTH ASSOCIATION, ELGIN BRANCH

The Chair (Mr. Kevin Daniel Flynn): The committee is back in session. Our first presenter today is the Canadian Mental Health Association, Elgin branch. Heather DeBruyn is here with us, the executive director.

Also, just to remind the committee members and perhaps some of the presenters who are here today that for the afternoon session we'll be having some interpretation in ASL. So if you could speak very clearly, very precisely, that would be great, and that goes for all members of the committee as well, just to assist.

Having said that, are we all set to go? Good. The floor is all yours. You have 20 minutes; you can use that any way you like. If you want to take the whole 20 minutes for the presentation, that's fine. If you want to leave something at the end for questions and answers, that's entirely up to you.

Ms. Heather DeBruyn: Thank you. I did have a handout, so there would be the full report. I just wanted to highlight a number of things as opposed to going through the whole report with you.

I wanted to talk about decent, affordable housing being a priority. Even though we, as the Canadian Mental Health Association in Elgin, do provide 62 units across Elgin county to 84 individuals, we find that this is not enough to meet the growing need. There is also a dire need to make funds available for ongoing maintenance of these units. A recent example cited to me was of a tenant who had epilepsy with grand mal seizures. Due to the violent nature of her seizures, she has a number of holes in the drywall of her apartment, and she's concerned about repercussions that might occur with her landlord. Equally, she does not have enough money on Ontario

Works to repair the walls, nor does Ontario Works have any discretionary funds that would cover those kinds of costs. So I just wanted to make the plea that money needs to be made available to help support individuals such as this to be able to maintain their market accommodations.

It's of particular interest that seriously mentally ill homeless individuals have a greater number of visits to emergency rooms and typically stay longer in hospital than the general population. Increasing the number of affordable housing units, as well as increasing support and supported housing programs, can dramatically decrease the need for unnecessary emergency room and extended hospitalizations.

I also wanted to talk about intensive case management and building trusting relationships to help individuals get the services they need. I know that some of the reports around the new investments in services note that they have not necessarily seen a dramatic increase in improvement at this point in time, but what I wanted to say is that sometimes it takes a long time to create a trusting, supportive relationship.

For my example, we work with the Low German Mennonite population in the east end of our county. It's very difficult to engage these individuals in the formal health care system, partly because of their transient nature and partly because they have their own health support systems within their culture. Our example is a worker of ours, Neil, who worked with a lady who was going blind. She'd never accepted services from any of our health care services in the past, and it was her belief that it was God's will that she lose her sight. After working with her for a couple of years—and it did take a couple of years—Neil was able to convince her to go to a specialist in London. He would go with her and stay with her for the whole time period that it took to go there. It was discovered that she had cataracts, and a simple surgery would remedy the problem. To this day, the lady still believes that Neil performed a miracle, and she does tell me that every time I see her. But by being supportive and taking the time to build a positive rapport and being sensitive to the culture, Neil was able to connect with this lady and get her the services that she needed to have.

When we first start working with individuals, not just the Low German-speaking population, but other clients who have not necessarily tapped into mental health supports in the past, there is a great deal of work that needs to be done with them to connect them to regular health care pieces, whether it be regular checkups, med reviews, getting them on medication in the first place or appropriate assessments. So when we start working with individuals for the first couple of years, the workup actually is more taxing on the health care system, but it's our belief that in the long run it will be beneficial for them, obviously, but also the health care system will benefit from that.

I wanted to let you know about our crisis safe bed program. We served a total of 230 individuals over the past year, and, of course, the crisis safe bed program is to avoid unnecessary hospitalizations and incarcerations.

We conducted a five-year longitudinal study with the three most frequent users of our crisis service and also the crisis services of Regional Mental Health Care. What we found was that in the two years prior to our safe bed program opening, these three individuals used a total of 145 bed days at the crisis unit at the psychiatric hospital, and for the two years after the program opened, they used a total, altogether, of 14 days, showing a dramatic reduction in the amount of hospital bed days when you do have other services like crisis safe beds available to your community.

Elgin county has a unique population. Partly, it would be from being in the backyard of the psychiatric hospital for over 70 years. I've included in your package a picture that comes from the southwest region of the Ministry of Health. It's a 2001 census report. The only difference would be that our population in Elgin has grown from 81,553 to 84,500, but 41% of the homes with special care in the southwest region are located in Elgin county when we represent approximately 6% of the southwest population. That, on top of the growing number of private homes in Elgin, means that we have a total of 335 beds in group homes and homes of special care that are specifically for the mental health consumers, which contributes to the drift factor that we have. We also have emerging needs with regard to the unemployment situation in St. Thomas especially. According to the chamber of commerce, St. Thomas has a population of 36,115, and we have lost over 5,500 jobs since July 2007.

There's a general concern in Elgin county with regard to the loss of expertise held at Regional Mental Health Care due to the extended length of time taken around the planning of the hospital closure and restructuring of specialized services to be located in London. There has been a tremendous delay in schedule 1 being moved from Regional Mental Health Care to St. Thomas Elgin General Hospital, and that has created gaps in services and strains on other community services, such as how the police have to transport individuals from St. Thomas Elgin General to Regional Mental Health Care. Because we do not have schedule 1, there has been increased pressure on our emergency room department at St. Thomas Elgin General as people needing to be admitted into Regional Mental Health Care have to be medically cleared through the emergency department before they can go out there.

There's also a general feeling in the community that there is an erosion of psychiatric services provided by Regional Mental Health Care as they have pulled back services to match their mandate. Elgin county residents have come to rely on the expertise at Regional Mental Health Care and feel that our ability to get immediate services for our clients has been diminished. As cited by one of Regional Mental Health Care's crisis nurses at a recent mental health and addiction meeting, the crisis unit is approximately 110% overused. The example was January 28, 2009: The 20-bed unit had 23 individuals on the ward.

I also wanted to mention that yesterday a community consultation was held for the children and youth mental health in Elgin project. It was noted that mental health services were effective in Elgin, just too few. Dr. Bertoldi was there, and she cited issues with navigating the mental health and medical system. Her example was a child taken into the general hospital for an overdose, the overdose being defined as medical and the cause of the overdose being defined as mental health. The psychiatrist would not touch the child until they had been medically cleared and the medical team did not want to touch the child because it was a psychiatric problem.

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She further stated that we do not have the proper facilities in Elgin to deal with these patients as they have tried in the past. In this particular case, the child tried to commit suicide on the general hospital ward, where there wasn't the relevant expertise to help avoid that situation.

There's a need for dedicated crisis beds in Elgin to stabilize and assess children locally through a schedule 1 facility and then be transferred to a regional service, if need be. There's also a need for a well-articulated plan to ensure that the transfer of services from Regional Mental Health Care to a schedule 1 at Elgin General includes appropriate levels of service and expertise that we know already exist at Regional Mental Health Care, and to ensure that that expertise remains here in the county for our consumers.

That's an overview. I have given you more detail in your packages, and I've also included the Network magazine, which does talk about mental health in an economic decline.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left about 10 minutes for questions, which is great. We're going to start with France.

M^{me} France Gélinas: I tried to read your map while you were talking, and maybe it's because I'm looking at it too quickly but I can't figure things out. What do the "H" and the "B" mean?

Ms. Heather DeBruyn: The "H" is the number of homes, so there are eight homes in Elgin county that are homes for special care. And "B" is the number of beds. There are 153 specialized beds for homes for special care.

M^{me} France Gélinas: And "P" was the population, and you said that the population has grown.

Ms. Heather DeBruyn: Yes, and I didn't go through and see how the population had grown throughout the southwest. I'm just presuming it's relatively the same.

M^{me} France Gélinas: I think you mentioned 5,500 job losses since 2007. Has this translated into an increased demand for your services or do you deal with a population that didn't get affected?

Ms. Heather DeBruyn: We haven't actually seen much of that yet. The chamber is predicting that in 2010 there will be a dramatic impact on services needed for that population, but they're not seeing it at this point in time. It's my understanding that Regional Mental Health

Care has not seen an increase in people using their crisis unit at this point in time.

M^{me} France Gélinas: You'll have to forgive my lack of knowledge of the geography. I'm trying to figure out if Elgin is a part of the geographical area designated under the French Language Services Act to provide services in French, and if so, if you know of any services for the French-speaking population of this part of Ontario.

Ms. Heather DeBruyn: It's my understanding that we're not under that act. Predominantly, our next largest population in Elgin would be the Low German-speaking Mennonite population.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): The next speaker is Helena.

Ms. Helena Jaczek: I'd just like to go into the intensive case management aspect where you talk about building a trusting relationship and so on. Have you any experience with peer navigators through the system? We heard earlier today from Allan Strong of the Self Help Alliance, pointing to the value of someone who's been there who can help somebody else.

Ms. Heather DeBruyn: We do have a psychiatric network in Elgin county, and we do partner with them as well. They would do the peer support for that. We also have some staff hired who would be peers as well, under our regular intensive case management program.

Ms. Helena Jaczek: So you found it useful?

Ms. Heather DeBruyn: Very useful. There's certainly a difference in the perspective of being able to talk to somebody who has already been there, around what to expect and the hope and the recovery process. Definitely. I promised him I would come in and say "ditto" to his presentation.

The Chair (Mr. Kevin Daniel Flynn): It's a set-up. Maria?

Mrs. Maria Van Bommel: Just one quick question. I'm going back to the same map that France was just referring to as well. When we talk about beds, is that adult and children's beds or strictly adult beds?

Ms. Heather DeBruyn: Strictly adults' beds.

Mrs. Maria Van Bommel: Strictly adult beds.

Ms. Heather DeBruyn: Yes. It would be the 16-to-65 umbrella from the Ministry of Health.

Mrs. Maria Van Bommel: Do you have a similar breakdown for children?

Ms. Heather DeBruyn: No, I don't. Predominantly, our organization is working with the adult population. We do partner with Oxford-Elgin child and youth services for 16- and 17-year-old individuals, and then they partner with family and children's services and other people who were around the table yesterday to deal with children's mental health.

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Kevin Daniel Flynn): One more question from Liz, and then Sylvia.

Mrs. Liz Sandals: You mention on page 7 a crisis safe bed as cutting admissions, but I'm not sure exactly

sure what you mean by a crisis safe bed. Could you explain, please?

Ms. Heather DeBruyn: Our crisis safe beds are for anybody in Elgin county who has experienced a situational crisis or needs a safe place to go. If you're homeless and you're in St. Thomas and you need a place to go, then we would provide a bed for you to go to.

Mrs. Liz Sandals: And give me an idea of what sort of a place where these beds are located.

Ms. Heather DeBruyn: Right now, we have them in three different existing group homes in Elgin. We have one that is all-female, we have one that's all-male and then we have one that can be either male or female.

Mrs. Liz Sandals: Okay, so this is like an emergency bed in a group home that you have.

Ms. Heather DeBruyn: Yes. And the maximum stay would be five days, because our workers would work with them to get them to a more long-term place, and some of these group homes have different types of beds that they could then move into. We have a number of apartments that we would look—if we had vacant apartments or market accommodations.

Mrs. Liz Sandals: Okay, thank you. That's very helpful.

Ms. Heather DeBruyn: It's a non-medical component.

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

Ms. Sylvia Jones: As you move forward and are watching the change with London Health Sciences and St. Joseph's Health Care—we had a presentation from them earlier today, and it is my understanding that they are anticipating a net loss of 67 beds with the transfers. Does your organization have a concern or a comment that they would like to share with the committee about that change?

Ms. Heather DeBruyn: That's why I wanted to mention what the information was that we received from Regional Mental Health Care—the crisis nurse saying that they were consistently over-occupied in their beds, running 23 when they only have 20 beds, because the plan that had been put in place in the past was that 15 beds would move to the schedule 1 at St. Thomas Elgin General Hospital. So there is a general concern that 15 beds, which was the allocated number in the 1990s and early 2000s, may not be an adequate number for Elgin county, and it does not include beds that would be available for youth.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Any further questions? Being none, Heather, thank you very much for coming today. Your presentation was very well received. Thanks for taking the time.

Ms. Heather DeBruyn: Thank you.

ELGIN ST. THOMAS RAISE COALITION

The Chair (Mr. Kevin Daniel Flynn): Our next presenter of the day is the RAISE committee, represented by Jessica McKillen and Ron Elliott. Come forward,

Ron. Make yourself at home. There's some water there if you need any water. We'll get you all hooked up here.

You'll have 20 minutes like all the other delegations that we're hearing across Ontario. You can use that any way you like. We found it's better if you leave some time at the end for any questions that the committee members have. Other than that, it's all yours. If you'd speak maybe a foot away from the mic, apparently that works better as well. And if you could introduce yourself at the start of the presentation. Those are all the rules I have.

Ms. Jessica McKillen: My name is Jessica McKillen and I am the youth prevention worker for Addiction Services of Thames Valley. As you have mentioned, I have Ron Elliott here with me today. He's a pharmacist and the owner of Applegate Consulting. We are both here as representatives of the RAISE coalition, and I'm going to break it down. I'm just going to give you specifics on the RAISE coalition and then Ron is going to address some of the key points and factors that we've collaborated on to bring to you today.

As I mentioned, the RAISE coalition is a committee formed in Elgin and St. Thomas, and it stands for Reducing Addictions—Increasing Safe Environments.

I'm not going to go over our vision. It's pretty holistic of that. We want to see the harmful effects of substance misuse abolished from our community.

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Our committee formed in 2008 and we had a community meeting to discuss prescription pain medications. Once the committee had come and formed, we decided to address all substances and then incorporate mental health, as we can see that mental health is a predisposing factor for addictions. On this factor of concurrent disorders, we just wanted to stress as well that the percentage that you see here, 40% to 60%, is for the seriously mentally ill or severe dependence problems. With addiction services, the majority of our clients are—we see 18% with depression as our number one, and 6% with anxiety and post-traumatic stress disorder. Those aren't classified as severely mentally ill, but they are still predisposing factors for addictions.

