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Mercredi 9 septembre 2009

**Select Committee on
Mental Health and Addictions**

Mental Health
and Addictions Strategy

**Comité spécial de la santé
mentale et des dépendances**

Stratégie sur la santé mentale et
les dépendances

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS**

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

Wednesday 9 September 2009

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The committee met at 0917 in the Ottawa Marriott, Ottawa.

**MENTAL HEALTH
AND ADDICTIONS STRATEGY
STRATÉGIE SUR LA SANTÉ MENTALE
ET LES DÉPENDANCES**

SUCCESS BY 6 OTTAWA

The Chair (Mr. Kevin Daniel Flynn): Okay, let's get going, then. We don't have a gavel, but that was it.

Our first presenter this morning is Kelly Paolozzi. Come forward, Kelly. Make yourself at home. You're the first presenter this morning. Good morning. As we travel around the province, everybody's been getting 15 minutes so we can hear from as many people as possible. You can use that time any way you see fit. If you can leave a little bit of time at the end that might be better, so we can have a little brief discussion as to what you've talked about amongst the three parties. All that being said, the floor is all yours.

Ms. Kelly Paolozzi: Good morning. Thank you for giving me some of your time this morning. I know it's a very busy tour that you're on across Ontario. I'm representing Success By 6 here in Ottawa. Success By 6 is a collaborative community initiative. We are partners from the public, private and non-profit sectors committed to the success of all children in Ottawa. We represent education, police, the municipality, the province as well as business, so the multi-sector stakeholders that come to our table have a voice for all children and come together to champion and advocate so that we can have a better community for our children here in Ottawa.

We're working to help all children succeed for life by creating a community where everyone has the opportunity to reach their full potential. We've recently launched a framework for action that focuses on how we as multi-stakeholder champions can create change, which is based on the theory of change. We've focused on four key areas: creating public awareness, doing advocacy, focusing on the root causes of some of the factors that influence children, and we've based everything on the ecological model—so the child at the centre, the family having, obviously, a strong influence, and also the community and the society, based on policy.

We believe that families, communities, schools, neighbourhoods, as well as public policy decision-makers all have a role in helping children achieve their optimal development. We based all of this on a research project that we received funding for from HRSDC under Understanding the Early Years. We had done the EDI in 2005-06 on a sample of over 8,000 senior kindergarten children. In that sample, we received some interesting findings that helped us focus some of our attention on some key areas. One of them I want to highlight for this panel: the prosocial and social and emotional development—the prosocial and helping area. The children in Ottawa were not faring that well.

We know that in early childhood, the focus on mental health and addictions may seem kind of strange, at Success By 6, we thought that it was an important time for us to highlight that although our focus is early childhood—zero to six—it's still a critical time for early intervention and prevention, as well as the importance of pre-natal, maternal and parental focus on mental health and addictions. We know that a lot of the things that happen in a parent's life prior to birth—and we work with the Fetal Alcohol Spectrum Disorder Coalition in Ottawa as well as Healthy Babies, Healthy Children and public health—are key influences on how well the child is going to fare later in life. So we have started working with them on many things that have an influence. As well, we know that attachment is a key influence factor on how a child's social and emotional well-being is going to have an influence on their success later in life.

We've continued to reach out to the community to look at what the causes are, what's happening around social and emotional development, and we want to continue to do that work. But we wanted to present to this panel that it's critical that public awareness, a focus on early intervention, and focusing on the fact that there are many things that we can do before having to fund addiction programs and things like that that can happen early on in the prevention side of things—not to say that the intervention programs and school-age, youth and adult programs aren't necessary, but also that we strongly support the holistic approach that I think is critical in your document, the focusing on the family and that holistic approach to supports. Supporting an entire family is very critical.

The other piece that we wanted to highlight was that the collaborative approach you've represented in your discussion document is something that we strongly

support. Throughout our framework for action, we've advocated for an integrated and collaborative approach to service delivery in creating better access for families, that it is very critical that these are all community-driven and that you must work with community partners. Community partners need to get close to the clients. They need to have that voice at the table. We need to work with communities to find out how best to serve them in their local venue so that we can make sure that the services are accessible, culturally sensitive and appropriate for the families within those communities.

Our advice would be to ensure that within the local planning, you base your decisions on existing planning bodies, integrate with other provincial and federal planning that's already going on and build on the great work that's happening at the local level.

Around the awareness piece, we noted that you had a strong piece around public awareness and prevention. For us in early childhood, we note that as much as environmental risks are highlighted—and we know that mitigating risk factors in the environment within families are something that is always in the prevention, but they're often not highlighted when it comes to early childhood because there's a strong emphasis on building skills in early childhood that focus on numeracy and literacy. Often, those social and emotional skills are secondary to the preparation for school readiness, the focus on numeracy and literacy. An area that we would like to see highlighted in your work is obviously that social and emotional development is critical to mental health and prevention of addictions. Thanks.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Kelly. I'm sure there are some questions. Just so you're clear, probably what you're referring to is the report that was issued by the ministry.

Ms. Kelly Paolozzi: Yes.

The Chair (Mr. Kevin Daniel Flynn): The minister and his advisory group were a separate group.

Ms. Kelly Paolozzi: Okay, sorry.

The Chair (Mr. Kevin Daniel Flynn): But we're sort of travelling the same path.

Ms. Kelly Paolozzi: Okay.

The Chair (Mr. Kevin Daniel Flynn): I think we've just got a much shorter outlook on things, probably, at the end of our deliberations. The minister is putting together a 10-year plan with the advisory group. We're a committee of the Legislature from all parties. Our mandate is to report back to the Legislature by the spring of next year on a comprehensive strategy to address mental health and addictions.

Ms. Kelly Paolozzi: Sorry.

The Chair (Mr. Kevin Daniel Flynn): No, I just didn't want to take credit for the report because it's not ours, but I think we're on the same road or I think we're sort of going the same way.

Let's start off with some questions. Christine or Sylvia?

Ms. Sylvia Jones: Good morning. I wanted to touch on more of the early intervention and how to highlight that, if your group has put any thoughts together on testing or where that testing could occur—those types of things. You're not the first presenter who has talked about early intervention and capturing these kids before it becomes a crisis.

Ms. Kelly Paolozzi: Absolutely. We know that many of the programs that do exist, like Healthy Babies, Healthy Children and the home visiting programs—there are programs like Parents as Teachers that exist within the community but are underfunded. We know that reaching out to families within the home setting is the optimal way to be able to support them, but they are very resource-heavy, very time-intensive, and therefore require a lot of funding.

It's hard for reporting because you don't have high numbers, so a caseload has to be fairly small for the impact, but the impact is very great. It's difficult to represent it as showing a broad reach, although the impact is far greater. It's always that balance because you have to be investing quite heavily but the impact is much higher.

There are many examples of projects and programs but there also has to be a multi-pronged approach. We always struggle with how you reach out to the most vulnerable. Those are the programs that are the most costly and the most difficult to staff because of the intensity of the resources and the time commitment and the skill required to work with the families that are the most in need and the most vulnerable.

Ms. Sylvia Jones: Thank you.

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

M^{me} France Gélinas: If you're thinking in the short term and thinking along the line of prevention in what you've been presenting this morning, would you support something that is accessible to all families and all children, or does your organization really focus on trying to identify children and families in need or at risk and focus your attention on them?

Ms. Kelly Paolozzi: An age-old question; I think there are advantages to both. I think having universal, accessible programs, you're going to catch families who are probably your less likely, the ones you wouldn't suspect as having issues. Some of the interesting findings that we found in our research are that there are always those outliers. There are the ones that aren't who you would expect.

We had neighbourhoods that, based on the socio-economics and the demographics of that neighbourhood, shouldn't be doing well. They shouldn't be ready for school. Those children shouldn't be faring well, but they actually are. The same goes the other way—socio-economically they are doing quite well. If you look at Ottawa as a whole, as a community, we're doing quite well. We're well educated, but on the school readiness scale, using the early development instrument, we're not far exceeding nationally against other communities. So it's hard to pinpoint or decide who is the most vulnerable. How do you decide that? That's where it gets tricky so you do catch those vulnerable people, because vulner-

ability is in some ways difficult to determine, but there are definitely times when targeted programs are required. When you think of very vulnerable neighbourhoods, when you think of teen parents, when you think of people who have histories that are clear—violence or addictions or cycles of poverty. So I think there has to be a balance. I don't think it's one or the other.

0930

M^{me} France Gélinas: Do I have time for one more?

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

M^{me} France Gélinas: This is going to be an even tougher question. If you want to give up, you're allowed.

If you had to choose between the home visiting, post-partum, that takes place by the health unit or some of the early childhood programs where you work in groups, whether with targeted families or a universal program, which one would you qualify as the one we should invest our money in? We're talking good mental health.

Ms. Kelly Paolozzi: Do you mean—can you give me an example of the Early Years programs?

M^{me} France Gélinas: What I'm trying to say is: Should we invest very early, as soon as mom and baby go back home—have a visiting nurse going in and trying to teach good mental health and what skills the parents should have so that they look after the mental health of their babies—or should we focus more on programs once the parents start to go out with their children, once they're one or two or start to interact with one another? Is it better to invest very early, when they're infants, or invest when they're toddlers?

Ms. Kelly Paolozzi: I think there needs to be both, but I think the intensity of investment can be different. I'm a strong believer in building people's capacity, so I think that's the programs that you require. If you build a person's capacity early on, then their capacity to work and seek out opportunities to bond with other families and create opportunities for themselves is different if you've built that capacity early on.

The Chair (Mr. Kevin Daniel Flynn): Okay, thanks, Kelly. We'll move on. Helena?

Ms. Helena Jaczek: I'm wondering, when one of your stakeholders finds a behavioural issue that points to some underlying mental health condition, whether in your research you have followed up in terms of where the referral is made to? In other words, by category, is there a tendency to go—obviously it would be fairly individual, but would it be to the family doctor? Would it, obviously in some intense cases, be children's aid? Have you quantified where referrals are made to, and do you have any way of tracking outcomes of those early interventions, whatever they are?

Ms. Kelly Paolozzi: We've just started working on a pilot within our community with clinics that are integrated clinics: with Crossroads, which is our children's mental health unit in Ottawa; public health at the Ottawa Children's Treatment Centre; and our First Words, which is the speech and language and infant hearing program. They're doing screening clinics and assessments as a team across the community, and then doing referrals on

to each of their programs collectively. We had quite a high rate of referrals on to those programs.

In terms of referrals on to family docs, we don't have a strong connection to family physicians from our work as Success by 6. From the organizational perspective, I wouldn't be able to answer that.

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

Ms. Kelly Paolozzi: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Great presentation.

CANADIAN PAEDIATRIC SOCIETY

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is from the Canadian Paediatric Society. Marie Adèle Davis and Dr. Anne Gillies, if you'd like to come forward and make yourselves comfortable. I'll try to quiet the audience down.

Ms. Marie Adèle Davis: Thank you very much for inviting the Canadian Paediatric Society here to present to you today. I'm the executive director. Dr. Gillies is a community-based pediatrician here in Ottawa, so she is actually somebody who's out on the front lines and can probably give you really good vignettes as to what she sees and answer your questions.

I will just, as a start, simply quickly explain why pediatricians are interested in mental health. When we ask our members how much mental health they're seeing in their community practices, between 35% and 50% of their patients either come to see them because of a mental health issue, they've been referred by a family physician, or they've come for a stomach ache or a headache, but when they actually go through their diagnostic process, it actually turns out that the child has some type of anxiety or mental health issue. So they are dealing with a huge amount of mental health on a daily basis, and they're very important individuals in the continuum of care that we need to make sure our children, youth and their families receive.

I will very quickly go over what the CPS would like to see in a mental health and addictions plan for children and youth, and then I will pass it over to Dr. Gillies.

We very much agree with the previous presenter that there needs to be a focus on prevention and supporting families in providing a home that is, if you will, mentally healthy, the same way as we counsel families on how to keep their homes safe for children—now, of course, all we talk about is how they can try and keep them free of H1N1 and wash their hands—and also early identification of those children who may suffer from mental health challenges, because we know the earlier we intervene, the better the long-term outcome will be for that individual.

Once a mental health issue has been identified in a child or youth, we feel it is very important that they have timely access to the appropriate health care professional, be that a social worker, a psychiatrist, a psychologist, with no cost to the family. Cost, as I'm sure Dr. Gillies

can speak about, becomes a huge barrier for families without insurance to get access to timely care. We also know that when children don't get access to timely care, they fall further and further behind their peers in terms of their normal development. As pediatricians, we want to make sure that children stay on their normal developmental trajectory. Again, from a long-term prognosis point of view, we know that this is essential.

It's important that mental health care is delivered in a multidisciplinary team atmosphere. It's no one health professional who's going to be able to totally support a family. We feel that pediatricians have a very important role in that multidisciplinary team because of what they do for screening their patients for mental health issues, for the identification, for the treatment. Often, children with mental health issues or youth have comorbidities. If you think of young people with eating disorders, you also need to make sure that they're physical needs are being met. Also, pediatricians are important in providing ongoing care. In many cases, child psychiatrists will see a patient, they will identify and come up with a treatment regime, but much of the ongoing care is left to the community pediatricians in collaboration, and certainly that is part of Dr. Gillies's practice.

We also think consideration should be given for those children and youth who have some of the most severe mental health illnesses that they have access to a care coordinator who can help steer them through the system. In Ontario, there are a number of different ministries who have responsibility for different sectors of mental health care. For the family trying to navigate through that system, knowing which ministry to go to, what agency to go to, what community resources, such as Success By 6, are out there that can support their family can be very difficult.

My colleague was just sharing with me yesterday that the literacy statistics that came out for national literacy day were that the average Canadian has a grade 2 literacy level. One can imagine how difficult it is to navigate through government websites and everything else if that is your literacy level. So consideration should be given to identifying a care coordinator.

Lastly, before I turn it over to Dr. Gillies, given the size of the province of Ontario and the remoteness, especially for young aboriginal and Metis individuals, as well as Inuit, who live in Ontario, it's important that consideration be given to innovative ways of providing mental health services, be that through telemedicine, visiting health professionals, and that that care be given in a culturally appropriate way that makes it something that is welcoming for young people to seek out.

Now I will hand it over to Dr. Gillies.

0940

Dr. Anne Gillies: Thank you very much for the privilege of speaking to you this morning. I'd like to introduce myself briefly, because the scope of pediatric practice is vast, and people practise in varying ways across Ontario.

I'm what's called a generalist consulting pediatrician. I'm in private practice, and I see patients on referral from

family doctors about a range of issues, including biophysical health concerns, developmental concerns and mental health, behavioural and academic school concerns. I have a special interest in mental health. I've been in practice now for six years, and I work two days a week out of my private office and two days a week as a member of a multidisciplinary mental health team delivering outpatient mental health services at the Children's Hospital of Eastern Ontario. I've been there for three years. In that period, I've also participated in research related to collaborative care between pediatricians and other mental health clinicians. So this is an area very close to my heart.

In my private practice, over 50% of my patients are seen for the range of mental health, behavioural, school or developmental concerns that your committee is looking at. Addictions also surface regularly as part of the assessment process. In this part of my practice, I see patients ranging from two to 19 years of age, and I see them coming from a geographical area as far as a three-hour drive away. Pediatricians of every description are more plentiful in the Ottawa-Carleton area than they are almost anywhere outside this area in eastern Ontario. I see both Ontario and Quebec residents because I feel ethically obliged to do so, being a resident of west Quebec myself and knowing how scarce the resources are there.

The patients that I see in my practice I've divided artificially into those with biophysical issues and those with mental health issues, but, in fact, the two are often found in combination, and having a chronic physical or developmental concern places you at a higher risk, as a young person, of having comorbid mental health concerns.

I thought what I would do for you this morning is paint a human face on what we're seeing in clinical practice by telling you about three of my patients.

The first person I'd like to tell you about is a young woman called Jane—the names have been changed, obviously—who I first met when she was 13; she's now 17. Jane had a difficult beginning, growing up in a single-parent household where her mother's partner sexually abused her for several years, and this was not known to Jane's mother until she was in her mid-teens and manifesting many behavioural problems. She was involved with substance abuse, particularly alcohol, she did some drug experimentation, and because of family economic problems, found herself living in a shelter for a period of time with her mother. When it came out that she had witnessed violence against her mother by her father and had been sexually assaulted by her mother's subsequent partner, she was already in care for an eating disorder. She was diagnosed with depression while an inpatient in hospital, and returned to my care in the community, subsequent to her discharge from hospital. At that time—

The Chair (Mr. Kevin Daniel Flynn): Dr. Gillies, if I can jump in, the mikes get really sensitive when you get close to them. You can sit away from them and they pick

everything up, but they tend to pop when you get close to them.

Dr. Anne Gillies: Sorry about that.

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

Dr. Anne Gillies: At the time that she was discharged from hospital, she had needs that encompassed housing, education, and financial support, as she was becoming an emancipated minor. As a result of that, there were multiple agencies involved in her care.

In my role as pediatrician, I found myself case managing for her contact with these agencies. She did have two social workers involved, but the coordination of her eating disorder follow-up, her support for post-traumatic stress disorder, her sequelae of sexual assault and her depression fell to me. Resources for substance abuse being thin on the ground, I also followed her for this issue. That sounds like a pretty complicated basket of issues, but this is not atypical for some of the young people who I see in my office, and it raises lots of issues about integration and collaboration between agencies, and, in a very real sense, how pediatrics and how medical services are funded when we're involved with the care of these patients. They're not structured to provide this type of comprehensive care or case coordination, and it may well be that the appropriate housing of this role resides outside of a medical practitioner's office, but I was one of the threads of continuity in her life, somebody she trusts and who was able to help her therapeutically in ways that she might not otherwise have accepted from yet another professional. So one of the points that Marie has made about case coordination and about the continuity of care that is required in order to be therapeutically effective with young people is something I'd like to underscore by the example of Jane.

I'll just tell you very briefly about the other two. The second one is a young woman who I met at age 18, when she was almost out of the pediatric age group. I was asked to see her by a mental health colleague because he was very concerned that she was not receiving any services because, with her severe anxiety disorder and agoraphobia, she had been housebound for a year. She had been receiving outpatient mental health services at a local mental health facility, and she was in fact going to high school there, but when her agoraphobia became more severe she seemed to be lost to follow-up. I was appalled at the idea that an 18-year-old could be housebound for a year without receiving care, and when I did go to meet her at her home, I learned that she was self-medicating with her father's prescriptions and was severely symptomatic. She was ultimately, within a few months, hospitalized, received appropriate care and is now receiving follow-up care in the community from a psychiatrist she was able to find for herself.

Both of these young women have remarkable strengths as individuals. I meant to tell you initially that Jane, the first patient, is a fiery, independent survivor, who, if she was speaking here today, would blow your socks off—an amazing young woman who's going to do very well. And Maddy, also a pseudonym, is a very

caring young woman who loves working with kids and is so magnetic that people bring their children to her house; she has become well known in her neighbourhood through word of mouth. I hate to describe these young people only in terms of their weaknesses, because they have significant strengths.

The last person I want to tell you about is a younger person, a boy, who I've known since age eight. Matthew is now age 13 and has multiple diagnoses: ADHD, anxiety, OCD; he's experienced significant bullying partly due to his short stature. His parents separated, and that caused him tremendous stress. He was diagnosed with adjustment disorder. He felt very stigmatized by his problems, by his family experience and by his short stature. This is a remarkably talented skateboarder who's a thoughtful, insightful, perceptive kid. After being treated for his ADHD in my office; after we identified bullying and it was addressed on several levels by parents, the school and in our office; after his parents had psycho-education around understanding what the meaning of the ADHD was, what roles anxiety and OCD were playing in his life; and after his parents provided very strong role models for him by showing openness and accepting of their own issues and seeking help for them as well as reassurance for him, he's doing very well.

Those three people are quite representative; they're not extreme. In my role as a community pediatrician, one of the things that has allowed me to provide perhaps more care than I would have been able to is the experience of working in a mental health setting where I have informal access to a lot of complementary expertise. So I'd like to make a plug for collaboration between pediatricians and other mental health clinicians as one of the ways forward, because, as pediatricians working in the community, whether we choose to or have a mental health bent or not, as Marie said, 30% to 50% of the kids who are showing up are presenting with these issues, and many people feel overwhelmed and not adequately resourced to deal with them under the current set-up.

Interruption.

The Chair (Mr. Kevin Daniel Flynn): That means your time's up. I didn't realize—it's like an egg timer. I'm just playing with it today.

Dr. Anne Gillies: I didn't mean to speak so long. Sorry.

0950

The Chair (Mr. Kevin Daniel Flynn): That was a great presentation. Thank you very much; very informative. Unfortunately, we don't have any time for questions, but I think you got your point across very clearly. Thank you for coming today.

SUE CLARK-WITTENBERG

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is Sue Clark-Wittenberg. Come on up. Make yourself comfortable.

Ms. Sue Clark-Wittenberg: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Sue, if you'd introduce your colleague when you start—make yourself comfortable first—so we know who we've got.

Ms. Sue Clark-Wittenberg: I want to introduce my husband, Steven Wittenberg.

The Chair (Mr. Kevin Daniel Flynn): Pleased to meet you.

Mr. Steven Wittenberg: Good morning.

Ms. Sue Clark-Wittenberg: He's here for support.

The Chair (Mr. Kevin Daniel Flynn): Good. Like everybody else, Sue, you've got 15 minutes. You can use that any way you like. If you leave a little bit of time at the end for questions, that might work out well too.

Ms. Sue Clark-Wittenberg: I will do that. Thank you, sir.

Good morning, everybody. My name is Sue Clark-Wittenberg, of Ottawa. I am a former psychiatric survivor and now I'm an activist. I was psychiatrized for 18 years, from 1972 to 1990.

Bear with me; I had a mini-stroke a few years ago.

My first hospital admission was in the spring of 1972 at the Royal Ottawa Hospital. I was 17 years old. I was on the Whitney 4 ward. I weighed 125 pounds. I had never been locked up before. At my highest weight, I was 320 pounds. I gained 200 pounds; I've lost 90 to 100 pounds since.

I had gone to the emergency ward at the ROH because I run away from my upper-middle-class home in Ottawa because I was being emotionally and physically abused at home by my mother. In essence, I had a classic nervous breakdown, so to speak.

On the ward I was given lots of psychiatric medications which I had never been on before. On the medications I had many severe reactions—

Interruption.

Ms. Sue Clark-Wittenberg: That's bothering my ears.

Interjections.

Ms. Sue Clark-Wittenberg: It's hurting my ears, actually. Okay, I'll continue anyhow.

Mrs. Liz Sandals: Do you have any sort of electronic equipment in your—

Ms. Sue Clark-Wittenberg: We have cellphones that are off.

Mrs. Liz Sandals: It might be your cellphone—

Interjections.

Ms. Sue Clark-Wittenberg: They're both off. They're very sensitive, I assume.

It's gone now. I'll go over here. I'll continue. I hope you give me grace for that.

On the medications I had many severe reactions, like sweating, dizziness, dry mouth, agitation, slept 20 hours a day. I had an enormous appetite, slurred my words, had trouble with my coordination—I had to hang on to the walls—and I could not think clearly. I gained 30 pounds in the three months that I was on the ward. I was given a psychiatric diagnosis right away. I looked at my chart one night when the nurses weren't looking and saw on

my chart my psychiatrist had written I was a “schizophrenic”—

Interruption.

Ms. Sue Clark-Wittenberg: Oh, man, this is bothering me. I've got nerve damage in my ears.

Interjections.

Ms. Sue Clark-Wittenberg: Okay. Anyhow, I saw my chart when the nurses weren't looking one night and it said I was a schizophrenic and said that my parents denied abusing me. My brother was never contacted, who was 16 years old, a year younger than myself. Children's aid was never called, nor the police. Why? Because child abuse was a taboo subject in the early 1970s.

I was in and out of the ROH for the fall of 1972. In March 1973 I tried to hang myself in my room on the Whitney 4 ward and a nurse cut me down and saved my life. I'm very grateful to her.

I was getting more depressed at being locked up on the ward, so I was sent in the late part of March 1973 to the long-term-care facility in Brockville, Ontario, on ward H, a current ward, a locked ward. At BPH, I endured electroshock treatment, which damaged me, I got more pills and gained more weight. I had to endure public showers with my peers. We were not allowed to wear our clothes to the showers and there were no shower curtains while the female staff supervised. I got out of BPH in six months and went to a women's psychiatric group in Ottawa.

I had gone to these hospitals while I was psychiatrized for 18 years: the Royal Ottawa Hospital, Queensway Carleton Hospital and Montfort Hospital psych wards, and BPH. I received, from 1972 to 1990, 15 different psychiatric diagnoses and 14 different types of psychiatric medications. So I've been free of psychiatry, I've been off psychiatric meds since 1990, so I've been clean for 19 years. I've had no relapse. I've not gone to a psychiatric ward since 1990. I've been free for 19 years. My last psychiatrist, who was at the Ottawa general hospital—it was in the outpatient department—told me I should never have been hospitalized nor given medication or shock treatments. I had suffered trauma from my childhood and I only needed a stable foster home for a year to get back on my feet. Dr. Bijoor told me that.

I am dismayed I was treated so badly by the psychiatric industry. I started to question psychiatry at length. In 1990, I dumped my psychiatrist, I dumped my psychiatric medications—it's not a good thing to dump your meds. People should be weaned off.

I've seen since then—from 1992 to 2007, for 17 years—many social workers. I saw a regression therapist, art therapist, occupational therapist, feminist therapist and battered women's groups. I've been married three times, and my two former husbands battered me. I went to the rape crisis centre for help, the sexual assault support centre, the Jewish community centre, the Catholic family service centre, the family service centre, the Wisdom of Women Centre, and Rideauwood for my psychiatric drug addiction. I am very grateful for the support of all of those groups and the individual

counsellors and therapists who helped me on my journey into recovery from psychiatry and psychiatric drugs. I have been off the meds for 19 years.

I do not validate psychiatry's use of psychiatric medications, electroshock, the use of psychiatric diagnosis and behaviour modification. Why? When I tried to get off the meds, I was brainwashed into thinking, "Suzanne, you're sick, you're mentally ill and you have to be on your meds for life." Well, I started to question that, and I did. I was often threatened—okay, at the Royal Ottawa Hospital: "Suzanne, if you go off your meds, we'll send you to Brockville. You want to go there again? You know what happened, you tried to kill yourself."

In 1988, I started to become an activist, and I started the Ottawa Advocates for Psychiatric Patients, a lobby group; Psychiatric Survivors of Ottawa; and the Canadian Advocates for Psychiatrized People. And my present job: My husband and I are directors of the International Campaign to Ban Electroshock, ICBE, in Ottawa.

Electroshock always causes brain damage, according to psychiatrists Peter R. Breggin and Harold Sackeim in the US. There is documentation to prove this, so I'm helping to lobby the Canadian government and all the provinces to ban electroshock.

There is no scientific proof nor data to prove that mental illness exists. Dr. Paula Caplan, a psychologist, wrote the famous book *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*. Label jars, not people.

The Ontario government, I recommend, must do the following to ensure that people coming off their psychiatric medications have these services in place:

- facilities where a person can stay for a few weeks or months to get help;

- a 24-hour rehab program;

- counsellors who are psychiatric survivors, like myself, who have stayed off their meds for a long time;

- more affordable housing helping people when they come out of rehab;

- social assistance rates to be raised so people can have an adequate income to survive on;

- more 24-hour crisis lines in Ottawa. Once I called the Ottawa Distress Centre—and I'm not dissing them, because they're a very good service. I've used them countless times, but they do put you on hold. If someone's suicidal, that could be a problem.

- more programs like art therapy, massage, alternative therapies paid for by the Ontario government;

1000

- a crisis line run by psychiatric survivors who have been off psychiatric medications and who understand the issues and the withdrawal symptoms, like I had from mine.

When I got off my meds in 1990, I had no help and I had the DTs. I couldn't find a doctor to wean me off or a rehab, because they told me, "We can't help you here. This is for street drug addicts." I said, "I take psychiatric pills." He said, "Well, we cannot help you. Sorry."

- more family doctors trained in how to wean patients off psychiatric drugs properly;

- less prescribing of addictive psychiatric drugs like Lorazepam etc., with dangerous side effects;

- if someone is suicidal, the family doctor or psychiatrist should only prescribe minimal amounts of psychiatric medications;

- better training to 911 staff, ambulance and police regarding psychiatric patient issues;

- not labelling people with psychiatric diagnoses that do not exist;

- testing people for food allergies—I have a lot of food allergies;

- a national conference prepared by psychiatric survivors on recovery from psychiatric drugs, paid for by the Ontario government;

- employing more psychiatric survivors like myself with leadership skills to work with their peers. We have all been there; we understand all the issues. We are the experts.

I worked at the Royal Ottawa Hospital during the 1990s for many years. I was a speaker on psychiatric issues, so I was part of the consumer-as-expert program run by a peer, Marion Crow, and supervised by Mary Lou Weir of the Royal Ottawa education department.

I thank you for listening to me today.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sue. You've left about six minutes for questions. Let's start with France.

M^{me} France Gélinas: Thank you for coming this morning. It's a pleasure to hear you.

You talk about the need for more affordable housing. I'll start with this: In your view, how would you see it working?

Ms. Sue Clark-Wittenberg: I know that we have a shortage in Ottawa, that there's a 10-year list and there's something like 15,000 people on it. I got my housing because in 1988, I was a battered woman in my second marriage and I got to the top of the list. However, there are thousands of people and families, many who have addictions, waiting for their housing. A lot of them spend their money on housing and they have less for food.

M^{me} France Gélinas: You also talk quite a bit about peer support. In your experience, which kind of peer support works best?

Ms. Sue Clark-Wittenberg: For me, it was peer-to-peer support. I would call some of my peers and say, "I'm having an issue with a marriage," or this and that and then they'd help me. We'd go for a coffee or a meal or just go to the park and talk, because my peers would understand. I was on medication. I was very lethargic. They asked me, "Well, what's going on in your life?" I found that the peer-to-peer support, for me and psychiatric survivors like myself, we understand—being on the ward, being off the ward, how to talk to a psychiatrist, group therapy. I was in every program except forensic and the children's program.

M^{me} France Gélinas: And how did you get access to peer support?

Ms. Sue Clark-Wittenberg: I called, and then I started my own groups. When I started my own psychiatric survivor groups, then we started to accumulate

people and then we started to talk. Then we had a group for psychiatric survivors; it was a rap session once a week. We had it at the Dalhousie Community Centre many years ago. It was called the Ottawa Advocates for Psychiatric Patients. I founded that and we had a rap session once a week. People could talk about anything from A to Z and it was confidential.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sue. Are there any questions from the government side? Maria?

Mrs. Maria Van Bommel: Thank you. Your first suggestion or recommendation to us was a 24-hour psychiatric facility. Could you tell me a little bit about that? Is that an overnight? Who would be staffing it? How do you envision this?

Ms. Sue Clark-Wittenberg: Something like the Gerstein Centre. I did a leadership program there with Pat Capponi. I was impressed by the Gerstein Centre. Something similar like that needs to be in Ottawa and some major cities, because, in Ottawa, we don't have a Gerstein Centre where people can go to veg out for a few days and just try to regroup. We don't have that. The Gerstein Centre is very well run. I was very impressed. It was many years ago I went there to visit and do a leadership program.

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

Ms. Sue Clark-Wittenberg: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): There may be some more questions here. Christine or Sylvia?

Mrs. Christine Elliott: I just had one question following along on the housing issue. Once people are able to be moved from some place like the Gerstein Centre, there are a number of community agencies that offer supportive housing at various levels. Are you in favour of that sort of idea, from a place that's maybe double-staffed 24/7 down to virtually independent living, with the goal of allowing people to be truly independent?

Ms. Sue Clark-Wittenberg: Yes. I think there have to be a lot of levels of housing for my peers—like you say, the group home, a Gerstein Centre or something like that in Ottawa; also, that they live with one or two roommates and then they become independent.

What happened to me—I went to the Marguerite House after Brockville; I was there. Then I lived with roommates on my own. I live independently now. But I found the support from my peers and the counsellors there, and the staff were very good to me. They helped me a lot to get back on my feet.

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

Ms. Sue Clark-Wittenberg: Have a good day. Thank you.

DARE TO DREAM PROGRAM

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is the Dare to Dream program, Erin Smith and Anie Belanger. If you'd like to come forward and make yourselves comfortable. There should still be

some clean glasses there for you for some water, if you need any.

Like everybody else, you get 15 minutes to present before the committee. You can use that any way you see fit. If you'd like to leave a little bit of time at the end for questions, that would be great as well.

Ms. Anie Belanger: Probably more time for questions than talking because I'm very curious; I'd like to answer questions.

The Chair (Mr. Kevin Daniel Flynn): No problem at all. The floor is all yours.

Ms. Erin Smith: Good morning, everyone. I'm Erin Smith, and I'm actually the youth engagement coordinator at the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. I'm here to support my colleague, mostly, Anie Belanger is the coordinator of the Dare to Dream program. She's here today to chat with you a bit about the program and its importance and also, more broadly, the importance of youth engagement in developing policy and in developing things like this strategy, and policy and system change in the province around child and youth mental health in particular.

So I'll hand it over to Anie.

Ms. Anie Belanger: I'm just going to start and explain to you guys briefly what the Dare to Dream program is. It's run through the Provincial Centre of Excellence—

Interjection.

Ms. Anie Belanger: I was trying to avoid that.

Interjection.

Ms. Anie Belanger: Okay, perfect. Thank you. The Dare to Dream program is a unique funding opportunity that is run throughout Ontario which provides up to \$5,000 to groups of youth who want to implement new programming or projects or ideas to either help promote mental health or decrease the stigma associated with mental illness.

We have two deadlines a year where youth can apply online, or however, to implement these projects. We have youth who will review them and take them from there and help the groups of youth start up their projects.

One of the most important aspects of the program is the fact that we do require all groups to have an adult mentor. That, we feel, is super-important in trying to make sure that youth engagement is happening, and properly.

My experience started not much unlike Sue's, except that I'd like to think that the mental health system—well, I can only speak to the child and youth mental health system, but I'd like to think that it has definitely improved. I'd like to actually attribute that to other strategies, maybe not a 10-year mental health strategy but other strategies, such as the implementation even of the Provincial Centre of Excellence, the Mental Health Commission of Canada, even; I do sit on the child and youth advisory committee for them. So all of that to say, I think that this strategy is the key to helping improve our system and making sure that people are able to seek out

the help they need and the help that they—I don't know what I was about to say.

