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Vendredi 11 septembre 2009

Select Committee on Mental Health and Addictions

Comité spécial de la santé mentale et des dépendances

Mental Health
and Addictions Strategy

Stratégie sur la santé mentale et
les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

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SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Friday 11 September 2009

Vendredi 11 septembre 2009

The committee met at 0904 in the Valhalla Inn, Thunder Bay.

MENTAL HEALTH AND ADDICTIONS STRATEGY

CANADIAN MENTAL HEALTH ASSOCIATION, THUNDER BAY

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen, if we can call to order for this morning, the fourth meeting this week of the Select Committee on Mental Health and Addictions. Our first delegation is Maurice Fortin, Canadian Mental Health Association, Thunder Bay. Maurice, if you'd like to come forward.

Mr. Maurice Fortin: Here is all right?

The Chair (Mr. Kevin Daniel Flynn): Any one of those chairs you like, any one you're most comfortable at. There are some clean glasses and water there.

Mr. Maurice Fortin: There's a light on, so I assume it's the right one.

The Chair (Mr. Kevin Daniel Flynn): They'll control that for you.

Everybody today is getting 20 minutes to make their presentation. You can use that any way you see fit. If you could leave a little bit of time at the end, we find that works as well, but it's entirely up to you. It's all yours.

Mr. Maurice Fortin: All right. Good morning. Since I'm the first, I want to welcome you to Thunder Bay. We're certainly pleased to have you here. We know you've been in several communities thus far, and we're sort of on the tail end of all that, so welcome.

I'm going to read it mostly, but I'll divert from it slightly. First of all, I want to say thank you for being here. We appreciate the opportunity to talk about the mental health and addiction struggles of people in Thunder Bay and the surrounding region. We also applaud you for your goals in terms of trying to determine the needs of children, youth and adults and to hear about innovation in community services.

The CMHA is one of the oldest voluntary associations in Canada. We've been around since 1918. I represent the Canadian Mental Health Association, Thunder Bay branch, one of 33 branches in Ontario. We're a national federation of organizations, which means each of us is separately incorporated and governed by a local board of trustees. Our 15-member board of directors represents a broad spectrum of our community in terms of where they come from and in terms of their employment. Many, many of them have had a lived experience of mental health or a family member's.

The other thing I want to tell you is that we are truly a community-based organization. We focus on one business only: the delivery of services to support people with mental illness and addictions issues, to support them in recovering and living fulfilling lives in the community. We're all about helping people stay in their community and recover from mental illness.

I thought it would be useful today to try to paint a bit of a picture of who our programs serve. I think it's important for you to understand and have some sense of who our clients are and what their socio-economic struggles are. Some of the information I've taken is research-based, from the Matryoshka study, which is part of a larger provincial study that our organization was a partner in with the Centre for Addiction and Mental Health, specifically two programs: our court support services and our early intervention services. I've also solicited some input from our own services. I've gone and spoken to our directors and front-line staff in our case management programs in our crisis services. I thought it was important for you to understand what we're seeing on the ground.

Let me tell you a little bit about our clients. Our court support program reports that 23% of our clients are diagnosed with mood disorders, 15% with schizophrenia and 15% with personality disorders. In terms of substance abuse, 50% of our clients report that they struggle with drug and alcohol issues. Our staff, on the other hand, estimate that that number's probably closer to 80%.

Our crisis response service sees many people in situational distress. In this community, we're the provider of the crisis response services for the city of Thunder Bay and for the Thunder Bay district. Many of our clients presenting in that program have mood or personality disorders, and the majority of those clients struggle with substance abuse issues. Many, many of our clients have been the victims of physical, sexual and psychological abuse.

Within our early intervention service, 50% of clients have a schizophrenia-related disorder. Many people identified as having a mental illness may suffer from a brain injury or have been misdiagnosed with fetal alcohol syndrome, which we simply don't know enough about and tend to often misdiagnose. Often they suffer from co-

occurring issues, so they may have a brain injury but they also suffer from depression, or they may have a co-occurring major diagnosis of mental illness like schizophrenia. They often present with complex challenges that are difficult to assess and treat.

0910

Furthermore, these people also struggle with a number of important socio-economic challenges. For example, within the court program, 85% of our clients live on ODSP or general welfare assistance, and they report an average monthly income of $677. I want to say that again: a monthly income of $677. Obviously, they exist well below the poverty line. Across all of our programs, most clients have received ODSP. For the services that we provide, both clinical services and rehabilitation services, we are serving people who have a diagnosis of a major mental illness; we're certainly not serving the "worried well" and we're not serving those who are doing okay in community but need counselling services.

The wave 2 results of the court study show that 85% of our clients have not completed high school. Across all of our programs, most clients have not had an opportunity to attend college or university or to acquire a trade. In most cases—82% in the case of the court program—the lack of opportunity stems from the interruption of their education because of the onset or recurrence of mental illness.

Many of our clients across all programs have other accompanying health concerns such as diabetes or cardiovascular illnesses. Some of them also struggle with issues of obesity, which often stems from the long-term taking of psychotropic medications. In addition, most of our clients have limited or no access to very important dietary and other supplements needed to manage these other illnesses.

They also have poor access to psychiatric and primary care services. As a result, ongoing and emerging health issues go untreated or only become treated when they reach an acute phase. I've often heard it said that our clients live an average lifespan of 25 years less than the normal population. I also want you to know that mental illness and addictions kill. This year alone, my staff or myself have attended the funeral of a long-time consumer-survivor who had a heart attack in his mid-50s; we also attended the funeral of a wonderful young man who was a volunteer for CMHA and who committed suicide. He had long-time struggles with depression. Mental health and addictions issues kill. People die.

What do people struggling with these issues need? Certainly, they need housing. In preparing for this presentation, I spoke to some of our front-line staff. The need for housing arose immediately. As one housing worker stated, "We need safe, affordable housing, and lots of it." They went on to talk about the need for a continuum of housing. We need specialized transitional housing with high levels of support to ensure that people with complex needs, such as people who have co-morbid issues like fetal alcohol syndrome and other mental illnesses, have the level of support they need at that time. Housing strategies often need to ensure that the less desirable folks, such as the long-term homeless or people who are struggling with addictions issues, are properly served. In some cases, that means on-site support. Many can benefit from safe, decent, affordable housing supported by case managers.

In Thunder Bay, access to housing is a real problem. The wait list for accessible housing and the wait list for single housing is months, if not years, away. Many of our folks are single folks. They don't have families, so there is a need.

The issue of decent, safe, affordable housing is such an issue. You simply cannot move on with your therapy, with vocational issues or with any other kinds of issues if you're worried about the safety and security of the place that you live in or you're worried about trying to simply find a place to live.

Case management continues to be an effective strategy to support persons with mental health and addiction issues. Many of our clients don't have families, and so case managers are really the key person in terms of helping them navigate through the health and social services maze and also key in terms of providing them with ongoing support. We absolutely need more specialized services. We need to improve access to primary care, and I've talked at length about the struggles that our clients have in terms of access to primary care.

Some of the strategies that are working: We know that a couple of CMHAs have had funding to hire nurse practitioners. It's a strategy that makes sense. Certainly partnerships with nurse practitioner clinics and community and mental health clinics also hold great promise.

In this community—because you want to hear about some innovation—we have a partnership with a hospital and another community organization called GAPPS. What we're doing is we're going out into non-traditional places and outreaching to individuals that have complex mental health and addiction issues and trying to engage with them and trying to pull them into accessing services. The services that we're providing are everything from psychiatry to nursing and nurse practitioner care to deal with their primary care needs. While it is early days, we're seeing very good success in terms of helping to redirect these folks away from emergency departments, but we continue to have struggles in terms of accessing the kinds of service and the intensity of service that people need.

Anyone with a history of conflict with the law or someone who's had charges or convictions of serious crimes such as robbery or assault is often denied access in the mainstream services. Many of the folks have been labelled difficult, and folks who have a diagnosis of a personality disorder who are often resistant to care or treatment continue to have great difficulty in accessing service. Services for persons with complex needs that are hard to serve, that are specialized and that are targeted for their particular issues are absolutely important. We need to develop assertive community treatment teams and intensive case management teams that are actually

targeted for this population. It's the only way that we're going to deal adequately, and they need to be adequately funded because we need to ensure that the community's safe, that my staff are safe and that the clients are safe.

Once people are adequately housed and they receive the treatment and therapy that they need, then they can move on to try and resolve some of their issues in terms of vocation, education etc.

I want you to know that community mental health programs are working. We know from the study that our early intervention programs are demonstrating fewer hospital admissions and fewer emergency department visits. Our own crisis response program is being successful in diverting people from unnecessary hospital emergency visits. Only 10% of the clients that we see do we end up escorting to hospital to be considered for admission, because we're doing a very good job of finding community solutions. We know that case management works as well, and they're reducing hospitalization rates, especially case management when accompanied by decent affordable housing.

But we need adequate funding. Our crisis residential program in this community is only funded four days a week. You'd better not have a crisis and need crisis housing on the weekend because we can't provide you with service.

We know the select committee has already heard from the Auditor General of Ontario, and the 2008 audit of the community mental health sector speaks to the issue of high rates of unmet need, the shortage of supportive housing and the continued need to increase funding for community services. We've read the report; we think they got it right. We hope you're listening and reading that report as well.

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I want to thank you today for the opportunity to speak. We absolutely applaud you for being an all-party committee of the Legislature, because mental health and addictions is not a partisan issue. It's an important issue. We look forward to hearing your long-term strategy in 2010 and we want to let you know that we're committed to ensuring that together we want Ontario to become a leader in mental health and addictions care.

The Acting Chair (Mrs. Christine Elliott): Wonderful. Thank you very much, Mr. Fortin, for your presentation. We do have a few minutes left for comments, about four minutes, so I'd invite other members of the committee to ask any questions, starting with Sylvia Jones.

Ms. Sylvia Jones: Thank you for coming today. I had one quick question and then one more in depth.

Are you utilizing peer support workers in your programs?

Mr. Maurice Fortin: We are not at this point utilizing peer support programs.

Ms. Sylvia Jones: My second question was related to the partnership you referenced called GAPPS. The hospital was one of the—

Mr. Maurice Fortin: St. Joseph's Care Group, which was the receiving hospital for the former Lakehead Psychiatric Hospital, and another community organization called Alpha Court.

Ms. Sylvia Jones: When you say that you are doing outreach in non-traditional places, can you expand on that?

Mr. Maurice Fortin: We are going to places where street people are engaged, so we're going to some of the more difficult street areas where people are. We go to riverbanks, we go to any of the malls where they may hang out or the coffee shops. The two workers we have—one of them was a needle exchange worker and so he absolutely knows where those folks who are disengaged from the system are, and that's where we're connecting with them. Shelters is another example.

Ms. Sylvia Jones: Thank you.

The Acting Chair (Mrs. Christine Elliott): Maria Van Bommel has a question as well.

Mrs. Maria Van Bommel: You mentioned in your presentation that case management is critical because so many don't have families to help support them through their illness. We've been hearing repeatedly as well from families that are frustrated with the privacy regulations and laws that keep them from being as involved in the treatment and therapies as they would like to be. Do you have that similar encounter with the families?

Mr. Maurice Fortin: In some cases we absolutely do and we appreciate the struggle that families have in terms of trying to find out and be part of the care, and some of those are confidentiality issues or restrictions. But we have also some innovation—early psychosis programs, for instance. As soon as the client walks through the door, they also engage with the family simultaneously. So we're providing support and education to the family at the beginning of the process. Those are some very good models in terms of taking a different approach to making sure that the needs of families are met. But it is an issue across many programs.

Mrs. Maria Van Bommel: So the program you're suggesting basically is to bring the family in early. Do you find that works well or do you find, especially in some cases where the client's psychosis becomes increasingly worse, that they try to exclude their family, that there's a paranoia about what the family's intentions are for their treatment?

Mr. Maurice Fortin: That does happen on occasion. We discourage it with the client. We try to educate them. But in the early psychosis program, most of the folks we see are between the ages of 14 and 20, and so they tend to have a better relationship with their families. We're also treating people early in the onset of their illness and so many of those issues are not there yet, in terms of those difficulties. We're trying to negate them, really, by serving the client but serving the family at the same time. That program, sadly, is only one good example of a good approach to working with families.

Mrs. Maria Van Bommel: So are you finding that by earlier intervention and bringing the families in earlier,

there is less likelihood of this kind of alienation coming later on?

Mr. Maurice Fortin: Yes, that has been our experience. Obviously our families are the best folks to ask that question, but it's our observation that it certainly enhances the relationship that's going on.

We're also doing, in another program that we fundraise for, some very good work. We run a family recovery series. What we're doing in that program is that we're actually trying to help family members understand how to support their family member in recovery, and we're using very positive approaches and language. So really what we're trying to do is instill the family members with some sense of hope and that people can have fulfilling lives. Our philosophy within our organization is all about helping people recover to the best that they can from their mental illness and to live healthy and productive lives in the community. It's all about returning people to active community life.

Mrs. Maria Van Bommel: Thank you.

The Acting Chair (Mrs. Christine Elliott): Thank you very much for your presentation today. It's most helpful and we appreciate it.

ALZHEIMER SOCIETY OF THUNDER BAY

The Acting Chair (Mrs. Christine Elliott): Our next presentation is from the Alzheimer Society of Thunder Bay. Jennifer Fawcett and Dr. George Morrison, please come forward, sit where you'd like and make yourselves comfortable.

As you've probably heard, you have 20 minutes for your presentation and you can use the time in any way you'd like. If you want to leave some time for questions at the end, that's fine. Start whenever you're ready.

Ms. Jennifer Fawcett: Thank you. Good morning, Madam Chair, members of the select committee and ladies and gentlemen. My name is Jennifer Fawcett, and with me today is Dr. George Morrison. We are here to present today on behalf of the Alzheimer Society of Thunder Bay.

I am the Alzheimer Society's First Link coordinator, and Dr. George Morrison is the lead physician in the 25-bed dementia care unit of the Lakehead Psychiatric Hospital under St. Joseph's Care Group. Dr. Morrison is also a past board member for the Alzheimer Society of Thunder Bay and a very dedicated volunteer. Dr. Morrison works directly with patients with responsive behaviours, from a non-pharmacological and pharmacological approach, who are in hospital. In my role, however, as the First Link coordinator, I liaise with health care professionals in primary care to promote early intervention immediately following a dementia diagnosis. I also work with professionals in acute and chronic care to enable support for families at every point in the disease continuum. We wish to begin by thanking you for providing us with an opportunity to address you this morning.

There are 39 Alzheimer chapters across Ontario, reaching across all 14 local health integration networks. I believe you've heard from a few others in some of the earlier presentations. In all chapters, services and supports are in place to assist people with dementia and their partners in care throughout the entire continuum of the disease. However, in 23 chapters, a program called First Link helps connect people diagnosed with Alzheimer's or a related dementia to their local Alzheimer Society services and other community resources as early in the disease process as possible.

First Link has been shown to be particularly successful in providing early-stage support. This program provides physicians and other health professionals with a direct referral mechanism for their patients after diagnosis, at which point the Alzheimer Society introduces the person with dementia and their family to education about the disease in a timely manner which is best suited to the learning requirements of people with dementia and older adults; with ongoing counselling support; opportunities for peer support; and linkages to other supports and services when and as required. First Link is a program that has been designed to meet the needs both of people with dementia and their partners in care in the health care system. By providing people with education and support across the entire disease process, people are less likely to reach the system in crisis. People are more adequately prepared to make decisions about home care interventions, advance care planning, their entry to long-term care, should that present itself, and other difficult decisions that are oftentimes inevitable.

The Alzheimer Society of Thunder Bay serves the community and the district of Thunder Bay, which as you know is a large geographic area. The district includes 27 communities within almost 104,000 square kilometres. We have been in operation since 1986, and in accordance with all Alzheimer Society chapters across the province, our mission is to alleviate the personal and social consequences of Alzheimer's disease and related dementias and to promote research. We have a staff of nine, including a number of social workers, making up our clinical team.

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In recent years, the need for our programs and services has dramatically increased. In fact, this past year we have seen an increase to the extent that we have approximately 20 new clients per month coming through our doors looking for education and support through the new First Link program. This is not altogether surprising, as the latest statistics indicate that in Canada, one in 11 people over the age of 65 and one in three over the age of 85 have Alzheimer's disease or a related dementia. We believe that in Ontario there are over 160,000 cases, and it is expected that that will rise to nearly 170,000 cases next year alone, in 2010, and to 350,000 in 2031. Currently there are an estimated 3,150 people living with dementia in northwestern Ontario.

These are sobering numbers indeed, particularly when you think of the Alzheimer chapter providing services across the region for that number of people. In fact, within a generation, it is expected that the number of

Canadians with Alzheimer's disease or a related dementia will more than double, ranging between one million and 1.3 million people in Canada. That number is from a recent study, released in 2009, called the Rising Tide. In short, dementia is the most pressing mental health issue facing our seniors. As a result of the ongoing care requirements for people with dementia, mental health issues related to caregiver stress and burnout are also on the rise.

We are here today to ask you to consider the needs of people with dementia and their partners in care as you move forward with recommendations for a comprehensive Ontario mental health and addictions strategy. Specifically, we wish to draw your attention to the needs of people who have been newly diagnosed with Alzheimer's disease or a related dementia. These people are considered to be in the early stage. A diagnosis of Alzheimer's disease or a related dementia, as you can well imagine, brings a great deal of fear and anxiety for both the person receiving the diagnosis and their family, who will care for them.

Not unlike those with other mental health issues, people with dementia are often confronted with the stigma associated with Alzheimer's disease. Unfortunately this can not only prevent people from getting a diagnosis but also from reaching out for help. Most people are aware that there is no cure for Alzheimer's disease. However, few people know that there is treatment, with a history of success and support, and enabling people to stay at home and aging at place for as long as possible. Therefore we believe that often a person who suspects dementia, has some of the warning signs or has just received a diagnosis, may be inclined to ignore symptoms or signs for as long as possible or until a crisis occurs, at which point it is more likely that that person with dementia and their partners in care will enter our system without adequate preparation or warning.

Hence, in many of our communities we continue to face growing pressure on emergency departments, alternate-level-of-care beds and early admissions to long-term care. A 2009 report from the Canadian Institute for Health Information shows that dementia accounted for almost a quarter of alternate-level-of-care hospitalizations and more than a third of alternate-level-of-care days in 2007-08.

Another recent study, entitled The Burden of Neurological Diseases, Disorders and Injuries in Canada, identified Alzheimer's disease and related dementias as having the second-highest impact on health care costs among all neurological diseases, second only to strokes. Therefore there has been in the past number of years increased recognition that primary care has an early role to play in meeting the needs of people with dementia.

As indicated earlier, the Rising Tide study, released just this year, suggested that in the next decade we are likely to see a sharp rise in the number of people with dementia. We recognize that as a result, new and creative measures which incorporate inter-professional care and community collaboration will provide some of the best solutions for the provision of care.

We would like to suggest that the select committee consider potential solutions to meet the needs of people with early-stage dementia specifically as you consider the mental health and addiction needs of Ontario's seniors. As much of the current research suggests and some of our early findings reflect, people with dementia and their partners in care typically manage their disease much better when there is an early intervention after diagnosis. When access to ongoing, reliable support and education is provided in the early stages, serving to inform and support families throughout the continuum of the disease, crisis is often mitigated and prevented, and caregiver burnout and illness are avoided.

Since launching First Link in Thunder Bay in February 2009, we are seeing an increase in referrals and expect this number to continue climbing, and we will likely face a capacity issue in delivering our services, which are currently provided free of charge and without restrictions or caps of any sort to the consumers.

One of our greatest challenges with the First Link program is having the human and other resources to deliver this program within our vast geographic territory with a diverse population, including First Nations people. To this end, as a small non-profit society, we are embarking on evaluating telehealth services and community capacity-building projects, which, as you can understand, are often challenging for a non-profit agency to sustain due to fiscal restraints and our reliance on private and public support.

Over the past decade, with the divestment of some services formerly provided within psychiatric hospitals to a more community-based approach, there has been somewhat of a cultural shift in health care. We believe that, as part of this cultural shift, programs like First Link have strengthened the delivery of health care support. We believe that continued and expanded investment into services and supports for people with Alzheimer's disease or a related dementia may prepare us well for the rising tide that the Alzheimer Society of Canada study speaks to. That, most importantly, will provide the greatest potential to maximize quality of life for persons with dementia and to support these individuals and their families, while reducing institutionalization and overall health care costs.

In conclusion, we would urge the select committee to include in your report a specific recommendation to government to include support for people with early-stage Alzheimer's and related dementias.

Thank you, Mr. Chairman, members of the select committee, ladies and gentlemen. Dr. Morrison and I would now be very happy to take any questions you might have.

The Acting Chair (Mrs. Christine Elliott): Thank you very much. We do have some time for questions, starting on this side, if there are any questions. Yes, Ms. Sandals?

Mrs. Liz Sandals: Your name is the Alzheimer Society of Thunder Bay, but I take it from your com-

ments that you serve all of northwestern Ontario. What area are you serving?

Ms. Jennifer Fawcett: Our catchment area: There are two Alzheimer chapters in northwestern Ontario—the other is based in Kenora. They serve the Rainy River district and we serve the Thunder Bay district, so basically from Atikokan to essentially Longlac in the east. It's not the entire service. They don't currently have a First Link program in Kenora.

Mrs. Liz Sandals: So you would have difficulty, then, serving people in the smaller communities that aren't actually right in Thunder Bay?

Ms. Jennifer Fawcett: It's very challenging. We did a tour this spring where we went out to the smaller communities that are in our catchment area. We are confronted with caregivers who often are female—women who have never driven in their life—and their spouse is soon to be institutionalized and they are struggling to keep them at home as long as possible with very little support, very minimal support.

One of our projects is to do sort of a community capacity-building type of exercise, where we pilot a small community and we try to empower them to have support groups left behind that we can visit periodically and enable some community champions to come forward with a special interest in seniors' mental health and have them run support groups. We link quite strongly with the community care access centre in those communities and do work back and forth to enable those services.

Mrs. Liz Sandals: Okay. That was my next question, how you link with the CCAC, but you've got that link in place.

Ms. Jennifer Fawcett: Yes.

Mrs. Liz Sandals: Thank you.

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

Mrs. Maria Van Bommel: We're just getting back into things here.

Further to Liz's question about your catchment, so to speak, I'm just wondering, how do you work or interact with the aboriginal population in the north?

Ms. Jennifer Fawcett: That's another growing area for us. We have visited some of the First Nations communities. One of the things we are finding is that there is not the recognition that Alzheimer's disease is a concern within the community itself. It certainly exists. It's beginning to be recognized. I think, because it is somewhat of a younger population, they're not as confronted with the disease. I also believe it's somewhat accepted as a natural part of the life and death cycle, so it may not be seen as behaviour that might be out of the ordinary, but certainly they're coping with it by keeping people at home, again, as part of the culture for the home-based care.

We believe we have a strong role in providing education to caregivers on how to best enable to keep people at home and how to recognize the signs of dementia, that it isn't a normal part of aging, and that there are supports and treatment available. So it's an education process.

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We're in the process, this fall, of holding a number of meetings with aboriginal organizations in Thunder Bay on how we can do a better job of supporting. But some of it boils down to whether we have the capacity on the staff to deliver culturally sensitive programming, and that's certainly a concern for us and one of the areas that we'd be looking to invest in in hiring the right people to do that. So that's certainly a gap.

Mrs. Maria Van Bommel: Thank you.

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

Ms. Sylvia Jones: Just one question about First Link. That's all coming through the LHIN?

Ms. Jennifer Fawcett: Yes, our funding is through the aging at home strategy.

The Chair (Mr. Kevin Daniel Flynn): Are there any other questions? If not, I'd like to thank you for coming. I wasn't here for your presentation, but I bet it was a good one.

ANDREAS BUCHHOLZ

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is at 9:40, Andreas Buchholz.

Okay, it's all yours. Everybody gets 20 minutes this morning and you can use that any way you see fit. If you would leave some time at the end for some questions, that would be great. It's all yours.

Mr. Andreas Buchholz: All right. First of all, I'd like to thank you all very much for coming to Thunder Bay and giving us this opportunity to talk to you today about our concerns on the mental health system and considering our suggestions. My name is Andreas Buchholz, and I'm a volunteer with the Schizophrenia Society of Ontario. I also sit on the board of the Schizophrenia Society of Ontario, but I'm not speaking as a board member.

My purpose here today is to advocate for people who have a mental illness or a mental condition that is poorly treated or untreatable and have come in contact with or are destined to come in contact with the criminal justice system. To me, it doesn't make sense to charge people with a criminal offence whose thinking ability has been compromised by the effects of a serious mental illness. Sometimes even after a person's mental illness has been stabilized, the resulting cognitive function has been reduced to a point where they cannot make important judgmental decisions. These people should be also diverted from the criminal justice system.

Do we expect a person who has just broken a leg to get up and walk normally at that moment? No. Do we expect a person who has diabetes to have a pancreas that properly assimilates sugar? No. Then why do we expect a person whose brain is diseased to still be able to continuously make decisions that would keep themselves within the boundaries of the law?

What we need is a system that will divert people that have a poorly treated or untreatable mental illness from the criminal justice system so that they can get proper

treatment for their illness. Although there are systems in place to do that, they only apply to certain charges and are not available across the province; and for charges that are more severe, like assault, and where they do not meet the criteria of "not criminally responsible," they often end up in jail without treatment. The system needs to ensure that all mentally ill people receive the treatment they deserve regardless of the charges that are brought against them.

There was a study recently done in Edmonton—you can Google it; it was written up in the Edmonton Journal in July—to answer the question of whether treating mentally ill offenders for their illness would reduce the incidence of reoffending. They took a group of mentally ill offenders who were in trouble with the law over an 18-month period before the study began and arranged treatment for their mental illnesses, and provided them shelter and meaningful work. The result was that over the next 18 months following the treatment, 80% of this group did not reoffend. That leaves 20% that still reoffend, and in my opinion, a percentage of these reoffend because of the following reasons:

(1) They have an untreatable mental illness.

(2) Their mental illness was not effectively treated.

(3) They have other mental illnesses that have not been diagnosed alongside their treated mental illness. and

(4) Their mental illness has been effectively treated, but they are left with a reduced cognitive function caused by their mental illness.

So what do you do with people who commit crimes that are based on a poorly treated mental illness or condition? If these people were never sick, would they still commit these crimes? I would say, for the vast majority of them, no. The incidence of criminal behaviour, then, would be the same for the general healthy population. So in reality, they deserve the same quality of life as any healthy individual with some provisions to protect them from themselves and society. The problem is we presently do not have health facilities that can accommodate people who behave contrary to the laws of our society because of their mental illness.

My experience: I have a brother who is a couple of years younger than I am and has a serious mental illness; perhaps he has multiple mental illnesses. He was diagnosed with schizophrenia and is taking the last-resort medication, clozapine, to stabilize him. Although he is stable, he still hears voices and cannot distinguish reality from fantasy. He has been institutionalized for 30 years. Many attempts to integrate him back to society have failed.

One of his anti-social behaviours is that he tends to strike out with his fists at people without provocation. This behaviour tends to get assault charges pressed against him periodically from fellow patients and staff at the local institution. Everything attempted so far to prevent my brother from striking those around him has not been successful, except for one. This method involved having a member of the staff accompany him continuously through his waking hours. But he has to be monitored continuously. There was one occasion when a staff member assigned to him turned her back briefly and my brother immediately struck a fellow resident.

Over the years, my brother has had several charges pressed against him, and currently there are three more. Even though they have him in voluntary restraints to limit the extent of his arms, he is still able to harm somebody. His frequency of attacks has increased over the years. Ten years ago, there were two or three incidents a year. Over the last few years, it has ramped up to the point where there is now an incident every two weeks.

These are the emotions that my family and I have to live with:

Anguish: Each incident further reduces the options he has available to him. We fear that he will go to jail, we fear that he will have to leave our community for a long period of time, and we fear that with each assault, he may come closer to someone who could seriously injure my brother or worse. We fear that if he goes to jail, he will be a target of other inmates because of his mannerisms and nonsensical way of talking.

Frustration: Why can't his behaviours be stopped? Why can't he be in an environment that will protect those around him and give him a good quality of life until they find a solution to his behaviour? Why is he allowed to walk around other people without being closely supervised when everybody knows full well that he will strike out again? I know this costs money, but what about the emotional costs of his victims and families? Locking him up is no solution either. This would dramatically reduce his quality of life and would worsen his symptoms. Every incident increases the anguish and frustration we are feeling. We are very anxious and fearful about my brother's future.

