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**Wednesday 23 September 2009**

**Journal  
des débats  
(Hansard)**

**Mercredi 23 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 23 September 2009

Mercredi 23 septembre 2009

*The committee met at 1600 in committee room 1.*

**SUBCOMMITTEE REPORT**

**The Chair (Mr. Kevin Daniel Flynn):** We can call to order, ladies and gentlemen. Our 4 o'clock presenter is here. We're going to deal with the report of the subcommittee from September 10 first. Does that need to be read into the record? Would somebody like to read the report of the subcommittee into the record? You'll find it attached to your agenda.

**Mrs. Maria Van Bommel:** I will do that. Your subcommittee on committee business met on Thursday, September 10, 2009, to consider how to proceed with site visits to First Nations communities, and recommends the following:

(1) That the committee separate into two groups.

(2) That the first group—Mr. Leal, Ms. Gélinas, Mr. Balkissoon, Ms. Jaczek and Mrs. Elliott—visit Curve Lake First Nation and Alderville First Nation on Friday, October 9, 2009.

(3) That the second group—Mrs. Van Bommel, Mr. Flynn, Ms. Jones and Mrs. Sandals—visit Oneida Nations of the Thames and Six Nations of the Grand River on Wednesday, October 14, 2009.

(4) That the committee clerk and a research officer accompany both groups.

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

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Maria. Are there any comments? Jeff?

**Mr. Jeff Leal:** Yes, Mr. Chair. There's a change here. We've been working very closely with Ms. Gélinas to accommodate a very important event in her family's activities. So we are going to make our visit in the afternoon of Thursday, October 8, starting at 2 p.m. in the afternoon. We are going to, I think—because I know the logistics reasonably well—we can fit in three: Curve Lake First Nation, Hiawatha First Nation and Alderville First Nation. Mr. Balkissoon and I have arranged with the whip's office for us to be absent that afternoon. It was hard negotiations, but we were able to do it. So we can accommodate a couple of requests.

**The Chair (Mr. Kevin Daniel Flynn):** Very good. Great news. And I understand we'll be adding one to our tour, perhaps?

**Mr. Jeff Leal:** Yes. I just haven't—

**The Chair (Mr. Kevin Daniel Flynn):** Go ahead.

**Mr. Jeff Leal:** Sorry, Mr. Chair. We are working with the clerk and my office to make the appropriate logistical arrangements.

**The Chair (Mr. Kevin Daniel Flynn):** Super. Maria, we'll be adding a location to our tour, perhaps.

**Mrs. Maria Van Bommel:** There is a possibility of also adding another one, and possibly even a joint meeting at Six Nations with a neighbouring First Nations.

**The Chair (Mr. Kevin Daniel Flynn):** Okay. We'll make allowance for that, then. France?

**M<sup>me</sup> France Gélinas:** I have never felt so bad in a long time—everybody flipping over their House duty and everything. I cannot get out of House duty on the eighth. I cannot go on the eighth. I was able to talk to Christine yesterday, and she couldn't make it on the eighth either.

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

**M<sup>me</sup> France Gélinas:** Didn't it sound like a good idea at the time? So we're back to having to find a new date. We'll talk after the meeting today.

**The Chair (Mr. Kevin Daniel Flynn):** How we could leave it, perhaps, is that you still want to visit the three communities—is that right?

**M<sup>me</sup> France Gélinas:** Yes.

**The Chair (Mr. Kevin Daniel Flynn):** So why don't we leave it at "a date to be determined by the group"?

**M<sup>me</sup> France Gélinas:** Okay.

**The Chair (Mr. Kevin Daniel Flynn):** And then we don't have to meet again as a subcommittee.

**Mr. Jeff Leal:** Mr. Chairman, we can reconvene at some stage.

**The Chair (Mr. Kevin Daniel Flynn):** Yes. But just your group can get together and decide how you would want to do it.

With those changes: All those in favour of the subcommittee report? Those opposed? That is carried.

MENTAL HEALTH  
AND ADDICTIONS STRATEGY

FRANK O'HARA

**The Chair (Mr. Kevin Daniel Flynn):** As I said, we have a gentleman here who's from our 4 o'clock dele-

gation, and don't worry, I'll add all the time you need onto it.

We have before us the Family Council and the Secret Handshake. We've got Frank O'Hara with us. Frank, you've got 10 minutes to make your presentation. You can use that time any way you see fit. If you want to leave some time at the end for any sort of a discussion with the group, that would be great also, but entirely up to you. Welcome.

**Mr. Frank O'Hara:** Great. Thank you very much. I'm here not to talk particularly on behalf of those two organizations, although I am closely associated with them; I'm here to, you might say, plead my own case.

I guess cumulatively, with two sons having schizophrenia, I've got maybe 60 years or more of experience dealing with the system, and I could go on for a long time about that. But one of the serious problems that I recognize and I'm trying to do something about—I've put together a PowerPoint presentation that I propose to give to people in clubs like the Kiwanis Club or whatever—anyplace where someone will listen to me, because I think there's an important message to get out about the stigma associated with mental illness and what we might do about it.

*Interjection.*

**Mr. Frank O'Hara:** Unfortunately, we can't get there—you can't hear the audio unless you were very quiet, I guess.

Mental illness—the stigma associated with it and what we can do about it. The first thing is, how common is mental illness? I'm going to whip through these things very quickly because most of you are probably quite familiar with the statistics. One in five people everywhere, not just in Canada, have mental illness: schizophrenia, 1%; major depression, 8%; anxiety disorder, 12%; one in 10 Canadians over 15 years of age report symptoms of abuse from alcohol and other drugs; 43% of individuals with a substance abuse disorder also have diagnosable mental health problems; and 3.8% of adults in Ontario have moderate to severe gambling problems.

**1610**

You can't read this, and it's so small at the bottom I can't read it myself. I got those stats from CAMH.

We're having another little video here. Maybe you can hear the audio this time.

*Video presentation.*

**Mr. Frank O'Hara:** The cost to society: Every day, 500,000 Canadians miss work because of psychiatric problems. Mental illness is the number one cause of disability in Canada, accounting for 30% of disability claims and 70% of total costs. The Ontario economy loses \$34 billion a year.

*Interjection.*

**Mr. Frank O'Hara:** Thank you. Families suffer emotionally and financially.

*Interjection.*

**Mr. Frank O'Hara:** Oh, just a minute. I'll reshoot that.

Are we spending enough? Approximately 1.6 million Canadians have an undiagnosed mental illness. Only 5% of the total health budget goes to mental health, less than most comparable countries. Ontario's per capita investments in community health are much lower than in BC and Quebec and well below the national average. I think of myself, as an Ontarian, being number one. I think it's disgraceful. Only Saskatchewan and Newfoundland and Labrador spend less per capita than Ontario.

Only 40% of assertive community treatment teams in Ontario have the required psychiatrist.

The streets of Toronto—let's look at this. Seaton House: Maybe some of you are familiar with it. I'm more familiar with it than I'd like to say. There are 434 beds, but all the people in that place and in similar places in the city have to be out on the streets during the day. They are not allowed to stay there. There's no place for them to go. We wonder why there are so many people wandering around the streets. It's because 83% of the homeless in Toronto are mentally ill.

*Video presentation.*

**Mr. Frank O'Hara:** I guess we had Santa Claus out there for a little while, did we?

Support: The Centre for Addiction and Mental Health—everyone's aware of that, I'm sure, a very major organization in the province.

There are a couple of the organizations with whom I've worked. I produced a website. I happen to know something about websites, so I donated my time and my computer to doing a website for these two organizations. This is the one for the family council, and there's the story about it—at least that's the first page, what's going on. For anyone who wants to find out what's going on with this organization, the family council, there's all the information that's available. The schizophrenia peer support group: I won't take the time to show their website, but I've also produced a website for them. Other organizations for whom I have not done their website, a couple of them are below. But there are lots of organizations associated with mental illness.

Some people will say, "Well, you know, there aren't all that many people with"—Or if they don't think about it, they think there aren't that many people who have mental illness, or if they have, "Why should we be so concerned?" Well, here's a list of some people, just a drop in the bucket of the number of people who have contributed significantly to world economy and culture, who all had some form of mental illness. The list could go on and on.

So, what can we do? Well, every time we run into the stigma, let's do something personally, individually, about it. We don't stand for somebody making negative remarks about coloured people and various people, things that used to go on in our society. We still accept the stigma of mental illness. Support adequate housing—that's really important; support mental health charities; volunteer.

By the way, on the subject of volunteering, last spring I phoned up CAMH to volunteer. I have a criticism of

their website. It wasn't obvious how I could—it would seem to me that one of the first things on the website should be, "Here's how you can volunteer. Click here." On the websites that I've developed, I'm making that a priority.

The last word—this doesn't have any audio. The website that's mentioned at the bottom there and this particular video were developed by young people in London, Ontario. There you see their ages and their names. I think they've done a fine job.

*Video presentation.*

**Mr. Frank O'Hara:** And one final little jolt: It's not the person; it's the illness.

**The Chair (Mr. Kevin Daniel Flynn):** Frank, that was excellent time management. You left four seconds. I thought you were going to hit it right on the head there for a minute. With all of the moving around you were doing, I was quite surprised you could get it all in ten minutes. Thank you very much for your presentation—very well received.

**Mr. Frank O'Hara:** Does anyone have any questions?

**The Chair (Mr. Kevin Daniel Flynn):** Unfortunately, we don't have any time for questions, but I think you got your point across. I know the committee pretty well now, and I think you were very clear in your presentation.

Our next presenter today, then, is from the Mental Health Legal Committee. We've got Marshall Swadron, who is the chair of the committee. If you'd like to make yourself comfortable, Marshall, there's some water and, I would think, some clean glasses over there if you need any.

**Mr. Marshall Swadron:** As long as there are no meds in the water, I'm fine.

*Interjection.*

**The Chair (Mr. Kevin Daniel Flynn):** Oh, I'm sorry. Frank, I cheated you. I'm sorry, Barry, could you just step aside for a minute? Frank, I'm sorry; I cheated you out of some time. I want to apologize, and I want to give it back to you.