Our committee consists of a variety of service providers and we are quite unique in upholding a range of enforcement, medical providers, social service workers and health promoters to get quite a collaboration working together towards the prevention of substance misuse.

We'd like to address the nationally recognized model for health promotion, and the four pillars are incorporated in the package that I have provided you with. We kind of summarized some of the activities and ways that we incorporate the four pillars of prevention through our committee.

As well, in your packages we've incorporated some of the tasks and projects that we've been addressing over the past year and a bit. Some of these have recently formed, so youth and teacher education was actually brought forward—one of the principals came forward to our committee and requested a presentation on the upcoming trend that they were seeing with OxyContin—

providing education as it arises around new trends. The PIER project utilizes peers, information, education and resources to empower youth and give them a voice to speak out about illicit substance misuse.

As I mentioned, I'm going to pass it off to Ron. The committee has collaborated with all of our expertise around the table and summarized three key factors for your consideration today.

Mr. Ron Elliott: Thank you, Jessica.

Good afternoon, committee. Thanks for giving us the opportunity to present to you this afternoon. As was mentioned, we bring together a coalition of people from various aspects, both volunteers and employees, to try and bring this issue to both your and our communities' attention. Our focus is to increase the support for prevention and health promotion, and we do use the reference that prevention is in fact a key pillar in the health community model.

It's hard to believe that prevention funding will save dollars by keeping people out of the treatment and emergency facilities. At the same time, we think it's important that we increase awareness of and access to existing services. I heard the last speaker speak about navigating the services, and that can be a real challenge for a number of people in the community.

To expand on a program that currently exists, there are programs like Heartspace, a program designed to support and educate parents and pregnant mothers with substance misuse issues in the rural and county areas. This program works on prevention in a generation-to-generation model and has been very successful.

We need to have more health promoters available to do in-service training—or train the trainer, if you will—so they can present information to agencies and service providers, educators, youth and communities. That in turn frees up the clinical staff so they're not being pulled away from seeing clients in order to do presentations and attend these various meetings. This will reduce the stigma, we hope, and break down barriers, creating more open dialogue amongst people with mental health and addictions to get the services from existing supports such as teachers and community groups, those who currently feel somewhat uncomfortable when approached with the topics of mental health and addictions.

We have to look at funding in all of these issues, and we believe that one-time and short-term contract funding is time-consuming for agencies and management to apply for and maintain. So appropriate compensation is lacking.

We need to increase the support for the retention of qualified staff to work in community-based agencies. Currently, community-based salaries are considerably lower than institutional-based salaries, so what we have, in fact, is a loss of staff as staff are harvested from community-based agencies to work in institutional agencies.

The importance of standardized assessment tools and training across all service providers for mental health and addictions to increase client access to service: Workers gaining this higher level of education for their positions are not being compensated. The addiction treatment

tools—admission, discharge and so forth—to identify the level, intensity and type of services that a client needs in addiction treatment services must be emphasized. Common assessment of need to identify mental health needs of clients is required to better service and direct treatment of care.

Just to give you a couple of examples, the deinstitutionalization of the mental health system has increased the number of clients with severe mental illnesses accessing community-based social services. Social services staff are then put in a position where they are now doing the work that hospital staff previously did. Agencies and service providers are seeing clients with layered and more complex issues across their realm of influence and accessing their services.

It's interesting to note that when police are called to assist with a mental health or addiction crisis, they often dispatch two police officers to attend. The officers are then utilized to escort the client to the hospital and remain with that person until they are attended by a physician. Many times these officers have to wait in the ER until the client is medically treated or is no longer intoxicated. Clients are then discharged from the hospital without having been connected to any community support structure. This was sometimes referred to as "treat 'em and street 'em." So they have a short interaction with the health care system and they go back out on to the street, on their own. That can lead to, and does lead to, recurring incidents with the same client.

London CARES is a municipally funded program that allows a worker to attend and connect with the clients in the situation, freeing up the police to return to their active duties while then connecting the client to resources that provide a continuous support. They reference "governments needing to work together to obtain success in the healthy community model."

We looked at some of the load in the community when our group came together, and it seems that the Elgin county worker is beyond maximum capacity, often with a double caseload. This demand exceeds the supply of staff, and certainly problem gambling is something we've become more aware of and have seen in the community as well.

As was mentioned, I'm sure, by other presenters, Elgin-St. Thomas has a noticeable economic situation. This has led to a large impact on the community social service structures in the area, and we can predict that it will only become greater in the future. When people lose their jobs, they lose their benefits. Sterling was a large employer here in the city of St. Thomas. When they closed—all those unionized factory workers are now looking for other sources of income. Workers and their families who were accessing services under the benefits of these positions will be orphaned from private supportive services and needing to access community services, and thereby, entering the public system as their separation pay and EI benefits run out.

Elgin has a high population of children and a very high population of unemployment. Also, to clarify the

slide, some 51% of the youth in this county have not completed high school, and that's a concern.

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Funding has not been adequate to support the increase in numbers, so clients are having to access the emergency room for immediate care since it is often the only point of access to services. The social determinants of health show us that lowered employment and education resources increase poverty and contribute, in a correlated effect, to increase the likelihood of mental health and addiction issues. So when we track these trends, we see that the need for expansion of funding to include gaming support within gambling services as well, especially for youth, as an early prevention strategy has become a recognized gap.

So I'm going to stop here. Jessica and I will try and answer questions, Mr. Chair, and we have a number of members of our coalition with us today to help us. We really see a distinct, direct connection between addiction and mental health.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. Any questions? Maria?

Mrs. Maria Van Bommel: We just heard an earlier presentation about the population of this particular area of Elgin and especially the German Mennonite population, and I'm really curious about your comment or your fact about the percentage of the population that have finished high school. Especially looking at the ages, I could certainly understand that maybe in the older population, especially when you had companies like Ford and Sterling to go to, there wasn't the urgency about finishing high school, but that you would have such a high percentage of young people between 15 and 24 who haven't finished high school—is that in part because of the mix with German Mennonites? I guess what I'm asking is, can you explain the number?

Mr. Ron Elliott: I'll defer to Jessica for that.

Ms. Jessica McKillen: That statistic actually came from a recent study from the Centre for Addiction and Mental Health. I think one of the facts that we need to address too is that a lot of times youth aren't even typically completed high school between 15 and 17, so there's a number there already. And I'm not quite sure how they did their measures across the population. They didn't break it down into groups like the Low German population in the Aylmer area.

Mrs. Maria Van Bommel: From your own experience, would you be able to tell?

Ms. Jessica McKillen: I would say that, because it is a farming community, sometimes it's not the industrialized areas that some of these students are going to but possibly the farming areas, to work in that particular field.

Mr. Ron Elliott: In my experience as a pharmacist and seeing these people come through the store, it just wasn't in their priorities. It seemed that education was such that it was more important for them to work with the families and with the farms as opposed to completing school.

Mrs. Maria Van Bommel: It surprises me a bit as a farmer, I have to say, because farming has become so complex. I don't think anybody could farm with just a high school education anymore.

Ms. Jessica McKillen: Ditto for the farming, myself. I think that when we look at farming, there are different levels of it as well. There are the owners of the property and then there are the workers and the hired hands that come in to help with that. I think a lot of the time that's what we're seeing some of the youth going into, working as the workers, not as the mangers of the properties.

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

Ms. Sylvia Jones: I'm actually kind of curious as to how you got such a diverse group together to be studying some of these issues. We have a Safe Communities in our area, and I'd like to hear a little more about how your coalition came about, how long it's been in existence.

Mr. Ron Elliott: There's always been a concern—I shouldn't say always, but for a long time—with a number of us about addictions that arise from the misuse of prescription medications. So we have met off and on over the years in different groups to try and address the issue. There was a loose number of groups who were doing similar things, and we tried to bring those folks together in that earlier meeting in 2008. I have to give credit to the health unit here in our community who helped us bring that together and offered us meeting facilities. It was by invitation to emergency medical services, to the hospital, to independent pharmacy people, to addiction treatment people and so forth to try and find a way to wrestle this thing, if you will, to the ground, because the ongoing use of opioids, especially OxyContin and Percocet, has become a real community issue. We've seen that with a number of employment-assistance agencies and so forth who run conferences and conventions to try and address the same issue.

We have worked on a model to give to our city council, and we picked up an awful lot of information from Oxford county, who were very successful in bringing together a community statement just this past spring—last year, actually. They brought that together and they did the same thing. It was led by their city council, and they have, I think, 50 or 60 agencies involved in this coalition to try and address the issue. So we're modelling and, quite frankly, plagiarizing where we can, with their permission, some of the material from Oxford as well.

Ms. Sylvia Jones: Thank you.

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

M^{me} France Gélinas: I have this piece of paper that goes through your four pillars to support a healthy community. You go through prevention, harm reduction, treatment and enforcement. I was just curious if you could give us more details as to successful programs that you've had on the prevention side. Some of them, like ESTPH, mean absolutely nothing to me.

Ms. Jessica McKillen: Sorry; that's Elgin-St. Thomas Public Health unit. Those are just existing services that

do education and awareness and preventive measures upon the request of service agencies and schools and businesses and things like that.

A success for us right now—I mentioned the schools approaching the committee itself, looking for education information about the growing trend of OxyContin. A subcommittee was formed, we presented to all the teachers and we've been able to formulate a nice partnership with that school to continue the education and support to the teachers to be able to train them on how to assist the students and create a safe area and space for them. It's an ongoing preventive measure, but we're now a recognized support in the community for them to contact us.

M^{me} France Gélinas: And what do they do at the Talbot Teen Centre?

Ms. Jessica McKillen: The Talbot Teen Centre has been formed in St. Thomas as an area for local youth to go to for recreation. They have computer banks. It's kind of a drop-in centre for youth that creates a safe environment where they're not out on the streets, so it's doing preventive education. They have guest speakers come in and talk to them about varying topics such as substance misuse, and I know that they had a presenter in recently about sexual assault.

M^{me} France Gélinas: And who funds them?

Ms. Jessica McKillen: I'm not quite sure. Sherry Ball is from Talbot Teen Centre.

Ms. Sherry Ball: Actually, we're funded by the United Way. Right now we're open Wednesday through Saturday. Hopefully in the future we'll be open seven days a week.

A lot of our population range from 12 to 18. Mainly they come from at-risk backgrounds, so we are seeing the youth coming in who have little to no support systems at home. Although we do see 12-year-olds, the majority of the kids we have are 14 to 18, and they are the youth who are typically already in the justice system a lot of times.

We are doing prevention work, having speakers come in and also peers come in. Actually, just the other day, we had a young man come in who is in Guelph at rehab there and wants to come in and tell his story about how he got addicted to OxyContin and tell that to peers and youth his age so that they can better understand. It's obvious, with our population, that youth talking to youth is really something that works well. We're too old and not cool enough anymore. So the younger the better.

We just got approved for a grant as well from the Ontario chiefs of police to run another prevention program for substance abuse.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming forward today, and thank you for your presentation.

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KERRY FERGUSON

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this afternoon is Kerry Ferguson. Kerry, if you'd

like to come forward. Make yourself comfortable. I see you brought your own Diet Coke. Like everybody else, you'll have 20 minutes to make your presentation. You can use that any way you like. If there's any time left over at the end, we'll see if we can get a discussion going. You can speak about a foot away from the microphone. The floor is all yours.

Ms. Kerry Ferguson: All right. Thank you very much for this opportunity. I'm a psychiatric nurse at St. Thomas Psych, and I've worked there 23 years; 20 years on medium-secure forensic. I'm also an alcoholic who has been sober for three years. I really do appreciate the opportunity. From my heart, we don't have enough for either mentally ill or addicted people in the area and probably all of Ontario.

The Mental Health Act, over the years, has not allowed us to—you look back at the 1920s or even further than that; it was very archaic, what we did. But now we have people coming to our hospital and they watch TV all day. That's not helping them. They don't have to take medication. They refuse their medication. We had one lady—this was a few years ago. She was psychotic, and it took two and a half years, because she thought—she was very smart, though, and went to the Supreme Court of Canada and fought all the way. But that whole two and a half years of her life, we got to watch her be mentally ill, and it's very difficult.

There are not enough programs, even at our own hospital. I was going to bring up the community-based. We're trying to put them more out into the community, but there's not enough set up out there for them. As nurses, we've become quite apathetic. I'm glad I haven't. I still want to get these people help.

Many years ago, I started in London a group with family and caregivers together. That was too difficult because I was the only nurse there, and the families—I was hearing their stories of trying to get treatment for their loved ones, and the battle. That's what it is; it becomes a battle. I'm still friends with one lady and keep in touch, but with work and doing that, it was too much.

I know that it's costly to put people in a community too, versus an institution, but I don't know which way is better. With us being there we can see a decline, where, if they go out in the community, at first they might be seeing their nurse quite often, and then it slips. A lot of our patients are addicted too, and they'll start using and abusing and not using their medication; instead, they'll use alcohol and drugs.

The downsizing, which is happening all over: They're familiar with coming to the Psych—it's referred to as "the Psych"—instead of down the road, it's going to be at the General, a 15-bed unit. That's what they're comfortable with: coming to the Psych. It takes a lot to even admit that you're coming to the hospital, because of the stigma of mental illness and addiction. That's where I say, "More education." I educate people. My loved ones think it's like *One Flew Over the Cuckoo's Nest*—my friends and stuff. Well, that's not what it's like.

I'm just trying to think. What else? Long waiting lists. Like I said, I work medium-secure. We have people waiting in jail a year, sometimes, and they're just sitting and getting sicker. We are going to be building a new medium forensic unit on the psychiatric property; that was supposed to happen in 1999. It just keeps being put off as the facility itself caves in. It's very depressing, our hospital. There's plaster falling in. It's not pretty, and if you're in there for depression, it's kind of hard. I'm hoping that this will happen. They're now saying 2011-12, but they need also—they increased the beds because like the normal London Psychiatric and St. Thomas Psych, I think they're saying 180 are going to be placed at Parkwood. We have more than that, plus all the out-patients. It just doesn't seem like enough to me.

