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**Official Report
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Thursday 18 June 2009

**Journal
des débats
(Hansard)**

Jeudi 18 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

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
Greffière : Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS**

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

Thursday 18 June 2009

Jeudi 18 juin 2009

The committee met at 0906 in the Days Inn, Kingston.

**MENTAL HEALTH
AND ADDICTIONS STRATEGY**

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen, we'll call to order. Thank you very much for attending this morning. We're going to get the meeting started.

CAMERON STEVENSON

The Chair (Mr. Kevin Daniel Flynn): Our first presenter this morning is Dr. Cameron Stevenson. Dr. Stevenson, if you'd come forward.

Dr. Cameron Stevenson: Where would you like me to sit?

The Chair (Mr. Kevin Daniel Flynn): Any chair that's not occupied is yours. If you want to grab some water there, feel free.

Dr. Cameron Stevenson: Yes, I will.

The Chair (Mr. Kevin Daniel Flynn): As we've travelled across Ontario, everybody has been getting 20 minutes. You can use that as you see fit. If you could leave some time at the end, we've found it's better if we can get into a little discussion, some questions and answers, if you have time for that, but it's not necessary.

Dr. Cameron Stevenson: I did circulate to the committee about three weeks ago a background history of what's happened in psychiatry from the asylum time of the 1950s to the present, because I have lived through all that and practised through all these times. I'm very much aware of the significant changes that have occurred. That, I've already sent to the committee, and there may be questions arising from that document as well. I brought another document this morning, which is more focused on the local situation.

To give you my background, I graduated in medicine in 1955. I practised general medicine for three years and then entered training in psychiatry, and have been in that branch of the profession since. I have now done private practice for the last about 20 years. Previously, I worked for 30 years at the Kingston Psychiatric Hospital, 13 years of which I was the medical director and the psychiatrist-in-chief. I've actually worked in all the institutions in Kingston, including the Kingston General Hospital, Hotel Dieu and the former Institute of Psychotherapy, and have visited most of the penal institutions in

this area at one time or another. So I have a broad range of experience.

The reason I wanted to make a presentation is because I'm very concerned about the situation currently with regard to the delivery of mental health care. It's in serious trouble. Physicians throughout this city continually remind me that they cannot get psychiatric assistance, and when they do manage to get a patient into the hospital and the patient is discharged, the patient is not followed by the psychiatrist but is turned back to the general physician, who really doesn't feel capable of carrying out the directions that the psychiatrist in the hospital has provided them. This is a problem.

I had a phone call just last week from somebody very close to the head of the department of psychiatry, who asked me—she's a physician—if I would please take a patient of hers. I said, "Look, I'm in the process of trying to retire. I've reduced my caseload now to about 20 patients." The word was that she can't get help either, and she's closely aligned with the head of the department of psychiatry. That indicates there are some problems. Her story was that if she sent somebody to the outpatient clinic, they only see them about 10 times and then they drop them. The kind of patient she was talking about was somebody who needs long-term follow-up—not a serious case, but who needs long-term continued supervision, and that's not available.

What's happened in Kingston in the last 15 years or so is that we have lost half our psychiatric beds. We used to have three facilities to which we could admit patients. We're now down to one unit of 34 beds in the Hotel Dieu Hospital in Kingston, which was under threat recently of being reduced to 24. I'm very reluctant to send patients to that unit; in fact, I've only sent one patient there in the last three or four years, because it's a melange of all kinds of psychiatric disorders. You have a great mixture: Some are people who are quite ill and behaving in an ill fashion, and some are people who need quiet and calm. It has strange echoes, vague echoes to what the asylum used to be like 50 or 60 years ago, because you have these people being quite upset and not under control.

In order to get out of that unit to a more suitable place, they have to apply to the Providence Care Centre, mental health division, for admission. They refuse to take any patients directly unless they've been screened by the Hotel Dieu unit. This is a problem.

Kingston has over 40 psychiatrists, but I can tell you there are only about eight who are in private practice,

four of whom are very selective in what they take. There are two people only doing so-called psychoanalysis. There's one person doing only post-traumatic stress disorder. There's one person only interested in psychotherapy and nothing else. That leaves about two or two and a half general psychiatrists taking patients directly from the community.

The problem is, there is a financial arrangement that applies particularly to Kingston. Nearly all of the university-appointed staff operate under the alternative funding plan, which guarantees an income regardless of what they do. They collect, at the moment, around \$239,000 a year. That's to cover the clinical work, research and teaching that they do. That applies across not just psychiatry but all of the departments in the medical school. The consequence has been that because they have their money regardless of the clinical work, the clinical work tends to be neglected.

As strange as it sounds, psychiatrists working full-time at Providence Care Centre are paid more. They're paid \$246,000 a year for 37.5 hours of work a week. Nobody in private practice can even approach that kind of income, no matter how hard he works. I was talking to one of my buddies who does general psychiatry last night. He cannot make more than about \$170,000 a year working full-time on a fee-per-service basis. So there is a financial disincentive for anybody to do private practice within this city.

We have to get help from universities, and they're not driven to earn income through their clinical work.

I don't know how long I've talked. I've probably talked too long already. I'd better quit.

The Chair (Mr. Kevin Daniel Flynn): No, you're doing great. You've only talked for about seven minutes.

Dr. Cameron Stevenson: Okay. Anyway, the other thing that I'm concerned about and is at the basis of a lot of our problems is the quality of the senior civil service within the ministry itself. I've dealt with these people for over 30 years. We had a dietitian running a \$360-million operation. That was followed by a teacher from North Bay who took over her job. That was followed by an accountant who came from the Management Board of Cabinet, and they wanted a position to put him in so they put him in that. He had no knowledge of psychiatry.

The last position that was responsible was in 1971-72. He was the last psychiatrist, the last person who had any knowledge of the system. From that time onwards, it was either hospital-administrator types or—there was a nursing director who was put in for about six or seven years prior to the dietitian taking over. There's a lot of trouble coming from that level because the people who are running it and are responsible for the system really don't understand what it's about.

The other problem that's occurring more and more is that the psychiatric positions are being displaced from any administrative control, and that control is now in the hands of people with a master's of health administration—executive directors and so on—and that's fine. I worked in a senior management group at KPH for 13

years, and myself and the director of nursing were the only two of six people in that committee. I can tell you that trying to get attention on clinical matters was not always the easiest thing to do. They were more focused on anything but clinical care. They were interested in lawns, buildings, driveways, hallways, railings and all the other stuff, but we have patients here; they're the primary purpose for our existence. Let's discuss these matters.

I can remember on one occasion, I wanted a piece of equipment for the clinical laboratory which would have cost \$14,000 and they said, "Well, you'll have to wait till the end of year. If there's any money left over, we'll let you buy one." This is the kind of attitude. This is prevailing not just in the mental health system; it's probably in the general hospitals now.

Very recently, the temporary lay administrator at KGH told the public—and I was there listening to him—that they were going to cut 14% of the beds at KGH and that the clinical services would be just the same as ever. There would be no changes; it would be just as good as they ever were. That's nonsense; it doesn't work that way.

Anyway, I've said enough, okay? I'll respond to questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Let's start with Sylvia, and let me just give you an idea of what time we have. We've got about 10 minutes, so about three minutes for each party.

Ms. Sylvia Jones: Thank you. My question ties into how, when you are working in the hospital settings, are you precluded from carrying on any private practice, or is it just because you have a full 37.5 hours—

Dr. Cameron Stevenson: No. That may be true of the university, but they do their own outpatients anyway within their system. The psychiatrists who are working at PCC are permitted after-hours private practice, and I know two who are doing that. Of course, that can generate quite a bit more money than the \$246,000 they're already getting, and they're doing it. There's always opportunity to do some private practice.

Ms. Sylvia Jones: Okay, thank you.

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

M^{me} France Gélinas: Good morning, and thank you for coming. I hear what you say about a lack of psychiatric services for the people of Kingston, but in the document that you have submitted, you also talk about the longer-term support that is usually done by social workers and others. Are those other parts of the mental health system in Kingston working good? Is it solely psychiatry that is missing or is it the full continuum?

0920

Dr. Cameron Stevenson: No, I think it's mainly psychiatry that's missing. We have Frontenac Community Mental Health Services, which I mentioned in my recent report; the details of which are there. They are handling about 500 patients at any one time; there are about 100 staff. There are only four part-time psychiatrists attached to that service, so most of the work is being carried on by social workers, a few nurses and

others. They really service mainly the long-term, chronic patients who would normally, in times past, have been in the psychiatric hospital. They're now placed in the community, and that whole organization looks after that group which has been displaced from the psychiatric hospital. They can function in the community, but with a lot of support.

M^{me} France Gélinas: If you look at the practice of psychiatry, we've heard a lot of people saying, in other instances, that psychiatrists should be working within an interdisciplinary team to make sure that we offer the full continuum of mental health services from primary prevention, health promotion to crisis management, to support to all of this. You seem to not think that this is the way to go, or am I—

Dr. Cameron Stevenson: No, I'm not saying that's not the way to go, but I think too often there's a tendency to—the practice of psychiatry and making proper assessments and diagnoses takes some time and some experience to do properly. To say, “Well, we'll have one psychiatrist and a whole bunch of other people, and he'll see the patient for 15 or 20 minutes and that should be enough to sort the problem out,” isn't going to work well. It sometimes takes me many hours before I can conclude what is really happening to this patient and how best to tackle the problem, and nobody else is going to be able to do that. It takes my kind of background to make that kind of decision.

M^{me} France Gélinas: I have been in Kingston before. Most of the psychiatrists I have spoken with before were all very much in favour of the alternative payment plan, but you're saying that this model is actually bringing its own challenges, because not enough of them do clinical work and more of their time is toward research and teaching?

Dr. Cameron Stevenson: I think there's a drift in that direction. It's hard to see that in psychiatry, but I know in other branches of the medical school it's pretty obvious what is happening. For instance, in KGH the radiologists are outside the system. They refuse to be paid this way. They're close in with these people involved in the alternative funding plan, and they shake their heads at how little they're actually doing.

I know that, for instance, in the department of anesthesiology in Kingston the members stop working at 3 o'clock. They only handle emergency cases after 3 o'clock. Any elective cases, if they're not finished by 3 o'clock, that's it, the case isn't handled. That's the alternative funding plan at work: They work the hours they're supposed to work, and they work no further. This has caused great delays. One of the members of that department is a pain specialist. I contacted his office in November and was told, “Well, it'll be about 10 months before he can be seen.” Fortunately, I phoned about three weeks ago, and they managed to push it forward.

I know another case of a person I was dealing with who needed to be assessed. His assessment required that he get an anesthetic while getting an MRI image done, because he couldn't lie on his back and be comfortable;

he had to be put asleep to do it. He was under a neurosurgeon at that point. The neurosurgeon was told, “Well, he's got to wait a year. We can't possibly fit him in with this current schedule.” So there is a tendency to slow down. In a lot of these departments, some of the members do nothing but research and they let some of the other people do the clinical work. So the alternative funding plan does not work well. The University of Toronto's isn't all that good, I know that. The only people I know elsewhere are at CHEO in Ottawa. I have a distant relative who is a psychiatrist there, and he has joined this group. He thought it was wonderful: He could take his holidays and didn't have to worry about making any money. He was given the money right off the top; what he did was his business.

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

Ms. Helena Jaczek: I want to ask you a couple of questions related to what we've heard as we've travelled around the province.

We've heard from a number of parents of children in their late teens, early twenties, who feel very strongly that although they are relied upon to be part of the supportive network for their child, they don't receive enough information regarding diagnosis, treatment and so on, because the young person has not given consent. So I'd like your opinion as to whether the current provisions under the Personal Health Information Protection Act are appropriate. That's one question.

The second is, parents are also telling us that perhaps the 72 hours of observation—I think it's the form 2 that is completed—is not sufficient, and that they're well aware that their loved one, whoever they're caring for, is able to confabulate or somehow give the appearance of normalcy in 72 hours. So my question is, should that period be extended?

Dr. Cameron Stevenson: The answer to the first question is that under the health information privacy act—anything under the Mental Health Act is excluded from that kind of privacy, and that's not widely known, even amongst the secular hospitals. I've had to talk to a few of them about it. Under the act, for instance, you're not supposed to communicate, without the patient's consent, any information to anybody, but under the Mental Health Act that does not apply. You can raise the questions to anybody, including relatives, friends, and the patient's permission is not required. I don't know how that applies to the teenage group you're talking about, but if it's being done within the Mental Health Act format, that privacy act does not apply. I've actually talked to the commissioner's office about this, and that is a fact. It's written in the act itself. It's clear.

Ms. Helena Jaczek: So, if they're admitted to hospital under the Mental Health Act, PHIPA does not apply?

Dr. Cameron Stevenson: That's right.

Ms. Helena Jaczek: Perhaps some of these cases were still in sort of the emergency—

Dr. Cameron Stevenson: Outpatient.

Ms. Helena Jaczek: —and outpatient, and it was that kind of situation.

Dr. Cameron Stevenson: Well, it's really unfortunate because it does tend to hinder the necessary transfer of information, and I think it has perhaps gone a little bit too far.

I have a stepdaughter who's the principal of a school in Toronto, and she has a son who has a serious problem. He is now in the care of Toronto's Hospital for Sick Children, but he had previously been looked at by the North York hospital. She simply asked for a transfer of the information, and they said, "No. You've got to come in and sign for it." That's impeding health care by putting too many strictures on a transfer of information.

Is there one more?

Ms. Helena Jaczek: The 72 hours for assessment.

Dr. Cameron Stevenson: The 72 hours is a bit confining, and people can, in fact, play games. I sit on the Consent and Capacity Board, and they oftentimes play games there as well. You have to hang on to them long enough so finally they can't behave normally—after more than 15 or 20 minutes, they start to show their illness. There's always a tendency for people to put on their best behaviour and—

Ms. Helena Jaczek: Would you recommend extending the 72—

Dr. Cameron Stevenson: They should extend it. The whole thing is a bit tight.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Doctor, for your submissions and for your attendance here today. It was very interesting.

PHILIP BURGE

The Chair (Mr. Kevin Daniel Flynn): While I call forward the next speaker this morning, who's Philip Burge, the associate professor of psychiatry—a member of the audience wanted to know who we are, which is a little unusual but probably not a bad idea. So why don't we start with Maria, and maybe we can just tell everyone in the audience who we are.

Mrs. Maria Van Bommel: I'm Maria Van Bommel, MPP for Lambton–Kent–Middlesex and parliamentary assistant to the Minister of Children and Youth Services.

Mrs. Liz Sandals: I'm Liz Sandals, the MPP for Guelph and the parliamentary assistant to the Minister of Education.

Mr. Yasir Naqvi: I'm Yasir Naqvi. I'm the MPP for Ottawa Centre and the parliamentary assistant to the Minister of Revenue.

0930

Ms. Helena Jaczek: I'm Helena Jaczek, MPP for the riding of Oak Ridges–Markham and parliamentary assistant to the Minister of Health Promotion.

The Chair (Mr. Kevin Daniel Flynn): I'm Kevin Flynn, the MPP for Oakville. I'm the Chair of the committee and the PA to the MPP for Kingston and the Islands, John Gerretsen, the Minister of the Environment.

Ms. Sylvia Jones: Good morning. I'm Sylvia Jones, the MPP for Dufferin–Caledon, and I'm the Progressive Conservative critic for community and social services.

M^{me} France Gélinas: Good morning. My name is France Gélinas. I'm the MPP for Nickel Belt and the health critic for the NDP.

The Chair (Mr. Kevin Daniel Flynn): Everybody else with us is our supporting cast from the Legislative Assembly who makes sure these committee meetings get held on time.

The floor is all yours, Philip. You have 20 minutes, like everybody else does. We find the mics work best if you're about a foot away from them. You can use that 20 minutes any way you see fit. If there's time for any questions at the end, that usually works better. The floor is yours.

Dr. Philip Burge: Thank you. My name is Philip Burge, as you noted. I'm a faculty member with the department of psychiatry at Queen's. I'm actually a social worker, clinically, and I work exclusively with people who have developmental disabilities and another mental disorder.

I've prepared these brief six or eight—I think there are eight slides on PowerPoint, which I'll try and pull up, but I've given you a copy. I apologize to the folks here that I've got my back to you and I don't have extra copies beyond the 20 that I gave the committee. It's just going to take me a second here, as technology does sometimes.

Just to give you a bit more information about my background, I've been a social worker for over 20 years and worked in a number of sectors, always in Ontario. That includes the children's mental health sector, where I worked for over five years, primarily in the Peterborough area, and I've worked in adult mental health. I worked very briefly in the child welfare sector, which isn't the mental health sector, but I worked there. And I've worked in Toronto, Peterborough and Kingston primarily, and have been at Queen's for the last 12 years.

What I would like to do is just give you some brief background of the population that I'm wanting to speak about today and complement previous politicians and members of the public who fed into previous policies on mental health and addictions, and then talk about just three recommendations.

I'm having trouble here, so I'm going to just abandon ship. Please ignore that. You can probably look on your slides and I'll refer to them. I think you've all got copies.