Ms. Erin Smith: Youth engagement.

Ms. Anie Belanger: Youth engagement? What about youth engagement?

Ms. Erin Smith: Why is that so important?

Ms. Anie Belanger: Okay. As I was saying, the system has changed due to engagement of youth and consumers even at the policy-making levels, and I feel that not only is it important at a systems level, but also individually. The reason I believe that is because, when I was struggling with mental health myself, I was provided opportunities where I could make change and could help others who were in my situation.

1010

It started with a program called Youth Net. At first, I was doing programming there, but the way the programming was set up made it so that I was fully engaged; I had a say. I was able to make a sense of direction for the program. I enjoyed it so much that I did choose to do a co-op placement there, where I did start up different programming and was taken very seriously. My opinions mattered, and different things have come out of that, including my coordination, for example, of the Dare to Dream program.

I've been very fortunate to be able to have opportunities, such as this one, to speak to those who can make change, not only just here today but all over the province and, in some cases, all over Canada. I think that a lot of my recovery is due to these opportunities, being able to have a say and trying to make change. There's nothing more empowering, really, than to know that people value what I have to say and are actually doing things about it.

So that just goes back to, I guess, engagement, particularly of children and youth. I think it's 75% of cases of those who are diagnosed with a mental illness—their onset was before the age of 24. I believe that engagement of youth within the system, as well as this strategy in particular, is very key, not only to the development of the strategy but also to those individuals who are able to contribute, because, really, there is nothing better than feeling empowered and feeling like you have change, particularly with something as important as this 10-year strategy.

I have no idea where I'm at for time, but I think I'm running in circles with what I'm saying, so I'll let you guys ask questions.

The Chair (Mr. Kevin Daniel Flynn): No, you're not. You're doing a great job, and you've still got another nine minutes. But if you want to start answering questions, that may be the best way to go.

Ms. Anie Belanger: Yes, sure.

The Chair (Mr. Kevin Daniel Flynn): Let me start with one, and then we'll turn it over to the committee. My generation, when it was facing mental health issues, did it very quietly and almost with a sense of shame attached to it. You didn't talk about it with your friends. If there was somebody in your family who had a mental health issue, they were sort of hidden away. How do you

find it with your generation and your peers? Are you able to talk with your friends or with your family about issues like mental health?

Ms. Anie Belanger: I'd say that it has definitely come around. Is it absolutely there, where you can speak to it and you're not feeling stigmatized or whatever? No, and I think that's why this strategy needs to be implemented. But with programs such as Dare to Dream, with youth making their own projects and campaigns and whatever, I think that's definitely opening the doors.

You say your generation—because a lot of that generation still is around and parenting—

The Chair (Mr. Kevin Daniel Flynn): That's a good thing.

Ms. Anie Belanger: Yes, it is. It is. I'm trying to be really careful with my wording—really careful. But, no, based on the fact that that mentality still exists—though it is changing—there are parents with that mentality who are raising their children, perhaps with that same mentality; no, it's not completely gone. But are we getting there? I believe so.

The Chair (Mr. Kevin Daniel Flynn): That's good news.

Anybody from this side got a question? Liz?

Mrs. Liz Sandals: You talked about the Dare to Dream project and having youth being able to influence policy and their own outcomes. Can you give us some examples where your group would have been able to influence the policy at CHEO or influence what was happening to themselves? I'm trying to imagine the outcomes of what's happening here.

Ms. Anie Belanger: Sure. I should probably, then, clarify that when it comes to policy change and things like that, it's not so much the Dare to Dream program itself that is helping with that. There are other programs that are sort of partnered with Dare to Dream, for example, the New Mentality. That is a group of youth who are wanting to make change, to create a positive outlook in mental health—and encourage those to seek the help or however they want to do that.

There's one group in particular, either in Toronto or Hamilton, that had a scheduled meeting with the Minister of Children and Youth Services, actually, that fell through, unfortunately, I'm not sure on whose end, but they've created several different documents. For example, there's one document that was released as part of the new mentality, which is called Ready, Set, Engage!, which is pretty well a document or step-by-step guide to youth engagement, if you will.

So it's not so much the Dare to Dream program itself that I can speak to, but other opportunities that have been created through that provide that chance.

The Chair (Mr. Kevin Daniel Flynn): Any other questions there? Christine, Sylvia?

Ms. Sylvia Jones: Thank you for coming, Anie. Don't ever underestimate that you're the one who's making the change, not us.

I wanted to follow up a little bit on the funding program that you referenced at the beginning. I think it was \$5,000.

Ms. Anie Belanger: Up to, yes.

Ms. Sylvia Jones: Do you have to apply every year for that?

Ms. Anie Belanger: Every deadline, really. There are two deadlines a year. We don't tend to fund the same project twice. We try to encourage groups to seek other sources of funding after they've implemented their first project, but there are two deadlines.

Ms. Sylvia Jones: So have you seen those projects continue after that initial investment?

Ms. Anie Belanger: Yes, absolutely.

Ms. Sylvia Jones: And is there any consistency in terms of where they're getting funding after your initial set-up?

Ms. Anie Belanger: That's a very good question. I'm actually not sure where different groups have sought extra funding. I know there are also, for example, the United Way youth action grants which tend to do the same thing. It doesn't really need to address mental health, however.

Ms. Sylvia Jones: Trillium, probably.

Interjection.

Ms. Sylvia Jones: Trillium would be another angle.

Ms. Anie Belanger: Could very well be, yes.

Ms. Erin Smith: Community foundations as well.

Ms. Sylvia Jones: Community foundations? I'm not familiar with that.

Ms. Erin Smith: Some of the communities have tapped into—like the Community Foundation of Ottawa in the local regions, and then in other cases they've just found ways to sustain the programs in their schools. So they've seen the benefits during the first round and then they've just created the sustainability within the school budgets to have like a hangout room where people can go when they're stressed out or to do a campaign and a large assembly or that kind of thing.

Ms. Sylvia Jones: Are you finding most of the programs are based in the schools?

Ms. Anie Belanger: Yes and no. It depends on the time of year, which deadline it is. We tend to have a little bit more of the community—

The Chair (Mr. Kevin Daniel Flynn): Somebody's got their BlackBerry near the microphone.

Ms. Anie Belanger: Yes, there it goes. I just threw it away; sorry. So it depends on the time of year, I find, but no, a lot of people are tapping into places like Youth Net, for example, or just youth community centres, any place where they can find a reliable adult mentor who is familiar with their project and the mental health system or will be able to support them. It doesn't have to be a school.

Ms. Sylvia Jones: Thank you.

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

M^{me} France Gélinas: Anie, est-ce que ta langue maternelle est le français?

Ms. Anie Belanger: No, but I speak it.

M^{me} France Gélinas: Est-ce que tu sais si un jeune francophone à Ottawa serait capable d'avoir les services

équivalents à ceux qu'un anglophone reçoit s'il a des problèmes de santé mentale?

M^{me} Anie Belanger: Moi, j'aimerais dire que oui parce que les programmes et les services que j'ai trouvés ont été bilingues.

M^{me} France Gélinas: Puis quand on parle d'une offre bilingue, c'est autant accessible pour les francophones que pour les anglophones?

M^{me} Anie Belanger: Oui.

M^{me} France Gélinas: Dans les demandes de subvention que vous recevez, est-ce que vous recevez des demandes de groupes francophones?

M^{me} Anie Belanger: Oui, absolument.

M^{me} France Gélinas: Que dirais-tu est la proportion, disons, si on regarde la dernière fois? Je ne sais pas combien de demandes vous avez eues la dernière fois.

M^{me} Anie Belanger: Pas beaucoup.

M^{me} France Gélinas: Pas beaucoup?

M^{me} Anie Belanger: Dix pour cent.

M^{me} France Gélinas: À peu près 10 % des demandes? Et ce sont de groupes bilingues ou de groupes francophones?

M^{me} Anie Belanger: Francophones; nous avons reçu un peu de demandes francophones et aussi bilingues.

M^{me} France Gélinas: Moi, je ne viens pas d'Ottawa; je viens du nord de l'Ontario. Parmi les agences qui existent, est-ce qu'il existe des agences francophones en santé mentale pour les enfants ou est-ce que ce sont toutes des agences bilingues qui offrent des services en français?

M^{me} Anie Belanger: Je n'ai aucune idée. Je m'excuse.

M^{me} France Gélinas: Ça va. C'est bien. Merci.

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

Ms. Anie Belanger: Thank you for having me.

Ms. Erin Smith: Thanks for having us.

1020

RIDEAUWOOD ADDICTION AND FAMILY SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is Paul Welsh from Rideauwood Addiction and Family Services. Paul, if you'd like to come forward. There are probably some clean glasses there, if you'd like some water.

Mr. Paul Welsh: You can see the dirt from here?

Laughter.

Mr. Paul Welsh: Bonjour à tout le monde. Good morning, ladies and gentlemen. I'd like to thank you for the respect and the compassion that I've seen so far in your ability to listen and ask questions. I'm glad, though, that I've got you early in the day. You have a pretty long list and I'll try not to lose you.

Can I just ask you a question? Because you have the written stuff in front of you, my plan was to kind of speak to it and follow along, but not read it identically. Is there actually going to be a transcript of what I say?

The Chair (Mr. Kevin Daniel Flynn): There will be a transcript in Hansard in both languages of what you say. We'll get everything you do by printed material and anything you say.

Mr. Paul Welsh: Great. Thanks.

I've worked in addiction for 25 years. I'm the executive director of an agency that has about 60 staff. We actually treat about 2,200 or 2,300 clients, but that 2,300 is pretty shy compared to the 4,500 who actually ask for our services. So that's who you see before you: somebody who's pretty excited about our results and somebody who's pretty grumpy about what's not being done. I'll try to curb my grumpiness so I don't lose you.

Ontario's addiction treatment system has seen 15 years of neglect, and there is no other way to describe it. That neglect, by the way, has included Conservative, Liberal, NDP, Conservative and Conservative governments. So I feel fairly free in saying it's not about one party missing the boat; it's about the political will missing the boat.

I noticed about 20 years ago that youth started to go on our waiting lists. These are youth who are pretty well daily drug users, alcohol, and they're in fairly serious difficulty. Now, adults go on waiting lists as well, but when you're talking to a parent and it's about their 14-year-old daughter, it really kind of gets your attention. Many of the youth who go on the waiting lists do not reappear in the system for treatment. Of these, something like 2,500 youth who come to us, about 35% are 15 or younger. Many of them will not show up in treatment, but they'll show up later in our drug treatment court or our homelessness addiction treatment programs, or the work we do with pregnant teens and young women with addictions with St. Mary's Home, or our referrals from youth probation, or the work that we do in the youth mental health court, or as adults on the Ontario Works addiction services initiative.

By then, the damage and the social and economic costs have really mounted. Some will have chronic illnesses such as hepatitis, AIDS, diabetes, unplanned pregnancies—that's not a chronic illness, but it's an issue. They'll drop out of school. They will be on Ontario Works or they will be incarcerated or in long-term care. We'll see them on television and in the newspaper headlines. This happens to us just about every year: A name and a face we know, whom we tried to get to or who came and didn't stay—we couldn't engage them because we didn't have enough hours in the week to see them—will show up dead or injured or something like that. That's our reality.

The addiction treatment system was frozen without cost-of-living for 14 years, and that just started to end about four years ago, albeit with modest adjustments. So the addiction treatment system has essentially lost 30% of its capacity as a result of that, and that hasn't been made up. We have lengthening delays, and services are increasingly late, increasingly thin and increasingly short.

Now, our agency kind of doubles in size about every 10 years. That's because we stopped going to the

Ministry of Health, which is our prime funder, for funding. We've gone everywhere we can, and we've been reasonably successful. However, we now have three provincial, three federal, and two municipal funders, and each one has its own accountability, each one has its own financial reporting system, and each one has its own planning table that I sit at. So the more successful I am in getting funding for our agency somewhere else, the more actually we all contribute to the dis-integration of a health-funded addiction treatment system.

Ontario has stumbled through three efforts to solve the problem by mergers, amalgamations, moving around organizations on a piece of paper. If you really take a look at a merger or amalgamation, you've got two organizations that are pressured in many ways to come together, and there could very well be a 25% increase in their salary and benefits plans. That exists in our system. So what's going to happen? Do you think the higher-salaried folks who may be unionized are going to say, "No, no, no. We should take a pay cut so that we don't lose treatment spaces"? So mergers and amalgamations very often reduce the capacity of the system, and that's a very important point to remember.

It seems to me, as somebody with consistent waiting lists of about three months over many years, that the solution may be simplistic, but why don't we start by just funding the need and the demand that's at the door of the system? That's a pretty decent indicator of a need.

Addiction has not received a lot of interest from the mental health system, with some real, notable exceptions in Ottawa, I might add, particularly CMHA, but now we're hearing more about addiction, and it's couched as concurrent disorders. So the funding seems to be going toward concurrent disorders often tied to housing in the mental health system, and the addiction treatment system is still not seeing major increases in funding.

Now, it's important to make the point here that mental health treatment is good for mental health; it does not substitute for addiction treatment. No amount of good addiction treatment is going to deal with a serious mental illness. As much as antibiotics are good and useful, they don't work on viruses. So that's an important distinction. What I'm putting forward here is a focus on addiction as a specific problem. There's lots of planning and lots of integration of services that can be done with the mental health system, and should be, but addiction and mental health are different problems and they require different treatments.

Addiction treatment works and it saves the economy millions. When you serve family members, you get better outcomes in treatment. You have children and husbands and wives who are at high risk for mental health and addiction and crime problems themselves, and the prevalence of those problems in that population drops if you can provide service in particular to parents of kids with addiction problems.

We have a drug treatment court program here. It's funded by the federal government. What we know is that our clients are essentially homeless and they have

chronic addiction and a long, long string of really stupid and annoying but non-violent crimes. They're in court many, many times a year. They consume about \$450 worth of drugs per day. They fund it through crime.

We did a survey with a whole year's worth of clients a while back and we asked them, "Previous to coming for six months, what was the value of the drugs that you used, and then in the six months that you've been here, what's the value of the drugs that you used?" The value of the drugs not used in one year was \$6 million. Now, that \$6 million was proceeds of crime. If you sell something on the street, you get about one tenth of its value, so perhaps the crime that went into that was \$60 million. The program costs about half a million dollars to run.

Our agency is fairly well known for its school-based addiction treatment. We're providing full-blown treatment programs in 38 high schools in Ottawa, and that is treatment; it is not prevention. It's two days a week per school. The kids are served in school during school hours, and they are referred by the school.

What we see are some fairly remarkable results. Grades go up. Kids who have been failing are passing. The achievement of credits goes up. The use of alcohol and drugs goes way down. About three quarters of those kids are flagged by the school as being high risk for dropout, and of that cohort, 80% complete the school year.

1030

Now, there's a study from the States that says for every kid who develops an addiction, drops out of school, turns to crime, the lifetime cost to the American taxpayer is \$1.5 million. Would it not be easier to put \$1,000 or \$2,000 into that kid in high school and actually turn them into a taxpayer rather than someone who is a draw? That's about the harshest economic analysis I can give you.

Addiction is common, it's treatable, and it's an expensive health problem if it's neglected. About 80% of people who are in prison are addicted. Prison costs \$80,000 to \$100,000 a year—okay, there are my stats from the States.

As far as the economy is concerned, according to the Canadian Centre on Substance Abuse, addiction costs the Canadian economy about 3% of its gross domestic product every year. Sixty per cent of those costs are to business because most people with addictions are not the folks on the market. Most people with addictions are employed, they're going to school, and they have distressed family members who are employed and going to school and having trouble at work.

Addiction affects 8% to 10% of Ontario's population, and the addiction treatment system receives 0.7% of Ontario's health budget. The Ontario auditor, in 1998 or 1989, said that for every dollar the taxpayer spends on addiction treatment, the taxpayer will save \$5.60. That's a pretty darn good return on investment.

Often at conferences and meetings—but I won't do it today—I ask people in the audience to close their eyes. I tell them I'm not going to embarrass them or ask them

anything uncomfortable, but I ask for the people in the room who have no family history of addiction to hold up their hand while everyone's eyes are closed. I won't do it with you, but I'd love to. What I find is that I've never seen more than 20% or 25% of the hands go up, which means that any group I've ever seen—and it's politicians, lawyers, federal employees, conferences all over the place—75% of the population does have a family member with addiction, and yet it gets 0.7% of Ontario's health budget.

The cost of a homeless person in Ottawa is about \$100,000. Now, you think about it: When you're living in a shelter, you get a cot or a mat and you get a meal, but you're out at 9 in the morning, unless you're really, really sick. So folks are on the street. They've got flu, they're getting worse, they're feeling lousy. They have all kinds of unaddressed health problems. They get into a fight, or a drug or an alcohol deal goes bad, or they're drunk and they stumble in front of a car. So what happens? A police car shows up, then maybe a fire truck with a defibrillator and then an ambulance. Then they're taken to hospital and they get their health care when they are swarmed with a team at emerg, the most expensive health care you can get. This happens many, many times a year. That's why it costs \$100,000.

Now, you can put a homeless person into a supervised apartment with addiction counselling coming to see them and you can do that for \$30,000 a year. It just seems so simple to me.

The Chair (Mr. Kevin Daniel Flynn): Paul, we have everything. You're doing a great job. You've got about two minutes left, so I'm just wondering: If there was stuff ahead of you that you really wanted to cover, you might want to look at it.

Mr. Paul Welsh: Good grief. Yes, I was afraid that would happen. So here are my recommendations to you.

First, how about a policy and a funding regime that says that within three years, we will meet the demand at the doors of the treatment system, and then see what happens? Most agencies across Ontario, and I meet with them regularly, have waiting lists of about four months.

You can fund that through a tax, a penny a drink, or you can fund that through some proceeds-of-crime legislation. There are policies on that that exist. There are precedents. One is the tobacco tax. The other one is how we fund gambling treatment: 2% of gambling revenues go to fund gambling treatment programs. So there are ways to do this that are not onerous.

I would recommend you maintain a distinct focus on addiction while you look to integrate addiction and mental health services in each other's shop. Addiction treatment services should be available in all primary health care, all secondary health care and all tertiary health care facilities. It should be available in schools, jails, prisons, all of that. That's what I mean when I'm talking about integration, true integration.

Then, how about asking the addiction treatment system itself to spend some time and come up with some recommendations? In my 25 years, I don't think that's been a serious request that's ever been made. Ask the

experts. We ask physicians what they need. We ask nurses what they need. Try that.

Develop a strategic plan for addiction. It doesn't mean that you need to put a firewall between addiction and mental health, but I'm saying, don't lose the focus on addiction, nor on mental health.

I'm going to stop there because I'm probably out of time, but I'm happy to answer questions.

The Chair (Mr. Kevin Daniel Flynn): You'll probably have to do that outside this venue, unfortunately, but that was a great presentation. You're one of the few people who have focused on addictions, from all of our presentations. So it was well received, I'm sure. Thank you very much for coming today.

Mr. Paul Welsh: If you're having a break and you do want me to hang around, I'm willing to do that, but if not, I'll go back to work.

The Chair (Mr. Kevin Daniel Flynn): Well, we don't get a break and you'll probably do more good in the community.

Mr. Paul Welsh: You should come work for us, then. Thanks, everybody.

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

CANADIAN MENTAL HEALTH ASSOCIATION, OTTAWA BRANCH

The Chair (Mr. Kevin Daniel Flynn): Our next presenters today are from the Canadian Mental Health Association in Ottawa, Donna Pettey and Danny Lang. If you'd like to come forward and make yourselves comfortable. Like everybody else, you get 15 minutes for your presentation, and if you could save a little bit of time at the end, that might be helpful.

Ms. Donna Pettey: Thank you for the opportunity to be here today. We're very pleased to be here. My name is Donna Pettey, and I'm the director of operations at the Canadian Mental Health Association in Ottawa. This is my colleague Danny Lang, who's one of our community mental health and addiction workers. We were just figuring this out: Together, we have over 50 years of experience working in community mental health programs. Of course, most of that experience lies with Danny, clearly.

The Chair (Mr. Kevin Daniel Flynn): One of the old generation that's still around.

Ms. Donna Pettey: Yes.

We've provided a more detailed presentation to you in the package. Today, we're just going to hopefully do a bit of a Reader's Digest version, but also outline a case study that highlights what we mean when we say "an integrated treatment approach."

First of all, just a little background about CMHA Ottawa: We've been around here for over 50 years. We have a budget of over \$10 million, over 100 employees, and we're the grateful recipients of funding from the province of Ontario, the city of Ottawa, United Way and donations.

Who is it that we serve at our branch? Individuals with serious mental illness, as defined by the Ministry of Health, so we're looking at serious mental illness diagnoses, global disability and the likelihood of duration lasting for at least a year and certainly longer. Our clients are homeless or at imminent risk of becoming homeless, and we prioritize clients with multiple and complex needs. Last year, we served almost 1,000 clients, and 73% of our clients have a diagnosis of schizophrenia or bipolar disorder and about half of our clients, close to 500 clients, have a coexisting substance use disorder. Now, this is a very high prevalence point. Usually for a current prevalence point it's about 25% to 35%, but given where we engage our clients, it's not really surprising.

Our clients come from the emergency shelter sector, an inner-city health unit in particular, which is a unit within the shelters for individuals with complex medical needs; clients who are under the supervision of the Ontario Review Board within the forensic units; in the criminal justice system; in-patients, schedule 1 and schedule 2 facilities; and of course from families and self-referrals.

Now, for some of you, I'm sure, in a lot of your backgrounds you're familiar with the quadrant. The quadrant that we hang around in is: individuals with the high levels of psychiatric illness and the substance abuse to dependence.

1040

Specifically around concurrent disorders, a study that was done in the US—we don't have any comparable study here in Canada—found that less than 12% of those individuals who had a concurrent disorder were receiving treatment for both conditions. Now, almost 10 years ago we were faced with the reality that, on any given day, we have about 50% of clients with an SMI, a serious mental illness, and a substance use disorder, and as a mental health agency, we really didn't know what to do. There weren't many doors, wrong or otherwise, that were available to us, so we actually received some funding through the first federal SCPI grants and were able to spend some time in developing, first of all, a training program that last year in Dewars, where we trained about 200 clinicians in working with people with serious mental illness and co-occurring substance use disorder. But we also have a rather substantial group treatment integrated treatment program. Last year we served 150 of our clients in 18 weekly treatment groups that are ongoing treatment groups for this population.

This practice has been developed in best practice in the field, initially using primarily the Health Canada document, but also we had the privilege of working with Dr. Kim Mueser, who's one of the authors of the integrated treatment program book listed there as well and who is a consultant on the Health Canada document as well. Kim Mueser is one of the few researchers, psychiatrists, in the field who has developed specific group intervention strategies for working with this particularly marginalized population.

Quickly, then, what do we talk about when we talk about what are the ingredients of integrated treatment?

The Chair (Mr. Kevin Daniel Flynn): Donna, just before you go on, I should have mentioned something at the start; with the mics, you don't have to get right on them. I noticed you're trying to do this and trying to do the mic. You can stay a foot away from the mic and they'll still work perfectly.

Ms. Donna Pettey: Okay, thank you very much.

The Chair (Mr. Kevin Daniel Flynn): So you don't have to contort yourself.

Ms. Donna Pettey: So, integrated treatment: There are several components, and this is based on the Mueser model. First of all, we're looking at the integration of services, so we need to be able to provide treatment for both mental illness and substance use disorder simultaneously by the same clinician at the same time, ideally, within the same organization, but at the very least a coordinated treatment. The case study that Danny's going to talk about highlights how it is we're able to do that.

Comprehensive: We need to be able address all life domains. It's not just about addiction treatment, it's not just about symptoms of illness; it's about homelessness, it's about poverty, it's about work, it's about education, it's about family, and so we need to have that ability to look all the way around the individual and help them. We need to be assertive and going out to where people are. We wouldn't be engaging too many clients if we waited for them to come to us; we have to go and kind of hunt them down, which we're very good at.

It needs to be a long-term perspective—and I have a slide I'll show you at the end; we're talking about a substantial investment of time—motivational-based treatment based on the stages of change and stages of treatment, so that if people are at a persuasion change, they're not even thinking about their addiction problem—we need to have strategies for engagement for them to get them into treatment. And we need a lot of multiple, bio-psycho-social interventions. We need to have nurses, social workers, addiction workers, housing, and that is what is really known as a comprehensive, integrated treatment approach.

Danny's going to talk, specifically, about what that looks like at CMHA Ottawa.

Mr. Danny Lang: This is an example of what integrated treatment would look like at CMHA, and if you have that handout that we had given you—kind of the disco ball one there; that one, exactly—in the middle, the case manager and the client work together to develop the plan. The case manager and the client hold that plan and they bring in the supports that are necessary. So it's not the client—how it has often worked is that the client goes from treatment to treatment to treatment, tells their story X number of times, and they carry the plan; whereas now there's somebody who helps them to manage that and brings in the supports to support them as needed. You can see what CMHA offers. We can do an integrated treatment model in-house, and we also really like to work with the community.

The case study that I'm going to give you is an example of three community partner agencies working together to help an individual through the stages of treatment: from starting in, an early persuasion, actively using, not really wanting to change, to sobriety.

I'll go on with the next slide. This is kind of a little bit of our motto: one client, one team, one plan. Really, the basis is we don't want that client bouncing around managing their own plan because it takes a lot of energy, and often they give up on it. We want to be there to help manage that.

The individual I'm going to talk about has been known to CMHA for about two and a half years. The partner agencies that were involved were the psychiatric hospital as well as a transitional group home with a recovery focus; those were the three partners that worked together. Initially, CMHA and the psychiatric forensic unit have developed a low-threshold concurrent-disorder group. We have an in-patient group that is for forensic clients with severe mental illness and concurrent substance use disorder. It's an in-patient group that's held weekly. That's where I met Rhonda; we'll call her Rhonda. I met Rhonda while she was attending this weekly concurrent-disorder group.

At the time that I met Rhonda, she had been in the hospital for two years. That's over 700 consecutive days of hospitalization. I'll give you a little bit of a rundown of the two and a half years that we've been with Rhonda and Rhonda has been working with our agency, and what it looked like.

Rhonda attends the weekly group, not really wanting to come at all, being forced by her doctor, and meets with the case manager. They're developing a rapport and starting to meet weekly. Rhonda is in group not really discussing a lot about what's going on, not really having any focus with her goals. Over time, the relationship starts to build, and all of a sudden Rhonda is talking about her substance use; she's talking about the length of stay she's been in hospital. All of a sudden she doesn't want to be in the hospital anymore. Rhonda's like, "I wanna get out of here. How do I get out of here? What do I do?" The hospital, the case manager and we were working together to support her. The plan is constantly changing, and we're adapting with it. Rhonda starts getting reintegrated into the community because she's been in the hospital for a long time. She's going out regularly with her case manager, integrating back into the community. Rhonda's four months clean now.

She gets an offer for a transitional group home where she's able to go in, have the opportunity to spend up to a year there with a recovery focus where she can do groups, continue working on life skills and stuff towards living on her own. She spends eight months in the group home. As she's transitioning in, there's this whole group, like a case conference, of people getting together, with Rhonda at the table, who's actively involved in her own plan and what's going to work and what's not going to work—and bringing in the necessary supports as needed and working in that integrated way. Rhonda moves into

the house; eight months later she's at a point now where she moves out. Through CMHA, where we have some rent supps, she's able to move into her own apartment for the first time in 13 years. She has sobriety now for over a year; she's working on almost a year and a half. She attends groups, attends her recovery groups, her focus stuff.

She transitioned from the hospital to the group home to her own apartment, all in an integrated fashion, with everybody working together, and not Rhonda running around talking to everybody and saying, "I did this," "I did this," and telling her story 50 times. Her energy is focused on getting better and on what she needs to do. When I talked to Rhonda about what really worked, that was one of the things she really appreciated, the fact that she didn't have to go out and do all the footwork all the time, that there were people there managing that. The resources were there, and she could focus her energies on what was needed, which was a full-time job, for really getting better.

1050

When Rhonda left hospital, she had been in the hospital for over 1,000 hospitalization days. So the first year of work with Rhonda was just around building a relationship and starting that process of change around her substance use. That's part of this process. Donna will talk about it. It just doesn't happen overnight; it takes sometimes a period of time.

I'm good, yes. Yes, I'll just run through this. This is one of the—

The Chair (Mr. Kevin Daniel Flynn): Just so you know, Danny, you have two minutes.

Mr. Danny Lang: Actually, I'll just pass it on to Donna. Thank you.

Ms. Donna Pettey: So the challenges are, as we move forward—pretty typical recommendations that we would have. We need a multi-faceted approach that addresses housing, that addresses issues of income, but really focusing on concurrent disorders.

Our last slide—nobody likes to see this—is the reality. On average, 60% of our clients in our concurrent-disorder groups have been in our group program for more than a year. So this is not a short-term, one-shot-deal type of investment, but at the end of the day, you can really solve problems for people as complex as Rhonda. This really does work.

Interjection.

Ms. Donna Pettey: Yes, it's within there.

The one last point is, we really endorse the notion of investing in community mental health and evaluation and research in looking at programs such as ours. It's very difficult to secure funding, so that's a really critical piece if we're really going to look at building an evidence-based practice and being able to make really good decisions with few dollars.

The Chair (Mr. Kevin Daniel Flynn): Thank you. That was a very good example of time management. You've got about 12 seconds left. Thank you very much for coming today. There was—

M^{me} France Gélinas: Can I use the 12 seconds?

The Chair (Mr. Kevin Daniel Flynn): Can you use the 12 seconds? You won't get the answer out in 12 seconds. I've been watching you.

M^{me} France Gélinas: What does "mixed French persuasion" mean? It's one of your 18 groups.

Ms. Donna Pettey: That's mixed men and women. Most of the groups are separate-gender-based but that's one group that is mixed. We're actually developing two more groups that will be gender-specific.

M^{me} France Gélinas: And I take it they're called "French persuasion" because they speak French.

Ms. Donna Pettey: Yes, it's a francophone group. "Persuasion" is the first level of engagement. It's persuasion, then active treatment and relapse prevention.

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

Ms. Donna Pettey: Thank you for your time.

M^{me} France Gélinas: Was I 12 seconds?

The Chair (Mr. Kevin Daniel Flynn): Way over 12 seconds. I knew you would be, though.

ONTARIO ASSOCIATION
OF NON-PROFIT HOMES
AND SERVICES FOR SENIORS—REGION 7

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is from the Ontario Association of Non-Profit Homes and Services for Seniors, region 7. Come on forward, Josée Belke and Noreen Langdon. Make yourself at home. Like everybody else, you get 15 minutes. Use that any way you see fit. You can stay about a foot away from the microphones and they work perfectly.

Ms. Noreen Langdon: Okay, thank you very much. My name is Noreen Langdon. I'm the administrator of the Peter D. Clark long-term-care centre. It's a municipal home, one of the four in the city of Ottawa. My colleague Josée Belke is executive director and administrator of Residence Saint-Louis and Residence Élisabeth Bruyère.

We would like to thank you for this opportunity to present before the Select Committee on Mental Health and Addictions. We wear two hats today, Josée and I. We come as administrators responsible between us for 700 staff and for approximately—well, actually, 486 residents—no approximation there.

My home is a 168-bed long-term-care centre, plus a 48-bed dementia-care-bungalows centre for people at very high risk. Josée has two long-term-care centres, one which has a day program specializing in very high risk seniors who are waiting for long-term-care replacement, and she has that respite program two days a week. That got some extra money through the ministry to provide services for that program. My specialized unit—bungalows which were built in alliance with the Alzheimer Society of Ottawa-Carleton in those days—is funded through the same long-term-care dollars that ordinary long-term-care beds get.

We are here as administrators, we are representing 21 homes and we are administrators in the LHIN region 7 area.

Josée is going to present a case that most administrators of long-term care from across the province could give you if they were here today with us. It is an example of the day-to-day reality of all staff, residents, families and volunteers living in long-term-care homes in the province. So I'll turn you over to Josée, and then I'll come back with a few concluding sentences.

Ms. Josée Belke: I will tell you the story of Kevin. Yes, like many of you present, when we hear of a special case, we're quick to offer our solutions to everyone, and we do end up creating a band-aid solution, like for this gentleman, but at what cost?

So the case study is a 50-year-old gentleman, Kevin, who presents with depression and significant cognitive deficits. He has a wife and young children. He presents with episodes of aggression that were not listed on his admission paperwork when he came into long-term care. One night, he started uttering death threats to other residents, family members and staff. His physical aggression escalated to the point where, unfortunately, police had to be involved, and he was removed from his home.

He was assessed by psychiatry, admitted and experienced no further episodes of aggression while under their care. The reason for his behaviour was identified as a situational factor, most likely looking at the environment in which he's in—a long-term-care home—and he's only 50. The recommendation was to have a private room for him where he could be alone, have one-to-one staff supervision and take all the meals in his room. Now for me, being close to 50, taking all my meals in my room, I think of isolation. I think of, "Wow, now we're going to have to have staffing one on one with this gentleman, and where do we get the resources?"

The recommendation as well was that we should ensure that our staff know how to deal with these kinds of behaviours and that we should train them appropriately, so we readmitted him to the home, but we were fearful. A special volunteer was assigned for stimulation. We thought that maybe if we get extra resources like volunteers to spend time with him who are from the same culture, same language, this would help, but we had no success. We had special activities that were based on his needs and his current interests that were planned extensively with his family; again, with no success.

He used to go visit his home—just keep in mind that he's 50, so he has a house, a yard, a pool, neighbours and a neighbourhood—but the visits started decreasing because he started exhibiting sexual interest in his wife and behaviours that she hadn't seen in a long time. She was afraid for herself and she was afraid for her children.

More outbursts happened, and more extensive behavioural testing was done, looking at his activities of daily life—nothing observed, again, even when he was provoked in a specialized setting. Again, this must be due

to staff approach. That's what's going on in long-term care.

We explored the potential of transfers, looking at what's out there, and found that there wasn't much out there. On top of it, now there was a stigma attached with Kevin because he was aggressive. He transitioned back to our home, accompanied by behavioural staff that was to help us look at the behaviours and what we could do in-house. She soon realized that when he was admitted to our home, he actually got very aggressive and struck her. For the first time, they had seen the gentleman whom we were seeing under our care.

