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Mercredi 30 septembre 2009

**Select Committee on
Mental Health and Addictions**

Mental Health
and Addictions Strategy

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

Stratégie sur la santé mentale et
les dépendances

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LEGISLATIVE ASSEMBLY OF ONTARIO

**SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS**

Wednesday 30 September 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

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

Mercredi 30 septembre 2009

The committee met at 1601 in committee room 1.

**MENTAL HEALTH
AND ADDICTIONS STRATEGY**

MRS. H.M.

The Chair (Mr. Kevin Daniel Flynn): If I can ask the members to take their seats, we'll try to keep on schedule here. We've got a presenter at 4 o'clock, and we're a little bit beyond that now.

If we can call to order, our first presenter this afternoon is Mrs. H.M. Would you like to come forward? Please make yourself comfortable. Choose any seat you like. There's some water there if you need some. All our presenters are being given 15 minutes, and you can use that any way you see fit. Should you leave some time at the end, we can share that among all the parties that are here for some questions and answers, but it's entirely up to you.

Mrs. H.M.: Okay. We're not waiting for everyone to come or—

The Chair (Mr. Kevin Daniel Flynn): You know what? They will trickle in. In fact, they're still coming in behind you as you speak. We do have a quorum, and I would like to keep us on schedule.

Mrs. H.M.: Do you want me to start?

The Chair (Mr. Kevin Daniel Flynn): If we can have everyone's attention, and perhaps we can close that door behind us so we have the full attention.

I'll let you know when there's about a minute left.

Mrs. H.M.: A minute? Okay.

The Chair (Mr. Kevin Daniel Flynn): Yes. Okay? We're all yours.

Mrs. H.M.: Thank you for inviting me to speak to you today. I am actually here today as a mom. My son was born six years ago, and from day one he suffered from severe gut pain, explosive bowel movements, sleep deprivation, fevers, rashes, no eating, no expressive or receptive language until two and a half years of age and stare-offs. We saw 14 medical doctors in Ontario over two and a half years, as well as nine other supporting professions, like speech-language pathologists and so forth, and got no answers, no help, no diagnosis. I did research for myself and decided that we needed to take our son to the United States for treatment, which we did. I am here to speak about personal experience; I do not have a medical background.

The statistics for autism right now: One out of 100 children is getting diagnosed in the States; one out of 60 in the United Kingdom. Canada doesn't even track it, but it's likely to be similar. There is a 10% to 17% increase every year. Boys are four times more common than girls to get it. More children have autism spectrum disorder than cancer, AIDS, Down syndrome and diabetes combined, and the lifetime cost to care for these individuals is \$3.2 million each. The old model, which is what you're probably familiar with, is that autism is a genetic disorder, that it's hard-wired and characterized by behavioural issues. But here I am today to talk to you about the new model of autism.

There's been a significant paradigm shift over the last—more than a decade now—where it's considered to be a genetic predisposition with environmental triggers affecting the body and the brain, with a lot of metabolic problems. What the Defeat Autism Now group in the States, out of the Autism Research Institute in California, does is address the underlying medical problems that these children have. These children are physically ill, and their illness is treatable with appropriate biomedical intervention. But this is done in the States; it's not available in Canada. Most of the children who are treated biomedically improve, and some even recover. There is no cure, but some of these children have recovered. So the old model is that this is a mental disorder; our group views this as an environmental disorder.

What I would like to propose is that, as you're looking to rejig the system, you shift the focus from a disease-centred model to a patient-centred model, which is what this group of physicians does: looking at the whole person rather than an isolated set of symptoms; looking at the interactions between the genetics, environment and lifestyle factors that can influence long-term health and complex chronic disease.

So we're looking at vicious cycles with these children—and not just with the children. This is applicable to many chronic conditions, and that's what I'm hoping to share with you today. With the kids, we're looking at gastrointestinal problems, immune system problems, toxicological problems, neurological problems and problems with their endocrine system, and all of these issues are in systems that are intertwined, so we need to look at it from a systems perspective, a whole-body perspective. Genes load the gun with a genetic predisposition, with autoimmunity in the family, allergies, sensitivities to food and environment and also hormonal imbalances, but

environment pulls the trigger: food, water, air; heavy metals, chemicals, pesticides and plastics that are surrounding us; medications, vaccines, viruses, bacteria, parasites, yeasts and moulds. In your PowerPoint presentation, I put just some conclusions of a few studies that have linked mercury and other environmental toxins to autism.

So the key to treatment is looking at the individual. We're all unique. One size does not fit all. We're looking for individual biomarkers and vulnerabilities to address through customized treatment; every treatment plan is different for every individual. The child is the best lab. There is no magic bullet for this. And I think that one of the reasons why this project in the States has been so successful is that researchers, clinicians and parents work as partners.

This would be of interest to you today, I hope, because it also is applicable to other chronic medical conditions. Many of the psychological conditions that you're focusing on are amenable to the same sort of treatment: Alzheimer's disease, bipolar disorder, schizophrenia, depression and other psychological disorders. There are also other chronic medical conditions: cancer, Parkinson's disease, diabetes, obesity, allergies, MS, reproductive disorders and so on.

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So, getting back to autism and looking at autism as a medical disease: It's not a psychiatric disorder, and therefore the Ministry of Health needs to take back responsibility for the children who have developmental problems.

The Ministry of Children and Youth Services does not have the mandate, the resources, the medical knowledge, the medical expertise or the funding to provide our children with the necessary medical care that they need.

The medical care of seniors with Alzheimer's is not overseen by the Ontario Seniors' Secretariat, and patients with Alzheimer's and patients with ASD have the same underlying medical problems.

Barriers to treatment—the primary one being the label of “autism.” It precludes kids from getting the necessary medical care that they need. Their underlying medical problems are not investigated. Many of them are suffering. Doctors and other providers are uninformed about what to do with them. And no one is taking responsibility for really helping these children.

Families are deterred from trying medical treatments by people who have not even looked into it themselves, let alone done it themselves. OHIP labs are outdated. The doctors don't want to adopt complicated patients who take too much of their time. It's impossible to get referrals to specialists when the doctors we're trying to get them from don't even understand what we're talking about.