As far as educating family doctors and staff about mental illness more, the police are getting much more education—they really are—over the years. Before they used to think, "They're just nuisances," but it's not like that anymore.

I'm trying to think of what else. I could go on and on; 23 years of—I'll turn to the addiction part. As we all know, addiction is a disease. It's just like diabetes and cancer. It becomes progressively worse; I know how I was getting. It's also hereditary. I had an uncle who passed away in January. It was hard to watch. It was a slow suicide. There is nothing—I tried to get him to go into the Psych. We probably could have deemed him a danger to himself, but within three days, he's out. It's the revolving-door syndrome; that's what I know, as a psychiatric nurse, it is.

There are not enough services for addiction at all in St. Thomas-Elgin county. I know when I first called Thames Valley with my own situation, I was told it would be three to four months until I got to see a counsellor. I just wanted to go back out drinking. I was just like, "Oh, thanks a lot." It was a stab in my heart. I just wanted help and I couldn't get help help. Thank God for AA. I turned to AA and it has helped me, because that's a support group. There are nightly meetings somewhere. But that's also difficult. There are people who aren't driving because of impairment charges—whatever. Or I look at people going to the cancer clinic—they're getting rides. It's all washed under the table, alcoholism and psychiatric illness.

I pushed. Being a psych nurse and kind of knowing the system, I called almost every other day just to get myself in for treatment. I got accepted; it was only two and a half months that I had to wait to see Thames Valley. I got to see a counsellor. I learned a lot, because there's a lot. Even though I'd been working this for 23 years, there's a lot I didn't know. AA, like I said, has really helped me a lot. While I was seeing the counsellor here in St. Thomas—and that was only like, Tuesdays and Thursdays; anything else you had to go to London for. I was pushing to go to a treatment centre, and she said, "No, they're too long a waiting list. You really don't need it," but I just wanted more. I wanted to learn how to live with this illness. That was hard too, because

it's just another fight. I'm pushing and pushing. There are a lot of people who don't have the fight in them to even try to do something like that. They'll just turn and go back out drinking. I've known six suicides this year: four people who worked in factories and two of our patients. They are increasing. The economy is really bad in Elgin county.

I'm trying to think what else. I wrote little things down here.

That's the other thing. I heard these people talking about—especially the younger generation. We are seeing so many more out at admitting with—well, it's not as much as ecstasy anymore, but there are so many drugs out there—the OxyContin, the Percocets. The availability is just amazing. I look back at my life as a high school kid. We had marijuana—that was it. Now it's like every type of pill you can think of. They're all getting wrapped up in that. It takes over, and that's where I'm saying the medical doctor needs to be cautious with giving these to parents and stuff and really explaining how addictive they are, because I've known three or four 14- and 15-year-olds who have become addicted. It's just dreadful, because it takes a long time and a lot of education, because people want to escape, they want that high, they want to not have to think, and a lot of people are dealing with their own parents who have lost jobs and bad situations.

I'm just going to glance at my notes—just mainly, more services. More money is needed so much for psychiatric and addictions. I know it's not just here; it's all over. It really is, and it's increasing. I see it where I work, and I see it just talking with friends and family. I don't have any major answers, but I keep pushing.

1420

The Chair (Mr. Kevin Daniel Flynn): Okay. Why don't we try some questions, then, from the committee? It sounds like you're about ready for that. Sylvia, you're first.

Ms. Sylvia Jones: Thank you for coming and appearing, Kerry. I wanted to expand a bit on something you raised when you talked about your uncle's addiction and the example you gave right at the beginning. I hear a lot from family members and parents who want to be involved, want to be part of the process of rehabilitation. Can you tell me, from your experience as both a nurse and a family member, how we can do a better job of that?

Ms. Kerry Ferguson: It's difficult, because it is the person themselves who has to admit they need help, with mental illness or with addictions. I think more programs are needed. The stigma is the main thing, it really is. People don't want to say, "I'm an alcoholic" or "I'm mentally ill. I'm crazy." It would really help just having more programs available, and easier access. I went to a women's group in London every other Tuesday. Well, it was every Tuesday that I could have gone, but with my shift work, it was every other Tuesday. That was something I wanted; it was more on addiction. But there are so many people who can't drive to London, either economically, they don't have a vehicle or whatever. We need

more supports, more systems in place; just to say, "Here. Here's a list."

With my uncle, all I said was, "Here are all the AA meetings." We argued a lot about it, but the person has to decide they want help. There's really nothing—I wish I could have handcuffed him and brought him to the hospital, but I couldn't. He was dead in his house for six days because I stopped going; I didn't go see him the last year. It was too difficult, plus I didn't want to find him dead. I knew that was how he was going to end up. He was a schoolteacher all his life. Some people sit there and say, "Well, they're just an alcoholic." They think of a brown-bagger alcoholic. No. He was a brilliant man. He had life in his hands—my grandparents' farm is 180 acres. It's very close to my heart, both psychiatric illness, because I work there, and addictions. More programs—more.

Ms. Sylvia Jones: I got the message.

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

M^{me} France Gélinas: In other comments you made, you talk about your work as a nurse and how some of the clients that you see have actually been referred a long time ago but end up spending a long time in jail before they actually get to be treated. Is this something new? Is this something that has always been there?

Ms. Kerry Ferguson: It has always been there.

M^{me} France Gélinas: What kinds of delays are we talking about?

Ms. Kerry Ferguson: There has been up to a year. Recently, I heard it's three to six months.

M^{me} France Gélinas: How long would you say the clients stay in your unit? You're medium, you said.

Ms. Kerry Ferguson: Medium secure, yes. It's usually a year to three years.

M^{me} France Gélinas: A year to three years? Is that the length of their sentence or the length of their treatment?

Ms. Kerry Ferguson: They have a review board every year which gives recommendations on if they should go on to minimum security, on to the next level, or sometimes be completely discharged. Usually they go to minimum security from us and then to the community.

M^{me} France Gélinas: What kind of catchment area do you cover?

Ms. Kerry Ferguson: From Windsor to—I'm trying to think—up Owen Sound, Woodstock. It's a huge area.

M^{me} France Gélinas: The whole southwest?

Ms. Kerry Ferguson: Yes.

M^{me} France Gélinas: I had one more. You talked a lot about stigma and how that has to change. Have you come across any programs or solutions where you said, "I think this could work"?

Ms. Kerry Ferguson: Just education. You know, people accept that if you've got cancer, you go get treatment for that. You're seeing it out there in literature in doctors' offices, in the paper. It just needs to be more education for everyone now.

M^{me} France Gélinas: To be more visible and be more out there in the mainstream.

Ms. Kerry Ferguson: Yes.

M^{me} France Gélinas: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. Anybody from the government side? Helena?

Ms. Helena Jaczek: I've been thinking a little bit about concurrent disorders. We've heard that of mental health patients, some 40% to 60% have addictions. What about the reverse? What about people with addictions—and I'm thinking particularly of, say, the teens who are now so exposed to chemicals that they are just experimenting with. Would you know from your experience how many are getting involved to begin with because of some underlying mental issue and how many are just kind of, "Oh, I'll try this," and then they get hooked?

Ms. Kerry Ferguson: I would say, as a guess, a fairly large percentage, probably 20% to 25%, because that's what the alcohol or drugs do, is keep—and that's the age group to become schizophrenic too, 15 to 20, and if they're hearing voices, then at least the alcohol or the drugs will take that away. We had an addiction program at the Psych. I'm trying to guess—it's been quite a few years. It was taken away from us; it's at London. It's called concurrent disorders. But there are so many I have met with AA and throughout my years who have said, "That program saved my life." It was a 28-day program. They went to it and they were locked in. They weren't allowed to go home and stuff. But they worked. They worked hard and learned a lot. And now the concurrent disorders program at London is going to become a day program. You say, "Oh, it just doesn't"—but I do believe there's quite a big percentage, especially that age group, because that's when schizophrenia does hit. Also, when they start taking these things, it can cause mental illness because of the chemical imbalance. Drugs and alcohol can cause mental illness.

Ms. Helena Jaczek: So they're both really very entangled.

Ms. Kerry Ferguson: Yes.

The Chair (Mr. Kevin Daniel Flynn): Do we have any further questions? We've got about a minute left. Maria?

Mrs. Maria Van Bommel: It's a bit of a personal question, so if you're not comfortable in answering, I could certainly understand that.

You say you've been a psychiatric nurse for 23 years. What drives you? What motivates you, in 23 years, to stay in that field? Certainly, as a nurse you could change to another specialty at any point and be very welcome anywhere in the health care system. So what motivates you and keeps you going day to day?

Ms. Kerry Ferguson: I think just the hope to see them get better, and I have seen so many over the years. They are a totally different person from when they're mentally ill to when they are on their meds and living in the community and they become just part of society. That just gives me the hope. Seeing them get better is the main thing.

But as I said, it is a difficult profession. You feel like you're banging your head against the wall. We've always said, you know, it's a revolving-door system. A lot of it, I do believe, is the stigma and stuff. Somebody can't walk out from a psych hospital and say, "I just got treated for mental illness," whereas if you walked out from the cancer clinic and said, "I have cancer," everybody would be saying, "Poor you." It's hush-hush, right?

Mrs. Maria Van Bommel: Thank you for your years of dedication.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Kerry. It's really appreciated.

Ms. Kerry Ferguson: Thank you all.

DAVID SIMPSON

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is David Simpson. David, if you'd come forward and make yourself comfortable. You've sat through a few of the presentations now so you know what the rules are. You get 20 minutes. Use it any way you like. If you want to leave time at the end for some discussions, that would be appreciated. Speak about a foot away from the mic. It's all yours.

1430

Mr. David Simpson: Good afternoon, Chair and members of the committee. Welcome to St. Thomas and thank you for coming to us and to our community to afford us the opportunity to participate in the process. I think we've heard some excellent presentations both today and in other locations across the province.

I appear here today as a mental health advocate and human rights advocate with more than a decade of experience working with those who are most vulnerable amongst us: those with serious mental illness. I've learned some important lessons during that time.

Individuals with mental illness have been my teachers, my mentors and my inspiration. They've been pioneers, explorers and trailblazers, often willing to challenge a system that has treated them poorly by at times violating basic and fundamental human rights, failed to listen to their concerns or take their wishes into account. It has treated them against their will and failed to see the humanity and potential within them. But we must remember that they dared to challenge the system, to stand up for their rights and to be recognized as people first, who happen to have an illness. They are not their illness and they are more than their diagnosis and the symptoms that are so liberally applied to it. There's been a history of human rights abuses, social injustices, of being exiled from their own communities and tucked quietly away in asylums. It has often been an existence of loneliness, despair and isolation, shunned simply because of their illness and the stigma and discrimination so often associated with it.

But things have changed and people are now more willing to tell others of their mental illness, their struggles and what they need as they travel along their personal road to recovery. We have come so far, but we

still have so far to go before we can proudly say that as a community we are understanding, accepting and inclusive of all members of our society. It has often been said that a society is judged by how it treats its most vulnerable citizens, and I'm wondering today, will history look upon us kindly or judge us an uncaring and callous society?

Individuals with mental illness want the same things in life as every other Ontarian: to have a family, a home, a job, to love and be loved, to be able to provide for their families, to worship and express their spirituality, to be well and stay well, and to participate in the community to the extent that they are able and wish to. But individuals with mental illness must also be welcomed and embraced by a community that is willing to support them as they embark on their personal journey of wellness and recovery, and to provide them with equality of opportunity and a sense of belonging and recognition that the world is a better place because of what each of us has to offer to others.

We are those individuals. There is no "us" and "them," it is "we," because any one of us might experience mental illness at some point in our lifetime. It is for this reason that we must always apply the "family test" to all of our actions and how we treat others. The test is really simple: If this were my mother or father, my brother or sister, my grandmother or grandfather, would this be good enough for them? Because if not, then why do we expect that it is suitable and appropriate for someone with a mental illness? Let's always apply that family test before we speak or act.

I hope that both your committee and the minister's mental health and addictions advisory committee will work collaboratively to provide guidance, direction and visionary leadership in shaping a true mental health care delivery system that is responsive to the needs of all Ontarians, that is accessible, that provides equitable access no matter where you live in Ontario, and one that is truly person-centred, person-directed and person-focused. The system as I envision it would be based on the principles of recovery. It would be holistic, client-centred, client-directed, allow for self-management of illness and address all of the social determinants of health across the lifespan from cradle to grave. It will be a system where the client has the knowledge necessary to make informed decisions, to retain responsibility for their own illness and recovery, and they will be able to individualize their own plan of care. Currently we do not have a system, but rather a collection of services and supports that are often fragmented, disjointed, and fail to work collaboratively to the benefit of all who require service. It's also important to work with the new Mental Health Commission of Canada to develop a made-in-Ontario strategy to address our unique and special needs regarding stigma reduction, system design and integration, funding and service equity, and the development of a mental health strategy that is integrated into the national strategy.

It's a very positive step that this committee was formed and that you will report back to the Legislature your findings and recommendations. I would urge you to consult and listen, and then act with both passion and conviction on what you have heard. Please don't think about simply formalizing or codifying what currently exists, but rather think how you can mobilize resources, provide visionary leadership and work with consumer-survivors to bring about transformational change to mental health care and treatment in Ontario. You have the opportunity to be a catalyst for profound change and I would encourage you to be bold, knowing that your actions will have an impact on mental health care for generations to come.

I believe that transformational change can and will occur if a strong foundation is built and four key cornerstones laid, on which the rest of the structure will be built. To me, the four cornerstones are: independent advocacy and rights protection services; inclusion of peer support and self-help; public education and stigma reduction; and lastly, addressing the social determinants of health from a recovery perspective. Let me address each of those four cornerstones in turn.

Independent advocacy and rights protection: Ontario needs to have strong and effective independent advocacy and rights protection service to protect the legal and civil rights of all individuals with mental illness, regardless of where they receive their care and treatment, hospital or community. A mental health rights advocate would be able to address individual case advocacy issues as well as work to address systemic issues across Ontario. The advocate would have provincial oversight and would be able to report regularly on the state of mental health in Ontario, identify gaps in services and work collaboratively with others to address these gaps. This is important, given that each local health integration network is going down their own path, and each is addressing mental health issues in a different way.