He was retransferred again. Unable to improve with his mobility, his activities of daily living, and now being incontinent, we needed a more integrated-systems approach, because he had nowhere to go and we were his home, so we took him back.

What I'd like to demonstrate today is, we took a look at these cases that happened in long-term care from a resident's perspective. Certainly the multiple transfers for treatment—the results were negligible, but the disruption to his world was significant.

He spends time in his room with little or no interaction, but he's not aggressive. Should that be our treatment or plan of care? He's 30 years younger than all of his roommates or people on that ward. Quality of life: I ask, what quality for a 50-year-old man? The stigma, his dignity is threatened, and his sense of being a member of his community is really eroded. He's devalued and misunderstood. He has lost his family, most of all.

1100

From the staff's perspective, the resident requires more care than we can reasonably accommodate. We try our best. We pool all our resources, but all those resources are pooled for one gentleman, while the other 169 don't have as much care as we'd like to offer. They're afraid of him, and I'm sure he can sense it.

We have high-intensity special funds that we receive from the ministry when we have a case like this, where we can access dollars for extra one-to-one, but it's for 72 hours. Seventy-two hours is long gone.

Staff continue to care and advocate for his needs, but they also feel devalued due to comments like "failure of not being able to fix this." This is not a success story for us; it's a sad story.

From the family's perspective, they barely visit. They've begun to be afraid of the behaviours and have admitted to being ashamed of the behaviours. They don't understand it and it's difficult for them. They're not sure how to explain it all to their friends, families and neighbours who ask.

People ask, "Is this a functional or a dysfunctional family?" I mean, does it really matter? They're going through and living through this. They've lost a dad and a husband, and he's lost a wife and his kids. They feel that they are to blame, that they're incapable of dealing with their loved one—sorry, I'm getting a little bit nervous—and the family has passed the burnout stage, which is

disheartening to us. The staff have become their family, at least an extension of this.

From a partners perspective, we've had other care areas that threaten not to take cases like this again from the home because they feel they have become a dumping ground, but we just don't have the resources or the care needs to be able to accommodate. I think there's a misunderstanding of our staffing levels and the structures in our homes.

We underestimate our advocacy for our residents and their families, because we do try to provide a holistic approach. So when we look at our opportunity today to present to this committee, we really want to reiterate our passion for our residents and the care that we do, but we have key elements that resurface during our discussions. This is not one typical case. These are cases that we discuss amongst ourselves with colleagues in long-term care. We need to look at the admission process and the documentation, the staffing resources, the training and entry to practice—why do people come to long-term care?—look at criminal checks.

Having support groups for these families: We do our best. They become part of our extended family, but we're not equipped to really be able to deal appropriately with them and all their needs.

We need to look at design for homes and have supportive legislation for this, and most of all, make sure that the homes that do accommodate these specialized units like we have are funded accordingly so we can feel we do a good and safe job.

Better integration of services and being at the table for solutions: We need to have respect amongst care providers in order to be able to look at the client in a holistic approach.

All of the key elements need to be incorporated in the mental health strategy in order to achieve a successful approach for the future and to enable us, in a safe manner, to look after the individuals who are an integral part of our society.

Quality of life is a way of living. It shouldn't be a luxury for anybody.

Ms. Noreen Langdon: Thank you, Josée.

Josée and I, as you can see, are not policy-makers. We're sort of action women. We have a lot of staff. When I talk about the almost 500 residents in long-term care, that means 500 families. I can't imagine, when I look around this room—with all due respect, there are mature faces like my own, and I'm sure that long-term care may have touched each one of you, particularly long-term care with family members who have dementia.

I've totally gone off my script. How much time do I have?

The Chair (Mr. Kevin Daniel Flynn): You've got almost four minutes.

Ms. Noreen Langdon: Oh, excellent. Okay. I'm better without a script. I wish we could script our day every day, but we can't.

Josée and I found a passion, and it's wonderful to find a passion for long-term care with somebody who's going

to remain in long-term care, probably while I'm getting it.

I'm very encouraged by what I see for staff coming into our business. But I would have to tell you that really Josée's case is a case, as I said earlier, where every one of us, and every one of the administrators in any area that you live in, can tell you a similar story.

I have specialized dementia care bungalows—fortunately, we were able to have an alliance with and great support from the Alzheimer Society of Ottawa. But I can't respond to the needs of the community in the way that the community expects, because I don't have the staffing dollars. It's not a specialized program. I have the same funding that Josée gets and that I get from my 168 beds in the long-term-care centre next door.

We do make a tremendous effort and we have taken on some very serious cases in the eight years that we've been open. Without an integrated system that talks to one another, you get burned really badly and people are at risk. I had a situation a couple of weeks ago where two lovely ladies in their 80s ended up in hospital. I refused to take that resident back, who went out to psychiatry. I'm considered in the community as a bit of a pariah because I did it before the 21 days of being out were up, because I didn't want that person back at 1 o'clock in the morning for my staff to deal with.

So long-term care needs to have specialized areas for people with mental health issues. Yes, there's overlying dementia when you get a little bit older, but the bottom-line aggressive resident needs housing and the proper care and the proper options to care. We have been trying to do it in long-term care for as long as I've been in it—I'm not going to tell you how long that is, but it's a while—and we are still struggling.

Our association, the Ontario Association of Non-Profit Homes and Services for Seniors, will be submitting, I think, one of the best submission papers that I have ever read. They'll be doing that sometime hopefully soon and probably in Toronto, because that's where the association is housed. Our recommendation to this committee is that it act on the recommendations that you will read from our association. I think they are succinct, they cover all the categories, and they cover everything that Josée has talked about in her example.

What Josée and I will do: Our next steps are to continue in the short term to, first of all, encourage colleagues to come into the business. That's what I will do. This is a systemic issue; it's not just a public sector issue. We're in the public sector, but it's a private sector issue. All long-term-care administrators would be singing the same song here today before you. A lot of us are getting closer to entering homes over the years, so we want to make them a better place and we want to attract young people to come into this business, and unless we make some changes, it is not going to happen. It's not a business of choice anymore. It's very difficult to find excellent staff, managers who are willing to manage 700 people. The young people out there who are applying for jobs don't follow the corporate line. I'm sure you've

noticed that. They have expectations of the corporations they work for to keep them safe. The ministry has many accountabilities—it's called safety. We're being accredited on Monday and it's all about resident safety. We can't do it and keep our residents safe. I'm hoping that we'll be listened to and that some specialized program and funding will come our way.

Thank you very much.

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

Ms. Noreen Langdon: Thank you. We didn't have any mod cons, but we came. Thank you for listening to us.

ALZHEIMER SOCIETY OF OTTAWA AND RENFREW COUNTY

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is from the Alzheimer Society of Ottawa and Renfrew County: Kelly Robinson. Kelly, come forward. Make yourself comfortable. You've been here for a lot of the morning, so you know what the rules are. You have 15 minutes; use that any way you like. The mics work well if you're about a foot away from them. It's all yours.

Ms. Kelly Robinson: Hi. I'm grateful for the opportunity to talk with you today about the First Link program on behalf of the Alzheimer Society of Ottawa and Renfrew County.

When I was considering how I would open this presentation, I was thinking about the reality of the numbers, the prevalence of Alzheimer's disease and related dementias in our communities. We know that there are 2,500 new cases of Alzheimer's disease or a related dementia diagnosed in Ottawa and Renfrew county each year. We know that one in 11 people over the age of 65 in Canada will be diagnosed with Alzheimer's disease or a related dementia.

1110

I thought about these numbers and how likely it is that at least one of you would be directly affected by Alzheimer's disease or related dementia. I hesitated to mention these stats as I don't intend to frighten you. I realize the diagnosis of a dementia and all that is related can be incredibly scary to consider. That said, I decided before I went any further that I would ask you to think about someone you care deeply about, someone you will have the pleasure of knowing in their senior years, whether it's your mom, your dad, a sibling or your spouse. Today's presentation isn't about scaring you, it's about discussing the truth of the matter, how it affects us personally and how we can best respond. It's because the situation is so scary that we need to pay attention and respond accordingly.

What is First Link? The First Link program is a community support service developed in 2002. Its creation and implementation was a collaborative effort among the agencies within the Dementia Network of Ottawa, now the Champlain Dementia Network. Since then, the First

Link program has been piloted by nine Alzheimer Society chapters in Ontario. This pilot was completed this past spring of 2009, and now there are 25 chapters in Ontario rolling out First Link in their respective communities—communities such as Sudbury, Guelph, Toronto, Peterborough and so on.

The First Link program was developed as a response to the reality that persons affected by dementia typically only start to ask for support at a crisis point, at peak times of burnout or exhaustion. This is when people were reaching out, when they were their most emotionally and physically vulnerable. The intent of First Link is to prevent this, to at least minimize these points of crises as much as possible. The idea is to reach people early enough in the disease progression and connect these people to the various opportunities for support and information.

A diagnosis of dementia can be overwhelming. People need a starting point, a first step to what can be a very complicated system to navigate. We know that with in-time access to support and information, people are better equipped and knowledgeable about what's to come. With timely opportunities to discuss and plan, people are able to mobilize their support systems, develop the strategies they need to cope and tend to any unfinished business.

How does the First Link program work? At the time of diagnosis or identification of a dementia, a health care provider sends a First Link referral to the Alzheimer Society for us to initiate contact. We initiate the call, establish a relationship, determine the needs and make appropriate referrals. We connect people to the available opportunities for learning, services and support. We want people to feel invited to call us to strategize about a particular situation or simply for us to listen. We want people to know about the available services in the community and how they can connect with these supports.

Inherent in the structure of First Link are three key components: (1) outreach to promote early identification and early intervention; (2) to provide ongoing opportunities for in-time learning and support; and (3) community collaboration fostering best practice through a strong network of expert helpers throughout the continuum of care.

Outreach to promote early identification and access to early intervention: The outreach to primary care practitioners and community partners to promote the early detection of dementia are integral activities of the First Link program. Our regional experts tell us that in the average GP's office, 50% of existing cases of dementia go undiagnosed. That's a lot.

Outreach is essential to First Link. Regularly, we get calls from people like last week's Mr. M. Mr. M called into the office in a panicked state, feeling overwhelmed and frightened and unaware as to where he would turn. He described symptoms that sounded a lot like the presence of a dementia. However, when he described these same symptoms to his physician, they fell on deaf ears. Can you imagine how disempowering and demeaning it would be to be certain there's something wrong and to be told by a care provider you trust, simply, "Not to

worry. You're 80 years old. It's par for the course. What can I do about it?"

Our outreach message is one of support to primary care providers, that there are avenues available to access the tools and resources necessary to build their capacity to assess and treat dementia. First Link is here to help primary care with the related complexities that go with a dementia diagnosis. First Link can be a resource for primary care, to help lighten the load with what can be an onerous diagnosis.

Thanks to the direct referral process, we are able to move closer to our goal of early intervention and better able to establish a supportive relationship with our clients early on. Once we receive a First Link referral, we initiate that contact. At the time of the call, we simply ask how things are going, and based on the response of that call we find out what type of information or support is needed. Depending on the circumstances we'll refer, we'll connect people with opportunities for education, and again, we may just simply listen. Then the practice is to follow up on a regular basis, throughout the continuum of the disease—ongoing. The idea is that we establish a rapport early and maintain contact over time, that we create a meaningful relationship and stay in touch.

First Link has been deliberate in providing ongoing opportunities for in-time learning and support. Support and information need to be accessible and they need to be timely. Throughout the continuum of the disease, the Alzheimer Society support staff will check in periodically to make sure people are coping all right and are connected to the ideal resources. This in-time support, through follow-up, proves to be such a proactive and worthwhile practice. At the time of the initial First Link call, a person may report, "Everything's fine, we're just fine, no problem. Thanks for calling," but then at the time of a subsequent call, six months later, we'll hear a different response: "Oh, my gosh, perfect timing. It's awful. I don't know what to do. I didn't know who to ask for help."

In-time learning is also a key feature of the First Link program. We offer a five-stage progressive learning series, and each series is designed to build on one another. The sessions in the first series focus on what one might encounter in the early stages of the disease, and then subsequent series are offered in which the topics addressed are those that might present themselves further down the road, in the middle or later stages. These learning opportunities are provided repeatedly throughout the year so that there is a regular opportunity to access the required information, just in time, at any stage of the disease.

The third key component integral to the First Link program is that of community collaboration. We couldn't possibly serve the people the way we do without our community partners. We are very fortunate in the Champlain region to be so well connected with such great community partners and resources. The leaders representing the various organizations within the Champlain Dementia Network are actively involved in the First Link

program. First Link is an effective vehicle in the way of promoting best practice and enhancing quality care through strong connections among the experts in the field.

Based on my description so far, you may have the impression that First Link is such a success we have the situation well in hand. There are indeed challenges to speak of. I used to get frustrated by what sometimes seemed to be a very slow response to what felt like a very urgent situation. I developed a mantra for myself. "It takes a series of conversations," I would say to remind myself to be patient. It takes not one speech or presentation, but a series of conversations to effect change.

I learned quickly in this role that it takes a number of attempts to articulate to a family practitioner the benefits of adapting his or her practice to screen high-risk patients and refer to First Link. I realize it takes a number of repeated conversations with a caregiver in order for her to give herself permission to take a break and access the support of a respite program. I'm awake to the reality that it also takes a series of conversations with the powers that be, with government representatives like yourselves, to get the message across that we need to proactively prepare for the upcoming demands on our acute, community and long-term health care systems or we will face a devastating reality.

Currently in Ottawa and Renfrew county, there are 12,000 people with Alzheimer's disease and related dementias. In Ontario, by the end of 2009 there will be 180,000, and one in six of those people will be under the age of 65. We at First Link only reach a fraction of these people, in great part because of stigma. Just as I was hesitant earlier to scare you away with the statistics, similarly the majority in our community would rather pretend dementia is not a part of our reality. Fear is a reasonable response; however, this fear response perpetuates a taboo. We are afraid to talk about dementia. The absence of discussion means an absence of the necessary planning and adequate resources to support the cause.

1120

This is not rocket science; we've been aware of the upcoming increase in numbers of our seniors population since the baby boomers were born. We need sustainable resources to enable First Link to reach all those people who will need support. It would be incredibly short-sighted not to include the needs of seniors diagnosed with dementia in your discussions as you develop your systems and policies related.

Think back to the loved one you brought to mind when I first started talking. Can you be sure that person will not be diagnosed with a dementia? Are you confident that, if diagnosed, this person would have access to the necessary supports and quality care? Have you done everything you can to make the difference? Thanks.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Kelly. You've left a little bit of time, probably time for two questions. Anybody on that side? Liz.

Mrs. Liz Sandals: I'm assuming that your First Link program is mainly concerned, then, with education and with linkages to services. Is that the right assumption? You're not directly providing treatment?

Ms. Kelly Robinson: Yes, we are.

Mrs. Liz Sandals: Oh, you are directly providing treatment?

Ms. Kelly Robinson: We have a team of people in our program department of family support providers. They'll either provide voice-to-voice support over the phone, in-person counselling, or family meetings. If the situation warrants, then we'll refer to another organization. For example if there are extra psychiatric problems, if there is aggression or something, then we'll refer to geriatric psychiatry. But otherwise, we provide the support and the counselling, the learning, the support groups and in-office one to one.

The Chair (Mr. Kevin Daniel Flynn): Are you done, Liz, or do you have another one?

Mrs. Liz Sandals: I was going to say, then, in what percentage of the cases do you find that the disease is progressing to the state where you do need to refer on to psychiatric resources or institutionalization?

Ms. Kelly Robinson: I was afraid I'd get asked a percentage question. I don't know what per cent—

Mrs. Liz Sandals: Well, give me a sense; I don't need the exact per cent.

Ms. Kelly Robinson: Maybe in about a third of the cases we might consult with psychiatry or have someone get extra support from psychiatry, but for the most part, we can support people with the resources we have. All people will eventually need more support as the disease progresses.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you, Kelly. We're going to move on to Christine or Sylvia? No. France?

M^{me} France Gélinas: I'm just curious to see, where does your funding come from? For the other communities that are just starting up with their program, are they all funded through aging at home?

Ms. Kelly Robinson: Yes. For two of our positions, I believe, at the Alzheimer Society of Ottawa and Renfrew County, First Link funding is from the aging-at-home program, but otherwise, our Alzheimer Society chapter, 75% of our funds come from fundraised dollars.

M^{me} France Gélinas: From fundraising. So aging at home is not ongoing funding?

Ms. Kelly Robinson: Right.

M^{me} France Gélinas: So you have to have a strategy in place to continue to fundraise or hope that it becomes ongoing funding?

Ms. Kelly Robinson: Right.

M^{me} France Gélinas: And it's the same for all your colleagues? I think you said there were 25 of them opening up throughout Ontario.

Ms. Kelly Robinson: Right.

M^{me} France Gélinas: Are they all in the same boat where aging at home is only a part and they have to fundraise for the rest?

Ms. Kelly Robinson: Yes. That's why we're here.

M^{me} France Gélinas: Right. So stable funding, I guess, is at the top of your list?

Ms. Kelly Robinson: Yes.

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

Ms. Kelly Robinson: Thank you.

C.J. McCaffrey

The Chair (Mr. Kevin Daniel Flynn): If I can ask C.J. McCaffrey come forward. C.J., if you'd come up and make yourself comfortable. I notice you've been here for a lot of the morning too, so you know what the rules are. Just make yourself comfortable, and you've got 15 minutes like everybody else.

Ms. C.J. McCaffrey: Well, I'm very nervous, and I don't do well without a script, so I'm going to read.

My name is C.J. McCaffrey, and I was diagnosed with Alzheimer's disease in 2003, when I was just 58 years old. Are you aware that this disease can hide in your brain for about five to 10 years before it manifests symptoms? It takes about three years after that to be diagnosed and about three months to go through the testing. You have to do the math because I can't do that any longer. Suffice to say that I have had it for a very long time. No one person presents the same symptoms.

After crying in traffic at a red light because, suddenly, I did not know where I was going, I called my medical doctor and I asked her if I could be tested. My mother died of this disease, and I wanted to know how far down the road it was for me. At that time I was told there was a 18-month waiting period before I could get tested. Eighteen months is an extremely long time to get answers when early diagnosis is imperative to treatment of this disease—and I say "treatment" because there is no cure and there are no survivors.

I was referred to the Memory Disorder Clinic here in Ottawa, where they specialize in diagnosing early and complex cases of dementia. As I sat across from the doctor, frightened beyond belief, he gently told me, "It's not down the road; it is here, now." And he gave me medication right on the spot. Oh yes, and he told me that I had to quit working as a private duty nurse and go on disability pension. It was because I was in nursing that I did not have the 18-month waiting period.

Stunned, I went to the Alzheimer Society and learned about the First Link programs, which I attended enthusiastically. I was determined to fight this chapter of my life head-on, no matter what it brought. There, I learned about the workshops, the support groups and a lot about the disease itself. It was very empowering.

Then my journey stood still for about a year and a half as I slipped into denial and a dark depression. After all, I'm only 58 years old. As a single person, I was facing this alone with very little family support, and when people found out that I had this disease, they either rejected the possibilities completely or were too afraid to deal with it. I even had longstanding friends walk away

from me. You see, the problem is that I did not fit the profile of a person with dementia. I was not a little elderly lady in her 70s or 80s who lived on her own. My friends and family were more confused than I was.

After what seemed an eternity, I was able to reconnect with the Alzheimer Society and began fighting for myself. I was the youngest person at the groups, but I went. One of the biggest challenges that I had to face was to allow other people to help me find my new way. I was very grateful to the Alzheimer Society family for that. I learned that the sooner you are diagnosed, the better the chances are of having this medication work longer for you. When I woke up every morning wondering how much of myself I've lost today, I learned to listen to other peoples' stories. I am now in a support group where participants are all in the early stages of Alzheimer's disease or a related dementia, more in my age group, some even younger. We learn from each other's experiences, and I no longer feel alone. We help each other.

I was invited to participate in a blind drug study for a new medication and was then reintroduced to the special, caring and wonderful people at the Memory Disorder Clinic. I found out that they do much more than just diagnose Alzheimer's disease. They and the Alzheimer Society family gave me back my hope, and I began to look at each day as the first day of the rest of my life instead of with dread.

1130

There's a great need for more experts like them. The drug treatment that I am on now only helps my symptoms and will only work—I don't know how many more years. It does not stop the disease and it won't work for everyone.

One common thread for people having memory problems is that they're afraid to come forward and tell their doctors and families or even go for diagnosis. Doctors need to be better trained in this area to pick up on these things.

I'm watching a family member in this situation at the moment. She's been denying things, just like I did, so no one will find out that she is having problems. Maybe if it isn't Alzheimer's disease but another problem, then it can be treatable. If it is Alzheimer's and it's not talked about, then that person misses out on valuable treatment and support for themselves and their family. The Alzheimer Society can help in so many ways.

After diagnosis of Alzheimer's disease, you can lead a meaningful life. Some people, like me, who have been diagnosed early with this disease, want to speak out in hopes of helping others. I want to help fight the stigma that is still very much an issue.

We are told of the large increase in the senior population that's coming up in the next few years. What will happen to them? I believe doctors need better training to diagnose this disease. We need more doctors, period. You do not have to be in your 70s or 80s to get this. I'm living proof of that. The problem is now, not 10 years down the road. The longer that you're able to help people stay in their homes and live independent lives, the less it costs government in health care.

It has been very difficult for me, someone who is on their own, to accomplish that. I have no health benefits for medication, no spousal support, and every time that I went to the government for help, I got turned away because I was not in my 80s and I was not living on my own. We must look at this disease in a different way.

Yes, we need a strategy to help people learn more about brain health. We need a support system to help people with dementia and their families, regardless of what age they're diagnosed. Yes, we have an aging population. The time to act is now. We have a reason to care now. Our families and health system will feel the strain of more than 180,000 people in Ontario with dementia. Remember, this number of 180,000 is the number of people with dementia in Ontario right now. It does not even include the family members who must cope with its effects.

I thank you for letting me come and speak with you today. I feel that I have accomplished something every time I'm allowed to do this, and I hope that I've given you something to think about. If you have any questions, I'll try and do it without script, but good luck.

The Chair (Mr. Kevin Daniel Flynn): I'm sure you can. You've left about five minutes for questions, C.J. Thank you for your presentation. Let's start with Christine and Sylvia. You have questions, Christine?

Mrs. Christine Elliott: Thank you very much for coming today, Ms. McCaffrey, and telling your story. I think you've raised some really important issues with the comments you've made.

I have two questions. One is with respect to the home care aspects and any services or benefits that you're entitled to. Are you receiving help of any kind right now?

Ms. C.J. McCaffrey: When I reconnected with the Alzheimer's Society—actually it took me about two years to get a social worker, mostly because I fell into the depression. I did get Meals on Wheels for a while because I wasn't looking after myself—that kind of thing. But for the most part, the friends that I have and one connection with my family helped me stay—I'm able to look after myself in other ways.

My concern is, what's going to happen to me when I can't look after myself? Other people have spouses or money. Every time I went to the government, they said, "Well, we can't help you because you have a little bit of RRSPs, so you have to spend your RRSPs to pay for your medication." So all my RRSPs are gone, and now I'm living just on my disability pension. I never thought that I would want to be 65. I crave for when I go to 65, because now my medication will be paid for.

The Chair (Mr. Kevin Daniel Flynn): We have to move on, C.J., to the next question. Maybe you can keep covering it off. France?

M^{me} France Gélinas: You mentioned that, after you found out, you had a year and a half to two years of depression. Were you receiving care? Was it recognized that you had depression, and who helped you?

Ms. C.J. McCaffrey: Well, the lady that spoke before me about the First Link said that they did follow-up calls

and that kind of thing. At that time, I didn't get follow-up calls. I got the original referral, I went to the First Link programs, I saw all these older people and then I went home and I said, "I'm only 58. I'm not anywhere near them. I really don't have this." I slipped into denial, and then, even though I'm saying I don't, yes, it's there and you know it.

Other than going to my medical doctor, who I trusted for a long time—and she kept scratching her head. She said, "C.J., I don't think you do," but she kept treating the depression. So that's how I knew about the depression. I was treated for it, but it took me a long time to admit that I really, really needed help with the disease itself, and that's when I reconnected back with the Alzheimer's Society.

The Chair (Mr. Kevin Daniel Flynn): I think you have a little bit of support that came up there.

Ms. Kelly Robinson: I just wanted to add one comment, because that's exactly why we implemented the follow-up process. Initially, we trusted that once we made an initial call and reached out, and sent a package of information and provided the initial information, people would initiate their own calls and maintain contact—plus, we didn't have the resources. But we found out that we lost people quickly and easily, and that first call was nowhere near sufficient to support people, to empower them, to connect to what they needed. We needed to implement regular follow-up.

The Chair (Mr. Kevin Daniel Flynn): Thank you, C.J., and thank you again, Kelly. Unfortunately our time is up, but that was a wonderful presentation. You did great.

Ms. C.J. McCaffrey: Thank you.

Applause.

The Chair (Mr. Kevin Daniel Flynn): You're the only one that has got applause in all our hearings.

THE MEN'S PROJECT

The Chair (Mr. Kevin Daniel Flynn): Okay, our next presenter this morning is the Men's Project. Rick Goodwin, if you'd like to come forward and introduce perhaps who you're with. You've got 15 minutes like everybody else. You can use that any way you see fit. The mikes work when you're about a foot away from them. It's all yours.

Mr. Rick Goodwin: Okay, thank you very much.

My name is Rick Goodwin. I'm the executive director of the Men's Project. I'm sure you've been very patient through all these presentations. The only spin I would like to suggest is that I don't think you folks have heard a presentation from the perspective that we'll be offering today, given our status in being the only service provider in Ontario, funded by the Ministry of the Attorney General, to work with male victims, or survivors, as we refer to them, of sexual abuse. That will be our focus today, but before I start, I'd like to introduce Mark Feldstein. Mark Feldstein is my president. Like any non-profit, we have a board of directors—good-hearted

volunteers—and Mark's been a very impressive president, may I say. On with the presentation.

1140

We appreciate being invited to present to you folks. I think, before we start talking about sexual trauma and services for male victims, we need to speak a little bit about the agency. The Men's Project was formed about a dozen years ago out of perceived gap in community services here in Ottawa. The YMCA-YWCA were very important in establishing the agency to serve men around various needs, particularly those men who were sexually abused and sexually traumatized as children, but also to speak on other issues including men's violence in intimate relationships and issues of emotional integrity and fathering. Those are kind of our main shticks, if you want to use that term. Since then, we've become—well, we still are the only service provider of our kind in Ontario, and one of four in Canada. So we're speaking to an area of service that's fairly new, fairly innovative and not well resourced.

What we're trying to do at the Men's Project is establish a kind of one-stop shopping for mental health services for men. We've been doing this with those areas of interest and working with the province around particular hot spots and particular critical issues concerning men, and that also involves the Cornwall inquiry. I'll be speaking to the Cornwall inquiry in a minute.

Of a few things that we do offer is a model of treatment for trauma survivors that has been recognized not only by the inquiry in funding a guidebook that has been published on that, but it has become the model of service in the state of California, of the 1in6 organization down there. It's a model of service that's recognized as a best practice now in Europe through the refuge model or system association of service providers. So we think we're on to something because the notion of working with men and working around issues of sexual abuse is fairly new, not well thought through, and in so many ways we recognize that women, women survivors and the feminist movement have been about a generation ahead of what, as men, we're trying to do in terms of finding ways of healing and recovery.

When I talk about sexual abuse or sexual trauma, it is essentially a mental health issue. It falls under the justice system in many ways. What these men who attend our services need is counselling, mental health therapy, as you will.

Just a couple of more claims: In 2007, the Attorney General gave us his inaugural victim services award for service innovation. As well, the Aboriginal Healing Foundation sees us a promising healing practice for First Nations men. Part of the inquiry—we have official standing with the Cornwall inquiry. We're the only mental health agency with that standing, and as many of you know, we will be hearing from Commissioner Glaude as he reports on October 15. We're on the cusp of a three- or four-year effort to participate in gaining an understanding of what happened there.

In our presentation, we've included our contributions and our recommendations to the Cornwall inquiry. We

don't have time, certainly, to talk about that, but I want to underline the first one, which is, there's a need in Ontario to have services like ours for male survivors of sexual violence to find healing, recovery or treatment for that issue. It seems kind of a shame that in 2009, we're talking about this like it hasn't happened, but in fact, apart from Ottawa and Cornwall, there are no services funded by the Ministry of the Attorney General for male victims. This is an interesting issue because there are 39 centres in Ontario that serve women survivors. They're often referred to as sexual assault centres or rape crisis centres, and that funding has been delivered through the Attorney General's office for a number of years.

What we're pointing out here is that there is a gap in services that has stemmed from a policy—a very old policy, but one that is still with us—that says that victims' services, in terms of sexual violence, are only for women. So even though we know that sexual abuse happens to boys—we know one in six is the accepted figure of that form of violence—as men, there are not those resources because the funding mandates say that services are only for women victims.

We think by 2009—and we're hoping with the commissioner's recommendations with the inquiries—we'd like to see that changed so that victims of sexual violence in Ontario, whether they're women or men or children, all have access to needed services. If there is anything from this presentation today that will stay with you, it would be that piece. A victim is a victim is a victim, and no longer should we deny people services because of their gender.

We do believe that this lens of sexual abuse can add light to the connections between mental health and addictions, in speaking, of course, about men. In terms of actual numbers, that one in six figure adds up to close to a million males in Ontario who have been or will be sexually abused. If we combine that with the unknown figure of how many men are sexually assaulted as adults—we know that certainly occurs in our institutions and in other scenarios—we're talking about the needs of over a million Ontario men.

So what are the mental health presentations of these individuals? We know depression is the number one mental health issue for survivors. We know that suicide is a critical issue. Men commit suicide four times as much as women do. We know that, generally speaking, survivors are much more prone to suicide. Certainly, there are many studies of the higher rates of alcohol and drug use. Here we've quoted some studies showing two, four and 10 times higher addiction rates for those sexually abused as children. And we know with men there are particular mental health issues that we often don't even think of as mental health issues. But if you look at patterns of men's violence, patterns of men's risk-taking behaviour, of inappropriate expressions of anger, self-injury, all these can be attributed to early forms of childhood abuse. There is enough of a research base there that we are confident of these statements. Again, the Cornwall inquiry has funded us to provide that research to the Ontario government.

I'd like to go back to the fact that we've got in Ontario—and God bless them—39 centres for women, to work with women victims of sexual violence. It gives that notion that in every community there is a place for healing, and if we can attend to people's core injury—that's kind of the lingo in our business—we may not then need to spend as much attention on addictions issues because addictions issues will drop with those people who receive treatment. You won't find these individuals as much in our criminal justice system, because a victim who receives attention about their childhood trauma tends not to be in conflict with the law. Unfortunately, especially in Cornwall, we've seen that as a recurrent pattern.

I think, getting back to the notion of fairness and equality, we would like to underline the fact that all victims of violence should receive support, not only because it is the right thing to do, but it's also beneficial for our communities as a whole.

So that in essence is our presentation. If there are a few more minutes, we'd be happy to receive questions.

The Chair (Mr. Kevin Daniel Flynn): There are a few more minutes, Rick. That's great. There is probably time for a minute and a half for each party. We start with Christine and Sylvia.

Ms. Sylvia Jones: A quick question: You said the Men's Project began in 1997.

Mr. Rick Goodwin: Yes.

Ms. Sylvia Jones: But you don't have annualized funding?

Mr. Rick Goodwin: No.

Ms. Sylvia Jones: Is it considered a pilot project 12 years in?

Mr. Rick Goodwin: Project funding by its definition suggests funding of less than a year. However, for those 12 years, our funding has been renewed for project funding at March 31. One of our recommendations—I don't know if you saw it there—is that we would ask for permanent funding, given our record of service to the province. It would give us as an organization incredible security versus a question of whether we have funding next April 1.

1150

Ms. Sylvia Jones: So when you started in 1997, your mandate was specifically related to the Cornwall inquiry?

Mr. Rick Goodwin: No. When we started, it was community awareness in Ottawa of the gap in services with the Y sponsoring that initiative. It provided the original house at the Y.

Then the province invited us into Cornwall because Project Truth was starting up and no one knew what was going on with the male victims concerned with Project Truth. About 95% of the victims connected to Project Truth or the inquiry are male.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you, Rick. France?

M^{me} France Gélinas: I don't want to seem not supportive. I had never heard of your project and 15 minutes

ago I didn't know you existed, so take it as ignorance and nothing more.

There is a strong body of evidence that supports having female-only treatment. Do the same things exist to segregate men from general treatment? I'm thinking that in the community I'm from—I'm from Sudbury—we deal with a lot of survivors of residential schools. We deal with a lot of men who have dealt with the problems that you're talking about, but they receive their services through mental health agencies that target both men and women. The first question that came to my mind is, is there a body of evidence that shows that men do better if they receive their services from a gender-centric provider?

Mr. Rick Goodwin: That's a great term, "gender-centric." We do believe that therapy, as well as trauma therapy specifically, has to address one's gender, because the sexual violence inflicted upon these children is based on their core identity, which is being a girl or a boy, and trying to perceive why they were abused because they were a girl or a boy. I believe this is the basis for the network of women's centres which provide a feminist framework for their service offering.

I think our agency does it a little bit differently in the sense that half our staff are women. So it isn't the therapists, but it has to work in a way that speaks to men. We have to incorporate aspects of men's violence and understand it in their past abuse. We believe that that is a really important way for the trauma to be resolved.

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

Mr. Jeff Leal: Just quickly as a follow-up to France's question: numbers or percentages that you have of male victims who came to you from the residential schools—do you have that number?

Mr. Rick Goodwin: I'm sorry—are you speaking about aboriginal men?

Mr. Jeff Leal: Yes, who were from the residential schools and were victims of sexual abuse.

Mr. Rick Goodwin: Yes, we do have them. I don't have numbers for them. They would be a minority, certainly, of our services.

Mr. Jeff Leal: Okay. Thanks.

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

Mr. Rick Goodwin: Okay, thank you all.

JANE RUSSELL

The Chair (Mr. Kevin Daniel Flynn): Our final presenter of the morning is Jane Russell. Jane, if you'd like to come forward and make yourself comfortable. You know the routine probably as well as I do no, so I'll just turn it right over to you.

Ms. Jane Russell: Okay. My name is Jane Russell and I now live in Madoc. My son was diagnosed in 2000 in Peterborough with bipolar schizophrenic affective disorder.