The biochemistry is too complex for a 10-minute OHIP appointment in this complex, fragmented system. And in Canada, we can't even purchase the care that we need for our children. Another problem is that we have a lot of double standards with off-label treatments for these children that are not applicable to other conditions.

From the perspective of finances, it's very expensive for families to fund this. Access to treatment is entirely dependent on a family's ability to pay. If the family does not have money, the child does not get treatment and the child has no chance for recovery.

Catastrophic drug costs are deemed to be 3% of household income, but autism medical costs exceed 100% of household income. This includes consultations, lab work, couriers, supplements, medications, occupational therapy equipment, speech and language therapy, travel, accommodation, duty, shipping costs—just shipping things back and forth across the border increases costs by about 50% through taxes.

Overall, it costs Canadian families who are going down to the States about double the cost that Americans pay to treat their children.

Private insurance plans cover nothing in the States. Our RRSPs, when we cash them in to pay for these treatments, are taxed heavily so we have less principal to cover the medical costs for our kids. There is very little government funding available, if any at all, and there are very long wait-lists.

The HST that's going to be implemented is going to increase our costs significantly and take away from the money that we have to spend on our children for their health care. So the government is going to be making money from the fact that our children have medical needs that are unmet.

We can't claim many expenses on our income tax, like nutritional supplements, which are a key part of it, and diet.

The special services at home program, if people are able to get it, provides respite only. There's no money for treatment.

It is my understanding is that in Alberta, for each child who's diagnosed with autism, the family is given \$80,000 to spend as they choose, be it on ABA, biomedical, far infrared saunas and so forth.

This is a human rights issue. Patients with the same underlying medical problems but without the autism label are entitled to treatment covered by OHIP. These children's basic medical needs are not being met.

Steve Edelson, the director of the Autism Research Institute, says, “All men are created equal, except if they have autism.”

The Canadian Cancer Society sent out a report last week, saying that all Canadians must have access to drugs without financial hardship, because the person needs to focus on their health and shouldn't have to worry about how they're going to pay for their health care. The federal and provincial ministers are already addressing this. What about our families?

Urgent action is needed. The government needs to acknowledge that there's an epidemic. They need to allocate appropriate resources like we have for the H1N1 flu, AIDS, SARS, cancer and diabetes.

We need to ask why this is the sickest generation ever and the first generation that's likely not going to outlive their parents.

We need to transfer the kids to the Ministry of Health from the Ministry of Children and Youth Services now and not wait until this report is done.

We need to provide OHIP coverage for medical treatments now. And we need to train doctors and revamp medical schools so people are educated in the biomedical or functional medicine approach.

We need to invest heavily in new labs. The \$1 billion spent on eHealth might have been better spent on increasing our ability to identify the biomarkers in all people with chronic conditions.

I'd like to ask for your help to stop proposed federal legislation that is going to restrict access to nutritional supplements, which is a key part of the biomedical approach. We don't need to use drugs. We're looking at nutritional deficiencies and how that all blocks up the system and makes it unable for children to detox the mercury, lead, arsenic, aluminum and pesticides from their bodies.

We need to clean up the environment, our food, our water and our consumer goods. We're poisoning our kids and ourselves. We need to provide them with early and continued intervention because it is shown that is where you get the best outcomes. We need a department at the public health agency of Canada to develop a strategic plan and collaborate with the DAN doctors in the States to get them up and running and not duplicate efforts.

We need to fund meaningful research that's going to help people now and study the children who have recovered to see why they recovered, how they recovered. We need to broaden the disciplines involved like toxicology, immunology, gastroenterology and endocrinology. Right now, no one thinks they're responsible for these children.

We need to investigate the health outcomes of vaccinated versus unvaccinated populations, and this study has not been done.

I'd like to invite you to attend the Autism One conference that is taking place at the end of October. This is the first time that many DAN practitioners are coming from the States; many key people are coming up here and it's a great opportunity for all Canadians to see what's being done in the States and see how we can bring that up here and help our children.

The kids are the product of the current system and it's not working, and tinkering is not going to help with this system. Our doctor in the States says, when trying to figure out what tests to do, "Don't bother wasting money doing something unless it's going to change our approach to treatment," and I hope that the same will be done with this group. I'd like to see that the money be spent to improve the knowledge at the labs and covering treatment options and helping to clean up the environment, and overall, to prevent chronic conditions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. We've got about three minutes left, so probably time for a very brief discussion, if you're up to it.

Mrs. H.M.: Oh, sure.

The Chair (Mr. Kevin Daniel Flynn): We'll start with Christine.

Mrs. Christine Elliott: Thank you very much for joining us today. We have had the opportunity to discuss the issues that you've raised in committee today on several occasions, so I'm very familiar with the things that you're speaking about.

I think it is fair to say that because we don't really know what causes autism—we don't even know how to categorize it right now—I think that we need to be open to a number of approaches with respect to treatment. Certainly you've raised our level of awareness with respect to these issues and we take them very seriously. I have been provided the information with respect to this conference. I do hope to be able to attend at least part of the conference.

Mrs. H.M.: Great. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Peter, any comments?

Mr. Peter Tabuns: Thank you for the presentation. It's quite comprehensive.

You made a comment and I just want to make sure I heard it correctly: Ontario does not at this moment track people with autism, so we don't have reliable statistics. Did I hear you correctly?

Mrs. H.M.: Ontario and Canada. At Health Canada they have departments for diabetes, cancer and AIDS, but there is nothing there for autism. We do not even know how many kids are affected here, so we always go by the American figures, and even all the studies that are done there always reference the American Academy of Pediatrics. Canada has no ownership over anything.

Mr. Peter Tabuns: That's very disturbing. Thank you.

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

Ms. Helena Jaczek: Thank you, as well. I have actually attended a DAN conference in the past, in the US, having been on a board of a school for children with autism.

Obviously, a very complex issue. You've made a number of recommendations. If you had to choose the most important thing that you would want to see done in Ontario, could you say what that number one priority is?