The patients there have their own issues to deal with, and we are very concerned about the people who live with and work around him. They don't need to live in fear of someone who strikes out at them at random. We also feel very much for their families—some of their relatives are quite old—because they have this additional burden of worry for the safety of their loved ones.

Anger: We also feel anger at the mental health system, because they are unable to do more to help him because of limited resources and exceedingly difficult access to available resources. They have never dealt with a patient like him, even though they've known and cared for him for 30 years. Shamefully, we also feel anger toward my brother for his continuous acts of aggression, even though we know he may not have any control over them.

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Legal fees: We have been hiring the best lawyers we can afford to represent my brother. This has cost us thousands of dollars, and now he has three more charges against him: all unnecessary had he been prevented from getting himself into these situations using strict supervision. These incidents have caused us great heartache, frustration, anger and thousands of dollars in legal fees, and it doesn't seem to end. In fact, it's getting worse.

One-on-one supervision of individuals like my brother will cost a lot of money, but putting these people in jail

or in some form of isolation because of something that is no fault of their own is no solution either, not to mention legal costs, court costs, costs involved with the actions of the individual, police costs, emotional costs to victims and family members of the victims and also the emotional costs to the mentally ill person. For those who reoffend because of a poorly treated or untreatable mental illness or condition, there needs to be a community-based environment that is safe for the individual and safe for the community. At the same time, it must give them a quality of life that is as close as possible to the average person who is healthy.

The best place to keep the mentally ill reoffender is in their home community close to their families, instead of shipping them out to designated facilities in other communities. But community-based facilities are just not equipped to deal with mentally ill reoffenders, particularly those who are violent. I have a friend who lives in Kenora, Ontario, who has a severe form of depression and is possibly also bipolar. In one particularly bad incident he was having, he checked himself into the hospital there. There, they encouraged him to be open about his thoughts and feelings so that they could properly diagnose and treat him. He thought, "Okay, great." So he told his doctor that he was having violent thoughts toward people. The doctor told him that he'd better keep those thoughts to himself. If he mentioned that to the staff, they would bring in large staff members to restrain him and call the police, as the hospital is not equipped to manage patients who are violent: "If you are violent toward yourself, we can deal with that, but not toward other people."

Care facilities need to be equipped to manage violent patients too. Jails are not psychiatric hospitals. How can patients be honest about their symptoms and receive the care they need and deserve?

What are the solutions? Here are my solutions to keeping the mentally ill charged with offences from the criminal justice system and providing them with the best quality of life:

(1) Instead of charging the mentally ill with offences, treat them for their mental illness.

(2) Equip all care facilities with means to manage violent patients.

(3) Assist them with housing if they require it.

(4) Assist them with keeping to their medication schedule.

(5) Assist them to discover and pursue their interests.

(6) Assist them in establishing meaningful work.

(7) Assist them in establishing a social network.

For those whose mental illness or condition is such that it cannot be effectively treated and who are at a high risk to reoffend, then I propose the following:

(1) Provide supervision to ensure the safety of the individual and society. Some require little supervision; some, like my brother, would require constant, one-on-one supervision. This, of course, would be extremely costly, but there also would be cost savings from the actions of the mentally ill offender: court and legal costs and the emotional costs of the victims.

(2) Have the option of using restraints if the person is unpredictably violent.

(3) Maintain a quality of life as close as possible to the average healthy person. This includes social interaction, daily activities like hobbies and exercise, meaningful work, etc.

Conclusion: People who commit crimes because of the effects of their mental illness or mental condition have every right to be treated for their illness instead of having to go through the criminal justice system, regardless of the crimes they commit. The Edmonton studies show that had they been healthy, they most likely would not have made the same decision. Ideally, society will evolve to the point where mental illness can be recognized, diagnosed and treated before the individual begins to commit crimes.

Community care facilities need to be equipped to care for individuals who are violent, so that they can get the care they deserve. People who have mental illnesses and conditions that are poorly treated or untreatable still deserve a quality of life, just like everybody else.

Thanks very much for listening.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Andreas. Great presentation. You've left about six minutes for questions. Christine? Sylvia?

Mrs. Christine Elliott: I have one factual question. First of all, thank you very much for coming. I think you've highlighted some of the really significant issues that we need to deal with. There's no question that for many people with a mental illness, putting them through the criminal justice system is not the answer, so we're taking your comments very seriously.

I'm just wondering where your brother is now. Without naming where he's living, is he in a hospital setting, in a secure facility in hospital?

Mr. Andreas Buchholz: Yes.

Mrs. Christine Elliott: Okay. I'm sorry that that's necessary, but we are taking your considerations very seriously, because there is a significant gap there that we need to address. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Other questions?

You must have done a wonderful job explaining everything. Thank you very much for coming.

SANDRA MacLEAN

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning—we've all been looking forward to this one—is Sandra MacLean. We've heard a lot about it. We knew it would be a little different. Come and make yourself comfortable.

Ms. Sandra MacLean: I'm leaning on the hockey stick, and I figure nobody can go uncheered with a hockey stick.

The Chair (Mr. Kevin Daniel Flynn): That's right. There are some clean glasses and some fresh water there,

if you need any. Everybody is getting 20 minutes to make their presentation, and you have 20 minutes as well. Use that any way you see fit. If you leave some time at the end for questions, that usually works out pretty well too.

Ms. Sandra MacLean: Thank you. I've got contacts in as well. I'm just trying to see if I can—I have bifocals and I still have a hard time seeing. This is as bright as it gets, eh? All right.

Thank you very much for giving me the opportunity to come today and speak. It's been just wonderful.

Presentation to the Select Committee on Mental Health and Addictions seeking input on mental health and addiction needs in Thunder Bay and northwestern Ontario.

I would like to thank the honourable members of the provincial Legislature for coming and for the opportunity given to me today to tell my story as it relates to the need for psychiatric emergency services both in our community and across the province. As a mental health nurse working on the front lines in our community for the past 12 years, I have witnessed how things have evolved and changed. I hope that after hearing my story, you will be able to come to appreciate the challenges that we face, but also our strengths as a community and service providers as we strive to make things better for the people we care for.

Memories of my past experiences working as a mental health nurse always come back to me when I think of why I still love my job. I remember a couple of years ago, while at a concurrent disorders conference in Vancouver, a woman approached me in the elevator at the hotel. She said, "You don't recognize me, do you?" I shook my head, and she replied, "You saw my son in Thunder Bay, and I just wanted to tell you that he's doing much better." The door to the elevator opened and I got out and smiled all the way back to my room.

The people I see on a daily basis are struggling with so many issues that it would be best to prioritize them. The first is access. Access to services for individuals experiencing a mental health crisis or a mental illness is difficult if you do not have a family physician. A family physician is so important when someone is considering starting an antidepressant or is seeking counselling for mental health issues. I have witnessed people's frustration first-hand after they are told that psychotropic medications would not be prescribed because they do not have a family physician to follow up with their response to the medication.

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Lack of access contributes to people not coming for care, and we on the front lines see that it is usually not until they are acutely ill with a psychiatric illness and come to the attention of police, fire or ambulance that they are brought in for assessment. At this time, we see individuals incapacitated by their symptoms to the point where they require longer hospitalizations because they've been struggling on their own for so long without services.

My next priority is providing a safe and welcoming environment. Safety is something we're always aware of, as sometimes individuals who are acutely ill and struggling with depression, panic and obsessive thoughts find it difficult to get help when front-line services are so noisy and chaotic. We find that these individuals often leave before being assessed because they can't cope with the environment. Our only recourse is to call police and have them brought back for assessment, offering no therapeutic advantage at all. Front-line services have no lock on the door, they can turn no one away and, as a result, people can leave before help is provided.

I've been lucky in my time as a mental health nurse to meet wonderful people who present seeking help. I'm in awe of their gentleness and quiet strength. I find that I often have to apologize for the noisy environment I work in and the lack of privacy. I encourage them to bear with me as we are interrupted and asked to move and make do in an environment that is ill equipped to ensure that confidentiality is maintained.

We try our best but I feel for the individuals I speak with who have thought and thought at length about coming for help. When they finally have the courage to come to tell their stories, their struggles are often overheard by strangers. For a person coping with a mental illness, this only adds to their feelings of alienation and vulnerability.

Timely response when people do access front-line services is my next priority. This is critical. For individuals at risk during withdrawal from substances or suffering from a decompensation in their mental health, prompt intervention is crucial but often not possible as front-line services also manage traumatic injuries coming in the door. One would speculate that if someone presented with cardiac symptoms, they would be connected to a cardiac monitor immediately, or if a physical trauma was endured, a trauma team would be contacted to ensure that the appropriate intervention and treatment was begun. In the case of someone who presents with acute depression, obsessive thoughts, panic and paranoia—their wound, their trauma—they are often left to wait until actually admitted to a mental health unit before interventions are initiated to reduce their distress. Caring and capable nurses who are not trained as mental health nurses are providing care for these individuals, and they often say to me, "There has to be a better way."

It has been said that a crisis is a time of danger and opportunity. For an individual living with a mental illness who also has problems with addictions, a crisis is often the time when they are most motivated to make positive changes in their life. Missing these opportunities because of lack of front-line services such as a medical detox, pre-treatment beds or spaces in treatment programs can have dire outcomes for these individuals as they often go back to an environment filled with drug-using friends or dealers. Extricating themselves might not be so easy the next time.

People who have chronic mental health and addiction needs are often marginalized in our community. They

live on the fringe and associate with other individuals with similar problems. It is estimated that at least 60% of individuals diagnosed with a mental illness also have problems with addiction. For individuals who suffer with co-morbidity, they are often the hardest to find services for as programs are saturated and clinicians are stretched to the max as they cope with larger caseloads and people lining up to get into their programs.

I have spoken with parents who have gone into drug dens to bring their opiate-addicted child in for assessment and I can feel the parents' sorrow and fear as they look to the professional for help. Their child denies that they plan to hurt themselves, and with no medical detox available and only one opiate female bed at detox, I feel as if I have nothing to offer except support. I encourage the parents to bring her back if she becomes worse and meets the grounds for a form 1. They look at me in disbelief: "How much worse can it get?" Their child's foot is swollen from injecting IV drugs. The cellulitis is treated, and their child is then sent back to the environment from which she has come.

The IV drug use in our community, whether it is opiates or cocaine, is crippling the lives of individuals of all ages. Compound this suffering with a mental illness, and you can see how complicated things can get. I can only hope that one day, flexible, responsive and immediate services might be available in our community and other communities with the same issues across Ontario.

Size and geographic location are so important and have an impact on front-line services. Northwestern Ontario is roughly the size of France. Northwestern Ontario is dotted with remote First Nations communities and reserves. Flying out of these communities is often the only way people have to access professional mental health and addiction services. I have spoken with families who have driven in from Kenora, Dryden, Schreiber and Terrace Bay with extremely ill family members either suffering either from decompensation of their mental illness or who are acutely suicidal. We then have a huge responsibility on the front lines to get it right the first time, as these individuals have precious few resources to return to.

Mental illness and addiction issues across the lifespan: Children are special. We try to do our best for them because they have usually come from school referred by a counsellor or teacher who is keenly aware that this child may need help. We feel the pressure because of the long wait lines for children with addiction and developmental problems. We have only one child and adolescent psychiatrist in Thunder Bay. The children I speak with are wonderful, funny, bright and resilient. I'm amazed that these qualities come through even when they are coping with past traumas and have problems with emerging mental illness and addiction.

You might ask, "Where is the hope when it appears that issues affecting individuals of all ages in Thunder Bay are so acute?" My hope is in the individuals themselves and their loved ones who bring them to our attention. Their trust is something that I take very seriously. I've been honoured and privileged to hear their stories over the past 12 years, and it is their trust I will try to repay by offering my advocacy for the best care that can be provided for them.

Better care for individuals coping with mental health and addiction issues in Thunder Bay and northwestern Ontario could be provided with the creation of an integrated psychiatric emergency service attached to the ER at Thunder Bay Regional Health Sciences Centre. My dream fulfilled would be built on four major initiatives:

—The newly created psychiatric emergency service would be staffed by psychiatrists and mental health nurses, ensuring that recovery from crisis and psychiatric illness begins at the door.

—A safe and secure environment for individuals presenting in crisis would be assured. Confidentiality would be maintained, and stories shared would be respected and honoured.

—The attending psychiatrist and mental health nurses in the psychiatric emergency service would provide initiation of treatment, limited follow-up, and referral to providers in the community. Most of all, it would ensure continuity of care and timely intervention for those individuals not requiring admission.

—The psychiatric emergency service would address the addiction issues of individuals with co-morbid mental illness. Timely intervention and response to those with addiction issues would be addressed with community agencies invited to participate in the discharge planning process from ER.

This is just a start, ladies and gentlemen, but if we don't begin, we will never get finished. The right care for the right person at the right time is waiting, yet to be provided. I believe that an integrated psychiatric emergency service should be the model of care for all of Ontario and not just Thunder Bay.

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I would like to thank the select committee for giving me the opportunity to tell my story. If we have time for questions, that would be great.

The Chair (Mr. Kevin Daniel Flynn): That is great, because we do have time for questions. Thank you very much for your presentation. We'll start with Christine and Sylvia.

Ms. Sylvia Jones: Thank you for your presentation. It was excellent. You referenced the child and adult challenges. Yesterday we heard strong advocacy for removing the artificial line between adults and children. I'm gathering from what you're saying in your presentation that you would support the same thing. Is that right?

Ms. Sandra MacLean: As front-line mental health nurses, we see people of all ages. Children are especially important when we look at mental health and addiction issues, in that if we can initiate treatment at the front line, we can possibly affect mental health and addiction issues sooner and turn those addiction and mental health issues around so that our mental health services aren't taxed when these individuals become adults. They have a better chance for recovery if we address their issues sooner.

Ms. Sylvia Jones: Thank you.

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

Mr. Bill Mauro: Ms. MacLean, thank you very much for your presentation. I'm interested in the first point that you raised around access for people with mental health challenges, and specifically around primary care.

As you know, in all of northern Ontario and now broadened out into the entire province and country, and globally, there are significant issues related to access to primary care. In northern Ontario and northwestern Ontario we chronically face that challenge. As a government we've taken several steps to try to increase access, and I think many more people now do have access, but there are still big gaps, especially here in northern Ontario.

One of the pieces we brought in was the creation of family health teams where they roster patients. I guess my question to you, as a practitioner dealing with mental health issues on a daily basis, is, do you find that that model is working and creating access for people with mental health issues or are they being—it has always been difficult for them to get access to primary care. Is this model helping them to get care? Do you find that they're being refused to be rostered by primary care physicians? Or do you even have a sense of how that has evolved?

Ms. Sandra MacLean: Thank you for your question. I can only speak from my own experience, and that's on a daily basis over the last 12 years.

With psychiatric emergency services initiated, where someone can be started on medication immediately when they present in crisis or with symptoms and can be seen by a psychiatrist and mental health nurses who can make recommendations back to a practitioner, whose expertise may not be mental health and addiction, that would support that practitioner. I feel that then would open the gateway for dialogue that they would actually take that patient on, because they realize that the medication has been started by someone who knows, so that they have a sense that they're not operating in isolation, that there's actual support out there for them. I think that continuity of care would be continued, then, right at the front door of front-line services. I think it can only help.

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

Ms. Helena Jaczek: Thank you so much for your presentation. We've heard in the course of these hearings some really quite heart-wrenching stories from parents who have a teenaged child who they're very aware is having terrible mental health issues. They've gone to the family doctor and they've gone to emergency, where in fact the diagnosis is made that the child is mentally ill. They run into issues around confidentiality, where the teen really does not want the health care professionals to share with the parents the issues that are in fact there. The child can be discharged, sometimes very prematurely, certainly, in the views of the parents, and they're expected to pick up the pieces without really having had any input.

Now, realizing that there's a balance between confidentiality rights of the patient versus those of the parents, who are in fact required to continue with care, how do you see this issue? Do you have any solutions related to this balance?

Ms. Sandra MacLean: I guess what I see on a daily basis on the front lines when I see individuals is that they usually present in a mental health crisis, whether that's something that's primarily mental health or something that's also triggered by addiction issues or a combination of both.

Across the lifespan, front-line mental health nurses would be the ones who would interview someone with a mental health and addiction issue if they were a child or adolescent; 80% of the recommendations that we put together for the front-line doctor would be based on collateral information obtained from parents. It's not done in isolation. Recommendations from what we can see as mental health nurses, right at the very beginning, involve 360 degrees. They involve the child, the adolescent, the parents and also getting a picture that the parent and the child are actually on the same page.

When you have mental health nurses able to do those kinds of assessments, you get that comprehensiveness. You get that because risk is so important at that stage. We need to have as much information as we can to make qualified recommendations. That is totally important to us. Again, it speaks for psychiatric emergency services for all ages where mental health nurses are involved in that interview process from the time they present in emergency.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): I have one question for you. Thank you for the presentation, by the way.

It's interesting how systems evolve. I guess when somebody is going through a crisis, the first thing they think of is, "I'm having an emergency, therefore I should go to emergency." I think any sound analysis would tell you that that would be almost the last environment you would want to be in while you were going through a crisis: You've got people having heart attacks; you've got traffic accident victims; you've got elevated emotions; people are sort of running all over the place; you've got children in pain who are crying. That, to me, seems to be the last place you would want to be when you're dealing with somebody with a crisis. How would you describe the place where they should go? What would the environment be like where somebody should go?

Ms. Sandra MacLean: My dream is actually to have a psychiatric emergency service integrated with and adjacent to ER at Thunder Bay Regional Health Sciences Centre so the kind of busy, chaotic environment that you're describing wouldn't be the one that individuals have to deal with who are struggling with mental health and addiction issues.

If the psychiatric emergency service was adjacent to emergency, you would have treatment beds; you would

have interview rooms; you would have assess-to-admit beds; you might even have a holding bed; you'd have interview rooms where discharge planning could begin right from emergency with community service providers. You'd have a safe environment where people couldn't just run out the door before you had a chance to assess their level of risk; you'd have treatment and intervention begun by mental health nurses and psychiatrists who can begin to talk to individuals and help them reframe the way they're thinking, get to the bottom of their symptoms and start that treatment process right at the door. It's so important and, unfortunately, because of our lack of front-line services at this moment, that is not happening.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. That beep was telling me that your 20 minutes were up. You've got to tell us about the hockey stick, though.

Ms. Sandra MacLean: One last thing that I have to say—it's a quote, actually. First of all I'd like to thank everybody who has come today to support my story because this is their story as well. These are people who work in emergency, community service providers, head of emergency, mental health nurses, psychiatrists, and they've all come today to support this story because this is theirs as well.

The reason for my hockey stick: In closing, I'd like to quote from a famous Canadian hockey player, number 99, Wayne Gretzky, now turned philosopher. Wayne has said that "you can pretty much guarantee that 100% of the shots not taken will never get in the net."

Ladies and gentlemen, this is our shot.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. An excellent presentation.

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ONTARIO PSYCHIATRIC ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): That's going to be followed up by the Ontario Psychiatric Association: Dr. Paul Mulzer. Let's see you top that.

Dr. Paul Mulzer: I think it's always problematic when you come with no props.

The Chair (Mr. Kevin Daniel Flynn): That's right. Where's your stick?

Dr. Paul Mulzer: I'm in trouble from the beginning.

Sandra's a wonderful example of the quality of mental health care providers that we actually have on the front line. First, it was just wonderful to hear her speak. She was very worried about her presentation, but clearly she's very articulate and very passionate in her perspective of the emergency needs here in Thunder Bay.

I'm representing our provincial organization, the Ontario Psychiatric Association. It's a great honour to be able to address the group today. I'm very pleased that this is an interministerial group. I think that's really critical. In fact, I think it's one of the most important initiatives: that it really transcends partisan politics and that it's something that can continue subsequently. I think it's a very important initiative in its own right.

The Ontario Psychiatric Association represents the needs and the services of psychiatrists in the province, both through the OPA, the coalition of psychiatry, and the OMA section on psychiatry. Effectively, with the exception of a small group of renegades, we represent most of psychiatry in Ontario. We're very committed to seeing the growth and development of mental health and addiction services and issues around accessibility that are articulated in the Every Door is the Right Door document. In fact, the issue of comprehensive care delivery is something that we've been very passionate about for over 90 years.

I had the great fortune of attending the summit in July and appreciated having an invitation to attend. I certainly enjoyed dealing with my colleagues there—and of course family members and patients as well, expressing their hopes, really, for another important initiative. Unfortunately, I also have corporate memory, so I've attended many similar things and seen lots of other initiatives that became leather-bound volumes—dusty, wonderful books on shelves going back to, certainly, the Graham report and before. So it would be very important and we're really committed to seeing this not suffer a similar fate, to see it become an initiative that really takes flight.

I note with interest that you describe "transforming" the health care system. I think it's important, the selection of terminology. You're not talking about simply tweaking the system, oiling it, fine-tuning it; you're talking about transforming it. I think that's a powerful statement. It's one that usually comes with a significant financial commitment—

The Chair (Mr. Kevin Daniel Flynn): Just so you don't have to sort of confine your statements, the report was authored by the ministry and by the minister. We're a select committee of the Legislative Assembly, so we're travelling the same road, but the report was not authored by us. Certainly, I think it's a report we find a lot of agreement with, but if you find you need to make remarks outside the scope of that report, feel free to do so.

Dr. Paul Mulzer: That would be excellent. I do want to limit some to the report, and certainly I'm very happy to speak outside of the report and welcome questions as well.

I won't belabour most of the issues within the report. I thought there were some extremely important points raised in the document as well. Particularly on page 16, where they talked about the impact of the expenditure of a dollar spent on mental health care, the $7 in terms of health cost savings and $30 of actual productivity and social cost savings, it seems like, as a stimulus incentive expenditure, it may be one of the most fruitful and productive ones the government may encounter. So really, again, we see the need to fund this initiative appropriately. There's some degree of scepticism that some of the objectives that one wishes to achieve can actually be successfully achieved without an infusion of new

capital. Again, I'm not an accountant, but I see that as logistically an extremely difficult process to achieve without that.

I certainly see the stigma for our patients as a barrier to access and care. We also see the stigma as care providers. I think this becomes a very critical issue when you talk about recruitment and retention. I think of the great Biblical quote, "The harvest is plentiful and the labourers are few." One of the difficulties with recruitment—and of course the other challenge is the aging of our profession—is that we're a very stigmatized profession. There is a sense of disregard for the role that psychiatrists play in teams. Quite frankly, Every Door is the Right Door has the flavour of that in its document as well. There are some issues that we have with its minimization of the importance of treatment as part of comprehensive care. We see those things as being a very critical part of it. There's a tendency to have a reactive/proactive kind of discussion in that document. We see a need to be proactive and reactive to some of the crisis issues that we see as well, so I don't see those as mutually exclusive issues.

There's a tremendous amount of stigma and misinformation. It's not limited to individuals of the public. We certainly see it professionally. There's a fair amount of ignorance even among our professional colleagues that we contend with on a regular basis. These are significant barriers for care acquisition that make people reluctant to access it. They make medical students reluctant to consider psychiatry as an area of specialty, which is very unfortunate.

I joke with my students that we're the area of medicine where something doesn't go "beep." Basically, our tool, our instrument, is the effective relationship we establish with patients, and we have the great Hippocratic tradition, so it's really the ability to establish relationships and build rapport. That's the fundamental foundation of all treatment. I think that's a marvellous thing. It's why I went into psychiatry, so I don't have to worry about things that go "beep"—jokingly. Things get funded if they go "beep"; if they don't go "beep," they don't get funded. We recognize that as well in terms of research and development in mental health. I think one of the greatest strengths we have in this profession is that relationship, and it's really a wonderful relationship we have with the patients.

My particular field is both in mental health and addictions. Concurrent disorders has been a field where there's been a real burgeoning of interest, but it has really been in the last two or three years, remarkably, because of course it has been an issue, as Sandra eloquently stated earlier, throughout our history of mental health care delivery, whether we talk about opiates around the turn of the century or our current crisis here in the northwest.

I think we need to recognize that the challenges that we face are really integrating those services effectively. They do exist as silos. They exist as silos largely because addictions was never considered a legitimate field of medicine, and there are some people who would still challenge that even today despite clear evidence to the contrary. That becomes an important challenge in terms of recruitment, service provision and integration of services.

I do refer to the document Every Door is the Right Door as well, and the idea of the provider-driven health care system. I've personally been in practice now for just over 20 years. I've never seen provider-driven care. I've seen administratively driven care, but not provider-driven. I have very little control over the allocation of resources. I'm very seldom directly consulted, as is true of many of my colleagues, on how resources are allocated, which is extremely unfortunate. I use the term "administratively centred." I think patient-centred care is a goal that we can achieve; I think it's one we need to achieve. It's a very critical one. But I frankly don't think the barrier to it is the provider.

I think, again, it's a really stigmatizing issue. We frequently see the comments of the psychiatrists as a barrier to change in the system. I've never seen that. I've not seen it from the period of deinstitutionalization of psychiatry, through our entire history of psychiatry. That's not been the issue; that's not been the barrier that I've seen. The barriers are really largely issues around funding models provision, and mandates that are established by various ministries.

The comments that I frequently hear aren't among therapists who are prepared to integrate services; they are among administrative systems that say, "That's not my mandate," or "How are we going to fund that?" or "Who's going to pay for that? I like that integration, but who's going to pay for that service?" To me, that takes us away from patient-centred care, and I see those as administratively driven concerns. I see them as having tremendous medical implications, but the root is not with us as providers. I think if you leave with nothing else, that may be the element of folklore, almost, because it has reached the level of folklore, that needs to be dispelled. It's probably one of the most important barriers.

I think we need to fund. I think we need to fund research and we need to fund addictions services, and education is a critical part of that. Certainly, rampant opiate addiction is an issue around education. It stigmatizes two groups. One is the addicted patient who has found himself or herself addicted to prescription opiates, and the other is the chronic pain patient who has no addiction at all but can't access chronic pain care medication and is in a state of tremendous distress as well. We need to recognize both of those two poles of distress and we need to be very mindful of the skill set required in order to meet both of those needs.

I think the other critical issue is that centres of excellence exist outside of the GTA, and we need to recognize that. I have tremendous respect for CAMH as an organization, but it is not the voice for the province. It does often have the influence of government, but we need to look beyond that and recognize that we need to build centres of excellence elsewhere.

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I posted the ASAM exams for December 2008—I just pulled them off before I came here—because I'm curious

as to how many people sat the American Board of Addiction Medicine, which we consider our standard for addiction medicine in Canada; unfortunately, by proxy, we use the American standard. Thirty-three people sat the exam in the entire country, 19 in Ontario, and most of those in the GTA. Again, CAMH seemed to have the lion's share of those, and Homewood Health Centre. North of Kitchener there were two, and I'm the only one in northwestern Ontario. That tells you, again, the harvest is great, the labourers are few. We need to promote the acquisition of skills in addiction medicine because we need to recognize its critical importance, and that needs to be disseminated.

Stigma needs a public education campaign. It's the same kind of aggressive campaign we looked at with HIV in the 1980s when people were concerned about sharing hand towels and "Can I drink out of that teacup because you've just handed it to me?"—all of those concerns. We attacked that with an aggressive public education campaign, and I think we need to do likewise when we look at issues of stigma around mental health and addictions. I think those are really critical.

The field of concurrent disorders, a field that I have tremendous passion for, is a rapidly growing field. It has very few practitioners within it. They are overburdened. They burn out. They go into general psychiatry. They do it at rapid speed so that those 19 that we have currently in our population that have just sat their boards—and I congratulate them for doing that. I hope they stay in that field; that's the other great concern I have for recruitment.

I think Sandra talked very well about the transition between youth and adolescent services. That's an area of real passion for myself. I see a lot of young people drop out of youth services at 16 or 17. I see them again at age 20 with full-blown addictions and hepatitis C status, and I think that's entirely a preventable level of morbidity that we really need to address. Those things are critical.

Issues around smoking cessation in our population and gym memberships to address things like metabolic syndrome may seem like simple interventions, but they have tremendous medical and overall health implications in the quality of life of our patients, which I think are really important.

Again, Sandra epitomizes, from my point of view—and I think she's a wonderful clinician—the motivation, the drive, the initiative of individuals within mental health and addiction, and that gives me great pride, and it gives me great hope for the future. I think we have some very fine people. I think they're very motivated to build comprehensive services, and I think the key is the opportunity.