Adam's illness reached psychosis in 1998, but as early as the age of five, he was having difficulty with noise and crowds. He suffered migraines for 12 years, which I treated with diet and environment as I was told that they were probably growing pains.

By 2000, he had been in and out of hospital countless times because of psychotic episodes. As a result of his being released while ill, I called the police to get him to hospital again. I was told to agitate him enough to strike me so they had reason to come. I did. The police arrived. They took Adam to jail.

Taken away in handcuffs, my son spent three months in the Brookside detention centre without his meds even though he had a diagnosis. His recovery was compromised and he suffers from fused discs as a result of being beaten by another inmate. Upon his release, he chose to self-medicate with methamphetamines and he became suicidal.

My question is, why was Adam allowed to make the decision to self-release, to voluntarily release himself when he was clearly not capable?

Skip ahead four years. Adam has accepted health and is able to go to the STEP program in Whitby. He arrives at Whitby hospital weighing 160 pounds—he's 6'1". That's not unusual. I visit every week for five months and notice he's gaining weight. I question doctors and nurses, and no one has an answer. Adam does: trips to the mall and freedom to use the hospital cafeteria at will. He doesn't have to exercise or attend the night activities.

When I pick him up for his release, he is 310 pounds and toting a certificate from the nutrition and wise diet classes that he attended at STEP. He is also on meds that are not working, and I am told by a leading psychiatrist that Belleville, which would be the service host since moving to Madoc, is void of any worthwhile mental health care. So now I'm faced with my son, and I will not have any help in Belleville and will have to deal with Adam's obesity and meds myself.

Four years later, Adam lives with my partner and me. He sleeps all day. I have to make all the meals so he won't overeat. He has two friends. He feels completely lost.

In January 2009, after working with him considerably on motivation and getting him up and doing things with him, as a group home is not an alternative, he has decided to move to Port Hope and has learned to invent activities to occupy himself. This is possible because Belleville does have a good mental health facility and we are pleased with his meds and his doctor, whom we still have. Adam has a worker, but I'm not sure where he is.

What he does now: In order to have a life and get ahead, he needs guidance. I still provide that. He has no professional to talk to or help him through the process of gaining any self-worth. I go to Port Hope twice a month. I help him cook, clean, exercise, find new activities in the town and try to motivate him to learn on his own. It works for a couple of days, and then the pattern continues.

I have not been able to take a full-time job, so I'm attempting self-employment. Adam might be able to find

a career if he had somewhere to go and somewhere to motivate himself. I have seen him work at the theatre with my brother, who is the manager of the Capitol theatre in Port Hope, and this kid never makes a mistake when he's asked to do a job. But the job ends in a couple of days, once the theatre performance is over.

What I am asking from mental health:

—Perpetual care. Gaps in treatment from diagnosis to independence affect results.

—Rethink voluntary release based on illness instead of age. The only important thing is wellness. What does age have to do with anything? We—family, parents—are trying to find reasonable care for the ill person. My son went to detention because of voluntary release.

—More involvement with family, as caregiver, regarding results, treatment and education.

—Periodic testing to assess ability and progress toward education or work possibilities. Right now that would be perfect for my son. What are his abilities? What has he been able to rise to since he's been on his own?

Gaps in the existing system: voluntary release comes up again. It creates a condition in itself and puts family in uncontrollable situations. There's no safe place for the ill person. Self-medicating with drugs and alcohol becomes so easy. Psychotic episodes can happen anywhere. Chances of staying on meds as prescribed are slim; chances of the right medication being prescribed in early diagnosis are unlikely. Ongoing monitoring of deterioration or recovery does not happen. Family members are affected in every way.

My final want is nutrition and exercise. Obesity is everywhere, but when it comes to treating mental illness, it obviously goes out the window. It must be a part of wellness. In my opinion, it has never been part of recovery, nor has alternative health care.

My asks:

—Create activity-driven programs for independent living that include skills development, artistic interests, and nutrition and exercise as part of a recovery program, and make it important to medical professionals.

—When a mentally ill person comes for help or is in crisis, allow enough time for that person to self-realize that they need help, not be told that they are ill, "These are the choices, now go away and let us know what you want us to do." That's more or less what happens when you're allowed self-release: "Here's three days, here's some meds. You can sign out any time you want. Bye."

—Create family network programs wherever there is a need or an interest, developed by consumers-survivors and caregivers.

1200

I've dedicated my life to Adam's wellness; I don't mind. However, there are many out there who can't do that. I receive phone calls in my area all the time, either anonymously or openly, from parents who don't know where to start. I'm not a psychiatrist but I've been able to help somewhat. But it's really bad in my area. I think, without having to put more money into any kind of help or programming, there's no reason why, as family networks or as these three things don't allow voluntary

release—that's ridiculous. And being able to create family networks so that we can talk among ourselves and find out what are the best avenues to go down first before running to hospital, running to the emergency—I've been there, I don't know, 20 times. It doesn't work. You need to be able to take the situation in hand, calm down, and direct that crisis to the right avenue and the right people. I think we can only do it through families and through open conversation. And, absolutely, we have to take nutrition into consideration. I know my son buys crap when I'm not there. Is Kraft dinner going to help this kid get better? I don't think so, but he doesn't know what to buy because he has no one who comes to his house once a week and says, "No, no, no. You don't do that." I do that, but should I be doing that? I don't know.

Anyway, there are the considerations, and Adam and I thank you for this time.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left quite some time for questions. I think our first person is France this time.

M^{me} France Gélinas: Thank you for your presentation. We, not this morning but through the different sessions we've had, have heard an awful lot about families finding that we haven't found the right balance between the right to freedom and liberty and the right to treatment. Most of the families or family members that come to talk to us or people with severe mental illness who come to talk to us approach this. Where would you see the right balance being struck as to the right of the person to make their own life choices, I will call it, the level of risk that they want to take, versus the family who have to pick up the pieces because the person is discharged too early and everything goes wrong? Where do you see that?

Ms. Jane Russell: I believe that in the early stages, when psychosis starts, as with Adam—he had an outburst and he was taken to hospital. It was clear that this child, at that time, was psychotic, that he was suffering from some sort of mental illness. I knew because of the things that had happened. So when he was taken to hospital by police, by family and by his teachers—the whole group of us were there—he was admitted and he was told openly, "Okay, you have three days to be under assessment. We're going to do this: We're going to put you in a straitjacket, we're going to put you in a lock-up room, we're going to try medication, we're going to sedate you, and three days later you have to make a choice." He is still thinking, "What happened to me?" So in three days, he doesn't know where he is and he decides, "I'm out of here. This is crazy. I could get better on the street by myself." Nine times we went through that exact same scenario.

So to answer your question, I believe that every person—especially youth—who is taken to a mental health facility because of a psychotic episode needs to be given the time to not only realize they've had a psychotic episode but the fact that they are going to need help and these are their options. Yes, they're going to be violent or perhaps they're going to be upset and they're going to say, "I have rights. I have rights." Well, you know what?

The world has rights too. To let that child out on the street, regardless of age—I don't care if they're 16 or 36; to let that person out on the street in a psychotic state like that because they have rights is not taking into consideration the rights of everyone else around them.

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

Any questions from this side? Helena.

Ms. Helena Jaczek: Thank you very much for sharing your story. Obviously, you've had a great deal of negative contact all through the process with agencies and so on. Is there any example of a best practice that you could tell us about?

Ms. Jane Russell: Oh, yeah. I was really lucky. In Peterborough, after that horrible thing with the police and everything in Brookside, which was negative, Adam was then able to get to the schizophrenia clinic in Peterborough, where we had a really terrific experience, and God bless.

Ms. Helena Jaczek: What was the element that you found particularly good in that site?

Ms. Jane Russell: We had a worker who just never let us down. He was there whenever we needed him. He attended to Adam and Adam's needs and to every other client that he had. When he couldn't, he made sure that Adam was with someone else and that Adam knew that person equally and felt equally comfortable with them. The psychiatrists who were there were wonderful. They put Adam on the right path, absolutely. I had a fantastic experience, and it was the schizophrenia clinic in Peterborough.

Ms. Helena Jaczek: Having that one connection—we've heard the terms "case coordination" and "case management." I don't really like those terms, but that seems to be a really important aspect.

Ms. Jane Russell: It's very, very important, and that's what we're missing right now. That's what Adam and I are missing right now. I have had to invent everything I could possibly think of to motivate. I include him in my work. I say, "I need you for this drawing," or "I need you for that drawing," just to keep him motivated. What he's missing, we call it the Gord effect, because we don't have that. We tried in Belleville, but it didn't exist; it was just sort of, "Where do you want to go? Do you want to go to the mall?" We have amazing psychiatric support in Belleville, and I'm very thankful for that, but what he needs right now as a young man is to be with young men and get out there, to get up himself, and not go down the street and go, "Well, what do I do now?" He doesn't want to be with ill people. He doesn't need to be with ill people. He wants to be with well people. He needs someone to help him, to say, "You can do that." I've seen him work; I know he can work. He wants to work.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Jane. Final question of the morning, Christine.

Mrs. Christine Elliott: Thank you very much, Ms. Russell. I think you've touched on really important points, and I want to reassure you that we are listening to parents, particularly with respect to the voluntary release issue. I think that's one of the most critical things we're

dealing with on this committee, so I really appreciate your comments and suggestions on that.

With respect to the whole issue of what to do and how to motivate people and so on, I think there is also a real need to educate employers more about the vocational opportunities that present themselves and that it's worth the investment to hire somebody who may have some or have had some mental health problems in the past. I think there's a whole community education process that has to be undertaken, and I think it's something that we should be looking at as well as part of this committee, because at the end of the day, everybody wants to feel that they have a meaningful life, that they're making a contribution, and I think that's an essential part of wellness as well. So I just wanted to let you know that we are thinking about all of those things, and thank you for being here.

Ms. Jane Russell: Well, thank you.

The Chair (Mr. Kevin Daniel Flynn): Maria, we have about 30 seconds left. I know you had a question.

Mrs. Maria Van Bommel: First of all, I want to say thank you very much for coming in. I know it's not always easy to talk about your own personal life. I had a sense of real frustration, an edge of frustration in your voice.

You mentioned a number of things that you would like to see happen. I was just wondering, if you had to pick one thing—I know all of them are important, but if you had to pick one thing that would give you some relief and would help your son Adam, what would it be?

Ms. Jane Russell: It would be having someone for him to go to so that he doesn't feel he's all by himself to make decisions. For me, it would be to create a network in a town where people who are facing situations such as mine have a chance to come and talk to people like myself who have been through it so that they can be directed to start the ball rolling. But more importantly, I want my son to have some support. He just needs a mentor.

The Chair (Mr. Kevin Daniel Flynn): That's a great way to end the morning, I think: Everybody gets one wish.

Ms. Jane Russell: That's my wish.

The Chair (Mr. Kevin Daniel Flynn): Thanks for coming this morning.

For the other members of the committee, lunch is in the Mackenzie Salon on the 27th floor, and for those of you who haven't checked out, checkout is at noon. More properly, I should say checkout was at noon.

The committee recessed from 1209 to 1305.

The Chair (Mr. Kevin Daniel Flynn): Okay, if we could all take our seats and perhaps get ready. Our staff's all set to go? Okay. We will call back to order again. We're a little bit ahead of ourselves, which is good. We'll try and keep it that way.

UNITED WAY/CENTRAIDE OTTAWA

The Chair (Mr. Kevin Daniel Flynn): Our first presenter this afternoon is the United Way—Peggy Austen and Dennis Jackson.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): It's you, yes.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Okay. Well, we'd just like to start earlier, if it's possible.

Mr. Jeff Leal: What about Chief Daniels?

The Chair (Mr. Kevin Daniel Flynn): Chief Daniels isn't going to make it today, unfortunately.

At 1:45, OPSEU is presenting. They asked if they'd be allowed to take some pictures during the proceedings. I said that shouldn't be an issue, unless anybody didn't shave.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): That's right. I'll just leave it at that.

If you were here this morning, you'd know that every group is getting 15 minutes, and you can use that any way you see fit. If there's any time left at the end, we'll just split that amongst the three parties and maybe have a discussion about what you've presented. Welcome, Peggy and Dennis. The floor is all yours.

Ms. Peggy Austen: Thank you.

Mr. Dennis Jackson: Thank you very much. Good afternoon. I hope you all had a great lunch in our great city. First of all, my name is Dennis Jackson. I am chair of the board of the United Way/Centraide Ottawa—le président du conseil d'administration de Centraide/-United Way Ottawa.

In my other day job, I'm a vice-president with Scotiabank. I'm responsible for Ottawa and west Quebec. We sincerely appreciate the opportunity to be here to speak to you today. We sincerely thank you for your investment of your time, your energy and your resources in what we consider to be a very important subject.

The United Way/Centraide Ottawa's mission is to bring people and resources together to build a strong, healthy, safe community for all. In 2009, United Way/Centraide Ottawa made a record community investment of over \$17 million to support nearly 200 projects, programs and partnerships—and we emphasize “partnerships”—in more than 100 community organizations that promote individual and community safety, well-being, supports to unemployed and underemployed individuals, and programs that address crises due to poverty, unstable housing, violence and family difficulties. This amount does not include the substantial investment through additional leveraged opportunities with other key funders and partners.

The vast majority of these programs address mental health and/or addiction issues ranging from prevention to direct intervention in a number of populations, including children and youth, families, seniors, people with disabilities and new Canadians and immigrants. Our impact areas connect the lifespan of our community, beginning with Success By 6 through to aging at home.

Our vision for community impact is also about achieving meaningful long-term improvements to the quality of life of all Ottawa residents, addressing not just the symptoms of the problems, but also getting at the root

causes. It's also about making fundamental changes to social conditions and communities through research, public policy development, collaborations and partnerships.

Our Measures of Change document, which we've left with the committee—sufficient copies for everyone—is an example of how we are at the beginning to measure key performance indicators. We are quite proud of this research.

The United Way/Centraide Ottawa strategic partners in this work include all levels of government, donors, the health, social services and education sectors, business, labour, community leaders and other organizations, all wanting to make a positive impact on our community. Together, we target our community's most critical problems and challenges.

Unquestionably, addiction and mental health issues present significant challenges. We validate the belief that for too long people with mental illness and/or addictions have been stigmatized and marginalized. Creating healthy communities requires a shared vision and commitment from all segments of the community to work together.

1310

In the past few years, we have witnessed this harnessing of community energy in a number of initiatives to address mental health issues and addictions that we have been involved with—for example, Project STEP. Project STEP is our community's response to addressing the need for residential substance abuse treatment as well as education, prevention and early intervention for young people between the ages of 13 and 17. STEP stands for support, treatment, education and prevention. With the engagement of community partners, local champions and leaders, this campaign is raising funds to support the enhancement of a comprehensive substance abuse education and prevention program in our high schools, as well as to provide specialized treatment and counselling in a 24-hour residential setting in Ottawa. United Way/Centraide Ottawa manages Project STEP and is building on the work of the funders, donors, service providers and networks to leverage a community's ability to channel the resources to meet the needs of youth.

A commitment by the provincial government for the operating funds for the residential treatment centres and the school-based programming has to date leveraged over \$3 million in our community capital campaign. It is clear that community organizations, businesses and private donors are rising to the challenges of bringing both awareness and resources to address youth substance abuse issues.

The school-based substance abuse education and prevention program is a collaborative model involving schools and school boards, addiction agencies, teachers and student professionals, as well as students and parents. Other community partners include social services, Ottawa Police Service and Ottawa public health. Substance abuse counsellors partner with each school to support education and prevention initiatives and work with the

students and their parents who may require substance abuse intervention. The school-based substance abuse program has an unprecedented equal-funding partnership between our four school boards, municipal, provincial and federal partners, as well as Centraide/United Way Ottawa. Our shared vision has led us to begin to develop an agreed-upon evaluation framework.

On a personal note, STEP is something that we've been talking about for a number of years in Ottawa, but it has only been recently that United Way has stepped up to the table and has been aggressive with a number of other partners in saying, "It's time that we make it happen," and we sincerely appreciate the support of the province of Ontario, which is certainly going to go a long way to make this become a reality in the very near future. We know that because we're getting substantive commitment, both in leadership and in financial resources from the community, so we're very excited. "Excitement" is maybe not the word I should use, because it's something that's needed; it's crucial for our youth and our community, so I should maybe find a new word. You'll have to help me with a new word for "excitement."

Another example of our community coming together to address issues related to addictions and mental health can be found in the Leadership Table on Homelessness. In partnership with the city of Ottawa, the United Way is working with business leaders, government officials and community representatives to develop a comprehensive housing homelessness strategy with the goal to eliminate chronic homelessness in Ottawa. This strategy, called Destination: Home, involves adopting a housing-first plan, housing chronically homeless people and providing support and services, including mental health and addictions, that they need to remain housed.

I got the French one, right?

Ms. Peggy Austen: There's French and English.

Mr. Dennis Jackson: This is our most recent analysis of this project, Destination: Chez-soi.

In looking at the health and mental issues of our seniors, we have an aging-in-place strategy to support underserved, low-income seniors in their homes and to increase their independence and quality of life. United Way/Centraide Ottawa has provided both staff and financial support to the development and creation of the affordable supportive housing framework. This is another key initiative that has representatives from the city of Ottawa, business, the community and government leaders.

The aging-in-place model of supportive housing has leveraged provincial health funding and is currently in five Ottawa community housing seniors' buildings. This type of supportive housing can significantly reduce health care costs. For example, one elderly person had presented herself to the emergency department six times in a 10-day period, expressing depression, anxiety and feeling generally unwell. It turned out that there was no food in her apartment and that she was feeling very alone and isolated. Providing supports to vulnerable seniors where they live has demonstrated initial evidence of

significant decreases in the use of emergency services and in the diversion to long-term care.

With these examples in mind, we'd like to underscore our message today that the Ontario government must tailor strategies and services to meet the unique needs of the community and to stress that local planning not only on a needs basis, but with a strength-based lens, is critical to the success of the mental health and addictions long-term strategy.

The Ontario government's goal to mobilize a much broader range of support and services to address mental health and addictions will require engaging non-traditional partners and finding new and creative ways to work together.

We have found that the champions for these issues can be found both within government and, more importantly, within the communities themselves. Together, we need to amplify the voices of those who not only experience mental health issues and addictions themselves but of all those around them. Because of the nature of United Way's work with the community, we bring a wide variety of partners to the table, both traditional and non-traditional, to address mental health and addiction issues.

United Way/Centraide is in a unique position to support the efforts of the Ontario government. We are community-based, with partnerships across all sectors. We look holistically at the individual and do so across the lifespan. We combine the voices of many to develop true community responses that are not only reactive but are forward-thinking.

United Way/Centraide applauds an all-party governmental approach and offers its ongoing support in helping to achieve this vision in addressing addictions and mental health issues.

That concludes the summary of our presentation. I didn't check the clock, so I don't know if we have any time left.

The Chair (Mr. Kevin Daniel Flynn): You did. You left a lot of time. I think we'll probably get one question from each party. So let's start with either Sylvia or Christine.

Mrs. Christine Elliott: Thank you very much for coming today. Your presentation was really interesting and I really like the emphasis that you place on getting the community involved in the solutions. Maybe just using project STEP as an example, I was wondering if you could just go into a little bit more detail about how you engage the business community to get on board with this project and what you find works for you in that respect.

Mr. Dennis Jackson: I have the subject matter expert with me but I will start off by saying that we've had some people on the committee who have had their own children or grandchildren in some cases where we needed help and had to go as far as Minneapolis to get assistance. There just hasn't been enough care. So when we go to business people and say that we have opportunities to do things right here in our community, we can get them engaged fairly quickly.

The chief of police has been a big start—I won't say "a big start." We've had various people working for 20 years on this, saying that we need it. But the chief of police showed a keen interest. We were able to bring two other parties together who had shown a keen interest, including Janet Yale, who has been a very strong supporter—I'm sorry, not Janet. Janet is in the leadership on homelessness but she started working in STEP.

So to answer your question briefly, by us being able to show what resources we had, what we've heard that we need from mental health and addictions people on the ground, we've been able to bring together everybody. The province of Ontario really helped us by saying, "If you build it, we will come and help you run it." That really does help. That puts the sense of urgency in the community to raise the capital money we need to do it.

I'm not sure if I completely answered the question.

Ms. Peggy Austen: I think when it comes to the business community, it's also about finding the teachable moments and the language to be able to share the stories. There are a lot of misconceptions about addictions and mental health, and when we go out, it's identifying what the real issue is and how it affects our community. That's why we talked about being really relevant to different communities.

People don't know the extent of the problem and there's a helplessness about what they can do to help. So we're finding that in having our champions, which is really important because—for years I was part of the social service sector—we were beating on the doors and saying that we need to do this. But it's got to be a whole community voice and then everyone feels they have a unique and essential voice in that conversation. Some of our best advocates are those business people themselves now, and they're going out and doing the talks and talking about mental health as a community issue.

1320

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

M^{me} France Gélinas: Can I be brief? I have lots of questions for you, but I'll pick just one. I see that you've adopted the Housing First strategy, which a lot of us have. We have in Sudbury. I don't know how long ago you went with it. Are you at a point where you can measure success?

Mr. Dennis Jackson: Do you want me to start with that?

Ms. Peggy Austen: Go ahead. Sure.

Mr. Dennis Jackson: We're coming to the end of our second full year; we're into our third year. We've created in this past year 80 new affordable residences for people on the street. I'm not sure what we did in the first year.

Ms. Peggy Austen: It was about half that.

Mr. Dennis Jackson: About half that. So we went from 40 to 80, so about 120. So we have started to measure it, but we've got a long ways to go.

M^{me} France Gélinas: Were you able to develop a range of housing options, as in 24/7 supervision to

transitional to supportive housing, "We call you when we need you"?

Ms. Peggy Austen: That's in the beginning stages. We've really just leapt off with, "Here's the plan and the action plan," but we are looking at all types of housing. The real importance is around the supportiveness and the things that will happen around them. We do have two youth shelters which have shelter beds, transition beds and then long-term housing.

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

Ms. Peggy Austen: Thank you very much.

M. Dennis Jackson: Quand tu passeras à Sudbury [*inaudible*] un bon nom français, Marcel Séguin—Marcel Jackson, je veux dire. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thanks for coming today, Dennis.

CHAMPLAIN ADDICTION COORDINATING BODY

The Chair (Mr. Kevin Daniel Flynn): Our next presentation this afternoon is from the Champlain Addiction Coordinating Body: Deborah Hook, Lise Laframboise, Mike Beauchesne and Jonathan Moore, if you'd like to all come forward. Make yourselves comfortable. All groups are being given 15 minutes. You can use that any way you see fit. Hopefully, there's some time at the end for some discussion. The mikes work best when you're about a foot away from them—not that I'm trying to intimidate you or anything, but some people get very close to them. It's all yours.

Ms. Deborah Hook: Thank you. Good afternoon. Bonjour. I'd like to introduce my colleagues. Actually we were going to be four; we're three because we're hoping to have time for questions and be able to give you a spectrum of expertise. To my right, Mike Beauchesne is the executive director of the David Smith Youth Treatment Centre, an outpatient day facility for youth between 13 and 18. On my left is Lise Laframboise, who's the executive director of Pathways Alcohol and Drug Treatment Services of Renfrew county, an outpatient addiction treatment service. And I'm the director of the Ottawa Withdrawal Management Centre, a level 2 residential service for men and women 16 years of age and older.

The Champlain Addiction Coordinating Body is a community of practice, presently composed of 21 agencies, which has existed since 2002. As in many regions in Ontario, the addictions and mental health sectors are presently uniting to form a community of practice that will provide joint expertise and a common voice.

I'm going to carve out pieces to speak and the full presentation is here.

Ten per cent of the Ontario population lives in the extended Ottawa Valley region. It contains a dense urban centre, populous suburbs and remote rural areas, and

covers a large geographic area—almost 18,000 square kilometres. Close to 20% of the population is franco-ophone, and there also exists a strong multicultural presence, with 14% of the population being members of a visible minority.

For our presentation today, we have focused on issues that affect the vulnerable population of persons with high addictions and comorbid mental health needs—concurrent disorders—who are presenting at addiction services.

According to a report presented by the ministry for 2008-09, there were just over 11,000 new referrals and just over 12,000 service discharges for the Champlain region. In 2008-09, there were over 18,000 service events that were delivered across the continuum of care throughout the 21 addiction agencies in the Champlain region.

Of those who have addiction problems and who are presenting at addiction services for help, there is a high prevalence of co-occurring mental health problems. For example, 77% of persons with alcohol-related problems have been found to have at least one psychiatric disorder.

With these complexities in mind, we will identify three key issues facing the Champlain region and suggest solutions that fall under the themes of “strengthening the workforce” and “system design” in the 10-year mental health and addictions strategy.

We have framed the issues and made recommendations using a client’s perspective as they seek treatment and move through the system and along the continuum of care.

At the outset, and even as we make recommendations for solutions, we must emphasize and remind you that while mental health and addictions have achieved enhanced public attention in recent years, overall funding for support in this area remains low in Canada relative to other OECD countries and low in Ontario relative to most other provinces.

First key priority: clients and their families. Accessing and then navigating through the many paths of the addictions and mental health system can be confusing and discouraging for clients and family members, particularly those with concurrent disorders. As a result, clients can often become lost in the shuffle between service providers. Moreover, clients and family members are not always fully aware of their treatment planning options and spend critical time on wait-lists while their condition deteriorates. Clients, along with family members who are trying to support their loved ones, are left with a sense of hopelessness as they struggle to obtain the services they want and need in a timely manner.

Although funding insufficiency rests at the core of problematic and untimely access to required services, we also believe concrete steps can be taken to help address issues related to access and navigation. More specifically, we are proposing an access model that directs newcomers to a central hub of coordinated service providers with structures and procedures for early identification, provision of supportive services and referral to a full service range.

Clients would receive motivational and entry-level supports through case management workers while awaiting access to treatment availability. At the entry level, case management support would also include linking clients to other required services such as primary care, income support programs, housing programs and other community support services. Treatment procedures would include a declaration to all clients of such partnerships and that the assessment/examination of their circumstances would address both mental health and addiction issues in their lives.

This coordinated access and navigational model would involve service providers across mental health and addictions interacting through trained case management workers. Clients would be connected with services in a coordinated treatment plan, without having to unnecessarily retell—and often retell—their stories.

Improving system design in this way will help to accomplish the noble objective of every door being the right door. With this coordinated access and navigational model, providers and programs work collaboratively to provide integrated and coordinated treatment options to meet consumer needs. Allied professionals can provide each other with navigational support that will ultimately lead to services that are appropriate for the client, proactive and ongoing.

Second key issue: geographic disparity in Champlain. There are important social, economic and geographic reasons why many people do not have access to addictions and mental health services in the Champlain area. As about half of the addictions service providers are located in central Ottawa, rural Champlain communities are often ill-equipped with necessary treatment services, and consumers face barriers of transportation and affordability.

We are suggesting that consumers in rural communities be better supported with an increase in personnel in the addictions sector in rural regions and by establishing transportation to and from addictions and mental health service centres.

We are also calling for an expansion of community withdrawal management services to allow consumers who are facing multiple barriers to access necessary support.

These improvements, in conjunction with coordinated access, will allow the addictions sector to develop system protocols to reach out to consumers, regardless of the geographic area. Also, stronger community support networks within the addictions sector will allow our service providers to create strong linkages with other sectors that will benefit consumers facing the most complex of needs.

Increasing the number of professionals and improving the rural/urban system flexibility will contribute to a more seamless system that is able to deliver comprehensive treatment to clients across our region.

Third key priority: the workforce. The addictions sector is experiencing serious staff recruitment and retention problems. In our region, qualified addiction treatment personnel are frequently lost to larger health institutions—hospitals—as well as to other sectors—

education and even mental health. Addiction agencies are not able to offer competitive salaries and benefits packages to attract or retain personnel and must often offer contract positions to save costs. As such, qualified professionals who have gained valuable experience in addictions often gravitate to other, better-paying, more secure positions elsewhere, outside the sector. This human resource instability is detrimental to the clients we serve and poses unnecessary hurdles in an already-challenging work environment.

1330

In addition, our education system does not adequately train and equip the emerging workforce to work with the complex needs of clients with concurrent disorders. While the majority of clients entering the addictions and mental health system have concurrent disorders, the majority of counsellors are under- or ill-equipped to provide fully appropriate support and services.

Lastly, continuing education in the addictions sector is often more about what particular agencies can afford rather than what is needed—obviously an inadequate reality, given the complex and ever-changing needs of the clients we serve.

We recommend establishing wage parity between professionals in addictions, then in mental health, and then with other related health sectors.

The education sector must work with practitioners to ensure that the emerging workforce is fully and adequately equipped to provide specialized services to clients with concurrent disorders.

Personnel already within the workforce must be required—but also supported—to attain the appropriate competencies to work with clients with concurrent disorders and update their skill set as needed.

Finally, associations within the addictions and mental health system must be given the means to further develop a standardized clinical certification procedure and capacity to enable workers to be certified and maintain up-to-date clinical qualifications.

In conclusion, we believe there is an urgent need for all clients who are battling with addiction issues and related problems, particularly those with concurrent disorders, to receive adequate and appropriate services. Clearly stated, this means developing a continuum of care with a range of easily accessible services and where mental health and addiction services aren't siloized and aren't stigmatized; help and assistance through a deep understanding of addiction issues, particularly at the front line, which meets the individual needs of the client where that person lives, in a timely manner, using well-trained staff, coordinated access, navigational support and an urban/rural system flexibility.

In order to finance the needed changes, we suggest as one example that the government take more money out of the profits realized by the promotion of gambling and apply these funds to mental health and all kinds of addictions. For numerous reasons, not the least of them stability and planning, it is also critical that the govern-

ment provide agency funding for periods of at least three years.

Thank you to all of you for your marathon of going across Ontario to listen to people like us, for coming to our region, and thank you for your commitment to developing a client-centred 10-year plan to strengthen mental health and addictions services across Ontario.

We right now would, we hope, have some time left, and be happy to answer your questions.

The Chair (Mr. Kevin Daniel Flynn): Yes, we do have a little bit of time left, about a minute and a half for each. Let's start with France this time.

M^{me} France Gélinas: I'll be very brief. You've talked about wage parity. Right now in Ottawa region, where would the mental health worker in a community agency fare vis-à-vis somebody working in a hospital?

Mr. Mike Beauchesne: In our experience—and I work in a youth-related sector—we're looking at about a 20% difference in terms of comparable staff members.

M^{me} France Gélinas: And could you give me an idea of the salary range?

Mr. Mike Beauchesne: Sure. It would not be unusual for a starting counsellor—and this would be someone who often comes in with a university degree as well as perhaps a graduate degree—to be making in the range of \$18 an hour on a contract basis. Compare that with some of the individuals we're losing who are making twice as much as that in some situations, with more job security and benefits to go along with that salary.

M^{me} France Gélinas: What would you say the percentage of unionized positions is within the community mental health sector?

Ms. Lise Laframboise: In the mental health sector? In the mental health sector we wouldn't necessarily be able to answer, since we're addiction.

M^{me} France Gélinas: Addiction; sorry.

Ms. Lise Laframboise: Very few unionized across the addiction sector in the Champlain region.

Mr. Mike Beauchesne: It would be quite low.

Ms. Lise Laframboise: Maybe 5% or 10%?

Mr. Mike Beauchesne: Maybe in the 5% to 10% range.

M^{me} France Gélinas: Thank you.

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

Mrs. Liz Sandals: Yes, a couple of questions. One, you talked about people who are having to deal with a concurrent diagnosis but the counsellors really don't have concurrent training. What would be the ideal training for somebody to be able to deal with both addiction and mental health? Where would you like to see that evolve?

Ms. Lise Laframboise: At this time, there are various concurrent disorder training certificates available, but it's a matter of being able to cover the staff time to attend those types of certificate trainings, which are often 10 days in length. So it's being able to cover staff time and travel. For example, in Renfrew county we would need to be travelling down to an Ottawa area to obtain that kind of training. So you're looking at, possibly, with

the residential service that we have, having to backfill, and then just on top of being away from the office for the day and all that kind of stuff—

Mrs. Liz Sandals: So the training is available. Because you then go on in your recommendations to talk about needing to land on a standard for the certification, which led me to believe that perhaps there isn't the recognized training—

Ms. Lise Laframboise: There's certification in addictions. I'm not sure about mental health, but there is a certification that's recognized in addictions, which takes just over three years to obtain and a great deal of training.

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

Ms. Sylvia Jones: Thanks for your presentation. You have touched on an issue that we've heard over a number of presentations, and that's the need for coordination. I'm going to ask Lise and Mike, particularly, because you deal with youth. At this stage, how are you doing that coordination from transitioning from youth into adult?

Mr. Mike Beauchesne: That happens in numerous ways, but most predominantly it's through coordinating of groups such as the Champlain Addiction Coordinating Body, working with our mental health partners as well as the other partnering sectors—the schools, criminal justice—but mostly just through direct conversations with our service providers and keeping close-knit conversations ongoing with those groups. That's really essential.

Youth is a specialization with unique needs, and I think we're getting more and more to the point where that's being recognized. Also, I think it's being recognized that putting the investment in when these individuals are younger really has tremendous benefit over the long term. That seems like a common sense notion in many respects, but it's not always something that has been acted upon.

Ms. Lise Laframboise: We deal with 16 and over, so we have only 0.5 FTE for the entire county of Renfrew to deal with youth. Once they turn 16, then they can access other services. I believe that here in the whole Champlain district, youth is quite underserved, so we certainly could use more monies being funded into our youth and prevention. Not many of the agencies in the Champlain region are funded to do prevention or early education.

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

ONTARIO PUBLIC SERVICE
EMPLOYEES UNION

The Chair (Mr. Kevin Daniel Flynn): Our next presentation this afternoon is from the leadership of the Ontario Public Service Employees Union: Mr. Thomas, the president, and David McDougall, the president of Local 439. Please come forward and make yourselves comfortable. Okay. You know the rules: 15 minutes, use

it any way you see fit, and if there's any time at the end we'll use it.

Mr. Smokey Thomas: Thank you. It's a pleasure to be here. My name is Smokey Thomas, and today I have with me David McDougall. David is the president of OPSEU Local 439 at the Brockville Mental Health Centre, the former Brockville Psychiatric Hospital.