Mrs. H.M.: To look at the underlying medical problems these children have and address them now.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Just from the Chair, then, if I took one thing from your presentation, with all the discussions that all parties are engaged in around IBI and ABA, what you're saying is that they treat the symptoms, but we're not getting to what is actually causing the autism in the first place. Is that accurate?

Mrs. H.M.: Yes. What they have found is that if you treat the underlying medical problems these children have, they're better able to benefit from their other therapies. So when you have a child who's in severe pain from gastrointestinal problems and who can't focus, or you've got some child whose brain cells are actually being killed by excitotoxins in glutamate and MSG and

having brain fog because of food sensitivities, they can't think. For my son, no receptive or expressive language abilities at two and a half years of age; we took gluten and casein out of his diet—those are the proteins from dairy and grains—and within one week he was doing sign language and within one month he was talking.

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

Mrs. H.M.: But we still had to take him to the States for speech therapy because the same type is not done up here.

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The Chair (Mr. Kevin Daniel Flynn): Is this view accepted in the Canadian medical establishment yet or is it fairly cutting-edge?

Mrs. H.M.: It has been used in the States. They started it in the 1960s. The Autism Research Institute has really been ramping up the last 15 years or so as more children have been affected, and more doctors' children have been affected, so more doctors have joined the fold.

In Canada, I'm aware of two physicians who are doing this but not to the degree that it's being done in the States.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. That was an excellent presentation.

Mrs. H.M.: Thank you so much.

JANE MEDERAK

The Chair (Mr. Kevin Daniel Flynn): Our next call today is a conference call. It's from Jane Mederak. Is Jane on the line?

Ms. Jane Mederak: Yes, I'm here.

The Chair (Mr. Kevin Daniel Flynn): Hi, Jane. How are you?

Ms. Jane Mederak: I'm just great. How are you?

The Chair (Mr. Kevin Daniel Flynn): We're all doing wonderful. We just had a great presentation, and you're presenting next. I'll tell you who's in the room with us. There are a number of members of the public. There's Christine Elliott, from the Progressive Conservative Party, who's the Vice-Chair of the committee; Peter Tabuns is sitting in today from the NDP in place of France Gélinas; and Jeff Leal, Helena Jazcek and Bas Balkissoon are here from the Liberal Party. I'm Kevin Flynn; I'm the Chair. You've got 15 minutes. We can hear you very clearly. You can use that 15 minutes any way you see fit. If we've got a little bit of time at the end, perhaps we can engage in some questions and answers, but that's entirely up to you.

Ms. Jane Mederak: Questions and answers are great if there is time. I think there might be.

The Chair (Mr. Kevin Daniel Flynn): Okay. If you can talk a little bit more clearly, I think we'll be fine.

Ms. Jane Mederak: If I'm not talking clearly enough—am I talking too loud or too quickly?

The Chair (Mr. Kevin Daniel Flynn): No. Right now you sound great.

Ms. Jane Mederak: Okay. I'll try to keep that up, then.

Thank you very much for allowing me to speak to you today by telephone. My name is Jane Mederak. I am 66 years old and am probably one of the few people who have been diagnosed with Alzheimer's and who's happy with the diagnosis. After my diagnosis and start of medication, and experiencing a huge, happy and wonderful change in myself, I started to tell my family, friends and co-workers about my journey in the Alzheimer world.

When I first told my story, their faces were very sad and horrified. It seemed to me they thought that what I had was the very worst thing to have acquired, not something to put a smile on my face about.

I was baffled, and it took a while to understand why I was getting this reaction, but I thought, "I'm not sick in bed, I still work a little in real estate with my partner, I'm still on the right side of the grass, and if I listen to my doctor and behave, I may be like this for a very long time." I could have danced in the street.

But most people question my diagnosis and wonder if it is just in my head, or if maybe I'm one of those people who like to be sick and seem to always get the latest and worst ailments to be had. But that's not me.

This is how it all played out in my life. Back in 2007—we say 2007, but I think it's about four years ago—my husband, Rick, and I spent the months of December and January in Melaque, Mexico, and I was my normal, happy self. We arrived home at the beginning of February, and I was still a really happy person. I felt anxious to get back into my real estate business and reconnect with my clients.

As I eased back into my life here, it became evident that I was starting to get forgetful. It was quite funny at first, and then I became embarrassed at my mistakes when talking to people, or I would get partway through saying something and I would suddenly go blank and couldn't continue. I would say, "I can't remember," and change the subject. This is okay with friends and family but not okay when talking to my real estate colleagues and customers. I was forgetting more times than remembering.

Also, my head felt like there was a fog inside it. Sometimes it is very thick and sometimes it gets quite clear, and sometimes I have a quick dizzy feeling. I also started to get quite weepy and cried at the drop of a hat, which is not at all like me. I'm used to being strong, working hard and long hours and being very on top of my business world. The new me was now afraid to go into the office, and seeing customers was very stressful.

With hindsight, I think my first experience with memory loss happened about four years ago, when I sold a house in Paris for an old customer and had my own offer competing with another offer from another real estate office. The vendor was an older gentleman, who was one of my oldest customers. I really liked him and he really liked me. Over the years I have mailed out funny postcards to my clients each month so that they would remember me if they needed a realtor. I was amazed

when this old gentleman showed me that he had saved them all. On offer presentation night, the other realtor had dropped off his offer and it was there when I arrived. I never did see him or talk to him face to face. Both offers were presented and the vendor decided to accept my offer. He had met my client and liked her.

As time went by, I was notified by the Real Estate Council of Ontario that my client's sister had complained about me and a file had been opened and an investigation started. They wanted many questions answered, among which was to know who was the other agent, and I couldn't remember. I even called a few realtors and asked if they were the other agent but was never able to solve that mystery—nothing like feeling foolish when I was doing that, let me tell you. This process of calling other agents was very degrading to a proud, successful realtor like me. The RECO investigation was eventually closed, and they decided that I was not guilty. However, the experience, after being in this business for 25 years at that time, was awful. I have other notes about other occurrences. None are as bad as this one was, but it did make me pay attention to my memory and notice how very forgetful I was becoming.