The mental health rights advocate would be a partisan advocate for their clients, empowering them to be involved in all decisions affecting their care and treatment, supporting them in gaining access to services that would facilitate and enable recovery, and working with them during transitions between levels of care, from hospital to community and community to hospital. This would allow continuity and seamless access to services while dealing with any inequities that might exist with respect to availability and utilization of services.

Many individuals with mental illness are vulnerable because of their life circumstances, the very nature of their illness and, at times, their inability to speak on their own behalf. The mental health rights advocate could give voice to these issues when necessary, and when the person is able to speak for themselves, they could support and strengthen that voice.

Advocacy done well improves outcomes, restores relationships and communication between clients and providers, and it allows them to be empowered during their recovery. Independent advocacy is essential as it

heightens transparency and accountability, allows the client to develop and refine new skills with respect to resolving issues and problems, and addresses inherent power imbalances between clients and professionals.

At the systems level, the mental health rights advocate could address issues related to barriers to inclusion, access to care and treatment, stigma, discrimination and human rights violations. However, to be successful, the roles, responsibilities and authority of the advocate would need to be enshrined in law, and ideally the advocate would be an officer of the Legislature, like the child advocate. Independence and authority would ensure the success of the role.

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Without legislation, the role could potentially be ineffective, as the advocate would only be able to make recommendations and rely on goodwill in order to resolve issues and facilitate change. The advocate requires authority to address issues, to make lasting changes and to hold people to account. Transformational change will only occur if the system is pushed beyond its comfort level, if it embraces change and a new perspective toward the people they serve, and if they understand that the system must become person-centred and holistic in its approach.

The second cornerstone, peer support and self-help: Transformational change will only occur when peer support workers and peer support specialists become equal partners in the mental health care system, when they are part of every team and every agency, and when their services become widely available to every consumer who wishes to have their support and benefit from their mentoring.

If we want to be bold and promote change, then we would demand that every agency, service or support that receives mental health funding be required to have peer support workers or peer support specialists on staff as equal members of the team. If they failed to meet this standard, their funding should be terminated. There will be those who will speak against the required inclusion of peer support workers, but there will be those who will embrace a can-do attitude and make it happen, to the benefit of all of those who seek services.

If we don't have enough peer support workers, then we can work with consumer-survivors and consumer-survivor organizations to train a workforce that is responsive to the needs of those to whom they will provide service. What a great employment opportunity for those who have progressed in their recovery and have the knowledge, expertise and life experience to share with clients, families, staff and health practitioners alike.

I also want to talk briefly about the importance of self-help and learning from others who have a shared experience. It is important that we not lose sight of the importance of self-help and how telling one's story can, in fact, promote recovery. Telling your story and sharing your pain and achievement with others allows you to develop inner strength and reclaim your life while increasing self-esteem, a sense of meaning and purpose, and self-

acceptance. Others can learn from these experiences, and it shows others that tomorrow can be better than today and that there is hope for the future. This is both empowering and liberating to those who have struggled along their road to recovery. Let's recognize the importance of self-help and provide the necessary funding to ignite a movement that allows people to help people.

The third cornerstone is public education and stigma reduction. The portrayal of mental illness in popular culture is often one that is negative, demeaning and dehumanizing. It has perpetuated the myths of mental illness and fostered a fear of the unknown. It is for this reason that the government of Ontario must immediately embark on a public education campaign to educate the public and professionals about mental health, mental illness and addictions. All too often, our system has focused on illness instead of wellness. We need to put the faces of mental illness before the people and to humanize it so that it is accepted as any other medical condition. Demystifying the illness and providing information will lead to the community being informed and knowledgeable, and hopefully acceptance will be the end result.

There's an urgent need for education for health practitioners and service providers because, unlike other areas of medicine, there is a legal framework against which all mental health care and treatment is provided. They need to know and understand mental health law to know how it impacts on care delivery and the rights and entitlements of individuals with mental illness. We cannot stop human rights abuses if service providers and the medical community don't fully understand the law and the rights of patients. I would encourage you to develop a system where such education is required and where broad-based public education campaigns are conducted regularly.

Information and discussion of mental health, mental illness and addictions should become a part of the curriculum at all levels of education, from elementary school to college and university. This will have a positive impact on societal attitudes toward mental health, mental illness and addiction.

Stigma reduction is key to making transformative change. We need to call it what it is: It is discrimination. As a society, we need to develop zero tolerance for those who discriminate against individuals with mental illness. We need to strengthen human rights legislation, adopt a mental health patient bill of rights and educate the community about the harmful consequences of discrimination and the impact on vulnerable people. We must engage consumer-survivors in providing the education and conducting the stigma-reduction campaigns. Only when people see themselves reflected in the faces of mental illness will they understand that "It could be me," and they would want to live in a community free of stigma and discrimination.

I would encourage you to require the involvement of consumer-survivors in all public education campaigns, in educating people about stigma and discrimination and in letting the community know that people can and do recover from mental illness. We must develop a positive

message about recovery and demystify the illness and the misconceptions that abound.

The fourth cornerstone is social determinants of health. In order to have an effective mental health strategy, we must address the social determinants of health, those economic and social conditions under which people live. We must deal with the lack of safe, affordable and decent housing. We must acknowledge that most people with disabilities in Ontario live in government-imposed poverty due to inadequate Ontario disability support plan benefits; that most individuals are either unemployed or underemployed; that most lack social, recreational, spiritual and educational opportunities; that most have experienced some form of stigma and discrimination; that many lack access to medical services; and that many don't believe that they live in communities that are accepting, understanding and inclusive. Most individuals want to have a sense of belonging, meaningful activities to engage in and to participate in the community to the extent that they are able and wish to. Citizen engagement and participation are key to recovery, as are having a home, a friend and a job.

We must provide greater supports to family units where a member of the family experiences mental illness and where it has an immediate impact on the family and the community at large.

If I had more time today, I would also address other issues that are having an impact on the mental health sector in Ontario, including: the lack of a full range of mental health services and supports in long-term-care facilities, in jails and in institutions for children's mental health; the criminalization of people with mental illness; the lack of mental health and drug treatment courts across Ontario; the disparity in services between rural and urban Ontario; the lack of mental health services in your first language; and the lack of knowledge about mental health law and patient rights. But I will leave these discussions for another time.

I believe that the four cornerstones I have identified this afternoon, if implemented, would create a solid foundation on which to build a true mental health system in Ontario. They would be a catalyst to transformative change and the creation of a person-centred mental health sector in Ontario. I would encourage you again to act boldly, to make tough decisions and to provide visionary leadership, as your work will have an impact on generations to come. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David, for your presentation. We've probably got time for one short question. France, you're up.

M^{me} France Gélinas: I really like your idea of a mental health rights advocate. I'm starting to read more and more, but it is the first time I've seen it articulated the way you have. Are there other groups that are also advocating for a mental health advocate?

Mr. David Simpson: There are, and I think you would hear within the consumer-survivor community that there need to be both professional and peer advocates in

the system to support people at all levels of their recovery.

When the province of Ontario ran the provincial psychiatric hospitals, patients at that time had access to the Ombudsman if they had a complaint about the quality of care or their treatment within that institution. However, when those facilities were divested to local hospitals, they lost that right of complaint. So that is one thing that has had an impact on the system. There are times when people need not an ombudsman or a patient representative but an advocate, somebody who's there just for them and to support them with their issues and to hopefully achieve a win-win outcome.

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M^{me} France Gélinas: I also like the report on the state of mental health in Ontario, which you saw. Do you know if other jurisdictions do this, where you have somebody who has to report on the state of mental health with the next jurisdiction?

Mr. David Simpson: Yes, I believe there are other jurisdictions in Canada that do that. Part of my thinking here too is that we have an opportunity with the new Mental Health Commission of Canada to work in partnership—this committee, the commission and the minister's advisory committee—to come up with a made-in-Ontario solution that in fact will protect the rights and entitlements of people with mental illness and be there to support them across the lifespan, that whole cradle-to-grave concept.

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

STEVE ELSON

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is the Schizophrenia Society of Ontario, London chapter. Steve, if you'd like to come forward. We do have a copy of your presentation. You've got 20 minutes to use any way you'd like. If you'd leave some time at the end, that would be great.

Mr. Steve Elson: I will. Good afternoon. My name is Steve Elson and I'd like to begin by thanking you for the opportunity to present my remarks today. I'll be speaking to three issues, but first I'd like to give you some personal background.

I'm a father of a son who lives with schizophrenia and has done so for nearly 15 years. Our son has been lost on the streets; in jail, charged and found guilty of an offence; he has been admitted to hospital and discharged without a diagnosis; and he has been totally psychotic and out of control while living at home, a danger to himself more than to others. Today that same person is happily married, has two children, friends, holds down a full-time job and is a productive member of society.

So, I'm here today knowing a bit about the good, the bad and the ugly from personal experience because I know that there is hope and that the right medication, together with the love and support of friends and family, an understanding pharmacist and psychiatrist, and a

meaningful purpose to life, as a package, can make all the difference in the world. My wife and I are also active members of the Schizophrenia Society of Ontario and have been for quite some time.

The three issues that I would like to highlight are as follows: mental illness as a chronic disease, family involvement in the treatment process, and separate but unequal access to services.

First, mental health as a chronic disease: For those of us who are involved with persons living with a mental illness throughout their life, this can translate into a 40- to 50-year commitment, given that most people with schizophrenia develop the disease in their late teens or early 20s. Let there be no doubt: We take a long-term view of this. As we sometimes say, "It's a marathon, not a sprint." Our loved ones can cycle in and out of illness; they can do well, but we are ever watchful and ever vigilant. In many cases, families are the primary support and social connection for their family member, especially if they live at home. This is a life-changing and a life-defining experience for everyone who is involved. Life can be richer because of it, but it certainly tests our capacity for compassion and understanding.

I say this because this is the context within which we live our lives. As a lifelong illness, some people will never be independent, while others will. Regardless of the progression or course it takes, it never goes away, as most do not fully recover to their pre-disease state. In terms of the health care system, we are always struck, sometimes laughably so, that it functions as if this is a disease or illness that can be fixed. Don't get me wrong; people do get better, but because a person leaves hospital or a service does not mean they have a place to live, money, skills, can function independently, manage money, stay clean, eat properly, get a job, have a social life or take their medication on a regular basis. The relative isolation of many health care providers from the reality of life beyond the walls of their organization, unit or facility, I think, allows this acute care, or fix-it, mentality to persevere, in spite of how it is contradicted by the life experience of families and others.

What needs to happen, in my view, is that the mental health system, especially for people with serious mental illness, needs to adopt a chronic disease model of treatment and support. It's a well-established model for chronic physical illness and conditions, but it's largely underdeveloped in mental health.

Family involvement in the treatment process: In spite of what I've already said about the impact of mental illness on families, families often feel like they're on the outside looking in on the treatment process. Last summer, I made a presentation to the Standing Committee on Social Policy that reviewed the PHIPA legislation, and I made the case that in provinces like British Columbia, there is a much more open approach to the involvement of family and friends, and information is more readily and consistently shared because they recognize the valuable contribution we make to the treatment process. Alas, such is not the case in Ontario. We know that we

live with the consequences of what the health care system does or does not do. We live and walk with our family members before, during and after any involvement they have with the health care system. By excluding families and friends—those who love and support the person with mental illness—not only does the system shortchange itself, but the ill person is shortchanged as well.

In large measure, with mental illness, the client or family should be redefined as being the entire family. We all live with it, directly or indirectly, and if this were acknowledged and acted on, it would fundamentally transform the mental health system as we know it today. Redefining the unit on which services are based would reframe the way in which services are provided, and it would open the door to a partnership and collaboration that we could only wish for today.

Separate and unequal access to services: My third and last point involves how the mental health system has evolved to be both separate and unequal. For example, community mental health services are chronically underfunded compared to community services for developmentally handicapped persons, and yet the client population has many of the same characteristics and challenges living day to day. It is a sad reality that the criminal justice system is developing programs and services that seem to be more responsive to the needs of people with a mental illness than the health care system—by default, really. It's hard to come to grips with the fact that criminalizing the mentally ill might actually open a doorway to services that they might otherwise not get.

The in-home personal care and support services available to people in Ontario through community care access centres are not available to people with mental illnesses, and yet somehow this systemic discrimination is allowed to continue.

With other cases, when people with a mental illness need access to specialized services, they don't get them. Just ask the police or family members what the hospital's emergency department is like when they bring their psychotic family member in for help. It's a sad reality that far too often, people who need help don't get it when they need it, and that somehow their own denial of their need for help, in spite of their psychosis or total lack of insight into their illness, can be used as just cause to deny them what they need. The right to be ill is a gross injustice to the ill person and their family, but it's one that gets played out every day in this province.

So what to do and where to begin to right this wrong, this social injustice? The first is to recognize and acknowledge the reality of the situation for what it is and not pretend that what we have today is in any way adequate. A chronic disease does not need to mean chronic pain and suffering, but for many, this is exactly what it means.

The second is to develop an approach to mental illness that actually works, building on the chronic disease model referenced earlier.

The third is to take mental health treatment seriously and provide incentives that will reward physicians, nurses and allied health care professionals to apply best practices and innovation to mental health services, in hospitals in particular, as they do in many other fields. It's a challenging field and it deserves the best of what society has to offer because we're talking about one of our most vulnerable groups of citizens.

I'd like to close by quoting from the 2006 Senate of Canada report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*:

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"Family members who provide care and support to relatives living with mental illness and addiction face a twofold challenge. First, they must suffer with their loved ones through their daily hardships and use their limited personal resources to try to alleviate them. Second, they must contend with a mental health system that often excludes them from involvement in the information-gathering and decision-making processes while simultaneously leaving them to serve as the fail-safe mechanism to provide unlimited, unpaid care, filling in the cracks that open when any part of the so-called system fails.