Thank you so much for accepting me to come today to speak with your committee. By way of background, when I talk about developmental disabilities, I want to note that in the DSM, the Diagnostic and Statistical Manual of Mental Disorders, we talk about mental retardation. That's a term that the parents I work with and the individuals I work with cannot stand. However, that's still the diagnostic term we use, so I'm just noting that that's the population I'm talking about. There are three criteria for people to be diagnosed with that diagnosis: cognitive impairment, usually done through IQ tests; adaptive functioning impairments that are considered to be very significant, also on the various standardized measures; and the age of onset has to be before age 18. This, in Ontario, constitutes approximately 1% to 3% of

the population. We don't have very good monitoring of segments of the population and so the estimates are pretty much used worldwide—1% to 3%.

Eighty per cent of those people with what I will call a developmental disability from here forward have what's called a mild level of this disability. Studies have shown that when we think of developmental disability, or when the public does, they think of people with moderate to severe levels, but most people, the vast majority, have mild levels of developmental disability and wouldn't readily be recognized by us. There may be perhaps people in the room who would have that label in some manner.

You might ask why I would want to come and speak to you about 1% to 3% of the Ontario population. This doesn't necessarily make up a large segment of the population, and you've got far more pressing issues perhaps. The main reason I want to talk about this group, besides my personal and professional interest in their welfare and my work with these individuals, is that they have a high, high rate of mental health issues arise in their lives. By various estimates and studies that have been done in Ontario and internationally—there's a wide range of figures, but the lowest end usually is about 40%. So at any given time, this 1% to 3%—40% of those individuals will be suffering from another mental disorder. They experience the full range of mental disorders from, let's say, the DSM—whether psychosis, mood disorder, anxiety; the full range—and that's been proven, but obviously at much higher rates than the rest of the general public. We've done studies in Kingston and there have been studies, seldom, elsewhere in Canada that have shown that the length of stay in acute care psychiatric units is about the same as for other individuals.

Why is this important? First of all, while they have the same length of stay in acute care psychiatric admissions, when we've looked at hospitals we find that they make up almost 3% of the admissions. So we're talking about 40% of 1% who are making up almost 3% of admissions. Then when we look at length of stay in the psychiatric hospitals, the nine psychiatric hospitals that were surveyed over the years, I believe it was 1999 to 2003, we found that they made up 18% of the population in our hospitals in Ontario. Again, 1% to 3% of people, of which 40% might have a mental disorder, were making up almost 20%; almost one in five of the in-patients in Ontario have a dual diagnosis of developmental disability and another disorder—not to be confused with that other “concurrent disorder” we now use in Ontario, which helps to get rid of confusion. In the past, people thought of dual disorder being an addictions problem and another mental disorder. So we're talking 18%.

When we've done studies in Kingston to look at this in more detail, we've found that when we looked at the psychiatric hospital in Kingston over a five-year period and all the admissions with developmental disabilities, and compared that to a group of people who didn't have a developmental disability, they were staying much longer. What was keeping them there much longer tended to be a

need to move to a higher level of home supervision, residential supervision. If they didn't have a worker in a developmental service agency or an adult protective services worker or a supportive independent living worker or a social worker out in the community, they were also staying longer. So the people with dual diagnosis tend to stay much longer in the psychiatric hospitals.

In fact, in my work that is a really sad situation, when we have to have someone transferred from the downtown hospitals out to the psychiatric hospital because, anecdotally, I tend to see that as a five- or a 10-year stay at minimum, and I don't often see people ever come out. That's because they often are not accepted back by family, who need more supports, and those supports aren't available to keep the person at home; or the agency, if it's a developmental service agency, kind of orphans that individual and gives away their bed to another individual. So we find a lot of people who are stuck in the psychiatric hospitals and it's a very pressing issue.

We've seen Ontario close institutions for people with developmental disabilities. We need the institutionalized people in our psychiatric hospitals who are simply waiting for supports and residential services to have that opportunity to leave the hospital.

I want to turn attention to talk about some policy and access issues briefly. In Ontario we have at last count—and this is from the technical adviser chair of ACTT Ontario—78 ACT teams in Ontario. ACT teams locally, when I survey them, and across other parts of Ontario, will tell me—and this isn't borne out by intense research—their belief is that 10% to 15% of their clients have a developmental disability and another mental disorder. Sometimes they feel a little pressed to serve those individuals and would like some more training. This is, again, an incredibly large percentage of people served by ACT teams in Ontario.

The policy issue that I want to highlight is really that there was confusion in Ontario between about 1997 to 2000 about whether people with dual diagnosis should be served by ACT teams. It wasn't the group that the ACT teams were originally designed to serve when it was a type of team started out of Madison, Wisconsin in the 1970s. However, the document that the Ministry of Health put out some years ago, *Making It Happen*, which I've got here today, cleared up this problem immediately after some consultations that happened. As people in the developmental service sector of the mental health services, we could turn to this document and say, “Page 38 names what is the first priority population and what are the diagnoses that qualify,” and clearly it says, “Dual diagnosis.” Sure enough, that has led to confusion being sorted out.

0940

People with dual diagnosis need to have other qualification factors. They need to have axis I disorders of psychosis—which is the majority of axis I diagnoses for Ontario ACT teams—or a mood disorder. So they clearly

had to qualify, but having a developmental disability did not exclude them. That has turned out to be an incredible thing for accessing service for this clientele, and 10% to 15% of the ACTT clientele have a developmental disability. That's only one little, tiny part of the continuum of services in Ontario, but it represents up to almost 800 people that are receiving this intensive level of service. And a document produced by the Ministry of Health, not buried in some regulations but actually in the implementation plan and the document that went out to all of the service providers, helped sort that out.

Unfortunately, when we turn to children's mental health, and I know you've had quite involved presentations by the children's mental health sector through the Ministry of Children and Youth Services, children's mental health is in shambles, except when it comes to recent autism initiatives that have usually gone, or have sometimes gone, to children's mental health agencies. We find children's mental health agencies extremely poorly trained to serve our clientele, and unwilling to get some of that training. Because in their policy document, called *A Shared Responsibility*, there's no real definition of which population is served beyond what I've put on the sheet here—some very vague references to age eligibility and some nice statements about serving people with severe and complex needs. We need diagnostic categories to be placed there.

People with dual diagnosis are being sent off to get services from behavioural teams, which exist in most counties, but have two- to three-year wait lists. They are often not being served adequately, and when they do receive services—and some of these children's mental health agencies do better than others, and some actually do focus more so on developmental disabilities, like the Griffin Centre in Toronto. But often what happens is that as soon as the developmental disability becomes evident by those service providers, they're quickly looking to refer that clientele to some other agency, and there really aren't many other agencies that can serve children.

My last slide, of course, would be the recommendations, and I would make some very clear recommendations regarding children's mental health.

Firstly, that they receive a very clear policy document—and it's not just me saying that they have a vague document in shambles. The organization of children's mental health agencies has indicated this, that they're not happy with the document. But I strongly believe, and believe a large sector of Ontario clinicians and family members would say, that people with developmental disabilities deserve to get served by that massive sector that is supposedly for children.

Secondly, I've spoken earlier about the folks who are in-patients. We badly need supportive housing efforts. This isn't just for people with dual diagnosis. For a lot of the people in our psychiatric hospitals who are able to move out, there's a fair bit of management of their psychiatric illness. They've got a lot of the skills; there's just not enough supportive housing initiatives. And you might say to me, "Well, in the last 15 years, the adult mental health sector has become five times bigger in the

community agencies." All those agencies across Ontario that are the adult mental health services, their budgets have increased by about five or six times in the last 15 years. Some of that has gone toward housing initiatives to help bring people out of hospital, but not enough, by far.

My final recommendation is around training. If we're really going to be able to increase services to people with dual diagnosis, we need to make sure that the children's mental health sector and the adult mental health sector can benefit from targeted training activities about how to serve these individuals. Although I said that people may be ill-equipped in some sectors like children's mental health, they definitely have 90% or more of the skills and the experience. They need a little bit of extra knowledge in terms of how to serve our clientele—maybe knowledge of how to use some of their already advanced communication skills specifically for our population—and some information about some more best practices. So we do see a lack of training initiatives at this time.

Really, this comes back to these three recommendations. I hope I've made a compelling case to try and influence you, to influence the other committee members and the ministry to make some changes in terms of children's mental health policy, supportive housing initiatives and training initiatives.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Philip. Great presentation. We've probably left time for one quick question and answer from each party, starting with France.

M^{me} France Gélinas: Thank you. Good morning. You did make your point very well, and a point well taken. Would you be able to give me some examples of supported housing for people with developmental disabilities and mental health that works well? Are there best practices out there where those people really get it and make a difference?

Dr. Philip Burge: There are agencies around Ontario that have pockets of these really good practices. Even our local agency, Frontenac Community Mental Health Services, has some very good services. Sometimes what happens, though, is that those mental health agencies are expecting a quick flow-through of people: People leave hospital, will gain skills, and then can move on to less supported types of housing. Often, people with intellectual disabilities, developmental disabilities and another mental disorder need lifelong supports that might really only be two to three hours every other day to help them with some things like budgeting and shopping—some basic supervision. But you kind of have to go to the developmental service sector to see a sector that has some benefits in that area, although it's underfunded and their supported, independent-living-type services have long, long wait lists.

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

Mrs. Liz Sandals: I just have some technical questions. You've been quite specific here talking about DD. I assume that dual diagnosis would also include autism and a mental health diagnosis?

Dr. Philip Burge: When we get to autism, people talk about that as a spectrum. Within that spectrum in the DSM, they have autistic disorder, and people with that disorder qualify as having mental retardation or developmental disability as well. When we get to people who are on the end that is referred to as Asperger's or PDD-NOS, they typically do not have an intellectual deficit that puts them in that range. They actually are denied for service by and large by 95% of the developmental service agencies, because the developmental service sector of MCSS does not currently include those people as eligible.

Mrs. Liz Sandals: Although they may have quite serious behavioural issues.

Dr. Philip Burge: Exactly.

Mrs. Liz Sandals: So my instinctive reaction is that they also belong in dual diagnosis.

Dr. Philip Burge: Yes.

Mrs. Liz Sandals: Are there stats around autism and its intersection with mental health issues both at the DD end of autism and at the high-functioning end of autism?

Dr. Philip Burge: In terms of Ontario service usage kind of stats, I don't think they exist. We've done surveys of hospitals and whatnot. I'd have to double-check; there may have been. The study that happened out of CAMH in Toronto that looked at a four-year period with the Colorado assessment scale, the secondary analysis of that by Dr. Yona Lunsky, may have pulled some of that out. I have a copy of her paper which I can leave behind, but I don't have them in my brain right now.

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

Ms. Sylvia Jones: Thank you. My question tacks back to access under children's mental health. You mentioned behavioural teams and waiting lists of two to three years. Is that to get assessed by the behavioural team, or is that access to service after the team?

Dr. Philip Burge: That's just for a basic assessment by a behavioural team. Behavioural teams are constructed so there are behavioural therapists always working with a consulting psychologist. In most counties, there will be two to three therapists covering one or two counties, and they will have two- to three-year wait lists. Sometimes they struggle to find a psychologist to supervise them. This service is highly needed and unfortunately is underfunded.

Ms. Sylvia Jones: Are most of those referrals coming through the school system or through GPs?

Dr. Philip Burge: Those teams will accept referrals from the school system, parents, hospitals, MDs, other team members of multi-disciplinary teams. They can do that, yes.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Philip. Your presentation was appreciated.

JOHN HOWARD SOCIETY OF CANADA

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning is from the John Howard Society of Canada: Dr. Craig Jones, the executive director.

Just for the audience's information, we started this tour in Windsor on Monday. We've been to Hamilton. We've been to St. Thomas and have paid a visit to the hospital in St. Thomas along the way. Along the way, we've been joined by MPP Christine Elliott, Gilles Bisson, Bas Balkissoon, MPP Jeff Leal, MPP Mike Colle, MPP Mike Brown. The Speaker of the House, Steve Peters, joined us in St. Thomas, and today we're joined by staff from John Gerretsen's constituency office. So we've been seeing a real cross-section of Ontario this week.

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Dr. Jones, the floor is all yours. You've got 20 minutes. Use it any way you see fit.

Dr. Craig Jones: Thank you for inviting me. I'm going to open with a little bit of humour—unintentional, but that's the way it works out.

I am the executive director of the national John Howard Society of Canada, which advocates to the federal government for changes to criminal justice policy across the entire criminal justice system, including mental illness and mental health. That is the target for whom this paper was written.

How did it come about? Well, when Susan contacted me a month ago now, something like that, I was in negotiations with a couple of members of Parliament in Ottawa about a similar panel that is touring the country to call on people like me in various regions. So when I got Susan's call, I thought, "Okay, this is the federal panel. Here I go." I wrote a paper for the federal level. So I would almost suggest that you bring Phil Burge back and let him talk for another 20 minutes, because he's got more to say about this that may be of direct relevance to you.

But I can speak to a couple of things. From the standpoint of the John Howard Society as a national institution, the single biggest problems we confront, where mental illness is concerned, relate to stigmatization and continuity of care.

I've drafted a little section on stigmatization in the first section of this. My previous research on mental illness concerned the—I was the integration writer for the southeastern Ontario mental health implementation task force a couple of years ago. We heard from numbers of service providers, consumers and epidemiologists, and the message that came to us again and again was that stigmatization is in many instances worse than the condition itself.

I'll just give you a little anecdote from that period. As the writer for the integration committee of that task force, I was to present to the integration committee on the issue of stigmatization. The day before I was to present, an incident made the newspapers in Toronto. The current Minister of Finance in Ottawa—at that time, he was running for the leadership of the Conservative Party of Ontario—made a comment which got a great deal of press coverage when he advocated rounding up homeless people and incarcerating them. So I went into this meeting of the task force the next morning, and half of

the committee were just dumbstruck by what had happened the day before—I mean, here was a blatant example of the stigmatization of the mentally ill—and of course the other half of the committee were political appointees and friends of that individual, who were not inclined to kick up too much dust about it.

I want to bring to your attention that where we are talking about federally incarcerated prisoners, we are talking about multi-stigmatized persons, the large percentage of whom come to the prison system with untreated trauma, mental illness of some kind, very often a developmental disability, and criminality. We layer on to these people various forms of stigmatization, and then when we release them into the community, which is another issue altogether, we wonder why they fail. We restigmatize them and restigmatize them and restigmatize them.

My argument to you is that we, as Canadians, need to take a hard look at ourselves, and particularly our political elites have to resist the temptation to stigmatize. The example I use in this paper relates to the national anti-drug strategy. I know you didn't draft the national anti-drug strategy, but it's a really good example of stigmatization, maybe not deliberate stigmatization but stigmatization nonetheless.

I'll draw your attention to the text on page 5. When the Prime Minister introduced the national anti-drug strategy in Winnipeg, he said, "If you're addicted to drugs, we'll help you. But if you deal drugs, we'll punish you." You will recall that drug policy and addictions experts pounced on these two sentences as evidence that the national anti-drug strategy, or at least the people who drafted that speech, either fundamentally misunderstood or misrepresented the nature of drug addiction and substance abuse, particularly the nature of their complex interactions and the proven uselessness of punishment. So I call on you to take up the challenge of resisting the political imperative to stigmatize for short-term political gain. That's my first request to you.

The second thing is that in the preparation of this paper I did a number of key informant interviews across the country, and what we hear from coast to coast to coast are challenges in the continuity of care. In other words, we have in Canada some of the best treatment programs available—evidence-based, best practices. We don't have as many as we need, of course; resources are always a problem. But the real challenge is, we have currently in place a mental health system with incentives—that is, at the community level—to refuse care when somebody is released to the community from a federal prison. Obviously, while they're incarcerated in a federal prison, they're under federal jurisdiction. Once they're released to the community, they're under provincial jurisdiction, and this is where the gaps in treatment become unbearable. That is the message I would bring to you today.

I'm sorry I drafted this for the wrong audience, but you might get something out of it anyway. I'm happy to answer questions if I can, and if I can't, I'll simply refer you back to Phil.

The Chair (Mr. Kevin Daniel Flynn): That's great. You've left a lot of time for questions. Let's start on the government side: Maria, then Liz.

Mrs. Maria Van Bommel: On page 6, in the little box, I find a very interesting comment in number 4, where you say, "We're too focused on risk management—we need more early intervention." Can you just elaborate on that particular comment?

Dr. Craig Jones: A comment I picked up from a couple of people across the system in CSC is that over the last 15 or 20 years, CSC has moved increasingly toward risk management and away from rehabilitation. So the emphasis has shifted. The kind of complaints I hear are that front-line social workers, psychologists, psychiatrists, counsellors and so forth spend much more valuable time writing reports and doing risk management assessments than actually delivering services to the people who need them.

Mrs. Liz Sandals: I have a past life as a parliamentary assistant to community safety and correctional services, so let's talk about provincial corrections, where you've got a different scenario. You've got people who are on increasingly long periods of remand and then potentially a very short period of post-remand incarceration. We get everybody first, which means we also have a very high percentage of people who often have addiction or mental health issues or both. Do you have any specific recommendations for provincial corrections, and where we need to go to handle that population that is really more mental health than corrections?