**Mr. Frank O'Hara:** I realized that, but I'm too nice to say anything.

**The Chair (Mr. Kevin Daniel Flynn):** You and I would get along. I would do the same thing.

Let's start with Christine and Sylvia. Let's have maybe one question each.

**Mrs. Christine Elliott:** Thank you very much, Mr. O'Hara, for being here today and raising the issues that you have.

If you don't mind, if we could ask you a few questions about your experience, because as a parent you have a lot to share with us. We've heard from some parents that they experience frustration in not having any kind of input, not being listened to, necessarily, by some of the mental health professionals and not being able to seek the help they need for their children when they can see that they need some treatment and there's nothing they can do to assist with that. Could you please comment on that?

1620

**Mr. Frank O'Hara:** I have experienced every kind of thing, from wonderful attention to none. Let me just pick one on the negative side.

I had a son who was in the hospital in Whitby. As you know, there are all degrees of schizophrenia. His was quite serious. He'd been there for some time, and they asked him one day if he'd like to leave. He said, "Sure, I'd like to leave." They gave him \$100 and a ticket on the GO train to come to Toronto, which he did. They never informed me. They just sent him to Toronto. I found out when I went out to visit him a week or so later.

So after about six months, some good Samaritan picked him up on the street and drove him down to 999 Queen. This was a number of years ago. At first he gave another name, but finally he gave his proper name and then somebody contacted me. I took him back to the hospital in Whitby and they said, "He's been discharged. We can't take him back here." I said, "I don't give a damn whether he's been discharged or not. You're taking him back."

If he hadn't had somebody like me to plead his case then and various other times, he would have been in deep doo-doo, believe me. He would have been walking the streets, as he did for six months and damn near starved to death.

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

**M<sup>me</sup> France Gélinas:** It was interesting. You have such a breadth of knowledge and hands-on experience with severe mental illness, but yet you chose to talk to us about fighting stigma, which I applaud you for. I think it takes courage. You basically put out a four-point plan, simple but effective. Have you seen it work anywhere else? If we follow those four points, will it make a difference? Will it work?

**Mr. Frank O'Hara:** No, I'm carving a new road here. I haven't shown this presentation to anybody else. I've just developed it recently. I hope to get some results, but I don't know of anybody else who's done something similar. There's the odd video that you can get on YouTube—I downloaded these videos. But in terms of somebody launching a crusade, I don't know of anybody.

**M<sup>me</sup> France Gélinas:** But you picked those four points, I guess, because you feel that if we try this, it may work.

**Mr. Frank O'Hara:** I'm open to any more that you might suggest. I'm wide open. Those are the only ones that I thought of. They're not scientific. After careful thought I figured: What can you do about this thing? Not a lot. As an individual, I'm doing my part, I think, to just make people aware.

**M<sup>me</sup> France Gélinas:** Thank you.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Frank. Unfortunately, our time is officially up now. So thank you very much for coming, and thanks for your patience.

## MENTAL HEALTH LEGAL COMMITTEE

**The Chair (Mr. Kevin Daniel Flynn):** We'll move on now to Marshall. You're all settled in. You, like Frank, have 15 minutes, and you can use that any way you like. If you leave some time at the end, maybe we can get into some questions and answers.

**Mr. Marshall Swadron:** Thank you. I appreciate it very much. My name is Marshall Swadron. Suzan Fraser is also present here, but I'll be speaking on behalf of the Mental Health Legal Committee. I'm a lawyer with a six-lawyer firm in Toronto. I've been practising for just over 20 years, and much of my practice is in the area of mental health law.

The Mental Health Legal Committee is a group of lawyers and community legal workers practising in the area of mental health law. It was established in 1997. The committee has advocated for the rights of consumers of mental health services in many forms. Our approximately 60 lawyer members appear in all of the mental health-related tribunals, and the two main tribunals are the Consent and Capacity Board, which is a provincial body that deals with issues relating to involuntary committal, capacity with respect to treatment, capacity to manage one's finances and other issues, including community treatment orders—another body before which we appear regularly is the Ontario Review Board. This board is established under the Criminal Code and deals with issues of detention and reintegration into the community of persons who are found either unfit to stand trial or not criminally responsible in respect of offences under the Criminal Code for reason of mental disorder.

The Mental Health Legal Committee has intervened in five significant Supreme Court of Canada cases, as well as in others. Next month, the case of Paul Conway will be heard by the Supreme Court of Canada, and the Mental Health Legal Committee will be intervening. That case, in particular, relates to whether the board that deals with—the Ontario Review Board, but these boards are of course across the country, because they are under the jurisdiction of the Criminal Code—can give remedies under the Canadian Charter of Rights and Freedoms.

The committee has made submissions in respect of a number of legislative initiatives, including Bill 68, which was the amendment of the Mental Health Act in 2000, which put into place community treatment orders and also expanded the involuntary commitment criteria under the Mental Health Act; also, legislation in Bill 135 that was the amendment with respect to the use of restraints in public hospitals.

The Mental Health Legal Committee has been involved in inquests into the deaths of patients in psychiatric hospitals. This year, we also made submissions with respect to amendments to the Coroners Act, which ultimately were enacted, that require inquests into the deaths of persons who die while in restraint in psychiatric detention.

We receive no funding, and we operate on the basis of the volunteer contribution of services by members of our

committee. I want to tell you this specifically and categorically because not all those who come before you will be able to do so: that we receive absolutely no funding from the pharmaceutical industry—my effort at humour. I submit that it is important, and the influence of the pharmaceutical industry on mental health policy is one that we must be very mindful of. I hope, toward the end of this discussion, in the time that I have, while leaving some time for questions, to be able to speak to that issue in the context of screening, early detection and early treatment.

What I'd like to dedicate most of this talk to is the issue of coercion as an element of mental health treatment. By coercion, I mean the use of violence, either actual or threatened, as a means of delivery of psychiatric services.

I'd like to give credit at this point to Professor David Cohen, formerly of the University of Montreal, who now teaches at the social work department at the College of Health and Urban Affairs at Florida International University in Miami. Dr. Cohen has agreed to assist in a challenge with respect to the overbreadth of the community treatment order provisions and the expanded criteria for involuntary commitment that came into effect in 2000 with Bill 68. The other name for that bill, in case you also hear reference to this name, is Brian's Law.

### 1630

We begin from the principle of individual autonomy: A person who is capable of making their own treatment decisions ought to have complete autonomy in respect of those decisions. If we are going to carve exceptions in respect of the principle of basic autonomy, it's going to have to be on the basis of well-thought-out and principled grounds.

In other areas of medicine, the examples that I can give would be the right to refuse blood transfusions, for example, on religious grounds, or the right to refuse cancer treatment which may or may not prolong one's life. We do not question the ability of people to make these decisions when they are dealing with their own lives. In the area of psychiatric care, however, in the name of society's obligation, as it were, to care for vulnerable and helpless citizens, which is sometimes called *parens patriae*, we have an exception.

If I were to suggest one huge source of stigma, it is the differentiation in our treatment of decision-making in the context of psychiatric care as opposed to any other kind of medical care. Such differentiation might be justifiable if the treatments that are involved were benign or objectively and universally beneficial to the people who were to receive them. But the treatments and the range of what is available to psychiatry in particular is anything but benign or universally beneficial.

I had an opportunity to look at a memorandum that was prepared—it's dated yesterday and provided by researchers—respecting the question of mental health law and involuntary hospitalization generally, and the ability, as someone had suggested, to sit on their right to refuse treatment, even to the point where they may turn

up dead. Firstly, such inflammatory language is extraordinarily—making decisions on such emotional grounds is something that we have to guard against. But I'd like to deal with the medications that are the traditional first line of treatment for schizophrenia and for any type of psychosis. These are medications called neuroleptics or antipsychotic medication.

In 1991, the Court of Appeal, in a case called *Fleming v. Reid*, described the side effects of these medications. It indicated that, "The use of neuroleptics in the treatment of various psychoses is generally effective in improving the mental condition of the patient by alleviating the symptoms of mental disorder. It is clear, however, that they may not be helpful in every case. Moreover, the efficacy of the drugs is complicated by a number of serious side effects which are associated with their use."

I'm just going to summarize some of the side effects that the Court of Appeal identified, and this was after extensive research was given to them. First is a condition called dystonia. This involves muscle spasms in the face and arms, irregular flexing, writhing or grimacing, and protrusion of the tongue. Another is acathisia, which involves restlessness, an inability to stay still. Then, Parkinsonisms: a mask-like facial expression, drooling, muscle stiffness, tremors, and shuffling gait. The whole panoply of side effects is described, all the way through to the occasional sudden death attributable to the antipsychotic medications. There's a description in the case of the condition of tardive dyskinesia, the uncontrolled flailing of limbs, as a result of long-term use of antipsychotic medication.

In the 1990s, the pharmaceutical industry developed what is a new generation of antipsychotic medications, and you may have heard of atypical antipsychotic medications. But I'm going to tell you a little bit about the research, and this is material that Professor Cohen has assisted me in putting together. It is essentially that any lessening of the side effects or improvement insofar as these different conditions that I described as associated with the traditional antipsychotics was simply a result of a reduction of doses. There was no increased efficacy or greater likelihood of success associated with the medications.

And this is what is most distressing: In the case of Zyprexa, a medication that as of 2006 was generating \$4 billion annually in sales for its manufacturer—and this is from a well-sourced article in the *New York Times* from 2006—there were extensive efforts to downplay the unique metabolic side effects that were resulting from administration of these medications, in particular the side effect of significant weight gain: in 30% of patients, more than 10 kilograms, or 22 pounds, and many patients in the first year of use had as much as 100 pounds of weight gain. The result—and this is what the manufacturer took great pains to downplay—was an explosion, amongst the population of people with schizophrenia, of diabetes, high-blood-sugar diabetes, something that, on a scale of debilitating illnesses, one would have to say is a very high-ranking concern. It reached the point where

there was litigation, of course, over these medications. I want to make a disclaimer here: I'm involved in none of that litigation.