"Family members who provide care and support to relatives living with mental illness have their own unique perspective on the" health care system "and its reform. They have shown the committee that despite their frustration and fatigue, they will continue to search for assistance for their loved ones and to provide it themselves when they come up empty-handed. The committee acknowledges the contribution to this study made by these individuals. Their stories are valid; their voices must be heard; their recommendations must be acted upon."

Thanks for your time and attention.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Steve—a wonderful presentation.

You've left quite a lot of time for some questions. Let's start on the government side. Liz?

Mrs. Liz Sandals: I'm really interested in your comments—well, on our page 3—"It's a sad reality that far too often people who need help don't get it when they need it and ... somehow their own denial of their need for help" leads you there.

I know I've dealt with a number of families who have been very concerned about a son, a daughter, a brother or a sister who's schizophrenic and is off medication. They see the warning signs, but yet they can't reintroduce the relative, the loved one, to the system to get the help that they know they're going to need until they go into total crisis.

Do you have any comments on what we should do to change that culture that sort of pushes the caring family member away?

Mr. Steve Elson: Yes.

Mrs. Liz Sandals: Would you like to share?

Mr. Steve Elson: Certainly, thank you. I think there's an important reality, and it gets played out many times,

and that is that the person who is ill can, in fact, fake wellness and that they can be quite "un-ill" and quite dis-oriented and delusional in many ways, but they're not so out of touch with reality that they don't realize where they're going or what might happen to them.

There is a capacity for a person to interact with a health care professional and present themselves as if they are normal and to say, "There is nothing wrong with me. I am perfectly fine. It's my parents who are at fault. It's all made up in their minds," blah, blah, blah. If the person is talking to them perhaps for 10 or 15 minutes, they will present themselves in a very realistic way. They will respond very appropriately. There would, perhaps, be no obvious hint that the person is not well. But if the person was to sit down with them for an hour or perhaps go a day later into the family, there would be a very different picture that would play itself out.

Sometimes, that's exactly what happens: The situation is such that the way in which the person presents themselves in an emergency situation, where they're very uptight because it's a completely new environment to them, they're meeting strangers, they're very nervous, they think that something very bad is going to happen to them—they can present themselves in a way that, for the service provider or for the emergency physician or for the health care professional, is normal.

I think one of the key factors is, would we be able to take the information that family members or friends, who have a much more intimate and personal understanding of what has led to this situation, the action taking place in the present—for them to be interviewed and for their information and their reality and their understanding of the situation to be factored into the decision-making that the health care professionals are making.

As an example, when our son was taken and was presented for a consultation in what used to be the Clarke Institute of Psychiatry in Toronto, my wife and I were interviewed, as was our son, and it was the combination of the psychiatrist talking to us and accepting the reality of life as we presented it as parents, together with our son's behaviour, that led to the recommendation to have him admitted. But I think far too often that does not happen.

Mrs. Liz Sandals: That information is protected. Thank you.

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

Ms. Sylvia Jones: I'm really pleased that you came this afternoon, because after access to care, how to engage families in the process is the number two issue that I deal with. I'd like you to continue on that same vein of what we can be encouraging, what we can be recommending to ensure the patient has their rights maintained, and yet still allow those individuals who want to be that circle of support to be engaged.

Mr. Steve Elson: Sure. Thank you. I don't know if you're familiar with the concept of the circle of care, but it's one that is used to basically describe and give access to information to people who are involved in the treatment process of an ill person. For the most part, health

care professionals who are actively engaged in treating a person are considered part of the circle of care; families generally are not, unless the family member is legally defined as a substitute decision-maker or has a legal status with respect to having access to information. So I think one of the things that would be very helpful would be to make it possible for family members in general, particularly if the ill person is living with the family and is obviously actively engaged with the family, to be considered part of the circle of care without having to assume a legal status in order to gain access to information.

There's obviously a delicate balance between the right to privacy and the right to information. What we find is that, as I referenced again in the BC situation, there's an opportunity where in legislation, family members and friends who are involved with the ill person have access to information where it's clearly going to make a positive impact on the continuity of care. They are recognized as part of providing care. Now, we're not professionals, but the acknowledgement is that we are part of the system; we're part of a team of individuals who in fact have this person's needs and interests at heart. So formalizing and recognizing that role for family members, I think, would be a significant step forward.

The Chair (Mr. Kevin Daniel Flynn): Thank you again, Steve. France?

M^{me} France Gélinas: I guess I knew this, but it never dawned on me until I heard you say it that in-home personal care and support services will be denied to you if you have a diagnosis of mental illness. So if you have a hygiene issue and you need somebody to help you bathe or if you have ADL, activities of daily living, that you would need an occupational therapist to come to you for, if you have a diagnosis of schizophrenia, by example, you won't be allowed CCAC services, community care access centre services?

Mr. Steve Elson: That's correct.

M^{me} France Gélinas: It's as blunt as this? Because you have a diagnosis, you're excluded?

Mr. Steve Elson: That's correct. The community care access centres don't like it, but when they're asked that question, they are told—I suspect it's probably not a legislative requirement but a policy situation at the present time that they are denied from providing service to that population. You're quite correct.

M^{me} France Gélinas: Through your knowledge of and involvement with the Schizophrenia Society, had there ever been a CCAC with a bigger heart someplace that actually saw the light of day and helped those people?

Mr. Steve Elson: I suspect, like in any system, people find workarounds; they find ways. "Is there some other diagnosis or some other presenting problem that will give us an excuse to come and provide you with service that you might not otherwise get?" But it's kind of under the table or not explicit. It's a very troubling situation.

The expectation is that in fact there are alternate community services available to people with mental

illness elsewhere in the community, and that's simply not true.

M^{me} France Gélinas: All right. Thank you.

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

Ms. Sylvia Jones: Chair, can I impose on our researcher to get a little more detail on the BC example and how they actually do that?

The Chair (Mr. Kevin Daniel Flynn): Absolutely.
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RICHARD CSIERNIK

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is a professor from the School of Social Work, Rick Csiernik. Rick, if you'd come forward. Make yourself as comfortable as you like.

You've been here for the other presentations, so you know everybody's got 20 minutes. It's yours to use as you see fit.

Dr. Richard Csiernik: Thank you very much. I appreciate the time and the opportunity. My first internship as a social worker was as a constituency assistant for an MPP in Hamilton East, so I appreciate the enormity of your task at hand.

Just some context: I've worked in the addiction field for 20 years, including a 10-year, million-dollar-funded project looking at the issues of homelessness, mental health and addictions. I've been teaching addiction since 1987 and was one of the co-founders of the addiction studies program at McMaster University, which has trained more addiction professionals in the country than any other program.

Interjection.

Dr. Richard Csiernik: Sure, we can. I'll make sure I try to squeeze my 20 minutes in well for you.

The Chair (Mr. Kevin Daniel Flynn): Also, Rick, you'll find that the mics don't work very well if you're close to them and they don't work if you're far away, so you've got to be about a foot away.

Dr. Richard Csiernik: About a foot away: Thank you for that. I'm used to teaching walking around, so this thing—

The Chair (Mr. Kevin Daniel Flynn): We'll have to nail your feet to the floor for the presentation.

Dr. Richard Csiernik: Anyway, the opening dialogue was just how important and educated I am; that's all that was about.

I've read some of the presentations that you've received already online. I've sat and listened to some of the presentations on this afternoon, and much of what I have to say follows them, but there are two critical points I want to share with you that I share with all my students. They're greater than the sort of incremental issues that you'll deal with on a day-to-day basis, and they're of the more large structural issues. One is how we conceptualize the idea of addiction and mental health. This basic conceptualization hinders the way treatment is provided

in the province, how treatment systems are developed and how you create policy. The other reality that you're well aware of is that you simply do not have the budget to do the type of programming you need to do. One of the greatest issues we have is that there are at least 10 different ministries at the government level that somehow touch addiction and mental health, and they don't work together. The project that we've worked on in the last 10 years in the London area has been working on trying to break down some of those silos.

So again, my presentation's there. I've written a hundred journal articles; there are books. Your researchers can find me everywhere on the Internet if they need to, but what I want to share with you—

Interjection.

Dr. Richard Csiernik: Surely.

Interjection: If you'd just take a breath between sentences, that's all that's needed.

Dr. Richard Csiernik: It's one long sentence.

Addiction and mental health have three constituency components: a biological component, a psychological component and a social component. The training we do in this province is very good at dealing with the biological. We have wonderful medicines and we have wonderful detox centres for people in withdrawal. Counselling programs have grown tremendously in the 20 years I've been an educator. We are good at providing psychological counselling—not perfect. We have more insights; we have more programs.

The difficulty that my students encounter when they hit the field, the difficulty as researchers, is the coming together of the three elements: the bio, the psycho and the social. The most difficult one—and the one other presenters have spoken to you about—are issues such as poverty, issues of inadequate income and issues of inadequate housing. We did a wonderful study here in London that said that people would love to have treatment, but they'd rather have something to eat first; they'd rather have somewhere to sleep first. So you can get them to my students and they can counsel them, they can help them through detox, but you put them back on to the street, you put them back in an untenable situation and you undermine all the money you put into programming. The social context that we speak of in schools of social work are the wider structural issues that need to be put in place, or you're really wasting money.

And it's the same thing when you have competing ministries. Again, from housing to aboriginal affairs to seniors to health, obviously, to correctional services—they all have some connection to this field. Your goal, when you go back, is to have these ministries co-operate on this topic.

A huge project we developed at the University of Western Ontario was this intercollaborative, interdisciplinary work. We're literally putting down the doctors with the psychologists, the social workers and the OTs to talk together about patient-client care. This is my challenge for you: When you go back to the committee room,

back to the panel, how can you get these various ministries working together on this theme?

The rest is very straightforward. Everything that is on the forms comes from my own research and my own data, so it's empirically supported. Key, obviously, will be the continuum of care. You have this nice, beautiful blue diagram in front of you; a prototypical model. The largest issue, of course, is that this is a very standard model on continuum of care, what's necessary. There are very few communities in our province that have that. I live in Hamilton, I work in London; half a million people, 400,000 people, we don't have this continuum of care in our community. There are gaps. So as people come forward saying that we have consumer-survivors to support, we have family members to support, the professional services from community to community have been cut back. Again, there is not enough funding, but what can be done to coordinate what there is and to maximize what there is is the challenge that I put upon you as our elected officials.

Page 4 of the presentation just speaks to some contemporary issues that are necessary. Harm reduction, obviously, is a new part of our treatment of care since I joined the field 20 years ago. Controversy in prevention is always quite ironic. The initiative we speak to here: harm reduction initiatives like methadone treatment, needle exchanges and safe injection sites remain very controversial as prevention initiatives—quite unique in the field of helping, where prevention is seen as controversial or stigmatizing.

In mental health services, we have some excellent case management programming. When you move to the addiction field, that same type of service doesn't exist. Case management is probably the biggest deficit in the addiction dilemma. I come from a day when the Addiction Research Foundation and the Clarke Institute were different institutions. I lived through that amalgamation. They are related—obviously you've heard that—and yet they're integrated.

There's nothing functional about mental health. Often when people begin using psychoactive drugs, there's something functional about that; it serves a purpose. It's a negative, destructive purpose in the long run, but there's some functionality to it. Obviously, the issues of trauma are something we've come to realize. Trauma services are grossly neglected in the development of addiction services in this province. They emerged in the 1970s. The issue of trauma is a relatively new one. So they've not been integrated because of the different developmental cycles. So that's there, documented for you. Obviously, issues of diversity are great. We've heard different populations that we need to support and care.

The last thing I want to leave you with is the poor staff people who are working there. They come to me, they've spent four years in education with me and I teach them about 40% of what they need to be an addiction worker, to be a mental health worker, and then they go into the field and they learn very, very quickly. We're currently

doing a study of the trauma of counsellors in the field that actually should scare you. What they need is ongoing, continued support. It's so easy to put clients first, and for the counsellors, the social workers, the psychiatrists, the psychologists, the nurses in the field, there is a huge rate of rustout and burnout in this field. So, as you're considering the needs of clients, I'd also ask you to consider the needs of those supplying support, be they family members, be they consumer-survivors, but also professionals, and to ensure that they receive consideration for the type of work they give.

Those are the highlights. I'd be happy to answer any questions you have.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Rick. Thanks for your presentation. We're starting this time around with Sylvia.

Ms. Sylvia Jones: Actually, I don't have a question.

The Chair (Mr. Kevin Daniel Flynn): Okay, wonderful. Thanks, France?

M^{me} France Gélinas: I have a million. I didn't think I was going to go first.

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

M^{me} France Gélinas: The first model you presented to us, the biological, psychological and social aspect, you call it "a phenomenon," I like it; it's very visual, and it's easy to understand. But did I hear you properly when you said that treatment is all for nothing if you don't have a roof and food?

Dr. Richard Csiernik: We did a study examining what stopped people from going to treatment, and it was very interesting. We did focus groups; we did interviews with 300 individuals who are homeless. Their concern was not with their addiction, their concern was not with their mental health; their concern was where they were going to eat today and where they were going to sleep today. A funny little example is that people chose a shelter by how good the meals were; they really didn't care where they were staying. They needed to eat and were hungry. Those core human needs need to be met before we can move to higher-order needs, which include taking care of your mental health and your addiction issue. So that's that core element. It's very Maslovian. It's nothing phenomenally new; it's just now proven with a study saying, "My basic needs need to be met before I can think of dealing with a mental health issue, before I can think about dealing with my addiction issue."

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M^{me} France Gélinas: Which is something we've started to hear more and more. When we hear about recovery, we hear lots about needing a home, needing a job, needing a friend.

Dr. Richard Csiernik: Yes. It's a basic issue of poverty. It also speaks to the need of the continuum of care in terms of having both residential programming as well as outpatient programming. I realize there's a huge cost differential. The issue about residential programming, though, is that it's actually cheaper than outpatient counselling when outpatient counselling doesn't work.