I stress once more the importance of finances. I use a Jerry Maguire quote: "Show me the money." I cannot see these effectively being achieved without a massive infusion of capital.

Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We appreciate the presentation. You've left about eight minutes for questions, so we'll start on this side with Liz.

Mrs. Liz Sandals: Actually, I'd like to go back to something that Sandra said and follow up on whether you have suggestions: her comments about the inability to start treatment with psychotropic drugs because there's no family physician to do follow-up. Given that a lot of the emergency clients will have a lifestyle that isn't going to lend itself to having a stable relationship with a family physician, how do you get around that? You're not likely to solve the problem of having them have a family physician. Is it an outpatient follow-up or having a nurse follow up? How do you manage that problem?

Dr. Paul Mulzer: Unfortunately, that's a very critical problem because those patients will frequently drop out of service provision because there will be no consistent provider of care. That's a very, very critical problem. Some of them will begin to use the after-hours clinic, the nurse practitioner clinics etc. to try and bridge that gap, but very frequently those individuals will be the ones, to use the analogy, falling through the cracks, who will actually not have ongoing care because they may not be connected to outpatient services.

The other issue is that patients in crisis who are really distressed may actually need someone back to navigate through the system to make sure of that follow-up. It's the power of making a phone call. One of our case managers had a recent situation with a client. Because he didn't respond to our appointment, we went and found him. He said, "Jeez, you know, we really appreciate you doing that, because you guys really are interested in our well-being." Those are important, especially early on in therapeutic relationships to establish that connection, but this would be precisely the patient where that would be very likely not to happen.

Mrs. Liz Sandals: So even if you can connect to do the initial intervention, we need to look at how you then follow that up in a stable sort of way.

Dr. Paul Mulzer: Absolutely.

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

Mrs. Christine Elliott: Thank you very much, Dr. Mulzer, for joining us today. I think you've given us an important perspective from a professional perspective. I'm really interested in the education of physicians and what you would recommend to assist primarily family physicians in recognizing and dealing with mental health issues as they present in their offices: what's missing from education now, if anything, and what you would recommend.

Dr. Paul Mulzer: There are some really good initiatives. The OCFP, the Ontario college of family practice, has a program called MMAP, which is really to provide support to family doctors. It's sort of like a mentorship program around addictions and mental health. Sandra Sass and myself serve in the northwest region. That's a really important initiative to begin to have that mentoring relationship where questions can be asked around medications and managing more challenging clients and can be done in an informal setting where we'll be setting up to do a social thing, which is part of the equation of

building those relationships. I think those resources can be very helpful and I think it's a very good initiative of the college of family practice.

Other initiatives would be around free—and I always stress free, because physicians are attracted to free—podcasts and other things that would allow you to do some online CME, which can be very helpful.

I think funding initiatives and resources, where I would fund an opportunity for speakers to present on various addiction topics, might be very timely in the northwest—for example, on opiate addictions etc.—at some of those conferences where some of that information can begin to be disseminated. I think those are very helpful.

And I think just a bank of presentations much like Telehealth has, where you can access various topics on addictions, can sometimes be very useful too, where someone in their down time can begin to explore that. Again, looking for CME—and free CME is often a real inducer. So I think creating those kinds of resources could be very helpful.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Paul. I have a question. During our hearings in Kingston we heard from the former chief of psychiatry at Kingston General talking about what was a perceived lack of psychiatrists and child psychiatrists in his community. His point, if I can sort of paraphrase him, was that there is no shortage of psychiatrists in Kingston; in fact, there are over 40. The problem is, less than 10 will see a patient. If I recall correctly, it was less than five would actually see a patient; the others were all doing research at Queen's, I think it was.

What percentage of people who are psychiatrists actually see patients in the province of Ontario?

Dr. Paul Mulzer: I can't give you that number. I actually don't have that number, but I think you raise a very important point. Academics is incredibly important and funding research is important, but not disproportionately. Again, not to speak to Kingston's specific challenges, but to speak in general across the province, that balance of academic to service delivery is a critical one. I think, yes, you can on paper have some very impressive numbers but it really is how many people are doing—that's why I don't seek promotion, because I like to do clinical things. I actually try and let other people do the administrative stuff.

One of the problems, as people develop and go through the system, is their administrative load increases and their clinical contact load can decrease. That wouldn't just be true of psychiatry; it would really be across a specialty issue. I think that's a legitimate concern, and certainly if you're talking 10 clinically, 40 actually in the community, I'd call that a major concern in that particular community.

Around children in general, though, I think the issue around specific recruitment for children and incentives for child psychiatry becomes very important. Psychiatry, as you know, is one of the more poorly remunerated of all specialties. Psychiatry, pediatrics and geriatric medicine are probably the poorest remunerated among all specialties, which is quite ironic, but it is what it is. What's interesting is that if you look among private practice child psychiatrists, they're the most poorly remunerated among all psychiatrists. So again, we need to recognize that it's funding models, resource allocation. All those things impact people's specialty selections when they're in medical schools, their formative years. Those are not insignificant variables that people look at as well.

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

Dr. Paul Mulzer: My pleasure. Thank you.

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JOHN HOWARD SOCIETY OF THUNDER BAY AND DISTRICT

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is the John Howard Society. Would Liisa Leskowski like to come forward?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): You don't have any hockey sticks? Make yourself comfortable. There are some clean glasses there if you need some water. You've got 20 minutes; you can use that any way you see fit. If you want to leave a little bit of time at the end for questions, that would be great too.

Ms. Liisa Leskowski: Okay. I've tried to time this for 15 minutes so we'd have some time. You have the handout that goes with my presentation—the coloured one. It kind of outlines the main points of discussion.

Thank you for giving me the opportunity to make a presentation before you today. What I will share is largely based on my experience as a service provider, but I can assure you that these same experiences reflect numerous community-based agencies in Thunder Bay and in the 18 John Howard Society affiliates across the province. Our collective concern for the numbers of clients we support with mental health and addictions issues, coupled with how resources have been allocated by provincial ministries in the past five-plus years, has been much cause of discussion and concern among ourselves and is really the impetus for my request to meet with you today.

My name is Liisa Leskowski, and I'm the executive director of the John Howard Society in Thunder Bay. As a community-based criminal justice organization, our mandate is to support people who are at risk or involved in the criminal justice system through service, advocacy, education and reform. We serve individuals involved in the correctional system, the court system and the educational system, and in First Nations communities. The John Howard Society of Thunder Bay provides supportive housing in a 48-unit housing facility, and we deliver programs with the courts and corrections systems, and community-based programs to individuals in conflict with the law.

Each year, thousands of individuals—men, women and youth—come through our doors for support. I would estimate that 70% of them have an addictions issue and 40% to 50%—and I think that's modest—suffer from a mental health issue. We do our best to provide necessary front-line support, engaging as many of our mental health partners as possible. Some of the things we've done in the past number of years: just this past year, since there have been more mental health workers in the community, having mental health workers come on-site; we have a nurse practitioner that we get to come on-site; and we've attempted to have a mental health nurse on-site in our building. Unfortunately, these collaborations have had a really limited impact.

I believe that timely and thorough assessments and early identification and case management are essential and required, but equally essential is the provision of direct front-line support in the community, provided not just on a 9-to-5 weekday schedule but reflective of the episodic nature of someone suffering with a mental illness or addiction. Because we provide housing in addition to daytime programming, counselling and support, we are consistently on our own when it comes to providing support for our clients with an addiction or mental illness. To illustrate this, I'd like to share a story of one of our clients. I'll call him John.

John came to live with us after his release from a local correctional facility. He had a diagnosis of paranoid schizophrenia, and we were advised that it was manageable with medication. He had violent tendencies, which were noted by his Ontario disability worker, his probation officer and his mental health worker. He suffered from depression, and a few weeks after his release he refused to take his medication and became increasingly agitated and depressed. After threatening numerous of our residents with a knife, followed by just as many warnings, we advised him that he could no longer continue living in our facility.

In an attempt to find him alternate housing that did not put the community at risk, we discovered that he had been banned from all other housing providers in the city, including the emergency shelters. Fearing that we would be putting the community at risk, we allowed him to stay with us until we could find him housing. So we went out and found him housing. He moved into his own place, and a month later he made headlines in our local paper for assaulting a taxi driver with a knife and was subsequently charged and incarcerated. This would have been two years ago, so I'm assuming he has been released by now.

John is one individual, but his story represents hundreds of individuals we support each and every year who face the same challenges compounded by a mental illness and addiction. John's story might have been different had we had the resources to provide the front-line, one-on-one support he needed. Unfortunately, there are virtually no sources of funding—health or otherwise—for us to tap into to hire mental health workers to provide this essential support to our clients. It is woefully inadequate to have mental health workers come on-site for two hours a week and expect us to make referrals to them—they do assessments—and assume that there's any assistance for us.

I've been with the John Howard Society almost four years. I found out about the provincial funding in 2006. When I discovered that the province was beginning to spend money on mental health issues for individuals in conflict with the law, I became encouraged and understandably excited. My excitement quickly turned to disappointment and frustration when I began to understand that none of the resources that were being allocated would be coming our way. We were advised that only agencies that had health numbers would be eligible for funding from the province. In fact, community criminal justice organizations were largely excluded not only from the funding but from the advisory groups and the planning tables, despite the fact that we serve some of the highest-risk and highest-needs clients in the social service sector.

Individuals with a mental health concern who have criminal justice involvement often walk through our doors first. They come to us because we are known to provide services that are accessible, welcoming, safe and knowledgeable. Those who have experience within the criminal justice system know who the John Howard Society is. We know more about the language, experience and challenges of this group, because we specialize in this area. Our staff have credibility with this client group and have developed unique skills to ensure we are best meeting client needs. Criminal justice organizations include the 18 John Howard Society affiliates throughout the province, the Elizabeth Fry Society, Salvation Army, St. Leonard's House and a host of other agencies.

As funding was rolled out for mental health and addictions workers a few years ago, they joined us in the trenches, working with individuals in conflict with the law. But the lack of awareness of our work and the separate streams of service, isolated and disconnected from existing community criminal justice services, created an overlap of services at the ground level. As well, it did not address the huge gaps in service we experienced.

An example of this would be when a mental health discharge worker claimed at a reporting forum to have found housing in our community for a client—these numbers of the work they're doing are then sent to the ministry. In fact, that housing was in the John Howard Society supportive housing facility. He was one of our clients, and he had never even been seen by this worker outside the institution. We provided the individual with food, shelter, clothing, supportive programming, and pre- and post-discharge services, with none of these services provided by funding from the Ministry of Health. All these services that target the social determinants of health prevent health crises. Without funding, we cannot provide the level of mental health support required by our clients each day, and each day another client like John falls through the cracks.

True collaboration is more than co-operation; it is the sharing of expertise and resources, both internal and

external. It is creating something far greater than one agency or sector can by working alone. If only one sector receives the funding, there will be no true collaboration. Changing lives and supporting individuals who face mental health and addictions issues cannot be done by one agency, one sector working alone. All systems must work in partnership. I can tell you that those collaborations do not exist on a rubber-meets-the-road community level. True collaboration will only happen when resources are shared.

Although the provincial Human Services and Justice Coordinating Committee response to the 10-year mental health Every Door is the Right Door strategy suggested that resources need to flow through the health system, I strongly disagree. The resources should flow through the systems where the clients are, whether that be an emergency shelter, a community-based criminal justice organization or a traditional health provider. As chair of the Thunder Bay District Human Services and Justice Coordinating Committee, I have seen the benefits and challenges of developing a strategy to address these issues. These committees are beneficial for knowledge sharing and for networking but they are not collaborations. This work does not translate to on-the-ground support for individuals or the agency that provides it.

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There is as much serious, meaningful, full-service, evidence-based provision going on every day in agencies just like ours as there is in any local mental health agency that may have come to speak to you today. Our post-secondary educational requirements for employees are the same as those required by traditional health service providers. If this 10-year strategy continues to fund as the province has funded the Human Services and Justice Coordinating Committees, the HSJCCs, the services and the support will not reach the individuals who suffer with the mental health and addictions issues who come through our doors. I strongly believe that the money should follow the client through the door if you truly mean every door to be the right one. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Liisa. You've left about nine minutes for questions. We'll start with Sylvia.

Ms. Sylvia Jones: Thank you for your presentation. You mentioned that you now have a mental health—

Ms. Liisa Leskowski: We've tried to create partnerships with mental health organizations that have the funding to deliver the services to bring them into our facilities. They're not coming in at the moment, but once a week they would come in on Wednesday afternoons and they would take referrals from us to do assessments.

Ms. Sylvia Jones: Your point is that they are simply not enough hours—

Ms. Liisa Leskowski: Nowhere near the support. An assessment is great; they'll do an assessment. But at the end of the day, in the evening, on the weekend, when someone's having a psychotic episode and he's in my facility, I have no funding. We call the police. We take them to emergency. There's nobody there to provide the support for that individual or to work with them. There's no wraparound individual.

If I had three full-time mental health workers, that would be fantastic. They would work with the mental health clients. But having someone come in for two hours a week to do just an assessment? They don't do front-line support. That's my issue.

Ms. Sylvia Jones: One of the recurring themes that's coming up as we hear the deputations is this—it's a poor phrase, but continuum case—

Ms. Liisa Leskowski: Case management.

Ms. Sylvia Jones: Case management. Yes. Would you envision that kind of role?

Ms. Liisa Leskowski: Okay, I'll get on my other soap box. Case management is important; it's great. You need to get all the players to the table to talk about it. But we don't need another case management model. What we need is front-line individuals willing to do the work. There's case management going on—every agency seems to get funded to do case management: "Let's all get together and talk about what we're going to do." But at the end of the day, who's helping that client if they're living in a shelter, if they're living in my facility? We run a completely unfunded 48-unit housing facility. Individuals in conflict with the law: Half of them have mental illness.

Ms. Sylvia Jones: Would part of the argument for the case management be that in fact as they go through the various agencies that you're—

Ms. Liisa Leskowski: A case manager works Monday to Friday, 9 to 5, and expects that mental health client to come to a meeting. I'm talking about a worker who can be available for that individual, then go to the case management. You can put the case management in place so that the worker has to come to them and discuss, but who's providing that front-line support after that case management meeting?

Ms. Sylvia Jones: Thank you.

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

Who funds the John Howard Society in totality? Out of all the money you spend, where does it come from?

Ms. Liisa Leskowski: Okay. We are funded under various ministries to deliver certain sectors of our work. So for example, we get money from the Ministry of the Attorney General to deliver a bail program. These are individuals released into the community who are at low risk, and we do their supervision. We get funding to deliver programs such as community service supervision. We deliver a remote aboriginal intervention program with youth. We deliver a school-based diversion program and we do reintegration work, so we get United Way dollars that fund a worker who goes and does discharge planning at our local correctional facilities.

There is no ministry that will fund housing for this client group in the community. I have barked up every tree and tried to get funding, so we get funding, for example, from the Ministry of the Attorney General to deliver a bail program. Of those clients, 48 every month

are living in, and they rotate through, our building. They won't give us any money for housing. No one gives us money for housing. It's not in anybody's mandate. We fall between jurisdictional gaps and ministry mandates to deliver housing for this client group.

We do it on a business case model, so we are able to—we get United Way dollars to pay for the staff, the housing manager and my reintegration coordinator. We get almost every—well, not almost. Every individual is on Ontario Works or ODSP, which means they get their rental portion. We are able to collect that rental portion and we're able to provide a room and a shared kitchen—they go to the shelter house and eat—but it's a safe, secure facility.

We made the decision a number of years ago to provide housing because we found it completely ineffective, for an individual who was coming out of jail, who had a mental illness or who had an addictions issue, to deliver a program—whether it was anger management; life skills; anti-criminal thinking; substance use programs, which we deliver on a regular basis—if the person was living in the shelter or didn't have stable housing. The only way we felt that we could provide effective service to make them change their lives was to provide the housing.

So we run our housing on a shoestring, but we know that we change lives because we do it. We've just gone out on a limb and done it.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Liisa, for coming today. Oh, sorry. Liz?

Mrs. Liz Sandals: Thank you very much for sharing that information with us. You just mentioned that you get funding—well, you get the ODSP rent allowance but you also get United Way funding. My experience with the John Howard Society is that they're not providers of housing, so in—

Ms. Liisa Leskowski: It's unique in Thunder Bay.

Mrs. Liz Sandals: Okay, that's what I was going to say, that the model—

Ms. Liisa Leskowski: Yes. There are John Howard societies that do do housing, but they're usually ministry funded. I think Ottawa has numerous houses, but it's either by Corrections Canada or it's by the Ministry of Children and Youth Services.

We are unique in our housing model, absolutely.

Mrs. Liz Sandals: My experience is that John Howard is not normally a housing provider. John Howard is usually the provider of the services you list—

Ms. Liisa Leskowski: Yes, that's right, and we do both.

Mrs. Liz Sandals: —and the rest is funded by the justice system. Okay, that's helpful to get that clarified.

Ms. Liisa Leskowski: And I think for us in Thunder Bay, because we service so many outlying northern remote communities and a population that's 70% aboriginal, it was absolutely imperative that, to be able to have any success, you provided housing.

Mrs. Liz Sandals: Thank you.

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

NORTH OF SUPERIOR COUNSELLING PROGRAMS

The Chair (Mr. Kevin Daniel Flynn): Next is our 11 o'clock appointment, North of Superior Counselling Programs: Bastian De Peuter and Laurie Knutson.

Ms. Laurie Knutson: Good morning.

The Chair (Mr. Kevin Daniel Flynn): Good morning. Thank you very much for coming this morning. Like all other delegations, you get 20 minutes. You can use that any way you see fit. If you can leave some time at the end for questions, that would be appreciated. There are some clean glasses and some water if you need it. Other than that, we're all yours.

Mr. Bastian De Peuter: All right. Thank you.

North of Superior Counselling Programs is honoured to be here today. My name is Bastian De Peuter, executive director of North of Superior Counselling Programs. With me today is Laurie Knutson, director of adult mental health and addiction services. We appreciate that there is a great deal of effort taking place on both a provincial and federal level to address the issues of mental health and addictions, and to come up with strategies that better meet the needs of Canadians of all ages in our province. We welcome you to Thunder Bay and hope that our presentation may remain in your memory, and in some small way inform the important work that lies ahead of you. We cannot ask for more than this.

Our presentation for the Select Committee on Mental Health and Addictions today is on why rural mental health matters.

North of Superior Counselling Programs is a small rural community mental health agency serving children, families, adults and seniors. Our offices are located in Nipigon, Schreiber, Marathon, Manitouwadge, Longlac and Geraldton. Our mental health staff serves people in 13 rural communities and five First Nations in the surrounding areas. If you were to go to each one of the offices, starting in Nipigon, in the communities we serve, and going back to Nipigon, it would take you 12 hours of uninterrupted driving between the farthest offices in the communities we serve—and that's going the speed limit. Our agency's catchment area covers a vast geographical area of over 80,000 square kilometres.

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Our agency is special to us because it is filled with good people doing lots of good work within very limited budgets, and in that way we are like every other rural community mental health agency. Our agency services a shrinking population, increasingly comprised of baby boomers and beyond. Many of the communities that we serve have been largely mono-economy towns depending on the forestry industry. This industry has all but vanished. The social and economic ramifications are obvious and have occurred many times across Canada in boom-and-bust industries.

The people who utilize our services are not more important than those living elsewhere, but it must be said,

similarly, that neither are they less important than people living in large urban centres, mid-range cities or any other rural part of Ontario. Yet rural citizens have access to a much smaller range of mental health and addictions services than do people living in more populated locales.

The Mental Health Commission of Canada this year released its framework for a mental health strategy for Canada, entitled Toward Recovery and Well-Being. The province of Ontario has also addressed its 10-year strategy for mental health and addictions, and we commend the great effort of many dedicated, intelligent people on doing this valuable work. It's not our intention to reflect on those documents per se; it is our intention to use our allotted time to discuss how rural mental health and addictions services may have unique needs. Rural practice may also have gifts and insights to share with people in much different ways.

The fallacy of formulaic funding: While the 10-year Ontario strategy for mental health and addictions allows that there is no health without mental health, the funding allotted for rural mental health and addictions says differently. Under the underserviced areas program, the Ministry of Health and Long-Term Care has allotted the communities we serve with the ability to hire 27.5 medical doctors at their full complement. Between our agency and the two already-funded family health teams in our district, there are only seven full-time equivalents for adult mental health and addictions. We are delighted that medical doctors are seen as the necessity that they are. We are simply appalled that mental health and addictions is seen by the same funding ministry as not as important to deserve similar resources.

Our agency is funded for five adult mental health and addictions counsellors, 7.5 children's workers, and five ISNC—integrated services for northern children—case managers for special-needs youth. There are also the two social workers currently working for family health teams in the district. However, the funding disparities are abhorrent. The funding for medical doctors, who are at the top of the financial food chain, is out of balance. This does not mean that we would wish that our communities have fewer doctors allotted; we only wish that we were funded more equitably.

Funding also fails to account for the inevitable reality that costs per service unit are going to be higher in rural, multi-site agencies. We maintain six offices, all of which require the same technology access and equipment. An agency of 25 to 30 people in a more urban centre supports only one rental agreement, one fax etc. Multi-site agencies cannot be compared on those cost efficiencies.

The increased costs in rural areas are those of travel and training. Our staff are often required to travel to various communities, and therefore the cost of such expenses will be higher than in urban communities. This is also true for staff development, training and recruitment of staff.

The question that we are left with is, what will it cost the medical system of this province and this country to not adequately fund rural mental health and addictions for all ages? We suggest that if mental health continues to be grossly underfunded, rural communities will show increasing loss of hope, economic viability and community cohesion.

Ms. Laurie Knutson: We are also wishing that the funding we receive would allow for more multiple levels of care. Currently we are funded to do primarily counselling for children, families and adults. These are the highest-level services that we can deliver, and they are delivered by the best-trained professionals that we can attract to the district. There can be no compromises here. We are proud of the gains we have made in professionalizing the staff.

However, we have people attending counselling who could benefit from care delivered by people with less training and thus assure that the utilized therapy is absolutely needed. However, we are not funded for the community support workers or behavioural interventionists in the school that could address situations out of a formal setting and therefore be more cost-effective.

And if you are unfortunate enough to be born in the rural district and you have any kind of developmental delay or extreme medical problem, you just need to pack your bags and move to the nearest city as soon as possible, because you will hardly be serviced at all.

We are also suggesting that there is a huge need for increased tele-video and tele-site facilities.

Just a test now: Were you listening? How many adult mental health staff do I have for all these communities? Five. Okay? Thirteen communities, First Nation communities, six offices: I don't have one adult mental health and addictions counsellor per community.

The best one that I have to deliver one service may be in this corner, and that specific skill that he or she has is needed in the far corner. I can put them six hours down the road to deliver this service. If I had capacity to have tele-video, I could have that person link across the district. Yes, we have access to use those at the hospital. However, we will get bumped if it is needed for a medical consult or for training for nurses or doctors. That is as it should be. We need more capacity across the system to deliver tele-mental health.

There are usually funds available to help purchase the equipment, but keeping the lines viable and going is a costly venture which I think would cost the equivalent of almost one FTE for the year. It's too expensive. Small agencies cannot sustain this cost on their own.

Crisis care: I'm not going to spend much time on that. You've already heard some of the issues, from Paul Mulzer and other people, about the need for more crisis care.

In rural communities, the hospital emergency room after 5 o'clock is it. When regional says that it's closed to the district, it can be closed to the district. Therefore, a psychiatric crisis is what the doctors can provide in the hospital, which is not a psych bed, and there's a number that we can provide for telephone counselling in Thunder Bay.

There are times when a more secure hospital setting is required, to keep our clients and individuals safe from

harm or risk of suicide. Unfortunately, these resources are not available in our communities. Therefore clients are escorted by ambulance and police to Thunder Bay. This is disruptive to the clients and their families and takes police off the streets. It's a problem that we need to solve.

Dr. Mulzer has also addressed the extremely limited psychiatric care that's available in the districts.

Can I ask how we're doing for time?

The Chair (Mr. Kevin Daniel Flynn): I'm just trying to get this on my BlackBerry. You've got about nine minutes. You're about halfway.

Ms. Laurie Knutson: Okay. Services for seniors: Northern Ontario is aging at a faster rate than the rest of Ontario. In northwestern Ontario virtually all but First Nations communities reflect this trend. This trend will mean increased demands for social service and health care supports, including mental health services. This will also mean increased training for the staff that we do have, who are expected to do everything in adult mental health.

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The problem of addictions: We know that addictions and mental health go hand in hand and concurrent disorders are not only the rage of the day but the reality of the day. If you live in a district that doesn't have anywhere in its catchment area a movie theatre, precious few cultural events and a teen population with diminishing pro-social activities in which to participate, the weekends are going to be filled with less healthful activities, may we say, such as alcohol and drug use. Sometimes it gobbles up the week as well. These have become normative in many of our communities. The tri-task force that covers the areas around Thunder Bay is busy doing drug raids in the region.

We are proud to say that one of our communities has the highest cost for street drugs anywhere in Ontario, and that's due to supply and demand. A Percocet on the streets of Longlac will sell for $12.50 for one pill; OxyContin, 20 milligrams, 40 bucks, 80 milligrams, $120 per pill. There are people locking their refrigerators and their food cupboards to keep their family members from stealing food because whatever money they have is being spent on this insidious opioid problem.

We have the largest community in our district that does not even have AA. There is no NA in the district, and several of the smaller communities have AA. The province spends a huge amount of money sending people to treatment and then sends them back into communities in which there are either no or limited supports. That's like throwing water down the toilet. We need to resolve this.

Getting everyone to shoulder their fair share: Our agency and likely all rural community mental health agencies are asked to deliver more than they are able to do with their funded resources. For example, in our communities, as the loss of jobs has caused out-migration and depressed housing prices, we are seeing the composition of the communities change. New entrants to the community are likely retirees or people on disabilities who may not be able to afford a nice home elsewhere.

There is also a concomitant rise of those with legal histories. Currently, we are asked to provide services for probation and parole clients from both the provincial and federal systems. Our services are meant to be voluntary, yet all of these people entering our system with orders from a judge to attend are usually required to attend for drug and alcohol assessment and anger management. Often they are referred to PAR training, for those who have been assaultive in their families. The problem is that there is no PAR training in our district. We would love to provide this, but my five adult workers cannot adequately meet the needs of the voluntary clients as well as the mandated clients coming through our doors. The Ministry of the Attorney General and the prison system need to carry some, if not all, of the costs of these programs. I suggest I would currently need two FTEs just to form the forensic team to meet the needs in our district.

Similarly, there are increasing pressures on the school system and our agency to collaborate. We would love to do this. It's a great idea to have more social workers in schools. I just can't pull them out of the sky.

Forging linkages beyond the usual suspects: In our communities, the most likely collaborations have been with schools and the medical system. As our communities continue to change in size, demographics and socio-economic stability, mental health may need to forge more alliances beyond the traditional ones. We might likely need to link with municipalities and faith communities that are part of maintaining a vibrant community.

Increased focus on communities: Although we are funded as a community mental health centre, the concept of community has, in large fact, been an afterthought in the funding and delivery of services. With the exception of public education on subjects related to mental health and addictions and sitting in on the local communities with other stakeholders, the overall importance of the concept of "community" in community mental health has been given a seat at the back of the bus. Funding focuses have been on providing mental health services as if they are somehow distinct from living in community. As for actually using our resources to actively try to create communities, well, that is an idea whose time needs to arrive.

I'm going off-script here because I know we're running short of time.

Spirituality: It was mentioned in the Mental Health Commission of Canada as part of their thing—and I wish they would have taken it farther—that we in mental health need to quit being afraid of spirituality as a part of the healing. I am not talking about religion; I am talking about seeing interconnectedness as part of the healing. I wish that people could come to rural communities and see how they do this better, sometimes, than urban centres.

When the mill closed about two years ago in Terrace Bay, the food market—it's a small little food market, okay? It doesn't have all the nice things that are here in

Thunder Bay—let families charge their food. Where does that happen in a city? The community members are worried about the local businesses. They don't want the food market to close.

People in rural communities know something about support systems that we could actually take to the city. I'm going to suggest that maybe we move some of the treatment facilities out of the cities and let people come to places where they can heal because they're in nature, it's beautiful and it's part of their healing.

I'm going to stop.