My first attempts to find out if I had Alzheimer's were frustrating, even to the point of being turned away from the Alzheimer's office in Brantford. I then attended a talk by Dr. Braun, an Alzheimer's specialist, with my daughter Lisa and her mother-in-law, Sylvia, who's a nurse. Sylvia asked me after the presentation if I could draw the face of a clock. I said, "Sure." She said, "Well, then, you don't have Alzheimer's." However, I decided that I needed to see my own GP, who referred me to Dr. Braun, who after a period of time and many, many tests diagnosed me with early-stage Alzheimer's and started me on medication that allows me to live a very happy, normal life today.

Rick and I now live for six months of the year in the summertime in Paris, Ontario, and six months of the year in the wintertime in Melaque, Mexico. It's a very simple, wonderful life of sunshine, warm sand, water exercises, walking everywhere, eating very healthy food, learning to play mah-jong—big mistake—learning Spanish, learning to play my new guitar and seeing all our great friends again.

Oh, crap—I was typing as I was thinking this out when I was writing it and I just kept on typing—I forgot where I was going with this, but one thing's for sure: My husband, Rick, is a happy guy. This is a little off colour and I hope you don't mind, but I can never remember if we had sex last night or last week, and I think we make love a lot more than we ever did: one of the few benefits for my other half and a great benefit for my brain.

What could make my life even better? Actually, a change in attitude regarding Alzheimer recognition and diagnosis. People like me need help sooner. Let me try to explain. I am any Jane thinking I have a memory problem. I go to the Canadian Alzheimer site and look for warning signs, and here they are:

"(1) Memory loss that affects day-to-day function," and then it explains: "It's normal to occasionally forget

appointments, colleagues' names or a friend's phone number and remember them later. A person with Alzheimer's disease may forget things more often and not remember them later, especially things that have happened more recently." This is not a description of me. I'm completely normal until, and only until, I get stressed. I can go for weeks without being stressed. In fact, I work hard at not being stressed. I am very protective of my brain and work hard to stay clear of stressful situations.

"(2) Difficulty performing familiar tasks:

"Busy people can be so distracted from time to time that they may leave the carrots on the stove and only remember to serve them at the end of a meal. A person with Alzheimer's disease may have trouble with tasks that have been familiar to them all their lives, such as preparing a meal." This is not a description of me. When we're living in Paris during the summer we're constantly having friends for dinner, and I seldom have problems cooking or entertaining. Recently, there was a bit of a disaster when I was preparing a dinner for my friends. The dinner was five courses, and the recipe was from an old gourmet magazine and had very faint small print and multiple pages. I became confused at times and frustrated at times and vowed never to cook that menu ever again.

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"(3) Problems with language: Everyone has trouble finding the right word sometimes, but a person with Alzheimer's disease may forget simple words or substitute words, making sentences difficult to understand." This very seldom happens to me. I still have my real estate licence, now work with my partner and absolutely love visiting my old faithful customers. It's a highlight of my day, and conversations are very easy for me.

"(4) Disorientation of time and place: It's normal to forget the day of the week or your destination—for a moment. But a person with Alzheimer's disease can become lost on their own street, not knowing how they got there or how to get home." This also does not describe me. I would never get lost on my own street, but the reason I'm not there with you is that to take the train to Toronto and get off at Union Station and find my way to a taxi etc.—yikes, it could have been a disaster. I value my brain function and protect it with all my might—I, who used to be on the board of directors of the College of Massage Therapists of Ontario as a public person, when my most interesting job was that of being the judge at discipline hearings for the college. During this time, I travelled to Toronto on the train frequently. Thank you for letting me talk to you by telephone today.

"(5) Poor or decreased judgment: People may sometimes put off going to a doctor if they have an infection, but eventually seek medical attention. A person with Alzheimer's disease may have decreased judgment, for example, not recognizing a medical problem that needs attention or wearing heavy clothing on a hot day." I am happy to say that I have never worn my bikini on the street in the winter. I may someday, as my journey progresses, but this is so far from being a problem for me that I won't waste time talking about it.

“(6) Problems with abstract thinking: From time to time, people may have difficulty with tasks that require abstract thinking, such as balancing a chequebook. Someone with Alzheimer’s disease may have significant difficulties with such tasks, for example not recognizing what the numbers in the chequebook mean.” I told you my real estate story at the beginning about my memory loss. In hindsight, I am very happy that this happened to me. To have such a profound insight into my failing memory at such an early stage is like a gift from God. To be able to get help this early is totally amazing. Please don’t let me down. Please change the warning signs because there are lots more people like me out there.

“(7) Misplacing things: Anyone can temporarily misplace a wallet or keys. A person with Alzheimer’s disease may put things in inappropriate places: an iron in the freezer or a wristwatch in the sugar bowl.” I’m sitting here laughing at this one because I lost my car yesterday. I was working at our huge church fall fair in the book boutique. When I arrived, I parked at the back of the building to save the good parking spots for customers. At the end of the day, when it was pouring rain, I said goodbye and went to get into my car, except I couldn’t find it. I went into the building where my husband was working and couldn’t find my husband. I started to cry. Father Steven saw me, put his arm around my shoulder and said, “Let me help you”. We went back to the book boutique building and started to look around. At the back of the building was my car. Oh man, did I feel foolish—another Alzheimer’s moment.

“(8) Changes in mood and behaviour: Everyone becomes sad or moody from time to time. Someone with Alzheimer’s disease can exhibit varied mood swings—from calm to tears to anger—for no apparent reason.” See above.

“(9) Changes in personality....

“(10) Loss of initiative.” Both of these things affect me only very mildly. Therefore, I thank my lucky stars every day that I screwed up only one real estate transaction and called for help immediately.

Thank goodness I have great docs like Dr. Jeff Manning and Dr. Ann Braun who listened to me, tested me and gave me an early diagnosis.

When I tell people that I have early stage Alzheimer’s, they look at me so sadly, but I want to shout, “Stop! I’m still leading a very normal life. I’m so lucky. Just think of all the horrible diseases that I could have.” Every six months Dr. Braun tests me, and for every test so far I have scored better. The drugs are doing their job and I still get to dabble in real estate with my partner in the summer and travel and live in Mexico for six months in the winter.