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Dr. Craig Jones: Actually, I would refer you to my Ontario policy shop, which specializes in this, but I can tell you that one of the reasons that we take an interest in this is—my Ontario policy shop is in Toronto, off Queen Street West, and they see the same people cycling through the system at an extraordinary rate, as you know, and getting worse every time they cycle through the system. So they may go in for a short period of remand and then they're out; they may go in for a second period of remand, and they've lost their apartment or their place to live, so now they're on the street. If they have an untreated mental disability, every time they cycle through the system, they're probably getting worse or they're picking up various other behaviours; they're becoming more criminalized in the process. So without having deep expertise in that, I would happily refer you to my Ontario policy shop because we have a housing specialist there.

Really, from what I understand, the issue is stability of accommodations, stability of housing. We seem to be able to keep these people, some of whom are quite injured, at a relatively stable state if we can house them in decent accommodations.

Mrs. Liz Sandals: Thank you.

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

Ms. Sylvia Jones: Good morning. I would like you to expand on your comment that as people leave institutions there's an incentive to refuse care at the community level. What did you mean by that?

Dr. Craig Jones: This is what I hear from my key informants across the country, that, for example, here in Kingston, somebody will work up an inmate to the point where they're stabilized on their meds, they're stabilized with a therapeutic regime, they've got a counsellor and so forth, and then they're at warrant expiry or they're under supervision in the community for a period of time. My contacts on the inside tell me stories about spending hours and hours and hours on the phone trying to find somebody in the community to pick them up and care for them, to maintain the continuity of care, and they say to me, "Thank God for John Howard, as one of the few agencies that will actually take an interest in these people." Because the way the system is structured at this time, and you can probably learn more about this from Phil, there is no guarantee to pick up a case from the federal system in the provincial system.

Ms. Sylvia Jones: But where does the incentive come in, the incentive to refuse?

Dr. Craig Jones: Maybe I've overstated it a bit. In many cases these are very high-needs individuals, so a lot of buck-passing goes on. Maybe "incentive" is the wrong word.

Ms. Sylvia Jones: Or they're at over-capacity, and that's where the challenge lies.

Dr. Craig Jones: Yes. So again, a resource issue.

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

M^{me} France Gélinas: It's a pleasure to meet you. I must say that in Sudbury, John Rimore is the executive director of our John Howard Society, and he does phenomenal work. He was very instrumental in bringing the Housing First model to Sudbury, where, exactly what you say, if we can give them stable accommodations, a place to live, then you have something to work from to address the other issues, but if you don't have this then all is for nothing; you're never going to move forward.

I don't know if you have, through your work, specific examples of housing accommodations that work well or of successful transition programs that exist and could become models for us to look at.

Dr. Craig Jones: Yes, we do. We have a very successful housing system in Ottawa, and the executive director in Ottawa is Don Wadel. He is very knowledgeable, and he has been running, I believe, six different houses, 100 different units, for going on 12 or 15 years, very successfully.

The other part of the network that is running housing very successfully is British Columbia. I know you're probably not mandated to go to British Columbia, but they've been very successful at accommodations there as well. So the answer is yes.

M^{me} France Gélinas: How about for transitioning?

Dr. Craig Jones: Both of those are transition houses.

M^{me} France Gélinas: Not transitioning to housing, but transitioning to mental health services. You say that the inmates have a hard time finding community-based mental health services to support them once they're released. Are there examples out there where it works

well, that when a person gets released, there are mental health services out there to continue with them?

Dr. Craig Jones: That, I don't know. That, I would have to canvass my provincial EDs about. Where the best transition happens in Canada—I can't answer that.

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

The Chair (Mr. Kevin Daniel Flynn): Thank you, Craig. If I could close with a question, one of the issues we've been dealing with—and we've certainly heard from Senator Kirby on it—is to remove the stigma from the entire issue; that it's something we need to do at the national and provincial level. The sentence you picked out as an example of the stigma was interesting. It says, "If you're addicted to drugs, we'll help you. But if you deal drugs, we'll punish you." I don't usually stick up for the Prime Minister, but on this one, I would think that the average Canadian would read that and say, "Yes, I agree with that." Could you expand on that a little bit? Why is this sentence an example of what we need to do about stigma?

Dr. Craig Jones: The sentence sets up a dichotomy between dealers and users, but the reality on the street is that most users deal in order to support their own habit, so there's not a distinction between them. The sentence aspires to create the impression that there are these, if you will, drug kingpins who ride around in stretch limousines and who make the big money, but those are such a small minority of drug dealers in the entire system. The vast majority of drug dealers are themselves small-time dealers dealing to support their own habits. That's why.

The Chair (Mr. Kevin Daniel Flynn): Okay. That makes some sense. I know that people in the field of addictions, when they hear somebody who maybe confesses to kicking drugs, point out that there's a big difference between a drug addict and a drug abuser. Do you see that with your clientele, people who are truly addicted to drugs or people who choose to do drugs, or is it all really an addictions issue?

Dr. Craig Jones: That's a very good question. I can give you a three-sentence answer, and I can give you a three-volume answer. The fact is that the vast majority of so-called illicit drug-taking in Canada produces no problems for the users themselves. They are casual, for example, marijuana smokers. I've read peer-reviewed literature that argues that even if we were able to cure every heroin addict in Canada, it would make no dent in the overall demand for heroin in Canada because the vast majority are what's called "weekend chippers," and they're not addicted. They just occasionally go out and get a hit of heroin and bliss out for the weekend. You see? So there's a lot of mythology and misunderstanding around drug use and drug abuse.

I can say quite categorically that the vast majority of drug users suffer no consequences from that drug use in their life. It might be a weekend thing, it might be something they do after work. All the attention is drawn to drug abusers because they're the ones who develop criminal lifestyles, who cycle in and out of the criminal

justice system, who break into your cars and so forth. That small minority of people, for example, who live on the Downtown Eastside of Vancouver are, like, 0.001% of all the drug users in Vancouver, but they are the ones who get all the attention because they're the hard-core drug addicts. You see?

If you're interested in this, I refer you to Senator Nolan's senate panel from 2002, which goes into a great deal of detail about these kinds of distinctions, which are usually obliterated in popular conversation, table-talk conversation, around these things.

I have to say that the Prime Minister and the whole national anti-drug strategy has only deepened the mystification and the myth, not only around drug use and drug abuse, but around the role of the criminal element in it.

The Chair (Mr. Kevin Daniel Flynn): Very good. Thank you very much for your presentation today. That was very interesting.

Dr. Craig Jones: Thank you.

ONTARIO TELEMEDICINE NETWORK

The Chair (Mr. Kevin Daniel Flynn): If I can call the next delegation forward. From the Ontario Telemedicine Network, Stewart Stein. Is Stewart with us?

Mr. Stewart Stein: A delegation of one.

The Chair (Mr. Kevin Daniel Flynn): A delegation of one.

Mr. Stewart Stein: It'll just take me a second to set this up.

The Chair (Mr. Kevin Daniel Flynn): No problem.
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Mr. Stewart Stein: Ah. Seems the PowerPoint gods are with me today.

The Chair (Mr. Kevin Daniel Flynn): With the gods on your side you have 20 minutes to use any way you see fit. If you could leave some time at the end for some questions, that would be great. The mikes work generally better if you're about a foot away from them.

Mr. Stewart Stein: Okay, thank you. This is appropriate.

So thanks very much—

The Chair (Mr. Kevin Daniel Flynn): You can move the mike if you want to.

Mr. Stewart Stein: As long as you can hear me, that's good.

Thank you very much for allowing me to present to you today. I really appreciate the opportunity. I'm Stewart Stein. I'm the manager of mental health and addictions for the Ontario Telemedicine Network. My role is in developing the strategy for increasing utilization of mental health services over the Ontario Telemedicine Network. I'm going to tell you a little bit more about us.

The Ontario Telemedicine Network plays an important role in facilitating access to mental health services for patients and providers in Ontario. I will delve a little bit further into this to explain exactly how we're doing that.

First of all, for those of you who may not be familiar with telemedicine: What is telemedicine? This photograph that you're seeing on the screen right now is a prime example of how telemedicine works. You've got some kind of health care provider sitting at one end and you've got a patient—or patients and spouses, in this case—sitting at a remote end, and medicine takes place over videoconferencing, and it's interactive.

We use telemedicine in three primary buckets: what I call clinical, as today we're going to be talking about mental health; education, for the dissemination of information and education amongst folks across Ontario; and also for administrative use, so non-clinical, non-education, just for meetings that people might want to have between remote sites.

About the Ontario Telemedicine Network itself: We're an independent, not-for-profit corporation funded primarily by the government of Ontario. We're an integral part of the eHealth strategy and our key partners include eHealth Ontario, who provide our network over the province, Canada Health Infoway, who also provides us with some funding, and our northern First Nations partner, called Keewaytinook Okimakanak tribal council, who run the KO telemedicine network.

What exactly do we do? We're a membership-based organization, so all the folks who use telemedicine join us as members of the organization. We seek to promote the adoption of telemedicine broadly and we set the standards for the use of telemedicine over the network. We don't actually provide clinical services ourselves, but we facilitate connections between providers and patients or between providers and providers. Some of our services include the deployment of new sites. We provide total training and e-learning. We provide turnkey technology management, which means that when a new member approaches us, we set them up and we hold their hand through the whole process. We provide a scheduling and referral management service and we do bridging, which means that we connect multiple points together at the same time. We also provide a webcasting service.

Some quick facts about us—and I'm just building to the ubiquity of telemedicine currently in Ontario. Last year, we conducted about 71,000 events over the network. I want to be quite clear that when I say "events," we're talking about, especially in the case of clinical encounters—in fact, we did 54,000 patient-to-provider encounters last year. We also provided about 19,000 administrative and educational events. What that doesn't tell is the complete story of 150,000 people participating in those educational events, all over telemedicine. We've got about 1,300 end points around the province, 700 members, and we offer a number of clinical programs.

Two important facts you'll see on this slide is that in providing these telemedicine services, we were able to assist in avoiding \$15 million in northern travel grant costs. So people who did not have to travel were able to be seen over telemedicine and did not have to access the travel grant. It was about \$15 million in savings last year. Also, we avoided over 36 million kilometres in travel, so

you can imagine the impact that that has on the environment.

Specifically about mental health, what we are doing around mental health, there are a number of instances where—and programs that are being offered over telemedicine. These are just a few examples; I'm going to give you some specific examples shortly. People are doing individual and group therapy over telemedicine. MMT, which is methadone maintenance therapy, is being offered over telemedicine. We're expanding into community mental health agencies like the ACT teams, like the Canadian Mental Health Association.

The shared-care model of service delivery lends itself very well to telemedicine. I'll talk a little bit more about that. Adolescent mental health services are being offered. We're connecting with Veterans Affairs to facilitate post-traumatic stress assessments and treatment. And, of course, we're doing a lot of psychogeriatric assessments over the network.

This just gives you a sense of the utilization of the network. I talked about the big numbers. Specifically around mental health, last year we conducted over 22,000 mental health events. A little less than half of those were related to addictions.

This is OTN's view of the mental health landscape and where, I think, we really can add some value and are adding value. I know this is not a complete picture of the mental health landscape as you might understand it, but for me, this represents all the organizations that we're currently engaged with. What you're seeing on the screen are a lot of the Ministry of Health sites, the ACTTs, the CMHAs. We're in all of the hospitals in the province, the psychiatric hospitals, and we're connecting with all the family health teams and, obviously, the primary care providers individually.

There's a large network within our network of community networks of specialized care sites, which are primarily funded by MCSS. We're working with the Ministry of Children and Youth Services as well. We're connecting with children's treatment centres, and there's also the youth justice component and the telepsychiatry component and so on. So you can see that we're across ministries.

Does telepsychiatry work? Yes, it does. There are many examples of this. One specific one that I pulled out was a recent study published in June 2007 that found that telepsychiatry encounters were equivalent to those of face-to-face encounters, in addition to reducing costs. Now I have to say that, in this particular study, the technology used was a little bit older. I know that today the technology would cost even less, so that savings would be far in excess of 10%. So I say it works; patients say it works as well. These are numbers that you don't commonly see in health care—satisfaction rates from patients who are saying they would use it again, that they like it, they were able to see their provider and it was easy to use.

I'd like to provide a few examples of current telepsychiatry initiatives. There's this program that has been

developed by the Middlesex Hospital Alliance and the Chatham-Kent Health Alliance. I'm sure you're familiar with the shared-care model of service, but what we have is a family health provider in the community providing, essentially, the psychiatric services under the guidance of a psychiatrist. This really leverages the resources available.

In this particular case, a nurse practitioner has been substituted for a doctor and is being mentored by a doctor at a distance. This would have been otherwise impractical, if not impossible, without telemedicine. So the nurse is conducting intake assessments, monitoring medications and so on, and the doctor is providing guidance and support for the care plan. The outcome of this is that patients with severe and persistent mental illness are receiving more timely care and getting treatment closer to home. They're not having to travel now. In this particular location, at any point of the compass, somebody would have to travel over 100 kilometres in one direction only to receive services. You're talking about 200 kilometres for one trip, and they're avoiding that by using telemedicine.

This is an initiative that I think is extremely interesting. It's a virtual psychiatric emergency room, again, between Chatham-Kent and Leamington. Interestingly, the budget for this program is only \$5,000 annually. What has resulted from this program is that the need to hold unstable mental health patients in a non-psychiatric facility was reduced by 100% because of the ability to be assessed by video conferencing. Wait times have been reduced from 48 hours to two hours to access these services. Again, patients are receiving timely care with continuity, and closer to home. This model has been so successful that it's being replicated at Grey Bruce Health Services, with 10 emergency rooms, and Owen Sound will be the consulting site for this, and it's soon to be implemented at the William Osler centre, which will be supporting Headwaters Health in Orangeville. So it's a successful program that's being replicated in many places.

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Another virtual emergency room, in partnership with Lakeridge Health, Ross Memorial, Peterborough and Whitby—again, the goal is to improve timely access. This is a relatively new program, so I don't have a lot of results for this, but my understanding is that wait times, which have been anywhere from six months to two years—now patients are being seen within 72 hours because of the access through telemedicine. And you can see some of the other peripheral benefits: Parents are missing fewer work days, children are missing fewer school days, and so on.

Another example—some people call it Claude Ranger in North Bay. What's interesting about this one is that not only is telemedicine facilitating the psychiatrist in Toronto seeing patients in North Bay—we've been thinking mostly about telemedicine over vast distances, but in this particular case there are also some health professionals at North Bay General who are accessing the Claude Ranger

centre, which is only about half an hour away. But you can imagine that if you're a busy physician or social worker, to take that time to travel in a crisis, something that's unscheduled, for half an hour across town—whereas you can simply sit down at your desk and within a couple of minutes be on by telemedicine and providing services would be a huge benefit.

We were just talking about corrections a few minutes ago, and there are a number of correctional facilities that are connected through the Ontario Telemedicine Network. There are some federal institutions that are connected and certainly there are a couple of provincial institutions connected, and we're seeking to connect even more. As you've heard, the typical population, the in-custody population, has many of the same health concerns as the regular population, if you will. OTN is enabling consults, preventing unnecessary transfers, so we're saving costs there, reducing risk to the community. The Consent and Capacity Board can do assessments by video, and timely forensic assessments are also enabled over video conferencing.

In summary, I think the committee should consider OTN and telemedicine key enablers for the delivery of mental health services across Ontario.

Hopefully that leaves us some time for questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Stewart. We appreciate that. Let's start this time with Sylvia, then France and Helena.

Ms. Sylvia Jones: Your presentation is timely because when we went to CAMH, one of the messages they were leaving with us was that psychiatric treatment and assessment is a perfect match for telemedicine.

My question relates to the communities that are currently being served by OTN. Is that on an on-call, as-needed basis, or are there structured times when those consults are set up? How does that work?

Mr. Stewart Stein: The vast majority of activity over the network is elective. Although I've talked about some emergency examples in here, most of this is scheduled; hence our referral management and scheduling service which coordinates the effort to bring the two sides together. For the users, it's seamless; for us, it's quite complex. But we realize that and we're trying to make this as easy as possible for people to use, so we help coordinate all the various services that are required to bring the two end points together. So when somebody sits down at a studio in Fort Severn and is connecting to Toronto, they just sit there and it sort of happens automatically.

Ms. Sylvia Jones: When you talk about your members, hospitals in particular, is there an annual fee, a maintenance fee, that they have to cover?

Mr. Stewart Stein: For any ministry-funded organizations or LHIN-accountable organizations, there are no membership fees or set-up costs. For other ministries, there are annual fees, typically around \$5,000 per site. Once you're a member of OTN, whether you're a paying member or a non-paying member, it's an all-you-can-eat buffet. All the services are included. There are no additional costs beyond the annual fees.

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

M^{me} France Gélinas: I come from northern Ontario, I worked 25 years in primary care, and I've used your services extensively. They work well, but also, being from northern Ontario and having worked in the field for a long time, the need for recruitment and retention of professionals in northern Ontario is always present in our minds. I would say, having used it, that it works well in psychiatry. It also works really well in dermatology. Those little cameras work really well.