The point that I'm making, though, is that we have to look at the different choices that we might propose to make for people who can't make their own decisions in a very different light than simply saying, "This person can't make their own decision, and therefore we should make the decision that they should take this medication." Because the side effects and the negative aspects of the medication—in some cases the intended effects of over-sedation—are simply too much for many reasonably-minded people to accept.

**The Chair (Mr. Kevin Daniel Flynn):** Mr. Swadron, you have a minute left.

**Mr. Marshall Swadron:** Well, I'd just like to talk about the impact, then, of coercion generally and how it works.

Many people are seen to take psychiatric medication voluntarily, and indeed many do. But when there is always the spectre either of detention or, in some cases, the use of direct violence, somebody being held down and injected with medication when they refuse to take it voluntarily and someone has made the decision for them to take it—this is a spectre that any person admitted to a psychiatric hospital, even voluntarily, will witness, not to themselves necessarily, but they will know that this is the end that will meet them if they do not take matters into their own hands and, in some cases, accept medications that they would rather not take—we have to be very careful and concerned about that.

I'd say that community treatment orders, in many respects, are just that: You do not get out of hospital unless you agree to take these medications. Resources are overwhelmingly allocated to people only if they're on community treatment orders.

People need three things, and I'll finish with this: People need a home, people need a job, and people need a friend. You can't tie these things to insistence that people take medications that aren't as effective in helping people with mental illness as any of these three things that I've just mentioned.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Marshall. We really appreciate the presentation. I suspect you've got some more to say. If there's a written submission you'd like to make to the committee, if there's anything you'd like to expand upon that you weren't able to today, please put it in writing and we'll make sure it gets out to every member.

**Mr. Marshall Swadron:** I'd be grateful. Thank you.

1640

BARRY HUDSON

**The Chair (Mr. Kevin Daniel Flynn):** Our next speaker this afternoon is Barry Hudson. Is Barry here?

**Mr. Barry Hudson:** Yes, I am. I've just made a PowerPoint presentation to follow what I'm going to discuss.

**The Chair (Mr. Kevin Daniel Flynn):** No problem. Like everybody else, you get 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll see if we can split it amongst everyone who's here for any questions and answers.

**Mr. Barry Hudson:** Thank you very much. As introduced, my name is Barry Hudson. I'm talking on behalf of my son, pictured here, Barry Hudson II. I'm talking about autism. I've seen it in the periphery of the Hansard record, the transcripts for these hearings, but I've never seen anyone talk directly about it, so I figured it's my turn to talk. I want to talk about the reality of autism in Ontario that my son faces, as well as many other children, preschool-aged children, as a matter of fact. What I want to discuss is Autism Ontario, so we're on the same page educationally; the reality of wait times; the benchmarks that, as a completely biased individual, I will admit I see as administrative, not clinical; adult issues, the non-existent, the invisible; and concluding what I'm talking about.

The first issue: I'm sure you've heard about the DSM-IV as a diagnostic and statistical manual for diagnosing mental impairments, mental disabilities and mental diseases. It defines autism as a qualitative impairment of communication—a person may not be able to speak, may not be able to sign, may not be able to use pictures to display what they want to talk about, or get their needs met; qualitative impairments in social interaction—they can't join in social activities, there's no joint attention, eye contact, not part of the group, and isolation behaviour; and also restricted, repetitive stereotyped behaviours referred to as self-stimulatory. The stereotyped ones you hear about are hand-flapping, but they could be spinning wheels on a toy or spinning in circles in a room, and that can go on for hours.

From Autism Ontario: They say there are 70,000 people in Ontario with autism, children to adults, based on 2004 estimates.

The real issue is a growing prevalence and our lack of meeting that prevalence. The source for this information is the Centers for Disease Control in Atlanta, United States, and the UK health authority in England: In the 1960s it was one in 2,500; in the 1970s it was one in 450; in the 1980s it was one in 266; in the 1990s it was one in 200; in the 2000s it was one in 150, which is the typical number today. But UK health reports just recently—the CDC doesn't want to adopt the number yet, although they are looking at it quite closely in their own studies to be renewed this year—that one in 100 individuals will be born with an autistic disorder in the UK—confirmed, validated, and that's the number they use in their official literature today. I have a preference for the UK number because it's based on one national collection system, one national entity, one national body. It's probably more reliable than one in 150, because the one in 150 is based on survey and statistical results of six monitoring sites, as they call them, in the US. So that's an observed fact in the UK today: one in 100.

Why is it growing? There are many reasons. There have been many arguments about why: an expansion in

criteria, an expansion in diagnosis. That question is important to be answered, but if you're facing it—that's truly not a relevant question that I care about today for my son. I just know it is what it is, dealing with it daily.

The reality we have in Ontario, as I'm quite sure we're all aware—you've just got to pick up a newspaper now and again; and I just mean it's in the popular press, and I'm not surprised. The reality of wait times: According to the Queen's Park bureau reporter on August 18, 2009, we have 1,513 preschool children waiting for therapy.

The number may have come down a bit recently because the practice of the regions is to cull the herd, so to speak, in June. There has probably been some ebb and flow in that number, but it probably was not materially affected. If it has gone down 10% or 15%, I'd be surprised.

What is the reality? Children wait two to three years—plus to access clinical therapy. We know as a fact, through five decades of research, confirmed by 47 countries, 84 universities and 320 practitioners, that early intervention is critical. Not to point the finger at the government; it's just that the government's the current sitting person that has to deal with it. But even our sitting government agrees that early intervention is critical. I was on a television show last year, W5, and the minister, the Honourable Deborah Matthews, was on the same show, and she said exactly that, so we're not making things up.

What does it mean for a person with autism, a small child? In very simple terms—and I'll probably be vilified for simplifying it, but it's just to get the point across: If you're one year delayed in your skills and abilities at the age of two and you have to wait three years, assuming everything else is fine and dandy, by the time you get therapy, you're four years behind the curve. Our own personal wait time, in my family, was 34 months. Our funding starts October 1 of this year. It has taken 34 months to get there. That's a long time.

To impart our case again, just so you understand it, we've re-mortgaged our house. My wife quit her job to be our son's lead therapist and director of the program. We have depleted 100% of our savings and retirement funds. I even had the superintendent of financial institutions for Ontario unlock my locked-in pension funds so I could get the money to spend on my son's therapy. I do have to say that they turned it around quite quickly; I appreciate that. We lost almost everything. If our funding did not occur this October, our house would be going for sale. I actually signed the paperwork two weeks ago to sell our house.

I am not complaining about that—I want to be crystal clear. There's nothing I would not sacrifice for my son; absolutely nothing I would not give up for him. But what about the single parent making minimum wage? What can they sacrifice? What can their child face? What will their child see? What will happen to their child? These are rhetorical questions, obviously. But the reality is that the most unable to help their children are the ones who languish, and again, we—our society, collectively—are

doing this to preschool-aged children. That's the important thing to understand.

The reality of the wait times is poor fiscal management. We all have to take care of money competently, obviously. I did my own math. It is better than what U of T has come up with, but I'll take their numbers—you could throw a rock and hit the professor's window from here, I think. The University of Toronto in 2006 wrote a study in a department of health policy paper entitled the Cost-Effectiveness of Expanding Intensive Behaviour Intervention to All Autistic Children in Ontario—it's a long title.

At that time, the population they were looking at was 1,309. By expanding the therapy to all children for three years, the savings, based on ministry numbers—freedom-of-information act numbers; I didn't make up any of these figures—are \$45,133,011. That's assuming a 25% best outcome. What does "best outcome" mean? The research in the field calls "best outcome" a child who can integrate with his peers and not be noticeable as an afflicted individual. There is no cure, but I think the street term is "recovered." That individual can function, they can communicate as well as I can, they can hold a job, they can live independently. Twenty-five per cent is the figure they used, whereas the research supports 35% to 47%, so it's a very conservative estimate, and fair enough. That's what we should do: be conservative.

**1650**

I extrapolated that to the wait list today. It makes the savings over \$93 million, and these savings are solely on living supports. It doesn't bring into account any SSAH funding, any of the drug funding, any of the occupational supports funding. It's solely based on housing individuals with autism, based on the ministry numbers at that time. Indeed, the Canadian Senate, in 2000, confirmed the fiscal costs and the human costs.

The next issue I want to talk about is the benchmark criteria for how we continue help with our children. There are new benchmarks in a proposed state, and they've become the effective criteria today. When we went to our regional provider to sign our contract for funding yesterday, they gave us a copy of the criteria. It was the proposed benchmarks in a different font. I can quote them by word. I know them quite well. And even though they shouldn't be imposed, they are. Again, I have to live with it. I can't change it.

The only people I can find supporting these benchmarks are the panel itself and government employees. Not to be rude, but I spoke to 27 psychologists in four countries and I can't get any of them to agree to these being criteria to use in the treatment of individuals with autistic disorder.

What happens is, the required trajectory of that criteria only suits those that will be the best outcome, whether it be natural consequence, luck or whatever. It's a self-fulfilling prophecy: You delay therapy until the individual can't partake in therapy, and you say, "Oh, they can't partake in therapy. Cut them off." It's beyond deplorable.

Our son had challenges when we first started at home—nothing in terms of aggression, but he simply

would not comply; he would not attend. Compliance is not about stopping tantrums or making them quiet; it's about being able to partake in an educational activity to learn a skill. That's what compliance means in the world of autism. If our son had gone into the program under the current criteria, he would have been kicked out in six months, guaranteed. So we never would have seen what we've seen today.

Today, when's a verbal child. He had absolutely no words when he was diagnosed. He could not attend to any of his own needs. He couldn't express any of his desires. He couldn't indicate where he was hurt. And his self-stimulatory behaviour took over most of his day. It was a pretty rough time. If we had given up, we wouldn't see what we see today.

I have a little video of my son singing last night. It's one of his favourite songs.

*Video presentation.*

**The Chair (Mr. Kevin Daniel Flynn):** He's got a showbiz career ahead of him, I think.

**Mr. Barry Hudson:** The noise in the background, his brother, is just a typical two-year-old suffering from being a typical two-year-old.