In our union, we have 130,000 members. We all work in the public service, and about 30,000 of our members work directly in health care, either in clinical or support situations. Also, we have several OPSEU activists with us who work in mental health, and they're interested in what we have to say and what's going on. We have 7,500 members who work directly in mental health, and we believe that we know the issues as well as anyone, and for a very good reason: Our members are nurses, psychologists, social workers, occupational, recreational and child therapists, who work alongside clients to strengthen their lives. We work in institutions and the community. In fact, it was the psychiatric hospitals that started the move to the communities about three decades ago.

1340

We're the carpenters, the plumbers, the electricians, people who keep the physical plants operating. I'm a registered practical nurse—I haven't been on a ward in years, mind you; I've been in the leadership of OPSEU for a few years—from the former Kingston Psychiatric Hospital. I actually started there when it was still called the Ontario Hospital. So I've been around since about 1971 in mental health. That's the only thing I've ever done in all my adult life other than union. I must say that over the years in OPSEU we've been very much involved in mental health issues: in 1980, Ontario's Mental Health Care Breakdown; in 1983, Recipe for Restraint: A Discussion on Mental Health; in 1985, Where Are They Now?, a report on deinstitutionalization—two of those; and in 1994, Mental Health Reform in Ontario: Developing our Vision. We go way back even earlier than that into the 1970s. Based on that, I believe we have credibility when it comes to mental health issues.

I read the discussion paper, Every Door Is the Right Door: Toward a 10-Year Mental Health and Addictions Strategy. It's my understanding that this paper will help frame many of the key issues your committee is studying before your final report. At the outset, let me say that it's hard to quibble with the goals set out in the discussion paper. They're very good goals, very lofty goals, and, we hope, attainable.

We all seek to identify illnesses and intervene appropriately. Who among us wouldn't want superior-quality care? I regret to remind you of one thing, though: Health Minister Caplan's advisory group was composed of 24 individuals. None of them were from organized labour, and we think that's a travesty. We believe that the absence of labour's voice in that group was a mistake and we certainly believe that we would have had a lot to add. But, with that being said, I was especially attracted to

section 4 in the discussion paper, which talks about strengthening the workforce. I have quite an interest here.

The report says all the right things. It talks about skilled workers on the front lines with adequate capacity. It talks about improving recruitment and retention of skilled workers while enhancing competency in the community sector. We agree.

In other words, it repeats the same goals and objectives that OPSEU has been saying to governments and review panels for the past 30 years. I've seen a lot of these committees come and go; I've read the recommendations. I've been doing it for a long time. Still, the need for community mental health and institutional mental health has never been met.

So it's sad to say that I sit before you today to make the case that by closing the Brockville Mental Health Centre and transferring beds to Ottawa, this government is undermining everything that it claims will strengthen the delivery of mental health care services. Let me remind you of the facts.

The Brockville Mental Health Centre is scheduled to close by March 2011. If this goes ahead, as many as 450 well-paying jobs—is it?

Interjection.

Mr. Smokey Thomas: Close—will be lost to that local economy that has already been battered by the deindustrialization of the St. Lawrence Seaway. They'll be lost to that community. Sixty-four transitional beds will be transferred out of Brockville, thereby depriving a community of 22,000 of a vital local treatment service for the most vulnerable people in our society. And all this at a time when we're supposed to be experiencing infrastructure building. The government is dismantling a vital part of the local infrastructure. Worst of all, it's being orchestrated by the local health integration network of southeastern Ontario. This is a politically appointed, unelected, unaccountable body, and it's making decisions that adversely affect community-based patient care while at the same time weakening the local economy by tossing away these skilled jobs.

To add insult to injury, the CEO of the Royal Ottawa Health Care Group has said publicly and to us directly that he will not implement a human resource labour adjustment plan to accommodate those Brockville workers who say they are prepared to follow their jobs to Ottawa.

Then there's the matter of money. It will cost \$26 million to eliminate the jobs, but it would only cost \$20 million to refurbish the Brockville unit, thus preserving jobs and the services in the community.

If you add it all up, is this how we want to build stronger mental health and addiction services to meet the needs of our communities? Is this how we strengthen regional infrastructure? Is this how we deal with workers and clients in the face of recommendations from the minister's own advisory group that calls for more trained workers working under conditions that make services more accessible and integrated to those in our communities who need them most?

My answer to that, and the answer from our members in Brockville, is clear: We do not accept that by closing down the Brockville Mental Health Centre we would be improving local mental health treatment. We do not accept destroying 450 jobs. We do not accept that the lives of workers and the treatment of patients should be tossed overboard by an unelected body who needn't justify their decisions in the court of public accountability.

We're calling on the Ministry of Health and Long-Term Care to order a one-year moratorium on any further hospital closures pending the outcome of the minister's task force on the delivery of health services to northern and rural communities.

Our position is consistent with the Ontario Medical Association and the city council of Brockville. Both groups support a one-year moratorium.

Let me conclude by saying this: Each of you on this special legislative committee represents a local community at Queen's Park. Each of you is sensitive to the many needs of your local communities, and it's fair to say that most of you would resist losing a valuable public service that meets the need of your local community, especially in the face of public opposition.

These are the benchmarks we are applying to the proposed closing of the Brockville Mental Health Centre.

We would hope that you will support the community by saying no to shutting down local mental health and addiction services.

Your choice is clear: You're either on the side of building capacity to meet local needs, as OPSEU and other groups have been advocating, or you're on the side of separating local services from the needs of local communities. In my view, there's not much middle ground.

With that, I thank you for hearing us out, and we will answer any questions.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you, Smokey. You've left a lot of time, so let's start with this side. We've got two minutes. Any questions from that side?

Maybe I can start with one, just so I'm more familiar with the centre itself. Just how old is it as a building?

Mr. Smokey Thomas: The buildings would vary in dates. Some would be from the 1960s; some would be from earlier. What's left to occupy would be from the late 1950s, early 1960s.

The Chair (Mr. Kevin Daniel Flynn): How would it compare to the facility in St. Thomas, for example? Around the same era?

Mr. Smokey Thomas: Probably, yeah. A lot of them were built in the 1950s and 1960s. Kingston opened in 1959.

The Chair (Mr. Kevin Daniel Flynn): Good. Are there any questions from that side? Maria?

Mrs. Maria Van Bommel: I just wanted to clarify it, because as I look through both your presentation and the press release, you use the number of 250 jobs.

Mr. Smokey Thomas: The number's wrong. That would be about full-time equivalents, but there are a lot

of people who work half-time, part-time, so it's more than the 450.

Mrs. Maria Van Bommel: Okay. So that explains the difference. Thank you. That clarifies it for me.

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

Mrs. Christine Elliott: Just a factual question, Mr. Thomas. Does the centre right now offer both mental health and addiction treatment services, both locally and regionally, or what kind of a population does it serve?

Mr. Smokey Thomas: They have a dual diagnosis unit.

Mr. David McDougall: There's some limited—not a lot. There's a little bit.

Mrs. Christine Elliott: And that's both for local—and is it a regional centre still? I know it used to be, but is it still operating in that way?

Mr. Smokey Thomas: Yes. Each psych hospital still has a catchment area. So Brockville serves a catchment area. It doesn't line up totally with LHINs. More than one LHIN can be involved in a catchment area of a psych hospital, which is a problem for the psychiatric hospitals actually because then you've got two groups that you supposedly don't report to but you do report to.

Mrs. Christine Elliott: Just one other question. What's the stated reason for closing it down and transferring to Ottawa?

Mr. Smokey Thomas: The current administration of the Royal—they go back to the restructuring commission reports of the mid-1990s. There was a reason that nobody implemented those restructuring commission reports on Brockville: because it didn't make sense then and it doesn't make any sense now. That's the rationale being used.

The public rationale from the CEO is that the buildings are too old and too decrepit to be occupied, but in the next breath has said that the federal government is perhaps going to move female offenders into these buildings. If the buildings aren't good enough for psychiatric patients, why would we consider that they would be good for female offenders requiring treatment?

1350

What I've witnessed about mental health all across the province is that each time after divestment the receiving hospital gets the money. The money was supposed to be protected, but it turned out that the Honourable George Smitherman—I don't know if he was mistaken or misled us, but the money envelope was only protected for a one-year period. So in London they took millions of dollars from mental health, and pumped it into other parts of the service. We see it in Kingston, we've seen it in North Bay—everywhere. It's one thing to say that you're going to take money out of the institutional budget and use it for other things, but if it's being used for things that weren't mental health, then mental health services are suffering.

The presenters before us said that there is a wage discrepancy in the community, and there is. It's very difficult to keep qualified people in the community when there are such wage discrepancies.

The promise from all three parties when in power was that mental health dollars were almost sacred. As the institutions closed, all those would be transferred dollar for dollar to the community. That has not happened by any political party in power, and I'm the person who was fighting the NDP in power that created the—and we finally agreed to shut our mouths and leave them alone. In exchange, they would create the community reinvestment fund. When it came out, it was \$250,000, and then they got defeated and the Tories never transferred hardly a penny. Frankly, the Liberals have done even less.

The local health integration networks, I would submit respectfully, do not understand mental health. Even everything the government has done to this day—to say that you can develop a 10-year strategy and not talk to the front-line workers makes absolutely no sense to me at all because you lose the input of the very people who work on the front lines, who tell you, "This will work. This won't."

I've been doing this since the 1970s. I've been on panels. I've gone to two-day strategic planning sessions under three different governments, all kinds of stuff, but what happens really and truly at the end of the day is that the clients, the consumers of the service, are only paid lip service and the people who actually work in the system who agree with the clients don't even get a seat at the table.

It's just an ill-thought-out plan. We would hope that the government would say, "A one-year moratorium on any further closures." We've been asking for this for years in the psych hospitals: "Please don't close any more beds until the community is adequately resourced." And that is not too much to ask.

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

M^{me} France Gélinas: When you say "64 transitional beds," those are the only operating beds left at Brockville?

Mr. Smokey Thomas: No. There would be the equivalent of an admitting unit, which is supposed to be transferred to Brockville General Hospital. However, they won't take it until they get capital funding to renovate the whole hospital, not just a ward. They want to renovate the whole hospital. Sixty-four beds—they're stopped readmitting and they say they can go elsewhere, but it's not that simple. That's not how it works. If you've been a patient in Brockville and you live in Brockville's catchment area, you can't just wander off to Kingston and get readmitted if you need readmission.

They did this in developmental services in those institutions. They went, "No more readmissions." Where do you go? You're not going to get into Kingston; Kingston runs at capacity.

Again, the notion, as the CEO said to us when they finally did have a meeting with us to tell us their plans, "They'll find somewhere to go," seems pretty callous to me. There's really nowhere. There will be something left in Brockville, but really, it's homeless right at moment. I'm not aware of any capital dollars for Brockville

General Hospital on any build list anywhere. You know what I mean? You don't just get \$5 million, \$10 million, \$15 million for that. So that's a problem as well. They may not be able to close it. So all their plans may be for naught.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Thanks for your presentation, and to the other members who attended with you.

Mr. Smokey Thomas: Thank you.

CANADIAN MENTAL HEALTH ASSOCIATION,
CHAMPLAIN EAST BRANCH
ASSOCIATION POUR LA
SANTÉ MENTALE, CHAMPLAIN EST

The Chair (Mr. Kevin Daniel Flynn): Our next delegation this afternoon is from the Canadian Mental Health Association, the Champlain East Branch, Michael Lloyd, Roger Villeneuve and Sylvie Lemaire. If you'd like to come forward and make yourselves comfortable, you have 15 minutes like all the other groups. Use that any way you see fit. The microphones work best when you stay about a foot away from them.

M. Roger Villeneuve: Good afternoon. Bon après-midi. Mon nom est Roger Villeneuve. Je suis président de l'Association canadienne pour la santé mentale, Champlain Est. Je suis ici avec Michael Lloyd, directeur général, et Sylvie Lemaire, directrice des programmes. Je suis certain que vous avez déjà entendu dire que les personnes vivant avec une difficulté de santé mentale sévère et persistante ou concomitante ont besoin d'un foyer, de travail et d'un ami. Ces besoins sont universels. La gestion de cas intensive ainsi que le soutien par les pairs peuvent épauler un individu à atteindre ses buts de se rétablir.

Fournir ce soutien est primordial dans un secteur rural ainsi que dans la plus grande concentration de population francophone de l'Ontario et comporte des défis considérables. ACSM Champlain Est comprend trois équipes de gestion de cas intensive, ou équipes GCI. Chaque équipe a son superviseur d'équipe et huit employés de GCI. Ces équipes sont situées à Cornwall, à Hawkesbury et une équipe satellite est répartie dans les comtés en quatre bureaux. De plus, nous dirigeons trois centres de ressources pour les pairs situés à Cornwall, à Hawkesbury et à Casselman. Un quatrième superviseur d'équipe gère ces trois centres. La filiale est orientée sur le rétablissement et elle a adopté une philosophie de difficultés concomitantes, ayant une approche portes ouvertes.

Au cours des trois dernières années, nous avons développé de la formation et des services en difficultés concomitantes. Tout le personnel de GCI a reçu de la formation mutuelle en toxicomanie et 12 de nos employés ont obtenu l'accréditation de conseiller en toxicomanie niveau 2 avec le Canadian Council of Professional Certification.

Champlain Est englobe deux groupes de comtés unis : Stormont, Dundas et Glengarry ainsi que Prescott et

Russell. On les appelle aussi les cinq comtés de l'est. Ils s'étendent sur 5 000 kilomètres carrés, représentant 30 % de la région de Champlain. La population compte 190 000 individus, dont 70 % sont francophones dans Prescott et Russell et dans l'est de SDG. Les défis sont reliés à la pauvreté ainsi qu'à l'ordre géographique, linguistique et culturel. Ces défis sont interreliés, tout est nuancé et rien n'est distinct.

Si on les compare avec les centres urbains, les difficultés géographiques sont le transport, plus de préjugés et ressources communautaires restreints en services externes et services à domicile. Nos équipes de GCI sont mobiles, et cela augmente les déboursés pour les coûts de transport pour desservir les cinq comtés. Les petites communautés requièrent de l'assistance pour fournir un accès juste et équitable aux éléments déterminants de la santé. Modifier le programme d'initiation pour les sans-abri pour inclure les propriétaires pourrait s'avérer une solution possible.

Dans le milieu rural, la stigmatisation est plus considérable que dans des grands centres urbains car l'anonymat est difficile à conserver dans le cadre d'une petite communauté où tout le monde connaît tout le monde et leurs problèmes. Ceci a pour résultat que les individus consultent hors de leur communauté ou ne consultent pas du tout. La réalité de la pauvreté étant reliée à la santé mentale, une grande majorité d'individus ne possèdent pas de véhicule, et ce facteur d'isolement réduit l'accès à un réseau de soutien qui peut les assister dans leur rétablissement. Même s'il y avait un service de transport, ces individus n'auraient pas les moyens de se le payer.

En réponse à ce problème, la filiale a commencé un programme de transport gratuit qui est incorporé dans le programme de soutien à l'emploi. Il procure à nos clients ruraux le transport pour accéder à nos centres de ressources par les pairs, ce qui leur permet de socialiser et d'acquérir de bonnes habitudes de vie, se rendre à leurs rendez-vous médicaux et acheter de l'épicerie et ainsi de suite. Les conducteurs sont des clients du programme de soutien à l'emploi. Ceci les responsabilise, favorise l'autonomie et leur procure une expérience de travail. C'est un tremplin pour l'emploi à l'extérieur de la filiale. Présentement, ce service n'est pas subventionné par le RLISS de Champlain.

1400

Les initiatives de client : suivance ne sont pas toujours faisables ou pratiques dans un cadre rural. En plus, de la stigmatisation croissante est peut-être difficile pour des groupes de gouvernance de se rencontrer à cause des grandes distances à parcourir sans moyen de transport.

La filiale dirige des centres de ressources par les pairs qui sont menés par des intervenants et intervenantes en soutien par les pairs et supportés par le personnel de GCI, qui en accroît la capacité de manière soutenue.

Les centres de ressources par les pairs et le service de gestion de cas sont interreliés, fournissant l'accès simplifié aux deux services et procurant un continuum de soin. Ceci permet au personnel de GCI de fermer les

dossiers des clients plus rapidement lorsque les besoins de ces clients sont comblés et qu'ils sont stabilisés, car leurs progrès peuvent être surveillés aux centres de ressources par les pairs, en plus du système de suivi de fermeture en place pour tous les services. La durée moyenne de la gestion d'un client par notre service de gestion de cas permet au personnel de GCI de servir plus de clients et de maintenir une pratique sans liste d'attente.

Dans les secteurs ruraux, il n'est pas réaliste d'avoir des services de gestion de cas intensive spécialisée telle que la déjudiciarisation ou une équipe de soutien au logement et ainsi de suite. Notre personnel de GCI a besoin de répondre à tous les aspects des besoins du client. C'est accompli en utilisant l'approche holistique. Ceci requiert plus de financement pour la formation. Afin d'offrir l'expertise, la filiale a sélectionné et formé le superviseur d'équipe et les membres du personnel chargés du programme, visant spécifiquement les projets suivants : ils sont difficultés concomitantes, soutien à l'alcool, déjudiciarisation, soutien au logement, soutien à l'emploi, vieillir à la maison, diagnostic double, soutien à la famille et soutien informatique. Ceci permet à chaque GCI de procurer tous les services avec le soutien du chargé de programme de son équipe afin d'assister lors de situations plus complexes.

Pour approfondir l'approche holistique, nous croyons qu'une masse critique de services devrait être créée pour assurer un continuum de soins entre les services en milieu rural. Des services de l'équipe communautaire de traitement intensif et des services de crise devraient être joints aux services de GCI. En ayant des équipes TCA et des services de GCI sous une structure gouvernante, le flux de clients en continuum serait moins compliqué et plus centré sur le client.

Les services de crise ruraux n'ont pas le volume d'appels pour garantir un service autonome et devraient être intégrés à l'équipe GCI, où tous les membres du personnel soutiennent déjà leurs dossiers respectifs et tous répondent aux crises dans leur secteur géographique respectif; par exemple, l'hôpital de Pembroke.

L'ACSM de Champlain Est a été l'une des premières agences désignées sous la Loi des services en français dans notre région, et nous maintenons une capacité de services francophones plus élevée que la demande pour ce service. Afin de s'occuper du contexte linguistique et culturel de certaines régions—les cinq comtés de l'est qui ont jusqu'à 70 % de population francophone—l'ACSM emploie du personnel francophone qui livre un service bilingue de façon à ce que nous ne négligions pas la population anglophone.

Tout le personnel travaillant dans ces régions est francophone, du front à la directrice des programmes. Trouver de la formation qualifiée en français crée aussi des défis et augmente les coûts.

Nos recommandations : renforcer les approches de portes ouvertes et le rétablissement à tous les niveaux de nos services; établir des repères pour tous les services en santé mentale et toxicomanie en considérant le fardeau

supplémentaire du cadre rural; élaborer et financer une campagne anti-stigmatisation pour les régions rurales, visant le manque d'anonymat dans le cas d'une petite communauté; créer plus de programmes de ressources par les pairs pour permettre une fermeture de dossiers plus rapide du programme de la gestion de cas intensive, ce qui permettrait à un plus grand ratio de clients par GCI de recevoir des services; créer plus de flexibilité avec les politiques de programmes gouvernementaux; assister les communautés à fournir un accès juste et équitable aux éléments déterminants de la santé; utiliser une approche holistique pour les services ruraux—chaque membre du personnel de GCI fournit tous les services au lieu d'équipe spécialisée; créer une masse critique de services pour assurer un continuum de soin entre les services en milieu rural; et les services d'équipe communautaires de traitement intensif et les services de crise devraient être joints aux services de GCI.

En conclusion, des personnes vivant avec une difficulté de santé mentale sévère et persistante ou concomitante ont besoin d'un foyer, d'un travail et d'un ami. Nous espérons que vous remarquez les défis liés à pourvoir des services dans les régions rurales qui nécessitent une approche compréhensive et holistique. Merci. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Merci, Roger. First, you've left about five minutes. The first question this time is either Christine or Sylvia.

Ms. Sylvia Jones: Thank you. One question on your second recommendation: You mention establishing benchmarks for all mental health and addiction services. Can you expand on how you would see those benchmarks being laid out?

Mr. Michael Lloyd: We've had different committees work on these things in the past. The last one was the mental health implementation task force, where they came out with benchmarks in different communities. Certainly, we did that in our area. But what we think we need is to know how many intensive case managers per population, right down to psychiatrists and peer support workers. If we could have benchmarks, then we have something to go towards.

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

M^{me} France Gélinas: Je vais commencer par vous remercier d'avoir fait votre présentation en français. Vous êtes les premiers, les braves, à l'avoir fait et on a entendu des centaines, donc je l'apprécie beaucoup.

J'aimerais que vous partagiez avec moi—quand on parle de santé mentale et de toxicomanie, être servi dans ta langue est important. Est-ce que vous avez des données probantes qui pourraient démontrer ça, que le fait que vous êtes capable d'offrir des services en français à 70 % de la population qui est de langue française est un avantage?

M^{me} Sylvie Lemaire: Sur le plan de l'évaluation de nos services, on a des sondages qu'on fait puis ça, c'est une des remarques qui revient souvent, qu'il est apprécié d'avoir le service en français, dans leur langue.

M^{me} France Gélinas: Et du côté clinique, est-ce qu'on est capable de prouver que ça fait une différence?

M^{me} Sylvie Lemaire: [*Inaudible*] citer les lignes, mais je pourrais être convaincue, personnellement, étant francophone, et toi-même, quand je me fais servir en français, surtout si je ne me sens pas bien.

M^{me} France Gélinas: Est-ce que vous savez si dans la région d'Ottawa—on a quand même entendu de différentes agences qui sont venues nous présenter. Est-ce que vous savez si les services sont disponibles en français, les services spécialisés que l'on retrouve surtout à Ottawa?

M^{me} Sylvie Lemaire: Ils ne sont pas tous accessibles. Tu as peut-être des employés qui peuvent communiquer en français, mais ils ne sont peut-être pas disponibles quand une personne est là, alors je ne pourrais pas parler pour exactement leur nombre. Je peux parler pour nous. Je sais qu'on peut l'offrir à n'importe quel de nos bureaux, soit à Hawkesbury ou à Cornwall ou n'importe où. N'importe où que tu rentres, par quelle porte tu rentres, tu vas avoir quelqu'un qui va parler en français.

Le Président (M. Kevin Daniel Flynn): Merci, Sylvie. Jean-Marc?

M. Jean-Marc Lalonde: Merci de votre présence et d'avoir pris le temps de venir nous parler de ces centres de ressources dans la région de l'est, que j'appelle le « Far East » des cinq comtés. Je suis très intéressé à savoir si nous détenons un centre de toxicomanie dans les cinq comtés en français, un centre francophone?

M^{me} Sylvie Lemaire: Juste francophone ou qui donne des services en français?

M. Jean-Marc Lalonde: Francophone.

M^{me} Sylvie Lemaire: Juste francophone. An addiction centre where only French is spoken.

Mr. Jean-Marc Lalonde: A French addiction centre. We don't have that in the five counties?

Mr. Michael Lloyd: Not that I'm aware of, no. They're developing a youth one—

Ms. Sylvie Lemaire: Just French.

Mr. Michael Lloyd: —with five beds for a French unit.

Mr. Jean-Marc Lalonde: This has been a complaint, really, that I've been getting at the office from families. When I look at Hawkesbury, for example, it's 95% francophone and 20% of the people do not speak French.

Puis je dois dire que dans les régions rurales, le besoin diffère du besoin du secteur urbain.

1410

Dans le transport, j'aurais une question. Nous avons mis à la disposition des vans pour « Vieillir chez soi ». Est-ce que nous nous servons de ces vans-là pour des cas semblables, pour se rendre aux centres de ressources dans les cinq comtés?

Ms. Sylvie Lemaire: The vans are only being used for the elderly; they're not being used for mental health, as far as I'm aware.

Mr. Michael Lloyd: The vans that were under—

Ms. Sylvie Lemaire: Aging at home.

Mr. Michael Lloyd: —the aging-at-home project?

Mr. Jean-Marc Lalonde: Yes.

Mr. Michael Lloyd: They're mainly for the elderly. They don't involve our program.

Mr. Jean-Marc Lalonde: I know definitely they've been using those vans to do their groceries instead of having them service the people who need to go to a doctor. In this case, we have people who are seniors who need your help, and those vans are not being utilized properly.

Mr. Michael Lloyd: Well, our clients wouldn't fit into that program anyway because they're mainly for people going from hospital to a doctor's appointment. They don't have any money for it, and our drop-in centres or peer resource centres are not classified as a medical appointment. That's why we set up our own service.

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

Ms. Sylvie Lemaire: Thank you very much.

Mr. Michael Lloyd: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for making your presentation.

M^{me} Sylvie Lemaire: Merci.

M. Michael Lloyd: Merci.

Le Président (M. Kevin Daniel Flynn): Merci.

PSYCHIATRIC SURVIVORS OF OTTAWA

The Chair (Mr. Kevin Daniel Flynn): Our next presenters this afternoon are the 2:15 group, the Psychiatric Survivors of Ottawa. Sonja Cronkhite and Tyrone Gamble, if you'd come forward. Make yourselves comfortable. I see you have some water already so you're all prepared.

Ms. Sonja Cronkhite: We have to be ready. We know we're the post-lunch-lag spot.

The Chair (Mr. Kevin Daniel Flynn): Every group is getting 15 minutes, Sonja, so use that any way you see fit. If you do want to leave some time at the end, that would be great as well. It's all yours.

Ms. Sonja Cronkhite: We'd like to speak with you about peer support, what it is and why it's important in mental health. Tyrone and I are both individuals who have experienced mental health and associated challenges first-hand and we've both sought peer support as a cornerstone for our recoveries. This search has led us to become involved in our local consumer survivor initiatives—I don't know if the group are familiar with those so far—where we were able to hone our skills and build confidence. Tyrone is now a board member of Psychiatric Survivors of Ottawa and I'm now the program coordinator.

I'll start out with a bit about my story. I, like many people in the mental health system, saw myself as a recipient of services. My view of myself was that of a sick, problem person and this view was really reaffirmed daily in almost all my relationships. Everything was all about my problems, my symptoms and my failures, and how they should all be handled. Service providers, family, friends, even my teachers—I became unwell

quite young, in high school—they all kind of joined in with their agendas of what I needed to become well or at least not to harm myself or someone else. I was seen as someone sick who would always need to be taken care of.

Then one day I met a group of women in a whole other context, outside of the mental health system, and these women really changed my life. I told them about my illness but they chose not to interact with me in that role: me being the sick person, they being people who responded to the sick person. They treated me as a friend with whom they were going to exchange ideas, make plans. I was expected to contribute. We were talking about environmentalism and feminism at that age in our lives and we were all really stirred up. We were talking about analyzing systems and having a lot of fun.

It was really different for me. I was expected to bear my share of the responsibility for these friendships, and I did that at that point because I loved what we had together. It was something that really had value for me. They helped keep me alive through some of my crises—I don't know that I would have survived otherwise—and I helped them through their crises. Theirs were different; they were talking about custody battles and whatnot. But our job was to support each other through those things.

Then I was reminded of the pleasure of mutuality, that there's a give and a take in really treasured relationships. Suddenly—well, it wasn't suddenly. Over time I realized I was no longer a needy psych patient, and I really fell in love with peer support.

At Psychiatric Survivors of Ottawa and the other valuable consumer-survivor initiatives, this is our passion. This is where it starts. When mental illness defines your roles and your relationships, it's really difficult to start your recovery journey towards your life as a full citizen. We all need relationships to grow and learn if we're going to reach our full human potential. I'm not there yet, but it's coming. Peer support provides an intentional framework to build and inform these relationships between users of the mental health system to mutually move towards our potential.

These peer-run, minimally funded organizations do a lot for peer support in our community. Psychiatric Survivors of Ottawa runs peer support and peer recovery groups; women's groups; a wellness recovery action plan that provides tools for self-mastery over symptoms and crises; Pathways to Recovery to redefine our post-patient identities, as that relationship did for me; activity groups, informal peer support in the drop-in and our Peer 2 Peer Wellness program.

At PSO, Psychiatric Survivors of Ottawa, we train peers in the philosophy and skills of peer support, and then we match people up with in-patients from the Royal Ottawa Mental Health Centre, so when they're discharged, they have a connection with a peer in the community. They can have that relationship that brings them out, and they have a place to grow from. Our initial research and experience have shown us that these peers do very well when discharged from hospital.

People who were working in the hospitals were a hard sell on this project in the first place: "So we're matching our patients up with crazy people?" I can tell you, the staff in the hospital are amazed at the differences in the people who have been matched up versus the people who they used to see coming back in all the time.

I'm going to turn it over to Tyrone for a while.

Mr. Tyrone Gamble: Good afternoon. Like many others, I became stuck in my illness, hopelessly lost to it. I was overwhelmed by my illness, its associated challenges and the mental health system. After all the little losses and giving up pieces of my life and myself, I developed hopelessness and learned helplessness, losses to my identity, freedom, personal responsibility, accountability, social network and my abilities and capabilities. I became the sum of all my losses and failures.

Those around me managed and discerned my care, treatment and manner of living through various means, from suggestion and persuasion to outright coercion. They became the final arbiter of what was best for me. Their priority was my stability and continued existence. Some of them were merely content that I was basically alive. They did not understand that it is simply not enough to be alive. I was alive, but I had no life. I merely existed. I became the living dead, a soulless automaton. This was my existence for many years until I stumbled upon peer support.

None of my health care providers ever told me that peer support existed. The option was never presented to me. I had to learn about it on my own. I had to learn to navigate the mental health system on my own, even if it was by accident in the beginning. The first thing I was struck by in peer support was the way people related and interacted with one another. It was totally egalitarian. No one had greater authority than anyone else. I was given the opportunity to once again have mutually beneficial and reciprocal relationships. I was offered interdependent relationships instead of the dependent ones I had become accustomed to. In short, they treated me like a fully capable and competent person—a human being. It was liberating to have these types of relationships and interactions.

1420

Peer support was a humanizing experience. I was no longer a label, but a person. My peers treated me with the dignity, respect and the unconditional high regard one person has for another simply because they are a human being. There was no judgment about my decisions or me. They also respected my right to make decisions and be personally responsible for my care, treatment, recovery and life. In return, they expected me to follow and practise these principles and attitudes and to reciprocate what I was given. I had to choose to be a part of and help build the community.

Peer-run consumer-survivor initiatives such as Psychiatric Survivors of Ottawa and Mood Disorders Ottawa introduced me to the idea of recovery. It filled me with hope that I could have a meaningful life, a life beyond my illness, one in which I could reach my full potential. In order to help me achieve this, these groups

helped me to learn and apply many skills. The programs also helped me to begin to see myself in terms of strengths rather than deficiencies. As a result of these programs, I became personally responsible and accountable for my recovery.

After being a part of peer support for a while, I decided to become a peer supporter. In the peer supporter training, I learned that I had experience and expertise to offer others. I discovered that I am a specialist in survival, recovery and humanizing mental illness and its associated challenges. It is a specialization that gives me, as a peer supporter, a unique role within the mental health system. It allows me to journey with peers in need in a way that other mental health providers cannot in a multitude of situations, a way that many individuals struggling with mental illness have found tremendously beneficial.

It has been a shock to me to discover the lack of support and funding for peer support, especially since it has been so instrumental in not only my wellness, but also in the wellness of others I know personally. I cannot believe that it doesn't have a recognized and respected place within the mental health system. This is surprising, as I have seen the great need for it in my past work in the human services, including working in emergency shelters. Most people do not realize the need for peer supporters and consumer mental health workers in shelters, hospitals, mobile crisis units, community centres, drop-ins and riding along with police like psychiatric nurses etc. What a difference it would make to have a peer supporter sit with you in an emergency department rather than a security guard.

Across Canada and the US peer support is being given an appropriate and significant place in the mental health system. It is being recognized and accepted for how it can complement other areas and disciplines within the mental health system. More people and professions are recognizing the benefits. Real paid positions on par with other mental health workers are opening up, and more are needed.

It is time to legislate peer support and consumer mental health worker positions throughout the mental health and addictions fields. This legislation will help empower and strengthen the practice of peer support and peer services. Give us and our expertise a place. Consumer-survivor initiatives and others have already created training modules, are building networks of peer supporters and see potential roles for them throughout the system. We need you to recognize the work we are already doing by investing in us.

Ms. Sonja Cronkhite: We have seen and continue to see the tremendous changes in the wellness of peers actively engaged in relationships of curiosity and mutual-ity, relationships without agendas and not centred exclusively on the mental health experience. We watch people expand and build other roles for themselves beyond that of mental patient. This focus on creating healthy community through genuine and mutual relationships is what makes the practice of peer support different from the other services.

Mr. Tyrone Gamble: Peer support is an integral part of a mental health system seeking to improve the health and wellness of its citizens.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left time for maybe one question. We'll give it a try anyway. France, you're up first.

M^{me} France Gélinas: We have heard a whole lot about peer support, but I would say that you are the group who put it in context the best, and I think I finally get it, so thank you.

My question is, then, in the rollout of this, who would hire the peer support? How would you get paid? Where would the money come from? The money would come from the government, I assume, and then go to—have you figured out that part?

Ms. Sonja Cronkhite: Well, the services are already running. There are hospitals, there are emergency rooms, there are crisis teams. What we're seeing is actually having a role in each of these areas that is specifically for a peer supporter. We also have concerns that there's an understanding of what peer support is on all of those teams. It's not just a cheaper person at the other end of the needle. It's someone who's having a different relationship. We're just talking about embedding it throughout the system. We're talking about support for consumer-survivor initiatives that provide this training, but also that peer support is throughout the system and that it's understood throughout the system and that there's an understood role for it.

M^{me} France Gélinas: So would you see the peer support attached to the client, or do you see it attached to the care provider? The example that you gave—you'd much rather sit in the ER with a peer support than a security guard—rang really loudly.

Ms. Sonja Cronkhite: There are hospitals in Ontario and throughout the US where, if you go into emerg and say you want to see a peer support worker, you'd go into another room, there would be a futon, low lighting and someone who'll sit there and talk with you or just listen to what you need to say. They're often finding that people can go in and talk with a peer supporter, have a cup of tea and can leave and go back to their usual support systems the next day. They find they don't often need medical emergency services. They're in a crisis. They need to be heard. It all depends on why people are there. But there are a number of people who don't need to use emergency services if they can just have someone sit and listen to them for a while.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. It was a great presentation.