But there are a number of grumblings in the north regarding telemedicine, as in clients who used to come to Timmins and clients who used to come to Sudbury are now being seen by somebody sitting at CAMH in Toronto, which means that the volume of work for us to recruit and retain a stable workforce in the north is sometimes a little bit compromised because some of the referral patterns have now shifted through telemedicine. We still need live bodies on site in northern Ontario. I certainly support what you've done. It has done a lot of good work for the people of the north, but I certainly wouldn't want the committee to go away thinking, "Oh, there's no need to recruit and retain professionals in northern Ontario" because of this.

Also, there is screening that is done by the people in the field in mental health. You didn't mention that. It works well for the people who have addiction issues. It doesn't always work that well for people with mental health issues who really think that their neighbours and God are also connected to that little TV. Those people are screened by the people, usually nurse practitioners and nurses, in the field. Those people still have to travel to their appointments, and they will never be candidates for telemedicine just because of the problems that come with their illness, whether it be schizophrenia or other mental diseases that tend to make them leery of technology. I want to bring that in the balance.

I would never do anything that would impede the development of telemedicine. I recognize the important role it plays in the area that I represent. As I say, we've used it, we've learned to love it, but at the same time, we always have to balance this with the fact that people in northern Ontario are Ontarians and they deserve the same level of service as everybody else. I'll leave it at that.

The Chair (Mr. Kevin Daniel Flynn): I'm not sure that was a question.

M^{me} France Gélinas: No. He can—

The Chair (Mr. Kevin Daniel Flynn): I think the answer would be, "I agree" anyway, and the time is up except for one more from the government. Helena.

Ms. Helena Jaczek: I was particularly interested in your child and youth virtual emergency consultation practice. Certainly, as we've travelled across the province, we've heard from parents how frustrating it is to get that diagnosis, that early recognition. I think you said that this was a specific area, was perhaps a pilot that is being conducted. Here's my real question: If you're in every hospital in Ontario, is it possible for a family physician

confronted with a situation that he's perhaps unsure about, a teen behavioural issue, to go to the hospital, say, "I need a consult on an emergency basis for this young person" and have some connection to, say, CAMH and a psychiatrist?

Mr. Stewart Stein: Certainly it's possible. The delivery of the service and how to access it, depending on where the psychiatrists are, can be a little bit more complex. For example, there is a telepsychiatry network. It's somewhat independent of OTN, and it's funded largely by MCYS. You can't access the service through a hospital; you have to go to an MCYS organization or gateway, if you will, to access that. There are certain criteria for accessing it.

There is a funding proposal on the table by the same folks to receive funds so people can access it in the way that you've described. We're hoping that that gets funded so that people can access it, because there's a network of some 70 child psychiatrists who are involved and a great resource to all of Ontario.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you very much for coming today, Stewart. That was a great presentation. Good news.

1030

PATRICIA FORSDYKE

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning—perhaps she can get ready—is Patricia Forsdyke. Make yourself at home there. I'm sure you'll find a clean glass of water, if you need one.

Ms. Patricia Forsdyke: Yes, thank you.

The Chair (Mr. Kevin Daniel Flynn): I think you've been here since we started this morning, so you've heard all the—

Ms. Patricia Forsdyke: Yes, and I agree with much of what has been said. But I will be critical of some points. I will reflect some of my concerns in my presentation.

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

Ms. Patricia Forsdyke: I'm going to actually read it because I think I'll be better off doing that. I've given you all a file; I would ask you to listen to me first before getting involved in the stuff that I've put in the presentation. Basically, I want to make it very clear that my big message here is beds—acute beds and some chronic beds—being put back into the system. The other point I want to make is that—I'm sorry, I've lost my train of thought. I think I'll just read what I'm about to do.

When I use the words "consumer-survivor" it's not meant to be derogatory, because a lot of the people I know call themselves that and I've been involved with them over the years. I wanted to start off by—I've put a lot of material in your packages, but basically this week, for instance—yes, I know what I want to say. I'm not speaking for the Schizophrenia Society. I've been involved with them for three decades but I'm not a member this year. It's simply the structure of the organization that bothers me. I'm not anti- some of the things

they've done; I simply think that it's no longer grass-roots, and this is what we used to do to help.

So I'll begin with my presentation. One of the telephone calls I had this week—I was just about to have my lunch on Sunday, and one young woman—I knew her when she was a young woman; this is about two and a half decades ago. Anyway, her friend, who also has schizophrenia, phoned up and said, "So-and-so is in jail." In other words, "What will you do about it?" As far as I'm aware, this person has never been in jail before; she's about 50. She has chronic schizophrenia; she's very paranoid, so I won't mention her name. Anyway, she has gone through the hospital system in the last very short while. I think she has been homeless. She has never been homeless, as far as I'm aware, until very recently. Anyway, she ended up in Quinte jail. So she's an example of the way the system has gone.

Now I'll plow into my presentation.

I'm not here to praise the system of care for the seriously mentally ill. It is derailing and is in for a big crash. I hope that you, as elected officials, listen carefully to what I have to say and act upon it. This mess was not created by one party. It was a long time in the making. If you all survive the next election, you could help to put in place something that might work for the 3% of the population with the most serious mental illnesses. Families and their loved ones will be eternally grateful if you do so.

For three decades I have seen activists who call themselves consumer-survivors aggressively push some very scary agendas. People paid by the system and bureaucrats have supported these agendas, often out of self-interest. You will hear from these people often. Much of what you hear will be dead wrong and very dangerous for the 3% with brain diseases. Some courageous professionals have spoken out against the nonsense but have often been sidelined. Compassion through real understanding would be a step in the right direction. Those consumers who deny that schizophrenia and manic depression are medical illnesses should not speak for those who need medicine to put their lives back on track.

Beware of those who use phrases such as "mental health issues"—you've used it a lot this morning, but you've used it in the right context this morning. I want the word "illness" put back in when people are ill, and I think you were relating to that when you were talking about North Bay. Beware of wellness models, alternative therapies, medicalizations of the mentally ill—these are terms that get used constantly—and anti-medical models. Some of them even say that the stigma is worse than the illness itself. That's absolute nonsense. If you are acutely psychotically ill, the illness is much worse than any stigma.

I came across the following very recently: "Consumers have a personal responsibility for their own self-care and journeys of recovery.... Consumers must strive ... and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness." Where does this come from? Concept 9,

the Mental Health Services Administration, Department of Health and Human Services in the USA. Would they dare say that to someone paralyzed by multiple sclerosis or motor-neuron disease? As Dr. Sally Satel says, “If any psychiatrist followed the 10 fundamental principles of recovery elaborated in the statement from NIH to the letter, he or she would be at risk of malpractice.” I’ve put in the document, *Catalyst*, which has some of these issues in it.

Such utterances have displaced more important priorities like careful diagnosis, state-of-the-art medical treatment and much-needed stabilization for those with these serious illnesses. The silly politically correct talk has so far won the day, and many who have the more serious diagnoses are left to fend for themselves on the streets and in our jails. The mess is clearly here to stay unless families have the courage to speak the truth and professionals and politicians act on that truth.

Am I going too fast, by the way?

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

Ms. Patricia Forsdyke: Right. Thank you.

There will likely be many more chronically ill unless someone heeds these warnings. This will place a bigger burden on families and on the long-term-care system. By the way, I did agree with much of what the first psychiatrist said.

Schizophrenia and manic depression must be accepted as no-fault illnesses. Those afflicted have lost in genetic roulette. These are physical illnesses just like multiple sclerosis, and the much-touted recovery model clouds the issue. It would be more honest to talk about stabilization and management, as one does with insulin-dependent diabetes. We must counter the discrimination that leads to dollars and services being denied to the seriously mentally ill. Other serious neurological conditions are obviously treated as no-fault conditions and do not require us to demonstrate that they need health care dollars.

Family blaming is still going on. It now comes with a new twist. I’ve put an e-mail in your package. This was written by someone who did a survey for the Schizophrenia Society. I was stunned and flabbergasted by this one.

Evidence of the system’s failure: The evidence indicates total system failure. We see more mental health courts, increasing police involvement and fewer hospital beds. In droves, the seriously mentally ill are landing in jail instead of in hospitals. The numbers in jail instead of hospitals are mind-boggling. I refer you to a study which I got my hands on a few days ago. It’s 110 pages long, and it has diagnostic categories in it. It’s a BC study, and it was done by Simon Fraser University. I recommend that you get hold of a copy of it.

Those professionals who are trying to do an exemplary job caring for those with the most serious diagnoses, schizophrenia and manic depression—obviously, there are others—are given little encouragement to do what they were originally trained to do. Many opt to look after the more frequent, milder psychiatric conditions. The

current mantra is that one in four people have a mental illness. Grief is a mental illness when you’re going through it; one is not quite okay. But I’m saying that using these statistics in such a way is bound to eventually backfire. Do we give service to the common cold or do we treat pneumonia? Both are important, but the question is, which takes precedence? Ignoring those with schizophrenia and allied disorders places a very heavy burden on society, families and taxpayers, for make no mistake, the public pays one way or another.

I should tell you a little bit about me. Ironically, the person who was talking about teleconferencing this morning—I know the person who does it in Kingston, and he was trained in the same way as I was, in England.

1040

Someone knowing a bit of my training drafted me to participate on a Canadian Mental Health Association committee in 1980. They were just getting going in Kingston. The money was rolling in for the CMHA at that time. I attended the committee for about six months, then left out of sheer frustration. The organization seemed to know little about psychosis. It was passing around silly bookmarks—“Have a daisy for your mental health.” I felt it wasn’t responding to people with really serious illnesses. The mess is clearly here to stay unless families have the courage to speak the truth and professionals and politicians act on that truth. There will likely be more chronically ill unless someone heeds these warnings. This will place a bigger burden on families and the long-term-care system.

Schizophrenia and manic depression must be—I’m sorry. I’m repeating myself. I’ve gone back to page 3. I beg your pardon. I’m on page—excuse me.

The Chair (Mr. Kevin Daniel Flynn): I have you in the middle of page 3, under “My Expertise.”

Ms. Patricia Forsdyke: “My Expertise.” Yes. I just must have turned it over. I’m so sorry.

The Chair (Mr. Kevin Daniel Flynn): No problem.

Ms. Patricia Forsdyke: I knew if I didn’t staple it together, I’d have trouble.

The Chair (Mr. Kevin Daniel Flynn): No problem. You were just about to join the Friends of Schizophrenics.

Ms. Patricia Forsdyke: Yes. I walked down the road and I looked at the Friends of Schizophrenics outfit. It had just started. This was in 1980. It was started in 1979 by Bill Jefferies, who was from Oakville, a very fine man, and Dorothy, his wife. Later, it become the Schizophrenia Society. Bill’s main thing was that if anyone ever needed a friend, it was a schizophrenic.

My involvement has lasted almost three decades. I knew that what the CMHA was talking about had little to do with what I thought were serious mental illnesses. The CMHA was driven by ideology and was astonishingly naive. This continues to this day, to some extent. They’ve changed quite a bit. Just taking a look at who ends up on committees illustrates where the power is and the direction that the government has gone. Those connected to

the CMHA in the early days have garnered most of the funds and power.

Prior to having children, I had been a registered nurse in England and then a registered psychiatric nurse. In addition, I had a background in neurology. I did my psychiatric training in a private hospital but worked later in a state mental hospital. Fraudulent Freud held a lot of sway in those days. I can tell you that psychosis has little to do with which station in life one is born to or what your family did to you. It is the disease that inflicts the wounds.

I sat on multiple focus groups and committees, both at Queen's Park and here in Kingston. I served for years on the executive of the SSO. I was the chapter president here for many years. We helped families navigate the system. Many of their loved ones were rescued from crippling delusional symptoms. Some are now lovingly attending to the needs of their elderly parents, driving them to appointments etc. But initially, it took years to get these people to treatment. We had a lot of skills.

I'll explain to you about why I left the SSO. Bill Jefferies had two brothers with schizophrenia and one of his four children was also afflicted. That started him doing the organization. One of my four children is afflicted with a serious mood disorder. Alas, this did not become evident until five years ago. Again, there is some family history in generations past.

About the Mental Health Commission of Canada: It seems to have little sense of direction and its priorities are questionable. Please see my response to their recent draft. A quick online trip to a recent mental health commission of Britain, which has now closed down—and I've put that in your package—will tell you some of the problems that they find, which are all, in my view, very predictable. Note that the British have allocated 18 million pounds to battle stigma. In my view, the money should have been allocated to address the most pressing problems that they have. Yes, there is stigma, but decreasing it should not be overplayed as a cure-all. There is a naive assumption that removing stigma would take people to treatment. Lack of insight—anosognosia—is the biggest problem in terms of accepting treatment. If you do not think that you are ill, why would you agree to have treatment? I've lost my place again; sorry.

Stigma is not part of this equation. As for the anti-stigma campaign, one beheading on a bus will reverse any public gains they are attempting to make. I don't want to go into that, but I have a lot of views on it.

Prompt treatment seldom happens. Michael Wilson co-chaired an inquiry which stated that only 25% get the treatment they needed. It would be lovely to reduce wait times, but if the system is clogged with the ever-revolving door and lack of trained staff, what can anyone expect?

Those who cannot speak for themselves are at the mercy of those who can. Those calling themselves consumers and sometimes survivors are taking over the system. This other population will continue to hold the high ground along with those professionals who have a vested

interest in following along with such agendas. Those with the very serious forms of these illnesses are often let go by the very teams that are supposed to look after them. I'm talking about them as difficult to serve, who get into drugs and all the rest of it.

Much remains to be known about these devastating diseases, but enough is already known to tell us that these sufferers have been unlucky in genetic roulette. Yet, the mental health commission goes on about prevention. Since we do not understand the mechanisms of these disorders, how can we possibly prevent them? But we should be able to put services in place that will minimize collateral damage.

Society has a lot to answer for, but one's personal biochemistry is not one of them. It should be stated and understood by those planning services that these are no-fault diseases. The commission should stop going on about primary prevention.

Major mental illnesses run in families—I'm repeating myself again. Those who say that stigma—I'll skip that to save time. I think, really, it's like, if one suggested to an insulin-dependent diabetic that he did not need insulin, malpractice suits and culpability would follow, and I think that's one of the main points I'm getting at with some of the people who say "alternative therapies." These are not perfect treatments but they should be continued and monitored.

We've heard reports galore—Heseltine, the Graham Report, which said that the top priority must be for the seriously mentally ill. It got whittled down; nothing happened there. I won't list the reports, but I would like to know what happened to the recommendations that were in Michael Wilson's report, where he co-chaired the report. That seems to have disappeared off the agenda.

My recommendations are:

—Take a serious look at what happens if there are not enough acute and long-term beds.

—Accept the fact that there is no way to prevent the illness.

—Make top-notch medical care the first priority.

—Accept that access—and this is a very important one—to the full range of psychiatric medication is pushed forward because it is cost-effective to keep people stable. These are powerful drugs and patients need close monitoring when they're taking them, and I think that more people should be in hospital when these drugs are given, especially for the first time.

—Revise the Mental Health Act in Ontario. It must be made to work; it's not working.

—Families must be allowed to act in their loved ones' best interest.

I've left a quotation for you. "Along with community treatment orders, we should fund a treatment advocate"—I think this is really important; with the law not working properly, you've got to have somebody who's going to try and push for treatment. We've had the Starson case; we've had Vincent Li, and that's going on; and we've had, in this city, Tony Rosato.

1050

Tony Rosato is quite a well-known theatre person. He had six lawyers; he fired them all. He had several judges. He didn't fire the judges, but they moved on. The last person who represented him, first of all, came in as an amicus, and then he became his defence lawyer. He argued that he shouldn't be an NCR because he wouldn't get a job afterwards. If anyone heard Tony Rosato in court in his own defence, you would have known that this person was a time bomb waiting to go off. He was very dangerous. Anyway, he eventually went to hospital, but he wasn't treated for quite a long time.

I think you need to do something about ODSP. It's ridiculously low.

I think you've got to put more emphasis on not muddling up the walking wounded; that's not a derogatory thing that I'm saying, but people with lesser illnesses. You mustn't muddle them up with the ones who have psychosis, because if you do, we know who is going to lose out. It will be the people with the psychosis.

I leave you with the following quote. It was in an e-mail which was sent to Marvin Ross. He wrote this book. I recommend you get it. I've listed it in your material. This came from somebody who did the quality-of-life study for the Canadian schizophrenia society. I've just included part of the quote. "Framing mental illness, and schizophrenia in particular, as genetically based, biologically driven diseases of a broken brain is actually increasing discrimination and social distance. The unintended consequences of emphasizing the disabilities and deficiencies of the illness and the pain"—I'll stop there. She then goes on to say, "I know that no one involved in the schizophrenia societies believes that they may be contributing to the worsening of stigma and discrimination, but that in fact may be happening." Then she goes on to say, "I think we need to dramatically reframe how we talk about schizophrenia if we are to achieve truly transformative change." That's so stupid. Can you imagine saying this to families of diabetics or of those afflicted with multiple sclerosis?

Families have often lost friends when a loved one is stricken, but this kind of statement is insulting beyond measure. They neither caused their relative's illness nor stigmatized their relative, but sometimes they have had to keep quiet for obvious reasons. I would say that the author of the quality-of-life report is adding to family stress. I assume she got government funds to do this quality-of-life study.