**The Chair (Mr. Kevin Daniel Flynn):** Your time is up, but if you'd like to summarize, I'll give you a minute there.

**Mr. Barry Hudson:** I do appreciate that.

The summary, the bottom line that we're looking at, is that we're preventing the best outcome in what we do. It's poor fiscal management. If we look at the long term rather than the short term, we'll spend our money more effectively.

It's a human rights failure noted by the United Nations in 2006. The human rights committee of the United Nations, in commenting on Auton, said it's the most shocking thing they've seen, the BC lawsuit from parents against the BC government for autism therapy. They cut through the diplomatic language. They basically said, "Your charter means nothing now. If you don't enforce the fundamental rights, it's just a piece of paper," and I actually kind of agree with that. We must meet the standards of science today, and sufficient and appropriate funds are a requirement, not really a choice.

That's all I have today.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you very much for coming, Barry. We really appreciate it, and thanks for the performance by your son there.

#### COALITION AGAINST PSYCHIATRIC ASSAULT

**The Chair (Mr. Kevin Daniel Flynn):** Our next presenter today is the Coalition Against Psychiatric Assault, Don Weitz, if you'd like to come forward. The presentation from Don is part of the members' package. You'll find it under your agenda. It begins with electroshock.

Don, like everybody else, you have 15 minutes. You can use that any way you see fit, and if you'd like to

leave some time at the end for questions, that would work out. If not, it's entirely up to you.

**Mr. Don Weitz:** Thank you very much. I thank the committee for allowing me to speak here today on an extremely serious issue which some of you may know about, namely electroshock, but the psychiatrists call it electroconvulsive therapy, or ECT for short. I hope by the end of my submission you will at least start to seriously question whether it's therapeutic as such and deserves the name "therapy."

I'm an anti-psychiatry activist. I've been critical for many, many years, over 30 years, of the system—in a constructive way, I'd like to say—here in Ontario and Canada.

Now, I'll get to the point very fast about electroshock. I just want to let you know that I think it's a serious mistake for you to get any kind of understanding of electroshock from watching the film *One Flew Over the Cuckoo's Nest*. Many people will probably have that shock scene fixed in their head. Basically, the only thing that is different from what you saw in *One Flew Over the Cuckoo's Nest* and the way they give it here in Ontario and other places is that the person doesn't shake as much. That's because the muscle relaxant is a muscle paralyzer, so that the diaphragm is totally paralyzed. I will get into the procedure, very much so, but my basic thesis, my basic point, I'll say flat out, is that we are here to urge this committee to recommend a total ban or at least a moratorium on electroshock in Ontario.

This is not the first time that many of us have spoken out to urge a ban. As you can read, CAPA is a group I've been associated with for about six years that does strategic political action around both electroshock and psychiatric drugs.

**1700**

Now let me go through, in the time I have, the procedure itself, which you'll probably not read about too much in the media or you probably won't even know about if you've seen a film. The first thing that happens is that the person—although I never had electroshock, a lot of my close friends have and I've read extensively in the literature—is given a tranquilizer the night before and not allowed to eat or drink anything for about eight to 10 hours. Then you're given a sedative and a tranquilizer so that you're asleep or unconscious during the treatment. Then you're given a muscle paralyzer which paralyzes all the muscles in the body so you can't move. It's called succinylcholine; that's the medical name. It's a derivative of the Indian root curare. Then the shock machine is turned on while you're lying, usually flat on your back. Oh, sorry: The electrodes are usually placed on one side or both sides. If they're on one side, it's called unilateral; if the electrodes are on both sides, it's called bilateral. They're usually placed over the temporal lobe, the seat of memory. That's why memory loss following shock always occurs and is devastating.

The current is probably twice the amount that comes out of your electrical outlet in this room. We're talking in the range of 200 volts, currently. It used to be lower, but

since the medication that's given to you before the current is turned on raises the seizure threshold of the brain, more electricity is required to produce the desired seizure, which is dishonestly, fraudulently called therapeutic. There's no seizure in medicine except in psychiatry that's called therapeutic. Only psychiatrists call it therapeutic. The neurologists do whatever they can to prevent you from having a seizure; not the psychiatrists. This is a deliberate induction of electricity to cause a seizure. It lasts about 60 seconds, then you go into a coma for 10 to 20 minutes, and you wake up in a recovery room, usually with a splitting headache that can last a day or longer; if you're lucky, it's a few hours. You may vomit, throw up a bit, be dizzy. You're confused, you may not know where you are—you're disoriented, is the medical term.

That, in short, is the ECT procedure, which is paid for by taxpayers' money in Ontario to the tune of \$1 million to \$2 million a year. That's a ballpark figure. I can't get accurate statistics on the OHIP amount of money, on the health tax dollars that are spent to produce a seizure in Ontario's citizens, but I have seen that it's at least \$1 million, and I would expect it's close to \$2 million.

The major effects of electroshock are memory loss and brain damage. The permanent memory loss can extend many, many years back—that's called retrograde amnesia; or it can extend forward—that is, after you've learned material, then you can't remember it. That's called anterograde. Retrograde amnesia is very common, so people sometimes are missing not just a few months but a few years of memories. I won't go into all of the details. There is survivor testimony in the paper that you have which I feel is just a very small sample of the growing and voluminous personal testimony of shock survivors in Canada and the United States. It's not pleasant to read, but it's honest and it's accurate. People generally don't lie about the effects of electroshock that they've had. Permanent memory loss, which the psychiatric profession had denied or minimized, including the Canadian Psychiatric Association, is extremely serious. How are you going to study or go to school and pass the exams when you can't remember the material—which Sue Clark, a survivor in Ottawa, has testified about? There's also the effect of psychological trauma. I've met a number of people who still show the effects of trauma.

You may wonder: Is this a minor treatment? Is this just a few people we're talking about, so we don't have to think about it? Well, I'd say one person to get shock is one too many. I have statistics from the Ministry of Health and Long-Term Care, as of 2004—and they're in your brief—that show we're talking about 1,400 or 1,500 people, sometimes every year, who get electroshock.

Most of the shock given nowadays is given as an outpatient procedure, I suspect, but I don't have accurate statistics because the Ministry of Health hasn't consolidated or doesn't have a competent method of collecting ECT statistics in Ontario.

By the way, no hospital is required to report ECT to the Ministry of Health. I got that from the horse's mouth,

so to speak. That's curious as well as disturbing, because when you give a medical treatment, you're supposed to report it, I thought, to OHIP. Of course, in order to get paid, you have to submit it, but when it comes to ECT, the doctors don't have to report complications; they don't have to report the number of ECT treatments or the major effects. I think that's scandalous, to say the least. It's also not very professional. How are you going to get a fix on a so-called treatment if you can't depend on hospitals to be honest? Listen, this comes from the Ministry of Health—and you can check it, and I hope you will: There is no regulation from the Ministry of Health that requires hospitals to report ECT. I'd love to see it.

By the way, the consent forms vary from hospital to hospital. Also, the ECT patient consent forms conspicuously avoid brain damage and memory loss, which has been documented for over 50 years. They're not just side effects; they're direct effects. This is knowledge that the psychiatric establishment has known, but they go to great pains to deny it or sanitize it in their position papers.

The best study of brain damage and memory loss, particularly affecting women and the elderly, as you can see in my paper, the main target groups—particularly elderly women over 60—is the Sackheim study, which I urge you to read. It's the best, and I'm not just saying it. Other people who study this say it is the best study, the largest study, we have to date on the effects of ECT. What did Dr. Sackheim, and four associates, find? He found massive, permanent memory loss, brain damage, particularly severe in women and the elderly. I'll repeat: particularly severe in women, including women with postpartum depression, but particularly elderly women.

1710

I myself have written a paper called *Electroshocking Elderly People: Another Psychiatric Abuse*. I am now calling it *elder abuse*. This is elder abuse sanctioned by psychiatry and the state, and that's not an exaggeration.

We have tried to interest the Ontario government several times, whether we're peacefully demonstrating at Queen's Park, as we did, some of you may know, on Mother's Day this year and Mother's Day two years ago. We did invite Health Minister Caplan, who replied by not replying, who replied by not bothering to even ask one of his bureaucrats or somebody in his department to show up to even find out what's going on and whether these people have something to say. That was a serious insult to citizens.

**The Chair (Mr. Kevin Daniel Flynn):** Don, you have about half a minute left.

**Mr. Don Weitz:** I will close by reiterating our basic request. This procedure, called electroshock, that always produces memory loss and brain damage has no legitimate therapeutic value. It must be banned. There have been other procedures in the history of medicine and psychiatry that have been banned with less evidence. It is time for the government of Ontario, and I hope this committee, to take seriously what I am saying, not just for myself but for many, many other people who have been victimized, traumatized and stigmatized totally unnecess-

arily by a procedure which is not scientific and which always causes harm. So I would hope, and I'm open to any questions—

**The Chair (Mr. Kevin Daniel Flynn):** Unfortunately we're out of time for questions, but you've been very clear in your presentation.

**Mr. Don Weitz:** Am I the last speaker?

**The Chair (Mr. Kevin Daniel Flynn):** No, you're not the last speaker. There are many others after you. I did want to thank you for coming today. We understood your presentation very clearly. I know the committee will take it into consideration.

**Mr. Don Weitz:** I should just add one quick thing; that this is—

**The Chair (Mr. Kevin Daniel Flynn):** I wish I could allow you to, but there are people who are waiting.

**Mr. Don Weitz:** It will take five seconds.

**The Chair (Mr. Kevin Daniel Flynn):** Okay, five seconds.

**Mr. Don Weitz:** This is a global human rights issue and it isn't restricted to Ontario or Canada. There are people as we speak, both professionals and survivors of electroshock, who are speaking out and want it banned. I wouldn't be surprised if there is a member's bill introduced in the Legislature soon calling for the ban of electroshock in Ontario. Thank you very much.

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

PETER ANDRUSKI

**The Chair (Mr. Kevin Daniel Flynn):** Our next speaker today is Peter Andruski. Is Peter in the audience? If you'd like to come forward, there should be some clean glasses there and some water. You can sit at any one of the microphones where you're most comfortable. Like Don before you, you have 15 minutes. You can use that any way you like. If you'd like to leave some time at the end for questions, that's entirely up to you.