Please, please take the stigma away from Alzheimer’s disease and promote early detection—and change the warning signs, also. Imagine a world like mine for everyone suffering memory loss. Imagine them living with their loved ones for many years. Imagine the savings of keeping them in their homes much longer and happier with their families. Please take the stigma of Alzheimer’s away.

The Chair (Mr. Kevin Daniel Flynn): Jane, thank you very much for your presentation. You used your time very, very wisely. Unfortunately you used it all up, so we’re not going to have any time for questions and answers.

Ms. Jane Mederak: That’s okay.

The Chair (Mr. Kevin Daniel Flynn): You can’t see everybody in the room, but I can tell you everyone was listening very attentively, including the members of the public. You certainly got your point across.

Ms. Jane Mederak: Thank you. I’m very glad I did, because it’s a much happier life. The help needs to be there for people and the stigma needs to be taken away from this disease because it’s not a sad thing to have. My life is very normal and wonderful. It’s only the odd time that I sink into problems.

The Chair (Mr. Kevin Daniel Flynn): Thank you for joining us today, Jane. It was really appreciated.

Ms. Jane Mederak: Thank you for allowing me to be there.

JORDAN STONE

BOWEN McCONNIE

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is at 4:30, and that’s Jordan Stone. Jordan, would you like to come forward? Make yourself comfortable. Pick any one of the chairs you like.

Mr. Jordan Stone: I just wanted to thank Patricia Teskey—she’s with the Schizophrenia Digest Magazine and the Schizophrenia Society of Ontario—Jyll Simmons, who’s with CAMH family council; Annick Aubert, who’s with the family resource centre; and Susan Allen, who’s the director of the family council. They really support what we’re doing.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you. It’s great to have all your friends here.

Let me tell you what the rules are before we start. You get 15 minutes like everybody else. You can use that any way you see fit. If there’s any time left over at the end, we’ll split it. If you could introduce your colleague as well just so that everybody at Hansard understands.

Mr. Jordan Stone: This is Bowen McConnie. He’s another member of the group.

The Chair (Mr. Kevin Daniel Flynn): Okay. It’s all yours.

Mr. Jordan Stone: We just want to show a film first. It’s four minutes.

The Chair (Mr. Kevin Daniel Flynn): If any members of the public would like to see the film, you could probably see it from over in this corner, here.

Video presentation.

1640

Mr. Jordan Stone: The reason why we showed that is because it’s kind of like a glimpse into the schizophrenia experience, and also to show that our members are very talented. We have three Ph.D.s in the group, artists, musicians and amazing people.

What we're doing is different. Nobody has done this in Canada; I can't speak for the United States, but I haven't found anybody doing what we're doing. I started the first and only diagnostic-specific schizophrenia peer support group and network in the country.

What we have done in five years is save the government tens of thousands of dollars in hospital admissions. Not one of our members has died—and I know that sounds grim, but you know, it's a 1-in-10 suicide rate for schizophrenia, higher than any other mental or physical condition.

We have basically—we just lost our clubhouse. We received maybe four or five donations in five years. I think there's a handout showing about 30 or 35 different mental health organizations we've approached, including the provincial government, for help. We've not received a dime from any of them, with the exception of CAMH, who paid for three months of our rent before we lost our place.

Maybe you can go to our website sometime. On our endorsements page we have some of the top researchers in schizophrenia, doctors and social workers, from the pro- to anti-psychiatry movements, supporting what we're doing.

I guess why I'm here is because although everybody supports what we're doing, they can't help us because we don't fit into anybody's mandate. Basically, what I've discovered is that mental health is a business first, and whoever has the best fundraiser and marketing people and whatever wins.

Nobody has done what we're doing and I know why now: because it's very difficult. We deal with stuff 24 hours a day, seven days a week—crises and the poverty. When you're living at one third of the poverty level and you have nobody to talk to and you've lost everything, sometimes even your family, it's pretty sad. You're basically dealing with that wreckage. Most people with schizophrenia will not talk to other people who don't have it in the same way they will talk to people who do have it because of the shame and stuff like that.

So I guess—

The Chair (Mr. Kevin Daniel Flynn): If you need some water, we've got a glass of water down there.

Mr. Jordan Stone: No, I'm all right for water. I don't need water.

We want to somehow have the government change, shift—how I also figured how it works is, whoever has the money is in control of your care and your life. We've had 30, 40 years of a model that is not working, and we've actually developed our own recovery model which does work. CAMH has recently adopted a model which is a non-diagnostic-specific model coming from the States, which is very well marketed and not very practical.

Everybody is talking about peer support and recovery, but nobody is defining it, and we have. It's not life skills like the program they're doing at CAMH, and it's not just befriending somebody. It's understanding and learning how to manoeuvre a thought disorder or a paranoia or a

hallucination or whatever and be there for somebody when they need you.

We've also developed this thing called psychotic symptomatology, which the PANSS Institute in New York—they're taking what we're doing very seriously. The PANSS scale is the most used rating scale for people with schizophrenia in the world—almost every psychiatrist uses it—and they actually are developing, based on what we've done with our new scale, a new scale for clients.

What we're doing is a little bit more scientific. We want to have best practice statistics, but we have nothing. We've been doing what we've been doing for zero; nobody has been paid anything. All the other mental health organizations out there have staff who are getting paid, okay? We have nothing. Almost everybody's on disability and the few people who aren't are examples to everybody that there is hope.

I guess that's why maybe something can happen so that some time in the future, it's not so difficult. We just lost our clubhouse. We had a donation from a family member that ran out. CAMH helped us with three months of rent and then we got kicked out. The place fit six people; we have 25 members and 85 on the waiting list. The place was a cockroach-infested dive in Kensington Market. The toilets stank. It was cheap, though, and it was all we could afford. This just may be an eye-opener for you people to see that we can do something ourselves. We know what we need and we want to somehow make it work.

I'll just pass this off to Bowen, who has been a member for many years as well.

Mr. Bowen McConnie: Hello.