M^{me} France Gélinas: Then I go to your nice blue chart. I love the title: "Prevention and Health Promotion." I have asked a lot of presenters to give me a good example of primary promotion that works. Most of them go straight to early intervention, but are there—not early intervention, but strictly health promotion—disease prevention initiatives that are proven to be effective in the field of mental illness and addiction?

Dr. Richard Csiernik: I have a whole chapter for you—absolutely. You need some sort of strength in your life, and we've heard about family. Family strength is critical; success in education is critical; friendship relationships and social relationships are critical. You can have any one of those three and they can overcome deficits that you have.

There needs to be some sort of substantive success. We've just finished looking at a study of the role of culture and cultural norms, family norms, friendship norms, education norms—if there can be some sort of stabilization. The reason it's a bio-psycho-social model is that each individual will be strengthened by different elements. Why we talk about the continuum of care is that one program won't meet the needs of a group of children. You could have two young people, side by side—same family, same neighbourhood—and the one program will connect and the other will not. This is the whole notion of continued education, from kindergarten through to high school. We haven't talked about the workplace; in fact, once you hit the workplace, that is gone—so integrated ideas, of course, that build upon the various strength areas and address deficits. Again, I'd be happy to send you the chapter on that; it's well referenced with 300 resources.

One-off programs don't work. Someone coming into a classroom environment, saying, "Hi, I'm a recovering addict," for half an hour doesn't work. It needs to be integrated into the ongoing curriculum, which is why the Ministry of Education, of course, is a critical component of the administrative work.

M^{me} France Gélinas: Can you give us a reference by heart as to this chapter on health promotion—

Dr. Richard Csiernik: I will send it by e-mail to whoever would like it.

M^{me} France Gélinas: Okay. To our head of research.

Dr. Richard Csiernik: Absolutely.

M^{me} France Gélinas: That will work.

It just escaped me—it's something you just said. You were talking about it having to be ongoing—

Dr. Richard Csiernik: Ongoing and integrated.

M^{me} France Gélinas: —and a lot of it has to do with the Ministry of Education.

Dr. Richard Csiernik: Absolutely. I've worked with a variety of community groups who want to make presentations to school boards; the school boards have their own. There's so much information out there, where best practices exist, but we don't know what the best practices are. Again, I'd be happy to share that with you.

M^{me} France Gélinas: Okay. My last question is, is there any good work that you know about that focuses on stigma?

Dr. Richard Csiernik: Oh, huge good work. Most community services do it when they put in a treatment facility and a mental health program. They go around and talk to the neighbourhood and introduce them to real people. The second you personalize an addiction or mental health issue it becomes real. Again, I teach at McMaster, where a third of my students are in recovery, and I'd let them babysit my kids.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Rick. The next is Helena.

Ms. Helena Jaczek: I'm looking at your practice model: "Addiction is a Bio-Psycho-Social Phenomenon." Now, obviously many teens experiment with drugs, potentially addictive. Kerry was kind enough to elaborate from some of her experience that some of those teens no doubt are perhaps dealing with symptoms that are very uncomfortable, the schizophrenic potential precursors, whatever. Then, of course, there's this whole entangled mental health/addiction piece. But my real question is, on your psychological causes, would you say that there are some particular personality characteristics underlying a kind of—I don't even want to call them symptoms, but some sort of particular risk factors that lead some individuals to have a very major problem with addiction, as opposed to those who are able to kind of walk away?

Dr. Richard Csiernik: Absolutely. That's a brilliant question. It's the ongoing issue: Is there an addictive personality? That's a term we want to hear. The original thought was, yes, there is. The problem empirically is that when you have this set of characteristics, more people who have those characteristics do not have an addiction than do. So, yes, there is a grouping. What we're discovering is, the key element is some sort of trauma. It can be early childhood, adolescence—trauma can occur at any time. Trauma can occur as a senior. But there's some huge disruption. The correlations between sexual and physical abuse and substance use are beyond 50%, and thus my comment here about trauma counselling, which is not integrated presently into addiction services; they're distinct. We just finished a doctoral study at Western. A nurse spoke about the fact that she went to agencies and they said, "Yes, we know this is necessary for women particularly, but we don't have the funding for it; we don't have the time for it." So again, it's not that we don't know this; it's that the way the systems have evolved has not allowed for it.

So your answer is, yes, there are. There are certain traits and characteristics that are associated with them. Most are connected to trauma. We know trauma changes brain chemistry, so again, there's your bio-psycho-social connectedness when they come together.

Can we do some prediction? We can. If you tell me you were sexually assaulted at the age of 12, I'd say, "We'll put you in a prevention program, full bore, right now, because you have an 80% chance of developing an addiction issue." It may not be full-blown, but again, it

can impair your life so it doesn't come in the full richness it could.

Ms. Helena Jaczek: If I could just follow up on that, because again, like France, I'm always trying to think of the health promotion. The population-based strategies that you might use on a teen population: Are there any sorts of messages that could be used to kind of—obviously, on the trauma side those are dramatic situations. Is there any utility in trying to warn in some way?

Dr. Richard Csiernik: The best health promotion programs involve families with children. The greatest difficulty is finding a place for families to come in with their children. School-based initiatives—families with the most chaos in their lives are often the ones least engaged with their children. Those are the ones that are more susceptible. Again, I'm stereotyping, because as you well know, any family can be impacted by addiction.

You're asking how to maximize your health promotion dollars. Engage long-term, school-based, family-involved programs. I don't think you'll find anyone who's going to argue with me the fact that kids and families should be supported by the government.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Helena, and thank you very much for coming, Rick. It really is appreciated.

Dr. Richard Csiernik: My apologies to the audience for speaking too quickly. Thank you for your time.

The Chair (Mr. Kevin Daniel Flynn): It's your enthusiasm coming out, I think.

Dr. Richard Csiernik: Again, this is very important work. I want to thank you for volunteering for this committee. Those of us in the field appreciate it very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Copies of your work are available on the table, I would assume?

Dr. Richard Csiernik: There are some copies there, and if I have a card, I will e-mail that to you this evening.

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

THAMES VALLEY DISTRICT SCHOOL BOARD MENTAL HEALTH AND WELLNESS COMMITTEE

The Chair (Mr. Kevin Daniel Flynn): If I can ask, then, the Thames Valley District School Board Mental Health and Wellness Committee to come forward. Cathy Johnston is the co-chair. We've also got Tracy Grant and Deb Reitzel-Jaffe. Make yourselves comfortable. You may not have been here when I announced that we have some ASL interpreters with us this afternoon, so if you could assist them by being very precise in your language and perhaps slow your pace down a little bit, that would certainly be appreciated by everybody.

Just like everybody else, having told you to slow down, I'm also telling you you've got 20 minutes, so we've got competing interests. If you could save a little bit of time at the end for any questions perhaps, that would be helpful as well. Thank you.

Ms. Cathy Johnston: Thank you very much for the opportunity to speak to your panel on behalf of the men-

tal health and wellness committee of the Thames Valley District School Board. Our committee is a diverse group of Thames Valley employees and community partners—

The Chair (Mr. Kevin Daniel Flynn): I'm sorry. I have one more rule. It's not my rule; it's Hansard's rule. They won't be able to tell who is who, so before you speak for the first time, if you would identify yourself.

Ms. Cathy Johnston: I am Cathy Johnston, the co-chair of the committee.

Our membership includes the superintendent of special education, a number of principals, several trustees, psychologists, learning coordinators, a representative from the Ministry of Children and Youth Services, and a representative from the Canadian Mental Health Association, and also from family and children's services of Elgin.

Our vision has not yet been clearly defined, but our committee focus has been twofold: (1) capacity building to improve mental wellness for our students and (2) attitudinal awareness and change.

Our committee representatives today, just a few of the members of the committee: Deb Reitzel-Jaffe to my right, a psychologist with the board; and Tracy Grant to my left, a trustee with the board. Again, I am Cathy Johnston, and I'm an elementary principal.

I'll now turn it over to Deb to make her presentation.

1530

Ms. Deb Reitzel-Jaffe: Thank you again for giving us an opportunity to meet with you today.

Just to shine a light on the importance of your meetings today, I'm a little later than planned in getting here because, as often happens in my week, I was called out to do a suicide-risk assessment on a grade 8 student at one of my schools, and it really underscores, I think, some of the themes that we are going to talk to you about today.

We did divide the three things that we want to focus on; we'll each focus on one of those three issues. I'm going to talk about the emphasis that we feel needs to be there on prevention and early intervention, and I was glad to hear some of that coming from our previous speaker as well, because I think it's so important. There is such clear research, literature, on the efficacy and the cost-efficiency of really putting your focus on primary prevention and early intervention.

Before I worked for the school board, I did train as a clinical psychologist. I worked at one of our hospitals in child and adolescent psychiatry. When I took the job at the school board, my colleagues were all so excited for me, and I was very naively excited as well, about all the work I would be doing in prevention and early intervention, because we were at the other end, only seeing kids who were quite severely along the way in terms of their mental illness. It has been quite disheartening—not that I don't enjoy the job; I quite do—in terms of the lack of opportunity to do that preventive and early intervention work, and it really is a shame. I find myself running from crisis to crisis, as I was doing today, rather than being able to get to do some of that early inter-

vention and prevention work. I'm looking for any assistance that we can get in terms of having the resources available so that we can do some of that work.

I think that there are a number of barriers to doing the prevention and early intervention work, and I'll highlight just a few of those. Sometimes it's a lack of awareness among school staff about early indicators of mental health issues. Sometimes minor issues might go unnoticed, especially with internalizing types of disorders. With externalizing disorders, sometimes those early symptoms, those early issues, are misinterpreted as discipline problems, and that's the way they're dealt with. So I think—

Interjection.

Ms. Deb Reitzel-Jaffe: Slow down? Sorry. I was going to say in the beginning that those things you asked us to do, none of those are my strengths—speaking slowly and clearly. I will slow down.

I think sometimes, just in terms of the training, the breadth of training, the amount of training that needs to happen to help staff to be able to recognize what those early warning symptoms of a possible mental illness are so we can catch it early, that's a problem.

I think even when they are aware—and we do have some excellent staff in Thames Valley school board; some of them are very aware. There's a real problem with a lack of mental health staff—primarily, that would be psychologists and social workers in our board—in the school system. Because there's not enough of us, what happens is that they only call me if they've got a kid totally off the rails, and they're just going to manage all the rest themselves, because they know I don't have time to deal with the more minor ones who are not a big problem for them yet. They're managing them. The problem is that they're not getting assistance or help, so they're worsening, and then when they are right over the edge and they can't stay in school or they're a danger to themselves or others, then I get called, like I did today.

The boy I met with today has been having problems since the end of last year with bullying, feeling left out, feeling lonely and feeling ostracized. I met with his mother after I did the risk assessment today. She was a very fragile, extremely anorexic and wasted-looking woman. The parents are separated.

Interjection.

Ms. Deb Reitzel-Jaffe: Slower yet?

The father is not working at all. The mother works a little bit. So look at all the risk factors we have. But when am I involved? When he threatens to kill himself. That's just the reality of not enough resources for us to be doing more of the early intervention, the prevention kind of work.

In terms of the lack of mental health staff, we miss the kids with more minor symptoms. That's one of the problems of doing that. We also miss the kids with internalizing symptoms. If you have a child that's very anxious and withdrawing, they're not very disruptive to the classroom. I don't mean this in a pejorative way of our teaching staff, but it does mean that they can cope with

them better than they can with the child who has got more of an externalizing type of a disorder, because they can't teach anybody in the class then and they are on the phone to me asking me to do something. First, the child that's more of an internalizer might miss a lot of school and might eventually even drop out of school, but you can still teach the rest of the kids, so they're probably less likely to get services. It also means we don't catch those internalizers early.

Often, when I see a child who has got anxiety issues, who's school-phobic, they might have been out of school for a couple of months before they called me in. Well, it's really hard to get a child back to school who has been out a couple of months. If I see them after two days of missing school, I can probably be much more successful getting them back in, but again, they know how busy I am, so they're not calling me. I'm not even faulting them; I'm just saying that there's a problem, I think, with the resources.

Another barrier has been a lack of mental health resources in the community. I think that there are some great models out there. I forget who the author is of the two inverted triangles—one stands this way and one's inverted—where it shows the community really spending all their time and their energy and their resources with the most ill children in the population, and less and less resources and primary prevention, as you go down, for the ones who are not as acutely ill. The school, in dealing with mental health with kids, would be the flip of that: We are spending most of our time on primary prevention and intervention, and those things fit nicely together.

One of the problems is the fact that we find a lot of the kids are not able to access the resources they need in a community. The boy I saw today is an Elgin county student. There's only one free service available for him in Elgin county. Our understanding is that the wait list is now four to six months. Because I determined that he's not going to harm himself today, he's probably going to just go on that wait list, and it will be four to six months, and there's nothing else for him. His parents do not have money to go privately for him, so he's going to probably go without service for four to six months, and his problems will escalate. So the lack of mental health resources in the community is also a significant barrier.

I'm just going to highlight one more, because I'm going over my five minutes. Another barrier is often the stigma of mental health, and that makes it really, really difficult for us. Even when the school picks up on some of those early warning signs, because of the stigma of mental health, it makes it difficult for us to encourage the parents to go to a community mental health provider. It's hard sometimes for them to follow through on that, as well as what I talked about before in terms of a lack of resources. If you don't have a car and your mental health service provider is quite far from your home, or if you live in Port Stanley and you have to go to Edgeware in St. Thomas, unless you have a parent who can drive you there, you're not going to get the service. I'm going to let Tracy speak more on that.

I think there are a lot of costs to missing opportunities for primary prevention and early intervention. The child with mental health issues tends to be very ill before getting help, which often results in a worse prognosis for the child's mental health. It results in significant social isolation for that child and a lot of loss of school instruction opportunities.

The situation is extremely stressful for parents, for the teachers and for other kids in the classroom. It happens quite often. We have parents calling in about a child in the classroom that has been aggressive and has hurt kids, and they want the kids out.

Interjection.