Mr. Bastian De Peuter: Just to summarize, it is essential that a provincial mental health care strategy develop improvement to the existing lack of resources to save and enhance vital mental health services in Ontario's small, rural and northern communities. Everyone should have access to high-quality mental health services in the same way that they have a right to health care, no matter where they live. The local community mental health services are severely lacking resources during a time when the needs are greatest. We encourage the Select Committee on Mental Health and Addictions to create a mental health care strategy specifically for Ontario's small, rural and northern communities so people get the care they need and have a right to.

We are proposing a strategy that focuses on six essential requirements:

—adequate mental health and addiction services guaranteed in each rural community;

—24/7 emergency room access for those seriously ill mental health patients who are in crisis, with access to specialized resources for consultation when required, even just for a brief period of time;

—early intervention, community information and public education on mental health issues;

—accountability and transparency guaranteed;

—fair, flexible and community-based funding guaranteed to small rural communities for mental health and addiction services for both children, families and adults; and

—continuum of care and mental health interventions between the age span and between funding ministries.

These strategies would include:

—recognizing that community mental health agencies have a close affiliation with local hospitals as the hubs of small, rural and northern communities;

—that there is delivery of local emergency care and mental health services;

—that they provide access to specialized psychiatric resources through telepsychiatry and regular, consistent locum visits to each rural community;

—establishing a rural mental health care staff recruitment and retention strategy;

—ensuring availability of early intervention and treatment for children with mental health problems;

—establishing a shared care strategy and create connectivity between hospitals, community mental health agencies and family health clinics;

—ensuring that ERs are open on a 24/7 basis for mental health patients in crisis when they need a psychiatric bed;

—creating a comprehensive awareness and education campaign to inform those living in small, rural and northern communities about mental health and addiction services;

—recognizing that the government, local health integration networks, hospital boards and community mental health agents must be accountable to the communities they serve;

—recognizing that funding needs are different in small, rural and northern communities; and

—creating guidelines for increased, fair and flexible funding based on community mental health and addiction needs instead of per capita funding.

We thank you for your time today and your interest in improving the mental health services to our northern rural communities in Ontario.

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The Chair (Mr. Kevin Daniel Flynn): Thank you, Bastian. Thank you, Laurie. A very thorough presentation. Unfortunately, we have no time for questions, but I think you got your point across very clearly.

Ms. Laurie Knutson: Thank you very much.

SCHIZOPHRENIA SOCIETY OF ONTARIO, THUNDER BAY

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning is from the Schizophrenia Society of Ontario, Thunder Bay, George Tucker. George, if you'd like to come forward. Make yourself comfortable. There are some clean glasses of water over there if you need any water for your presentation.

George, everybody gets 20 minutes for their presentation. You sat through a few, I think. You get 20 minutes as well. You can use that any way you think you should, and if at the end there's any time for questions, we'll see if we can share it among everybody.

Mr. George Tucker: Good morning, everyone. Thank you for this opportunity to come and give my presentation. I'm going to begin quickly on the page underneath the cover page.

We are a chapter of the Schizophrenia Society of Ontario. Our purpose is to advocate with governments for better services, increase awareness of schizophrenia, educate the public about schizophrenia and provide support for families and people with schizophrenia. We continue to raise monies for research and better treatment for those who suffer from this biochemical brain disorder. These funds and research will lead to improved treatments and, ultimately, a cure.

Beginning on the next page, omitting that small top section there: Thank you for this opportunity to present the needs of people with mental health issues. As a volunteer mental health organization, we have many contacts with families and consumers. The needs are many and varied.

Studies done 20 or 30 years ago are still relevant today, as these needs have only been partly met. Up till now, there have been many fine terms used in describing the desired mental health system. Terms like "best practices" and "comprehensive and coordinated" litter the literature but have brought little substance to the effective treatment and support of the many who struggle with mental health issues.

Many times, the increased funding has been gobbled up by increasing costs. At one time, there were almost twice as many mental health beds in Thunder Bay. With the building of the new regional hospital, closing of the two older hospitals and phasing out of the psychiatric hospital, we have lost many of these beds. When we had those beds, they were needed, and we still need them.

Thunder Bay Regional Health Sciences Centre serves a large portion of northwestern Ontario. Many people with mental illnesses from smaller communities across our region end up in Thunder Bay looking for mental health services. This includes people from First Nations communities. There are 56 First Nations communities across northwestern Ontario. Many people from these communities come to Thunder Bay, and those with mental illness strain our already inadequate mental health services.

After deinstitutionalization was begun many years ago, Health Canada reported that people who once had been in mental institutions were appearing in jails. The reports also stated that most of these people were being criminalized because of behaviour motivated by symptoms of severe mental illness. At present, the token few who receive help are indeed fortunate, but there are many who are turned away. Our contacts from corrections inform us that one third of those in the correctional facility on Highway 61, Thunder Bay, have a mental illness.

The textbooks say that 40% of people with mental illness are not being treated. This has implications not only for worsening mental health: Because of the condition of severe mental illness, these people become unable to properly care for themselves or to seek needed health care. This has implications also for worsening general health across the population. This could have disastrous results because of homelessness, the inability to monitor the health of the homeless and the low level of health experienced by this population. Many of the homeless suffer with mental illness. The textbooks state that the mentally ill, in general, experience poorer physical health because their complaints are often ignored. In fact, the textbooks also state that the negative impact of mental illness worsens physical health.

Next, I would like to list the needs of the mentally ill: mental health beds as needed; access to psychiatrists; medications and other required treatments; safe, affordable housing; adequate community supports; and high-level support group homes.

As for the need for mental health beds, sometimes tragedies occur because the response is too little too late, as it is at present. To demonstrate some of these tragedies, I would like to tell you about a man I knew who had a wife and several children. He developed a severe mental illness, and something was finally going to be done about it. One day during the waiting period for this help, he closed himself in a closet at home with his moose gun. When his wife and children heard the bang, they ran into the room in time to see the blood flow from under the closet door. What impact do you think this had on that family? Could there have been a better outcome if he had been hospitalized earlier? The 2006 Canadian edition of Abnormal Psychology and many other textbooks state that medications significantly reduce the prevalence of suicides.

For some years now, the aim has been to treat people in the community and avoid hospitalization. The problem is that many of the mentally ill are being treated even later now than they were before this began. One man had come out of the prison system after being in and out for some years. He had been in crime, was drug addicted and had five suicide attempts in six years. He was really tired of ending up back in jail. While he was in the Thunder Bay community, he expressed a desire to make it and stay out of jail. He talked about getting his life back and straightening up. It took almost a year to see a psychiatrist and by then he was starting to think nobody really cared, and his many problems caught up with him. He has been diagnosed with several mental illnesses which aggravate each other. By the time he finally got his medication changed, he was already unravelling. He had stayed off drugs and out of trouble for almost a year. He told us that that was the longest he had stayed out of jail. He started to hang around with drug-using friends and ended up in a cocaine psychosis. He did considerable damage in the apartment in which he resided before he was taken to hospital by police. Instead of being kept in hospital, he was released that same morning. He was evicted from his apartment and disappeared on the streets, stealing to feed his drug habit. From there, he returned to the prison system.

The system has surely failed this person, as it has failed many others as well, but instead of a lesson learned, we see collective shrugging of shoulders and always a blaming of those the system failed. Individuals certainly do have a responsibility, but it is well known and beyond dispute that mental illness makes it much harder for these individuals to take responsibility or even see their best interests.

The next situation is a woman with severe paranoid schizophrenia. She had been desperately hanging on for many years, highly symptomatic, her voices urging her to self harm or to take her own life. People like this person desperately attempt to achieve a sense of self and community amid all the craziness that swirls inside them. None of the medications reduced the severe symptoms enough so that she could live at peace within herself. She has to be on constant guard to prevent tragedy. She has been so unsure of herself, experiencing so much fear, that small daily hurdles would send her into a panic. She would go into a panic attack, scream out of control and

couldn't stop. Someone would have to straighten things out for her as she just could not even reason any more. Because of her paranoia, she was constantly thinking everyone was against her. When she recently got worse, she threw out or destroyed most of her prized possessions. She also became assaultive and received an eviction notice from her landlord.

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She had a case worker, but during her hardest times this was no help as she was so paranoid that she turned against her case worker. Her case worker was very afraid of her as she was very hostile towards this person. Everyone in her apartment building was afraid of her as she was hostile towards them and very confrontational, accusing them of things that were products of her own paranoia. She spent a fairly lengthy time in the hospital and has returned to the community. She is no longer actively hostile or assaultive and not in as much fear as before, but she has fired her case worker and homemaker and still does not trust many people.

This situation shows the need for mental health beds. There is no way she could have been treated or supported at home. She needed a hospital stay to ensure she got medication and got stabilized. She needed that time in a safe haven to keep her safe from herself and any harm that may have overtaken her in the community.

A man with severe paranoid schizophrenia recently relapsed and had to be taken to hospital by police. He had gone completely off his medication. He was hallucinating and saw and heard things that meant to him that there was immediate danger. "The enemy" had come for him and he made a complete shambles of his apartment in the fight to save himself. All his furnishings were upset, and there were damages to repair and things to replace. He was completely into his own world of his hallucinations, constantly believing he was in danger. When the police had arrived, he was all alone in his apartment fighting off imaginary enemies.

In these most difficult times in this person's experience, he must be in hospital to keep him and others safe and get him back on medication. He has to have enough time in hospital to make him stable enough so that he can continue to function well and prevent relapse.

The people in these true examples I have given to you could not be treated and supported at home. They are too out of control, especially when the person believes he or she has to defend him or herself. Outside of a safe environment and living on their own, these people have access to things that can be used to harm themselves or others, such as knives in the kitchen. When a person is out of control, anyone bringing medications or other help, persons such as support workers or a homemaker etc., are at risk of injury or even death.

There are a fair number of people who remain untreated and unsupported and cannot gain access to treatment, and those who come to help are at risk. These people are uncounted and just disappear off the radar and are forgotten. Then, when the mental illness urges them to desperate acts, it becomes a matter for the criminal justice system. When it gets to that stage, sometimes something terrible has happened. This is a tragedy for the families of the victim and the families of the mentally ill person who committed the act. Why we wait for the worst-case scenario I shall never understand.

There was the beheading on a Greyhound bus in Manitoba and the knife attack on a Greyhound bus outside White River, Ontario. In both incidents, the perpetrators suffered from schizophrenia. In the second incident, the man had gone to a hospital for treatment and was turned away.

When these tragedies happen, if anyone questions the reasons, there is just a collective shrugging of shoulders and no one has learned anything. No one is held responsible. No one is accountable. If these tragedies happened involving a failure to treat a physical disorder, there would be a hue and cry, but because it only involves mental illness, we hardly even hear a whimper.

The severe mental illnesses like schizophrenia are not taken seriously, even when injury or death comes as a result of non-treatment. A large percentage of families of the mentally ill are caregivers and some have a severely mentally ill family member living at home. There is no recognition of how hard this is for families.

I remember looking into the eyes of a mother who was—pardon me.

The Chair (Mr. Kevin Daniel Flynn): Take your time. We have lots of time.

Mr. George Tucker: Thank you—who was telling me her story. Her eyes were just black holes; there was no life left in them. She was totally exhausted. She looked ready to drop right there in front of me. She has no life; she has nothing. This is a life worse than death, and she is not the only one. There are others. There should be more high-level support group homes for those who are too much for their families. There are families who fear for themselves because they cannot get adequate treatment or care for their mentally ill family member.

In Ontario, there are families who barricade their doors at night because they fear for themselves and cannot get help for their sick loved ones. These families cannot get relief from burdens that are crushing the life out of them. It is too hard to get into hospital. It is too hard to see a psychiatrist. It is too hard to get treatment.

Many of the things the mentally ill have to do in the community are so hard that their stress and danger of relapse is increased. They have enough fear already from their illness, and many of the criteria they have to meet in order to live in the community cause increased fear and distress. Most people with severe mental illnesses, like schizophrenia, relapse. Many of the small stresses contribute to a total of stresses that causes relapse. This increases the numbers and duration of hospital stays and many other attendant negatives.

We need psychotic disorders like schizophrenia to be taken seriously. At present, many people remain untreated even when they ask for help.

To repeat, the needs are mental health beds; access to psychiatrists; access to treatment/medications; safe

affordable housing; adequate support; and high-level support group homes.

Thank you for this opportunity to present our concerns. Will there be any questions?

The Chair (Mr. Kevin Daniel Flynn): I'm sure there are. Thank you, George. You've left us about maybe four minutes, so there's time for a couple of questions. Howard, do you have anything? You'd be next in rotation.

Mr. Howard Hampton: I'm not sure this is a fair question, but there used to be a psychiatric hospital here in Thunder Bay.

Mr. George Tucker: There still is. It's downsized. At present, they're just running one small ward containing from about 50 to 75 people.

Mr. Howard Hampton: When that hospital was downsized, the public was told—and we're talking here over many years—that more services would be available in community hospitals, more services would be available in the community. Is that true? Is that what happened?

Mr. George Tucker: That's not what happened at all.

Mr. Howard Hampton: What happened?

Mr. George Tucker: What happened is that after de-institutionalization and they were sent back into their community, the services were not there. We have a large mentally ill population on the streets. The Salvation Army, just a few years ago, reported that 75% of their clients have a mental illness. The other—a housing corporation reports that a 50-plus number of their clients have a mental illness. There is not the support. There is not enough support for these individuals.

For some individuals, no amount of support would be adequate for them, they are just too sick, and a number of them require a great deal of support which is not available. The support systems are stretched to the limit. Funding does not require them to support—and they're not supporting all; they're only supporting a portion of those who require support.

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

Ms. Helena Jaczek: Thank you very much, Mr. Tucker. Rest assured we're here, we're listening. We will be reporting back to the Legislature on the issues that you've expressed. You've painted a really vivid picture of what's happening in your community.

I just wanted to know if your society has any peer support programs for those perhaps who have recovered or are moving towards recovery in terms of being able to counsel and to be kind of a friend to those in more acute situations?

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Mr. George Tucker: We don't have peer support per se, but we have support meetings and we do help when we can. People can call us on the schizophrenia line. One person calls as many as six to eight times a day. He is really struggling.

Ms. Helena Jaczek: So it's a volunteer position, manning the phone line?

Mr. George Tucker: In Thunder Bay we're all volunteers.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Sylvia, we've got about a minute left. Do you want to take it?

Ms. Sylvia Jones: Yes. Thank you, Mr. Tucker. A real fast question. Considering the role you're playing with the society, it may be an unfair one, but does the schizophrenia society in North Bay have a relationship with the John Howard Society? I'm interested because many of the examples you've used in your presentation had a justice component to them.

Mr. George Tucker: We don't really, but we will work together with anyone, and we have worked with other organizations in the past to help people with mental illness. We have gone to court on occasion to help people with mental illness and tried to keep them in the community and out of jail.

Ms. Sylvia Jones: Thank you for your presentation.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, George. You did a wonderful job.

Mr. George Tucker: Thank you.

KINNA-AWEYA LEGAL CLINIC

The Chair (Mr. Kevin Daniel Flynn): Our last presentation of the morning is the Kinna-aweya Legal Clinic, Sarah Colquhoun. Is Sarah —I'm sorry. You're right in front of me.

Ms. Sarah Colquhoun: Yes, here I am.

The Chair (Mr. Kevin Daniel Flynn): I was looking in the audience. You've been here, I think, for a few of the presentations, so you understand everybody gets 20 minutes. You can use that any way, and if you leave some time at the end, that would be great.

Ms. Sarah Colquhoun: Thank you. You've been hearing and will be hearing from many health care providers about the lack of treatment in northern Ontario, and I'm sure throughout Ontario, and about innovative health care initiatives and ways to improve delivery of services in mental health and addictions treatment.

What I would like to speak to you about today is that many of the most important supports for people with mental health and addiction problems are not health programs. They are investments in affordable housing, income support and employment that promote full inclusion in our society. I know you've heard that, and I just heard George talk about the need for supported housing in the community. It's a key component to treating mental health and addiction problems and also to reducing the incidence of mental health and addiction problems.

Just by way of introduction, I'm one of the staff lawyers and the coordinator of legal services at the Kinna-aweya Legal Clinic. Our agency is a non-profit corporation that's funded by Legal Aid Ontario to provide poverty law services in the district of Thunder Bay. In addition to providing summary legal advice and

actual case representation for clients, we also have a mandate to do law reform work and provide public legal education.

The priorities that have been set by our board of directors in terms of the actual casework that we do focus on income maintenance issues and tenancy issues. "Income maintenance" is a term that includes all of the various income programs, such as Ontario Works and the Ontario disability support program, which are funded by the Ontario government, the Canada pension plan and employment insurance. All of the income support programs have appeal processes, and we help people do appeals if they have been denied assistance or aren't receiving what they should be.

We open somewhere around 600 files a year. We have contact with several thousand people in terms of summary advice and referrals. Most of our clients are on social assistance. Many of our clients have unsuccessfully applied for Ontario disability support program income support, and we assist them in appealing their cancellations. In the vast majority of those cases we are successful, which is financially very beneficial for clients because the amount that a single person receives on ODSP is almost twice as much money as they would be getting on Ontario Works. In the last few years, we've opened more than 200 files on that specific issue, and it's becoming an increasing amount of the caseload of all of the general service clinics in Ontario, to help people get on to ODSP.

We're successful in restoring or establishing entitlement to social assistance for hundreds of clients every year, but more and more we recognize that the biggest systemic issue with respect to social assistance is the inadequate level of benefits. We aren't able to provide specific statistics, but we know that the majority of our clients do have some kind of a disability, and most of our clients with a disability have some kind of mental health or addiction problem.

We're very pleased that the government is currently involved in efforts to establish a poverty reduction strategy, and we've been involved in that process over the last few years. People with serious mental health and addiction problems frequently experience barriers to securing adequate employment and education. They live in chronic poverty. I don't think anybody would question that. Living in poverty exacerbates mental health and addiction problems, so it's a circular kind of thing.

In our opinion, safe, secure and affordable housing is a key component to anyone's mental health. Not having enough money every month to pay the rent, pay the utility bills and buy groceries causes anxiety and depression. In our opinion, in many cases it would be better to treat that anxiety and depression by giving people enough money to pay the rent and buy groceries than with medication—or in addition.

I'd like to address several specific points with respect to the intersections between poverty reduction and the improvement of mental health and addiction services: inadequate social assistance benefits, discrimination against disabled people with addiction issues in the ODSP, the need for continued funding for the addiction services initiative, the need for supported housing, and the need for improved accessibility to primary health care.

People on social assistance in Ontario don't get enough money every month to meet all of their basic needs. It's all very well to propose poverty reduction strategies that include employment programs and after-school programs, but they have to be combined with the basic issue of a significant increase in social assistance rates.

Just as an example, a single person on Ontario Works, which is the basic welfare program in Ontario now, receives $216 a month for all of their basic needs other than shelter. So that's food, clothing, transportation, over-the-counter medication, everything: $216 a month, and up to $356 for shelter. So this single person gets $572 a month for all of their needs, and it's just hopelessly inadequate. It's inadequate in Thunder Bay; it's inadequate in Toronto. There's nowhere in Ontario where you can live comfortably on $572 a month. It's just not possible.

I'd like to give you a specific example of a client I recently opened a file for. She's a single woman who has been supporting herself in the workforce for 35 years. She's 50 years old. She has been working since she was 15, often at more than one job because she wasn't able to find full-time work. She had a long-term job with a large corporate employer that has a policy of not giving people more than 28 hours a week of work so that they don't have to pay benefits, and she had other jobs as well to supplement her income and had been supporting herself.

In the last few years, she's developed some serious health problems. They haven't been totally diagnosed. The neurologist thinks maybe it's multiple sclerosis, although usually that's diagnosed earlier. They don't really know what's wrong with her, but there's no question she has some serious health problems.

She has no health benefits. She used up her savings and she had to apply for Ontario Works assistance. She was referred by her caseworker at Ontario Works to the Ontario disability support program because they thought she should be on ODSP, but that application was denied, and that's what brought her into my office, to help her appeal that denial. That's going to take six to seven months to get through the appeal process. We have to obtain medical evidence and go through an appeal process.

In the meantime, she's getting $572 a month from Ontario Works, which is the most that she can get. For the apartment where she has lived for 11 years, the rent is $500 a month. That's cheap. That's well below the average cost of a one-bedroom apartment in Thunder Bay, which is almost $700 a month. There's nowhere cheaper for her to move to, other than somewhere where—she can't imagine living in a room in a rundown rooming house or one of the motels on the strip that rents rooms by the month. Not surprisingly, the anxiety disorder that she has lived with for years and coped with while still

continuing to work and support herself has, in these circumstances, worsened. She's experiencing frequent panic attacks, and it's clear that the financial stress of being unemployed and not getting enough money to pay her rent and just live her life the way she wants to is causing the exacerbation of her mental health problems.

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Even if her ODSP appeal is successful and she moves to the much higher level of benefits from that program, it's still just over $1,000 a month. She'll still be paying half of her income for rent. The maximum shelter amount is $445 for a single person, so she's still going to be paying out of her basic needs amount for rent if she manages to hang onto that apartment over the next few months, which is questionable—whether she's going to be able to do that.

As part of the poverty reduction strategy meetings, a Liberal cabinet minister told me last year that the problem of poverty is complex—which I agree with; it is a very complex issue—but it cannot be solved by throwing money at it. My response was and is, how do we know? Nobody has tried solving the problem of poverty by throwing money at it. I'm absolutely, totally convinced, and I think you will find that there are many others who are convinced, that if benefits are increased to the level where people can pay their rent, buy groceries and pay their utility bills, that will solve many of the problems. There still will be problems, obviously, but giving people enough money to pay the rent and feed themselves and their kids would go a long way to solving the problems. They wouldn't have to use emergency utility funds, which are, half of the year, out of funds anyway. There wouldn't be as much use of food banks across the province, which has been skyrocketing. All of these programs are band-aid solutions to the fundamental, serious problem that our social assistance program does not provide adequate benefits to people. Clearly, it has an effect on people's mental health and also on addictions.

I saw an interesting film in Sault Ste. Marie last year that was done by a number of people in the homeless community in Sault Ste. Marie. I still remember this interview of a young woman, who'd been homeless, who said, "You know, people talk about the intersection between addictions and homelessness as if people are homeless because they have addiction problems." She's convinced from her personal experience of living on the streets that lots of people are having addiction problems because they're homeless. They're clearly interrelated.

I'm going to speak briefly about the issue of the need for adequate housing. I just want to speak about two specific issues. One is discrimination in the ODSP against people who are alcoholics or substance abusers. There's a section of the Ontario Disability Support Program Act that says that if a person with a disability is dependent on alcohol and that's the main reason for them being substantially restricted in their activities of daily living, they're not eligible for disability benefits. This has been challenged through the courts. It's been up to the Supreme Court of Canada, then back down to the Social Benefits Tribunal, and then it was appealed to the Divisional Court. Litigation has been going on for about 10 years now, and at every single level, there's been a finding saying, "Yes, this contravenes the Ontario Human Rights Code. It's discrimination against people with alcoholism and substance abuse," which is recognized by the Ontario Human Rights Commission to be a disability, "and it should be stopped."

The Ontario government continues to appeal this. The Divisional Court decision that came out supporting the Social Benefits Tribunal decision, which just came out in January—the provincial government is now appealing that to the Court of Appeal. I think it's a waste of resources. It's a clear example of blatant discrimination against people with mental health and substance abuse problems. The government should stop discriminating against those with addiction problems in that disability program.

The addiction services initiative is a pilot project through the Ontario Works office, funded by the Ministry of Community and Social Services. Thunder Bay was one of the locations chosen for the pilot project. The project has been very successful. There are currently several hundred people in the project. They get additional supports. They've identified themselves that substance abuse is a barrier to them entering or re-entering the workforce. They get treatment, various additional financial supports and programming. The entire program is now in jeopardy. The ministry has said that they're not going to continue the funding for this program, which is very short-sighted.

Ironically, the existence of the addiction services initiative, even though it was only a pilot project in three municipalities, was one of the key arguments that the ministry used in justifying their discrimination against people with alcoholism in the Ontario disability support program. They said, "Oh, we don't need to put them into the ODSP and give them more money because there's this great addiction services initiative to help them," and now they're stopping funding for the addiction services initiative.

The need for safe, secure, affordable supported housing is a key component to anyone's mental health. All of us would be stressed and possibly depressed and anxious if we didn't feel that our housing was secure.

A single person on Ontario Works gets a maximum of $356 for shelter if they pay for their own food. If they're in a room-and-board situation, they get $450 a month. If that person is in an emergency shelter, the government provides $1,200 a month for per diem payments. It doesn't make sense that you wouldn't give people more money so that they could pay for their own housing, instead of paying twice as much or three times as much to have them in an inadequate emergency shelter—not to cast any aspersions on the emergency shelters. I know people work hard and they're vitally important in our communities right now because of the lack of affordable housing, but that shouldn't be the primary choice for people.

If stable, affordable housing is provided to chronically homeless individuals with severe alcohol problems, the result is reduced alcohol use. There have been a number of programs, such as Housing First, where they'll take people off the streets and give them housing that's affordable, that they can maintain, and the results are very positive.

Independent housing with appropriate supports, if necessary, improves the quality of life and wellness of people with mental health and addiction problems, and it would take some of the pressure off the need for treatment if people were feeling better because they had better, secure housing and were able to maintain their housing. The need for supported housing is much higher than the supply, and the supply has to be increased with funding not just for the housing but also for the supports that are needed.

Just one final point on the need for primary health care: Many of our clients don't have a family doctor, which is the important entree into the health care system. You can't get into treatment programs and get in to see specialists and get medication if you don't have a family doctor or some other primary health care. There are thousands and thousands of people in the city of Thunder Bay who don't have family doctors or any entree into that and can't even get a proper diagnosis of their mental illness, let alone treatment.

In conclusion, I'd like to say that adequate income and affordable housing are key determinants of mental health and must be considered when you're considering development of a strategy to improve access to mental health and addictions treatment.

The Chair (Mr. Kevin Daniel Flynn): We definitely are hearing about the housing as we travel around just about everywhere in the province, so thanks for bringing that forward again.

We've got about three minutes left, so let's start on this side. Any questions?

Mrs. Liz Sandals: You mentioned the Housing First strategy. Do you want to talk a little bit about that? Is there a Housing First place in Thunder Bay?

Ms. Sarah Colquhoun: No. I'm just aware of it in other communities.

Mrs. Liz Sandals: Okay. Because that certainly is something that I've heard about in my community that people are trying to get started.

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

Ms. Sylvia Jones: I have one quick question and then I'd like your thoughts on another. When is the pilot project for the addiction services initiative winding up?

Mr. Iain Angus: It has only been cut by a third and then it will continue. It's being spread across the whole province.

Ms. Sylvia Jones: Okay. My other question relates to the ability of individuals who are receiving ODSP to have part-time jobs. There have been a number of presenters who have concerns with the clawback, that it happens too quickly, that it's there at all. You haven't raised that in your presentation, but I wondered if you had any thoughts on that.

Ms. Sarah Colquhoun: One of the things with the recent changes to that was they went to a straight 50%, so that 50% of your net earnings are deducted, which had more of a detrimental impact on people who were just working a small number of hours. There used to be a flat rate deduction, where nothing was deducted on the first $160 that you earned, so people who were only working a little bit still had some benefit from their employment to help them. Really, you don't get enough money even on ODSP, which is a long-term program. For a single person, it's just over $1,000 a month. So if you can earn a few hundred dollars a month, it's really helpful for people.

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Ms. Sylvia Jones: It seems to be yet another barrier to getting back into the workforce.

Ms. Sarah Colquhoun: Our focus recently has been on getting people into the program. There are lots of problems with the way the program is administered and how it works. Certainly, allowing people to keep more of the income that they earn while they're on the program would be helpful for them, I would agree.

The Chair (Mr. Kevin Daniel Flynn): The final question of the morning goes to Howard.

Mr. Howard Hampton: A two-part question: Is the housing problem getting better or worse in Thunder Bay, and are you seeing any supportive housing units?

Ms. Sarah Colquhoun: There are some supported housing units for mentally ill people with Alpha Court and a number of other agencies, but I don't think there have been any new units for some time—but that's not my area of expertise.

I do think it's getting worse, from our experience of the people who are coming in. The vacancy rate is going down in Thunder Bay, and certainly in terms of actual affordable housing for people who are on social assistance, it's very challenging for them to find housing. They also have issues with respect to things like George raised earlier: We have lots of clients who come in with notices of termination because of the way they've behaved and that kind of thing.