**Mr. Peter Andruski:** First of all, I'd like to thank you for the opportunity to speak to you today. I don't have any handouts for you, nothing for you to take away, other than what I'm going to tell you, and any questions you might have at the end I'll do my very best to answer as candidly as possible.

My name is Peter Andruski. I am the stepfather of a 25-year-old man who is recovering from the effects and the stigma of schizophrenia.

Over the last eight years, my wife and I have experienced the difficulties of obtaining help for our son, having had to resort to the justice system to access initial support. It's unfortunate that our health care system is structured in such a manner that an individual in need of help due to a medical condition must often reach a point where police involvement is required for them to receive the services and support they require.

Over the years we've struggled to access services for our son and ourselves, to help understand schizophrenia and cope with the changes that it has brought to our lives.

We've experienced a disjointed system, where there are pockets of good work being done, but unfortunately the lack of service integration limits its effectiveness.

Now that our son is doing well, I volunteer my time in support of individuals and families managing mental health concerns. I facilitate family education groups focused on recovery, participate as a regular speaker for family education groups and have delivered a number of public presentations encouraging people to see that mental health recovery is more than a possibility; it's a reality.

Over the last two years I've been a member of the core group of the Mississauga Halton LHIN detailed planning and action team for mental health and addictions, and their community engagement task team, as well as having been a member of the core group of their system integration group for mental health and addictions and the associated education and training task team. As a member of these teams, I've been able to provide the perspective of a family member as the LHIN's integrated service delivery model was developed and the process of implementation initiated. I've since resigned from my role with the LHIN to pursue focused educational opportunities directed at providing family members with the skills they need to help an individual manage a mental health concern, as well as the skills they need to sustain themselves while providing support to their loved one.

In speaking to you today, my perspective is solely that of a family member and a father. Please also understand that although I refer to mental health concerns, I am in no way intending to minimize the importance of addressing addiction issues as well. I consider them to be equally important, but my experience is with services providing support for mental health concerns rather than addictions. So today I'd like to offer you my thoughts on how I believe some areas of the system could be changed to improve the potential for positive outcomes of those individuals managing mental health concerns, and their families.

I had the privilege to attend Open Minds, Healthy Minds and have reviewed the Every Door Is the Right Door discussion paper. The desired outcome as set out in the paper of having an integrated mental health and addictions system, with the individual accessing services at the centre, directing their care and selecting their care options in the least intrusive setting possible, is the system that many of us wish for. From the perspective of a broad desired outcome, this is where I believe we should be setting our sights.

In the time that I have today, I would like to speak to you in particular about the involvement of the family and the supports that the family might need to be a positive influence in an individual's recovery. When I speak of "family," I use the term broadly to include any person that an individual considers as family rather than a purely biological classification.

My perspective comes from my experience as a father who has been challenged by the system to help his son recover from a significant mental health concern, while at

the same time struggling to find supports for myself and my wife to help hold our family and our relationship together and resist the silent push of our mental health concerns as they attempt to consume every aspect of our lives and our identities.

My experience has been that family and family involvement is viewed in many different perspectives on the path of mental health recovery. At times we are seen as unwilling to co-operate with a system that we feel doesn't do enough to solve the problems that mental health concerns have brought into our world. We're often seen as a nuisance, interfering in the attempt of service providers to provide care that they believe an individual should receive. We are often viewed by our loved ones, the ones we are trying to support, as unsupportive, interfering and manipulators of the system to achieve our goals rather than theirs.

On the other side, there are times as well when we are viewed as important if not integral: an integral component of our loved one's recovery. We're viewed as the primary support system for our loved one as they travel on their path of recovery. It is this perspective that I would like to see as the norm rather than the exception.

#### 1720

Respecting those cases where individuals do not want their families to be involved, I'd like to offer you my perspective on what needs to be done so that families that want to be supportive acquire the appropriate skills and resources to be effective contributors in our loved ones' recovery.

In order to be effective in supporting a loved one, one of the most difficult challenges for family members is to accept that a mental health concern has become part of our life and that it is not something that is going to be addressed with the expediency of mending a broken limb. We also have to accept that the system is not going to house our loved one until the problem has been corrected.

It is at this critical time that family members need to be supported in order to persevere through the initial period of disbelief, grief and the sense of lost expectation that is often experienced when we learn a loved one has a mental health concern to manage. My opinion is that it is at this critical time that family members need to be presented with reinforcement that mental health concerns can be dealt with effectively and that people with mental health concerns can lead independent lives that are fulfilling to them. It is also at this time that family members need to begin the process of becoming educated about the mental health concern their loved one is trying to manage. In my opinion, it's imperative that during this period, family members need to be provided with supports to begin developing their own coping mechanisms to enable them to manage the emotions and pressures that being the source of primary support requires.

In my experience, I have found that it is during this critical time that support for family members is often lacking. At the time when we need it the most, it's often least available. There is advice available to guide us on

what we should do to provide effective support for our family member, such advice as, “Provide a supportive, stable, calm environment.” Service providers are equipped to provide us with specific guidance in supporting our loved one.

Unfortunately, that’s not always the case when it comes to providing support for us. To support ourselves, we’re offered suggestions such as, “You might want to find a support group,” which at that particular phase is not particularly helpful. There appears almost to be an underlying attitude that if our family member is able to manage their mental health concern, any issue that we might have will naturally work itself out.

I would caution against taking this perspective and overlooking the need of family members for appropriate support of their own. Doing so will only serve to substitute one person managing a mental health concern with another. If we are not provided with adequate supports for ourselves in supporting our loved one, there is a risk that we will only take their place or join them in the system.

So my suggestion is: Rather than focusing solely on the role of the family in an individual’s recovery and leaving support of the family to those service providers that choose to offer it as part of their service, I would like to suggest that structured family support be incorporated into the recovery plan of the individual from the beginning, and that it become a formalized part of working with someone who has a mental health concern. Supports for the family, as for the individual, are expected to change in focus as the individual and the family progress on the path of recovery. With that in mind, supports for the family as well as for the individual need to be available across the continuum of care and varied according to the needs of the family across that continuum.

I think it’s important to take a minute to speak briefly of those cases where an individual does not want to have their family involved in their recovery plan. The reality is, that is the case sometimes, and individuals don’t want their family involved, for whatever the reason might be.

If this is the case, one should not assume that the family is not in need of support. We are fortunate, my wife and I, that our son has wanted us to be involved in his recovery. Having spoken to many family members where this is not the case, where their loved one does not want them involved in their recovery, their need for support is still substantial. Not only do they want to understand the mental health concern in an effort to understand the behaviour of their loved one; they also have to cope with the realization that they may have little, if any, opportunity to be involved. In cases such as these, please consider that these individuals may be in need of significant support as well, and they should not be excluded from services because their family member has not included them in their recovery team.

As the system changes, my belief is that if provided with appropriate and ongoing supports, of which education is a key component, families can be a significant asset to the recovery of individuals managing mental

health concerns. In supporting families to support our loved one and sustain ourselves, system capacity can be increased by increasing positive recovery outcomes, subsequently increasing individual and family independence, and ultimately resulting in a reduction of individual and family reliance on specialized mental health services.

To this point I’ve talked about what the system needs to do, what we’d like to see changed in the system and how the system needs to support us, but it won’t work if we don’t do what we need to do as family members. We need to understand as family members that we have a role to play. It’s not all about doing for us; we have to do as well. In order to achieve the best outcomes possible, we need to accept the responsibility of a partner to the system, the service providers and our loved one. It’s through a working partnership and an attitude of collaboration, trust and mutual respect between family members, service providers and our loved ones that we will achieve the best outcomes possible.

I believe that as work continues to educate youth and the public in general about mental health concerns, the stigma attached to mental health will begin to subside. My hope is that it will become easier for people to see mental health concerns as manageable and those managing them as contributing members of their community.

To you, the committee, I would commend you on your vision and for taking this step forward to bring change to the way that mental health services are delivered and mental health concerns are viewed. I suspect that as you attempt to move the vision into practice, you will encounter challenges at many levels. You may need to accept that in order to effect significant change to the system, there will be difficult and in some cases unpopular decisions to be made. Resistance to change should not be unexpected, and agreement from all sides may not always be achievable. What I would like to ask of you is that you accept the challenge to lead us to our goal. To only provide guidance and encouragement will not be enough. Without strong leadership, I’m afraid we will be left with an opportunity to change the system that fades to the background because the will has not been there to make it a reality. We need your help, and I hope that you’re up to the task.

Thank you for your time.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Peter. You’ve got about 30 seconds left, so I think probably the best thing for me to do is to thank you for coming today. Thank you for telling your story to the committee.

VINCENT DE MERCEDES-ANGELSSSEN

**The Chair (Mr. Kevin Daniel Flynn):** If we could move on, then, our next speaker now is Vincent de Mercedes-Angelssen. Please come forward, Vincent. Make yourself comfortable. I think you’ve been here since the start. Like everybody else, you get 15 minutes. You can use that any way you see fit, and then at the end,

if there's any time for questions, we'll split it up amongst everybody.

**Mr. Vincent de Mercedes-Angelssen:** Thanks. I'm afraid the previous speaker ruined my presentation. I intended to be dramatic, but he said it so well.

I have to warn you, I'm feeling very emotional and I might cry. If that happens, I hope that you stop your timers so I have my 15 minutes.

**The Chair (Mr. Kevin Daniel Flynn):** Do you want to grab some water before you start?

**Mr. Vincent de Mercedes-Angelssen:** Certainly.

**The Chair (Mr. Kevin Daniel Flynn):** We're all yours.

**Mr. Vincent de Mercedes-Angelssen:** All right. As you know, my name is Vincent de Mercedes-Angelssen. I have no professional credentials in the field of mental health and little formal education. I am simply what has come to be known in the mental health system as a family member and a primary caregiver.

1730

But I am also a man of many hats. I have learned, in some 30-odd years of caring for my loved one, to serve as a cook, a barber, an errand boy, a nurse, an impromptu social worker and a spur-of-the-moment advocate. I have learned when to rage and when to pray; when to curse and when to hold my tongue. I have learned how to ask—no, to beg—for help, for understanding, for support.