Ms. Deb Reitzel-Jaffe: Still too fast? Wow. This is my slowest.

Interjection.

Ms. Deb Reitzel-Jaffe: I trained with a colleague who also was deaf, and we used to have joint supervision. She could lip-read if it was just the two of us, but it drove her crazy because she said that I spoke so fast, that it was making her eyes really sore. So it's a chronic problem with me. I apologize.

I think the lack of prevention and early intervention services creates an increase for the need for more intensive services in our community, like day treatment and residential treatment. I think if we could be doing more primary prevention and more early intervention, hopefully we wouldn't have as many kids needing those residential and day treatment services. I think it's absolutely a much more ethical way, rather than sort of saying, "Until they're suicidal, I won't be seeing them." I'd love to see them early, before they're in such significant distress. How hard is that for kids? It's an awful thing to put them through.

1540

The final thing I'll mention in terms of the costs of not catching things early is just—when the mental health needs of a child are severe and under-resourced, it stretches the ability of teachers to meet the many other learning and behaviour needs of the kids in the classroom. The classroom is a really complex place these days. There are numerous kids in every class on an individual education plan, with everything from learning disabilities to physical needs to behaviour issues, which often include a mental health issue. If you have a child with a severe mental health issue in the class and it's under-resourced in terms of getting the supports they need, the availability of that teacher to manage all the other students and their needs is just so compromised.

In summary for my portion, I'm saying that we propose that the allocation of resources to school-based primary prevention and early intervention initiatives will result in fewer young people experiencing severe mental health issues, which makes this both a very effective as well as an ethical means by which to address students' mental health needs. A focus on broad-based mental health and wellness initiatives will benefit all the students in the school system, and the ripple effects of that will

extend to school staff, their families and, I think, the community at large.

I'm going to turn things over now to Cathy.

Ms. Cathy Johnston: Thank you.

I have agreed to speak to you today about the need to build teacher capacity, and I apologize for reading, but I wanted to make sure that I said everything that I needed to say in my time allotment.

I'm going to start on a bit of a personal note. As an administrator and as a teacher, I have experienced considerable struggles meeting the needs of children with significant mental health challenges. I've watched as parents have attempted to manage crisis after crisis and attempted to navigate limited or geographically inaccessible mental health resources. I've watched parents of children with mental health challenges struggle to keep their jobs as the school calls again and again to ask them to come and take their children home. I have watched as teachers experience incredible stress and anxiety in their efforts to address the behavioural needs of these children, often at the expense of learning.

As a parent, I have experienced having my own 10-year-old son become diagnosed with an anxiety disorder. Over the past year, my child's school has called me on numerous occasions to inform me that he is in the office, unable to go to class because he's experiencing thoughts of self-harm. Often, the trigger is his perception that a teacher has yelled at him or does not like him. We have sought private testing. We have visited the clinics of CPRI, after months of waiting, and the child and adolescent mental health care centre at the London Health Sciences Centre. We have spent hours in the emergency department of Children's Hospital, first for suicidal ideation and most recently for an episode of self-harm. We have stretched our schedules and personally paid for transportation to manage the shuttle of our son to and from a day treatment program. My husband and I struggle to balance the demands of our schedules with the needs of our child. We worry about our son's increasing daily medication dosage, and we struggle with helping him through the unfortunate side effects. Whenever I see the dark clouds pass over my child's face, I fear what may be yet to come.

I have the advantage of considerable knowledge about the education system as a principal and knowledge of community supports, and yet we continue to experience frustration in our attempts to address our own child's needs. I cannot begin to imagine the challenges facing parents who do not understand the school system or who lack the awareness of community resources and supports.

Educators touch hundreds of lives every day. Educators have the potential to change attitudes and perceptions of mental illness through their actions and beliefs and through their instructions. Educators have the potential to reduce discrimination and intolerance. Educators have the potential to prevent attitudes that may lead to continued stigma. An educator's reaction to the externalizing and/or internalizing behaviours of a child can have tremendous lasting impact.

The Ministry of Education has made improvements within the last few years with respect to new teacher preparedness. The new teacher induction program is a remarkable step forward to better prepare new teachers for student needs. Recently, mandatory special-education professional development days for all teachers offer the hope that the issues of mental health may be addressed under the umbrella of special education.

The TVDSB Mental Health and Wellness Committee firmly believes that all teachers are in need of additional information and training about effective practices towards prevention and early intervention. Our committee would like to see additional efforts from the Ministry of Education to ensure that all teachers receive further training and education in the areas of prevention and intervention. Training must be offered in our teachers' colleges, and further professional development needs to be implemented within our school systems. Our committee strongly believes in the value of preventive programs such as BMS training or the CASEL social/emotional learning program in preparing educators to effectively support students.

Teacher coaching and collaboration is beginning on a more formal basis and has tremendous capacity for changing practice and perceptions. We encourage you to work together with the Ministry of Education and the Ministry of Children and Youth Services to ensure that best practices are established and followed.

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

Ms. Tracy Grant: How much time will I have?

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

Ms. Tracy Grant: Okay—slash and burn.

The Chair (Mr. Kevin Daniel Flynn): To be fair, if you think you have more than three minutes, why don't you just take the time that it needs and ensure that everybody in the room is able to understand it.

Ms. Tracy Grant: Thank you very much. I timed it at five minutes and 20 seconds, so I felt that I would speak faster than I would like to.

The Chair (Mr. Kevin Daniel Flynn): We're getting almost ready to leave town, so I'm sure we've got five or 10 minutes that we can add on to the end of our day.

Ms. Tracy Grant: Thank you very much. I'm Tracy Grant. I'm pleased to speak to the issue of school as a hub for services and assessments for children attending school.

The school-as-hub model has been suggested in many government documents. In order to better serve children in our communities, there is a huge agreement with the view that earlier diagnosis and treatment is beneficial to our vulnerable children and youth. In fact, there are several studies showing that for many disorders, later diagnosis or an inappropriate placement or treatment plan can exacerbate their condition and lead to co-occurring conditions.

While school personnel are trained to recognize the signs of a learning disability and react to externalizing behaviours which can seriously impact the safety and

learning of their whole class, there are many conditions which do not respond to traditional behavioural interventions. Therefore, the traditional response to behaviour which might be beyond a child's control is often progressive discipline. Clearly, this leads to a vicious cycle impacting the child's self-esteem and ability to function normally. Even positive reinforcement in disregulated individuals sets up a negative spiral, as they are unable to achieve the reward they desire. Further, mental health issues characterized by internalizing behaviours are often minimized or completely unrecognized.

My background as a parent, foster parent, adoptive mom, service provider, school volunteer, and trustee on SEAC, as well as our mental health and wellness committee, has made me acutely aware of the difficulties faced by children and families in accessing appropriate services in the many communities encompassed in our board area.

Recently, our board approved a permanent line to address mental health for students. I would like to highlight two partnerships in our board which have benefited many children and youth and which, if expanded and more widely available, could improve the emotional wellness and access to treatment services for children in their community. We believe that this approach to mental wellness would decrease stigma, improve service, decrease wasted wait and misdirection time, and ultimately be more cost-effective.

The first model is the wellness centre at the West Elgin Secondary School. We previously shared the paper written by Dr. Varpalotai—

Interjection.

Ms. Tracy Grant: Wellness centre.

The Chair (Mr. Kevin Daniel Flynn): I'm starting to learn something here, I think. As people speak, their speed picks up, I've noticed, so if you could just keep that in mind. You're doing great.

Ms. Tracy Grant: We previously shared the paper written by Dr. Varpalotai on this collaboration, but I would like to share some specific information on its creation, maintenance, and services available. This is a partnership between the high school, the West Elgin Community Health Centre and the Elgin-St. Thomas health unit. The parent council was also involved in the planning and is represented on the ongoing wellness committee. The committee provides lunch-hour information sessions and has offered wellness fairs at the school. These activities promote the services of the centre and encourage healthy lifestyles.

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Many services are offered in private offices provided by the school, such as individual and group counselling, anger management groups and healthy living support, as well as a variety of health services through a nurse practitioner. The single-point access to local services allows students to seek help for many concerns in a confidential but coordinated way. The social worker reports working with up to 50 students a year individually and in groups, offering 18 sessions weekly, while

the nurse practitioner and dietitian see up to 20 students per week. In addition, the Oxford-Elgin Child and Youth Centre ran a group this year called SOS for youth who self-mutilate at West Elgin Secondary School. The wellness centre also ran a relaxation noon-hour drop-in program monthly, and had 40 to 50 students participate each month, all in a school of 515 students.

The students self-refer to the wellness centre services, and can be directly referred to outside practitioners as needed. This rural community has suffered a lot of tragedy in the past few years, and the services of the wellness centre help youth at the school be ready to learn and cope with a variety of health and mental health conditions. While this exact model might not be possible or practical in all situations, it certainly improves access to services for students of the rural west Elgin community and is worthy of consideration when attempting this kind of coordinated service in a school setting.

Of probably greater concern to our committee, though, is earlier intervention and provision of appropriate supports, which we believe would be well-placed in schools to avoid disruption for the students and decrease stigma in the community. This could be accomplished in an itinerant way for smaller schools or by having centres of service in larger schools or in high-risk areas.

We have enjoyed a partnership with the London Learning Clinic, which had medical staff on site at Lorne Avenue Public School in London to diagnose and treat conditions such as ADHD, ADD and anxiety disorders, which impair a student's ability to function in class. Their report of activity for the 2007 school year identifies the numbers of students served by a single physician in a one-year period. This partnership ends at the end of June because of issues with sustainable funding. The clinic was initially served by seven physicians, and in spite of overwhelming need, the physician who remained was unable to bill for much of the time required to provide the service and was unable to recruit assistance or a replacement under those conditions. Again, in this partnership, our board provided the site at the school and in the past year helped with funding as well.

Additionally, the Southwest Ontario Aboriginal Health Access Centre has been attempting to bring a fetal alcohol spectrum disorder diagnostic clinic to the area in order to better identify that neurodevelopmental disorder. FASD affects at least 1% of the general population, and secondary mental health conditions occur in over 90% of affected individuals. It is extremely difficult to access assessment and service locally. The board has recently facilitated a cross-sector networking group for FASD, but provincial support and direction is urgently needed to catch up with supports and services available in other jurisdictions.

If improved health and mental health screening and assessments were available on-site, earlier identification and provision of appropriate services would prevent many maladaptive behaviours and secondary conditions and improve outcomes for children suffering from untreated mental health conditions. When you look at the

characteristics of various mental health conditions—and you’ve got that sheet as well—it is obvious that the children will have difficulty in a school environment if not appropriately assessed and treated. The school-as-hub model would significantly improve assessment and treatment opportunities and hopefully reduce disrupted school experiences with a view to improving life outcomes for all students.

In order to facilitate a school-as-hub model, there are many barriers which have to be addressed. Access to information needs to be coordinated and labour issues addressed. Questions about the funding for support staff needs of a combined or shared staff of professionals and allowance for removing vacant space costs for school boards need to be answered. Funding streams should be coordinated to allow professionals to straddle various sectors in serving individuals. The student support leadership initiative is off to a good start in looking at the logistics of consumer-centred services, but some ministry-level changes will be needed to make a true co-operative service model a reality.

Thank you very much for your consideration of our issues.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Cathy, Tracy and Deb. Your presentation was well received and was paced well, but unfortunately there is no time for questions, and we are going to move on to the next delegation. But thank you very much for coming today.

CANADIAN HEARING SOCIETY

The Chair (Mr. Kevin Daniel Flynn): For our next delegation, we’re going to change things around a little bit. We’ve got the Canadian Hearing Society next, and we’re just going to make a few alterations before that begins. Now, do you want your mic live all the time? Okay.

Thank you very much for coming today. We’re learning as we go along, so it’s been a learning experience for us all. We have your printed presentation before us, and we’re ready to hear from you.

Ms. Karen Frayn: Thank you very much. My name is Karen Frayn, and I’m the director of Connect Counselling Services at the Canadian Hearing Society. You have had a live, lived lesson this afternoon in accessibility, as you saw that the last two presentations were quite inaccessible at times for deaf participants in the audience, and I say that not to blame or criticize anyone. This is a group of committed, high-functioning, dedicated, interested people who want to exchange information. Your audience, your presenters, are sophisticated, high-functioning mental health professionals and consumers who want to exchange information, and nonetheless, it was very challenging to make it accessible with three sign language interpreters.

Now, imagine that you are a psychotic deaf person who doesn’t know anything about the system, is short on information, has compromised language skills; you’re a

signing deaf person, and you go into the local emergency department where the hearing emergency doctor has never seen a signing deaf person before in his life, has a lineup of people waiting to see him—imagine what access is going to be like for that deaf person. It’s going to be non-existent, not to mention the fact that the deaf person is probably clogging up that emergency department unnecessarily; they could be served better elsewhere—cheaper, faster and more effectively.

My colleague Gail Brunson and I are here today to talk about the fact that there are a quarter of a million Ontarians who have both a significant hearing loss and a significant mental health or addiction issue, and because their hearing loss is so significant, our consumers cannot access mainstream mental health and addiction services. It is not a matter of how long they have to sit on a waiting list. I worked most of my career, before I came to the Canadian Hearing Society, in mainstream mental health services; I know how short of resources they all are. I know nobody has enough funding; everyone has waiting lists. But I listened to our fellow presenters today with envy, frankly, because they can talk about their waiting lists. Our consumers can’t sit on a waiting list somewhere. They don’t have a choice of which waiting list to sit on. There simply are no services apart from Connect, our program. We are the only mental health and addiction services in Ontario for deaf and hard-of-hearing consumers.

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Deaf and hard-of-hearing people are denied access to mental health and addiction services in Ontario, in violation of their charter rights. For those of you in the room who are MPPs, I can guarantee that you all represent deaf and hard-of-hearing constituents in your ridings who cannot get service in your ridings. They cannot get service anywhere in the province of Ontario. You would be astonished at how many service providers simply say, “I’m sorry, we don’t serve deaf.”