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

Ms. Patricia Forsdyke: I'm sorry; I came on with a lot of stuff, but—

The Chair (Mr. Kevin Daniel Flynn): No, no. I think we got your point very clearly. Unfortunately, we don't have any time for questions—

Ms. Patricia Forsdyke: I've left you a lot of material, so you can go through that.

The Chair (Mr. Kevin Daniel Flynn): Our bedtime reading.

Ms. Patricia Forsdyke: This is the last report, may I just say, and I don't buy it. It's got large pictures of people in the report. I don't know why anybody needs a large picture to put out a government report on expensive paper. I'm sorry you won't ask me questions, but please do read what I've given. Thank you very much.

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

PENNY PATERSON

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning is Penny Paterson. Penny, if you'd like to come forward. You came prepared with your own water. Make yourself at home. Like everybody else, you've got 20 minutes.

Ms. Penny Paterson: I brought my brother John along as well, because this is for both of us and involves both of us.

I'm very glad to have the opportunity to address you today regarding our concerns with the health care system in Kingston's mental health facilities. That's the area that we know. These concerns are from our sister's recent admissions to both Hotel Dieu, our general hospital, and the Providence Care mental health facility.

My talk could be entitled "Let's put the 'care' back into mental health care," or "Putting a human face on mental health care," a good corollary to the last talk, I would say.

As the sister of someone who has had a lifelong struggle with a bipolar disorder, we have a different and much more personal perspective. My sister is now a senior, so that represents over 40 years of a troubled existence. With her aging and the recent separation from her husband, my brother and I have become directly involved as caregivers and caretakers. Our focus is on streamlining treatment practices, earlier intervention, and a more integrated and comfortable process which includes family input.

During our sister's last two relapses, we've had to call on the assistance of the Kingston police as the only means of getting her to hospital. Incidentally, they could not have been kinder or more professional. How can we ensure earlier intervention and prevent her deterioration to such an undignified and irrational state?

A protracted and uncomfortable time in emergency ensued, finally followed by admission to that hospital. After a few weeks and little progress, she was transferred to the Providence continuing care facility. Within a short space of time, she had experienced two sets of health care providers and two treatment approaches and environments. To my knowledge, there was no liaison with the team that supports her in the community—making it now a third set of caregivers. In her fragile and confused state, it was a difficult adjustment, further contributing to her distress and progress. We'd like to see a focus on and discussion of this process. Is there a way to streamline this transition and to avoid so many steps? Ultimately, how can we work together to decrease the duration of the

hospital stay and promote mental health stability for our sister and others requiring care?

Our sister is fortunate in that we are involved in her life and try to keep vigilant, but with her judgment and behaviour rapidly becoming skewed, she is at risk. During her relapses, she became the social worker for Kingston's street people, bringing them into her home. In one week, she spent \$8,000. We shudder to think what could have happened if we had not intervened. She was in both physical and financial jeopardy. I fear she would have been at risk of becoming a street person herself.

It is our hope that we can generate some discussion of increased support for mental health clients in the community. Let's offer some better alternatives to ending up on the street and the discomfort it causes for those involved and for a caring society such as ours.

Are we offering enough support to our mentally ill, once discharged from hospital? How carefully are clients' post-discharge needs assessed? Is client contact sufficient? Should these needs be individualized or minimum standards mandated?

During her last two admissions to both hospitals, all her belongings were lost. Her clothing, jewellery, eyeglasses and personal effects disappeared, never to be retrieved. This occurred despite the fact that everything had been labelled. It's our belief that she was not able to be responsible for anything, let alone her belongings, at this time. There's some comfort in dressing in clothing that fits and is of your own choosing. She was dressed in some pretty bizarre outfits and shoes dug out of a communal cupboard. According to other ward mates, this was a problem for all of them.

I wrote a letter to four staff members with the suggestion that all clients have a labelled bin, kept in a cupboard, where all articles will be kept and accessed by staff when needed, and that valuables be sent home with family. I received no response from all of my letters. I dare say that this plan would save staff precious time, as they would not have to weed through a Pandora's box of a cupboard to clothe people. Perhaps another solution exists, but we do feel this issue needs to be addressed, and I look forward to hearing that it has. I think what was most upsetting to me, having written, I felt, a fairly positive letter, was that I received no response.

1100

As well, our sister has diabetes, which is a condition requiring special care. When acutely ill, she's not able to attend to her basic needs, let alone any special needs. Her grooming and personal hygiene were neglected, and this aspect of nursing care seemed to be lacking. The positive effects of being clean and well-groomed greatly affect a person's dignity and might even have lifted her lagging spirits and self-esteem. When questioned one day about brushing her teeth, she advised me she'd long since lost her toothbrush and toothpaste. The situation was the same in both hospitals. As a result of several months of neglect, she lost two teeth and has had extensive dental work upon discharge. It's our belief that attention to physical care must be adopted as a part of nursing care

when people are not responsible for their actions and neglect themselves.

When she began to improve, our sister was moved to a ward for people further along in the treatment process. Here, she spent her days sleeping, watching TV or listening to the radio. The family saw no evidence of any programming to assist her in resuming a normal life or enriching her stay. It seemed that efforts promoting interaction with others or exercise programs were sadly lacking. Opportunities for behaviour modification strategies or life-skills teaching were missing entirely. We tried to bridge the gap ourselves between hospital life and a return to her own world by visiting daily, taking her out shopping, etc. She did not seem to have been made aware of places within the hospital that she could take advantage of, like the library, gift shop, canteen and second-hand clothing cupboard. Perhaps she improved more quickly by our involvement. I like to think so, but wonder about those not being visited by family or friends. We very rarely saw other visitors—a void; that needs to be encouraged.

All this left us with a few questions. Is enough care taken to assess an individual's ability to be self-sufficient? Are family members brought into the loop? Is there adequate communication between professionals? Has housing in a safe and supportive environment with ongoing and regular follow-up been arranged prior to discharge? A focus on some life-coping skills, when the acute stage is over, would surely be cost-effective, as it just may reduce frequency of readmission and extend periods of good health.

As you can see, we have serious concerns about the care our sister received during her recent relapse and her subsequent admission and treatment. It is our hope that you will give these matters careful consideration. As stated, our concerns are for all stages of treatment as applied to all clients, as well as our sister. I hope this address will provoke more discussion about the value of earlier intervention, a more seamless handling of treatment, family as an integral connection, improved treatment programming in hospital, and improved discharge planning.

The "human face" mentioned in my introduction doesn't only refer to our sister's story but also to the need to put more humanity into our care of people unfortunate enough to be afflicted with a mental illness.

The Acting Chair (Ms. Helena Jaczek): Thank you so much, Penny, for your presentation. You've left about three minutes per side for questions, starting with the government.

Interjection.

The Acting Chair (Ms. Helena Jaczek): Even more time, Sylvia.

Ms. Sylvia Jones: My question relates to the early intervention. I'm assuming that you're talking about the fact that your sister had to get to the critical or serious stage before any intervention was offered or available. Do you have a suggestion for the committee on how that early intervention could occur?

Ms. Penny Paterson: Well, I think more frequent visits by health care professionals in the community would have picked this up.

Ms. Sylvia Jones: So she was under the care of—

Ms. Penny Paterson: It happened very quickly in this case, so in fairness I don't know exactly how it could have been, but perhaps with more frequent visits by health care professionals.

The Acting Chair (Ms. Helena Jaczek): France?

M^{me} France Gélinas: The question is a little bit personal, so if you don't want to answer it, you have to be very—

Ms. Penny Paterson: This was all pretty personal.

M^{me} France Gélinas: But it's different to volunteer than to be asked.

You mentioned that your sister was diagnosed 40 years ago and lived with the disease for 40 years. Did she live in the community all that time?

Ms. Penny Paterson: Pretty much, yes. We rescued her, as we felt, golly, when she was in her early 30s, I guess, from an institution and got her into the community through group homes and that sort of thing. She has largely been in the community, yes.

M^{me} France Gélinas: And where did she live and how did she support herself? Did she work?

Ms. Penny Paterson: Yes. She was able to in the early years, but not for years. She's been on a disability pension, largely, and she has some independent funds.

M^{me} France Gélinas: Where did she live?

Ms. Penny Paterson: Kingston.

M^{me} France Gélinas: Did she live alone?

Ms. Penny Paterson: She was married, so some of that time she lived alone.

Mr. John Paterson: She actually was in institutions in Ottawa, Guelph, Kingston and Brockville. So she's actually lived in different places in the province.

M^{me} France Gélinas: Where she was in institutions?

Mr. John Paterson: Yes.

M^{me} France Gélinas: Let's say we look at the last two—I think you called them relapses. At that time, what kind of community support was she linked to and through which agency, and how did that work?

Ms. Penny Paterson: She has a psychiatrist in the community and—I don't know the terms, but she has a social service nurse who visits as needed and on a regular basis who she has a very close and caring association with.

M^{me} France Gélinas: And is this a long-standing relationship she has with this nurse?

Ms. Penny Paterson: Fairly long, yes; five years, perhaps. I don't know. Is it that long?

Mr. John Paterson: It's been quite a while. I think they were seeing her about every two weeks before her relapse, but it was within the period of two weeks. It was sort of about two weeks before that Penny and I said to each other, "Things are not going well." It just needs to be more frequent, I think.

Ms. Penny Paterson: And it is more frequent just now.

M^{me} France Gélinas: Were you able to communicate with that nurse that you were worried?

Ms. Penny Paterson: She was on holidays, unfortunately. It's just a situation that developed that fell through the cracks.

M^{me} France Gélinas: And there was no backup while she was on holidays?

Ms. Penny Paterson: Yes, but not by someone who knew her well.

M^{me} France Gélinas: I see.

Ms. Penny Paterson: We've taken from that that we need to see her on a set basis and we will always continue that so that this doesn't happen again.

M^{me} France Gélinas: Now your sister is back in the community, the nurse—we don't know where she comes from—continues to come and see her and she sees a psychiatrist and, I guess, her family physician for her diabetes.

Ms. Penny Paterson: Yes.

Mr. John Paterson: I'm not quite aware of all the three different levels of treatment, the ACT and the—she's at the lowest level that is provided by the—it's through the Providence Continuing Care office. They have a satellite office. There are three levels of care, of which she's on the lowest and has been for a while.

But I think Penny's point is that one of the things is that there's no communication between the different levels, between there, Hotel Dieu and Providence Continuing Care. If there was any communication, it was because of our input and demand for communication.

M^{me} France Gélinas: Other families have told us that they have a hard time being included in the circle of care, they have a hard time knowing what's going on. Has this been your experience also?

Ms. Penny Paterson: Yes. We asked for a family conference when she first got into hospital, and that was excellent. But then, when she came close to discharge, we asked for a discharge conference and were told that no, only one conference is granted. We felt that it would have been very helpful for us to know the doses of drugs, the nature of the drugs. There was a lot of information that we'd have liked to get that wasn't offered.

M^{me} France Gélinas: And you made the request and your request was turned down?

1110

Ms. Penny Paterson: Yes.

Mr. John Paterson: Can I add also that while she was in Hotel Dieu in the assessment period, she was there for about three weeks. I have personal power of attorney for her care, and I requested—I have my notes at home—eight different times to meet with the psychiatrist, and I finally had to actually say, "Do I have to get somebody legal involved in order to have a meeting with that psychiatrist?"

Ms. Penny Paterson: We actually stormed the door.

Mr. John Paterson: Yes.

Ms. Penny Paterson: We just arrived one day and said—and that's how we saw her.

M^{me} France Gélinas: And you have power of attorney.

Mr. John Paterson: Yes.

The Acting Chair (Ms. Helena Jaczek): That's all the time we have. Thank you very much, Penny and John.

PAUL FINN

The Acting Chair (Ms. Helena Jaczek): The next deputant is Paul Finn. If you'd like to come forward and make yourself comfortable.

If you could introduce yourselves—

Mr. Paul Finn: This is my wife, Denise.

The Acting Chair (Ms. Helena Jaczek): Thank you. So, as you know, you have 20 minutes to make your presentation. You can use it however you wish. If you want to leave time for questions, we certainly do appreciate that as well. Thank you.

Mr. Paul Finn: I just want to say good morning, and thank you. My wife Denise and I, we have six children. Our 23-year old son Luke was diagnosed with schizophrenia around 2005—you'll have to forgive me. I'm not nervous about being here, I'm nervous about what I'm talking about.

That's not the beginning of Luke's story. By the time Luke was eight, we knew he had learning disabilities. Our doctor referred us to the Hotel Dieu child development centre. We filled out all the paperwork and handed it in, and they called and wanted to know why we didn't complete the paperwork. They said, "You didn't write anything down about behavioural problems." Well, Luke has none, or had none at the time. Needless to say, we were very frustrated. We were then told that they would only help children with learning disabilities who had behavioural problems at the same time. Needless to say, we were frustrated. We went to the school board and were told that there was a three- to four-year wait for this to be done, and Luke was in grade 2.

After two years, when he was in grade 4, we opted to do it privately and we found somebody who would do it for us. She did it and she didn't charge us—and I'm probably not supposed to say that because she'll get in trouble because she did it for no charge. Once tested, we had an IEP put in place, and we started to see some progress for him.

By age 11, in grade 5, we saw the first signs of depression. He told us when he was 12 he was tired of being different and he wanted to kill himself. We were stunned and we had no idea what to do. We had lots of bad times and we had some good times as well.

Luke started to come to grips with his learning disabilities when we moved and changed schools. He went from two 20-minute periods of special ed a week to a minimum of one hour a day. He began to improve quite a bit. When he hit high school, as hard as it is for any of your children to go to high school, the transition for Luke, on top of having learning disabilities and depression, made that even worse. Our doctor referred us to

a psychologist, but we couldn't continue with it because of the cost involved, and we couldn't see anyone at child services at the Hotel Dieu.

After a lot of discussion with our doctor, we found a psychiatrist who would see Luke. He was very helpful and Luke made a real connection with him in a short period of time. The only issue was that he was an adult psychiatrist who worked out of the forensic unit at the Ontario hospital, now the PCC. This essentially was a jail; you go through barred doors. We had no idea what was going on and we didn't know what to expect. It terrified us all. It was just not the right place for him, but the doctor there did help him.

Luke worsened, and by the age of 15, in grade 10, he was admitted to the adolescent psychiatric unit at the Hotel Dieu for three weeks. He had to leave that psychiatrist because he didn't have privileges to see him in the hospital in that situation. His time in there was horrible. At Luke's admission, Denise and I were reading the rules of the ward to him. We explained to the nurse who was watching us that he had a learning disability and that's why we were doing it. A few days later, there was a group session and Luke got up and read something to them. We were immediately called in and accused of teaching Luke learned helplessness, that he didn't have learning disabilities, that Luke was faking it and they were going to prove it. They said that they were going to test him again. Our opinion was, "Great," because we knew he'd have to do it later in high school if he wanted to go on.

They started the testing and after one day, they came to us and said, "Yes, he's profoundly learning disabled." What we really wanted to say was "We told you so," but we couldn't. Once they said that the testing would continue with the school board, it took another year and a half to get that done.

At the same time, Luke was telling the doctors that he was hearing voices and seeing things that weren't there. Then the doctors told Luke and us that he was having obsessive thoughts. I realize how hard it is to diagnose adolescents with mental illness because they're up and down, their hormones or whatever, so we accepted that.

Things were going fairly slowly, but he was being seen. He started as an outpatient, at first very sporadically, then bi-monthly and then every week. Things were going really slowly, but he was making some headway. I think some of that slowness was happening because it came to light that Luke had been medicating himself with marijuana.

The week before Luke turned 18, we were told matter of factly that he could no longer be seen by the adolescent psychiatrist and the team members but would have to be referred to an adult one. We objected, saying he was in the middle of treatment, and were told, "Sorry, hospital politics." It took another six months to get him to be seen by a psychiatrist, and after three very short visits she phoned us and told us that Luke was out of her realm of expertise. She referred him and us to the early intervention in psychosis clinic at the Hotel Dieu Hospital.

Once in the program, he finally got the treatment that he needed.

It has not been easy and Luke still struggles daily. There has been a real drain on our family. We can't tell you what it's meant for Luke to get into the program. I'd like to tell you that his story is unique, but I can't.

Through this program, Denise and I have been asked to sit on an advisory committee for the eastern Ontario early intervention in psychosis program, now called the HeadsUp program. I don't know if you know what it is; it's made up of medical professionals, community stakeholders, parents, consumers and, in the beginning, a member of the Ministry of Health. Through the committee, we have seen a small portion of the inner workings of the mental health system and its limitations.

Our family has been very frustrated in trying to find someone who will see us: frustrated with the time frame we got for the initial appointment, frustrated with the time between appointments, and frustrated with the lack of resources available. And guess what? Those same medical professionals and community stakeholders on the advisory committee and the front-line case workers on the ground have the same frustrations.