I am by nature a caring, even solicitous, human being, but I can be at times the monster, the hypocrite, the scheming two-faced stranger who wants to harm and plot against the one I love and care for. I am the one who runs for help and the one who runs for cover; the one whose presence is abhorrent yet needed and expected; the one who loves and cares too much and yet not enough. I am, in short, my brother's keeper.

I want, first and foremost, to thank you all for allowing me and other family members to voice our hopes and our concerns in order to help, if ever so modestly, in the commendable task at hand: the transformation and optimization of our mental health system. This is, needless to say, a truly ambitious project, and we praise and applaud the will and the efforts from all of you in the government, the various agencies and organizations, and all the other people that have come together in this endeavour.

I will not attempt to dwell on what has already been presented, discussed and proposed by others far better endowed with knowledge and talent, but perhaps I can offer a handful of ideas and experiences that might prove of some value along the way.

Our concern, as primary caregivers, is that, as the provincial health system is shifting from a focus on acute care to the education, prevention and management of chronic diseases, an important group of people in need of immediate medical help—in particular, the so-called chronically ill—will be bypassed in order to concentrate valuable, always scarce resources on models that will not, frankly, help or even alleviate our seriously compromised situation and would not, in our opinion,

based on our long and arduous dealing with the system, provide us with the professional services and care that our family members so desperately need.

Another thing that worries us is the apparent eagerness—well-intentioned as it may be—to shift the rendering of services from hospitals to community care facilities. There is merit to that idea, but the truth is that at present, the transition from institutional to community care is in many cases non-existent, and when it does exist, it is jagged, ineffective and, sadly, in a considerable amount of cases, downright detrimental, particularly when, more often than not, decisions to discharge patients into the community are made in haste, pressed as the hospitals are for the need for beds. This is not to say that we should reject this concept. I am sure that it has worked well in many cases, but we should try first to put in place a safer, more efficient program to coordinate transition and to ensure proper continuation of care and service.

On the issue of emergency services, much has been said and studied regarding this essential, invaluable service, so we all know by now how strained their resources are and how understaffed they are. But the sad reality is that making use of emergency services at any hospital in Ontario today can be just as traumatic as the condition that brought you there. For a mentally ill person, the experience is even worse. Emergency services for psychiatric patients can only be classified, without fear of exaggeration, as miserable, and this is not to reflect on the quality and general disposition of the good doctors and the rest of the professionals who happen to work in those facilities.

Let me just say that if you are in need of fast medical attention, do not try the psychotic, disturbed approach. It doesn't work. You will still be told to take a seat and wait your turn. It is no wonder that many, as my own family member has done, bolt for the door and leave in disgust. I cannot help but wonder: If a person arrives, by whatever means, at emergency presenting symptoms of a mental illness, if their case is even reinforced by the input and testimony of people that go along with that person, why is he needlessly detained and delayed at triage?

If the facilities are there in the form of a psychiatric ward, why not streamline those patients to where they can get, if not immediate attention, at least some reassurance that they are going to be looked after?

The emergency rooms, as everybody knows, are populated by all sorts of people with all sorts of conditions: heart attacks, broken bones, burns. Their symptoms and their conditions are more readily perceived. A mentally ill person, even when a full-blown storm is raging in his mind, is less able to convey the immediate need for attention, but that person may have not been able to eat, rest or sleep for days. The voices in his head are threatening him, taunting him relentlessly.

His need for assistance is just as urgent, yet even after a mentally afflicted person manages to get through the triage ordeal and he is finally sent to the psychiatric ward, he will have to wait on a chair, a cot or a stretcher

for hours on end—more often than not, overnight—until a psychiatrist, an intern or a case worker comes to see him. If he is lucky enough, he will be assigned a cubicle where he can rest while waiting with a bit more privacy. But do not count on it, because he might be asked, many times, to go back to the chair outside, since that cubicle is needed to interview other patients.

Even when a Canadian emergency department triage and acuity scale has been put in place to minimize subjective determinations of urgency, and even after revisions have been made to further define the urgency of people with a mental health complaint at emergency departments, service is still more readily available for non-psychiatric cases.

Chronic psychiatric cases fare even worse. In a report in the *International Journal of Mental Health Systems* dated June 30, 2008, under the heading “A Qualitative Study of a Psychiatric Emergency,” it is stated that “people who had used psychiatric emergency services at least 11 times over the eight-year study period had lower rankings of urgency.” In my particular case, I would say I have used emergency, since 2005, five times already.

In a series of articles in the *Globe and Mail* of November 2008, even psychiatric professionals concur in that psychiatry is “a specialty relegated to basement” and that psychiatric wards tend to be hidden away in physically unpleasant places, and inadequately furnished, because mental health has always been “the last to be funded and the first to be cut.” No wonder mental health is called the pariah of the health system.

But it doesn't have to be this way; it must not be this way. We need to find ways to attend to those who are ill—now. Rather than the promise of prevention, we need assurances that strategies will be developed and methods found to provide efficient, expedient and consistent services now.

The need for this is great and is pressing for those who are affected by a chronic mental illness, particularly for those that are non-compliant: those who refuse to accept that they are ill and who are consequently far more difficult to treat. “Well, your brother is the one who refuses to be helped,” I have been told, not once but several times by many professionals to whom I went for help.

So what are we to do when it is in the very nature of the illness to suspect, to deny, to refuse service? Should we surrender? Abandon our loved ones to chaos and doom because they cannot objectively make what would be, in many cases, a life-saving choice? We need to revise rules that at present are confusing and draconian and only serve to scare mental health professionals and make them shy away from applying measures that could expedite the provision of service.

As the privacy act now stands, we are in limbo, or perhaps I should say hell, unable to get help, so that our loved ones deteriorate until the only recourse left to us is police intervention and emergency.

1740

The Standing Committee on Social Policy—

**The Chair (Mr. Kevin Daniel Flynn):** If I could just jump in, Vincent, you've got about three or four minutes left and you may not get through everything. So if you want to focus on the things you really want to get across to the committee—I just don't want to cut you off at a point where you've still got something left to say.

**Mr. Vincent De Mercedes-Angelssen:** Okay. I have to say that the system as it is now is not really helping because even though there are many agencies in place, most of them don't have the necessary things in place to help us. First of all, there seems to be a 9-to-5 approach to services. As you know, mental illness is not a 9-to-5 occurrence, and if you need help, you end up going to emergency.

On one occasion, my brother begged me to call emergency because he couldn't rest; he couldn't sleep. I phoned up and the person at the other end asked me to describe the symptoms, what was going on in our home. I said, “My brother cannot sleep,” and he said to me, “Well, this is not a hotel. You can't come here to rest.”

When we went for a referral that we needed desperately, his family doctor, even though he was on the verge of retirement, could not provide it. He did not know who to refer this person to.

When we looked at the website for the College of Physicians and Surgeons, we got a list of 30 physicians. We called; we only got seven replies. None of them would take him, either because they could not take more patients at the moment or they provided services in other languages or they said, “Go to a hospital. That's your best bet.”

So obviously there are no resources there. What we need is a central depot, if you will, that will be there 24 hours for us, the family members, and the patients, the clients, the people who are in desperate need of help.

Also, the facilities are terrible. When we go with our loved ones to an emergency service, not only are they made to wait overnight but when they are looked after, they have to sit on a cot or a chair for hours on end overnight. When they are put in a cubicle, they have to go outside because they have to use that cubicle for somebody else, to interview somebody else. So obviously hospitals need to expand the services for mentally ill patients.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you very much, Vincent. You got your point across very clearly. Thank you for coming out today on behalf of your brother, as well.

**Mr. Vincent De Mercedes-Angelssen:** I thank you.

HEATHER DRUMMOND

**The Chair (Mr. Kevin Daniel Flynn):** Our next speaker this afternoon, after Vincent, is Heather Drummond. Heather, if you'd like to come forward, make yourself comfortable. Like everybody else, we've got 15 minutes allocated. You can use that any way you see fit. If you don't use all the time, we'll split the time at the end for any questions.

**Ms. Heather Drummond:** Excellent. Mr. Chair and members of the panel, I'd like to thank you very much for giving me the opportunity to speak today. I am primarily here as a concerned member of the community, but what is informing what I have to say today is that I have been working in the mental health field for over 15 years. I am currently a full-time college counsellor in one of the 24 colleges in Ontario. I am a very active executive member of the Ontario College Counsellors' association. I'm also a very active member in the Ontario Coalition of Mental Health Professionals.

Also, I'd like to say that my colleagues thought I should mention this: Today is actually my 40th birthday. They thought this would be an excellent time for me to speak on a panel like this because I have wisdom now, so I have things to share.

I'll give you a little bit of background about OCC so you know where I'm coming from—Ontario College Counsellors. We're in our 42nd year of really advocating for quality, accessible, affordable mental health services in the college system here in Ontario. OCC has over 160 members well qualified to offer various forms of psychotherapy. We practise under the title of college counsellor or counsellor. OCC tirelessly promotes policies and practices that surround our ethical responsibilities to students suffering from mental health issues. We have very stringent standards of practice. We're dealing with students roughly from 17 to 65-plus; it's quite an age range. We're seeing mental health issues across the life-span, similar to what the communities are seeing as well.

OCC absolutely does support the objectives of the Regulated Health Professions Act, and we're very confident that when the College of Psychotherapists is fully in place, our members are well educated and well equipped to qualify under the auspices of the Psychotherapy Act.

So this is a great opportunity that my colleagues have volunteered me for, to be able to let people know more about college counselling, because there is that notion that college counselling is bad hair days and breakups. I'm not going to lie to you; there are occasionally those issues because of the nature of the population and the age. But we are seeing mental health rapidly increasing in severity, and at the same time a lot of the mental health services are rapidly decreasing. I can echo what has been said previously to me by the very moving talks by other people: It's the first thing to go; it's the first thing to get cut in a college. That's essentially why it was really important, even though I'm terrified today to speak in front of you, for me to have the voice of college counsellors and what we do in the college system.