Ms. Sonja Cronkhite: This also gave us an opportunity to sit down together and think again about why we do this, so I would like to thank all of you for the opportunity for us to do that, as well.

ROYAL OTTAWA HEALTH CARE GROUP

The Chair (Mr. Kevin Daniel Flynn): Our 2:30 delegation is the Royal Ottawa Mental Health centre. Dr. Zul Merali and Dr. Alison Freeland are with us.

Just make yourselves comfortable. Everybody gets 15 minutes. Use that as you see fit, and if there's any time at the end we'll see if we can split that amongst the groups. It's all yours.

Dr. Zul Merali: Good afternoon. I'm Dr. Zul Merali. I'm the president and CEO of the University of Ottawa Institute of Mental Health Research, which is an affiliate of the Royal Ottawa Health Care Group.

First, I'd like to start by thanking the committee for the opportunity to present. It is a positive direction on behalf of the Legislature to move forward on a much-needed review of the mental health and addictions needs and services of the province. We also commend you on the scope of the presenters and the depth of research the committee is giving out.

As background information, we have provided copies of the brief overview of the Royal Ottawa Health Care Group as well as the strategic plan. This said, I'll only speak briefly about the organization.

The Royal Ottawa is a specialized academic health science centre providing in-patient, outpatient and partial hospitalizations, as well as day hospital programs and research. Our specialized services also extend beyond the walls of our hospital, through outreach mental health care teams, bringing patient care directly to the homes, the community, the hospitals in eastern Ontario and beyond.

1430

Our integrated clinical and research programs are aimed specifically at treating people with complex and serious mental illnesses which are often resistant to treatment. Thousands of patients are referred to us for specialized care by psychiatric programs in hospitals and communities throughout the region.

To discover new treatments and improve quality of care, we need to invest in research. Through research, we can better understand the causes of mental illness and find ways to detect it earlier and treat it more effectively. The University of Ottawa Institute of Mental Health Research, or the IMHR, is one of the largest research centres of its kind in Canada and a crucial partner of the Royal Ottawa Health Care Group. IMHR has attracted some of the best and brightest researchers from around the world. Research is fundamental to developing excellent mental health services and is necessary to improve the detection and understanding of mental illness, provide a foundation for early intervention strategies, reduce the severity of illness, lead to faster recovery, develop more effective treatments and lead to better and more cost-effective interventions through the use of technology.

Being an academic health science centre, we have a strong capacity in producing new knowledge and translating this into optimal patient care. IMHR's greatest opportunity lies in its ability to work side by side with the professional clinical staff at the Royal Ottawa to develop innovative ways to treat mental illness.

I must stress the positive impact that knowledge transfer and update makes in all areas, including patient care, research, training and education and its link to

academic health science centres. I urge that it strongly be considered in the development of Ontario mental health and addiction strategy.

We cannot forget the important role that academic health science centres play in educating and training future health care providers as well as researchers. The dedicated research teams at the IMHR are rapidly translating findings from the laboratory to the clinic, where new knowledge can and must be used to improve the lives of patients and their families. IMHR's greatest opportunity lies in its ability to work side by side with professional clinical staff at the Royal Ottawa to develop innovative ways to treat mental illness.

A good example of the way that important new discoveries occur and evolve is Dr. Pierre Blier's pioneering work in the medical treatment of depression. He is a holder of the Canada Research Chair in Psychopharmacology. Dr. Blier's success with innovative drug research began with basic research in his laboratory. Promising initial studies led him to conclude that some pharmaceutical combinations promised far greater benefits than traditional single-medicine depression therapy. Financial support was obtained for limited trials on human subjects. When the experimental subjects in those trials experienced more than double the usual remission rate for depression, funding was secured for a study of the size and scope to attract worldwide notice. His work is now funded by the National Institutes of Health, a US agency—a highly prestigious and competitive award.

Today, Dr. Blier is seeking the most effective ways to translate the results of his groundbreaking studies into clinical practice, but he could not have reached this point had he not managed to secure support for his initial laboratory investigations. Obtaining those funds can be an uncertain venture because at that stage, no researcher can honestly claim to be on the verge of a breakthrough. New discoveries are only the first steps in a much longer process, but without them, influential later studies would never emerge.

Thank you for the opportunity to present. I'd now like to ask my colleague Dr. Freeland to address the committee.

Dr. Alison Freeland: Good afternoon. My name is Dr. Alison Freeland. I'm the associate chief of psychiatry of the Royal Ottawa Health Care Group. I'm speaking on behalf of my organization this afternoon.

We are very encouraged to see that this committee is looking at both mental health and addictions within its mandate. It is important that a comprehensive approach to concurrent disorder treatment services is offered in Ontario. I would like to start with this issue within the homeless population and how the Royal is working with other leading organizations to develop innovative approaches to treatment and care.

As I'm sure you've heard, concurrent disorders affect anywhere from 12% to 20% of people in the general population. However, when looking at the homeless population, this incidence rises dramatically to 60%, to 90%. In addition, concurrent disorders in this population

often include serious mental illness. For example, 40% to 60% of the homeless population with mental health problems have a psychotic illness—did I pick the wrong microphone?

The Chair (Mr. Kevin Daniel Flynn): Why don't you sit back a little bit from it and see if that does it any better?

Dr. Alison Freeland: See if that helps?

The Chair (Mr. Kevin Daniel Flynn): Yes. We'll try it, anyway. Everything else we've tried hasn't worked.

Dr. Alison Freeland: Just let me know if it's still buzzing.

The Chair (Mr. Kevin Daniel Flynn): It's research.

Dr. Alison Freeland: As a specialized mental health centre, the Royal has identified the need for development of unique treatment strategies to meet the needs of both the mental health and addiction aspects of the homeless. One of my colleagues, Dr. Susan Farrell, and our psychiatric outreach team are part of a national collaboration funded with over \$2 million by the Canadian Institutes of Health Research, looking to address the mental and physical health needs of the homeless through a longitudinal study of 600 persons in Toronto, Vancouver and Ottawa. We strongly support the need for ongoing development and evaluation of similar multi-site efforts that endorse collaboration between hospital and community as well as between professionals and consumers to continue this kind of work.

Balanced with the need to do research and evaluation in the area of concurrent disorders is the need for knowledge and education with respect to best practices. Concurrent disorder education needs to be accessible to a wide range of providers to assist with the integration of services to support consumers' mental health and addiction issues simultaneously. Effective treatment of concurrent disorders requires a balance between assessment and treatment of both addiction as well as the present mental illness. Our belief is that any provincial strategy that will successfully address this has to provide the resources and expertise to ensure that this balance is successfully obtained. Any strategy focused on providing housing alone for those with both mental illness and addictions will not allow for successful outcomes if the provision of evidence-based treatment and care is not instituted at the same time.

Access to care is another important point to address. Family physicians play a pivotal role through early detection and treatment, but they frequently advocate for the need for access to specialized psychiatric services for consultation and transfer of care, when appropriate. We strongly endorse the need to fund and support models of shared care between family physicians and specialized mental health service providers to improve family physicians' capacity to identify and address early signs of mental illness and addiction as well as to provide care for the high incidence of the physical health problems seen in the concurrent-disordered population.

We must also look at incentives for specialized mental health centres to provide indirect care such as education

and capacity-building to other health care providers so that persons with mental health and addiction issues can be supported in a full range of health care settings. The Royal is doing this through providing community education and training, as well as helping lead the interface between mental health and addictions within our region as we develop and continue to act as a resource and to do training and education in both these areas. We are also using new and emerging technologies such as urgent consultation services to physicians in remote areas through telepsychiatry. Education and training is key in our role as an academic health science centre.

Mental health and addictions system change will require substantial investment and interministerial co-operation. It is important to remember that it is beyond the purview of the mental health system alone to address all of the issues that impact on mental health and addictions, and that lasting system change requires collaboration across services and across ministries.

In the implementation of a new strategy, two key issues must be further considered and addressed. First is the role of the academic health sciences centre to provide integration of research and clinical service delivery with the education of students who receive training to be tomorrow's workforce. Academic health science centres play a critical role in system capacity, strengthening the workforce and creating healthy communities, and their unique role requires further consideration.

1440

Second, there is a need to ensure that the final framework and strategy address the interface between the hospital and community sector and the important role of the hospital in offering the full continuum of in-patient, outpatient and community-based services.

Once again, we thank the committee for the opportunity to speak to you today. We've tried to be brief. We know there's lots to talk about, but we would be pleased to answer any of your questions or to receive comments or suggestions about further information you might require. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. We'll go to the government, but I had a question, first, that came up just as you were talking. We seem to use emergency rooms as a place where people should go when they're in crisis. As you were saying, and as the previous presenter was making the point, sometimes a cup of tea and somebody to talk to in a nice room changes the world for you. It seems to me that emergency rooms, in a lot of cases, would be the last place you'd want to go. You've got people dying, you've got accident victims coming in, you've got people grieving, and you've got children in pain. If you're in crisis, you'd think it would be the last area in the whole community you would want to be in. Why are we using emergency rooms? How have we got into that situation?

Dr. Alison Freeland: That's an excellent question, and I think that's something that, in terms of a strategy, will require some careful consideration and thought.

If I can just offer a few comments about that: My clinical work is as a psychiatrist with a community-based multi-disciplinary team, and I service people who have serious mental illnesses, primarily psychotic illness. What's really interesting is, when you look at the scope of what a crisis is, we tend to see a crisis—and certainly it can be—as something where somebody feels suicidal or they're hearing voices telling them to hurt somebody else. In those situations, it is safe to ensure that somebody gets to a facility for proper assessment and possible admission. But just as equally, we can get calls in our 24-hour service—because that's what we offer; we have an on-call service as part of our team—where somebody has run out of cigarettes that evening and has no money. For that individual, because of the severity of their illness and difficulties perhaps with paranoia and going to a store and purchasing cigarettes, that is also a crisis and requires a completely different kind of level of intervention. When we're trying to understand crisis, we really need to understand crisis from a person's perspective. Somebody might phone and say, "I'm feeling really, really stressed out," but you need a way for triaging people to the right kind of crisis intervention.

I agree that many people don't necessarily need to go to an emergency room. We do have a range of services that might include things like a mobile crisis team, where people can visit a person in their home and try and understand what the situation is. I am also a very strong believer in peer support services, which you've just heard about in your previous presentation.

The Chair (Mr. Kevin Daniel Flynn): Okay, thanks. I'm going to go back to my colleagues because I think there was a lot of interest in asking questions. Jeff?

Mr. Jeff Leal: I'll be quick, Mr. Chair, because I think Helena wants a quick question.

The Chair (Mr. Kevin Daniel Flynn): Okay, well we've got about a minute and a half.

Mr. Jeff Leal: Closeness to CFB Petawawa—we have men and women in the Canadian armed forces doing four and five tours of duty in Afghanistan. Post-combat stress: Does that put any pressure on the services that you provide and the research that you're doing for these individuals who are returning back home?

Dr. Zul Merali: Yes. As a matter of fact, just recently we opened a stress injuries clinic affiliated with the hospital that deals specifically with that type of clientele. It's a huge need. We have, for example, from the education and research perspective, a symposium coming up in October dealing with post-traumatic stress using research-based strategies in intervention. They're even starting to talk about actually curing post-traumatic stress disorder. So there's a lot of excitement and a lot of need for this area to go further.

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

Ms. Helena Jaczek: What's happening to the beds that are being closed in Brockville?

Dr. Alison Freeland: Right now, we're in the process, from a patient perspective, of going through each client, meeting with their families, and making individ-

ualized plans in terms of where people would best fit, the goal being to help people return to the community, as most people express a wish to be there from a quality of life perspective, but definitely looking at, in terms of needs and services, where people are best placed.

Ms. Helena Jaczek: So those beds are actually going to be lost? It's not a question of transferring them to Ottawa or to other secured forensic units?

Dr. Alison Freeland: The beds that are closing are being closed at this point.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today—a great presentation. Thanks for your time.

MINWAASHIN LODGE, ABORIGINAL WOMEN'S SUPPORT CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our 2:45 presentation is from the Minwaashin Lodge, the Aboriginal Women's Support Centre. Deborah Chansonneuve, research and development consultant, thanks for joining us today.

Ms. Deborah Chansonneuve: Thank you for having us.

The Chair (Mr. Kevin Daniel Flynn): Make yourself comfortable.

Ms. Deborah Chansonneuve: We always start by welcoming people to the ancestral territory of the Algonquin nation, which is where the National Capital Region is located.

Addictive behaviours and violence against indigenous women and girls are two of the most urgent, widespread and preventable social problems facing our families and communities. The persistence of social conditions such as poverty, marginalization and prejudice helps to perpetuate this intergenerational cycle.

We also always begin with a story, so I'm going to tell you the story of one of our clients that will help illustrate what some of the problems are.

Rosemary T. is from a First Nations community in northern Ontario. Her grandparents on both sides are residential school survivors, as was her biological father. Her mother had been apprehended by the CAS at the age of 11 due to family violence and alcohol abuse. Because of her parents' alcohol abuse, and sexual abuse by her father, Rosemary was also in and out of foster care from the time she was eight.

Rosemary had been in Ottawa for two years when she came to Minwaashin Lodge's emergency shelter at the age of 23, two months pregnant with her fourth child. Though she had tried to quit on numerous occasions, Rosemary was addicted to crack cocaine.

Like Rosemary and her mother before her, her previous three children had been apprehended by children's aid. Rosemary wanted very much to keep her fourth child and worked closely with the shelter staff, with children's aid and with other services to do so. She attended parenting classes, a treatment centre and many other programs throughout the pregnancy. Nonetheless,

CAS still had concerns for the child and apprehended it at birth. The staff members at the shelter were shocked by this, given the number of changes and the progress that she had made. Needless to say, Rosemary was devastated, but slowly, over time, visitation turned into overnights and there was hope the child would be returned to her. Unfortunately, after nine months Rosemary relapsed for two days. Rather than understanding relapse as a normal part of the recovery process, CAS stopped the overnights and reduced the visits. Feeling increasingly defeated and depressed, Rosemary started to miss visits, behaving in ways the children's aid called "uncooperative." Due to the age of the child, and in accordance with risk protocols, CAS went to court, ceased visitation, and once again another child was adopted out.

Rosemary lost all hope at this point. Her substance abuse increased, and she went back to working the streets to support her habit. Five years later, at the age of 28, she is HIV-positive, still on the streets here in Ottawa, has no top teeth, is covered in physical scars, and we can only imagine the extent of the mental and emotional wounds.

As a direct result of policies of residential schooling, followed by those of the children's aid, no members of Rosemary's family have been raised at home by their own parents for at least six generations. This is a mental health problem.

I want to talk about mental health and addictions in an urban, indigenous context. No other population group in Canada's history has endured such a deliberate, comprehensive and prolonged assault on the family and on their human rights.

We have to ask, when a parent has an addiction, do they lose the human right to raise their child? Because that's what's happening in our communities. Yet many Canadians, including those in the human service sector, remain unaware of the full scope of these injustices or their impacts. In fact, the question we hear most often is, "Why can't you just get over it and move on?"

Marlene Brant Castellano talks about colonization in a way that helps answer that question. She says, "Confidence in the ethical order of the universe is instilled by experience in the family and reinforced by the larger community, by ceremonies that generate shared awareness, and by language, the signs and symbols by which we define and share our perceptions of reality. This concept of an ethical universe stabilized by family, community, ceremony, and language is not unique to aboriginal society. What is distinctive about our experience as aboriginal peoples is the history of having each of those stabilizers systematically undermined by the colonial experience, leaving individuals isolated and vulnerable in a universe that appears chaotic and is definitely threatening."

Not all survivors of residential schooling or their descendants struggle with mental health problems or addictions. In fact, many are a living testament to the resilience and the beauty of the human spirit. Their unshakable determination to heal themselves, their families and their communities and to revitalize language and culture is an inspiration.

1450

Even so, study after study consistently links disproportionately higher rates of addiction and mental health problems with the intergenerational trauma that is unique to the experience of indigenous people in this country. The response from our social institutions is at best a persistent, systemic indifference and is at worst, judgmental and punitive, blaming those with addictions for poor lifestyle choices, attitude problems, character deficiencies, being hard to serve or resistant to treatment. Our people are often re-victimized instead of helped in the process of going to health centres, especially around addictions and mental health. I can answer questions about that further in terms of some of the methods that are used to calm people.

Services run by and for indigenous communities, however, are grounded in the belief that history and culture matter profoundly; that the health of individuals, families and communities is inextricably connected; and that well-being throughout the lifespan, from birth to old age, has four interrelated aspects: the mental, emotional, physical and spiritual.

Minwaashin Lodge is a community-based service run by and for Inuit, Metis and First Nation women. It provides prevention and intervention services for grandmothers, women, infants, children and youth who are survivors of family violence and the residential school system, including intergenerational impacts. It has been operating for over 15 years, and it has grown to serve over 1,500 clients annually. I've included a list to show you the extent and scope of the services provided. The 19-bed emergency shelter is always full. The addictions recovery and support programs are active; 80% of those—it doesn't say here—are involved with the children's aid. There are also other programs, including housing outreach, employment preparation and professional education about cultural issues.

It's important to know that we do things very differently. I'm really hoping the committee understands this, because we cannot be—other mainstream programs receive money and say they serve aboriginal people. Sometimes they stick a feather on a program or they'll hire an indigenous worker, sometimes as a receptionist, and say that they're handling the problem, but we do things very, very differently in terms of our services.

In an indigenous worldview, healing is a lifelong process of restoring physical, mental, emotional and spiritual balance. Community-based services run by and for indigenous people provide a unique opportunity to be with others on the same healing journey; to learn the beauty, wisdom and vitality of traditional cultural teachings and practices; and to experience cultural safety. And that means a safe environment in which to speak the truth of one's experience without being misunderstood, pitied, misjudged, blamed or punished.

Such services identify and directly address the underlying causes of addictions and mental health problems unique to the historical experiences of indigenous people. They provide an opportunity to reconnect with and

maintain culture and a pride-based, versus a shame-based, cultural identity. They model and foster healthy relational attachments to staff, family members, kin and community.

There's a chart at the end of this report that depicts the life-cycle service model. Services and ceremonies are provided along a continuum from infancy to old age. For newborns, there are welcoming and naming ceremonies; for toddlers, there are walking-out ceremonies; for youth, vision quests and opportunities to challenge and lead; for the community, there are feasts, powwows, assemblies and seasonal celebrations; for elders, there is the opportunity to transfer cultural knowledge and wisdom to the next generation.

One of the critical gaps in services is for dual-disordered women—women with mental health and addiction problems. Minwaashin undertook a study last year to look at the feasibility—because so many of the problems seem to be centred around children's aid and child protection—of a treatment centre for women and their children, a long-term residential treatment facility. We walked to 31 stakeholders, including people from the Royal Ottawa Hospital, from the police department, from the children's aid, and every one of them was very, very enthusiastic and supportive about the need for such a treatment centre.

I have some quotes there. I'm not going to go over them. I'm just going to say that all of these quotes are from non-aboriginal, front-line service providers—some mental health psychiatric outreach nurses, some from police—and they talk about the incredible level of violence that indigenous women face in the streets of Ottawa. We know that many women who end up in the streets—aboriginal women—are murdered or missing. They talked about how, if we can get at the problems before they become hard-core, we have a much better chance of improving our outcomes.

In the five years since Rosemary returned to the streets, much has been achieved in Ottawa and in the province. The children's aid society and Ottawa police have taken concrete steps to improve their services and the way they respond to indigenous people in crisis. Services run by and for indigenous people have increased and expanded, and opportunities for respectful inter-cultural collaboration and service coordination are being sought more frequently.

Provincially, the aboriginal healing and wellness strategy has done a great job in developing a holistic framework for health and healing. Changes to the child protection act were very important and are being implemented, now requiring a differential response and alternative planning and decision-making for indigenous children. Yet there is still no comprehensive, coordinated provincial strategy capable of addressing the mental health and addiction problems of indigenous people.

We know what needs to be done. Most urgently, we need culture-based outreach services for pregnant women with addiction and mental health problems, and we need long-term dual disorder treatment centres where they can

recover in a supportive environment without the added stress and fear of losing their children. We need relapse support, aftercare and long-term follow-up run by and for our communities.

Another urgent need is for youth engagement and peer-led prevention services by and for Inuit, Metis and First Nation youth. We need to reach them much, much earlier. In that context, we crucially need education systems from kindergarten to university to tell a different story about indigenous people and history so our youth can engage in a positive, healthy way with their learning environment. We need equality of access to housing, employment and resources. It isn't in the report, but we need cultural competency in the mainstream. We need to do much better on this. Most providers only see our community and our people at their worst and have no idea of what we have to offer in terms of mental health and healing—and we have a great deal to offer.

Rosemary's story illuminates the unique complexity of mental health and addictions in an indigenous context. It's a story rife with missed opportunities. According to Thomas King, "The truth about stories is that that's all we are." Rosemary's story is Canada's story. This is our collective truth. If that story is to change, we all need to think, plan and act differently, and we need to do it before yet another generation is impacted by the dismal failures of our past.

I noted previously that no other population group in Canada's history has endured such a deliberate, comprehensive and prolonged assault on their families and their human rights. We see clearly the outcomes of this assault in Rosemary's story. In order to succeed, efforts to correct these outcomes must be equally deliberate, comprehensive and prolonged.

In the words of Buffy Ste. Marie, "We are faced with insurmountable opportunities."

Miigwech, marsee, qujannamiik.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Deborah. We probably have time for one question. We'll go to Christine or Sylvia.

Ms. Sylvia Jones: I'm going to go to the practical: You presented this feasibility study in July 2008?

Ms. Deborah Chansonneuve: We produced the report, yes, in July 2008 and now we're looking at trying to get funding to have a business plan.

Ms. Sylvia Jones: Have you presented it to the provincial ministry, the feds? Where has it gone since then?

Ms. Deborah Chansonneuve: We presented it at a national policy conference. I don't know how many places it has gone, to be honest.

The Chair (Mr. Kevin Daniel Flynn): A short one, France.

M^{me} France Gélinas: We don't have that. I come from northern Ontario and I would love to have one of those. We don't have one either. Is this to serve all of Ontario, or Ottawa only?

Ms. Deborah Chansonneuve: This is would be to serve eastern Ontario.

M^{me} France Gélinas: Okay.

Ms. Sylvia Jones: Sorry, I should have asked—can I go back?

The Chair (Mr. Kevin Daniel Flynn): Go ahead.

Ms. Sylvia Jones: Without me scanning it all, what's the dollar value of setting up this treatment centre?

Ms. Deborah Chansonneuve: We haven't done the business plan yet, but we're looking at probably in the area of \$1.5 million to \$2 million a year.

M^{me} France Gélinas: How big is the First Nation, Metis, Inuit population in your catchment area and how many First Nation communities do you have? Sorry; I don't know this area that well.

1500

Ms. Deborah Chansonneuve: There are 10 First Nation communities within a two-hour drive of Ottawa. There's a very high rate of migration between those communities and the city. At any given time, it's very hard to say. We have the largest Inuit population of any city in Canada, in an urban context: There are around 1,500 people in this city. We estimate that there are between 25,000 and 30,000 indigenous people in the area.

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

Ms. Deborah Chansonneuve: Thank you very much.

JOYCE McNEELY

The Chair (Mr. Kevin Daniel Flynn): Our 3 o'clock appointment is Joyce McNeely. Joyce, if you'd like to come forward.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): I think this is it.

Ms. Joyce McNeely: I'll try this one. Although I don't really need a microphone; I can do this without a microphone.

The Chair (Mr. Kevin Daniel Flynn): Well, you know what, that seems to have been the bad one. Why don't you try the middle one? That's the only one that hasn't gone funny.

Ms. Joyce McNeely: Eeny meeny miney moe?

The Chair (Mr. Kevin Daniel Flynn): Although it's working now, so maybe you should stay there.

Ms. Joyce McNeely: Because I'm sitting a little further back, I think.

The Chair (Mr. Kevin Daniel Flynn): Yes, you'll sit down and it won't work. I know it.

Ms. Joyce McNeely: Okay, we'll see how it goes.

The Chair (Mr. Kevin Daniel Flynn): We're all yours for 15 minutes.

Ms. Joyce McNeely: Oh, good. Well, I'm going to try and do this in 15 minutes. I know the microphone will get turned off and I'll be kicked out otherwise, but anyhow.

My name is Joyce McNeely. I'm 48 years old and I am living presently with concurrent disorders. I'm an alcoholic in recovery. I've been in the continuum of

recovery now for seven years, and I say "the continuum" because I had a relapse 16 months ago. I'm bipolar, medicated—yes, I took my medication today. That's a joke. You can laugh. And I have post-traumatic stress disorder, which I've been living with for a very long time. I suffered severe and multiple abuses as a child at the hands of my mother and many of her boyfriends. I knew neglect; I knew hunger; I knew poverty, intimately. Unfortunately, time and circumstance have rendered me back into the hands of poverty. I'm trying to live, not very successfully, on CPP disability.

I'm kind of curious as to where I fit in, because technically I'm considered disabled; but I'm very much an invisible disabled person because, for all intents and purposes, I look perfectly healthy and I can do this today. Today I can do this: I can sit here and I've managed to get everything in order to present to you my story. It's simply my story.

I would like to share with you my daughter. She is 11 years old, and I will try not to break down. I realized very quickly that I was not going to be able to care for her full time, and I left her in the care of her father here in Ottawa. She is thriving. It was the most difficult decision I ever made but it was the best decision that I made for her. I see her regularly, spend time with her regularly, unsupervised. I am not a threat to her in any way; I am more a threat to myself than anyone else, quite frankly. That's indicated by my excessive abuse of my body through my teens and twenties and now, finally, ultimately only seven years ago, coming into recovery for alcoholism.

I tried to commit suicide when I was 14. My mother abandoned me at the Royal Ottawa Hospital and I resided there for six months until my foster mother rescued me. I lived with her for three years and I still have an ongoing relationship with her. She's still in my life and she was actually in the delivery room when my daughter was born. Carol has supported me unconditionally, accepted me unconditionally, loved me and forgiven me unconditionally. Those are the things that I have needed in order to grow.

I can tell you what I understand about my disease, and I would like to share with you what I understand are the technicalities of it. I'm well-educated as far as self-educated is concerned. There were several books that I read in trying to understand my illness and my brain: Daniel Goleman, I believe is his name, wrote *Emotional Intelligence*, and he spoke about the very early experiences of a child and that those experiences are imprinted indelibly on the centre part of the brain. I believe it's called the hippocampus, and—I may be wrong—the technical parts of it. The brain develops around that and everything subsequently either reinforces—it depends; have you had a positive experience or have you had a negative experience?

I can tell you that for the most part the majority of my childhood was a negative experience. I was beaten regularly, humiliated regularly. As an example, after one beating that I was given for trying to look after my

youngest sister, I was black and blue from the middle of my back to the back of my legs, and my mother stood me up in front of my babysitter and her boyfriend and said, "Pull your pants down now so they can see what you got today." Not only was I brutalized but I was humiliated on top of it.

My mother and my siblings have chosen to disown me. Luckily, I have a common-law husband and, coincidentally, he happens to be Inuit. So I have a unique perspective about the Inuit population here in Ottawa and I could tell you a few things about addiction.

My common-law husband and I met in the basement of a church at an Alcoholics Anonymous meeting, so we figured there was nowhere to go but up from there, hopefully. We did. He will celebrate six years of sobriety from alcoholism on September 28. So it can be done. Peer support is the crucial aspect.

I would like to give you some hope. I have e-mailed an abundance of information. I realize that all of you are inundated with paperwork. I'm sure we've done a good job of killing a forest today. Nonetheless, there are a couple of articles that I would hope you would take the time to read. One of them is called *Healing Society, Healing Ourselves*. This is an amazing journey that has evolved into a business in Yonkers, New York. There's a little book that was published. The author of the book is Bernie Glassman. The book is called *Instructions to the Cook: A Zen Master's Lessons in Living a Life That Matters*. It tells us how to heal society and heal ourselves, and peer support is the central component of it. It's also talking about employment, skills training, meditation, which for some people seems a little esoteric, so I will reference Jon Kabat-Zinn's *Mindfulness-Based Stress Reduction*, which I'm sure any of you who have any kind of academic background are familiar with. I'm certain that the Royal Ottawa could tell you all about it.

I have had, to date no significant contact with the psychiatric community for as long as I have been asking for it. I was at Amethyst for two years. They do a wonderful job over there but they had to kick me out because they didn't have enough money to allow me to continue. I could have used ongoing support and help.

The other article that is attached to *Healing Society, Healing Ourselves*—and I apologize if I'm a little scattered. I didn't write anything down. I'm not good at writing anything down and referencing anything from writing. That's why I'm only going to reference what I have here.

The Chair (Mr. Kevin Daniel Flynn): We've been hearing you and you're doing a great job.

Ms. Joyce McNeely: Thank you.

I did reference *Mindfulness-Based Stress Reduction* and I do have information contained in that paperwork with reference to that specific program. I believe they are out of MIT in the United States.

Interruption.

The Chair (Mr. Kevin Daniel Flynn): We hid the wires under there just to fool you.

Ms. Joyce McNeely: Thank you.

Beyond Healing Society, *Healing Ourselves*, there is the Social Venture Network. What they started in Yonkers, New York, was simply going into one of the most difficult areas in New York, where there were the most homeless, the most addicted, the most mentally ill, and they started taking these people off the streets and they gave them a home, with the condition that they would go to whatever meetings were necessary, generally peer support—AA, NA—psychiatric support. If they needed psychiatric care, they would get it. They had a bed, they had food, they had clothing. They were given a job in the bakery; it's called Greyston Bakery. Greyston Bakery evolved from that small, low-tech operation into a high-tech, fully—I believe it's a Fortune 500 company now, this Greyston Foundation. They now provide the brownies and the cookies for Ben and Jerry's ice cream. They've gone beyond just doing social housing. They do health care, they do schooling and they do daycare. I would also suggest that that would be the other bit of information that you need to have: the social venture network connected to the Greyston Foundation.

1510

I want to leave you with the impression that there's hope. Yes, it's going to require money; there's no doubt. You can't get around it. There's going to have to be money put into something somewhere, but I believe that a peer support network of one kind or another is ideal. I did file an opinion with the housing ministry. The housing ministry is doing housing strategy consultation.

I've also included that in my paperwork because I referenced *Healing Society* and how we can do this here. We can do our own model, and I'd be happy to volunteer to be one of the first to do it. One of the things is that I'm losing my identity here in this city. I know that I have something to contribute. I don't know what my potential is. I heard one psychiatrist talk about curing me of my post-traumatic stress disorder and of all of the other ills that may be affecting me. Quite frankly, this is the way I am. God's will be done. I've survived all of this and I'm here to tell you my story. If I wasn't here to tell you my story, then how are you going to understand how to make the changes that are necessary to help us?

Yes, we are dying out here because there are not enough services. There's not enough housing. There's not enough money. There's not enough of anything. But if we have the will, it can be done. I would like to see something done for my daughter to ensure that I'm around for her. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left about three minutes, and we're starting off this time with France.

M^{me} France Gélinas: Thank you for sharing your story. We have heard quite a bit about peer support, and I'm sure we're going to do something in that direction. The piece that is kind of a novelty so far is that you're the first one to talk about social enterprise. You named one in the States, but there are some in Ontario also. I was curious to see, have you been in touch with social

enterprises here in Ottawa? Are they available? Have you had any exposure to them?

Ms. Joyce McNeely: I am presently dealing with multiple issues related to my former employer, my former union and my former disability carrier, from which I have been trying to get what is mine back. I don't have the energy, I don't have the time and I don't have the resources to be going out to all of these other places. I concentrate on my self-care.

I joked about it, but taking my medication first thing in the morning is really important. I had to get dosettes, because I couldn't remember whether I had taken my pill or not, and that was dangerous because I get depressed and suicidal very quickly without my medication.

This in itself has taken tremendous energy, and up until 12 noon today I really did not know whether I could do this. I had asked some friends to come and support me, and they were unable to come. It took great effort for me to come here. I did break down a little bit, but to not totally break down is an accomplishment for me.

M^{me} France Gélinas: I'm very proud of you.

The Chair (Mr. Kevin Daniel Flynn): Any other questions? Liz, do you have a question?

Mrs. Liz Sandals: Thank you so much for coming and putting all the effort that you have done into sharing your story with us, because it obviously has been a struggle for you to come. But it's really important for us to hear from you at first hand.

I was just wondering, having worked your way through your life, is there one support or one program that we could have had in place for you that would have made a difference and enabled you to be in a recovery mode sooner? What was the biggest missing chunk? Or is that hard to—

Ms. Joyce McNeely: The biggest missing chunk was when the children's aid investigated my mother on several occasions and I was never taken from that home. That was the first and the meanest strike against me. Then it just kept building up.

Mrs. Liz Sandals: So just going right back to that childhood experience and not having the intervention that needed to take place.

Ms. Joyce McNeely: Yes. And I've heard and seen things about children—and I will be the first to say that if there is anyone involved in addiction, who's active in addiction, then a child should not be in that environment, period. I'm witness to that.

The fact of the matter is that I have an article here on post-traumatic stress disorder; they talk about the ratio of this incident versus the chance that they're going to develop post-traumatic stress disorder. Out of eight or nine of the violent offences, I have six or seven of them, so it's no wonder that I've developed post-traumatic stress disorder. The miracle is that I'm sitting here and I'm semi-coherent, that I can speak to you and tell you my story. That's the miracle, that my brain has been able to heal well enough to do this. I know I have something to contribute and I do want that opportunity. I want the opportunity to contribute. I want the opportunity to help other people.

I haven't had access to psychiatry. They talk about healing me for post-traumatic stress disorder, but if I don't even have access to psychiatry—if I can't even get a psychiatrist to establish a trust-based relationship with and go into those traumas, how is it ever going to heal? All my medication is doing is just keeping a damper on all of those things. It's no wonder I go depressed and suicidal when I'm off my medication.

Right now, what I need most of all is a change from this urban environment. I am overly sensitized and I don't know—there's agoraphobia, there's sociophobia, there are other phobias that we develop, and that's directly related to the overstimulation of urbanization. We need—I need, and maybe we need—some little community where we can support each other and grow vegetables and spin some wool. It may be mundane, but I did actually learn how to spin wool and I finally learned how to knit. Doing things with my hands is very therapeutic.