Mr. Howard Hampton: I have another question if I have time.

The Chair (Mr. Kevin Daniel Flynn): No, she answered both.

Unfortunately it's time for lunch, but I did want to thank you, Sarah, for being our last delegation of the morning. You did a great job. Thank you very much for being frank and forthright with us.

The committee recessed from 1202 to 1303.

The Chair (Mr. Kevin Daniel Flynn): If we can come to order, we can get back together after lunch now.

CHILDREN'S CENTRE THUNDER BAY

The Chair (Mr. Kevin Daniel Flynn): We've got the Children's Centre Thunder Bay with us: Tom Walters and Roy Karlstedt—obviously that's not true.

Ms. Jan Inkster: Not quite.

The Chair (Mr. Kevin Daniel Flynn): I'll let you guys introduce yourselves. You've got 20 minutes. You can use that any way you see fit, and if you could leave a little bit of time at the end, that always works better for some questions and answers. It's all yours.

Ms. Jan Inkster: No, I'm not Roy. I'm Jan Inkster, vice-president of the Children's Centre Thunder Bay board of directors. I'm an occupational therapist and a retired assistant administrator, having worked in mental health for 23 years. With me is Tom Walters, executive director of the Children's Centre Thunder Bay. He has been in that position for 21 years.

I'd just like to review the agenda for today. We've done our introduction. We're going to summarize the state of our children, the state of our children's delivery system, human resources, the hopes for the future, and a discussion.

The state of our children: Most of these statistics are from the National Institute of Mental Health in the US but have relevance for our province as well. One in five children has a diagnosable mental health issue, and this information comes from Dr. Dan Offord, from McMaster University in 1998; eight to 10 out of 100 children have anxiety disorders; six out of 100 children have major depression; five out of 100 have ADHD; five out of 100 children have learning disabilities; four to 10 out of 100 children have conduct disorders; one to three of every 100 children have bulimia.

Suicide is the second leading cause of death among 10- to 24-year-olds—and this comes from Stats Canada; seven to 14 children out of 10,000 exhibit autism spectrum disorder; and three out of 1,000 adolescents exhibit schizophrenia.

The state of our system: Our system is called the "orphan of the orphan." This was labelled by Senator Michael Kirby in the report Out of the Shadows at Last. It states that if the mental health system in Canada is the orphan of the health system, then children's mental health is the "orphan of the orphan." In 12 of the last 15 years, no funding increases have come to provincial community mental health centres. The Children's Centre in Thunder Bay cut 10% of its staff in 2003 and 2004, refocused the mandate to serving those most in need and cut out preventive initiatives. We refocused on short-term counselling to serve more families, but our wait list is currently 312, with clients waiting up to a year, depending on their severity of situation.

Community mental health centres are cutting or laying off staff while the demand for services increases. Other parts of the service system are calling for increased resources—schools, daycares, youth justice facilities, child welfare organizations, doctors and social service organizations—and yet we've had to cut and lay off. By inflation alone, the system lost 25% of its capacity. Schools, daycares, youth justice facilities, doctors, child welfare organizations etc. are calling for more service for children, increasing calls for more funding for mental health services.

The Auditor General, Jim McCarter, in 2009 also indicated that the estimated total economic cost attributable to mental illness in our province was $22 billion a year when you include things like health care, law enforcement, motor vehicle accidents, crime and indirect costs resulting to lost productivity.

The review of the Roots of Youth Violence report, chaired by the honourable Roy McMurtry and Dr. Alvin Curling, was released on November 14, 2008. The report highlighted the need for more children's mental health services and recommended that an additional $200 million be injected into the system to help deal with the roots of violence.

Mr. Tom Walters: I'd like to highlight for you some of the issues in relation to human resources in the children's mental health system. I think most of you are aware that there is a great competition for very skilled mental health clinicians or professionals, particularly in the arena of psychiatry, psychology and graduate-level social workers.

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Children's mental health centres in this province have fallen behind over the last few years in relation to the salaries they can pay compared to health or education. Just to give you an illustration of this, our centre, Children's Centre Thunder Bay, has lost five psychology staff in the last three years. We are currently still searching for more psychology staff. I think we have three vacancies and have not been able to find people to come to work with us at the salaries we pay. We've had no full-time child psychiatry for four years, and only sessional services available to us, but that's not always there either.

In the district of Thunder Bay, we have two child and adolescent psychiatrists who are currently working full-time, spreading themselves across a number of organizations. The Canadian Academy of Child and Adolescent Psychiatry standards suggest that our district should have nine child and adolescent psychiatrists. Their ratio is one psychiatrist for 4,000 youth, and we have about 35,000 youth in the district of Thunder Bay.

The other issue that is happening, which I believe serves as a barrier in relation to human resources and human resources initiatives, is that we have no coordinated HR plan across government bodies to help. In early June 2009, a group of service providers that I chair wrote to the Minister of Children and Youth Services, the Minister of Community Safety and Social Services, the Minister of Education, the Minister of Health and Long-Term Care and the chair of the North West LHIN explaining the serious issue we're having in relation to child and adolescent psychiatry. We asked for a meeting with these ministries. We pointed out that there was a need for leadership across government to help approach the problems and to work with us on trying to come up with a solution.

I think the responses were telling. The North West LHIN, in writing back to us, said it's "not our mandate." The Ministry of Education said they're working with MCYS and the Ministry of Health and Long-Term Care,

but their primary mandate is education. The Ministry of Community Safety and Social Services said that this "does not fall under this ministry." We've had no responses from either the Ministry of Children and Youth Services or the Ministry of Health and Long-Term Care. I think this makes the point that we really do need to have a better and more coordinated effort across this if we are really going to be able to provide the services that are required for children.

We do believe there are some hopes for the future. One of the things that I think the government has done that really stands out for me in the 21 years I've been a director of a children's mental health centre is that there now is actually a policy on children and youth mental health that was announced by the Ministry of Children and Youth Services in 2006. However, it's a policy, and not a lot of that has been implemented.

I think the new no-wrong-door initiative by the Ministry of Health is excellent. It cuts across all service systems in looking at ways to provide services to Ontarians, but there is a need to tie children's mental health into that, particularly as you look at transition-age youth who go from our system into the adult system.

I think this select committee is a hope for the future. I'm really looking forward to the recommendations you provide to the Legislature, and I hope that it will provide some leadership in addressing all the mental health issues in our province. The Canadian mental health commission, I think, is a breath of fresh air and is calling upon all provinces and our country to really come together and start to address issues of mental health across all age ranges.

One of my board members, who is a past president and is now president of our foundation, coined the phrase: "It is far easier to mend children than it is to fix broken adults." One of the travesties for me as a professional is to watch the number of children and families that come to us for help and our inability to actually provide them with timely help in a way that's going to address the needs they have when they come to our front door. If you have ever experienced emotional trauma in your family, you know that you need help with it now; you don't need help with it later. There are many, many promising best practices across the mental health field, not only in the adult sector but also in the children's sector, that prove we can actually help people very well if they get in for the help they need.

The last point I want to make with you is in relation to prevention. Jan mentioned to you that we had to cut back on a lot of the prevention work we were doing when we cut back as heavily as we had to on staff in 2003 and 2004. There is a best practice called Triple P parenting; you may or may not have heard of it. It is a practice that comes out of Australia and has 30 years of evidence-based research behind it. Many children's mental health centres and health centres are getting together and trying to implement this practice in our province. We believe that if you can help parents help children, you're going to multiply the effect of making our jobs easier, and then we can deal more effectively with the ones who are most in need. But we really do need some kinds of preventive programs.

I call upon this committee to seriously consider making this a provincial program. Right now, it's piecemeal and is patched together by many children's mental health centres across the province, throwing extra money—a small amount of money for the Ministry of Children and Youth services. In our district, we have $86,000 that came to us to start this initiative. I've dedicated an FTE to it. Other centres have done the same. We've got the district health unit working with us and doing some prevention on it. We're talking to schools about it; we're getting some support from them.

Manitoba adopted this as a provincial program, funded it and is coordinating it centrally. I believe that's something this province should seriously look at. If you want to address mental health issues, let's start earlier. Let's support parents in doing the things they need to for their children.

Those are our main points to you as a committee. Thank you for your interest, and we're open to any questions or comments you may have.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Tom and Jan. You've left about seven minutes for us to split up. Let's start with Sylvia.

Ms. Sylvia Jones: Thank you for appearing. I think you're the first children's centre. I've got a lot of questions, but I'll limit them to your human resource challenge. You mentioned that you have lost five staff.

Mr. Tom Walters: We've lost five psychologists in the last year.

Ms. Sylvia Jones: You may not be able to answer this, but are those five still in the field, just not with—

Mr. Tom Walters: I can answer that. All those five have stayed in the field, but they've moved into different sectors. One went into education, two went into health, one transferred to another children's mental health centre where they could get paid more and I think one retired.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Next is Howard.

Mr. Howard Hampton: I just want to be clear on this: By inflation alone, the system has lost 25% of its capacity?

Mr. Tom Walters: That's correct.

Mr. Howard Hampton: You're talking about your capacity here?

Mr. Tom Walters: The children's mental health sector in the province has lost 25% of its capacity to deliver service.

Mr. Howard Hampton: And what about in your case here?

Mr. Tom Walters: When we did our cuts in 2003 and 2004, we cut 10% of our overall staff. When you look at numbers, we're still serving the same number, but we're serving them in very, very different ways. We're providing a lot less intense or long-term service; we're providing a lot more short-term service. We started in a

walk-in counselling clinic in partnership with Thunder Bay Counselling Centre as a way to try to give better access to people, but we aren't able to take them into the longer-term kind of treatment they require. Other centres in the province have had to cut even deeper in terms of dealing with it.

Probably the biggest issues, in terms of inflationary costs, have been employee costs, insurance costs and those kinds of things. Those are the things that have been hitting us, and we just haven't had base budget increases to be able to address those.

Mr. Howard Hampton: You mentioned what Manitoba is doing in terms of helping parents. Can you describe that a bit?

Mr. Tom Walters: My understanding is that they have a central office that negotiates with the University of Queensland, where the program is housed. One of the biggest costs that I'm finding with the program is that they have all copyrighted material. What we've been doing is buying that copyrighted material, having them print it in Australia and it gets shipped here. The shipping costs and the cost to have it done in another country are absolutely bizarre.

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I think if we had everyone pulled together into a common group and we had one central point, we could negotiate a deal with those people to have ways of having it dealt with here, where we could still pay them for their copyright but we wouldn't have all the extra overhead and the administrative costs. Plus, if you can centralize it and have it as a provincial program, there will be a standardization of the way in which it is delivered across the province and it won't be piecemeal as it is right now.

My understanding is, that's what Manitoba has done. They've adopted it as a provincial program. They have a central office that coordinates it; they have mandated that all of their service providers will provide this; and they are working on developing five stages to this that go right from prevention on to dealing with very intense, difficult kinds of issues, which is primarily what we're focusing on—what they call a level 4 and 5.

That's what my hope would be for our province, that we could look at something like that.

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

Mrs. Maria Van Bommel: I'm familiar, as the parliamentary assistant to the Minister of Children and Youth Services, with the Triple P program, but what I see of the Triple P is that it essentially teaches parents how to handle behaviour issues. I'm wondering how it actually helps parents, whose children have mental illness, identify and deal with mental illness issues. In some cases, the mental illness may manifest itself as a behavioural problem, but in other cases, you have a child who is particularly quiet and parents will congratulate themselves on having a very well-behaved child, not understanding that the child actually has mental illness.

Mr. Tom Walters: I don't think that what I'm proposing is that it would replace all kinds of parenting education. What it does is it provides levels of skills for people.

You're right that it does focus a lot on behavioural kinds of things and out-of-control behaviour, so I think it's particularly applicable for children and families who are struggling with oppositional behaviour, struggling with conduct disorder kinds of issues, or just general strategies around how to discipline, how to communicate, how to deal with those kinds of things, all of which I think are good building blocks.

But if you had a child with a specific mental illness, you would have to have some additional support, I believe, in helping you understand the best way to approach that child to understand the symptoms and understand what they mean.

I don't see it as a total replacement, but I think it would be a far cry better for us to have a standardized program where we could help—because most people parent based on how they'd been parented. If they happen to have lucked out and had good parents, that's good. But if they haven't, they really don't understand how to parent the best way possible.

Mrs. Maria Van Bommel: Are you aware of any programs that would help on the mental health piece specifically?

Mr. Tom Walters: Our centre has taken the approach to work more on a self-help kind of prospect. For instance, we have parenting programs and groups for parents with autistic kids where we work specifically with them on how to deal with that kind of thing. I'm not sure that the Triple P parenting would be effective or recommended for that group.

We run specific programs for parents around dealing with teenagers, just as an example. Triple P could do that kind of work. If you're dealing with a depressed child, I think you would need other kinds of skills to look at drawing the child out and engaging the child, rather than just dealing with the kinds of things Triple P does. But I do think those kinds of things are available. We are looking for best practices all the time in terms of different approaches.

The Chair (Mr. Kevin Daniel Flynn): Thank you. That was good time management. Thank you very much for coming today, Tom and Jan.

Mr. Tom Walters: Thank you.

CATHERINE GILLIES

The Chair (Mr. Kevin Daniel Flynn): Any one of those microphones is fine, Catherine. You can sit anywhere you like. You can get set up while these guys are maybe unsettling themselves. There are some clean glasses there if you need any water for your presentation. Like everybody else this morning—now this afternoon—you get 20 minutes. You can use that any way you see fit. If you'd like to leave some time at the end, the committee would appreciate that.

Ms. Catherine Gillies: Okay. I'm here representing myself. I'm not representing any organization or group.

I'm here because I've struggled with mental illness my entire life, and I think it's important that people hear from us.

I don't think many people would know this about me, because I have lived a very productive life and I probably haven't exhibited a lot of my problems with mental health—at least, I don't believe so. I believe I've been pretty good about hiding it. But it's important that someone like myself becomes public about my personal issues with mental illness because I think that we need to de-stigmatize the whole issue of mental health and addictions.

A little bit about myself: I was born in 1949 and I was raised in a two-parent home. Both my parents worked hard their entire lives and have now passed away. I have two brothers, one older than me and one younger than me. I was destined to be the peacemaker in the family, the ultimate caregiver in my family, because I was the child of an alcoholic.

My father returned from the Second World War incredibly scarred by that experience and began drinking during the war. Alcohol was considered a reward if you were in the navy, which is what he was in. He was a gentle man and he worked hard his entire life on the railroad. He brought home his paycheque and then drank it away.

My mother was raised on the prairies and was one of 10 children and was the result of an arranged marriage—her parents' marriage was arranged. My mother struggled her entire life to keep our family together. She was a registered nurse and worked my entire childhood years and retired at the age of 65.

Both my parents have passed away, which is why I can give you a little bit of that background.

When I was 16 years old and in high school, I became depressed. I would go to school every day and I would cry. I was always an excellent student and I always got good marks. I was very quiet and didn't create any waves at school, but I was depressed. I was seen by a number of doctors, including a psychiatrist at the time, who said, "Make her go to school." So my mother made me go to school, but it didn't get any better for me and I continued to cry.

I took matters into my own hands and went to the local hospital and had them page the psychiatrist who had seen me. I told him, "I won't go to school. That isn't something I can do right now." He got me a position as a volunteer at that hospital. It was St. Joe's hospital at the time, in Thunder Bay. I worked in the rehab department, in the occupational therapy department, as a volunteer for the rest of the year. That was the beginning of my struggle with depression.

I returned to school in September of that year. I lost a year of school but I finished high school. I was an Ontario scholar. I went to university, got my degree in nursing and started my working life. I struggled with hospital nursing because I was always worried that I would harm my patients by making mistakes with medication. So I decided I would work in the community and I did; I worked in public health, and my whole career was spent in public health.

The issues with medication were at the beginning of what I saw as my obsessive-compulsive disorder. In hindsight, I realized I had struggled with OCD for many years prior to that, but that was when I saw it exhibiting. The OCD that I have took many forms. I worried, when I visited newborns in their homes, that I would hurt them, so I developed my own strategies for making sure that I could have just one more look at that baby before I left them with their mum. I would drive around city blocks a number of times to make sure that I hadn't hit someone with the car, because I would not be able to bear it if someone had been hurt by something that I had done. I would open sealed envelopes to be sure I had put the correct papers inside before I could trust the item to be mailed. That's significant for me, because I worked in the genetic counselling program and we had many documents that were mailed and I made sure that they were correct.

I covered up my OCD and my depression through my whole working life and I don't believe that people would have known about those. I've been on antidepressants for many, many years and I don't think I will ever be off antidepressants, even though I'm now retired and supposedly my life is much more restful.

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The reason I feel that I can speak out now is because I'm no longer working—I'm retired—and so I don't believe that would be a concern for me, when it comes to an employer.

My life has had many ups and downs, as all our lives have had, but I have learned that admitting to depression has its own stereotypes. For example, I have recently been diagnosed with a non-malignant brain tumour and it's created many problems for me, particularly around short-term memory loss. When I went to the neurosurgeon—who happens to be in Toronto, since we don't really have someone who could deal with my problem here—to discuss the options that might be available to me, he gave me some information that I wasn't prepared to hear, so I started to cry, understandably. He looked at my chart, he saw that I was on antidepressants and he said to me, "Have you been seen by a psychiatrist?" I explained to him that I was upset with the information that he gave me and that was quite appropriate. It had nothing to do with my mental illness or anything else.

I guess I wish for the people of Ontario that mental health and addictions be taken out of the closet and talked about openly. I wish that instead of ostracizing those with mental illness and addictions, we see them the same way we see people with heart disease and cancer. We need to openly discuss these issues. My father was an alcoholic. He was sick. He had a disease. I suffer from depression and OCD. I have a disease. I've been treated and I'm no longer ashamed.

I believe I've lived a full life and have made many valuable contributions to my community. I sit on a number of boards and I have sat on a number of boards in

the past years. I believe there are many people who, like me, keep their illness a secret because of misunderstanding and prejudice. I believe there are many people who suffer in silence rather than admit they have a mental health problem.

I have some suggestions, and you'll have to bear with me. Because my background is in public health, I like to look at stopping people from falling into the water rather than pulling them out of the water downstream.

My first suggestion is to look at the Roots of Empathy program. If you don't know what Roots of Empathy is, its mission is to build caring, peaceful and civil societies through the development of empathy in children and adults. That helps all children to learn about empathy and inclusion, therefore removing the stigma of differences. I've been on the committee that brought Roots of Empathy to Thunder Bay and I am a true believer in that kind of intervention at the very start.

I think we should be incorporating mental health and addictions strategies in the Ontario public health standards since prevention and screening are less expensive both financially and socially than treatment. In the public health standards, the ones that are mandated by the government, there is a portion called prevention of injury and substance misuse, but that's way too small a component of prevention strategies.

I think we should make mental health and addictions a standard curriculum in all high schools, colleges and universities so that individuals understand what mental health and addictions are and they're talked about as a health care issue or as a part of health.

I think we should develop programs for physicians, nurses, police officers, paramedics and other front-line workers that make them sensitive to issues of mental health and addictions. I think we should develop programs in community health centres that would target street people, homeless and underserved individuals in order to create novel entry points into the system.

An idea that I've had and I've thought was something that we could consider is to provide veterinary services for the pets of low-income or street people, many of whom have pets because that's the only thing that loves them unconditionally. They would give up the food that they have and the care that they need in order to feed those pets. And it would help establish a trust relationship with care providers, using that venue to bring them into care settings.

I think we should be creating resources for physicians that would help them to work with patients who have become drug-dependent because of illness or injury. I know a lot of people who have become addicted through the need for pain medication and whose physicians don't know what to do with them. I think we should have the Workplace Safety and Insurance Board include addictions in their workplace disease category since many people develop addictions because of workplace injury.

I think we should have electronic health records for all of Ontario in order to allow consistency in the management of mental health and addictions and prevent overmedication and mismanagement of all health issues.

Finally, we must take away the shame and the stigma of mental health and addictions and openly view good mental health as a goal for all citizens to have. We must stop punishing those who are ill and struggling. We must be more inclusive. The silence surrounding mental health and addictions creates problems for individuals, families, schools and employers. We need programs that will help individuals to be understood and support them as they recover.

Imagine going for help to the emergency department of your local hospital and being treated with derision, ignorance and distaste. Never forget that feeling as you make your recommendations for changes to the system. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Very good. Thank you, Catherine. You've left six minutes for some questions. We're going to start with Howard. We'll get about two minutes each.

Mr. Howard Hampton: Thank you for a lengthy list of recommendations. Since your area of expertise is public health, of the things you talk about, how many of those things are being done now, in your experience?

Ms. Catherine Gillies: Of the things that I talked about, very little. Roots of Empathy, for one, is a very expensive program. There are a few programs available, one of which is out of NorWest Community Health Centres—Wendy Talbot is here—and a few other places, but it's not universal. It's a very expensive program and it needs to be universally funded in order for it to be provided in every school in the province of Ontario.

I saw from the listing you're going to be getting a presentation from somebody from the Drug Awareness Committee of Thunder Bay—I was on that committee at one point, too—and they can talk a little bit about what they're doing, but there aren't a lot of programs that would be available provincially and standardized, for example, in every educational setting to be able to provide that information. The WSIB I know because I did a project out of NorWest Community Health Centres funded by WSIB. It's certainly not open to anything to do with addictions as part of their system at all.

I know electronic health records has just been—

Mr. Howard Hampton: It's been in the news.

Ms. Catherine Gillies: —in the news, but I also know that if you can't doctor-shop, if you have something that allows the care provider to know exactly where you are, that can help in many ways.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Catherine. We'll move on. Liz?

Mrs. Liz Sandals: Thank you so much for sharing your experience with us. I've got two questions. One is a public-health-experience-related one: If you were going to put out information about mental health and addiction and beef that up in the provincial curriculum, what sorts of information would you include for kids?

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Ms. Catherine Gillies: For kids? Or for anyone—

Mrs. Liz Sandals: Well, or a range of ages.

Ms. Catherine Gillies: I mean, that's a huge—

Mrs. Liz Sandals: It's a huge topic.

Ms. Catherine Gillies: What can I tell you? It's huge, and better people than I would be able to give you specifics on that. But in the old days, when I first started in public health, we used to do a lot of home visiting with seniors, for example, or with people who might have been discharged from a hospital setting and who had some mental health issues. We didn't have a lot of rules that we had to follow that the government had put upon us. So we did a lot of that kind of visiting.

I'll give you one quick, quick example. I received a call—I was on what was called phone duty—from a person in an apartment block who was concerned about an elderly couple in that building. She just didn't want to give me her name but she was worried about them.

I went over to that building and knocked on the door and I said, "I'm just a public health nurse. I was just in the building and I wondered how you were doing." As it turned out, the husband had severe dementia that had been unrecognized and untreated. The wife was coping as best she could. Through building trust, we, meaning public health nursing, could get assistance for that individual.

That isn't in there any more. Public health doesn't have that mandate any more; the mandates are very specific. They've lost those community connections, and nobody has taken those connections up. So that's just one.

Mrs. Liz Sandals: And then the other is a more personal question, and it's up to you whether you want to answer or not. You've obviously dealt with your mental illnesses very successfully and had a wonderful life and contributed a lot to the community. Can you identify something that enabled you to cope?

Ms. Catherine Gillies: Irish stubbornness.

Laughter.

Mrs. Liz Sandals: I think that's a lot like Scottish Presbyterian stubbornness, which I also claim.

Ms. Catherine Gillies: I think I can say I've been lucky. I married a wonderful man who was very accepting and supportive of me. I've just been lucky, yes.

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

Ms. Sylvia Jones: One question, to tie back into your suggestion about electronic health records: A recurring theme that we're hearing a lot is that many people who have mental health illnesses are not getting access to family docs, which of course is the door to every other service. Do you believe that putting the electronic health records in place would give the family physicians a comfort level?

Ms. Catherine Gillies: It might. I guess I've been very fortunate to have the same family physician for many years, who is probably going to retire soon, and I will be without a physician. I don't know what I'll do then.

I think that electronic health records certainly give a bit more control and the ability to monitor a patient a lot better. Maybe that would help; I have no idea. I have a whole lot of suggestions around physicians, but that's for some other venue than this.

I don't honestly know if that would make them more comfortable. I think they need resources to make them more comfortable. I think they need to be able to know that they can give a particular client over to somebody who has expertise, who would support that client through whatever the issues are, but it's not there. Like I say, everybody who has presented is pulling the person out of the water at the end of the stream rather than keeping them from falling in, at least in today's sessions that I've listened to.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Catherine, and for telling your story. It was really appreciated.

Ms. Catherine Gillies: You're welcome. I hope it was helpful.

The Chair (Mr. Kevin Daniel Flynn): It was very helpful. Thank you.

ADVISORY COMMITTEE FOR MENTAL HEALTH AND ADDICTION SERVICES

The Chair (Mr. Kevin Daniel Flynn): The next person we have coming forward is Keith Zehr from the Advisory Committee for Mental Health and Addiction Services. Keith, thank you for coming.

Mr. Keith Zehr: Thank you. I first met Catherine about 48 minutes ago, and—

Interjection: She has that effect.

Mr. Keith Zehr: —if it weren't for probably the wrath of the rest of my advisory committee members, I think I'd allot the next 20 minutes to her.

Actually, to that end, I'm going to start with the last statement I was going to make in this presentation. I'd like to ask that you do one thing during your consultation, and that is to take some time to have a meaningful conversation with a person who has a mental illness or an addiction. Don't just listen to the person's speech, but truly engage with the person as you would with a colleague or a friend. I guarantee this one conversation will have a lasting impression. It has on me inside of that four or five minutes when we were actually having some dialogue about the personal issues beyond even the public health professional career, but also who you are as a person and how it is that you got to where you are in what would seem like such a successful manner. Thank you, Catherine.

Thanks a lot for allowing me to be here and to speak on behalf of the Advisory Committee for Mental Health and Addiction Services here in Thunder Bay. My name is Keith. I'm a member of this committee that provides advice to three health care boards of directors: Children's Centre Thunder Bay—you've heard from Tom—a children's mental health centre or agency; St. Joseph's Care Group, a multi-site, non-acute health care corporation that provides long-term care and physical rehabilitation services along with in-patient, outpatient and outreach mental health and addiction services; as well as

Thunder Bay Counselling Centre, a community agency focused on supporting individuals and their families.

Our agencies provide comprehensive clinical and support services for children, adults, seniors, and family members/natural supports through the continuum of care. We work in concert with numerous other mental health, addiction and health care agencies in the communities throughout our region.

Our mandate as an advisory committee is to keep the three boards apprised of emerging mental health and addiction service issues throughout Ontario and our region. Actually, it's really cool: I want to highlight the fact that it truly is three boards. This is one advisory committee that is accountable to and responding to the needs of three separate agencies and three separate boards. I think their foresight and their vision—if not, quite frankly, the realities of having dearths of services and people to be able to fulfill roles—resulted in some pretty creative collaboration for us to be able to come together as an advisory committee for three.

We also look at what are the emerging mental health and addiction service issues throughout Ontario, to support the boards in systemic change and potential strategies to advocate for system improvement; promote public awareness and address issues of stigma and discrimination; and support collaboration and partnerships with all health care, human services, youth justice, adult justice and social service providers.

The members of our committee are consumers and family members as well as representatives from mental health and addiction agencies, social service agencies, police, justice services and the general public. My day job is as executive director for Creighton Youth Services. We provide custodial and alternative-to-custody programs for—we still call them young offenders. I joined up 29 years ago, when it was under the JDA, and I worked at a training school, and it seems like "young offenders," even if they aren't part of the parlance of the YCJA, still seems to work. One would be too many, but sadly, our youth justice experience is, I believe, a replication of what we're seeing in the adult system. With kids, I see it as particularly tragic in that one would be too many, but we see many, many, many youth who are in custody not because they have criminogenic factors or needs, but because they have mental health issues that are not addressed otherwise. We are criminalizing our kids for having mental health issues, in my experience.

Although we all come to the table with different life experiences, we all have a clear vision about the future. We believe that some day, people with mental illness and addiction issues will be accepted into our neighbourhoods and communities without scorn, ridicule or discrimination. We believe access to mental health and addiction treatment will match access to other health care services, as Catherine talked about. We believe the overall health and well-being of our target group will improve considerably and be equal to that of the general population. And, finally, we believe families and caregivers will no longer be embarrassed to talk about their family member who is living with a mental health issue and/or an addiction.