We're pleased that you're taking this opportunity to hear real stories from the community, real stories from the mental health providers, because there is a wealth of professionals available in the communities now that are equipped to offer the services. It's just the money and how to place it and what kinds of services to offer, because there's always, obviously, like with every profession, a power struggle amongst who is the better

professional to offer programs, to be the ones to empirically deal with certain mental health issues.

But we are increasingly seeing very, very complicated mental health issues at the same time as our college counsellor complement has, year after year—I've been at this college for six years and since I've been there, we've lost three full-time counsellors, yet we've increased by 6% this year. We have five people at four campuses that see over 3,000 students a year. It's a free service. It's great, but it's dwindling rapidly.

Just to give you an idea, we're dealing with students who are actively suicidal, who are dealing with multiple levels of eating disorders, people who are engaging in self-injurious behaviour at varying levels, depression, anxiety, chronic illness, physical illness, people who are dealing with deaths in their family, physical and sexual assault, post-traumatic stress disorder. Also, just because of the span that we're dealing with, we're dealing with a lot of people for whom it's their first time away from home. It's very stressful to leave home, make new friends and all of a sudden have to do your own laundry. Just having that, alone, is very stressful, and also bringing on different mental health difficulties for them.

Also, it seems that in the community it's very easy for me to find mental health support for somebody who is incredibly severe. I can easily call up a psychiatrist, get a referral, get them into the hospital, but they have to be so severe. We deal constantly with high levels of suicidal ideation or high levels of threats to kill themselves, and very often I've sat in emergency rooms with students and they're in and out within an hour. The thing is, they're not well enough to be in and out within the hour. If they're not severe enough to be in that type of setting, there need to be settings within a continuum where they can be safe, where they can get the treatment they deserve.

Also, if they're not on the severe end, sometimes it's underappreciated just how being burnt out—handling school is very difficult. The reality of people in the post-secondary world, whether it be college or university, is that they have to maintain a job. Many of them maintain a job, a family—the sandwich generation, taking care of sick parents and taking care of their own children, all while attending a full-time course load. I came through the college and university system and am currently a doctoral student at the University of Toronto, and I'll tell you, the college system just packs these students full of courses. Where in university I'd have a nice five-course load, they can have six, seven or eight courses in a semester, so it's underappreciated, the level of stress that these students are under.

**1750**

For me to find somebody in the community, once they've transitioned from the college, who's affordable and accessible is near impossible. The only other agency—I work in Hamilton—that I can refer to for kind of a moderate level would be Catholic Family Services, a fantastic agency. However, they're limited in funding as well. So these students end up lost in the system, because

to pay for a private therapist is prohibitive for somebody who's just had several years of Ontario student loans, several years of trying to support a family, several years out of the workforce. So it's near impossible to get adequate mental health care for them.

Also, it would be very helpful to be able to have community agencies or college or university agencies—call it counselling departments—working in tandem, some sort of program funding where they can work together because, when students are transitioning out of the college or they need a little bit more support than we're able to offer in our particular college setting—to be able to work together for an easy transition to the appropriate mental health that they need.

Improving our society's mental health access is more than just throwing money at the existing programs. There are great programs; don't get me wrong. But on average, to get a student who's not incredibly severe—maybe they're moderately severe—into, say, a DBT program, dialectical behaviour therapy program, takes six months to a year. They may have dropped out of school by that point. They may not have been successful. They may have been asked to leave the college until they have sorted out their own issues. Once they're not a student anymore, the college counsellors no longer can see them for mental health support.

One thing the colleges and universities offer is just-in-time service, because we're dealing with the population a lot of time as it's happening on campus, in classes. They can come between classes. There tends to be less of a stigma when it's on campus. They'll access it quite quickly. When we do refer out, we tend to lose students. They tend to be more comfortable coming within the actual institution rather than leaving for counselling outside.

Within our population, especially on the younger end, there is a lot of early-onset schizophrenia, different kinds of psychosis. It's the age in the developmental age range, so college counsellors are often seeing the first mental health issue that that student has ever experienced. They often present—because I think it's one of the top five stressors, to go to school and maintain family life. Then add your car breaking down, and then you have a death in your family, very stressful events, so a lot of mental issues surface at the time of the college experience.

The reality is that, yes, there is private counselling available in the community, but we're looking at anywhere from \$120—you might get it for \$80 an hour—to \$350 an hour. It's not even in the realm of what a student can afford to pay for. Very often we're giving out food vouchers for \$25 just because they can't eat. They're not going to be spending it on their mental health.

There are community agencies available, as I mentioned, like Catholic Family Services. However, because of their limited funding, six to eight sessions is what they have available at the most. There are OHIP-funded agencies where they're very good at doing the assessment, but there's not enough funding or time to do the actual treatment, which is what the students need.

Like I said, wait times can be just astronomical, which then upsets their flow of being able to finish their college program on a timely basis so they can get out and feel like they're a productive, contributing citizen and be independent and support themselves.

The wait times in the colleges right now are getting longer and longer because the counselling complement keeps shrinking and shrinking, primarily because we don't have what's called targeted funding in the college system. Our disability services cohorts have targeted funding, meaning that the ministry provides money to the colleges to pay for the disability services that they offer. There isn't targeted funding for counselling departments, so what ends up happening is that when the college has to make budget cuts and has to balance the books—we cost the college money, we don't make money for the college, so we tend to be cut first. That's the reality.

My suggestions would be to increase accessible community mental health programs with both a medical model focus—I don't come from the medical model philosophy, but I'm not discounting what the medical model has to offer. However, that is all that seems to be available in the affordable realm for the particular population I work with. What I'm suggesting is, in tandem, we also have more psychosocial-based programs that are accessible and affordable for people in the community. Create community mental health programs that allow for community and different collaborations so that we're able to work together—flow of services and so forth.

I'm from Alberta originally, and I'm saying good things about Ontario. I think Ontario has been doing a great job with battling the stigma around mental health. I think that we need to continue with the campaign about just getting rid of the idea that people with mental illness have no worth or that they should be relegated to the basements of a hospital.

There's a program that British Columbia is piloting through the Canadian Mental Health Association: the Bounce Back program. It's a start. What I like about that program is, it's putting the locus of control into the client's hands. The client is learning how to improve their mental health. They're learning different strategies to help themselves, rather than relying on a physician, a psychiatrist or different antidepressant medications. It's a program that's teaching people skill sets.

There's an assumption in our society that everybody comes from a fabulous family and everyone has the same skill set, and it's not the truth.

**The Chair (Mr. Kevin Daniel Flynn):** You have about 30 seconds, Heather.

**Ms. Heather Drummond:** I can go really quick.

I think we need to decrease the hoops that clients have to jump through. For me just to get a student on a wait-list at a mental health program, I have to convince a physician that they should send a referral to that particular program. That's not always that easy because of physicians versus counsellors. So, lessen the hoops so that there's no reason why anybody from the college of psychologists, the college of psychotherapists, or social

workers, is not equipped to be able to refer to those particular agencies directly.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you. You did a wonderful job. Tell your colleagues the committee said you didn't look a day over 30.

**Ms. Heather Drummond:** Thank you. I'll come back tomorrow. No, I won't.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you very much for coming, and thanks for speaking out on behalf of the colleges.

**Ms. Heather Drummond:** Thank you so much for your time. This is a well-worthwhile effort.

#### VICTORIA LONG

**The Chair (Mr. Kevin Daniel Flynn):** Our last speaker of the afternoon is Victoria Long. Victoria, if you'd like to come forward. Make yourself comfortable. There should be some clean glasses there and some water if you need any. Like everybody else before you, you get 15 minutes. You can use that any way you see fit. If you'd like to save some time at the end for any questions, that's entirely up to you.

**Ms. Victoria Long:** Hi, everyone. My name is Victoria Long. I'm a recent graduate from the University of Toronto and a volunteer with the Schizophrenia Society of Ontario. I just want to thank you for the opportunity to speak with you today, and in particular, thank you, Mrs. Elliott, for introducing the private member's resolution that led to the formation of this committee. I can imagine that absorbing so many presentations is not the easiest of tasks, and I think that a review of Ontario's mental health and addictions services cannot be a light undertaking, but then again, mental health issues are not easy. They are complex, difficult, emotional and deeply personal.

This story is not entirely mine to tell. I cannot speak on behalf of my mother, who vivaciously and courageously fought her mental illness throughout several turbulent years. Even as a close family member, I cannot fathom how turbulent it must have been for her. So to speak on her behalf would be, in many ways, disrespectful. But I can speak as an Ontario citizen concerned with the well-being of other families who are dealing with the onslaught of mental illness, and I will speak as a daughter who suddenly became an unequipped caregiver and, as a result, struggled for several years as a young adult attempting to help make sense of what was happening to a loved one and often bearing the guilt of not having done enough.

**1800**

In 2001 I was 17. Midway through my last year of high school my mother never came home one day. After being held in suspense as to her whereabouts, my father and I received a call from a Toronto detention centre and learned that my mother was being detained as the result of a non-violent criminal charge. I learned that a mental illness had started to take over and that strangers had been affected by her inability to consistently distinguish

between reality and delusions. There had been no previous correspondence from any justice or law enforcement agent to our family, nor had there been any notice from the family doctor flagging any symptoms. My mother was and is a capable person, and, as a nurse clinician described, at the time she was competent in all spheres of functioning. So I did not know that there had been a severe problem developing, and I did not know enough about the signs and symptoms of mental illness.

Despite an outpatient court support program, my mother's health unravelled quickly, and it came to the point where she was not able to take basic care of herself and was not able to relate coherently with others. She needed constant support.

The period between 2001 and 2005 saw a long stream of discussions, meetings and calls taken by myself or my father and my mother with legal counsel, probation officers, police officers, social workers, nurse clinicians, psychiatrists and general practitioners. Despite the involvement of so many, there never seemed to be any comprehensive and coordinated health, housing and support program. There was no plan. Aside from the lack of affordable and suitable housing, I was generally not concerned about the lack of services but rather about the disarray of countless different services and an absence of communication between them.