Connect is a provincial program. We are managed provincially by corporate MOH as a provincially managed program. It’s the only mental health and addiction program in the province for deaf, deafened and hard-of-hearing consumers. We’re funded at slightly under \$3 million annually and we’re mandated by the Ministry of Health to provide a comprehensive network of services across the entire province: direct service and service partnerships from Hudson Bay to Windsor to Kenora. We have approximately 30 staff spread out across all regions of the province and more than 50% of our staff are consumers. They are deaf, deafened or hard-of-hearing themselves. We are mandated to be an entry point into the mental health and addiction service system in Ontario for our consumers. We provide direct access, if that’s the consumer’s choice, because we are a fully accessible environment. We can operate in the language and culture of the consumer. We have signing staff, we have interpreters, we have real-time captionists. A captionist is like a court reporter, who takes down verbatim everything that’s said in a meeting and flashes it up on a screen so

that if I turn deaf tomorrow, I can see what you just said on the screen. And we have a host of technical devices that are designed to facilitate access.

We are also mandated to do outreach to consumer communities and to mainstream service organizations like those that were here today. We're mandated to partner with them so that they can provide accessible and appropriate services for deaf and hard-of-hearing consumers. Many deaf people would do almost anything to avoid being in the hospital. For a deaf person to be in a mainstream, hearing hospital environment is very isolating and very frightening.

I'm going to turn it over to Gail now and ask her to speak about some of the specific challenges that we encounter in trying to get service for our consumers. I was just telling Gail, because she's going to stand, I'm going to hold the notes in front of her and she can either have me stand beside her and my hands will shake and her notes will shake, or I will sit in front of her and hopefully my hands will shake less. So if we play around a bit with access here for a minute, you'll understand.

Ms. Gail Brunson (Interpretation): Okay. Thank you, Karen. My name is Gail Brunson. I work as a support worker for the deaf community. I am nervous myself but I would like to thank you all for the opportunity to come here and present for you in my native language. It's a good experience for me and a first-time experience for me.

I'm not really sure where I should start but I'd like to explain my role as a front-line worker. I have direct service with deaf clients. I work out of the Canadian Hearing Society office. I just want to let you know I was born here in this community of St. Thomas. I've lived half my life in London, but I was born and raised here, so I know a few of your faces and who you are. It's nice to see you.

My personal experiences: I have suffered from physical abuse myself. My uncle was in the psychiatric hospital in St. Thomas for many years, about 30 years, and he died a few years ago. There have been lots of things in my life that have really impacted it. I've had four children. In all four of my births, I experienced depression afterwards. I didn't really understand depression; I didn't know what it looked like. Nobody taught me what to do or what I could do about it. I would go to a doctor and just say, "I feel sad and frustrated," and the doctor would say, "Here, take these pills." There was no understanding and no explanation as a deaf person. At the time, there were no interpreters available for service. I was written some notes by the doctor with vocabulary that was above my understanding. That definitely was a gap in communication. Those kinds of things happened my whole life.

The result of that has made me more motivated today to work for my clients. That's why I like to motivate my deaf clients and work with the deaf community. I've studied mental health for a number of years. I know where the gaps in service are. There are many specifically for deaf clients.

My role as a front-line worker is twofold. First of all, as an educator, I'm involved in community education, and it's not just about mental health and wellness; it's also about other illnesses as well, addictions, that type of information that I try to teach the community. Plus I'm involved with the families—maybe it's deaf parents who have hearing children, or hearing parents who have deaf children—just trying to educate what that actually means, deaf culture, the deaf experience. I travel a lot. I do presentations, and I've been doing them for over 25 years, so I've seen a number of gaps in service.

The two biggest barriers for deaf people with mental health issues are the lack of understanding about deaf culture—there is very little understanding—and accessibility, communication accessibility. There are lots of mainstream service providers, but they don't understand the communication issues. We've had problems with the police but also with the hospitals, and I've seen it first-hand.

I like to teach different service agencies that are already there. They deal with hearing clients. I've been involved with Alcoholics Anonymous programs in teaching accessibility for deaf people. I also try to train people on what to do if a deaf client does come in. I try to teach them how to make the environment accessible for a deaf consumer. That takes a lot of my work.

Across Ontario there are six people who have my role, so can you imagine servicing this many deaf people with mental health problems in Ontario? It's too much work for just the six of us.

I just want to keep looking for the interpreter to make sure she's keeping up and understanding.

There are four major challenges that we've seen over and over again for deaf consumers.

It's happened lots of times, and this has been over the past 50 years: Deaf consumers have been put into a psychiatric hospital, left there, given a diagnosis and left institutionalized, and really it was the wrong diagnosis. The problem was that there was no interpreter available; there was no communication access. Maybe these people were prescribed the wrong medication. There was just a lack of understanding of what was actually wrong with this person because there was no communication access. It's had a huge impact on the deaf community.

When that person, that consumer, finally leaves the hospital, they are then put out into the community with very little support. They are awkward. They don't know the world; they don't know how to communicate with people. That's where the Canadian Hearing Society likes to step in. We can communicate with them; we speak the same language. So that means we can form a partnership with these hospitals, and it has to happen. We have to figure out what our role is and what the institution's role is so we can work for the best for the consumers.

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Also with addiction programs, with how many beds are available, or the day treatment programs or residential programs—it doesn't matter whether it's a day program or a residential program; the problem is that the service

care providers don't know how to provide care for this person. The staff is often screaming for help, and they're left writing notes back and forth. This is not adequate treatment. Lots of times a deaf consumer is dealing with their second language as English, and written notes back and forth are not going to provide the treatment they need. Too many misunderstandings occur. So there are no addiction treatment programs in Ontario for deaf clients.

If a deaf client does have serious mental health issues, sometimes they're not diagnosed properly. Sometimes they might go to one place and they'll say they're depressed, and then they'll go to another place without an interpreter—and so it could be any of a number of issues. Sometimes they won't make an appointment or won't book an interpreter, or sometimes the care provider doesn't understand deaf access. It's rare that a service provider actually understands what they're dealing with when they do come into contact with a deaf consumer.

Treatment and addictions programs—there are none in Ontario. There is one, but it's in the United States, in Minnesota. That's a special program for addictions for deaf consumers. It's a 28-day program, with residential care, but in Canada there is no service, no program.

We have one client, a man who's 45 years old. He had trauma when he was young—he was abused—so a number of problems and huge communication issues. His family didn't even sign with him, so he is completely language-deprived. He detached and had a number of problems growing up. He became angry and had anger problems. He came for some help, but I wasn't able to give it to him because of the lack of service in Ontario. He was in and out of jail a number of times, with still no support for him. So when they called the Canadian Hearing Society and the Connect program specifically to try to go in to support him, I was not allowed to support him in court because I wasn't allowed to have an interpreter, and the whole process went off the rails. So servicing somebody like this is next to impossible. His lawyer didn't even understand deaf issues, the person who was supposed to be representing him. The lawyer didn't even understand how to hire an interpreter. So this person ended up being remanded for a longer period of time—until the court booked an interpreter, because they couldn't find an interpreter—and it was just an awful experience. There were no interpreters available and they didn't know how to book an interpreter. This was an incredible challenge for us. We were so frustrated, and the compassion we felt for this man was unbelievable. He tried to kill himself; he was depressed because he just couldn't get help anywhere. And this is just one isolated situation.

I've been working with him one on one trying to support him. He's still in treatment for addiction, but he doesn't have an appropriate program. The hearing programs will offer him, you know, "Come to an AA meeting. That's going to be a good place for you to be. There are people there and there's communication there and you can stand up and say, 'My name is so-and-so and

I am an addict." But for a deaf person to go into that situation is impossible, because he has to book an interpreter, and sometimes it's a two- to three-week wait before an interpreter's actually available. Then they finally get an interpreter available, and to go into that meeting is a different experience for a deaf person. Sometimes the meetings will be booked or counselling will be booked and the client himself will not go because he's tired or fed up. So sometimes the interpreter will show up and not have a client there. We're trying to provide access in some situations and sometimes that's not successful. This client is a really big challenge for us at Connect.

As well, this man doesn't want to go into the peer meeting; he's not comfortable there. The problem is, it's a hearing group, and he doesn't feel that he's getting access. The conversation happens too quickly, even with an interpreter. One interpreter has a hard time managing 20 people in that group. It's impossible for the information to be conveyed accurately, so he doesn't feel that he can convey his experiences or the trauma that he has experienced growing up. He doesn't want to attend that group. It's a huge challenge.

A third point I'd like to make is that deaf people who have mental health issues worry about the stigma—sorry, they have a misdiagnosis. Often what happens is they're assessed without an interpreter and a diagnosis is labelled to them without proper communication. So what we do at Connect is go with the client, make sure the communication access is adhered to and make sure the information is clearly presented to make sure we have an appropriate and accurate diagnosis.

This point, the third point, is really a complicated issue. Sometimes the client is deaf and doesn't just require one interpreter; they might need a second interpreter, who's called a "deaf interpreter." Because of their language delay—sometimes the person's language is delayed and a hearing interpreter may not understand them, so we hire a deaf interpreter to interpret from this deaf client's language into American Sign Language, and the hearing interpreter can then convey the message from American Sign Language to English. There are lots of complications about linguistics with some of our clients, and we try our best to avoid a misdiagnosis. So communication access is of huge importance.

My fourth point is mainstream services providing access. Clearly there are lots of services available. Connect has tried to partner with many of those services and tried to see if our clients could be a fit for therapy, whether it's day treatment, addiction programs or residential care. Often what we're met with is a fear: "We can't provide service for your clients." They have to follow their own policies; their policies don't provide access. So it's frustrating for us when we're trying to develop those partnerships. We're willing to train these staff and train these agencies on what to do. We often get rejected; it has happened to us many times. So the struggle continues for us—and, really, when I say "afraid of us" or "fear," it's a lack of understanding. They need some education so they're able to deal with deaf clients.

I think another problem is that people don't want to spend the money for the access; they have no time for that and no resources for that. Sometimes we do have funding available for interpretation, but the agencies do not want to forfeit their own. We don't mind paying for the interpretation services if these agencies don't have the budget for it.

In meeting with all of you today, my hope is to have some sort of a treatment program for deaf in addictions in Ontario. There are a high number of deaf individuals who do have addiction problems that lead to mental health problems that need treatment.

We have staff who know the language in ASL. It would be nice if they could be hired. I mean, in a deaf world, it would be nice if they had somebody who's deaf as well to communicate with them in their first language, especially when they're dealing with something as dramatic as mental health issues.

The program in Minnesota is willing to come and train us, train our staff and educate us on what they do. When I saw their presentation, I just felt it was a perfect fit for us and our consumers and what we need. I really do wish that we could set something up here in Ontario.

That's it for me. Thank you, and I'll save it for the question period.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. Thank you, Gail and Karen.

Gail, could we get that information sent to us from Minnesota or could you arrange to have it sent to us?

Ms. Gail Brunson (Interpreter): I sure can. I certainly will.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you. If you could send it to the committee clerk, that would really be appreciated.

Ms. Gail Brunson (Interpreter): I'd be happy to do that.

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

Ms. Karen Frayn: I just have a few wrap-up comments, but I want to check on how we're doing on our time before I move ahead—

The Chair (Mr. Kevin Daniel Flynn): Oh, I think the time has kind of gone out the window a little bit, so why don't you just do your wrap-up. We have to be on a bus at 4:30, so if you just—

Ms. Karen Frayn: And is the bus coming right here to give you door-to-door service?

The Chair (Mr. Kevin Daniel Flynn): The bus probably is here, so if you could do your summary, that would be great. I believe our bags are on the bus already.

Ms. Karen Frayn: All right. We could have done this presentation at any one of your stops around the province because ours is a provincial program and a provincial message. We have been very effective as a provincial consultation liaison program. We employ best practices. We have 90% positive outcomes, which is unheard of in the mainstream mental health field. Both our program

and the Ministry of Health have been publicly cited for very innovative use of funding to give access to a group of consumers who were formerly shut out of the system.

We cannot possibly serve a quarter of a million people from Hudson Bay to Windsor and from Kenora to Ottawa on \$3 million a year. We don't need an entire bailout package for a whole industry, but we do need some decent level of funding. I would ask all of you to ask yourselves why a specific disability group of a quarter of a million Ontarians is shut out of the system in Ontario. For any of you who have anybody in your family or your friends who is different, who has special needs, who has a disability, how would you react if you were to take your son, your daughter, your sister or your mother to a mental health service provider and have them tell you, "I'm sorry, we don't serve people who are blind. We don't serve people who are in wheelchairs. We don't serve people who have cerebral palsy. We don't serve deaf people"?

Please help us. This is unconscionable. We do our work because we can make a difference, and we do make a difference. For consumers who have never had access to service, when they get it, the changes are dramatic.

The Chair (Mr. Kevin Daniel Flynn): I think you've made your point very well, both you and Gail, and I think the point was understood by all members of the committee. I have a feeling they'll remember this presentation. Thank you very much for coming today.

M^{me} France Gélinas: One quick question.

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

M^{me} France Gélinas: I have a number of francophone deaf in my riding who use QSL. Is your service available in QSL?

Ms. Karen Frayn: The agency as a whole—LSQ?

M^{me} France Gélinas: Sorry, I used the French; yes, LSQ.

Ms. Karen Frayn: It's all right. LSQ refers to langue des signes québécoise. Pardon my pronunciation, Madame Gélinas. We are working as an agency, and as a program in particular, to develop our services in LSQ, which is the French equivalent of ASL. Your riding is one of two in the province, being Sudbury and Ottawa, where we have LSQ interpreters on staff. It's great that we have LSQ interpreters. That means, of course, that the consumers then demand that we provide them the service, and so we are working very hard to build our capacity to do that. But really, in order to fulfill our mandate under the charter as an agency—and we are a French services designated agency in most regions of the province—we should be able to provide our services in four languages: in ASL, in LSQ, in French and in English.

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

That's the end of our deliberations for the entire day, so we're adjourned to Hamilton.

The committee adjourned at 1623.

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