The Chair (Mr. Kevin Daniel Flynn): We've got about three minutes left, just so you know.

Mr. Bowen McConnie: Jordan Stone has been my friend now for about five years, since the beginning of the group. He's been critical for my ongoing recovery, in sharing knowledge about medication and supporting each other when you decide to change medications or you're going through a difficult period, which I went through. I stayed with Jordan for about a week. I went through a difficult process of changing medications, but now I'm on about one tenth the dose I was on before; I used to be just a zombie.

1650

Before the group, I had no friends, and now my life is a lot better; my quality of life has improved greatly. Now I have a number of friends who I can talk to and can understand, because we have similarities. Everyone's different in their symptoms, but we think the diagnostic-specific model is very important, especially for schizophrenia, because it's so different than just depression or whatever it might be.

We hope that we could receive support and we would like to have more dignity in having a clubhouse where we could work. Members could get some pay for volunteering—or not have to volunteer, but putting their time in and running the clubhouse. We have high aspir-

ations and we want this to be a model for other places too, other cities across Canada and the world, eventually, that a schizophrenic isn't just a useless drain on society, but has many important things they can contribute and talents. Just having a good clubhouse that can accommodate the number of people who are wanting to be part of this group would definitely save a lot of money for the government in hospital admissions and could ultimately save lives.

I had a suicide attempt and I was pretty overwhelmed with symptoms. I had a lot of people visiting me in the hospital and talking to me and so I didn't feel alone. Eventually, I came out of it and now things are much better. Most of the people in the hospital didn't have that at all and they were just alone, or relatively so. I hope you believe in the diagnostic-specific and could help us.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Bowen. Thank you too, Jordan, for the presentation as well and thank you for showing your film. I noticed that you produced and wrote it. Very good. Thank you very much for coming, both of you, today.

Mr. Bowen McConnie: Thanks.

Mr. Jordan Stone: Actually, it was produced by Workman Arts.

The Chair (Mr. Kevin Daniel Flynn): Okay. So you wrote and directed it?

Mr. Jordan Stone: Yes.

The Chair (Mr. Kevin Daniel Flynn): Sorry about that.

ONTARIO ASSOCIATION OF PSYCHOLOGICAL ASSOCIATES

The Chair (Mr. Kevin Daniel Flynn): Our next presentation today is the Ontario Association of Psychological Associates. We've got Caroline Koekkoek and—somebody I know very well—Tina Agrell. Welcome, Tina. Good to see you. Like the previous presenters and all of those today, everybody gets 15 minutes. You can use that any way you see fit. If there's any time at the end for any questions and answers, we'll split that amongst everybody. There should be some clean glasses there if you need any water. It's all yours.

Ms. Caroline Koekkoek: Yes, I think we're good to go. Can everybody hear me okay? My name is Caroline Koekkoek. I'm the president of the Ontario Association of Psychological Associates, the OAPA. With me is Tina Agrell, our vice-president. I work for the Halton District School Board and supervise professional staff in a variety of disciplines, and Tina is in the psychology department of the Peel District School Board.

On behalf our association and its members, I'd like to thank the Select Committee on Mental Health and Addictions for inviting us to present some of our perspectives and recommendations today. We sincerely hope that the committee, along with other government bodies that are engaged in various consultations on this issue, will be successful in moving the mental health and addictions agenda forward. For those of us who work in the mental

health sector on a daily basis, we recognize that the system needs to be improved and we believe that in fact it can be improved.

What is a psychological associate, I suspect you may be wondering. We are regulated health professionals whose title came into being in 1993 with the proclamation of the Regulated Health Professions Act. Psychological associates are registered members of the College of Psychologists of Ontario on the basis of appropriate academic training in psychology at the master's level, successful completion of rigorous written, oral and jurisprudence examinations, and at least four full years of professional practice as a provider of psychological services. Psychological associates practise autonomously in areas such as counselling, clinical, school, industrial, organizational and neuropsychology. We perform assessment, consultation, research and other services in a wide variety of settings such as schools, hospitals, social service agencies and private practice. The scope of practice for a psychological associate is identical to the scope of practice of a psychologist. Therefore our college has two titles, one scope of practice.

At the present time there are approximately 500 psychological associates working throughout the province. The vast majority of these are engaged in the direct delivery of mental health services.

We have some recommendations for you today:

(1) Access to existing mental health services is an ongoing, problematic issue that needs to be resolved. Clearly we should be doing a better job of connecting people suffering from mental health and addictions to existing programs, and I'm sure that the committee has heard a lot about the issues of access from many people over the last several months. If an individual has a physical problem, they know, of course, that they can go to a doctor's clinic with the expectation that this ailment will be assessed and treated in some way. Assuming that an individual is aware that they have a mental health issue, the question of where to go for treatment and whom to get it from is much less clear. This lack of clarity can be extremely problematic for vulnerable individuals.

The OAPA is completely supportive of the family health teams, based as they are on the notion of an integrated service delivery model, and strongly urges the government to adequately fund positions for psychologists and psychological associates so that patients with mental health and addiction issues are assessed and treated on a timely basis and in a cost-effective manner. In terms of the current lack of mental health services in northern communities, we strongly recommend that there is permanent, ongoing funding allocated for full-time psychological associates and psychologists in the family health teams in those areas.

Integrating mental health with other health services at the point of entry will allow more individuals to be diagnosed and treated. Doctors, nurses and other health professionals will also have the support and education they need to be able to fully treat the patients with physical and mental health as well as addiction issues.

(2) The OAPA strongly recommends that the government increase its support of the mental health workforce. One of our key recommendations, and one which we have been advocating over many years, is the streamlining of the titles in psychology. Currently there are two titles. We propose that there be only one. This would involve no monetary cost to the government whatsoever.