At one committee meeting we were discussing the need for the program to get its statistics together to present to the Ministry of Health. That's where they get their funding from, as I'm sure you're aware. The representative from one of the regions mentioned that they had a person who did their stats. Another mentioned that they used a certain program to do their stats and perhaps they could share the resources to get the job done. To me, this seemed like a breakthrough; they were making real progress.

The meetings generally last about an hour and a half to two hours. At this particular meeting, the Ministry of Health member was late. When they did come in, all cooperative discussion stopped. When I brought it up again, the first question the Ministry of Health representative asked was if the representatives had surplus budget and were they going to give it back to the ministry. Everyone hummed and hawed, backtracked and retracted. I was told that it is how it was. Perhaps your committee can get a better answer.

Back to the HeadsUp program that Luke attends: It has one part-time psychiatrist—just one. I can tell you that, listening to him give his medical report at the advisory committee, you can hear the stress and strain in his voice, and in my non-expert opinion, he's getting burned out. What if we lose him? Who do I blame? Who do I talk to? What happens to Luke and the 200 other clients in the HeadsUp program? Who do they talk to?

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The stigma that surrounds those living with mental illness doesn't stop with them. There is stigma around those who work and care for those people. I heard the comment that stigma is not the problem. A better term for me would be "ignorance," and that ignorance goes through not only the health system—the ignorance of the people you see at an emergency ward when you present yourself with your son.

As of last week, if you were lucky enough to get referred to the HeadsUp program and were seen within 14 to 21 days, your first follow-up appointment is not going to happen until mid-September. I ask you: Is that right? If a parent or a caregiver had their child seen for an extra appointment, they are now faced with a three-month wait. What options do you have? I can tell you: not many. While you are contemplating the lack of options, you must continue to go to work every day and care for your other children and try to act like everything is okay and wait to have your youngest daughter call you—

Ms. Denise Finn: And wait to have your youngest daughter call you at work every day when she gets off the school bus so you can breathe that sigh of relief—

The Acting Chair (Ms. Helena Jaczek): Please take some time to compose yourselves. I think I speak on behalf of all of the committee to say that we're very grateful for you to have come today. We know it's very, very difficult.

Mr. Paul Finn: So we wait for our daughter to call us to say that Luke hasn't killed himself.

So in the midst of all this and we have a crisis, what do we do? We go to the hospital. We've been sent home and told to watch Luke in case he tries to commit suicide, and, "Come back if it gets worse." I want to say to them, "Why do you think we're here? We're already past 'worse.'"

Luke has now made some large decisions in his life and has made contact with Options for Change, and that's to deal with his reliance on street drugs. His initial appointment, after he made his contact, is two and a half months away.

Someone mentioned ODSP. Denise and I made the decision not to have him go on ODSP because we didn't want him to leave the house and, as our psychiatrist put it, "get his penny from the government and live in a basement apartment." We struggled with that, but just within the last six months we realized that Luke is going to need to be able to support himself, so we had him go on ODSP. At home he gets \$797 a month, nowhere near enough for anyone to live on. I don't know what the alternative would be. I don't know how much more money you would give him. All I can say is that it's probably not enough, but I think it's the best that we can offer, which, unfortunately, doesn't seem to be very good.

I don't want to leave you with the sense that we need a new mental health system; I don't. I can't tell you what it's meant to Denise and I. If it wasn't for the mental health system, I firmly believe that Luke wouldn't be here today. As I said, he was diagnosed around 2005; they never really came out and told us for months and months after he was in the program. One of the things that Luke said to the doctors is, "I've been sick for so long. I don't need you to tell me what I don't have. I need you to tell me what I do have." His doctor said that they would not let him go until they knew what was going on.

When making any decisions, I don't want you to try to walk a mile in Luke's shoes; that's pretty easy. I want

you to lie on a couch or in a bed with your back to the world. Force yourself to do so for an hour or, better yet, put a pillow or a blanket over your head. Don't eat; don't shower; don't talk to anyone. Do it for a day, a week, a month or six months. You'll probably all get very frustrated and get up very soon. You have to realize the extent of what Luke and others like him go through and why they can't get off the couch.

What we need, I think, are more resources to have the best mental health for all Canadians. I think it goes back to how we see ourselves and what kind of society we want to live in.

I'll leave you with a simple thing: Just don't throw out the baby with the bathwater, but do your best to get a bigger bathtub.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Okay. Are you up for questions?

Mr. Paul Finn: Yes.

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

Ms. Sylvia Jones: Thank you very much for coming this morning. I think it's very important that we hear from families.

Based on the timelines, it looks as though your son was diagnosed right around 18, 19. You are obviously very strong advocates for your son, and I'm sure that is helping in his treatment. What I'd like to ask you is, because you were at that age when the privacy issues tend to come forward, did you have any issues with that in terms of getting information from the health care professionals?

Mr. Paul Finn: No, because Luke is more than willing to sign the form. We thought he would be here today, but he couldn't come. He's pretty articulate, and I think that has been a part of his problem. He's fairly bright and articulate and can talk about it and has a deep insight into what's wrong with him, so I think that it's a real challenge to listen to him and believe him, I guess is the only way to say it, because he is that way. What he said to the psychiatrist who accused him of using his learning disabilities when he got up and talked—he snapped at her and said, "I'm learning disabled; I'm not illiterate," and she got her back up, and we got our backs up. So that's where they really went to prove to us that he was faking, and I don't know how they were intent on doing it. But we had no trouble getting any of the information. As a matter of fact, the more we talked—generally, every time Luke would meet with the psychiatrist, we would sometimes get five minutes, 15 minutes, and a lot of that background, that family information, became helpful in getting him diagnosed.

One of the big turnarounds for Luke was when they put him on Tegretol—Denise has a seizure disorder—and he started to improve quite a bit. So that was very helpful.

Regarding your question about whether we're able to get the information, my feeling is, I don't care as long as he gets treated. I don't need to know. I don't want to know.

Ms. Sylvia Jones: But you were clearly playing a very active role in advocating for him, so—

Mr. Paul Finn: In one way we were, but in other ways we weren't. We weren't forceful enough. I didn't become a pain in their ass to make them talk to us. We're not good advocates. I'm not good at getting up and complaining about everything that's wrong in our particular case.

Ms. Sylvia Jones: You did an excellent job this morning. Thank you.

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

M^{me} France Gélina: I, too, want to thank you for sharing your story. It took a lot of courage, but I think it was worth it.

You did mention, in talking to Sylvia, that you were able to get five or 10 minutes with the psychiatrist. Was there any support offered to the rest of your children? You mentioned your daughter calling and saying, "Luke did not commit suicide. He's still here." I can't imagine a child having to report—

Ms. Denise Finn: Through the HeadsUp program, there is support for the family. There's a family education program which we took our children to. We have books available at home for our kids, and there's a little guide that's put out by the Canadian Mental Health Association—siblings living with a sibling with a mental illness—that they've all read and have passed on to their friends. We get Schizophrenia Digest in our home and it's out on the table, available for them to look at and read. They're all very well educated. In fact, our children have turned into these little mental health advocates. It has just been this little fallout that has happened.

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Our daughter, who is the youngest—she has five older brothers. It's her little crusade that people can't use the kind of terms that they use when they're—you know, they think they're just an offhanded comment. For example, her music teacher was explaining something to them recently and referred to it as "very schizophrenic." This same music teacher taught Luke, so he knows Luke's history, and Hannah went, "Excuse me, but that's not the proper term for that word," and he said, "Oh, you know what I mean. You know what I'm trying to say," and Hannah said, "I know what you're trying to say, but you shouldn't be using that word," and he said, "Oh, you know what I'm talking about. You know what I'm trying to say," and Hannah said, "Yes, I do, and I don't appreciate it," and then she said his face just dropped and he went, "You're right; I'm sorry." She said at the end of class he called her aside and he went, "I'm so sorry. I didn't realize what I was saying," and Hannah said, "That's okay. This is just what I do." She said, "I hope you didn't think I was disrespectful," and he said, "No, not at all. Thank you for calling me on it." And that's what they do. I think that's because they've had some education and they know about it.

We know it has been really hard in particular for our daughter to have to grow up with this and make calls like that, but we don't have any other choice.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Are there any questions? Liz?

Mrs. Liz Sandals: Thank you so much for coming and sharing your story. As we've gone from place to place, we've heard a lot of stories about difficulties with children's mental health and adolescent mental health and adult mental health—all these sorts of artificial age boundaries and programs. You've run into another conflict, I guess, between people who are trying to sort out learning disabilities and the education system, plus the health system, looking at mental health, and now you've got addictions layered on that. It seems to be very difficult with teenagers to find coordinated services because you've got all these different systems.

Do you have any recommendations for us about—you talked about not totally throwing out the system, but how would you make this system better so that you don't fall in this service war that you've obviously had to work your way through?

Mr. Paul Finn: No.

Ms. Denise Finn: I think, really, for us it has always just been a lack of resources. There were always people willing to listen once we got in there and got our appointments. If we got to talk to somebody and they knew of another available resource and they could just refer you, and in a reasonable length of time you could be seen by this other person, that would make all the difference in the world.

What Paul just said about Options for Change and Luke—actually, it was four weeks yesterday since he has not used any marijuana. This was a huge decision for him, and he has never, ever gone more than a couple of days in years.

We went with him to talk to his social worker at the HeadsUp program to say that this is the road he was taking and what were the next steps. And she said, "Well, we'll get you a referral to Options for Change." That was two weeks ago, and he sees them at Options for Change on July 3. That's too long. He needs to be seen right away. I know they can't help that, but there has to be a way. That's too long.

So now he's in this kind of limbo stage where he's afraid to leave the house, because he knows the reality is, he has to make all new friends. We live outside of the city. He can't come into the city for the day and just walk from place to place, hanging out with his friends, because he knows the temptation will be there. So he's stuck at home and we're bringing people in to have dinner with him and things like that. And we have to say to them, "You can't have anything on you; you can't have anything with you." We're going through this period right now where, if he could already be somewhere getting the help he needs—but that's not how the system is set up. And once he goes on July 3, when are they going to see him again? We have no idea, because we've lived that in every other facet. We don't know.

Mrs. Liz Sandals: Thank you very much. So your biggest issue is with the wait times and getting access to services.

Mr. Paul Finn: I think, as a comment, and I don't know how you'd ever get around this, the physicians and their lack of humility, in that I say, "I'm going to do the cognitive therapy," and, "No, no, we're going to do psychotherapy." Never will the twain meet, because, "He's his guy and this is your guy, and that's the way we do it." They never seem to get along.

If it was up to me, I'd leave the doctoring to the doctors and leave the running of the medical—you hate to call it "medical," because that infers doctors. Let the people who run the business do it. Experiences would be, in an emergency ward or in emergency—I run a computer help desk at Queen's. If I did my job the way they do theirs, not only would I get fired, they'd throw me out. I don't know how to argue or how to present that case, as difficult—

Mrs. Liz Sandals: There needs to be more consideration for how you interact in a positive way with patients and their families—

Mr. Paul Finn: Absolutely.

Mrs. Liz Sandals: —instead of this, "I'm God. Now just leave me alone."

Mr. Paul Finn: Yes. Call them. We've started to get very good at saying to them, "We disagree with you. What is it that you are"—lots of times, they still get their way, but they've at least informed us of how it is that things need to be done.

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

ONTARIO SHORES CENTRE FOR MENTAL HEALTH SCIENCES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is the Ontario Shores Centre for Mental Health Sciences, if you would come forward: Brian Hart and Glenna Raymond. Make yourselves comfortable. I'm sure we have a clean glass or two around if you need any water. If you don't, let's move on. You've got 20 minutes, the same as everybody else. If you leave some time at the end for maybe some questions and answers, that would be great. It's all yours.

Ms. Glenna Raymond: Thank you. My name is Glenna Raymond and I'm president and CEO of Ontario Shores Centre for Mental Health Sciences. I'm very pleased to have the opportunity to address the select committee this morning. With me is Brian Hart, past chair of our board of directors and a community member.

I appreciate also the opportunity to have heard some of the family stories and patient experiences. They impact so much what we do and our whole approach to care. I also want to share with you that over the last two years at our hospital we've made considerable inroads because of inviting patient stories, patient vignettes, and families to be part of the care environments, and in fact part of the board environment. It's made a huge difference in what we do in our care environment.

Today, though, we'd like to speak more at a system level and to some of the perhaps frustrations or

recommendations that we have, not so much for care and the direct delivery of services at our hospital and from other providers, but more from that system perspective.

We are encouraged by the commitment and attention to mental health and addictions that is being demonstrated at both the provincial and federal levels. The work of this committee, in particular, is an important step in addressing and resolving the challenges that are associated with the growing demand for mental health and addiction services. We commend the government for acknowledging mental health care as a priority.

Our hospital has one core business, and that is mental health care. So we've experienced first-hand the need for a provincial strategy that encompasses the various sectors to guide the transformation of mental health care, and indeed the transformation of the system.

For those of you who might be less familiar with our organization, I'd just like to quickly share a little bit of background about who we are and the work that we do to give you that context.

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Ontario Shores became a public hospital in March 2006, when governance of the organization was transferred from the province to a community-based board of directors. At that time, the hospital operated under the name of Whitby Mental Health Centre. In fact, it was just a few days ago that we unveiled our new name and our new mission statement at an annual general meeting that was standing room only for our community.

Becoming a public hospital really provided an opportunity for our board, senior leadership team, staff and clients to engage in considerable open dialogue with staff, patients, community members, health care providers and other partners in mental health care. These consultation sessions were held both internally and externally to identify strengths and gaps in services and to seek the creation of our organization's core vision, values, directions and purpose. That feedback was very helpful in helping us identify directions for our organization, but it also has given us since 2006 a very broad sense of input into the system on what the gaps in services were.

Ontario Shores provides a broad spectrum of specialized assessment and treatment services to those living with complex and serious mental illness. We serve a range of individuals of all ages and all backgrounds from across Ontario. Our mission is to provide leadership and exemplary mental health care through specialized treatment, research, advocacy and education.

We employ about 1,200 staff, made up of physicians, nurses, allied health professionals and support staff. Our main facility has 329 in-patient beds, and in any given year we typically will treat over 1,000 in-patients and several thousand outpatients. Patients come to us from across Ontario. Our approach to care is very much one that encourages collaboration with all providers and is attempting to put into place the transitions, the seamless care, that we've heard from so many of our clients was one of the gaps.

As specialists in mental health care, we are dedicated to advancing and transforming the mental health care system for the benefit of our patients and all individuals touched by mental illness. We see that our mandate goes beyond the direct service for those clients who are registered patients. We acknowledge the importance of having a coordinated and integrated approach to mental health care that considers a variety of factors, such as equal access to treatment, affordable housing, employment, education, dealing with the stigma of mental illness, and addressing the diverse needs of patients.

There are seven areas, seven recommendations or suggestions, themes, that I'd like to speak to today and leave you with. I'll focus on those seven points this morning.

First of all, serious mental illness is a chronic health condition like diabetes or heart disease. A policy framework and a management strategy that is similar to other chronic disease management models is what is needed. When providing diabetes care or cardiac care, our society has quite a different expectation and approach: concepts such as a client registry, given that there are multiple providers involved in the care; electronic health record tools; self-management supports; drug programs; consumer and peer empowerment; and primary care support. All are important for managing chronic disease and have been well recognized in the models that are currently in use for both diabetes and cardiac care. These are equally important for mental health conditions such as schizophrenia, bipolar disorder and organic psychosis. About half of the people whom we treat at our hospital have a diagnosis of schizophrenia, yet the system around us has not used a similar model to ensure that all of those supports are in place.

The second area where there's room for improvement: A framework and a leadership structure are needed to ensure coordination and accountability, and cannot be left to the individual provider. A champion or a provincial leadership agency or accountability structure is necessary to develop and deploy such a framework. Again, we've seen this in place with other diseases. The Cancer Care Ontario model, for example, has demonstrated a provincial approach to managing disease that could be applied to the delivery of mental health care. This comprehensive approach is required and could help standardize care; ensure equitable access, including wait-time management; deliver evidence-based practice according to research standards; and put in place province-wide measurement and coordination of resources using lead agencies that specialize in mental health care. Again, we have a model in place that was effectively used for other diseases.

Given the complexity and specialized expertise required, we need to ensure that subspecialty areas such as children's services and seniors' services are planned and delivered so that all residents of Ontario gain equitable access to care and services. The amalgamation of mental health hospitals into acute care or into complex care facilities over the past decade, and the 14 perhaps arti-

ficial boundaries created by local health integration networks make it even more important today to put in place some type of provincial coordinating authority or mental health agency.

Provincial-level coordination is of particular importance for forensic services and programming for mental health and the law. There are significant legal system and Criminal Code implications, and Ontario needs to have readily accessible assessment beds and to initiate treatment promptly so that clients who truly need mental health care are not unduly detained in the prison system instead. In addition, given the obligations that arise from the federal Criminal Code law, it's also important that these mental health care services have planning, standard-setting and measurement that is consistent across all providers across this province. Currently, about two thirds of our clients that we see on admission have a legal status that's other than voluntary. This highlights the role that specialized mental health care services provide in the safety of our community.