In our opinion, it's important for all of us to shift our thinking about mental illness and substance abuse. We need to acknowledge and accept that people with a mental illness and/or substance abuse issue did not choose the illness. They can't easily treat themselves or just "snap out of it." We need to embrace the concept of recovery and hope, and to celebrate, with our community members, every step in the journey of healing. We must open our hearts and our minds, because the person with the mental illness and substance abuse issue could be your daughter, your father, your spouse, your co-worker or your friend. It could be me; it could be you. We heard it was Catherine.

The statistics, as you're aware, are staggering. We've read it in the discussion paper, but I feel it's worth pointing out again: 20% of Ontarians will experience a mental illness in their lifetime. Rates of depression and other mental illnesses now exceed rates of cardiovascular disease. In the three years since I joined Creighton Youth Services as executive director, I personally know of seven youth who have been in our care who, when they returned to their home communities, chose to take their lives.

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Mental illness is the biggest cause of workplace absenteeism. One out of every 10 Canadians aged 15 years and older reported symptoms which indicated alcohol or illicit drug dependence in 2002 to 2003. Also in that spread, Ontario hospitals provided almost 1.5 million days of mental health and addiction treatment, with one third provided by acute care facilities, and two thirds by specialty facilities.

The waiting lists for treatment for mental illness are increasing in Ontario. Last year in Ontario, people seeking mental health services waited approximately seven weeks to see a specialist and another 10 weeks for treatment to begin. One of our mental health programs is now receiving over 200 new referrals each month. It suggests some success and awareness and "Let's seek some help." Sadly, the wait time to access specialized mental health care is 10 months. Do the math. People requiring counselling in a shared mental health care setting must wait four months, yet research shows that people with mental illness should wait no more than two weeks to access services.

I feel like I've missed an opportunity on behalf of youth justice to not have gotten 20 minutes for that—but the advisory committee picked me. With respect to some of the youth justice issues as I've already identified and will build on now with respect to access to services, we have kids here in Thunder Bay who would be best suited in what is known as a secure treatment designated facility. We have two in Ontario: One is in Ottawa and one is just outside of Toronto. We have kids here who have been told that they are too difficult for those programs.

The economic costs of mental illness and addictions are approximately $34 billion a year, including health care treatment, law enforcement and workplace absenteeism. However, many families will tell you that the costs of addiction and mental illness are far more than just economic. Sadly, people with mental illness and/or addiction issues have learned to accept stigma and discrimination as their reality and to hide their problems. This makes it even more difficult to provide appropriate services.

So what can we do to improve the system of care? First and foremost, we believe in working in partnership, as we've tried to exhibit in our collaborative fashion specific to this committee and in other areas across Thunder Bay and northwestern Ontario where, again, sometimes it's as a result of not having the resources that we are forced into the potentially, I suppose, counter-intuitive reality of needing to work together and therefore creating some collaborative efforts.

We believe that, first and foremost, funders, providers and policy-makers within Ontario's health care system and the social service and justice systems must work together to achieve a comprehensive continuum of care and service that is accessible, welcoming and based on best practices. Every door, in my opinion, might be the right door; I wish there was one and it was never locked.

Many of our current services are structured in silos that match the source of funding, including the various provincial ministries—health, children and youth services, community and social services, housing, and community safety and corrections, for example—as well as federal and municipal bodies. Consumers and family members are truly not concerned about the source of funding; they just want help.

We appreciate, in the discussion paper, that the transformation expectations discussed are pushing toward some of the things that I have talked about, in terms of rectification, and that I will offer as potential solutions. Our concern is that, without an extremely solidified, considered coordination and funding source that isn't siloed and isn't parsed out and isn't a part of somebody else's bailiwick rather than the main one, even the least of the recommendations might never see fruition. We see an incredible need for a dedicated and specific single source for coordination and funding.

We believe, for access, that clients must have access to the appropriate level of care in a timely manner. Access to services must be equitable. Social-economic status, culture and geography should not influence the type of care a person receives or the length of time it takes to receive these services. At the point in time when an individual has mustered up enough courage to walk into an addiction treatment centre or has decompensated enough to be taken to the emergency department, he or she should not be told that there's a six-month waiting list to see the appropriate health care provider, in our opinion. The system should have sufficient capacity to meet people's needs in a timely manner.

Integration: Mental health and addiction services should be part of the fabric of the health care, social and justice service systems. Health care and social service providers oftentimes work in isolation from mental health and addiction care providers, even though they are working with the same individuals.

Back to my little side agenda here: We see it in children and youth services. We were very, very, very happy to have a brand new ministry, only to see youth justice have a bigger silo than we used to have under ComSoc days. We work at it. We try and help our colleagues in the public service and governments to figure out ways of doing it. My experience is that it is very difficult to open and keep open the doors of silos rather than not building them or reinforcing them at all.

All providers, we believe, must identify the resources that are needed by the target group and work in an integrated and collaborative manner that is invisible to the people served. It doesn't matter to them. Sometimes we think we should have a guide to help people through the system. It sounds great until you realize if we had a system that didn't need a guide, wouldn't that be a whole lot better? In our opinion, funders, policy-makers and service providers all need to let go of their own turf and dismantle the silos. Leadership across ministries is required to set the stage for integration and the development of a system that meets the needs of all Ontarians, in our opinion.

Consumer voice: Consumers and family members must participate fully and have a strong voice in planning and decision-making, not only in meetings about their own care, but in system planning and design forums—we appreciate that that opportunity has been provided here—and would also look at any next stages such as figuring out if there are systemic barriers to even those who might be willing to speak to youth, to not exactly knowing how, or could they afford the call to Toronto to do it, if they weren't aware there was an 1-800 number.

For decades, health care providers have planned and established systems of care based on what they believe to be best for the people they serve. But the best care system truly is one that is designed with the full participation, in our opinion and experience, of the people receiving the care and their family members and natural supports. Consumers have clearly stated that the invitation to participate must be genuine and not an afterthought, when the majority of the planning has been completed.

Cultural sensitivity: The diverse needs of the population of northwestern Ontario must be addressed. It is estimated that in 10 years, between 35% and 45% of the population of Thunder Bay will be aboriginal. Although care providers are aware of the need to be culturally sensitive, we don't always fully understand or appreciate the social, political, language and spiritual needs of the people with whom we work, nor do we consistently practise in ways that will support them in a caring and respectful manner. We need to ensure that all people, regardless of age, language, gender, race, sexual orientation and geographic origin, feel welcomed into the system of care and fully supported during their journey of recovery.

Research and best practices: We believe that this information must be transferred into practice in a timely manner. It has been estimated that it could take up to 15 years to translate gains in knowledge into clinical practice. Aggressive efforts, in our opinion, must be made to significantly reduce this knowledge transfer time gap. People with a mental illness or a substance abuse issue deserve services and care based on the best available knowledge and scientific evidence as much as the person with cancer or cardiac issues.

Safe, affordable housing with supports: Supportive housing is a key component of a well-designed mental health and addiction treatment system. At this time, almost 50% of in-patients in Lakehead Psychiatric Hospital meet the criteria for long-term care or supportive housing. Due to financial constraints and restraints, insufficient capacity in the long-term-care sector, and lack of sufficient supportive housing resources, many people must remain in-patients of mental health facilities when that level of resource is no longer required. Many people with a mental illness or substance abuse issue and their families live in deplorable housing conditions, if not on the street. How can we expect them to even begin a journey of recovery if their basic needs are not being met? How can we expect them to have hope?

More resources, in our opinion, must be directed to establish safe and affordable housing with necessary supports to provide stability and safety and give them the opportunity to begin their journey. Long-term-care facilities must be funded appropriately to accommodate seniors with mental health issues.

In summary, we believe there is so much that must be done to improve the health care and social service system to better meet the needs of people living with mental health and/or addiction issues and their family members.

We thank you as a committee and I thank you personally for providing the people of Ontario with the opportunity to engage with you and to share their perspectives and priorities. We are hopeful that changes in the system will be positive and we look forward to being part of that changing system.

And I end where I started. I met Catherine about an hour ago. Thank you, Catherine, for sharing.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Keith. We appreciate your presentation. You've left about four and a half minutes, so if we make them quick, Helena, we can get three questions and answers in.

Ms. Helena Jaczek: Thank you very much, Keith. I really don't have a question about what you've presented, because it's so comprehensive and understandable. But we have heard quite a bit about peer support as we've travelled around and I was wondering if you have any specific recommendations about what that would really look like. We know we want people with mental illness to have a home, a job and a friend, and that friend piece can often be a peer. Do you have services in Thunder Bay that could be described as peer support? Do you have ideas for improvement?

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Mr. Keith Zehr: If there are services beyond some of the high school-implemented peer-to-peer counselling services, I'm not aware of them. I would defer, if it's okay—if Tom's still here—to Tom or to Wendy Talbot, who might have better ideas about it. Do you, Tom, in terms of what's available, or any recommendations?

Mr. Tom Walters: There certainly are some peer-to-peer support groups, some consumer-led initiatives. They certainly contribute tremendously to people feeling that there's someone who'll listen to them who has the same kinds of problems.

I had the opportunity a number of years ago to sit on the planning committee for mental health for this region, and there was a strong consumer contingent on that group who really, really kept pushing the need for consumer and family involvement. I think it's a direction that should be looked at very carefully.

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

Ms. Wendy Talbot: Since Keith asked me to come up—and I'll speak really quickly—the one population that that doesn't apply to is the population on the street. They're more interested in eating than peer counselling. So let's remember that group, and it's huge.

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

Ms. Sylvia Jones: I wanted to get further into your consumer voice, where you say, "Family members must participate fully and have a strong voice in planning and decision-making"—again, something that we have heard consistently. What we haven't got—and I'm wondering if your committee delved into it further—is how you balance the privacy rights of the individual against the desire of family to be part of the healing process.

Mr. Keith Zehr: In a bit I'll defer to Tom again, but in my experience families don't really care a whole lot about the privacy issues when it comes to whether they're going to be helping the system; it's more, "What are the legal issues that we're caught up with?" So—I should stop before I—

Ms. Sylvia Jones: I agree, but the law does, right?

Mr. Keith Zehr: Yeah.

Ms. Sylvia Jones: I mean, the law is very specific about what can be shared with the families and what can't. So I wondered if your committee had figured out how to deal with that.

Mr. Tom Walters: I don't think we have any golden answers for you on this one. I agree with you: It's a very complex issue. The only thing I can suggest to you is that when families say that they want to have a voice, I think their voice should be used in relation to the kinds of services that are required, rather than focusing on the individual care of their own relative. That's where you get into the confidentiality and privacy issues.

We run into the same thing with youth in our own children's system, where youth over the age of 12 can come to our centre and have services without their parents' knowledge. Now, certainly, we encourage them—and I would say 99% of them agree—to have that

information shared. With young adults that becomes, I think, a little more tricky, because sometimes they want their own privacy.

So the weight, I believe, to engage families is to really engage them in some planning of services and help them provide their perspective on what would be supportive, not only to them but to their loved ones. But you can't allow them to delve into the individual issues. You have to keep that screen up.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you, Tom. Howard? There's about a minute and a half left.

Mr. Howard Hampton: You deal a lot with work in partnership and integration, and you identify the problem of silos. I wonder if you could outline for us how you think integration and work in partnership should be achieved, because I think Cathy tried to answer the question. What I got from her is that she feels very strongly that the community mental health centre or public health could provide that integrating opportunity to do this.

There are a couple of places around the province where you have what are essentially community health centres and multi-service agencies, where you have nurses, social workers, psychologists, psychiatrists, nutritionists, physicians and educators all working out of the same building. Do you have any suggestions for us? Not only working out of the same building; they combine funding from various agencies. I'm told that people in the community feel they do an excellent job.

Mr. Keith Zehr: I'm going to defer to Wendy in about 30 seconds, but with respect—

The Chair (Mr. Kevin Daniel Flynn): I don't think we have 30 seconds.

Mr. Keith Zehr: We don't have 30 seconds?

The Chair (Mr. Kevin Daniel Flynn): You've got to handle this solo.

Mr. Keith Zehr: Okay. Then it might not be so much advisory as my own personal experience, and that is with incredible respect. I have colleagues who operate organizations that have children's mental health, child welfare and youth justice and they have three separate program supervisors from the same ministry that they're dealing with. That, for example, to me would be one way of starting to break down silos even within our funding ministry, to be able to have people talking to each other rather than, even inside, the divide-and-conquer mentality that people have to work really hard at not getting in the way.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you very much for coming, Keith. We appreciate it.

DISTRICT OF THUNDER BAY SOCIAL SERVICES ADMINISTRATION BOARD

The Chair (Mr. Kevin Daniel Flynn): Iain and Joe, if you'd come forward and make yourselves comfortable and introduce your third partner, whose name I don't have.

Mr. Iain Angus: Thank you, Mr. Chairman.

The Chair (Mr. Kevin Daniel Flynn): You've heard the spiel?

Mr. Iain Angus: I've heard the spiel a number of times over many years.

Mr. Chairman, members of the select committee, first let me thank you for conducting these hearings here in Thunder Bay so that the people of this region have an opportunity for input. The northwest is indeed different from other parts of Ontario, with mental health issues having their own story and perhaps their own solution.

With me today is my fellow municipal councillor, Joe Virdiramo, not only representing the city of Thunder Bay, but he's also the child advocate for the city of Thunder Bay; and our CAO of the District of Thunder Bay Social Services Administration Board—and that's the last time I'm going to say that—Mary Lucas. Our vice-chair, Elaine Mannisto, from the municipality of Greenstone, was unable to join with us today due to a prior commitment.

Mr. Chairman, we've reviewed the Ministry of Health and Long-Term Care consultation paper, Every Door is the Right Door, and wish to commend your government on the release of the consultation paper. It said a lot of the things that we've been saying as an organization. We are also very pleased to see two representatives from our community on the advisory committee: Nancy Black, director of community, mental health and addiction services, and Dr. Ty Turner, chief of psychiatry.

As you may be aware, TBDSSAB is responsible for the funding, management and delivery of child care, social housing and Ontario Works in the district of Thunder Bay. Just so that you're clear, there are two other districts, the district of Rainy River and the district of Kenora. We have no jurisdiction there. It's just the district of Thunder Bay. Our clients are the most vulnerable members of society, and all three of our portfolios have a relationship with and impact on the mental health of our communities and the people who live there.

Our board and our staff have long been concerned about the welfare of all of the people who rely on our organization for support. We view it as our responsibility to take a holistic approach to meeting our clients' often complex needs. In more recent years, the issue of obtaining supports for people with mental health concerns has become a focal point of concern for us.

A 2004 housing needs study prepared for the TBDSSAB by the Thunder Bay District Housing Corp. found that our waiting lists for seniors' housing had all but disappeared, our waiting lists for families had reached a more manageable level, but that the emerging issue for us was the provision of accommodation for individuals who required varying degrees of supports throughout the day and night. That same report also identified the challenge that while funding for the bricks and mortar came through the Ministry of Municipal Affairs and Housing, with a very significant contribution from the property taxpayer, which continues today, fund-

ing for supports comes from other ministries, mainly the Ministry of Health, and now through the LHINs.

Difficulties that our clients, service providers and staff encounter in accessing mental health services in our district were also formally raised to TBDSSAB by a deputation of concerned citizens back in June 2003, and our staff have also identified numerous concerns related to helping clients access appropriate mental health treatment.

Many of our concerns today echo the original worries about deinstitutionalization. As an MPP from 1975 to 1977, when all of this started, I remember well the concerns that were raised when the Ontario government announced that it would be moving people out of the psychiatric hospitals into the community. At that time we, the opposition parties and the communities, stated categorically that the community supports had to be in place before the shifting occurred. That did not happen.

In response to these ongoing concerns, our organization completed a report and environmental scan in late 2008 assessing the impact of mental health system reform activities on social service clients. Our report found that difficulties accessing mental health treatment and supports seemed to be continuing, notwithstanding many recent major mental health system reform plans, activities and improvements to treatment such as new medications.

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In order to illustrate just some of these access issues, we would like to share with the committee some of the results of psychological tests completed on our clients over the last several years.

We have found that many of our clients in the Ontario Works program have previously undiagnosed, untreated and apparently unsupported mental health problems as well as intellectual and learning disabilities. We have discovered these conditions by paying for psychological assessments, not available from the mental health system, for some clients who we believe may be unable to participate in our programs and/or maintain their independence.

Some of the findings of a sample of 378 psychological assessments completed between January 2004 and June 2008 include:

—231 of the 378, or 61%, were diagnosed with psychological disorders ranging from borderline personality disorder to major depression and schizophrenia.

—Approximately 27% assessed were found to have intellectual disabilities and/or were diagnosed with global intellectual and developmental disability, or mental retardation, but were nonetheless trying to participate in the Ontario Works program independently, without any community supports we were aware of.

—Approximately 32% were found to have learning disabilities such as attention deficit hyperactivity disorder, disorder of reading, disorder of written expression, or visual and math deficits.

—Numerous clients were identified as functionally or totally illiterate—not evaluated in all assessments.

—27% were diagnosed with substance abuse problems, typically severe or chronic.

—The average age of the individuals assessed is 39 years, so these were not new problems but were nonetheless untreated and unsupported.

—Upon completion of the ODSP disability application process, 83% of the applicants have been awarded provincial disability supports, meaning that their disabilities were confirmed to be quite serious, limiting the ability of these clients to independently seek and maintain employment, not just for today but for the long term.

The vast majority of these clients were previously undiagnosed and untreated for these disorders and were receiving no community supports that we are aware of. The fact that these individuals were attempting to independently participate in the Ontario Works program in spite of their serious disabilities indicates that they are, and have been, inadequately supported in the community. What is amazing is that they were able to get through the intake process that the province requires of them.

As Minister Matthews has pointed out herself in her own report, the application system is not designed to be a supportive and client-friendly process, especially for those with any type of disability. How can we expect someone who is bipolar or clinically depressed, who has difficulty getting out of bed many days, to spend the time trying to get through the process of applying for Ontario Works or ODSP, let alone to seek help for the pain they are enduring?

In addition to paying for testing, TBDSSAB has also hired a dedicated intensive-case manager to assist clients with the application and participation requirements of Ontario Works as well as to help them obtain treatment.

Many of these clients were referred for psychological testing from our Ontario Works addiction services initiative, or ASI. It is well known that the issues of substance abuse and mental health are inseparable, and our experience has confirmed this.

We wish to point out and to confirm what I said to you from the back of the room this morning: The province has expressed an intention to cut the funding for the Thunder Bay ASI program by almost one third by 2011. We feel that this cutback is particularly inappropriate, given the increasing prevalence of substance abuse in our district and the lack of supports that are available for our clients elsewhere in the system. We do, however, welcome the decision of the government to expand the program to areas in the province other than the pilot areas like Thunder Bay, but believe it inappropriate to do it by taking some of the funding from our program.

In the area of social housing, interviews with our housing providers indicated growing concerns with tenants who seem to have inadequately treated mental health and addiction problems. The behaviour of many of these tenants has led to their eviction from social housing, as housing providers are not adequately prepared to cope with these behaviours without outside assistance—and I'd like to add private sector housing as

well. It's not just social housing that they get evicted from.

Our largest provider, the Thunder Bay District Housing Corp., with a portfolio of 2,520 units, has only two community resource workers who are able to assist the tenants in getting the supports they need. They report extreme difficulty and a lack of response from the mental health system when they attempt to obtain assistance for the tenants. These are often the 2 a.m. phone calls that a property manager has to make.

Often, disruptive tenants are taken away by police and returned to their apartment the same night with no apparent treatment or follow-up from the mental health system. In some cases, tenants must be restrained, handcuffed and forcibly removed by the police only to be discharged from hospital a short time later, often becoming unstable again in a short time.

Those who are evicted due to their behaviour or for health and safety concerns, such as the fire risk that hoarding represents, are then forced to rely on Shelter House, our local shelter, which TBDSSAB partially funds through the per diem system of payment. Shelter House then works—and they do a very good job of this—with the clients and assists them in finding mainstream housing. They get them some supports for some time and then the cycle starts all over again. It would be better if there was a supportive housing facility in which we could house them so that they could get the assistance they need to remain healthy and secure.

In addition—and this is not just a Thunder Bay problem—we are receiving requests from community agencies, as well as smaller communities in the district, for supportive housing. For example, we're working currently with St. Joseph's Care Group to convert some of our existing units to supportive housing. We have the bricks and mortar. We don't have the supports. There is tremendous concern in our communities regarding appropriate supportive housing and the ability of citizens to survive in smaller communities.

We interviewed the Thunder Bay Police Service as part of our environmental scan, and they reinforce our concern that there are apparently many individuals with serious, inadequately managed mental health problems living in the community, and it is difficult to help them obtain appropriate treatment.

It is our opinion that many social services clients have fallen through the cracks in many different systems, including the mental health system.

Let me now turn to my colleague Joe Virdiramo, who will outline our recommendations to you.

Mr. Joe Virdiramo: Thank you. Our main recommendations include:

That the province fund increased community supports, and especially increased numbers of dedicated supportive housing spaces, for persons living in the community with serious mental illness. I just want to add—Iain was talking about the police services; I'm vice-chair of the police services board—sometimes in an evening we have six officers or more attending at the hospital because clients have been taken off the street. They're causing difficulty, they follow them to the hospital and they have to be there and stay with them until they are seen. With our police services that creates a great deal of havoc because the officers are not on the street, they're at the hospital with these people;

That the province better coordinate crisis response services with the police, acute care centres and mental health service providers, so that people in crisis receive the help they need, as well as appropriate follow-up treatment and support to prevent further crises;

That, at a minimum, the province continue to fund the TBDSSAB Ontario Works addiction services initiatives at their current levels;

That the province examine the adequacy of current inpatient treatment beds, programs and protocols for admission. We feel that the criteria which are used to assess whether or not someone is admitted to hospital, how long they stay and when they get discharged may need to be reassessed. Deinstitutionalization may have been a noble goal, but we may simply not have enough beds any more for the people who need treatment and have, therefore, applied criteria for admission that are too severe.

We believe our definition in social services, and the police services, of when someone presents a danger to themselves or others and requires treatment must differ from the mental health system's definition. We suggest that the committee examine the issue of consent to treatment, particularly when people have been brought to the hospital by police.

One of our shelter providers notes: "What exactly constitutes a danger to yourself? Does being completely disoriented, dressed in rags and sleeping on the sidewalk represent a danger to yourself, or is it just a danger for certain segments of society but fine for others to endure?"

In the winter, elderly ladies with Alzheimer's who are inappropriately dressed, confused and wandering the streets are whisked away and admitted for treatment immediately, but 40-year-old aboriginal alcoholic schizophrenics, possibly with developmental delays, as we have found, are sent to a homeless shelter or left to fend for themselves with no follow-up treatment.

TBDSSAB recommends the appointment of a lead agency in the district of Thunder Bay for application and waiting list management for all supportive housing in the district of Thunder Bay which would centralize this function, bring about consistency in application, improve customer service, offer sound waiting list statistics for strategic planning and improve services for individuals requiring mental health and addictions support.

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Currently, prescribed supportive housing providers are responsible for receiving applications for special needs housing—supportive units only—assessing for eligibility and maintaining a waiting list. In addition, there are a number of dedicated supportive housing providers under provincial jurisdiction that also perform the same

functions. While the TBDSSAB receives ongoing requests for more supportive housing in our service area, our ability to determine the need and scope of this type of housing is challenging under the current system.

Please note that TBDSSAB wishes to work in partnership with our colleagues at the local health integration network, the Ministry of Health and Long-Term Care and other provincial ministries to improve the access of our clients to mental health services. For example, some of our existing social housing facilities may be appropriate for mental health supportive housing units, but what we need is the expertise and services provided by funded mental health programs to provide client supports.

We wish to commend the province for its partnership with St. Joseph's Care Group for supportive housing in the Seniors' Centre for Excellence and hope that something similar is possible in the area of mental health.

Accessing mental health services in Thunder Bay is extremely complicated. There should be a one-door entry. However, currently, individuals must fit particular criteria to obtain the services. Some must also have a diagnosis from a medical practitioner before the program will accept them; some programs will not accept co-occurring clients; some programs do not want the more severe cases; some do not offer outreach services; some will give clients one attempt to make appointments and then discharge them. We find that our clients need a lot of support to get through the door and even more support to stay with a program once accessed.

As noted above, it has been our experience that there are different definitions, protocols and eligibility criteria for services that create barriers. Creating a client-centred system—making every door the right door—means a shift in culture in mental health and addiction services, in the health system and in the broader community service systems. According to the discussion paper's authors, "To get to where we want to be, we must change the way we work. There must be more collaboration and fewer silos. We must make effective use of change management strategies, such as communications, information technology and implementation plans."

Finally, we would like to note that it is not the intention of TBDSSAB to criticize or debate the extent or direction of mental health system reform efforts or the quality of mental health services available from the many excellent programs that are in operation. We wish to work in partnership to improve access of our clients to those services.

Mr. Chairman, members of the select committee, thank you for your time today and an opportunity for us to present what we see are the needs of people we serve. We look forward to any questions you may have.

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

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Is that right? Okay. Let me start with two really quick ones. Who funds ASI now? Which ministry is it?

Ms. Mary Lucas: Community and social services.

The Chair (Mr. Kevin Daniel Flynn): Thanks. Where I'm from in Oakville, the Halton regional police have what they call a COAST program, and that is, they team up social workers with police officers. Often a call that is expected to be a mental health call is accompanied by a social worker, and often the social worker will take over and the police officer can go and do what police officers do best. Is anything like that in place in Thunder Bay?

Ms. Mary Lucas: No, there isn't.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you. Sylvia, you're first up.

Ms. Sylvia Jones: I wanted to get back to your recommendation about an appointment of a lead agency in the district of Thunder Bay for application and waiting list management for all supportive housing. It's on page 5. How many are there now? I'm assuming that's the reason you put that recommendation forward.

Ms. Mary Lucas: I couldn't give a number but it would be in excess of 10, because, for example, each supportive agency maintains its own lists.

We can provide that information as a supplement to our report.

Ms. Sylvia Jones: So you're looking for a centralized list, essentially, to see what the unit has to offer, and where it is?

Mr. Iain Angus: Certainly it helps us to manage demand. We went through this with long-term care. A number of years ago the province put in place a central coordination facility, through the CCAC and its predecessor, and that has really helped us get a handle on the actual demand. A number of people are on a number of lists and everybody uses their list to justify the funding they need, and yet we don't have a clear picture.

Ms. Sylvia Jones: Okay.

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

Mr. Howard Hampton: I want to go back to something I asked earlier, only because you go back to it in your presentation here. When governments in the past announced that they wanted to move toward deinstitutionalization—that institutions like Lakehead Psychiatric Hospital would become much smaller and provide a much narrower range of service—we were told that these services were going to be made available in the community: "We're going to move out into the community, and we're going to provide services in that way." Yet everywhere I go, people say that didn't happen.

Why didn't it happen? What happened to the services that used to be available in institutions like Lakehead Psychiatric Hospital? I think we all know that literally tens of millions of dollars worth of resources must have come out of those facilities. Where did the money go?

Mr. Iain Angus: Certainly my sense over the years is that while there was a promise of community programs being in place, and at a certain point in time they were starting to get put in place, there was a time lag. A decision was made in year X, but it wasn't until year Y that the community programs were in place. In the meantime, there were already people living without supports in the

rooming houses and apartments in the low-income sections of town, getting evicted, getting further into addictions and just severely aggravating the mental health situation they were in and spreading it. Mary?

Ms. Mary Lucas: I think the most poignant point for me in this issue would be that the client must be willing to engage. What we see are the most traumatized individuals in the system, and that has been noted by St. Joe's. They cannot engage, because they don't have the ability or the know-how to engage. They're not willing participants in the system, and that's where I see a major flaw, if there is anything that could happen in terms of reforms. A person who is schizophrenic and who is not taking their medication will not engage in services.

Again, with the individuals we've identified, we've been able to do that basically with hand-holding to get them into testing and to get them on ODSP. But once they're on ODSP, they are on their own. They're left without supports. That's the flaw. Before, you could incarcerate, you could keep someone in the system. The willingness on the part of the receiver has to be there, and that's a flaw.

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

Liz, you're next. We've got Community Living from Dryden and Sioux Lookout on the phone too, so can we just keep this brief?