There's also some additional information in there about a program where they use horses. It's called Equine Assisted Growth and Learning. It's not an airy-fairy concept. There are many things that we can derive from being connected to nature, and that's another huge missing gap for me.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Joyce. We really appreciate it.

Ms. Joyce McNeely: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thanks for your time.

Ms. Joyce McNeely: God bless you all.

CHAMPLAIN MENTAL HEALTH NETWORK

RÉSEAU DES SERVICES DE SANTÉ MENTALE DU DISTRICT DE CHAMPLAIN

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this afternoon is from the Champlain Mental Health Network, Marion Wright. If you'd like to come forward? I'm sorry—Renée. You're not Marion. Marion was supposed to be here but you're here in her place.

Ms. Renée Ouimet: Yes. Unfortunately Marion's out of the country, so I've come to replace her as a representative of the Champlain Mental Health Network. I also co-chair a work group of the Champlain Mental Health Network which is quite an exceptional one, because it's called the mental health promotion and education work group, so therefore very much looking at the importance of mental health promotion, primary prevention, education and training, which has not been funded necessarily by governments in the past—some.

1520

The Chair (Mr. Kevin Daniel Flynn): You've got our attention for the next 15 minutes. You can use that any way you like.

Ms. Renée Ouimet: I'll just go through the slides. What I want to do is give you a little bit of background about the Champlain Mental Health Network as well as its priority issues and what it's up to, basically. Thank you for this presentation. Merci beaucoup.

The Champlain Mental Health Network has existed and has been doing continuous planning since 2004. It brings together consumers, families and service providers, and is really looking at organizing a seamless, person-centred mental health system within the Champlain network.

It also includes other members, or cross-membership, like the Réseau des services de santé en français, obviously for French-language services; the addictions world; primary care with regard to family physicians or community health centres; First Nations; children and youth; and now is really working very closely with an organization that I know made a presentation today, the Champlain Addiction Coordinating Body, to amalgamate, to really look at planning the integration of mental health services and addiction services in this region. They have been having several meetings to be able to integrate.

Our work at the network is grounded on diversity, which means many things, including French-language services, services to new Canadians, etc. We're really looking at it in terms of system thinking and very much a recovery focus.

How do I switch slides?

The Chair (Mr. Kevin Daniel Flynn): Do you need some help? I just recruited somebody for you.

Ms. Renée Ouimet: Merci, Alfred.

The Chair (Mr. Kevin Daniel Flynn): He is excellent for this job.

Ms. Renée Ouimet: Yes. He's a good colleague of mine too. Alfred got me here from CAMH.

As I mentioned, we've been planning and going into action, we've set priorities from 2006 to 2016, we've recently looked at the recommendations around the annual report of the Office of the Auditor General of Ontario on community mental health, which is all really helping us in the sense of our planning and priority areas.

Just to mention a couple of initiatives, there is a work group of the network that has been looking at integrated access of all in-patient mental health beds within this community—in other words, no beds belong to one particular organization—but really centralizing access, including the rural areas, and also looking at discharge and transition from hospital with regard to people with mental illness as well as developmental disabilities.

We've also been working on language and our target populations with the addiction systems. We're looking at clients and consumers. Our target population is people who experience or are at risk of mental health issues as well as problematic substance use, including gambling, and also very much a focus on how families can be integrated in the system.

Just to look at a few of our goals—they're far-reaching. The first one, really, is looking at the implementation of coordinated access to the continuum of mental health

care and addiction services with linkages to allied services—for instance, primary care—to meet the diverse needs of our target population in Champlain. Examples of that: We're looking at developing a navigation function—coordinated access to ensure that people get referred to the correct service; access to services closer to home—we have issues, for instance, of transportation in rural areas, for seniors and for other people; flexible hours—some of us are offering services after hours, and that needs to be looked at specifically, especially with people with mental health issues who are working.

Increased community support workers: we need many more in this region and for the gamut of continuum of care, from prevention to recovery to maintenance. An example of this is that we know that we need many more community mental health and intensive support in the Ottawa region. We know that if we had this, this would decrease costly emergency room presentations, inappropriate admissions, delayed discharge etc.

Our next priority is meaningful engagement of clients and families, and I think we have been very much trying to do that within the network, in the sense of engaging clients and families in service development, implementation, evaluation in our networks, system change and service provision. But we really need to continue education and training with regard to service deliveries, in the sense of including consumers and families within service delivery in our region. For instance, I think we need to continue education of service providers, peer support and self-help groups etc., which is still lacking.

Another priority is determinants of health. We definitely have issues with income levels in Ottawa and many people with mental illness who are still living in poverty. Issues like ODSP levels; maybe to look at employment with support, access to employment etc. We still have an inadequate housing stock in this region as well as support to that housing stock.

I think I want to put a little bit of an emphasis as well on that as an opportunity for many people with mental illness who wish to work and have difficulty finding work. We need to do some education with employers with regard to accommodation for people with mental illness. We know that over 90% of people who have severe mental illness are unemployed, and many would like to be employed.

Next one: prevention and early intervention. I think we've tended to emphasize early intervention with regard to mental health issues and addictions in the past. I think we really need to look at prevention of mental illness in children and youth. We know that many programs exist in this area in the sense of mental health promotion and resilience-building that we could have in schools, but we have no funding, and no funding to research it either. So, a definite need there.

Capacity-building: ensuring that the right people are in the right place at the right time, and I think the lady before has really been talking about that. We need the competencies, interventions and capacity to respond to client needs, and the inclusion of health providers, peers,

families and the broader community. We need to build and enhance the capacity and appropriate financial resources to provide those services. We have them, but we need many more along the continuum, in both official languages. We also need to increase the treatment services' availability as well. We are working very hard on standards of practice, performance indicators and accountability within this region.

Human resources capacity development needs to be looked at: education and training in both the mental health and addiction sectors.

To summarize, I think that the Champlain Mental Health Network has been working very hard—and working in both the mental health and addiction systems—to really look at an integrated model of services for people with mental illness and substance issues. Of course, we need to continue working on the development of services that are evidence-based and efficient. We need to continue working with our LHIN, which we are, at looking at outcomes. We are very prepared to continue with these responsibilities but are very aware that we still need dollar investments to be able to really have the efficient system that we need in Champlain.

1530

The Chair (Mr. Kevin Daniel Flynn): Thank you, Renée. You've left us a little bit of time for questions, starting with this side of the table. Liz?

Mrs. Liz Sandals: I'm just curious: First of all, who belongs to the mental health network? Is it all the service providers for both children and adults?

Ms. Renée Ouimet: The children are represented, but it's mostly the adults, as well as the addiction services. There are over 200 agencies that are represented in the Champlain network. But also, there is a council of the network that meets on a monthly basis and has representatives of different sectors like—

Mrs. Liz Sandals: So if you've got all those agencies, then, if I were a mental health patient or a family physician who was trying to connect me with the appropriate one of those 200 services, I'm guessing some are in the community, some are more accredited services, so there's a huge range. How would I get connected to the right one of these 200 services if I lived in Champlain?

Ms. Renée Ouimet: That's one of the things that we're working on—central access—because it is difficult right now. It's difficult for consumers; it's difficult for families, in a sense, to access—we're working on a central access; we don't have one.

Mrs. Liz Sandals: So at this point, there isn't?

Ms. Renée Ouimet: No. If you use ConnexOntario, there are certain things that you can use, but that's what we need. That's what we're working on.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Renée. Sorry. Christine and Sylvia? I'm sure you'll answer it eventually. Sylvia?

Ms. Sylvia Jones: Thank you for stepping in today, Renée. I wanted to talk about your priority of capacity-building and see if the network had made any comments or would like to share with the committee the decision

that's coming forward on the closure of the Brockville psychiatric facility, because that will obviously affect capacity.

Ms. Renée Ouimet: I think that it is being discussed in the sense of how that can be done with regard to the Royal Ottawa Mental Health Centre as well as community agencies. I know there has been discussion, but I don't know otherwise.

Ms. Sylvia Jones: So you see it as an issue coming forward if the—

Ms. Renée Ouimet: Oh, sure. Absolutely. And it is being discussed.

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

M^{me} France Gélinas: J'aimerais, dans ta priorité—toute la priorité de prévention et d'intervention. Est-ce que vous avez des exemples de programmes qui parlent de prévention primaire qui fonctionnent bien à Ottawa ou dans la région que vous desservez?

M^{me} Renée Ouimet: Je sais qu'il y en a plusieurs. Je peux vous donner un exemple d'un programme qui s'appelle Parlons de la maladie mentale. C'est un programme qui a été développé par l'Association canadienne pour la santé mentale, Ontario, CAMH et Mood Disorders. C'est un programme qui a été développé en partie pour que les enseignants l'offrent en plus pour des personnes qui ont une maladie mentale qui se présentent en classe en 11^e et 12^e année pour présenter leur maladie et parler de leur rétablissement, en plus de parler de services disponibles pour les jeunes.

Alors, c'est un exemple dans le sens que c'est un programme qui contre les préjugés nettement. Cela a été évalué à augmenter les connaissances des jeunes à contrer les préjugés à l'école et aussi l'identification précoce. C'est un programme qui est utilisé, par exemple, à Champlain et dans d'autres régions de l'Ontario, mais il n'est pas subventionné. Il y a énormément de difficulté à trouver des sous—un petit peu de Centraide. Il y a même des organismes qui font des levées de fonds pour essayer de le faire fonctionner. Ce n'est pas évident. C'est un exemple, mais il y a plusieurs exemples aussi de programmes qui ont été développés pour les enfants et les jeunes sur les résiliences, par exemple, la communication, la résolution de conflits, etc., qui ne sont pas subventionnés non plus. Puis encore, ça prend des outils aux jeunes pour pouvoir prévenir—n'est-ce pas?—les maladies mentales, ou au moins transiger avec leur maladie mentale si c'est biochimique.

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

Ms. Renée Ouimet: You're welcome.

ONTARIO COLLEGE COUNSELLORS
CONSEILLERS ET CONSEILLÈRES
DES COLLÈGES D'ARTS APPLIQUÉS
ET DE TECHNOLOGIE DE L'ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is Michel Lefebvre, La Cité collégiale.

You've got a printed presentation. Thank you. There should be some clean glasses and water, if you need any. Make yourself comfortable. Everybody's getting 15 minutes today. You can use that any way you like.

Mr. Michel Lefebvre: Thank you.

The Chair (Mr. Kevin Daniel Flynn): If you want to save us a little bit of time at the end for some questions or discussion, that would be great.

Mr. Michel Lefebvre: Good afternoon, Mr. Chair and members of the panel, my name is Michel Lefebvre. I'm a college counsellor and member of the Ontario College Counsellors. The OCC is in its 42nd year as a provincial and bilingual association dedicated to enhancing the quality of the counselling profession in Ontario's colleges.

In fulfilling its mandate, the OCC promotes policies and practices for the provision of accessible, competent, and accountable counselling services throughout the college experience in the human lifespan in a manner sensitive to the pluralistic nature of our society.

I guess I'm going to read this. I only had a chance to read my presentation a few times. This afternoon it took me 13 minutes. Anyway, I'm going to read pretty rapidly and if you have any questions at the end—but I want to make it so you can fully understand it.

The Chair (Mr. Kevin Daniel Flynn): Do it any way you like.

Mr. Michel Lefebvre: Thank you.

Ontario College Counsellors supports the objectives of the Regulated Health Professions Act, namely to protect the public from harm, to promote high-quality care, and to treat individual patients/clients and health professionals in an equitable manner.

Our standards of practice, statement of ethics and all our services are dedicated to using our counselling competencies to meet educational, career and the personal, social and psychological needs of our college community.

OCC currently has 160 members and serves thousands of clients in 24 community colleges. Our members practise under the title of college counsellor and they provide a wide range of mental health services.

OCC members regularly address a wide variety of mental health concerns, a wide variety of clients from diverse backgrounds and a variety of ages, from adolescents with behaviour problems through to seniors with issues related to aging and depression.

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. OCC believes that college counsellors will qualify to come under the auspices of the Ontario 2007 Psychotherapy Act, and will register with the title of registered psychotherapist or registered mental health therapist.

Ontario college counsellors are highly qualified and work with a significant and growing population of students presenting with severe mental health issues.

OCC est le comité représentant de tous les conseillers et conseillères des collèges d'arts appliqués et de tech-

nologie en Ontario. Notre organisme est responsable devant le conseil des présidents par l'intermédiaire du comité des collègues des services aux étudiants.

OCC est un organisme professionnel dont l'origine remonte à la création du réseau des collèges d'arts appliqués et de technologie en Ontario. Il a toujours eu pour objet de promouvoir des normes élevées d'éthique et de pratique dans les services de counselling des collègues, de contribuer au perfectionnement professionnel de ses membres et de faciliter les relations de travail efficaces parmi ses membres et entre les services de counselling des collèges et d'autres organismes.

OCC is proud of its efforts, which aim to protect the public interest and to ensure its members deliver excellence in their standards of service. It is from this viewpoint that we welcome the opportunity to offer our input to this committee.

We are pleased that the Legislature is taking a comprehensive approach to reviewing how the mental health of Ontario's population can be improved. I can certainly give you a view of mental health needs within the college system.

Improving a society's mental health is about more than simply expanding access to services presently funded by the Ministry of Health. In order to serve our mental health population well, improvements will particularly need to address issues of timeliness, affordability, appropriate lengths of services, choices of therapies and types of therapists, and always quality and effectiveness of services. It is also understood that services delivered solely on too little funding will not adequately address needs.

Individuals with serious and complicated mental health issues, such as severe depression, anxiety or eating disorders, often present first to the counselling department in colleges. The nature of these conditions, especially within the context of attending school, would necessitate timely response and would often require collaborative work with other professionals, some of which cannot be provided only by health and hospital facilities. College counsellors play a vital role in helping clients mitigate the effects of such issues and assist them to learn to cope with their symptoms of distress even as students attend to their school studies or await additional referrals.

1540

Improvement in access and referral are needed within college counselling centres in order to better service our students, especially those dealing with serious mental health issues. Across all of North America, counselling departments in colleges and universities report seeing a large increase in seriously mentally ill students. Waiting times to see a counsellor are getting longer as more students seek our services; as presenting issues increase in complexity and require longer therapy; and as counsellor positions have not kept pace with the increasing demands. Staffing college counselling services adequately would be very helpful to our ability to respond in time and provide ongoing therapeutic support.

Counsellors are also unable to refer in due time to appropriate services in the broader community due to

lack of accessibility. Improving overall accessibility to all mental health services would serve the student population better.

In the broader community there are too few and too limiting services for our students suffering from mental health issues. Firstly, students have very little money to access practitioners in private practice, whose waiting times are short but whose costs are high. Only a very minute minority of our students may have the financial support of parents for this kind of private care.

For students who must function at their best under the academic rigours of our school programs even as they cope with mental health issues, the time delay to access OHIP-covered psychiatric and other mental health services could lead to unnecessary disruption of their studies. Waiting up to six months to a year to see a psychiatrist is too long when one is still expected to write papers, take exams and make class presentations. Getting behind in one semester may result in delaying school for a whole year.

Even when students do receive community-funded services, the services may limit sessions and prove to be inadequate. Many organizations, due to the lack of funding and infrastructure, can provide no more than six or eight sessions of therapy or counselling.

Those clients who require immediate or more intensive long-term care, for issues such as childhood sexual abuse, can easily fall through the cracks. Whereas brief therapy and one physician visit can be very helpful for uncomplicated issues, each service would fall very short of meeting the needs of clients in serious distress or in chronic crisis.

The short-term model also necessitates the need for highly skilled professionals who are trained in methods of intervention, rather than just simply assessment, to treat these individuals on an ongoing basis and ideally to help them resolve their symptoms so that they may enjoy higher functioning.

As a result of these limitations and the increased number of students entering the community college with severe mental health issues, college counsellors come face to face with students with very serious mental health issues related to high-anxiety situations where they are simply struggling to deal with daily and numerous demands and changing variables: family breakdown situations, health problems, feelings of loneliness from being far away from home, financial problems, depression, suicidal thoughts, loss of interest, loss of friendship, and dealing with an intense environment where they feel lost and alienated.

Sometimes students are just burnt out by their intense new life as a young adult away from home, dealing with their new friends, dealing with their sexual orientation, starting new jobs in a different environment, and learning and studying in a new and demanding environment.

Some people, when they think of college and university students, think of bad-hair days and breakups, when the reality is often that the university or college has to provide a community health clinic where individuals

with severe disorders are treated, many of whom would not be able to afford or access other resources. In addition, many psychiatrists and some psychologists have a great deal of experience diagnosing, but don't necessarily have the resources to provide the ongoing psychotherapy treatment.

Counsellors work with students who are actively suicidal, who have intractable eating disorders, who are dealing with first-episode psychosis, and who are coping with depression, anxiety, illness, the death of a family member, and physical and sexual assault.

One of the benefits of having counsellors who are highly trained is that they also know when referrals to other professionals are needed to enhance the effectiveness of services to students. For example, if a student presents with psychotic symptoms, counsellors are quick to recognize the need to make the appropriate referral to clinics or a medical doctor. While waiting for the referrals to take place, counsellors continue to provide appropriate psychological support.

It's important for Ontario to work to improve access to all mental health professionals. One simple way to greatly enhance the services counsellors can offer would be to be able to refer a client directly to a psychiatrist. You can imagine the frustration when someone waits weeks for an appointment to see a counsellor, then has to wait another period of time to obtain an appointment to see a family doctor—if they have one—and then, yet another wait to be referred to a psychiatrist. Also, this direct referral to psychiatrists would immediately set up the consultative structure needed so that the psychiatrists and counsellors could work collaboratively on behalf of the student referred.

There are shortages in competent and accessible services for mental health in Ontario and there are also 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. We have great hope that once the new College of Psychotherapists and Registered Mental Health Therapists of Ontario is functioning, this issue will resolve itself.

The government's action to regulate the practice of psychotherapy through the Psychotherapy Act, 2007, was welcomed by our organization, but we are keen to see the legislation implemented. There is the potential for improving the outcomes in Ontario by better leveraging the full diversity of expertise that is available in the province.

For a mental health strategy to succeed, it is 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 available in the province. It is important that a choice of services be available in order to empower

people with mental health problems. There is 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.

Because of the diverse skill set of counsellors, they are able to provide counselling to adolescents, adults, couples, families and groups. Workplace stress, financial difficulties and similar kinds of problems, which often lead to depression, anxiety and contribute to family conflicts, are services 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 work with perpetrators of domestic violence, as well as people affected by abuse. A diversity of practice models both complement and take pressure off the OHIP system.

We were pleased to learn that the new amendments to the Psychotherapy Act, 2007, limit the exclusive use of the title “registered psychotherapist” to those who will be licensed by the new college. This is a positive step in terms of promoting clarity to the public and enhancing public protection. 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 is clear to the public that they are accessing care that adheres to a common standard of training and regulation. It is also clear that they can turn to the college for redress in the case of complaint.

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. OCC, Ontario College Counsellors, 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.

OCC is very grateful to have this opportunity to present our views to this committee on behalf of the Ontario College Counsellors. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Michel. You’ve used up all your time, but you used it well. Thank you very much for coming today.

Mr. Michel Lefebvre: Thank you.

1550

FETAL ALCOHOL SPECTRUM DISORDER COALITION OF OTTAWA

The Chair (Mr. Kevin Daniel Flynn): Our 3:45 appointment is the FASD Coalition of Ottawa. Diana Fox

and Elspeth Ross, if you’d like to come forward and make yourselves comfortable.

Ms. Diana Fox: Good afternoon.

The Chair (Mr. Kevin Daniel Flynn): Good afternoon. You’ve got 15 minutes, like everybody else. You’ve probably heard the whole spiel.

Ms. Diana Fox: Perfect. My name is Diana. I’ll start by just giving you a bit of background information. I do apologize. We have been very busy. Today is International FASD Awareness Day. As we’ve been involved in many activities today, I scanned the e-mail that a colleague sent for me to be here today and didn’t make enough copies for you, so I do apologize. I’ve made it up by putting lots of extra information in the handout for you, so hopefully you will scan and read as you feel fit.

Today is international fetal alcohol spectrum disorder day, and it is a day to raise awareness around the disorder. Fetal alcohol spectrum disorder is caused by a woman drinking during pregnancy and the alcohol effects on the developing fetus. There are a number of disabilities associated with it, both primary and secondary disabilities. The primary disabilities would be sensory integration issues, learning disabilities and cognitive functioning.

The secondary disabilities actually are trouble with the law—I’ll just go through some of them here. In a Canadian study, of the secondary disabilities of 92% of individuals affected by FASD, 65% had attention deficit hyperactivity disorder; 45% of the individuals suffered from depression; 21% suffered from anxiety, panic disorder, PTSD, OCD, ODD and bipolar; 92% were rated as vulnerable to manipulation; 82% were victims of violence; and 77% were exposed to physical and sexual abuse.

As a counsellor in trauma and as an addictions counsellor, certainly when we work with individuals with fetal alcohol spectrum disorder, which is both a visible as well as an invisible disability—some of the individuals with fetal alcohol syndrome that we’re a little more aware of are more visible when we see them. We can recognize there’s a disability and we often accommodate—hopefully we accommodate. But certainly partial fetal alcohol syndrome and alcohol-related neurodevelopmental disorder—that’s the invisible disability and we often don’t accommodate these individuals. As we heard from many of the speakers this morning at our event, they don’t want to let others know that they have a disability because everyone wants to be perceived as being normal, to fit in.

I think today what I would like to stress is more the prevention effort, and Elspeth will talk further about the intervention. But we do need to raise awareness and training. One of the things that I have been doing is training front-line professionals around the disorder and looking at accommodation and interventions that are most effective, both for women who are at risk of drinking during pregnancy as well as individuals who are living with the disability.

One of the things I have noticed across the country as I’ve done training is that we do not address this issue in

addiction centres for fear of stigma, for fear of driving women deeper into silence. But as we deal with the stigma, as we raise awareness, hopefully we can start talking about the disability and support people who are living with it.

I'll just pass to my colleague.

Ms. Elspeth Ross: My name is Elspeth Ross. I'm a member of the FASD Coalition of Ottawa. I co-facilitate an FASD group at the Children's Hospital; it's where we meet. It's a support and education group. I've been doing it for 10 years and we operate without funding. I do it with a psychologist.

I'm a member of FASD Stakeholders for Ontario. It's a provincial group. I'm on their intervention and support group. We're finalizing three consultant reports on FASD effective practices, one on FASD in schools and the third on respite services.

I'm a parent, with my husband, who is here today, of two young men affected by FASD and we're now parenting full-time our grandson, who is aged 11—not fetal alcohol affected but a victim of trauma and family violence. I work as an educator in FASD and adoption permanency, and I provide an FASD current awareness service by e-mail.

Our boys are both fetal-alcohol-affected—they're 27 and 29—and in many ways, we are a success story. By the way, we live in Prescott-Russell, and I see my MPP, Mr. Lalonde, present here today. Both of my boys have graduated from high school and one has graduated from college, in aboriginal studies. They both work seasonally. They live in our lower house. Having a second house is a very good way to cope with family members with fetal alcohol syndrome, but not everyone has one.

My older son has done very, very well, but when there were recent troubles in his life where he had depression, anxiety and panic attacks. He does not have sufficient resiliency to cope with the challenges of life. My younger one had a psychiatrist from a very young age, until age 22, for obsessive-compulsive disorders and now has an addiction counsellor for alcohol.

Our grandson only lasted six days, when he arrived in our family three and three quarter years ago, in school before being excluded—not suspended, not expelled, but excluded. You're only entitled by law to five hours per week with a teacher, if a teacher will take you, but we advocated for 10, got work placement, and he has been in school a year and a half out of almost four years. He just started his second section 23 placement yesterday. We're hopeful.

Not everyone can provide the external brain support that we do for our family. Not everyone can keep the records, remind them, take them to the doctor—I'm talking about adults—and manage money for them.

What do we need? We know about the co-occurrence between fetal alcohol syndrome and mental health and addictions. We know from Dr. Streissguth's research that over 90% of people affected by fetal alcohol spectrum disorder have mental health problems; 60% of children have ADHD—I believe it's higher than that—and 30% have alcohol and drug problems. There was Canadian

research done recently, in 2003, by Erica Clark—and by the way, I've provided you with a bibliography of these items so that somebody, I hope, can get hold of them. Unfortunately, her research found mental health diagnoses in 92% of those she studied, most with ADHD, depression, panic disorders, and 61% with destructive school experiences—it's probably often higher—and high co-morbidity with alcohol misuse.

Look at it the other way. What about the co-occurrence of FASD in individuals with mental health problems and addictions? Underneath the mental health and addictions is the FASD. Often people who are affected by fetal alcohol syndrome don't know that they are affected. It's not an easy thing to admit that you have a neurodevelopmental disorder or disability. They may not know that their birth mother drank alcohol early in pregnancy. FASD is often undiagnosed. It's an invisible disability. The people are not small. They're tall, good-looking, with no distinctive face, are very good talkers, and most are of average intelligence.

As an information professional, I monitor the news, I monitor reports, I do word searches. I know where FASD is not included. FASD is not included in your select committee's discussion paper Every Door is the Right Door. It is not included in the documents from the Mental Health Commission. It is not included, necessarily, in concurrent disorders or mental health or addictions symposiums, conferences, workshops and publications. It is not even really considered a disability. It crosses boundaries into many disciplines, from early childhood education to corrections—and what we're working for is to keep people out of corrections. My son has only spent one night in jail. After one night in jail, he came home and said, "Jail is horrible." I said, "Oh, good. I'm glad you feel that way."

FASD is a lifelong condition. The secondary disabilities are variable and can be minimized. Minimized with what? With early diagnosis, structure and supervision, tailored programming and adjusted expectations. There is hope that FASD-affected individuals can maximize their potentials. We need to build on strengths.

1600

What do we need? The stakeholders for Ontario asked parents. They said our biggest needs are in schools, school programs, and respite. We need respite desperately.

What do we need? An Ontario provincial strategy for FASD. The recent infertility and adoption panel asked for that, and we echo it.

We need FASD included in concurrent disorder strategies.

We need collaboration—other people, of course, have mentioned this—collaboration between ministries and with stakeholders. We need prevention campaigns; Diana talked about prevention. We need education and training about FASD for professionals.

We need an attitude change—people are not wilfully badly behaved; it's a brain disorder—support and understanding.

Basically, all that we really need is services. We need diagnostic services across the province, including distance availability. We need professionals—psychiatrists, psychologists, therapists, counsellors, addiction counsellors—who know FASD, who think FASD. We need special education, and not just inclusive classrooms; we need special programs as well. We need assisted employment, assisted job search, job coach, disability pensions, disability tax credits, a big variety. We need assisted living options, and we need respite care for families, respite care including babysitting.

There is hope. Things are looking up in Ontario right now. It's a very good time for this committee to be doing these things, because you can draw attention to FASD and where it's included in mental health and addictions so that we can maybe begin together to find solutions for Ontario. And this is FASD Awareness Day, so it's a day for us to be speaking to you about it.

The Chair (Mr. Kevin Daniel Flynn): Thank you. I was just reading about the diagnosis for FASD. I'm wondering—it's not a blood test, it's a series of tests, and it's an opinion, I guess?

Ms. Diana Fox: No. They actually have very stringent diagnostic guidelines, so geneticists, actually, and pediatricians diagnose with a team.

The Chair (Mr. Kevin Daniel Flynn): Okay. I was just cruising through them as you were talking.

Ms. Diana Fox: But no, it is not a blood test, and it is quite a lengthy process.

The Chair (Mr. Kevin Daniel Flynn): Okay. The first question, then, is from France.

M^{me} France Gélinas: Thank you. Well, that was a good entry into—I come from northern Ontario. The availability of specialists to diagnose FASD is horrendous. There are no teams willing to give a diagnosis. So how is it in Ottawa?

Ms. Diana Fox: That's a very difficult question to answer. CHEO does diagnose; the geneticists do diagnose both children and adults, so the waiting list depends on the time and the rush. It is a lengthy process. I do know some people, particularly youth and adults, who, because of the length of diagnosis and the amount of time and appointments they need to go to, will abort the process.

M^{me} France Gélinas: We all know that if we treat those children early, they do so much better. In the north, we're not having any successes whatsoever in getting our kids diagnosed early. Are you guys having any success?

Ms. Diana Fox: There certainly is a difference between the north and the south and urban and rural that—I mean, we can't say. We do certainly have better access to services, but I think, as Elspeth mentioned, there is a stigma attached to the disability and many people don't want to think of that as a possibility.

M^{me} France Gélinas: So the kids are still not diagnosed early and they don't get the support they need?

Ms. Elspeth Ross: One of the big problems is lack of knowledge about birth-mother drinking. This can prevent a firm diagnosis. So what we would really like is for

mental health people, doctors, to ask women about their drinking and for people to keep records, for all agencies to keep records, because it's very difficult to get a diagnosis without that information.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Anybody from this side? Jean-Marc.

Mr. Jean-Marc Lalonde: Thank you very much for being here this afternoon. I think it was very important, the presentation that you made, because I was visiting schools just last week, high schools especially, and the problems that we have in high schools at the present time start off really earlier, at grade 6, I guess.

You referred to special programs. I do believe strongly now, after listening to you, that in my next visit to a high school I'll be talking to the principal of the school, that we should have people—like in your case here, the FASD—talking to the girls down there. It's very important that they be made aware, really, of what could come from having some difficulties at one time or another. But I really appreciate the time that you spent to make this presentation today.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming. Your time is really appreciated. And we did hear from your group yesterday in Toronto as well.

Ms. Diana Fox: Wonderful. Great.

The Chair (Mr. Kevin Daniel Flynn): So we're hearing from you all over the province.

Ms. Diana Fox: Thank you very much.

CATHERINE DUBOIS

GERMAIN DUBOIS

The Chair (Mr. Kevin Daniel Flynn): Our next speakers today are Germain Dubois and Catherine Dubois, if they'd come forward. Make yourselves comfortable. There's some water there if you need it. You've got 15 minutes, like every other group today. You can use that any way you see fit. If there's the opportunity to leave some time at the end for some questions, we'll see if we can share it around the group here.

Ms. Catherine Dubois: Thank you. I'm Catherine and this is Germain. Usually when family members talk about their children, they start with the day they were born, so we promise you we won't do that. I thank you for this opportunity to speak to you.

We are parents of an adult child who suffers concurrent disorders. We are also new graduates of an education program given by Horizons Renaissance, in partnership with Maison Fraternité and Montfort Hospital here in Ottawa. We attended a 12-week course to learn about illness, addiction and all the related information that would help us, as parents, to understand and support our son.

Our son is also a new graduate of the homeless community. He is now housed in a small apartment here in Ottawa provided through Ottawa Community Housing. He had been on the streets for over three years. Throughout these years we experienced, as his parents, a very

solitary struggle as we tried to keep the lines of communication open with him.

Our beloved son, the child that was praised by teachers as somebody who would be the next Prime Minister, became ill at 13. He is now 31. His health status is very poor, as is typical of people who have been chronically ill and who have been living on the streets for a long time. He suffers, like many other people do on our streets, from mental illness as well as addiction.

For all of the years, in our experience, our family has never been able to access the services that Christian needed—from diagnosis early on, when it was important, to medication, to primary care throughout his adolescence and adulthood—as well as the social supports that he would need.

Like many other young people who become ill, his illness and addiction were, at the beginning, seen as a teenager that was acting out or experimenting with drugs. For all those years we as his parents were rarely able to either give or receive information that would have been key for treatment or key for follow-up, due to the silence and confidentiality that usually falls when a young person or an adult becomes ill.

We want you to know that we understand that families, and particularly parents, have to be assessed to see if they might be a part of the problem. We expect that and we respect that. In our case, as his parents, we loved him, we knew him best and we knew that he was ill.

Mr. Germain Dubois: If you know our city, you will know how homeless people gather on Murray Street and around the mission to receive services and beg for money for drugs. You no doubt have the generosity of spirit to acknowledge that homeless persons are sons and daughters, brothers or sisters, mothers or fathers. In our case, our son became one of the homeless community. So many families are unable to maintain a relationship with their loved ones who suffer from concurrent disorders because they have not been able to access education and other supports to learn how to live with such deadly diseases. Over the years, we had to educate ourselves about concurrent disorders. Catherine, for one, was in a group of family members who were trained to give Family to Family, an education program operating out of CMHA delivered by family members here in Ottawa. Family members paid for the training, paid to take courses and maintained the program for going on 10 years. For all these years, we have struggled as a family to help our son receive appropriate treatment while keeping our family together through crisis after crisis, including suicide attempts, broken limbs and broken hearts.

1610

Ms. Catherine Dubois: This year while accompanying our son through the court process, we met staff at Horizons Renaissance who are supporting Christian through the process. We were invited to take the family education course. We already knew so much of the material because we had to know it. We attended because we thought it would help our son in some way, that it

would allow the facilitators of the course, who were there representing Montfort Hospital, Maison Fraternité and Horizons Renaissance—that somehow they would hear about him and it might shine more light on Christian and know what might be helpful to him. For the first time in our lives, and our son is now nearly 32, we had the opportunity to hear and be heard by expert resource persons. We waited over 15 years. We're extremely appreciative of this opportunity, and that's why I wanted to mention those organizations more than once to you. For us, these workers and any other person that's helped our son along his road are heroes to us.

If Christian was here, I'm not sure that he would be able to express to you hope. He was not treated effectively as a teenager, as a young adult, and because he was not treated effectively, he has now the experience of living with serious and persistent mental illness and addictions to the degree that it's life-threatening. We don't know if he can maintain his apartment because the supports that surround him still after all these years are so tenuous. We know what we do: We have one day a week with him, but we obviously can't do seven days a week.

We want you all to know that from our perspective, parents would remain committed and effective supports to their children if they could be regarded as partners in care. We will continue to be part of our son's care for as long as we can and as long as he lets us. So we want you to see us as two of the many thousands of parents that you might already have been meeting as you do your work. We are pleading for more robust education programs and we are pleading for a process that empowers parents and providers to work together to improve care for people who live with concurrent disorders. We care deeply about the dignity of each and every person that experiences this in our province and in our country.

We hope and we trust, as we look at you, that governments and all your partners have the resources, the knowledge and the abilities that you have to make sure that services are improved and that consumers of services can provide adequate care. We would be happy to have any questions that you would have for us.