A coordinated approach is necessary for better client outcomes, wait list management and effective use of resources across the system. If you consider in our organization, just as one example, we have an occupancy rate of over 97%. At times, about 20% of our patients are ready for care in another setting, like a community treatment team, a longer-term-care setting or outpatient case management, some of which we offer ourselves. But on average, at any given time, we have another approximately 30 to 35 individuals who are waiting for admission to our in-patient specialty programs. They wait, on average, for more than 30 days to be admitted, and yet we're full—97% to 100% occupied. A coordinated approach can be accomplished through accountability with a central bed registry, performance management and capacity modelling that a lead agency could oversee for comprehensive mental health care and addictions services. This is probably one of the most significant changes that I believe we need to see in our mental health system.

The third area I'd like to speak to is the broader, if you like, physical or general health system's attention to mental health and addictions. Attention within the health care system overall for mental health and addictions must be elevated. Many of the current Ministry of Health and Long-Term Care initiatives such as the wait-time strategy, the quality agenda, the health human resources initiatives, mandatory reporting for certain indicators and the funding formula work are all functioning to transform Ontario's health system. However, these initiatives are currently designed without adequate consideration of their applicability to the mental health care environment, and we could do much to improve that.

The provincial mental health strategy must provide both direction and investment in health system clinical capacity and provide the tools, resources, clinical expertise, subspecialty care and alignment with other health initiatives to ensure equitable access to treatment across Ontario. Without such, clients who are experiencing

mental health conditions are marginalized within the very health care system that is supposed to be serving them.

A balanced approach to care is needed. We often hear the phrase that "a friend, a job and a place to live" is what consumers want and need, and we certainly agree with that. The expansion of community care, consumer initiatives, peer support, informal care, family care, employment and adequate housing are all important for those individuals who are recovering from mental illness. However, we must also attend to the desperate needs of those who require specialized care and access to specialized services, mental health subspecialty care, to get accurate diagnoses and access to specialist human resources, including medical and other professional staff.

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About 30% to 70% of a general practice physician's normal caseload consists of patients whose ailments are either of a psychological origin or are significantly related to psychological factors. We also know that there's an increase in patients who are requiring mental health care services. In Ontario in the last decade we saw that percentage among mental health requirements rise by around 13%, and yet the general increase in health service demands was only about 4%. We know as well that there's a shortage of nurses, doctors and psychiatrists. For the first time ever in our history at Ontario Shores, we're anticipating a full complement of psychiatrists by next fall with the recent graduating class.

We also know that the presence of co-morbid conditions is well documented. The prevalence of metabolic disorders and cardiovascular disease is much more frequent among those with serious mental illness. Obesity is twice as prevalent in patients with serious mental illness. Diabetes is up to three times more prevalent in this population, and 70% of patients with a diagnosis of schizophrenia die of cardiovascular disease, not their mental health condition. Expert clinical services, in conjunction with informal and social community support systems, are required to assist those with mental illness.

We believe that the provincial strategy needs a delicate balance of attention to four dimensions working in harmony: first, diagnostic and specialized clinical resources and improved capacity; second, specialized human resources, including medical and interprofessional caregivers; third, a focus on legislative, regulatory and policy initiatives; and fourth, consumer, peer and community resources.

The fifth area that I'd like you to give some attention to is to be able to leverage coordination and active involvement across many ministries, such as health, justice, children and youth services, housing—we could have listed probably all of the ministries. The impact and implications of mental health conditions cannot be addressed for individuals with illness, for their families, for society or for our economy without the participation and contribution at a provincial level of many ministries. Government needs to find ways to coordinate efforts across all of its departments as well as ensure identification of lead visible accountability for mental health in Ontario.

At a national level, finally, alignment with the national agenda and a strengthened research focus is important. The national agenda is emphasizing attention on things like stigma, the volunteer social movement, empowering clients and embracing recovery thinking. All of these are necessary elements of a mental health strategy. However, without significant attention to transforming how services are delivered, which is the provincial agenda, and the scientific basis for treatment and recovery, which I see as a shared agenda, we will not advance mental health treatment, recovery or indeed prevention.

There's an urgent need for investment in research, both in basic sciences and applied research and knowledge mobilization. Provincial and federal infrastructure funds are required to support this.

I'd like to thank you for the opportunity to speak with you today. Ontario Shores Centre for Mental Health Sciences champions and supports the efforts of patients, professionals and policy-makers to ensure that individuals with mental illness have access to care and the opportunity to fully participate in society.

The Chair (Mr. Kevin Daniel Flynn): That's great, Glenna. Thank you very much for your presentation. We probably have time for one question. You're first up, I think, France.

M^{me} France Gélinas: I only have one?

The Chair (Mr. Kevin Daniel Flynn): The whole group only has one. You have the question for the entire panel.

M^{me} France Gélinas: Oh, no.

I really like your suggestion under number 2, "A framework and a leadership structure are needed to ensure coordination and accountability," and some of the leads for the function of what that would have to do. I would like—and I only have one question so I'll make it a long one—to see how you see that. What would that look like? You made reference to Cancer Care Ontario. Is this in separate agencies from the government? Because then you come back with point 5, where you—is it point 5?—where you talk about needing to put all of the different departments of different ministries together to be successful. So I take it from this that you see this coordinating agency focusing on mental health being separate from the bureaucracy of the government.

Ms. Glenna Raymond: Yes, I do. I think those are two separate suggestions, comments, that we're making today. The lead agency or structure, I believe, can be separate from government. It needs to put in place the structure and the tools such as capacity modelling, bed registry, standards for assessment, evidence-based practice, wait-time management, those types of things. That would be the task or the focus of such an agency or a lead accountability council or group.

That's different than, but needs to be complemented by, some initiative within government that helps the various departments of government ensure that they are well-aligned and working on the same outcomes. For instance, the legal branch, the forensic services, the children's services, the health ministry—all of those have a huge

impact on recovery and the successful provision of care for mental illness. So how government treats that internally—I don't presume to make any suggestions. As a provider, I see the impact of having several different ministries contribute to or co-operate—or be in competition—in terms of the outcome of the services. The lead agency has a different type of function, in my suggestion, in our presentation to you. Have I made that clear?

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. Unfortunately, the time has expired. Do you have a closing remark?

Mr. Brian Hart: I could just add one comment to that. From a board perspective and as a community contributor to this, I could say that we had a rather unique opportunity here when the old Whitby was divested from the government in order to start fresh. It became very clear to us as a board, right from day one in this, that our involvement was not with this hospital as four walls and a particular silo within the health care system; that if we were really going to do our job as a board, we had to look at the full spectrum of mental health services. We couldn't just look at our entity and talk about maximizing the efficiency and the procedures within that. It was really the whole mental health system that was important, and we had to play our part in making that whole system as good as it could be.

So it's a philosophy that we've adopted ourselves, on the board and within the corporation. We've even brought that into the new foundation that we started. We now have a hospital foundation which can actually donate money to other agencies which help out with mental health patients. We've seen it ourselves; we've seen the requirement to talk about the whole mental health system. Now it's just sort of the intransigence of the whole system to make it move forward. It's that sort of static inertia that we have to try to overcome in doing that.

Glenna has brought forward some of the ideas that could happen legislatively and collectively to help with that, but I think we require that desperately.

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

CANADIAN COUNSELLING ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): Our next speakers this morning are from the Canadian Counselling Association. We've got Barbara MacCallum, the executive director, and Robin Cameron, the Ontario anglo-phone director.

Make yourselves comfortable. If you need any water or anything, I'm sure we've got some clean glasses there for you. Like everybody else, you have 20 minutes. You can use that any way you like. If at the end you could leave some time for questions, that usually works well. The mikes work well when you're about a foot away from them. It's all yours. Thanks for coming.

Ms. Barbara MacCallum: Thank you very much, and thank you for the opportunity. My name is Barbara MacCallum, and I'm the executive director of the Canadian Counselling Association, and this is Robin Cameron, who represents Ontario anglophones. I would like to at this time turn the presentation over to Robin.

Ms. Robin Cameron: Thank you very much for having me. Barbara and I were laughing on our way up to the podium because I think she thought I ditched her, which I did think about.

Two pieces before I start: One is that I won't be following exactly the document we've handed out, so I apologize. You're probably tired. You've been here at least for this morning; maybe you've been here longer than that.

1200

The second piece is that this will be a team effort. I'm very new to the executive of the CCA and what I do not know about them could easily fill this room. I expect the reason I got on the board in the first place, let's say, is because of my involvement in counselling and the counselling profession, advocacy for clients and the protection of the public, and mostly my advocacy for the mental health profession. For the last 10 or 15 years, I've been running workshops, in the last 10 years on the issue of compassion fatigue and the effects of the work on the helping profession. I've had the opportunity to travel all over Ontario and speak to helping professionals, in which I would also include doctors, nurses, counsellors, social workers, a variety of people who actually offer the services, our resources, to clients—and how that work does affect them.

Part of this work that we're doing is also advocacy for the helpers themselves. I think what you've been hearing about is that we greatly rely on having other resources to refer to. Without that, we're kind of all in trouble, so I hope one of the advocacy pieces today will be to support the other groups that have been here as well, like Ontario Shores.

I'll read a small bit of this presentation. If you have any questions, I'm quite comfortable to go ahead. I'll just read this for a minute and then you can ask me anything you like.

The Canadian Counselling Association is in its 45th year as a national and bilingual organization. We're dedicated to the enhancement of the counselling profession in Canada. In fulfilling this mandate, the CCA promotes policies and practices for the provision of accessible, competent and accountable counselling services throughout the human lifespan.

CCA currently has over 850 members in Ontario and over 3,200 members across Canada. These members practise under a variety of titles, such as counsellor, counselling therapist, psychotherapist, and creative arts counsellors, which can include art, drama and music. Many of us are trauma specialists, marriage and family counsellors, school counsellors—which might include elementary, high school or university—career counsellors, substance abuse counsellors. Our list is long and varied.

Because of the diverse skills of counsellors, they are able to work in agencies that provide counselling to children and adolescents, adults, couples and families. Workplace stress, financial difficulties and similar kinds of problems often lead to depression and anxiety and contribute to family conflicts. We are a service readily available to people. Working with people affected by mental health, addictions, chronic illness, death and dying are examples of areas in which counsellors work. Many counsellors also work with perpetrators of domestic violence as well as people affected by abuse. Through that, we also try to do our part to contribute to prevention of those problems through advocacy and educational initiatives.

Recognizing the significant growth of the number of counsellors in various public environments and in private practice, in 1984 the CCA actually established a credentialing service for its members called the Canadian certified counsellor program. This is how I came to the CCA. As a private practitioner, I was really looking for a way to offer my clients a place to go if I do anything wrong—I sort of think our clients have a right to that—and also a place where they can go to ask questions, and a way for me to have a group of people who are like-minded and involved in research and doing the practice of counselling as well. This provides a non-statutory certification process that is available to all CCA members who wish to apply and who fulfill very specific qualification requirements. Our goal is public protection.

There will be more detail on the certification process, if you're interested. Feel free to get in touch with us if you have any questions.

We're proud of our programs, which aim to protect the public interest and ensure members deliver excellence in their standards of service. This is really important to maintain in a regulatory environment as well, and I think that's one of the roles of something like the CCA: to make sure that the professionals have a place to stay involved, continue to do professional development and sharpen the saw, so to speak.

At present, as you are aware, the counselling profession in Canada is not regulated by a statutory process except in the provinces of Quebec and Nova Scotia. We also believe that many counsellors in Ontario will fall under the auspices of the 2007 Psychotherapy Act and be registered with the title of registered psychotherapist and/or registered mental health therapist, and our members will welcome the opportunity to be regulated under the new college.

We're pleased that the Legislature is taking a comprehensive approach to reviewing how the mental health of Ontario's population can be improved. However, we believe that improving a society's mental health is more than simply expanding access to Ministry of Health-funded services.

Individuals with serious and complicated mental health issues such as depression, anxiety or eating disorders often present first to their family physician or at an emergency department. The nature of these conditions

often necessitates treatment that cannot be provided by acute health care facilities. Counsellors play a vital role in helping clients mitigate the effects of such issues and also in helping them learn to cope with their symptoms of distress.

Since many organizations lack the funding or infrastructure to provide more than six to eight sessions of therapy or counselling, clients who require more intensive long-term care for issues such as childhood sexual abuse or addictions may fall through the cracks. Brief therapy and one-off physician visits can be very helpful for uncomplicated issues but do not meet the needs of clients in serious distress or chronic crisis, and the shortage of practitioners who offer these services means that clients wait or do not receive the help they need.

One of the benefits of having counsellors who are trained, although not qualified to diagnose disorders like psychologists or physicians, is that they know when to refer. For example, if a student presents with psychotic symptoms to me, in my role as a counsellor at Queen's, I may not be able to diagnose them, but I do know that it falls well outside the experience of a depressed individual who might come and see me. At that point, I'm really scrambling to find services to which to refer them. I believe you heard a little bit about this earlier. It's also very nice if we can follow the client to make sure that the referral has happened, and we try to do that at our service but you can imagine that also adds to the wait when you're trying to make sure that you're following up with someone to make sure that they were referred, but we like to do that when we can.

One way to greatly enhance the services counsellors can offer—and I have no idea if you're even the group to say this to, but I'll just put this in there—would be to refer directly to a psychiatrist, at our clinic especially. Somebody may wait four to six weeks to see me the first time and often, when the student comes and sits in front of me, I can't believe that they've waited. We have a crisis counsellor. We do have as good of an intake program as you can have if somebody is in crisis, but they have to say so. They have to say, "I can't wait four to six weeks." Our admin staff are fantastic. If they notice a hesitation in a student's voice, they'll ask, "Are you sure? Would you like to see someone today?" But people are incredibly resilient at times or they don't want to say it; they feel proud. I am stunned sometimes by the person who's waited six weeks to see me and then to have to tell them that they may be able to see a psychiatrist in six months—maybe—but I first have to refer them to their GP. If they present their symptoms seriously enough, they may get referred to the psychiatrist.

We are incredibly fortunate here at Queen's that we run a comprehensive service, so we have physicians, we have a couple of psychiatrists who are lovely and we have a great nursing staff and a wonderful admin staff. We have a cross-cultural counsellor, which is fantastic, because talk about students who fall through the cracks. You're going to a professor to ask if you can have a little

more time for an exam, and your professor may not actually know that you're from a country where there's a war going on. So you can imagine how this adds to a client's distress who may actually have acute PTSD and be trying to get treatment for themselves, but also be grieving, worried for family members, and it sort of goes on and on.

Again, when they see their doctor, they really do have to make sure that they're able to advocate for themselves. The doctor may only have five minutes. Some of our doctors see dozens and dozens of students in a day, so they really do have to sort of be able to snap right into it and say, "This is what's happening to me."

Our counsellors typically have two years of graduate level training in mental health issues. This leads to another issue, and that's the issue that's prevalent in our health care system today: There are shortages in competent and accessible services for mental health in Ontario and there are inequities or misunderstandings with regard to qualifications that are exacerbating these gaps.

Agencies in the system will often only hire counsellors who are registered with a statutory regulated body. Despite the fact that many, if not the majority, of counselling programs across the country have mental health counselling as a major focus, graduates from these programs are often unsuccessful at being hired within medical institutions such as hospitals and clinics. You often see this difference between people with a counselling master's and people with, say, a master's of social work. Social work is well recognized in Canada and particularly in Ontario. I have a master's in counselling. I think I was told even by the CAS in Ontario that I would be hired if I had a BSW, but not with a master's in counselling. I found that kind of shocking, given that I had two full years' experience and a master's rather than—anyway, some of the people I talk to say that's a little bit frustrating and it means that there's not as much access to qualified professionals, although we are very lucky that social workers are registered and we have their help too.

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We have great hope that once the new College of Psychotherapists and Registered Mental Health Therapists of Ontario is functioning, this issue will be somewhat resolved, but only if counsellors and their training are embraced by the system. The government's action to regulate the practice of psychotherapy through the 2007 Psychotherapy Act was welcomed by our organization, but we are keen to see the legislation implemented. We would urge the government to move quickly to bring the College of Psychotherapists and Registered Mental Health Therapists to life.

There is great potential for improving the outcomes in Ontario by better leveraging the full diversity of expertise that's available in the province. We also believe that it's vital that the transitional council for the new college includes appropriate representation from currently unregulated professionals. It does not live up to the spirit

of the legislation if the body is composed predominantly of those who are already regulated by other colleges. For a mental health strategy to succeed, it's important to recognize that not all people want or need to receive care within the medical model. Our members make an essential contribution to the overall care mix of mental health services that are available in this province.

It's important that a choice of services be available in order to empower people with mental health problems. As you're well aware from the other presentations and some of the things we've said today, some of these people don't want to go for help. They're really nervous about going for help. For example, if you know someone and you can refer—someone you know is qualified and competent, but they may be outside of a model that's covered or recognized. So it's nice if people can have more choices. There's a need to recognize the role that families and other non-professional caregivers play in the lives of people with mental health problems and to promote well-being among family members and reduce the burden for caregivers. An integrated approach is needed to provide effective support for people with co-occurring mental and substance use disorders. In the transition from child to adult mental health services, youth often fall through the cracks as there is no specific system of care available for this age group.