During this time, my mother was asked to attend many court hearings, was evicted from her apartment, was held overnight at our local police station because they were concerned for her safety and was escorted to hospitals by means of the forms that my father and I filed with a justice of the peace.

I think my key message here is that the justice system is not the appropriate framework in which to process mental health issues. The justice system cannot continue to be a revolving door into temporary services that only exacerbate the illness and treat individuals as offenders as opposed to patients. It was a devastating shock to first learn about a loved one's severe illness by way of the justice process, and it was confusingly painful to navigate a criminal justice system on top of managing the illness.

I find it deeply disturbing and rather outrageous that during the early stage of my mother's illness, we came across a comment from an involved professional that a jail sanction seemed to be a useful deterrent to her behaviour. At a later stage, I vividly remember a justice of the peace telling me that he does not like having to sign the forms under the Mental Health Act granting the police the right to escort an individual to a hospital because the repercussions of such legalities tend to tear families apart. I told him I wouldn't let our family be torn apart by this.

But that was a very heavy promise to keep, and that brings me to the issue of family support. I began by stating that I would speak as a daughter and a caregiver, and I want to underline that while mental illness primarily affects one individual, there is a damaging cascading effect on family members and caregivers.

After graduating from high school, I entered U of T, but over the course of my first few years, I was definitely

overwhelmed by my family's situation. I ended up losing my scholarship because I had difficulty maintaining the grades I was capable of, and as a consequence, my student debt grew. I withdrew from school and worked full-time for close to two years, but the situation took a heavy psychological and emotional toll. I spent much energy seeking out resources for my own stability. I had many appointments with psychotherapists, psychiatrists, counsellors and the university's AccessAbility services. I eventually did return to school, and I completed majors in peace and conflict studies and criminology, determined to gain a better understanding of systems that really do affect families.

It's now 2009, and it's only in the last couple of years that I can say that my family has settled from the reeling effects of mental illness. My mother is doing well. Upon her recovery, she volunteered with the CNIB. She learned Braille and transcribed books. She has reconnected with family members and is able to take care of herself, thanks in large part to her Ontario disability support program payments, which she relies on.

I am volunteering with the Schizophrenia Society of Ontario and I will be facilitating their Strengthening Families Together program. I am glad to speak publicly to you of my experience.

Looking back, it's difficult to prioritize what needs to be done, but as with most challenges, I think the best preparation is knowledge. I ask that education be brought into schools so that youth, guidance counsellors, teachers and administrative staff are aware of symptoms and know where to guide people towards the proper care.

I also think that those developing mental health policy might benefit from practical exposure to the issues they are addressing. As I highlighted, mental illness is deeply personal and I think it might be very beneficial for public servants to visit hospitals and to have face-to-face discussions with front-line caregivers.

My thoughts also veer towards educating family doctors about serious mental health illness so that if they are not equipped to handle those illnesses, they are able to recognize the signs, make timely referrals to specialists and inform and work with families.

Secondly, I recommend that the committee study the entry points into the mental health services framework. I believe there's an unnecessarily large number of people slipping in and out of the justice system who would gain a lot more from appropriate health services and benefit from support of longer-term social programming.

The lack of communication and coordination between various social services becomes really acute if we think about how many hours of court time are elapsing, how many legal aid dollars are being spent, how many valuations and repetitive consultations are occurring, and how many frustrating efforts are burdening families.

We don't tend to ask those with broken legs to run marathons, or those with heart failure to lift tonnes, but I feel we often ask so much of individuals with mental illness and their caregivers. Why?

We can't always control what happens to our health or the health of loved ones, but I think we do have a choice

in how we react, and we all have a role to play. We owe it to people who need help, to respond with compassion, respect and diligence.

Thank you for listening, and I'd welcome any questions.

In my handout, I have a chart at the back just to give an overview of the number of services we dealt with, and how many people were involved and had to be managed by a single family.

I'd be happy to take any questions or discuss anything further.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Victoria. You probably left time for maybe one question from each, starting on this side. Anybody? Helena?

**Ms. Helena Jaczek:** Thank you very much. That was an excellent presentation. You've certainly reinforced a number of things that we've heard. But I wanted to talk a little bit about the balance of the individual in terms of their rights to privacy, to refuse treatment. We heard a lot about that earlier today. You actually had to use a form 2 process. How do you see that balance?

**Ms. Victoria Long:** I think that was a very difficult thing to manage, to have to sign the form 2 and then know that my mother's privacy and individuality was at stake.

I think what might be helpful to look at is to notice that sometimes the individual is not able to manage these issues during crisis time. So in order to perhaps respect the person's privacy and abilities, it might be useful to not have to demand so much at a crisis period, whether that be demands coming from the justice systems, from forms having to be signed. If there's a lag time so that the person can at least recuperate and exit the crisis stage of an illness, that might be a helpful thing. At that point, families could discuss and interact with the professionals. And when that person emerges—because there are cycles of crisis—from that crisis, perhaps at that point they might be able to sign forms and answer questions.

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

**Ms. Sylvia Jones:** I really want to thank you for your being the last presenter, actually, because you've done a very nice job of bringing in the role of family. What we've heard a couple of times—and I'm pleased to see you've highlighted it as your third point—is that we have to stop dealing with mental health illnesses as a criminal issue. I don't know if we have enough time, but any suggestions that you would have to bring it back into the health realm.

**Ms. Victoria Long:** I think you could start at the very beginning. If a police officer or any law enforcement agent notices that an individual is behaving erratically and is detained, I wonder if at that point, before any detention or any legal sanction is imposed, families and family doctors could be consulted first. Because I think that's exactly the entry point at which it happens, at the very beginning, and then it just cycles through the justice system.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Victoria. France, you've got the last question.

**M<sup>me</sup> France Gélinas:** You mentioned that when you were in front of the justice of the peace for a form 2, he or she told you that they didn't want to sign this; it breaks family. Looking back, would there have been another way to get your mother the treatment she needed?

**Ms. Victoria Long:** I think it would have been much more comfortable if this was something—I understand the legalities that need to be addressed, but if this was in a family health setting, it would have been a lot more comfortable. I'm not too sure how else to answer that, but it was just very difficult to have to swear under oath and have the legal formalities, assigning that to families. Perhaps if family doctors were the ones to interact with the justice of the peace along with the families, it might make it more comfortable to be dealing with someone we're familiar with.

**M<sup>me</sup> France Gélinas:** More comfortable than what you had to go through?

**Ms. Victoria Long:** Yes.

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

**Ms. Victoria Long:** Thank you, and thank you to the committee.

**The Chair (Mr. Kevin Daniel Flynn):** Before the members run out the door here, there are two points I'd like to make. We can either do this in a subcommittee meeting or we can do it really briefly now with the full committee. It should only take about a minute. We have a group, the Ontario Association of Non-Profit Homes and Services for Seniors, which asked to appear before the committee in June. Somehow their request was not accommodated, for whatever reason. They've asked to appear as an expert group. Is there any objection to that? We'll try to squeeze them in as the schedule fits.

**Mrs. Liz Sandals:** So for the 15 minutes?

**The Chair (Mr. Kevin Daniel Flynn):** They're asking to appear as an expert group and they would get 30 minutes, then. That's what they asked for in the first place.

**Mrs. Liz Sandals:** We have denied some other folks who had asked to be experts.

**The Chair (Mr. Kevin Daniel Flynn):** Okay, and some we approved.

**Mrs. Liz Sandals:** We're getting into dicey territory.

**The Chair (Mr. Kevin Daniel Flynn):** Yes. Well, we can do it as a subcommittee if you prefer, if you think it's going to be anything controversial.

*Interjection.*

**The Chair (Mr. Kevin Daniel Flynn):** It's the Ontario Association of Non-Profit Homes and Services for Seniors. They represent not-for-profit long-term-care homes and housing. They deal with a lot of older adults with mental illness, challenging behaviours, dementia and chronic disease. These would be the people on the

front lines every day, dealing with some of the older people in our society.

*Interjection.*

**The Chair (Mr. Kevin Daniel Flynn):** Yes, I kind of agree. Is there any objection?

**Ms. Helena Jaczek:** They're certainly an excellent group.

**The Chair (Mr. Kevin Daniel Flynn):** Yes, very good. Okay, we'll try to accommodate them somehow.

Two dates to remember: The one is October 7. We're all getting together as a group, and there will be an agenda coming out to you about a week before that with some options that we'd like you to think about as to where we go next with the committee. And around the end of November—it's been suggested November 20 or November 22—we'd like to get together, if possible, for a lunch with the minister's advisory group again. That will be on the Friday. I can probably go to that date right now—the date that's being considered right now, anyway; it's not written in stone. It would be November 20.

**Ms. Sylvia Jones:** I cannot do that.

**The Chair (Mr. Kevin Daniel Flynn):** You can't do the 20th?

**Ms. Sylvia Jones:** I know that now.

**The Chair (Mr. Kevin Daniel Flynn):** Okay. Well, we'll see if we can find a date that's more—is there anybody else who could not do the 20th? This is with the minister's group. It's a lunch or a joint meeting like we had before with the—

*Interjection.*

**The Chair (Mr. Kevin Daniel Flynn):** November 20. It's a Friday.

**M<sup>me</sup> France Gélinas:** I forgot my BlackBerry, so right now it looks pretty good.

**The Chair (Mr. Kevin Daniel Flynn):** Anyway, let's give that some thought. The seventh is already set.

Just to tell you that research will be sending you out some options about a week before that, so if you can find a chance to give that a little read, that meeting is going to set the direction for the fall and for the eventual preparation of our report. It's still our intent, I think, to issue an interim report sometime late this year or early in January. Okay?

We're adjourned. Thank you. Oh, sorry, Sylvia.

**Ms. Sylvia Jones:** One of our presenters, Vincent, raised this on his second page and he didn't get to it: "The Standing Committee on Social Policy was authorized by the Legislative Assembly of Ontario ... to review the personal health information act..." I wonder if the clerk could give us an update on where that is with that committee.

**The Chair (Mr. Kevin Daniel Flynn):** Okay, we'll make sure we get that.

We're adjourned again. Thank you, and thank you, all members of the public who came today.

*The committee adjourned at 1813.*







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