Mrs. Liz Sandals: I just want to follow up—this is another one-door question, but this time the one door for mental health and addiction services, which is a huge issue. Everywhere we go, we hear about fragmentation of service: Nobody can figure out how to get matched up with the right service—silos.

Who should be responsible for setting up the one door, and who would operate the one door? Any advice there?

Mr. Iain Angus: Let me answer the first part, and I'll leave it to Mary to answer the second part.

The "who" should be the province of Ontario. The province has the constitutional authority on this issue. They've got the bigger dollars; they've got the ministries. They need to decide who is going to be in charge, much like they did around the whole issue of long-term care. Mary?

Mrs. Liz Sandals: But you don't have any particular advice as to who that sensibly should be?

Mr. Iain Angus: I'm going to leave it to Mary, who lives this every day, as opposed to me, being the chair.

Ms. Mary Lucas: Certainly, at our level, again similar to what is happening in social services—Ontario Works and child care—the province sets the parameters and lead agencies are mandated. Clearly, St. Joseph's is the lead agency in our community and is responsible. I think that setting the legislative parameters is critical. There are agencies that could do that work, and the largest in our community is St. Joe's.

Mr. Iain Angus: I think that's the one with the most expertise.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for attending today. Thanks for a very thorough presentation.

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SIOUX LOOKOUT COMMUNITY ACTION PARTNERSHIP FOR FETAL ALCOHOL SPECTRUM DISORDER

The Chair (Mr. Kevin Daniel Flynn): Is that Judy, Bruce and Janet?

Ms. Judy Kay: Hello. This is Judy, and we're all here.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. We've got you on the line right now. Most members of the committee are here today. We're short just two. Every member except Christine Elliott and Jeff Leal is here. We've got Howard Hampton sitting in for France Gélinas. Outside of that, you know all the other members of the committee.

You've got 20 minutes to make your presentation. You can use that any way you see fit. If you could leave some time at the end for some questions, that would work out great. It sounds like the place you're sitting at is working well; I can hear you.

Ms. Judy Kay: Great.

The Chair (Mr. Kevin Daniel Flynn): Just make yourself comfortable, and we're all yours.

Ms. Judy Kay: Okay. Thank you very much. This is Judy Kay speaking, from Healthy Generations Family Support Program. I'm employed by Community Living Dryden-Sioux Lookout.

Today we are speaking to you on behalf of a large committee of people in Sioux Lookout who are called the Sioux Lookout Community Action Partnership for Fetal Alcohol Spectrum Disorder.

I'm just going to ask the other two people I'm with to introduce themselves and their organizations.

Ms. Janet Paterson: Good afternoon. I'm Janet Paterson, the director of services and development for the Patricia Centre for Children and Youth. We're a children's mental health centre located in the communities of Dryden, Sioux Lookout and Red Lake. We also cover some of the more rural and remote areas. Thank you for the opportunity to speak with you today.

Mr. Bruce Siciliano: Good afternoon, everyone. I'm Bruce Siciliano, the director of Sioux Lookout Meno-Ya-Win community counselling and addiction services. We have an adult mental health and addictions mandate, as well as a youth addictions mandate. We serve the areas of Sioux Lookout, Hudson and Pickle Lake. We also provide services for people who come in from the 31 First Nations north of Sioux Lookout.

Ms. Judy Kay: We're really pleased to present to you today and to speak with you about fetal alcohol spectrum disorder and the impacts of fetal alcohol spectrum disorder on the mental health and addictions system.

Sioux Lookout and the district have been working on fetal alcohol spectrum disorder since the early 1990s. I understand that your committee made a trip to Sioux Lookout last week or the week before. We're pleased to know that you've seen Sioux Lookout and the north, and that you now have an understanding of the context of the information we're about to provide to you. I think it's really great that you made it up to Sioux Lookout and that you got to see our communities and some of our challenges and, as well, our strengths.

The Sioux Lookout Community Action Partnership for Fetal Alcohol Spectrum Disorder is a fairly new initiative, but it is also an extension of work that has been conducted over the course of about 15 years. Our mission for the partnership is to develop a community action plan that will lead to the creation of a comprehensive and sustainable service network aimed at effectively identifying and responding to the unique needs of children, youth and adults and their families affected by fetal alcohol spectrum disorder.

It's interesting, with your interest in mental health and addictions, that this project is funded by the Provincial Centre of Excellence for Child and Youth Mental Health, and it is a community mobilization award.

I know that you have the PowerPoint presentation in front of you. We've listed the partners for you. We have 15 partners at this table, and we'll be expanding next month to include more partners and more interest groups.

Just to give you an overview of what we're trying to do here today: We're trying to say to you that the province, but especially Sioux Lookout and district, needs the opportunity and the resources to address the devastating effect of FASD on individuals, families, service provision and service providers, and on our communities. FASD, left unaddressed, creates a huge impact on the whole system.

The solution lies in our response and starts with support for women, diagnosis, appropriate treatment for those affected, and supports within the community to address this.

What we'll be doing today, basically, is talking to you about what FASD is. I'll be providing you with some very quick background information, and we'll talk to you about the impact of FASD on the mental health and addictions system. We also have for you some very clear-cut and thought-out solutions.

Very briefly, what is FASD? It's an umbrella term used to describe the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. It is a very serious health and social concern to Canadians, and it is the leading cause of developmental and cognitive disabilities among Canadian children.

FASD is a permanent form of brain damage. It's a full-body experience in disability. It affects all aspects of a person's life, and without accurate diagnosis and a support system specifically designed to address the disability, the problem is further complicated. It's very, very clear that the low level of societal protection and support afforded to them by our system compromises their lives far beyond that caused by their disability.

In terms of prevalence, in a general community, we're seeing about 1% of all births being affected. It's the leading cause of developmental and cognitive disabilities. We have high rates in northwestern Ontario. One community found a positive screening of 23% of the students in the school. A Manitoba study found that 10% of live births were affected. So we see pockets of high prevalence rates in particular areas.

There was a large study done in the University of Washington that looked at 700 people who had fetal alcohol spectrum disorder. Within that group, they found that 90% had mental health problems; 60% had experienced disruptive school, so were kicked out or suspended; 60% had trouble with the law; 50% had experienced confinement; 50% had been a victim or perpetrator of inappropriate sexual behaviour; and 30%—this included children—had trouble with alcohol or drugs.

So looking at some of the key points for you to consider, early intervention absolutely improved outcomes. We definitely know that adolescents and adults have unacceptably high levels of difficulty managing in society, and often have very poor outcomes. The brain damage is significant, but it is rarely understood. Many people with FASD unfortunately do not conform to current standards or guidelines for service eligibility, or the appropriate level of service is not available. There are two issues there: eligibility and services available. Without appropriate support, adulthood presents a crisis point.

Just to help you connect the dots, although I'm sure you're thinking hard there, people with FASD are at high risk for mental health disorders and other serious social impacts. We are already providing these services to people with FASD, but in a very ineffective and costly fashion. So consider the cost of treatment homes: $300 to $800 a day for a child. Consider the cost of one day of jail. Just continue with that thinking, and imagine if we could redirect that money. FASD crosses all sectors and therefore calls on all of us to find a solution.

I'm just going to walk you through a little bit of information about children and adults. I'm not going to go through this whole slide, but I wanted to point out a few things, and I'll let you look at that later.

There's a very high rate of family and foster home breakdowns. In my work, I see family home breakdowns almost every week, and it's due to the disability not being supported.

For children who have FASD, the biggest complaint they speak to me about, their biggest sorrow, is that they're isolated from other children and they have no friends. Some 80% of children with fetal alcohol spectrum disorder do not stay with their birth families.

Tikinagan reports, in the book called Coming Home, that providing community care to children with fetal alcohol spectrum disorder is more difficult. Children frequently are placed in outside group care programs and residential treatment facilities in distant places.

Kenora-Patricia Child and Family Services researched statistics on FASD within their organization. Out of 213 children in care, 41 children had a diagnosis of fetal alcohol spectrum disorder and 86 children had an identifying factor and should have an assessment, resulting in 60% of the children in care potentially living with FASD. I just wanted to point out to you that we no longer have access to diagnosis, so that high rate of diagnosis within those Kenora-Patricia Child and Family Services children will be going down, because we don't have access to diagnosis at this point and we did previously. The overwhelming majority of children with fetal alcohol spectrum disorder, 89%, were found to be in the permanent care of a children's welfare organization. That was found by a Manitoba study.

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So, considering some of the key points with adults: Society is not so forgiving toward adults. They have difficulty navigating what seem to be simple tasks: filling out applications, attending appointments, following through on children's welfare probation orders, buying groceries, budgeting. Large portions—very large portions—in Sioux Lookout struggle with homelessness. The absence of housing is the absence of everything.

A very important point for you to keep in mind is that often people with fetal alcohol spectrum disorder do not conform to standards for service eligibility, or they're waitlisted for adult developmental services or mental health services. Of course, we see a high rate of substance use, especially when this condition isn't diagnosed and treated, and trouble with the law. People with FASD often will repeat the FASD cycle. So I see, in families where women who have fetal alcohol spectrum disorder haven't received treatment and care, who have three-plus, up to 11 children, in some cases all those children have been exposed to prenatal alcohol. As adults, lives often spiral out of control. The cost to them, their families and society at large is incalculable.

So, looking at your interests that you have at this table today, how does FASD impact mental health and addictions? Well, we know from that secondary disability study that 90% of those clients that had FASD suffered from a mental health disorder. Depression has been reported in up to 40% of the adults affected by FASD and, interestingly enough, adults with the highest IQ have been found to have the greatest overall adjustment problem. Looking at dual-diagnosed people—so people who have fetal alcohol spectrum disorder, and another diagnosis of a mental health disorder—it was very evident in almost half of the children described in a Manitoba study.

Something else to point out to you is that often a person with co-occurring fetal alcohol spectrum disorder and mental illness—so FASD plus the mental illness—who is not diagnosed is often not diagnosed with fetal alcohol spectrum disorder. The failure to recognize co-occurring disorders can increase the risk of inappropriate treatment, resulting in homelessness, alcohol and drug problems, legal problems and premature death.

Having a very quick look at fetal alcohol spectrum disorder in the criminal justice system: 23% of young offenders in BC, in a study done in 1997, had symptoms of fetal alcohol syndrome or fetal alcohol effects, which come under the umbrella of fetal alcohol spectrum disorder. A study was done at Stony Mountain prison, and with that study 10% of the sample were identified with FASD and a further 16% to 18% were found possibly to be affected by FASD. The FASD-identified were 10 times more likely than the normal population to have 15 or more convictions. Our criminal justice system is based on the premise that individuals have the mental capacity to appreciate the nature and the consequences of their actions, including the connection between an intentional act and punishment. Individuals with FASD challenge this underlying assumption. The management of people with FASD in the criminal justice system uses extensive resources that could be used in other areas.

So that was quick, but this brings us to our two slides, our 10 points that we're bringing forward as solutions. I just wanted to make you aware that I've been working 15 years in the field. I work with children and I see some very exciting results happening with children when they're identified early and diagnosed early, families are informed, we get to work with the families, they receive good support, and those children are now just coming up into adult services and they're doing very well. So even though I've presented you with some fairly serious statistics here, I'm telling you that we can do much better and that the children whom we're working with at this present time show us how well we can do. We just need to keep supporting them.

In terms of solutions, we need prevention programs that address marginalized populations of women who are impacted by substance abuse and related conditions.

We need access to diagnosis closer to home. At this time, Sioux Lookout is expected to travel to Toronto to receive an assessment. That's like asking Toronto to travel to Florida. We do have a proposal out. It has been out for more than a year. I am planning to send a few copies down to your committee for you to have a look at. We are capable of running a diagnostic clinic here in Sioux Lookout. We did do a pilot project for 18 months, but that clinic had to close its doors in July 2006 because operational funding wasn't provided beyond the pilot project, and that was despite success having been proven and a very high need proven as a result of that pilot project.

Going down the line, looking at solutions, we need removal of barriers and provision of appropriate interventions throughout a lifetime.

We need targeted funding for case management and service delivery specific to fetal alcohol spectrum disorder.

We need deployment of a flexible pool of resources targeted for FASD in order to provide a comprehensive package of services that address the multi-faceted complexities.

We need long-term, structured, supervised residential, educational and daily supports for people living with

FASD and caregivers, with a particular focus on looking at youth who are approaching the adult service system.

We need funders to think outside of the box, realign the resources and provide us with funding options and the flexibility to respond to the local reality of the individual with FASD and their caregiver's needs.

We here have solutions and we require the support and the integrated effort of multiple ministries and funders to do what needs to be done.

We need assistance and support with the implementation of FASD community-based strategic plans.

On a final note, before we open it up for more discussion, fetal alcohol spectrum disorder crosses all sectors of the government and the full range of community-based organizations. Therefore, the solution must come from that wide collection; not any one ministry should be responsible. No single organization can do this alone and all partners should be held accountable.

That is our formal presentation. I have Bruce and Janet here as well, and they're very able to comment further on any of this information.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you very much for the presentation. We've heard from fetal alcohol syndrome groups, I think, at just about every stop this week, so every time we hear from you, we learn a little bit more. You've left about three minutes for questions. We're going to start with Howard.

Mr. Howard Hampton: Thanks for your presentation. I want to ask this question because I think people need to get their heads around this: Speaking for the Sioux Lookout area, in your view, is the incidence of fetal alcohol syndrome greater, diminishing or staying the same? And related to that, are the problems that result from FASD growing, diminishing or remaining about the same? What's your experience?

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Mr. Bruce Siciliano: They're growing, Mr. Hampton, and we know that in the adult sector that I'm working in because the majority of our mental health and addictions assessments now are of the serious nature: serious mental illness, serious addiction, comorbid with fetal alcohol spectrum disorder and developmental disabilities. Our caseloads are increasing, so we just know from the numbers of people that we're seeing that it's no longer acceptable to provide traditional talk therapy in our adult mental health and addictions agencies anymore. These people require a comprehensive package of services—with talk therapy, of course, as an adjunct.

So in my agency, we're constantly working on our budget to invest dollars in the community to provide different interventions and different solutions for people; for example, working with our local associations for community living, which don't have money to provide beds for people with fetal alcohol spectrum disorder. So we're actually working on our base budget and flowing dollars to our associations for community living so that people with FASD can have a bed, so that we can provide addictions and mental health work to those folks, and so that they also have a safe place to sleep.

We have to partner with our homeless shelter here in Sioux Lookout, because if you look at the majority of the people in our homeless shelter, they have fetal alcohol spectrum disorder with a co-occurring mental health and addictions issue. So it's definitely increasing, and it's not just the number that's increasing; the severity is increasing. These are life-and-death situations in our community.

Ms. Judy Kay: I would just quickly add that the very lack of diagnostic services prevents us from having accurate numbers. We do believe that our incident rate is much higher, but it's hard for us to prove that when we don't even have access to diagnosis at this point.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Bruce, Janet and Judy. Unfortunately, we've used up all our time, but I did want to thank you for taking the time to join us in Thunder Bay here today.

Ms. Judy Kay: Okay. I would just like to add that I did send a copy of a DVD called Picture This: Life as a Parent of Children with FASD, and I would ask that everybody view the video and know that that was created in Sioux Lookout by mothers who have a message to give you to make changes on behalf of their children, some of whom are aging out of the adult care system and have nowhere to go. In fact, three of the children talked about in that video have nowhere to go in six months to a year because there's no provision for them. They don't qualify for developmental services and they are not able to look after themselves.

The Chair (Mr. Kevin Daniel Flynn): Thank you. All members received a copy of that.

Ms. Judy Kay: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thanks for joining us.

DRUG AWARENESS COMMITTEE OF THUNDER BAY

The Chair (Mr. Kevin Daniel Flynn): Our next presentation today is the Drug Awareness Committee of Thunder Bay, Jennifer McFarlane and Patty Hajdu. Come forward and make yourselves comfortable. There are still some clean glasses over here if you need some water. Any mike will do. Every group's getting 20 minutes. You can do anything you want with that 20 minutes, but if you'd like to leave some time for some questions at the end, you can see there's interest from the committee members in a discussion.

Ms. Jennifer McFarlane: Does that include interpretive dance as well within the 20 minutes?

The Chair (Mr. Kevin Daniel Flynn): You know what? We've been doing this all week. We're open to everything. It's all yours.

Ms. Jennifer McFarlane: Thanks. Hi, everyone. My name is Jennifer McFarlane. I'm a health promotion planner for alcohol and substance misuse and I work at the Thunder Bay District Health Unit. I'm also the chair

of our drug awareness committee. With me is Patty Hajdu, who's the coordinator of our municipal drug strategy. She works at the Thunder Bay District Health Unit and is the past chair of our drug awareness committee, so we work together on a number of projects.

We would first like to recognize the effort that was put into developing the discussion paper and we would like to compliment the advisory group on its comprehensive approach. We appreciate the steps taken to ensure an inclusive process, and specifically we would like to commend the minister for establishing an interministerial group.

Ms. Patty Hajdu: The Drug Awareness Committee of Thunder Bay is a collaboration of organizations that have an interest in or conduct work to reduce alcohol and substance use-related injuries, deaths and crimes in Thunder Bay and the northwestern Ontario district. We've been in existence since 1991 and we take a comprehensive approach to the issue of substance misuse by working on raising awareness of the issues of substance misuse through media campaigns, education sessions and presentations.

We work to support healthier environments as well for youth and the general public through projects that increase resiliency and build on strengths, such as peer mentoring programs and school leadership clubs.

We also monitor existing and emerging public policy that affects or addresses substance issues, and we conduct advocacy work as appropriate. We will provide you with a list of our partners as well.

I'm just going to give you a little bit of a snapshot of some of the statistics that we have. Maybe you've heard this already today, but one of the projects that we work on collaboratively with the Northwestern Health Unit and the Thunder Bay District Health Unit is the northwestern Ontario student drug use survey, which is a survey of student drug use that we conduct every four years. It's very closely aligned with the CAMH student drug use survey. In fact, Ed Adlaf has supported us in this initiative for many years. This is our fourth round that we've conducted. Actually, we've just completed the 2008 survey; we don't have stats for you that are that new, but the stats that I'll be telling you a bit about are from 2005.

In the 2001 and 2005 cycles of the survey, the survey demonstrated that youth in northwestern Ontario and Thunder Bay have a significantly higher incidence of alcohol and substance use as compared to youth in other parts of the province. First-time use for alcohol, tobacco and cannabis begins in and about grade 7, and it peaks in grade 9. These first-time use rates are higher in northwestern Ontario region. This is significant because early use of alcohol and substance are linked to higher rates of substance abuse and alcohol problems later in life.

In addition to higher first-time rates, youth in northwestern Ontario have significantly higher than provincial average usage rates of cannabis, stimulants, hallucinogens and methamphetamines. Youth in northwestern Ontario also report higher rates of binge and hazardous drinking.

In 2005, due to emerging reports of increased opiate misuse amongst youth, the survey questioned youth for the first time about their non-medical use of OxyContin specifically. The resulting data demonstrated that non-medical use of OxyContin in northwestern Ontario is nearly four times higher than across their provincial counterparts.

The Northern Ontario Child and Youth Health Report, which was conducted in June 2003, also draws some startling comparisons between northern Ontario children and children from the rest of Ontario. According to that report, substance-related mental health disorders are higher in our region for both adolescent males—33% as compared to 21% provincially—and females, with 18% as compared to 12% provincially. Illicit drug use was reported by 35% of youth in northern Ontario.

Something else we have been doing for the past several years is that we have a peer mentoring project that Jen will speak about a little bit more. It's conducted in our local high schools. In that process, we survey high school youth about what issues they identify as concerning to them. Drug use has placed in the top three concerns out of a list of 25 identified concerns for the past three years.

Youth in Thunder Bay report that they feel concerned that drugs are very easy to access in school and that it affects the functioning and health of their peers. They also, incidentally, talk about stress and depression quite significantly in those surveys.

Prescription opiate misuse, as you're probably very well aware, is becoming quite a significant challenge for our communities. The district of Thunder Bay is struggling with a significant increase in community members struggling with addiction and the harmful use of opiate-based medication. We've witnessed a series of pharmacy break-ins. All drugs that were taken were opiate-based pain relievers such as Percocet, Percodan etc.

Wait lists are high at both the private and the publicly funded methadone clinics. Thunder Bay has identified a lack of withdrawal management services, especially for those who have complex medical needs, and many people who have opiate addiction present with extremely complex medical needs.

Some First Nations communities have declared a state of emergency as a result of the crises they are experiencing in their communities. Social agencies such as Dilico Ojibwa Child and Family Services, the children's aid society and Ontario Works indicate that they are seeing a large increase in families that have been affected negatively by a member misusing prescription opiates, which leads, of course, to financial and personal stress and the inability to parent or maintain employment.

1500

Ms. Jennifer McFarlane: Our drug awareness committee has supported a variety of projects over the years, most of which were focused on prevention initiatives. During this time, the drug awareness committee has really evolved from traditional social marketing campaigns—things like posters and media displays—to

focusing our resources on a more comprehensive health promotion approach. We strongly support the brief prevention highlight within the strategy, section 1.4, and agree that prevention and early identification are priorities.

Another key area identified in the strategy, section 7, is building community resilience. Prevention and resilience-building has been our main focus for young people, and I would just like to comment on a few of the programs that have been successful in our district that promote peer mentorship and youth development, which we strongly believe is key to prevention.

One example is the Natural Helpers peer mentorship program. It's been operating through the drug awareness committee and local high schools for over five years now. The Natural Helpers peer mentorship program is unique in that its approach rests on the premise that there are already members of every community who act as support resources, or natural helpers. The Natural Helpers program builds on this premise by enhancing those helpers' skills and providing them with support resources and referral skills to enable them in their efforts to act as mentors and friends. So the goals of this particular peer mentorship approach are to teach the natural helpers effective ways to help their friends, to teach them positive ways of also taking good care of themselves, and to teach them how to contribute to a safe and supportive environment.

We've included some evidence that supports peer-to-peer approaches within our paper. We have a few copies here, and we will e-mail it as well so that everyone can get a copy. But basically, the common message states that peer support programs address protective and risk factors, develop youth competencies, create caring environments, identify areas of concern, and provide meaningful youth involvement. So these types of programs understand and involve youth. They are involved in identifying issues relevant to them, and youth decide which issues to address and how. These types of programs are an effective process leading to enhanced group interaction and knowledge and skill development.

The second successful program that I would like to highlight is the tobacco control strategy's Youth Action Alliance program. Despite recent cuts, unfortunately, this program was well regarded as a successful youth development model. So youth aged 14 to 19 were hired as employees of health units and partner organizations to work on tobacco prevention initiatives. Such initiatives involved peer-to-peer education, advocacy efforts, social marketing and policy change. Each Youth Action Alliance had a paid adult mentor—which was key to the success of the program—in the form of a youth adviser, and special care was taken to ensure a diverse group of youth with a variety of lived experiences were hired. The program offered paid job opportunities as well as skill-building and positive social outlets and interactions with both youth and adults within health areas.

Finally, the third program is unique to the city of Thunder Bay. The drug awareness committee supports a leadership program at Dennis Franklin Cromarty High School for aboriginal youth from remote reserves who have come to the city to attend school. The leadership group provides an opportunity for youth to talk about social and health issues that affect them. Their most recent campaign, called Just Ask Me, is an anti-racism campaign designed by the youth. The campaign aims to break down stereotypes and encourages communication between aboriginal and non-aboriginal youth through an interactive website. We'll be launching a movie theatre commercial in the fall—and other media outlets.

So much of the past work around substance and alcohol use prevention is focused on awareness and education. These types of programs that I've described build on that work by creating a supportive environment, which is essential to assisting youth in maintaining mental health, developing resiliency skills, learning, beginning to trust, and using the resources available to them in their community; also, avoiding substance and alcohol use and ultimately becoming a productive member of society. Such programs as these also empower youth to contribute to the health of their peers and community through the design and facilitation of health promotion strategies that address the needs of their peers.

While recognizing the importance of peer-to-peer education and youth development, it is also essential to recognize the resources required to build and maintain youth programming.

It's our recommendation that adequate funding be put into place to support successful prevention initiatives, and that those resources be sustained over a long period of time.

Specific resources and funding from the ministry to supply additional social worker support in schools is also essential. This should not be left up to school boards to fund but should come directly from the ministry and should also include additional training for teachers and guidance counsellors.

Ms. Patty Hajdu: The drug awareness committee would also like to comment on the importance of equitable funding for northern training opportunities. Often, geographically isolated communities don't have the same access to training and development opportunities as their southern counterparts. Access to technology is often not in place, and there are limited ways to participate.

It is our hope that the needs and challenges of the entire province are considered and that people living in all regions are consulted throughout the ongoing process.

Not only in Thunder Bay but also in the outlying communities, there is a great need for additional treatment options, beds and, critically, aftercare programs. For many remote communities, when a person receives treatment in a larger centre, they often return to a community that has no resources or support for continuing care. This results in a very high relapse rate for these individuals.

Culturally relevant programs must also be offered for the large aboriginal population in the north.

It's obvious to us that much thought has been devoted to the influence of social determinants of health as they relate to the prevention of mental health and addiction issues, as well as how they influence a person's ability to heal and move forward in their lives.

We are also very encouraged that this is an interministerial approach, as it is only by collaboration that we can address a person's situation in a truly holistic way.

We are concerned, however, with sections 6.5 and 7.1, "Promote Healthy Lifestyles, Including Self Care and Exercise" and "Strengthen Health and Wellness Promotion in Communities." Although we agree with the benefit of healthy behaviours, such as nutritious eating, adequate exercise and sleep, and reduced tobacco use, the barriers for people with mental health and addictions issues are vast and stem from the fact that many people are struggling with low income and unaffordable housing, stigma and exclusion, and lack of basic necessities.

For section 6.5, the concern is that the word "lifestyles" suggests choice and in fact diminishes the demonstrated evidence that with additional income and stable housing, many individuals indeed begin to adopt healthier behaviours. Many individuals would choose fruits and vegetables over highly processed, fat-laden foods if they had adequate income. When people are not exhausted from searching for a safe place to sleep or raise their children, more time becomes available for what are often perceived as leisure activities, including walking for no purpose instead of to an appointment or a convenience store, or running for exercise instead of away from something.

We also caution that health promotion that is based on telling people how to behave is a very limited approach. Comprehensive health promotion is necessary for any intervention to be successful. This includes strategies that change both environments and policies to make the healthy choice the easy choice. People must be able to afford and engage in health activities before they will do so, no matter the quantity or quality of health promotion campaigns.

Programs that work to include people are mentioned in 7.1, "Strengthen Health and Wellness Promotion in Communities." Others that have been effective and provide support in a non-stigmatizing way include the very successful PRO Kids in Thunder Bay, a model program that has been adopted internationally. This program works with organized youth activity providers to provide free spots, which are then utilized by children from homes without adequate income to otherwise engage in that activity.

Ms. Jennifer McFarlane: In conclusion, the drug awareness committee supports the comprehensive directions outlined in the discussion paper and is excited about a 10-year mental health and addictions strategy. We look forward to hearing about the progress of the strategy and the implementation plans as they develop.

While we are extremely encouraged by this comprehensive document, we have a concern. We have seen many task force reports, research documents and recommendation reports from all levels of government on the issues of not only mental health and addictions but also on poverty, social exclusion, racism, housing etc. How will adequate resources and collaborative efforts be made to ensure that this will be implemented? Also, can you comment on a strategy timeline or projected rollout?

I should have asked, are we allowed to ask questions?

1510

The Chair (Mr. Kevin Daniel Flynn): You know, you kind of just did.

Ms. Jennifer McFarlane: I did. Sorry.

The Chair (Mr. Kevin Daniel Flynn): It's tough to stuff it back in after you've let it out.

Ms. Jennifer McFarlane: I know. I should have asked at the beginning.

The Chair (Mr. Kevin Daniel Flynn): No, you—

Ms. Jennifer McFarlane: I'll sum up by saying thank you for travelling to Thunder Bay and hearing our thoughts and recommendations.

The Chair (Mr. Kevin Daniel Flynn): Okay. That's good. Actually, that was a good segue. I just wanted to make sure that you understood the process that's underway. Minister Caplan has an advisory group, which put together the report you referred to a lot in your presentation. Our group that you're before today is a select committee of the Legislature made up of members of all parties. We're to report back in the spring of next year, not to the minister and not to the ministry, but to the Legislature itself. The minister, at the same time, has his own advisory group and has put this report out for comment. He's looking at a 10-year strategy; we anticipate our report will come back with some much shorter-term issues and answers, we hope. We're to report back in the spring, so we're travelling the same road. It's just that, I think, the minister is looking at a much longer-term view whereas the view from this committee is what we should be doing in the next few months and years.