As an association, we have spent an enormous amount of time and resources attempting to educate government agencies responsible for establishing programs and policies about psychological associates and that our scope of practice is the same as that of psychologists. Our entire advocacy on this issue is a response to our members, who are constantly thwarted in their attempt to deliver psychological services by the fact that the title “psychological associate” is neither understood nor even remotely seen as equivalent to the other title in our college. This issue has created a substantial barrier to access, and we routinely see clients turned down in their applications for mental health services or for funding because they are seeking treatment or diagnoses from a psychological associate versus a psychologist. In other cases, a client might not even understand that a psychological associate is in fact a regulated health provider, whereas for another title, such as senior clinician, people may have a connotation of that title that it is a regulated title, and it isn’t.

1700

The government has told the OAPA over the years that we should continue to educate ministry staff who are involved in establishing policies and programs in the mental health area so that they understand that there is one scope of practice in psychology. We have done this and we will continue to do this, but it’s our hope that the government takes some responsibility for ensuring that they themselves know what they’re doing.

Our recommendation is simple: one title for all members of the College of Psychologists. This would alleviate a significant distress on the part of providers and clients alike. It would certainly save considerable resources for both the OAPA and government officials, and they wouldn’t have to answer all my calls and e-mails and visits. It would also provide absolute clarity to families and individuals seeking mental health and addiction services from providers in psychology.

(3) Related to the issue of title, we have again the current application of Bill 179, the Psychotherapy Act. It’s our recommendation that the government proceed with caution in its application of Bill 179, as the current direction taken by the Ministry of Health and Long-Term Care suggests that more confusion is being created in the mental health sector. This confusion is in part around access to the title of “psychotherapist.” The current changes to the RHPA would see this title limited to members of a new college, the College of Psychotherapists, although other people will have access to the controlled act of psychotherapy. But to date we have no sense of what the entry-level qualifications will be to this new college.

Members of other colleges, such as the College of Psychologists, would have to use the college title to precede “psychotherapist.” Therefore, if the psychological associate is treating a client via psychotherapy, the member would need to be referred to as “Jane Doe, psychological associate, psychotherapist.” If you didn’t need therapy before, you might when you’re trying to figure out who everybody is in all of this.

We feel this is needless confusion for the client. If “psychotherapist” is a meaningful term for clients, we believe that any regulated health profession with access to the controlled act of psychotherapy should be allowed to use the unencumbered title of psychotherapist.

Now I’m going to turn it over to Tina.

Ms. Tina Agrell: Thanks, Caroline.

(4) The other key recommendation we’d like to make today concerns the acute lack of graduate programs in psychology, particularly at the master’s level. We’d like to ask you to encourage universities to offer joint degrees in psychology and something applied, like social policy or public health or economics. The lack of capacity in graduate programs, particularly school psychology and clinical psychology, has directly led to a well-documented shortage of practitioners, so that positions in school boards across the province stay unfilled, to the detriment of children and families suffering from mental health issues. We know that children and youth who receive treatment for mental health issues, such as severe depression, have a remarkably high rate of successful treatment and go on to be successful students and members of the workforce.

School psychology staff are the key link in the system, as they are able to assess, diagnose and treat children with mental health issues. If not for the work of school psychologists, many children experiencing mental health issues across the province would go undiagnosed and untreated. You might broaden the role of psychology in school boards and hospitals to permit longer-term interventions in the form of cognitive behaviour therapy and counselling. The OAPA strongly recommends that the government increase the number of graduate places in psychology at both the master’s and Ph.D. levels at Ontario universities.

(5) The OAPA strongly urges the government to fill the gaps in the provision of programs for youth with mental health and addiction issues. In-province funding for drug rehabilitation programs for youth needs to be increased, and the complex funding structures for youth who are dually diagnosed with, for example, an intellectual disability and a mental health issue need to be streamlined so that the necessary treatment is accessed and delivered in an integrated and seamless process. Currently, it is in many instances easier to obtain funding for out-of-region placements than to provide support within the home community so that families can stay in close proximity during their crisis.

Do you remember the young boy who died of exposure after running away when his parents banned his video games? You might establish a centre of excellence

here in Ontario with a pool of knowledge and expertise around gambling and gaming addictions. You might establish a triage system in municipalities, with phone-in central intake, case managers for links and referral to local agencies. You might set up health clinics in isolated communities, with psychological services on-site.

(6) Our last recommendation is that the government look at extending OHIP provisions to cover the costs of therapy from psychologists and psychological associates. This would be a dramatic, systemic change that would signal that we, as a society, understand and accept that mental health and addiction is a central health issue whose treatment demands as much of our attention and resources as do medical conditions like heart disease, cancer and other physical ailments.

As the committee has been hearing over the last several months and as recently as 10 minutes ago in its consultations, mental health problems and addictions debilitate, create enormous human suffering and, in many instances, can lead to premature death.

Remember those scuffy figures shambling around Parkdale and sleeping on gratings? They are someone's lovely daughters, husbands, mothers, brothers. You could introduce co-location to provide subsidized housing with a nurse practitioner, psychological therapy, job skills training, and support for daily living skills, all on-site.

In conclusion, we recognize that members of the Select Committee on Mental Health and Addictions and the minister's advisory council have been receiving an enormous amount of input from mental health and addiction experts, front-line service providers and numerous organizations representing the mental health and addictions sector, all of whom are committed to serving their patient populations.

The OAPA has highlighted some of the fundamental issues that its members have faced over the years in their efforts to deliver exemplary mental health service, and we trust that the select committee and the government will give them its most serious consideration. After all, to know and not take action is not to know at all.

Thank you for your time. We wish you all every success in dealing with this very important issue.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Caroline and Tina. There is time probably for at least one question, maybe two. France, did you have anything?

M^{me} France Gélinas: I was not aware that two professionals with the same scope of practice had to use two different titles. I would certainly thank you for bringing that to my attention. This is something that I had not noticed.

When you talk about having psychotherapy services covered under OHIP, do you mean that you want people to have access to those services without paying?

Ms. Caroline Koekkoek: Yes.

M^{me} France Gélinas: You've talked about a family health team model being one—are there psychotherapists right now who work within family health teams?

Ms. Caroline Koekkoek: We know that there are some psychological associates who work with family

health teams. Off the top of my head, I can't tell you if they provide psychotherapy or other mental health-related services.