We're noticing a huge difference now that students are getting younger and younger as they come to university in Ontario. Some of them come at 15 or 16, and it's shocking how well resourced and competent an adult they are. And others are, you know, teenagers. They're still very, very young, and they're trying to deal with all of the complications of living on their own—and life does interfere. When you're a university student or a college student, it's not just acne and bad hair days. We are a mental health clinic and it's very, very busy, and I think most people who are presenting here today will tell you that. The strain on the system at this point is enormous. I don't know exactly what the answer to that is. If you doubled our staff, would that help? I'm not sure. I think what really helps is when you fund one organization, everyone benefits because then there are places for us to refer. We rely heavily on the Kingston community to refer students to when they're in real trouble. If they have to wait four to six weeks between sessions and they're dealing with something complicated and serious or they're chronically suicidal, that system won't work, so we need to find one that does. We have consummate, wonderful professionals in this town, and it is really nice to be able to access them, but we can always use more.

One final point: We're pleased to learn that the new amendments to the Psychotherapy Act, 2007, limit the use of the title "registered psychotherapist" to those who are licensed by the new college. This is a positive step in terms of promoting clarity to the public and enhancing public protection. I'm stunned at what clients think I am. They say, "Oh, I told my parents I went to see my doctor today," and I ask, "Did you mean me?" I'm not a doctor.

I have no medical training. I think this is really important. People really need to be educated about what we do, what information we have, and how we can help them, and how we can't as well. So I'm really thrilled to see this happen. Title protection helps the public understand that anyone holding themselves out to be a registered psychotherapist is regulated by the College of Psychotherapists and Registered Mental Health Therapists of Ontario. It's clear to the public that they're accessing care that adheres to a common standard of training and regulation. It's also clear that they can turn to the college for redress in the case of a complaint. We all like that. That keeps us all to a high standard, and that's why we entered this field. Nobody entered this field to do sub-standard work—well, hopefully; I certainly haven't met anybody in the thousands of health care providers whom I've met. They work harder than they have to. They work more hours than they get paid for. They are incredible people with amazing things to offer and they really care for the populations that they work with, but they can't do it all. So having a regulated body is really important.

It also gives them access to other resources, as I say. One of your clients is moving to another community and you don't know anybody there? It's really hard to just say to them, "Well, good luck. See you later." You have a place where you can find a list, you can find someone else to refer them to, and it's really important.

The creation of the new College of Psychotherapists and Registered Mental Health Therapists of Ontario offers Ontario a prime opportunity to enhance the quality and scope of mental health services in the province. CCA, in collaboration with the Ontario Coalition of Mental Health Professionals, looks forward to working with the Ontario government to bring the new college to life in a way that dramatically benefits Ontario's patients and clients.

I have lots of other things written down, but I would like to ask Barb for things that I've forgot, left out, mumbled over or said incorrectly.

The Chair (Mr. Kevin Daniel Flynn): Well, you've probably left time for one question at the end, so maybe we should go straight to the question. Anybody from the government? Sylvia?

Ms. Sylvia Jones: It's just a quick yes or no. Your association: Do you also cover pastoral care?

Ms. Barbara MacCallum: Yes. We have some of our members who are in that field, and we actually have a special interest chapter in the association for pastoral practice.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France, anything? You're good? Everybody's good?

Thank you very much for coming today. It was a great presentation.

Ms. Robin Cameron: Well, that's very nice. I'm not sure if it's true.

The Chair (Mr. Kevin Daniel Flynn): You did a good job.

ONTARIO ASSOCIATION OF
CONSULTANTS, COUNSELLORS,
PSYCHOMETRISTS AND
PSYCHOTHERAPISTS

The Chair (Mr. Kevin Daniel Flynn): Our final presentation of the morning is the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists. Naseema Siddiqui is the president, and you're accompanied by somebody else, by the looks of it. If you'd just make yourselves comfortable. You have 20 minutes, like everybody else has had, and you can use that time any way you see fit. If you'd introduce yourself for Hansard before each of you speaks so we have a record. It's all yours.

Ms. Naseema Siddiqui: My name is Naseema Siddiqui and I'm the president of the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists. I said it in the right order so I keep my job; otherwise, I would be fired. They told me that. With me is the secretary of the board, Penny Kawasaki, and she will be doing the presentation, but I would just like to introduce.

Thank you, Mr. Chairman and members of the committee, for giving us this opportunity to present our views and those shared with us by our clients. I have over 30 years of experience working with the dually diagnosed developmentally delayed population, a population which is not even on the radar for mental health.

As the title would indicate, OACCPP is a professional organization of mental health service providers and we wanted to be as inclusive as possible. In 1978, OACCPP was formed as a lobby group to lobby for access to mental health services. Later on, as time developed, we became a full-fledged association, but we wanted to be inclusive, and that's the reason for the cumbersome title.

Improving mental health services and protection of the public are the goals of the government, and as professionals, we share those goals. In my mind, the protection of the public could be summed up in one word and that would be the end of our presentation, and that single word is "access." I'd like to elaborate a little bit on it: access to qualified, trained professionals; access to affordable, cost-effective services; access to diversity of services; and access to timely services.

1220

I think we have heard a lot about timely services, but I found it interesting that just two days ago I was driving—my destination was 10 minutes away—and I spent a full hour getting there because I was listening to Scott Chisholm, who's writing a book called *Collateral Damage*. I kept thinking, "This select committee has to hear this broadcast." He said, "A broken shoulder has no waiting list but clients with mental health issues" have to wait for their turn. This is so evident, especially in northern and rural areas. I worked in Smiths Falls and in Lanark county. There's only one psychiatrist for the entire county. I don't know what the current population is, but the last figure I had was 35,000 people.

Access to research which is applied, which is not sitting on a shelf, and access to qualified, trained professionals from multicultural communities: I went down Gerrard Street and looked at all the signs, and some I could read. I found it interesting that they have their own psychotherapists, they have their own lawyers, they have their own professionals; they don't know what is going on in the outside world. When I started to talk to them about the Psychotherapy Act, the psychotherapists or mental health service providers there did not know what was going on there, so we do need that, and we need involvement of all these groups.

Now I'm going to turn it over to my colleague Penny Kawasaki to present our views from OACCPP.

Ms. Penny Kawasaki: Thank you, Naseema, and thank you, Mr. Chairman and members of the committee.

Just a little bit of background about myself: I've worked in the field of mental health across the lifespan, for over 30 years as a psycho-educational consultant in the school system—elementary and secondary—and for the past 10 years, at the community college level in Ottawa at Algonquin College. I appreciate the—sorry, can you hear me?

The Chair (Mr. Kevin Daniel Flynn): Oh, yes.

Ms. Penny Kawasaki: Sorry, I thought it wasn't working.

I appreciate the opportunity to present the views of our association this afternoon.

First of all, I want to acknowledge two initiatives in this brief, the Mental Health Commission of Canada and Ontario's establishment of the Select Committee on Mental Health and Addictions, because we're now putting mental health, as a public policy concern, directly in the political spotlight. We're very encouraged by these initiatives, but I want to get into some of the barriers that we're facing that we feel very strongly about.

One of the barriers that's very daunting is the stigma, of course, of mental illness that plagues people both socially and in their family and in the workplace. Lack of funding for mental health and addictions treatments prohibits full and uncomplicated access to services; lack of access to a range of services with diverse approaches and methods of treatment that are fully accessible and affordable to all segments of the public; lack of access to services in a timely fashion—a few metaphors here: "A broken shoulder has no waiting list but clients with mental health issues have long waiting lists." Fragmentation of services and a lack of integrated best practices in dealing with the needs of individuals is a systemic problem. Multicultural competencies is a big one that we feel strongly about. Multicultural competencies and training available to minority groups and service providers must be acknowledged, as our demographic profiles are changing rapidly.

Investment in mental health services is not the only answer or solution to dealing with the mental health needs of Ontarians. We feel that strategies should include:

—timely access to mental health services, essential for safety and health promotion;

—system changes that are holistic in nature and commitment, where the focus is on best practices and individual client needs;

—collaboration with other professionals so that we can identify our strengths and limitations;

—commitment to develop a network of auxiliary professionals to whom its members will refer clients as required;

—accommodating regional disparity and not creating new accessibility challenges for health consumers, especially living in remote areas; and

—more studies are needed to reveal how many Ontarians remain undiagnosed or have mental illness needs that are unmet.

There's some statistical information that we've included in our brief which I'm not going to have time to go over. I want to leave some time at the end for questions.

As far as mental illness and social factors go, I want to start with the issue of poverty. Many anti-poverty initiatives recognize the link between poverty and mental illness, but efforts to reduce poverty as a social determinant of mental illness have been largely ineffective, and they need stronger efforts. For example, the Ontario disability support program is often geared to people with low incomes, but well over half of people receiving those benefits have a mental health disability, and there's never enough money to sustain their needs. I run into this all the time seeing clients.

Employment, the working wounded: According to award-winning author André Picard, public health reporter for the *Globe and Mail*, "Mental illness is costing the Canadian economy a staggering \$51 billion a year, and each day 500,000 people miss work because of psychiatric problems." Employers are not doing a lot about this. Picard adds, "Society's silence about mental health is deafening. When you are diagnosed, you disappear. Yet the vast majority of Canadians suffering from mental illness ... are not in the hospital but they're in the community and at work. Mental illness accounts for a stunning 40 per cent of disability claims and sick leaves in Canada."

I just want to refer a bit to Bill Wilkerson; he's the CEO of the Global Business and Economic Roundtable on Addiction and Mental Health. He said, "There's this attitude out there that if you come back from cancer, you're a hero, but if you come back from depression, you're damaged goods."

Multicultural competence and health services: We need a broader understanding of multicultural issues, such as ethnicity, religion, language and support systems, as all influence the health care consumers' ability to understand their conditions and comply with treatment protocols. These protocols should attempt to incorporate or complement traditional forms of healing; for example, the aboriginal populations. Having an expanded awareness of what actually constitutes multicultural awareness in best practice principles is fundamental to improving access. In this respect, there's very inadequate data avail-

able in Ontario about the experience of ethnic minority groups in relation to the mental health system.

We need more funding and research in the mental health needs of our multicultural communities. This is promoted a lot in professional associations, including ours, where we promote training and multicultural competencies at our PD workshops and conferences. Such training needs to be available on a broader basis to all mental health and addiction professionals. We also need to involve the multicultural communities as part of research teams dedicated to integrated health planning and design of services.

The mental health needs of Ontarians cross ministry lines, so there are many ministries often involved in care and treatment. Services should be accessed using a multi-modal and multidisciplinary model to make the whole process more seamless. We need access to a diverse range of mental health professionals. We need consistent and reliable funding to prevent gaps; there are so many people falling through the cracks, sometimes because there are so many different ministries involved, and the funding seems to vary from time to time. For example, the Roberts/Smart Centre in Ottawa doesn't have sustainable funding so they are now in crisis for offering service to their clients in the community.

We need affordable housing. It should be available for those with addiction and mental health issues.

I just want to talk a little bit across the lifespan and cultures and talk a bit about youth and children's mental health. Health promotion and prevention have become key priorities in health care, but there are still challenges. We need to recognize that health promotion services should incorporate a greater awareness of the challenges and social complexities facing our younger generation. There are so many things involved; for example, self-esteem issues with our young generation and so many complex issues there.

Seniors' mental health: While psychogeriatrics isn't a new field, novel approaches to seniors' mental health are reflecting a shift away from the medical model governing that field. Social determinants of seniors' mental health and a shift to wellness models are two such innovative approaches.

There's a whole lot with First Nations' mental health and Inuit and the high suicide rates. There are many hypothesized determinants, but all of us know that suicide and self-harm are events derivative of enduring hopelessness, a fundamental belief that the social world holds no viable options for a satisfying, productive life. In this respect, we believe that social advocacy must become part of every service provider's repertoire of interventions.

1230

I think Naseema has mentioned some specific groups like the developmentally disabled population. When Rideau Regional was closed in Smiths Falls, all the people were put into the community, but this is a very genuine population that needs to be continually and increasingly recognized, because they need improved

access to mental health services in the community now that that facility has closed.

In Canada, few cultures are socially isolated. Social migration, technology and access to a global world through various media, including the Internet, all interact to influence the multifaceted world of the Inuit, First Nations or Metis client. Keeping this principle in mind, we feel that multifaceted professional consultation and collaboration is absolutely essential to delivering best practices to multicultural populations, especially in remote areas.

A spectrum of service settings should be available depending on the individual needs.

Prevention strategies should be in place to identify and treat early onset of problems so that these problems don't become more serious down the road.

There are lots of gaps and barriers: long waiting lists, as we know, to see certain types of service providers, like psychiatrists working with adults; funding barriers in hospitals in schools; and community agencies that have huge backlogs and waiting lists and that can't hire more professionals to provide those services. Also, there are parallel service providers that are available.

We need more outreach in cities and remote areas.

Evidence-based research should be done on all service initiatives to hold funding agencies accountable.

We need primary care teams of professionals working in the community, using a model of collaboration and co-operation among and between diverse professionals offering services.

So, in conclusion, we hope that the Select Committee on Mental Health and Addictions will review the funding for mental health, which is inclusive of all sectors mentioned in our brief. We hope that through your work you will explore systems change and make recommendations to improve access, as Naseema was saying, to services for the diverse populations in this province. We'd be very happy to collaborate further with you.

We will take questions. Thank you very much for this opportunity.

The Chair (Mr. Kevin Daniel Flynn): Very good; thank you very much for your presentation. Any questions from the government side? Helena?

Ms. Helena Jaczek: Yes, thank you very much. You've brought up a number of issues that we've been hearing as we travel across southern Ontario.

I was wondering if you've had any experience with peer navigators as it relates to mental health counselling and if you see that as a useful adjunct, any experience that you've had in that regard.

Ms. Penny Kawasaki: Peers?

Ms. Helena Jaczek: Yes.

Ms. Penny Kawasaki: I'll tell you my experience at Algonquin, at the college. We use peer support people in the counselling department. Sometimes that helps them come in and self-refer, because we don't go banging on doors. Students have to come to us, so we have to depend on their self-advocacy skills, which sometimes are

greatly lacking. So we feel that's important, but it isn't used enough.

We try to stress that when we work with high schools, to get the students, when they're talking about transition points and developing their career paths, to generate, through peers, this kind of advocacy, to make it a more seamless thing and to not feel as if they are kind of out there floating around.

Ms. Helena Jaczek: Thank you.

Ms. Penny Kawasaki: That's a good point.

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

Ms. Sylvia Jones: Very briefly, you talk about the integrated system on page 10. There have been a number of presentations where we have been encouraged to have a lead ministry, a lead agency. Have you any thoughts on that, and if you do, do you have a preference on which ministry would be that lead, or in fact a separate ministry?

Ms. Penny Kawasaki: I don't know. I think some ideas in the past have been tossed out, like the Ministry of Children—because right now, it's so mixed up. Depending on the need, you're crossing boundaries and then you're facing systemic barriers because of the limitations of the ministry, which may not all be on the same page. It would be nice if everything were integrated like that. I don't know at this point which ministry would—

Ms. Naseema Siddiqui: I'd like to take that question. First of all, before I forget, I did not introduce myself as the chair of the Ontario Coalition of Mental Health Professionals because today, I was representing OACCPP. Like CCA, OACCPP is also a member of the coalition. Having said that, I think if we are talking about our mental health, it's all health; it's all part of the same person. I don't think that we should be separating. We feel that Health is the lead ministry, but collaboration or integration with other systems is absolutely essential. I see that in the field of dual diagnosis where just two ministries are involved. This is based on my experience, 30 years of working in the field: When the communication is not there, we find just with the two ministries, the services fall apart.

The Chair (Mr. Kevin Daniel Flynn): Thank you. France, the final question of the day.

M^{me} France Gélinas: Just a quick one: I appreciate the emphasis you've put on diversity. I realize that working in Ontario, a number of your members would work in French-language-designated areas of the province under the French Language Services Act, so my question is, do you keep track of which of your members can provide services in French, and second, are there best practices out there for providing mental health services to the minority francophone population?

Ms. Naseema Siddiqui: We do keep some track, but unfortunately I don't have those numbers. We would be able to provide you with them if you are interested in those numbers.

As far as best practices are concerned, I'm not even sure if we fully understand what best practices are, because I looked at the definition, and in every different group I went to, the definition was very different. I know what I understood to be best practices, and that is a client-centred system. The services there are integrated when it is a client-centred system. But when I look at the definitions—I did some research on it a few years ago and then again before this committee, so I'm not sure what we understand by "best practices." It depends on the interpretation of the individual province, the individual region and the individual practice.

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

Ms. Naseema Siddiqui: Thank you very much. Thanks for the opportunity.

The Chair (Mr. Kevin Daniel Flynn): That is the end of our meeting for the day. Sylvia and France are off to the airport immediately. The rest of us are going to meet in the Frontenac room just beyond the hotel reception desk for lunch. Our bus will be here at 1:30. Stewart Stein from the Ontario Telemedicine Network put his PowerPoint presentation from this morning on the memory sticks that you've been presented with.

Thank you to those members of the public who attended this morning and stuck out the whole morning with us. We're adjourned.

The committee adjourned at 1238.

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