Ms. Jennifer McFarlane: Thank you.

The Chair (Mr. Kevin Daniel Flynn): We still have a little bit of time for questions, if we can be quick with it. Helena.

Ms. Helena Jaczek: As a former medical officer of health, I really want to say that I appreciated your description of the health promotion programs that you're engaging in here in Thunder Bay. My question actually relates to what Mr. Hampton was asking earlier. Between 2001 and 2005, did you see an increase in use?

Ms. Patty Hajdu: An increase in use amongst youth?

Ms. Helena Jaczek: Yes.

Ms. Patty Hajdu: What we found is that there has been an increase in cannabis but not necessarily alcohol use. The usage rates have actually gone down slightly overall. I guess the point that we're trying to stress today is even though the usage rates overall have gone down, they're still so much higher than the provincial counterparts. That's our concern really: even lowering them still so that they're equivalent to what the province is seeing as a whole.

Ms. Helena Jaczek: Of course. Can you attribute any of that alcohol use decrease to any particular circumstance?

Ms. Patty Hajdu: That's a question that comes up over and over. It's very difficult to speculate. Sometimes it can even just be the way the data is collected. We did notice a decrease from 2001 to 2005, but we also had a change in the way the data was collected. It's actually quite interesting: We've done a different process in terms of consent forms. Consent forms are the kicker. What would happen before is every child who participated in the student drug-use survey had to have a consent form signed by a guardian, essentially. As you can imagine, the problem with that is that the kids who are most at risk don't have a guardian, or don't bring the paper home, or don't get the paper back, and so you get to survey all the kids who are doing what they're told, in essence.

This year, we were able to pass, through our board of health and through the Northwestern Health Unit as well, a process called active information, passive consent and active dissent. Basically, parents have to indicate if they don't want their child to participate. So we're really excited to see what the data will hold for us here in 2008. Our guess is that the rates are going to be much higher, in fact, than they were before, because now we really will be capturing the data from those kids who are less involved and have less-effective households in terms of getting forms back and that kind of thing.

The Chair (Mr. Kevin Daniel Flynn): Sylvia, we've got time for one short one.

Ms. Sylvia Jones: Your Natural Helper peer support program, tell me how you're funding that. Are you training the peer support individuals? Expand.

Ms. Patty Hajdu: The funding was originally through crime prevention strategy funding, which was federal funding, and we received two years of that before the crime prevention strategy changed its focus to what they considered prevention but what we considered actually more upstream. They wanted to focus on gangs and guns. Our argument at the time was "We're trying to prevent kids from getting to the gangs and gunning stage," but that didn't wash.

Then we had a year where we basically cobbled together resources in the health unit and pulled from different sources, and so it was the Thunder Bay District Health Unit that supported it for a year. Then, we were fortunate to receive Trillium funding, and we received three years' worth of Trillium funding, which comes to an end actually this year.

But part of the challenge has been that part of that program is teaching kids when to refer, because one of the strengths of the program is that it builds on this already innate behaviour of adolescents confiding in each other, but what we find is that sometimes the problems are too big. For example, a friend discloses that they feel like killing themself, and the friend who is the natural helper doesn't necessarily know the resources or how to access those resources. Part of this program is training kids to know when it is time to pull in another adult and how to do that.

The challenge is that school boards aren't funded for social work. We have four social workers for four high schools, and each high school has at least 1,000 students, averaged out. You can well imagine that the caseloads of those social workers are extremely high. We've had some support from community agencies to come in and do some crisis support for us. But basically the frustration of that program is that we now have these kids who are trained and who know they need adult support, but when it gets to the point of adult support, the ball often gets dropped, through no fault, really, of the school boards, because they're not funded to provide those social workers. They are doing the same thing we are in cobbling together enough resources, and those social workers are hired on year-to-year contracts based on the availability of funds in those boards.

You raise an interesting question: It is very difficult to sustain, and the resources within the schools are so stretched that the schools are barely handling the problems that are the visible part of the iceberg. What we're doing is basically exposing some of the iceberg underneath, and we're in an overload situation.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming, Jennifer and Patty. We really appreciated your presentation.

BRAIN INJURY SERVICES OF NORTHERN ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next presenters today are Peter Gravelle and Nicole Spivak-Nigro, of Brain Injury Services of Northern Ontario. Make yourselves comfortable. You've got 20 minutes to make your presentation. You can use all of that for your presentation, or you can save a little bit at the end for questions and answers. It's entirely up to you.

Ms. Nicole Spivak-Nigro: Good afternoon, Kevin Flynn and members of the Select Committee on Mental Health and Addictions. Thank you for the opportunity to present to you today. I am Nicole Spivak-Nigro, community services manager, and with me is Peter Gravelle, program director. We're presenting this brief prepared by Alice Bellavance, our executive director.

We would like to thank the current government for hosting these hearings, along with other initiatives such as consultation by the local health integration networks on the development of a 10-year strategy for mental health and addiction, and the "Open Minds. Healthy Minds." mental health and addictions strategy summit in July.

BISNO is a non-profit charitable organization that provides rehab and support services within the community to individuals with a brain injury. Since 1991, we have collaborated with other agencies and professionals to develop and provide a complete range of services across northern Ontario.

Persons with brain injuries can have a complex series of physical challenges, such as paralysis or sensory loss; cognitive problems, such as short-term memory loss and

language difficulties; and/or behavioural problems, which may include personality changes, severe mood swings or acting out. Because of the complexity of the brain and the variety of insults that may occur, each individual and the sequelae of their injury is unique. Our mission is to provide services to these individuals to assist them in attaining their optimum level of functioning and to continue living, loving and doing.

In our almost two decades of providing service, we have identified that 65% of individuals we serve have a co-occurring AXIS I diagnosis that may be pre-existing or is due to the damage to the mechanical, electrical and/or chemical mechanisms in the brain following the injury or a sentinel medical event. Of these 65% of individuals, 80% have a co-occurring addiction, which may also have been pre-existing or subsequent to their injury.

To add to this complexity, 60% of the individuals we serve have had involvement with the criminal justice system, 50% as perpetrators and 50% as victims of crime. Many have a history of violence, which can exclude them from accessing other services that they need. Should fetal alcohol spectrum disorder be part of their profile or they are of aboriginal heritage, which now represents 30% of our client base, access to services is further compromised.

1520

Since mainstream mental health and addictions services are overburdened, individuals presenting with these complex, multi-jurisdictional issues cannot be served. BISNO was successful in securing pilot funding through the North West LHIN in the spring of 2008, and we offered a specialized addiction treatment program to individuals with a brain injury and co-occurring addiction. This program was highly successful, and we have since reconfigured resources internally in order to continue to deliver this service. It has further been identified by the North West LHIN as a promising practice.

Over the past number of years, we have received more referrals from the aboriginal child welfare system for children and youth who have sustained an anoxic brain injury by attempted hanging, brain injury due to assault and other forms of interpersonal crime. Many of these children and youth have a pre-existing mental health diagnosis and/or addiction, as well as fetal alcohol spectrum disorder. The impact of intergenerational trauma and the remoteness of some of the 98 First Nation communities in our catchment area make service delivery impossible unless they relocate to an urban centre like Thunder Bay.

We would like to recommend the following:

First, that when a system design is developed, it include consumer-derived standards of welcoming, accessibility, integration, continuity and comprehensiveness, which will result in functional and integrated outcomes; and also for continuous quality improvement through enhanced capacity, access, coordination and flow for seamless delivery into service, during service and out of service; and include flexibility for the individual to come in and out as required in order to maintain their health status.

Second, improve the health status for people living with the effects of an acquired brain injury, a mental illness and/or addiction by building healthy, supportive and accepting communities that provide fair and equitable access to the social determinants of health. Examples include health services; mental health services; income, housing, education, employment, gender, culture and social support networks and physical environment. We also want to note that Canada does not have a national housing strategy, and that there has been no development of social housing in the province of Ontario since the early 1990s. Previous initiatives, such as Project 3000, were highly successful; therefore, the wheel does not always need to be reinvented.

Lastly, we recommend that special attention be paid to First Nations people, as they are disproportionately represented in the mental health and addictions sector and in the criminal justice system, and have a high incidence and prevalence of FASD and brain injury. Further, there is a higher percentage of aboriginal children in the child welfare system who are at greater risk of engaging in high-risk behaviours resulting in injury and other forms of poor health status. Funding agencies such as ourselves developing culturally competent and safe services in partnership with aboriginal service providers and First Nations communities would begin to address this.

Thank you again for the opportunity to present.

The Chair (Mr. Kevin Daniel Flynn): You have left a lot of time for questions, which is wonderful. Let's get right to it. Everyone's going to get—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): That's right. That was so thorough.

It looks like everybody's going to get just over four minutes. Let's start with Sylvia.

Ms. Sylvia Jones: I'm going to sort of change tack a bit. With acquired brain injuries, have you had any challenges with the legislative requirement that you must be diagnosed prior to age 18?

Ms. Nicole Spivak-Nigro: What we do is, if an individual sustains a brain injury, acquired or traumatic—we don't really split that hair as much with service anymore—we rely on children's and developmental services. It's the 16- to 18-year-old range where we tend to have more of a struggle. We will serve individuals 16 years of age and older. If they apply for services prior to age 16—if they apply when they're 12, 13, 14—we'll take their referral, because by the time they turn 16 they're at the top of our waiting list. It's between 16 and 18 where different mandates between different service sectors, whether it's developmental, child and youth or adult services, tend to be more hard lines versus overlapping.

Ms. Sylvia Jones: Do you have a solution for making that a little more seamless?

Ms. Nicole Spivak-Nigro: Well, part of it is that we're better able to work around it when there is the required information, either diagnostics or previous access to a service. What we've done is not necessarily a formal recipe, but because we have been working in Thunder Bay and district for almost 20 years, we've developed partnerships and we have the luxury of being very flexible in our support. So if one agency would be able to provide services and their role needs to be case management, then we won't take on the case management role. We'll look at supporting the family or facilitating different opportunities or working on job skills. That's how we've adapted around it.

Ms. Sylvia Jones: Thank you.

Ms. Nicole Spivak-Nigro: Did I answer it?

Ms. Sylvia Jones: Yes, very well. Thank you.

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

Mr. Howard Hampton: Just a couple of points of clarification. While it's the Brain Injury Services of Northern Ontario, your work is primarily in Thunder Bay and the surrounding communities?

Mr. Peter Gravelle: We have a facilitator worker out in Kenora, and so she does work in the district. We're also close to hiring someone to work for a year up in Sioux Lookout. But our catchment area goes from the Manitoba border to Wawa, so it's a huge area—and, of course, Kenora. The bulk of our work is here but we do work in the district.

Mr. Howard Hampton: Would you say the bulk of your work is here, the bulk of your service work?

Mr. Peter Gravelle: The bulk of our service and the bulk of our staff. But we know that there are lots of individuals who have brain injury and addiction problems in the district, so it's not inconceivable to think that you could have several people working out in the district. So we're not as well-served as we could be.

Mr. Howard Hampton: So people who, say, live in Kenora, or Red Lake or Sioux Lookout: What kind of services do they get?

Mr. Peter Gravelle: Well, we have a full-time worker who has a caseload, and referrals go to her. We have a neuropsychologist who comes in there every two weeks and works with her. But it's like anything: She certainly could have more support. More workers could be working with her.

Mr. Howard Hampton: That's a lot of highway for one person to cover.

Mr. Peter Gravelle: That's a lot of highway.

Mr. Howard Hampton: You do a lot of fundraising as well, or you have done—or associated with BISNO, there's been a fair bit of fundraising in local communities. In terms of the services you provide and the funding you get, do you have a breakdown of where that funding comes from? How much of it's through fundraising etc.? How much is through—

Mr. Peter Gravelle: We have proprietary services, so a lot of our money will come through insurance, WSIB. We'll work with individuals who've been injured on the job, so some of our funding comes from that. Of course, other funding comes from the ministry.

We don't actually fundraise a lot in terms of working on our budget. I would say that's much smaller. More of it comes from our proprietary program and from the minister. So to answer your question, I'm not exactly sure what the exact breakdown is.

Mr. Howard Hampton: To be fair, I've often felt that what have been listed as fundraising activities have actually been raising-profile activities for the services that you provide, but oftentimes that's how you get people to participate.

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

Mrs. Liz Sandals: When you say the ministry, it's the Ministry of Health or Comsoc or—

Mr. Peter Gravelle: Ministry of Health.

Mrs. Liz Sandals: Okay. Could you describe what would happen to a child who, given the age issues—for the sake of argument, a 14-year-old who has attempted to hang themselves. When they come to you, they've got addiction or mental health issues; quite probably, especially given the last presentation we heard, FASD. Can you walk us through what support would be offered to that child and what your piece of it is, what programming you do?

Ms. Nicole Spivak-Nigro: Generally, it would start with the application and our intake coordinator and myself, because most referrals now come to our community programs. We're going to look at who is involved in that person's life, and first of all, do they want to be here? It's one thing to be a teenager; it's another to be a teenager with a brain injury and fetal alcohol spectrum disorder. We cannot necessarily always differentiate some of the challenges of building rapport. How well-supported is that person? So if there is FASD and mental health, especially with past suicide attempts, where are they located?

1530

Generally what we'll do is hold what we call a stakeholder meeting, so we'll want to invite children and youth services, whether it's the Children's Centre Thunder Bay or counselling services; the school, if they're involved, if there's an IEP; mental health services; and then find out who can be involved in what capacity with this individual's life. Because we will know right off the bat that although we can identify all of those needs, we're still going to have to prioritize them, and we will know we're not going to be able to meet them. And the best way to try to support this person, especially at that young age, is to find out who is going to be there. So the quicker the services can begin, and the more comprehensive, really, depends on the community partnerships that will be part of that person's life.

With fetal alcohol spectrum disorder, it's not a criterion for our services. We've had a few individuals with FASD in service, but the reason they were in service was because they had also sustained an acquired brain injury, an event that was sentinel, that we could say,

"Okay, we have the cognitive overlap." Trying to differentiate between the development and then the event is very different, and that's where we really rely on the developmental services to do that—also, because sometimes they can be more enduring as far as flux in support when it comes to supportive living, with group homes or supported employment.

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

Mr. Peter Gravelle: There's no specific pediatric ABI funding. That certainly would make a huge difference in terms of helping out families who have children who get an acquired brain injury.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Peter and Nicole, for coming—a great presentation.

Mr. Peter Gravelle: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thanks for your time and attention.

BRENDA ATWOOD
KAREN MILLER
LINDA KACHUR

The Chair (Mr. Kevin Daniel Flynn): Okay. Our last presentation of the week is Brenda Atwood. Come on forward. Everybody sits in the back row, just like in school.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): In church, yes—church, school.

Make yourself at home, Brenda, and introduce the people you're with. You've got 20 minutes.

Interjection: This is Brenda.

The Chair (Mr. Kevin Daniel Flynn): Okay, good.

Ms. Brenda Atwood: We are a family group.

The Chair (Mr. Kevin Daniel Flynn): You're a family? Wonderful. You've got 20 minutes. You can use that any way you see fit. If you would prefer to leave some time at the end, I know that that usually works out pretty well for any questions or answers. It's all yours.

Ms. Brenda Atwood: Thank you for giving us the opportunity to voice our concerns as family members of a drug addict. My goal here today is to give a face to the overwhelming devastation of having a life disrupted by substance abuse.

Addictions are said to be a family disease because of the impact they have on the entire family. Our entire lives become as chaotic and horrendous as that of the person with the addiction. Often our lives seem to revolve around one crisis or another. In many instances, drug addiction is associated with crime in order to finance the drugs. Many families live with not only the stigma of a family member's addiction but often are the victims of crimes committed by their own loved ones.

Research alludes to the fact that there is a high correlation between mental illness and drug addiction. It's a commonly held belief that there is stigma towards the mentally ill, but that pales when it comes to the stigma towards drug addicts. It's very difficult not to internalize that stigma as a family member.

I know all too well what the common perception is toward a drug addict and their families. Far too often, a drug addict is perceived to be from a family that doesn't care, that used poor parenting, that are substance abusers or criminally minded, or something else that just crawled out from under a rock. So we suffer that stigma also.

Our lives and our families carry the shame and humiliation. A lot of self-blame happens, especially with parents of an addict. And what help is there for those families?

So when your possessions have been stolen, not by a mysterious stranger but by the person you love, or when an elderly parent or grandparent gets shoved around because they don't want to hand over money for drugs, or when a young parent is fearful because of a spouse's addiction, what help is available?

Police services far too often offer little help in family situations. Often, if police are called and a child is in the home, children's aid is called, and now there's the added stress of being investigated by children's aid, through no fault of your own, and dealing with a loved one's substance abuse.

So what help is there? Most services are available 9 to 5, not the most beneficial time to be of any help. Services such as ConnexOntario, DART and other 1-800 phone numbers are pretty well only referred for the drug abuser when they're straight and able to navigate horrendous systems to attempt to get help themselves. Without being totally sarcastic, maybe you really should try to access some of those services before more money is spent on those types of services.

Family groups should not have to struggle for existence, nor should they face stigma. A family group, for me, is the only place where I feel free to talk about the struggles of an addict in the family, the place where there's understanding, where there's no judgment passed and where more than a few tears are shed. A family group, for me, is the only place where I felt free to talk about the deep devastation of the impact of an addiction on my life, the only place where I got some strength to cope.

As a local family group, we have tried to be involved with CAMH on a few occasions. We have tried to give feedback to the Ministry of Health's strategic plan for mental health and addictions, but it seems that service providers want to talk about the families, not talk to the families. To further illustrate that fact, as a family group we met at the local treatment centre, but we were given our notice to vacate. They were busy building a new treatment centre, but I'm afraid a new building will not make their service any more effective. When it comes to treatment services, perhaps it would be wise to reflect on that old adage that if you keep doing things the way you've always done them, you'll continue to get the same results. Simply put, the 28-day, 12-step program with little to no follow-up does not work. It's really time to start looking at what are best practices in treatment and then make those services available to all.

The prognosis for a drug addict is not good. Untimely death by suicide, drug overdose, drug-related illness, accidental death while under the influence or death as a result of violence are the most prevalent causes of death. For many of us, we've accepted this as inevitable because hope has gone out the window as we've seen our loved ones battle addictions and lose that fight.

Ms. Karen Miller: Good afternoon. My name is Karen Miller. I also just want to thank you for allowing us to speak this afternoon.

The Chair (Mr. Kevin Daniel Flynn): There's some water there if you need it.

Ms. Karen Miller: Just a deep breath. As parents of an opiate addict for eight years, we've encountered too many situations during this time that we were ill equipped for, uneducated about and emotionally and mentally exhausted from. This is the main reason I'm here today, to briefly educate you on what we as a family have to go through with a drug addict. Unless you've been in our situation, you will not be able to fully comprehend even a small portion of what we go through, but the encouraging part of today is that you're here and you're willing to listen to us.

I'd like to begin at the point in the addict's drug career when they think they want to quit using. This is the point where they say, "Where do I go from here?" When the addict comes to the point of brokenness and has an honest desire to be clean, they—the addict—and their family are faced with trying to find out where to start, and one of the many questions is, do we start with an agency and, if so, which one?

When the desire is there, time is of the essence, and the intake process can take up to three months, which is an extremely long time in the eyes of an addict. Please bear in mind that the addict is usually extremely stressed out with high levels of anxiety because, depending on if they are withdrawing, most are unable to focus and express themselves completely and precisely. The agency process includes the actual application, the assigning of a counsellor, the interview, the processing of the results of the interview, and appointments to gather all necessary information to be able to refer to the treatment centre. They need help today. There's an urgency that in so many cases is not being met, and then what happens? The addict is back on the street and he's using, stealing, cheating, dealing, lying, denying and manipulating. They're driving the family crazy. I'm not sure if any of you have ever had to, but my husband and I had to sleep in front of each of our doors so that our son would not go out at night to get high as we're trying to keep him straight in order to get into treatment. It's not normal to have to sleep in front of your doors, but when you're looking at three months to get an addict into a treatment centre, it's totally ridiculous. Your life becomes chaos. It's surrounded by the drug addiction.

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Drugs are an instant gratification to the addict, and patience isn't in their vocabulary. There's no immediate help for the drug addict; unlike if you were a cancer patient, a kidney patient or you had a heart attack and the help is readily available. It's just a drug addict.

Another question is, do you go to the hospital? When we first started our journey with our son, you had to be suicidal to be admitted to the adult mental health ward of Thunder Bay Regional Hospital. We told him to tell them he was suicidal in order to get into that hospital to be able to medically withdraw. The hospital is not well equipped to handle the complexity of addiction. The stigma that is attached to being an addict or an addict's family is huge, even from within the medical community. Some people have never even told their immediate family members that they, their spouse or their child is a drug addict because of the stigma that's attached. But if you've been fortunate enough to be admitted into the hospital, you're then faced with the medical withdrawal, which is a blessing compared to withdrawal on your own. Again, if you've ever experienced a loved one who is an addict writhing, vomiting, just in complete agony, and at the same time having to have diarrhea because of the fact that they're trying to withdraw themselves, you stand by totally helpless because there is absolutely nothing that can be done.

The most understanding caregivers are those who have been affected themselves by someone close with an addiction, otherwise you can become involved with some very cold-hearted people. When your patience and tolerance are at an all-time high level as a parent and you're talking to someone who cannot understand why they keep doing this to themselves, it's like, "You are just book smart. You have never been there. Do you know what an addiction is?" They don't understand, once the addict has become clean, why they can't just stay clean. As you've probably heard numerous times today, relapses happen, and they don't happen just once; they happen over and over again.

We here in Thunder Bay are facing a high shortage of psychiatrists. Locums are the only ones who tend to be available, and medication, once it's administered by the locum, can only be changed, reduced or increased by the locum psychiatrist. So if they're only coming in every three months or so—in the case of my son it was two months—you have to wait. The family doctor does not want to do anything that the locum psychiatrist has prescribed, so he won't adjust any type of medication.

Very brief assessments are being done, and often there are underlying mental health issues and concerns that are not identified, treated or followed up on. Sadly, it's the addict who is being released too soon from the hospital. They usually don't have anyplace to go. They have no food. They don't even know where they're going to be in an hour or so. To wait for days, weeks, even months for treatment just seems too far for them. This is the addict we're talking about. How long do you think they can stay clean on their own? Again, when we were going through this with our son, we drove for hours. The only thing that would get him past the desire to go and get high was going for a car ride. We saw northwestern Ontario to the limits. Our greatest fear was getting stopped at a red light

and him jumping out of the vehicle. It's just unfathomable the hold that this drug, which is the opiates, has on them.

Halfway houses are another option—again, a lengthy process to get through the doorway. Some addicts, where are they? They've burnt all their bridges; they no longer even have families that care about them. They only have one thought, and that is, "Can I stay straight for three months before I get in there?" or "Where is my next high coming from?" Probably, nine times out of 10, they go and get high because they can't see any further than right now. Their distorted thinking is that they might be dead tomorrow so "Let's get that one last high in."

Treatment options are very limited and not nearly enough for the demand. Often, it is not recognized that relapse does happen. Hospitals see an addict, law enforcement sees a criminal, but we see our loved ones. Assessments for concurrent disorders need to be more in-depth.

Again, getting into a treatment facility means another waiting list, paperwork, jumping through hoops, referrals, everything—three months to a year. Some communities will not even take an individual from another community.

The 28-day program at the Sister Margaret Smith hospital is definitely not long enough. I think by the end of 28 days, the fog is just starting to clear in their heads, and then they might be ready to begin the process of learning new tools for a sober life and moving forward with treatment.

But not only is there a lack of treatment facilities for the addict, facilities for families are even worse. There is hardly any support whatsoever. We searched out numerous agencies. We hit lots of closed doors and confused doors because too many times they had never heard of parents calling to ask for help for themselves. How could we help them if we didn't know what we were dealing with?

I happened to call the Sister Margaret Smith hospital and was put in touch with a counsellor who was very willing to sit down with us, my husband and I. She answered our questions. She tried to relieve some of the frustration that we were experiencing. But after a couple of sessions, we were still left to pick up the pieces of a fractured family and try to resume a normal life, whatever that was.

The Chair (Mr. Kevin Daniel Flynn): Karen, I'm assuming you're going to split this approximately three ways.

Ms. Karen Miller: Yes, and I'm coming to the end.

The Chair (Mr. Kevin Daniel Flynn): I'm just telling you that you've got about four minutes left as a group. I'm prepared to extend that a little bit because you're our last one, but it probably is time to summarize.

Ms. Karen Miller: Thank you. I don't know if you've seen this. This just happened to come into my mailbox today, which I thought was a wonderful coincidence. It's called Talking with Your Teen About Drugs. It's great; it's very comprehensive. It's put out by the government of Canada. The only thing is, there is nothing about opiate use in here. I think you've heard, probably a number of times today, about the high incidence of opiates in northwestern Ontario and the devastation it can cause. I suggest that something else get included or a new booklet get made, because opiates are a huge problem, and they need to be recognized as that. Thank you.

Ms. Linda Kachur: I promise I won't be long. My name's Linda Kachur. Thanks for letting us speak today. I'm here on behalf of our family group. Our family group is a non-profit group which has been in existence for a challenging three years. I say challenging because resources are not readily available to our community like in southern Ontario.

The district of Thunder Bay has the highest incidence of drug addiction in the province of Ontario. Today, our group would like to make a little bit of a difference in our community by presenting to this select committee the following recommendations.

Immediate specialized services should be available to our loved ones suffering from this disease of addiction. I call it a disease of addiction because I don't like the word "addict." When a person who suffers from addiction realizes they need help, they need it immediately. They do not need it the next day or the next week.

Sister Margaret Smith Centre has built a brand new treatment facility, which is our only treatment facility, with no increase in beds. And as you've heard, it's only a 28-day program. What are the statistics of the success rate of this 28-day program? A longer program, three to six months, with a more structured and disciplined program, teaching new life skills, credit counselling for budgetary and financial matters, and second-stage supervised housing would be an asset and very beneficial to the person with the addiction for successful recovery.

Services need to recognize that relapse happens—documented as part of the recovery process—and allot for this in the program.

Our loved ones or someone else's loved ones suffering from this horrible disease of addictions have become victims.

Mandatory treatment for persons convicted of committing a crime as a result of addiction—also probation and parole orders monitored should include urine testing.

They also need to adjust the services, not to punish the person but to provide quick re-entry to get them the same help they need.

Increased medical support needs to happen, such as psychiatrists, as you have heard, and other medical professions with training in the complex health needs of a recovering addict.

Support for family groups such as access to educational resources would be of benefit.

Housing for addicts before and after recovery is limited. For example, Three C's have gone above and beyond for families in need. However, Three C's funding and beds are limited.

That's all I have to say.

The Chair (Mr. Kevin Daniel Flynn): You did a wonderful job. It was nice of you to all get together and make one presentation as opposed to three.

We have to be on a plane at 4:30, but if there's anyone who wants to ask any questions, we probably have a couple of minutes. Sylvia?

Ms. Sylvia Jones: I just want to thank you for coming. If there was any doubt that what we are doing here with the select committee—you certainly reinforced it. Have faith that we're not going through a process. We actually want to make change because we are hearing from family members who are trying to help their loved ones.

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

Mr. Howard Hampton: One of the things that we've heard over and over again—and I know you were sitting here earlier—and now I think we're hearing it from you, the family members, is that for a variety of reasons, whether you're somebody who's suffering from schizophrenia or drug addiction or FASD, it's just damned hard to access anything. Do you have some recommendations on what needs to be done? We can have all kinds of programs, strategies and initiatives, but if people can't get to them, it seems to me we're just blowing money out the door. Do you have any advice?

Ms. Brenda Atwood: Wait times have to be reduced—quicker access to programs. Too often, it's everybody else's problem. If you're involved with the police: "You're the person with the addiction." If you go into a hospital: "No, it's addictions. It's not hospital-related." I think there has to be far more understanding across the board from a whole lot of services—and also services just being far more timely. A person with an addiction is not cured overnight, so if they go through one assessment and they relapse, why start with an assessment again? You know what the problem is.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. We have a plane to catch at 4:30, otherwise we'd sit and chat with you. We have to take that shack down over there, too, before we leave, apparently.

We're adjourned to Toronto next Wednesday afternoon.

The committee adjourned at 1554.

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