The Chair (Mr. Kevin Daniel Flynn): Good. Thank you very much for coming today. That was a great presentation. Let's start from this side. Any questions? Liz.

Mrs. Liz Sandals: Thank you so much for sharing your story. As you've described, you very much wanted to be able to be involved to support your son, to provide the information about what you were observing, but you found an obstacle to that partnership between the parent and the medical systems. Can you identify what the obstacles were? Was it legal obstacles or was it attitudinal or some other factor that was the obstacle?

Ms. Catherine Dubois: I think there are legal aspects in terms of confidentiality, once a person reaches a certain age, and those things are in place for good reasons, but I think that parents and families can quickly be assessed to see that either they're part of the problem or they can be part of the solution.

In our community, and I'm sure you hear this all throughout the province, we did not have a lot of choice in terms of good psychiatric care. In fact, we found that a lot of medical professionals will run away from it because they just feel that it's an area specialty they're not trained for. So it's very difficult to get the support early on.

I think the key to effective treatment is early diagnosis. We're just one family out of thousands who now find ourselves with a son whose future is not what it could have been. It's really not what it could have been. My husband will often make the case, and did so this morning, saying, "We're not really going to have the time to say what we feel," and we know that. But he was saying this morning, "How much money is it costing the system for all of the services that our son needed that didn't even work?" We would just really try and make a case for services at the beginning of the process. Especially for a young person, you don't have a huge window. When that child needs help, the child and the family need it then because there are so many ways that the child, as he grows, can disconnect. And when that person is also ill, my goodness, and would be experiencing all sorts of psychotic episodes, for example, and is self-medicating because in that young person's view nothing else works, it's a long journey down.

Mrs. Liz Sandals: Thank you so much.

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

Mrs. Christine Elliott: I'd also like to thank very much for being here today. We have heard from a number of parents and families. I just want to assure you, on behalf of the whole committee, that this is something that we're taking very, very seriously. We do want to find a solution so that other families won't have to go through what you've had to go through with your son.

One of the previous presenters mentioned that you can have housing, but without a treatment and care plan it's not going to work. It sounds like you're sort of in that situation right now with your son. What do you think he would most benefit from right now? What supports would you like to see in place to make sure this will be successful for him?

Ms. Catherine Dubois: He needs supports every day. Ideally, there would be a period where it would be easy for hospitalization for those episodes where he needs treatment in a very concentrated way, but at the very minimum he would need people to support him throughout the week. Now it's pretty well an optional thing.

The only thing we're really sure about is our day where we can go and help maintain the apartment and help see that there's food, and also be his parents. We want to be parents. We're not qualified to be mental health care experts. So we're looking for all of the organizations to see who's going to be doing what. It's either all or nothing for families. You're expected to do it all or else it seems, in our experience, you're totally excluded. What would help is if he would have someone to check in on him to make sure that things weren't

sliding and to see if his meds were happening. Now our son walks in the morning over—I don't know—

Interjection.

Ms. Catherine Dubois: —a distance from his apartment to the Salvation Army to pick up his medication in the morning and to pick up his medication at night. On one hand, that's helpful because he has a routine. On the other hand, there are lots of ways that that can go off the track. It's not easy. Why does it have to be so hard for somebody who's so ill?

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

M^{me} France Gélinas: Nous avons beaucoup entendu parler, madame, monsieur, des parents qui se sentent exclus, puis ils sont exclus à cause de lois de confidentialité. Pouvez-vous me donner un exemple précis, au début avec votre enfant; si vous aviez eu la chance de vous expliquer mais on ne vous l'a pas donnée?

M^{me} Catherine Dubois: La première fois que cela nous est arrivé, on est allé ensemble à notre médecin de famille qui était avec nous depuis sa naissance. On a demandé à Christian d'entrer dans la salle d'examen. Moi, j'étais exclue, puis je n'avais aucun moyen de partager. Notre médecin de famille n'était pas vraiment à l'aise avec ça. Être à l'aise avec ça, je le comprends, mais il n'a pas fait un aiguillage à quelqu'un dans le réseau de santé mentale.

Christian était suivi par un psychiatre pour une période assez courte. Puis ce qui a été partagé avec le psychiatre, nous autres n'en étions pas au courant, même si c'était nous qui amenions Christian pour les rendez-vous. C'en est un exemple.

Ça fait deux fois que Christian a été hospitalisé quand il était jeune. La première fois était à 16 ans pour un essai de suicide. Après, il a été mis dans la rue sans même un appel à sa famille, en plein milieu de l'hiver. Je ne comprends pas comment des choses comme ça peuvent arriver.

M^{me} France Gélinas: Il faut une balance entre le droit à la vie privée et le droit au traitement. Je pense qu'on n'a pas trouvé la bonne balance en ce moment parce qu'on a entendu parler de beaucoup de cas comme la vôtre, madame.

1620

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Thank you for telling your story. I think you got your point across very well.

MARIE-JOSÉ DEALBERTO

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is the 4:15, Marie-José Dealberto.

Dr. Marie-José Dealberto: Thanks for inviting me to give this talk on the increased risk for autism, schizophrenia and psychosis in immigrants. I am a psychiatrist and epidemiologist, and also I am an immigrant. Today I will speak as an immigrant and as a scientist. I come from France so I have a very strong French accent.

The increased risk for autism, schizophrenia and psychosis is a very sensitive issue in our multi-ethnic society. Canada is a country of immigration and there are six million foreign-born, according to the 2006 census, representing 20% of the population. The figure is more striking when you consider together the first and second generation of immigrants: 40% in Canada, 54% in Ontario and 76% in Toronto. I am considering both generations because we see the risk affecting both generations.

Autism is a neurodevelopmental disorder characterized by a deficit in social interaction and communication, and repetitive behaviour. Psychosis is a disorder of thought and sense of self, and schizophrenia is the most devastating and incapacitating type of psychosis, characterized by hallucinations, delusions, and emotional and social withdrawal, with cognitive symptoms. Schizophrenia is also considered as a neurodevelopmental disorder. There are other types of psychosis and I would like to insist on late-onset psychosis or very-late-onset schizophrenia-like psychosis, which affect elderly and very elderly subjects.

The human costs of autism and psychosis are enormous, but the financial costs are very important too. A US study estimated the cost of autism at \$3.5 million per case, lifetime. A UK study estimated the cost at C\$1.4 million to C\$2.2 million, lifetime per case. For schizophrenia, the total cost was estimated at \$6.85 billion in Canada for the year 2004.

The risk for schizophrenia associated with immigrant status is well known in Europe, and a recent meta-analysis calculated that overall the risk was 2.9. It means that immigrants are 2.9 times more at risk for schizophrenia than native-born subjects. What is important is that the risk differs according to generation because the second generation is more at risk than the first one. The risk for the second generation is 4.5 and for the first one is 2.7.

What is also important is that the risk differs according to skin colour. Black subjects are at an increased risk than other subjects. The risk associated with black immigrants is 4.8; it is 2.3 for white and 2.2 for other immigrants.

As this meta-analysis is concerned mostly with northern Europe, I reviewed studies in traditional countries of immigration and I found, similarly, an increased risk of schizophrenia in immigrants to traditional countries of immigration, such as Australia, Canada, Israel and the United States. The increased risk for schizophrenia differs also according to skin colour. We have seen that the risk is increased in black immigrants to northern Europe, but there is also an increased risk of schizophrenia in black subjects living in the United States, and most of them have been living in the States for a generation.

What is important to notice is that there are no increased rates in Africa and the Caribbean. This means that black immigrants to northern Europe and black subjects living in the United States are exposed to risk

factors for schizophrenia, and these risk factors do not exist in Africa or in the Caribbean.

There are Canadian data which show similarly an increased risk for immigrant status, an increased risk in immigrants to British Columbia between 1902 and 1913, an increased risk for foreign-born subjects compared to Canadian-born, data for all Canada by Malzberg and De Hesse. And I recently found an increased risk in foreign-born compared to Canadian-born in a sample of homeless persons in Ottawa. There is also an increased risk according to skin colour, and I found, with Sarah McDermott, an increased risk in black immigrants to Canada in a large cohort of immigrants arriving between 1985 and 2000. Also, the first-episode psychosis programs in Ontario found an over-representation of black subjects.

The situation is exactly the same for autism. There is an increased risk of autism in children of immigrants to northern Europe and an increased risk for autism in black children in North America. This increased risk is observed in immigrants for autism, schizophrenia and psychosis, but only for these disorders. There is no increased risk for other mental disorders.

The causes are probably neurobiological because there is exactly the same relationship for autism and schizophrenia regarding immigrant status and skin colour. The most probable cause is a vitamin D deficiency because subjects with dark skin need longer sun exposure to synthesize vitamin D, so they are more prone to vitamin D deficiency when they live in high latitudes, as in Canada. Vitamin D deficiency during pregnancy would be responsible for autism and schizophrenia, and vitamin D deficiency through epigenetic mechanisms would be responsible for an increased risk for schizophrenia and psychosis in immigrants.

In conclusion, immigrants to Canada and visible minorities are overburdened by the most severe mental diseases at all stages in their lives. Because of its large population of immigrants and its high northern latitude, Canada has probably one of the highest rates of schizophrenia. There is an urgent need for reliable estimates of rates of autism, schizophrenia and psychosis according to immigrant status and skin colour.

Action: I think it's very important to design mental health programs specifically for psychosis aimed at immigrant communities and visible minorities. There are specific programs for immigrants, but they are not specific for psychosis. These special programs would improve diagnosis, treatment and awareness and decrease stigma. There is a need for funding for epidemiological studies and there is also a need for funding for neurobiological research on both the pre-natal and direct effects of vitamin D deficiency.

Of course, the best action is prevention, and if there is enough evidence, prevention of autism and schizophrenia by monitoring vitamin D levels and treating vitamin D deficiency in pregnant women, especially those who are dark-skinned, immigrants and veiled; prevention of schizophrenia and psychosis by monitoring vitamin D levels and treating vitamin D deficiency in immigrants

and visible minorities. The cost is minimal because the cost of two vitamin D serum levels and treatment per year is inferior to \$150 per person.

Thank you.

1630

The Chair (Mr. Kevin Daniel Flynn): Thank you. That was very interesting. You left a lot of time.

Dr. Marie-José Dealberto: I welcome your questions but English is not my first language, so please speak slowly and articulate so I will be able to understand you.

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

M^{me} France Gélinas: On a l'interprétation simultanée, si vous—

D^{re} Marie-José Dealberto: Ça va. Si je ne comprends pas, je vous le dirai.

M^{me} France Gélinas: Parce qu'ils sont là.

The Chair (Mr. Kevin Daniel Flynn): Okay. First questions are from this side. Anybody? Helena?

Ms. Helena Jaczek: Yes, thank you. This was very interesting. I note that you've looked at this meta-analysis by Cantor-Graae and Selten, 2005. My understanding of meta-analysis is that this is where you take many smaller studies and, to increase the power and the number of subjects, you combine them, ensuring the methodology is appropriate, that they can be combined, and then you reach a conclusion.

What has been done to date in terms of longitudinal studies in terms of rates—let's use schizophrenia—in Canada over time? I'm a physician and I have a master's in epidemiology. Meta-analysis is useful to point people in the right direction, but I'm just wondering what do we have subsequent to that in terms of following rates of admission etc.? Does CIHI have any data related to immigration, ethnicity and schizophrenia?

Dr. Marie-José Dealberto: I'm sorry but I'm not sure I have understood your question.

M^{me} France Gélinas: Helena est médecin et elle a un degré en épidémiologie également. La méthodologie que tu as utilisée avec les meta—elle décrivait comment c'est fait, mais elle aimerait savoir s'il y a des études longitudinales également qui démontrent et appuient ce que tu nous présentes aujourd'hui. Elle faisait référence à différentes banques de données qui existent au Canada qui permettraient de faire ce type d'analyse longitudinale.

Dr. Marie-José Dealberto: The best studies for schizophrenia are incidence studies. It means that we study new cases of schizophrenia. To my knowledge there have been no recent studies. The only two studies on new cases of schizophrenia in Canada were performed by Malzberg in 1964 and De Hesse in 1967. There have been no recent studies since that time.

Ms. Helena Jaczek: That's very interesting. It seems a glaring omission.

The Chair (Mr. Kevin Daniel Flynn): That's right.

Dr. Marie-José Dealberto: Yes.

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

Ms. Sylvia Jones: Just one, thank you. Under "Prevention," you mention that vitamin D levels should be monitored for women who are pregnant. It's been a

while since I was pregnant. Is that something that is a standard physician test at this point for pregnant women?

Dr. Marie-José Dealberto: Your question is, is there enough evidence to test all—

Ms. Sylvia Jones: No, my question is, do doctors test vitamin D levels in pregnancy right now?

M^{me} France Gélinas: Elle veut savoir si en ce moment, lorsqu'une femme est enceinte, on regarde son niveau de vitamine D.

Dr. Marie-José Dealberto: I am not an obstetrician or a gynecologist so I am not aware of that; I don't think so. Some GPs systematically request vitamin D for their patients. But right now, for obstetricians, I am not aware of that. I will inquire. Thank you for your question.

The Chair (Mr. Kevin Daniel Flynn): Thank you. France, do you have a question?

M^{me} France Gélinas: C'est quand même très révélateur ce que vous nous avez dit, avec une solution qui est tellement simple : de la vitamine D. Ça s'achète à l'épicerie pour à peu près quatre sous pour mille unités internationales, une masse pour ta journée. Puis, si cela a des conséquences comme vous dites—4,8 fois plus de cas de schizophrénie, puis que ça pourrait être diminué de plusieurs pourcentages avec quelque chose d'aussi simple. J'appuie ce que ma collègue a dit, qu'on a besoin d'une étude longitudinale et de regarder ce que vous nous avez présenté plus en détail—pas qu'on doute de ce que vous avez fait mais vraiment, de notre côté également, voir ce qui existe. Si vous avez des pistes pour nous pour poursuivre ce que vous nous avez dit aujourd'hui, des pistes qui existent déjà—on a des gens qui font de la recherche pour nous et c'est certainement quelque chose qu'on va regarder.

Dr. Marie-José Dealberto: I think it's very important to continue research on this topic, but this increased risk of psychosis and schizophrenia is a taboo topic in Canada. So I am very, very thankful for the committee giving me this opportunity to speak about that and to speak for immigrants too. While I was working as a psychiatrist in Ottawa, I saw too many immigrants alone in Canada, without family, without support. There are more tragic stories than you can imagine. So I really want to continue working on that. I really understand that the committee needs more evidence, and I am working to continue collecting more evidence.

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

PROVINCIAL CENTRE
OF EXCELLENCE FOR CHILD AND YOUTH
MENTAL HEALTH AT CHILDREN'S
HOSPITAL OF EASTERN ONTARIO
CENTRE D'EXCELLENCE PROVINCIAL
AU CHEO EN SANTÉ MENTALE
DES ENFANTS ET DES ADOS

The Chair (Mr. Kevin Daniel Flynn): Our final speakers of the day are Dr. Ian Manion and Dr. Simon

Davidson of the Provincial Centre of Excellence for Child and Youth Mental Health at Children's Hospital of Eastern Ontario. Thank you very much for coming today. I understand there was a little confusion as to your time today. Did you prepare for a 15-minute or a 30-minute presentation?

Dr. Ian Manion: We're very flexible. You guys look tired.

The Chair (Mr. Kevin Daniel Flynn): Okay, let's make it 22½

Dr. Ian Manion: Perfect.

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

Dr. Simon Davidson: Thank you for allowing us to present. We do realize that you are toward the end of a really long day.

That said, we would contest that whether we're talking about mental health or whether we're talking about mental illness, it all begins with children and youth. Romanow talked about mental health services as the orphan of health care services. Kirby took that a step further and said, that being true, child and youth mental health services are the orphan of the orphan.

The Chair (Mr. Kevin Daniel Flynn): I'm sorry, before you go on, you're going to need to identify yourselves as you're speaking; otherwise, the guys from Hansard won't know who's who.

Dr. Simon Davidson: Sorry about that. I'm Davidson.

Dr. Ian Manion: I'd be Manion, then, by exclusion.

The Chair (Mr. Kevin Daniel Flynn): You're the other guy.

Dr. Simon Davidson: We wanted to congratulate the committee on putting together a really fine document. At the end of the day, the devil is going to be in the implementation of this document.

As I've already said, children and youth are where it all begins. Children and youth are not just little adults, and the approaches to intervening with them have to be different. The other caution is that in health care—and I was the chief of staff at the Children's Hospital in a prior life for about 10 years—there's considerable evidence that in across-the-lifespan initiatives—and I actually support this being across the lifespan—the ends of the age span get forgotten. So children and youth and seniors are often falling off in across-the-age-span initiatives.

The other thing that's really important—and again, kudos to this committee. In my 30 years in the field, I have never seen cross-ministry communication as good as it is today. It isn't that great today, but it's there and it's better than ever. For this initiative to succeed, cross-ministry integration is going to be fundamental. So for children and youth, that at least includes the Ministry of Children and Youth Services—MCSS—the Ministry of Health and Long-Term Care, the Ministry of Education, and probably others.

Finally, on the point of children and youth, for those of you who don't know, we have very good evidence at this point from multiple sources that more than 70% of adults living with mental illness had their onset at an age

less than 18. So it's not rocket science to say if you make a fairly modest investment early on, you may have a better chance later on.

1640

The second and last point I'm going to make before passing it on to my colleague has to do with the whole issue of a different kind of balance. The first balance was across the age span; the second balance is across the continuum, because when you have an underresourced system, you tend to invest all your money in the deep-end, more expensive, more intensive services. Two presenters ago, the point was made about early identification and early intervention and how important that is. It has truly been a privilege for me to have worked with that subcommittee of your committee. In fact, we have our first meeting post-report tomorrow morning of the early identification and early intervention committee.

So we have to make sure that health promotion and illness prevention is really a solid component of the full continuum if we're going to make sure that every door is the right door. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Just to correct something, we're getting some credit for something that we probably shouldn't get credit for. As much as we like credit, we probably shouldn't take it.

There are two streams that are going on at the same time. The minister has an advisory group, of which you're probably serving on a subcommittee.

Dr. Simon Davidson: Yes.

The Chair (Mr. Kevin Daniel Flynn): They prepared the report Every Door is the Right Door, and that's out for comment right now. At the same time, our committee is meeting as a committee of the Legislature, which involves all three parties.

Dr. Simon Davidson: I'm aware of that.

The Chair (Mr. Kevin Daniel Flynn): It's a private initiative, and we're going down the same road. I shouldn't say it's a private initiative, but it's not a ministry initiative; it's a Legislative Assembly initiative. It's a select committee, which is quite rare. So as much as I'd like to take credit for the report, and I share your opinion that it's a pretty good one, we didn't write it. But I think we're all trying to end up in the same place. Our task is to report to the Legislature next spring on a comprehensive strategy. The minister is working on a much longer-term view, on a 10-year comprehensive strategy. So I just wanted to be clear, but we'll take any more compliments you have as well.

Dr. Simon Davidson: Well, I'm done.

Dr. Ian Manion: That's a particularly nice tie you're wearing today.

We've actually circulated some information about our centre. We think that some of the work that we're doing is quite important to the conversations you're having presently.

I'm not sure how familiar you are with the Provincial Centre of Excellence for Child and Youth Mental Health. We've been around for about four years, and we are a provincial resource funded by the Ministry of Children

and Youth Services. Our vision is for the best mental health and well-being possible for every child and youth.

Nous sommes une ressource bilingue. On a des services en français et en anglais, et on travaille très fort pour que tout qu'on puisse offrir est disponible dans les deux langues. If you have any questions in French along the way, please don't hesitate to ask them.

The way that we do our work is by really building on three different pillars: knowledge, capacity and partnerships. In terms of knowledge, there is so much information out there on child and youth mental health that never gets into the right hands for it to be useful, whether that's in the hands of a parent who's looking for assistance, a young person who is trying to find their way in understanding what they might be experiencing, a service provider who knows that they have needs in the community while not necessarily being aware of the best way to meet those needs, a researcher who's trying to fill some information gaps, or even a policy-maker who is trying to make policy that can influence in a very positive way the lives of children and youth and their families.

What we try to do in terms of knowledge is bring all the knowledge together in one spot. We collate existing knowledge: What do we already know, and are we using it? Unfortunately, too often we re-research to death the same topics over and over again, and we're very good at keeping that information in very isolated places. So how do we make the information alive? How do we mobilize it? How do we make it move to people who can actually use it? Sometimes by doing that, we identify knowledge gaps, so how do you create new knowledge to be able to inform the activities that we do to improve the lives of children and youth?

In terms of capacity, we work a lot with the front-line service providers. How do we equip them to better use information to be able to plan their services, implement their services, but also evaluate their services so they know they are doing a good job not just in their hearts, but in what they can also measure and build upon on a day-to-day basis?

From a partnership perspective, we partner with everyone, and I really applaud the non-partisan approach that you have taken to having these conversations. Unless it becomes an issue that relates to everyone, where it's everyone's business, we're not going to get anywhere. There's been too much fragmentation, particularly in child and youth mental health, but you could argue right across the age span. Only efforts like this can start bringing those things together.

That's why we consistently partner with all those who are doing significant work in child and youth mental health, whether it's direct or indirect. Of course, we partner with policy-makers and researchers and front-line service providers, but we also partner with people in other sectors, whether it's education or youth justice or child welfare, developmental services or recreation. All these have roles in terms of outcomes for children and youth.

We also work directly with parents and with young people themselves. I believe you heard from an amazing

young person this morning, Anie Belanger, who has been associated with our centre from its inception, and actually before then, in some work that Simon and I have been doing in youth programs in this community and across Canada. How can you not want to listen to that energy, that creativity and that commitment? We might be able to develop a system that we think works for others. The reality is, they have to help us build the system for them; it's a partnership. It's not a "to them"; it's a "with them." The same thing goes for parents. You heard passionately from parents already. I was sitting and listening to the Dubois story. You can't help but be moved and wonder whether, if they had been partnered with more effectively along the way, their experience would have been a more positive one.

We wonder about how we can help you in your process. Obviously we have some expertise that we think might be valuable to you, whether that's in research and evaluation or even the development of indicators. We've worked with some of the different ministries in terms of indicator development for their agendas, whether it's in mental health as it relates to child health or in the Ministry of Children and Youth Services.

We have access to knowledge. We're constantly sifting through the knowledge base. Right now, an area of particular interest for us is school-based mental health and addictions. Again, there is a massive data set that is virtually untapped in terms of how we're using information effectively in our schools. There are wonderful programs all across the province and actually across the country, and yet we keep those pieces of excellence, pockets of excellence, some of the best-kept secrets around.

So how can we benefit more from each other's experiences and link people together so they can share their stories?

Training: We are developing tool kits and webinars and using technology, but also we see the importance of bringing people together to form networks and partnerships where they can have these conversations. Again, interestingly enough, one of your speakers was talking about FASD. We've been approached by networks—we have been the glue that has allowed these people to come together and to further their communication so they can get their word out.

You've heard of some of the work that's been done in terms of youth engagement. I won't go through that in detail. We are also involved in the Ministry of Health and Long-Term Care's consultation process for their document. They've asked us to facilitate some of their consultation with young people. We are not going to have them speak to a group of one or two young people; we're going to have them speak with several groups of young people from across the province. Not all young people are the same, so the solutions can't all be the same.

We work hard on innovations. We have grants and awards programs at our centre, but they are all a little bit different based on the realities of what we have seen in

the province. We are funding communities to mobilize around an issue, whether it's youth suicide or stigma reduction or FASD, among others. We're developing training tool kits based on what we know about emerging technology. The Dare to Dream program, which is another way of engaging young people, is an innovative way that we have found has gained some prominence not just in Canada but in other countries around the world now. So it's nice when we can take what we have developed in our own province and use it effectively, not just export it to other countries.

We have some innovative tools like *ementalhealth.ca*, which is a way for parents and young people but also service providers and front-line people to find out what services exist in their community, and those are services right across the age span. It's also linking it to knowledge about disorders and problems and mental health concerns. This is a service that is currently being expanded in the province of Ontario, easily expanded right across the life span.

We have looked at the use of psychotropics as a challenge. It's one of many tools, but we have found that many families and young people don't have a clue about what they're taking, why they're taking it and what their rights are around the use of psychotropics. We have developed information tools, with the input of young people in terms of the kinds of questions they have, but also the look and feel of the vehicles to transmit that information so it's useful for them.

We have also looked at innovations in terms of other partners in mental health care such as family doctors and pediatricians, developing a tool called HealthCheck. We are at the front line. While in the waiting room, an integrated mental health screen can be done for every well visit for children and youth at their doctor's office, available when they walk into the doctor's office, so that that family physician will have useful, current information in terms of what that person's needs might be, whether it's addictions or a mental health concern or a problem around self-esteem, whatever it happens to be, and then linking up that family physician to existing resources.

1650

We're just starting. We've been around for, again, a short period of time. We have heard what people around the province have told us about their needs. We have travelled to every corner of the province. We have heard the strengths of where things are going. There's a lot of optimism, but there's some pessimism about looking at restructuring things yet again without real change. We would really like to offer our services, our expertise and our experience in facilitating some real change. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. We've probably got time for one question each, starting with Christine or Sylvia.

Mrs. Christine Elliott: Just one, but I'd like to thank you very much for being here today. I suspect we will be

in touch with you with further questions and further issues.

I'm really interested because one of the things that we've heard from family members is that they've taken their children to family physicians, and they haven't really known what to do because they don't receive that kind of training, maybe, or they just don't feel equipped enough to handle it. So the HealthCheckPlus program is really interesting. It could fill a really important gap.

Could you just explain a little bit more about the kinds of things that it does? Does it assess whether the child needs to be referred on to a psychiatrist or psychologist? Does it give them some kind of an indication of whether there's a serious problem here or whether it's just, "You're a teenager; you're growing up" or whatever?

Dr. Ian Manion: That's an excellent question. It's based on a number of evidence-based screening questions. They start with very broad questions, depending on what the needs are from that physician and what they think they want to screen for. If you get enough hits, it gets more and more specific. So if it's just a general kind of angst and normal things, the questions are very superficial. No questions will end the interview. The more severe the problem, the more in-depth the questions become. It flags things for the physician, who then may request a more specialized assessment.

Right now, because the physicians are not trained on that, they may be asking questions about headaches and stomach aches and all kinds of things, looking for physical health concerns. We also know that those symptoms are often indicators of mental health concerns. So it assists a more comprehensive view of the physical and mental wellness of that patient presenting to that office.

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

M^{me} France Gélinas: Does the Provincial Centre of Excellence for Child and Youth Mental Health—

Dr. Ian Manion: It's a mouthful.

M^{me} France Gélinas: Yes. Does it have a position toward peer support?

Dr. Ian Manion: We have many positions on peer support. A lot of the youth engagement work that we do looks at youth-to-youth in terms of support. Our roots are in a program called Youth Net, which is a for-youth, by-youth program which started in Ottawa but now is across the country, and very much, how do you facilitate those conversations but with the safety net there? In other words, don't just leave people to their own devices. Make sure they are also linked up to the system that can support them when those situations become more challenging.

What we have done, as we have developed directories identifying researchers and programs in the province, is we have, on our website, put up a peer-to-peer support so that you can identify those programs in your community that offer peer-to-peer support. There's some research that needs to be done in peer support. There's an existing literature. It's not as clean as it could be. So that's one of our gap areas in terms of information.

We can see ourselves funding further research in specific areas around that. I think we've received a request looking at parent-to-parent support in Asperger's and autism, for example, and the effectiveness of that, based on more sound methodology.

I don't know if that answers your question or not.

M^{me} France Gélinas: Yes, it does.

My other one is, do you have a position on the law that prevents sharing of information with the parents once the child reaches a certain age? We've had a number of parents truly unhappy with where the balance lays, with catastrophic consequences on their child. Do you have a position on that?

Dr. Ian Manion: I won't speak for my colleague, but as I think you mentioned previously, it very much is a balancing point. We do a lot of work with young people. In certain circumstances, parents are their greatest ally, and not only do they want parents to have the information, but they encourage parents to be present. In other situations, parents may be contributing to some of the difficulties, in which case it might be counterproductive. We've had some situations, not in this program but in previous programs, where young people suffering from their first psychotic break or who are suicidal have had their parents refuse to allow them to get treatment, for the stigma that would cause them, the fact that it would ruin their career, even if this person was suffering quite significantly. So we're aware of the need to have balance.

We have conversations with parents and we have conversations with young people. That issue of where the consent lies actually has been an issue raised in our joint group, what's called our consumer and advocates network for the centre. We have parents and young people on the same committee, co-chaired by a young person and a parent, and they hash out these kinds of issues and make recommendations to us that we can then use to inform policy-makers.

Dr. Simon Davidson: What I would add to that, and I would strongly agree with what Ian has been saying, is that I chair the child and youth advisory committee for the Mental Health Commission of Canada, and we have parents and we have youth on that committee. In the very first meeting, this was exactly where the tension was, and when you put the parents and the youth together and they talk it out, they are much better able to find where the balance is. I think when we try to do this, we must include the people with lived experience and their parents. We shouldn't, as professionals, try to determine it on our own.

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

Mrs. Maria Van Bommel: I was looking through your presentation paper here, and there are a number of things that we've already encountered today—the Dare to Dream, when you said engage—that are being mentioned in here as well. But I also noted that it says here approximately 50% of all psychological disorders emerge before the age of 14. What is the youngest age at which you can diagnose a psychological disorder?

Dr. Simon Davidson: Well, there's a whole area of infant mental health. In my own experience, I was doing an assessment of a family where there was a 14-year-old who had pretty profound depression, and his parents were there. This was a program for school refusal, and this young man hadn't been to school for more than two years; he couldn't get there. I asked the mom, "How long do you think your son has been depressed?" She said, "Since before he was two." I said, "How did you know that?" And she said, "Tell me that it's not depression when on Christmas Day your son prefers to stay in bed rather than get up and open his Christmas gifts."

Mrs. Maria Van Bommel: Certainly, a child not getting up on Christmas Day is an indicator of something very serious, so what would a parent do at that stage?

Dr. Simon Davidson: Well, parents are in a real bind, and you're touching on a really passionate area of mine. Parents often are worried that they've caused it because their parenting wasn't good enough. Inevitably, that's not true; they've done the very best they could. But the stigma of worrying about that often precludes them from getting attention as early as possible.

The other point is that if we're looking at prevention, there is all kinds of international evidence about parenting that works well. Why do we not put together universal parenting programs for different aged kids, available in different modules, whatever the preferred learning style of the parent is, so that they could take these courses? I would suggest that they take a little test at the end of the course and get some kind of benefit, a tax benefit or something back from government, for taking it. That would allow them to know what normal development should look like and how best to parent their kids, and I think that would go a long way, from a prevention standpoint, to reducing the prevalence of mental health problems in our children and youth.

Mrs. Maria Van Bommel: Is there a parenting program anywhere right now that would—

Dr. Ian Manion: There are many.

Dr. Simon Davidson: Yes, there are parenting programs available all over the place, but I would suggest that for the most part, the people who need them the least get them the most. That's why you need to have some kind of carrot at the end of it to encourage people to take it.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. Your input certainly was appreciated. Thanks for taking the time.

Dr. Ian Manion: Safe travels.

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

Dr. Ian Manion: You're off to Thunder Bay?

The Chair (Mr. Kevin Daniel Flynn): We're off to Sudbury next, then eventually Thunder Bay.

Okay, that's our business for today. We're adjourned to Sudbury, and our bus leaves the hotel at 5:45 from the same place it dropped us off yesterday.

The committee adjourned at 1659.

Continued from back cover

Champlain Mental Health Network/Réseau des services de santé mentale du district de Champlain	MH-383
Ms. Renée Ouimet	
Ontario College Counsellors/Conseillers et conseillères des collèges d'arts appliqués et de technologie de l'Ontario	MH-385
Mr. Michel Lefebvre	
Fetal Alcohol Spectrum Disorder Coalition of Ottawa	MH-388
Ms. Diana Fox	
Ms. Elspeth Ross	
Ms. Catherine Dubois; Mr. Germain Dubois	MH-390
Dr. Marie-José Dealberto	MH-392
Provincial Centre of Excellence for Child and Youth Mental Health at Children's Hospital of Eastern Ontario/Centre d'excellence provincial au CHEO en santé mentale des enfants et des ados	MH-394
Dr. Ian Manion	
Dr. Simon Davidson	

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CONTENTS

Wednesday 9 September 2009

Success By 6 Ottawa.....	MH-337
Ms. Kelly Paolozzi	
Canadian Paediatric Society.....	MH-339
Ms. Marie Adèle Davis	
Dr. Anne Gillies	
Ms. Sue Clark-Wittenberg.....	MH-341
Dare to Dream program.....	MH-344
Ms. Anie Belanger	
Ms. Erin Smith	
Rideauwood Addiction and Family Services	MH-346
Mr. Paul Welsh	
Canadian Mental Health Association, Ottawa Branch	MH-349
Ms. Donna Pettey	
Mr. Danny Lang	
Ontario Association of Non-Profit Homes and Services for Seniors, region 7	MH-351
Ms. Noreen Langdon	
Ms. Josée Belke	
Alzheimer Society of Ottawa and Renfrew County	MH-354
Ms. Kelly Robinson	
Ms. C. J. McCaffrey.....	MH-356
The Men's Project.....	MH-358
Mr. Rick Goodwin	
Ms. Jane Russell	MH-360
United Way/Centraide Ottawa.....	MH-362
Mr. Dennis Jackson	
Ms. Peggy Austen	
Champlain Addiction Coordinating Body.....	MH-365
Ms. Deborah Hook	
Mr. Mike Beauchesne	
Ms. Lise Laframboise	
Ontario Public Service Employees Union	MH-368
Mr. Smokey Thomas	
Mr. David McDougall	
Canadian Mental Health Association, Champlain East Branch/ Association pour la santé mentale, Champlain Est	MH-371
M. Michael Lloyd	
M. Roger Villeneuve	
M ^{me} Sylvie Lemaire	
Psychiatric Survivors of Ottawa.....	MH-373
Ms. Sonja Cronkhite	
Mr. Tyrone Gamble	
Royal Ottawa Health Care Group.....	MH-375
Dr. Zul Merali	
Dr. Alison Freeland	
Minwaashin Lodge, Aboriginal Women's Support Centre	MH-378
Ms. Deborah Chansonneuve	
Ms. Joyce McNeely.....	MH-381

Continued on inside back cover