Ms. Tina Agrell: I think there is a provision of service, entitled PsychAid, where people who are in private practice are actually offering these therapy services, unpaid, on a basis similar to legal aid.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We've probably got time for one very brief question and one very brief answer. Bas?

Mr. Bas Balkissoon: Thank you, Mr. Chair. I just wondered if you could tell us, is there a difference in training between psychologists and psychological associates?

Ms. Caroline Koekkoek: The basic difference is that a psychologist, as our college is now, has a Ph.D., and a psychological associate has a master's degree.

Mr. Bas Balkissoon: Okay. Thank you very much.

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

Ms. Caroline Koekkoek: Thank you for having us.

The Chair (Mr. Kevin Daniel Flynn): We didn't put the jackhammer out on purpose. That was completely inadvertent, but you handled it very classily, just like it didn't happen. Thank you very much for coming.

EWA ZAKRZEWSKA

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is the 5 o'clock presentation, Ewa Zakrzewska?

Ms. Ewa Zakrzewska: Not bad.

The Chair (Mr. Kevin Daniel Flynn): Not bad for an Irish guy. You've been here from the start so you've seen all the other presentations. You've got 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll split it like we've been doing.

1710

Ms. Ewa Zakrzewska: Thank you very much and good afternoon. My name is Ewa Zakrzewska. I stand before you as a wife, mother, grandmother, fourth-year student in the family and community social services program at the University of Guelph-Humber and a placement student whose fourth-year role includes that of a groups facilitator at TEACH, an agency that teaches empowerment and advocates for community health.

I am also in recovery, life's journey of change, from a concurrent disorder, a combination of mental illness and addiction, a skill that seemed—I can't understand what I've just written, excuse me, so I'll skip that part.

Thank you for allowing me to speak about my idea of possible improvements to the mental health and addictions care system.

Not long ago, I read this adaptation of an old proverb: "You can care for people for a day. But if you educate people to become involved, you have helped them to care for themselves and others for a lifetime." How true that was for me, but in retrospect, I can ask, "Why did it take so long for me to become educated in recovery?" Unlike

most recovering individuals I have spoken to, I was most fortunate; I was able to use all the resources available for my recovery.

At this time, I could tell you about some of my personal experiences in hell where the fear was constant and the terror just around the corner, not for just an hour or a day, but endlessly for over two years. But I am aware you have heard such stories in the recent past. That information is included in the package I have prepared for your perusal, should you be so interested. In my opinion, there are more pressing areas to cover, namely, key points to be made concerning addictions and mental health care.

(1) First and foremost, I would recommend that your final report be guided by the recovery principle:

“What is recovery to me?”

“Knowledge and understanding of the self.

“Finding a way to live life on life’s terms.”

A person is not weak because she cannot stop using, and must be told so. Sobriety is not easy because of the physiological, as well as the psychological, factors involved. The same holds true of mental illness. Stop the stigma and labelling. Without the right knowledge and support, how can the victim understand the illness, let alone the public in general? Recognizing the traumatic event that so changed the individual is a challenge. Accepting the change in oneself, the loss of who you were, is an enormous challenge. “How do I recover? I don’t know how,” is what I experienced and continue to hear in people searching for a better life than the existence they now experience.

(2) The same recovery philosophy needs to be promoted in the medical health field. “You know” is not an answer, neither is standardized delivery of information. There is little of “commonly understood” or that dreaded word “normal” in the recovery process. I had suppressed emotions for so long that they were unfamiliar when they started to come through; I remember how long it took to react to those emotions. To be told that my reaction was normal invalidated all the work I had done to get to that stage of recovery. I believe that the future of a more successful recovery lies with educational strengths-based groups that augment the standardized care that is dominant in our health system.

(3) Be mindful of the importance of affordable housing with supports in place for those with mental health and addiction issues. Those with mental health and addictions need affordable housing, and there is little available. In Toronto, the waiting list is seven years long or more. Without support, many who are more seriously ill are doomed to a life of loneliness and isolation.

(4) Be mindful of the importance of food, clothing and transportation costs, as well as shelter if affordable housing is unavailable. The supplementary income barely covers the cost of food, let alone clothing and transportation costs, if there is no affordable housing. Some form of subsidy should be made available to those requiring assistance covering the costs of their housing needs. Transportation costs in smaller communities can be as much as \$15 per trip for a medical visit. If you had

to choose between eating for the next day or two or seeing the doctor for ongoing treatment, what would you choose? Going hungry for even a day may make the medications being used less effective.

(5) Equality of care is a principle of the Ministry of Health; why is this not the same with Ontario Works and the Ontario disability support program? Why are people with addiction problems discriminated against? On the one hand, they are considered worthy because they are ill and are helped by the Ministry of Health to recover, but on the other hand, they are not worthy of government assistance through Ontario Works because they have a specific illness: addiction. What’s more, Ontario Works punishes not only the person with addiction but his or her family as well. Even if the spouse receives assistance for the rest of the family, what happens if the rejected person is still in the picture? Are they not fed and sheltered by that family to the detriment of the whole? How does less food affect the mental and physical health of the children present?

Why is the ministry drug plan initiative not honoured by Ontario Works? Under ODSP, recent recipients continue being covered under the ministry drug plan, if their employer does not have one, for a full year. Why not longer? Under Ontario Works, you get any type of job and there is no such bridging coverage. Why not?

Without proper food, prescription drugs and supports, recovery becomes almost unattainable for those with mental health and addiction illnesses. Poverty and homelessness must be addressed now.

Consumer/survivor initiatives, CSI: I understand why the professionals don’t give us the answer, why each individual in recovery has to find what works for himself or herself, but can we not help them find their individual answer? After all, recovery is discovery, and even more so, self-discovery is recovery. The healing might be easier if recovery information and possible solutions were presented in such a way that the individual could pick and choose his or her own personal fit, as I did; in my case, after years of searching for such options.

Financial investment needs to be made in the consumer/survivor initiatives such as TEACH. Groups are cost-effective. They bring together people who have, in the past, isolated themselves through ignorance, resulting in lack of self-worth. No more isolation, no more shame, no more need for excuses for being the person one is. Furthermore, I believe that a recovery plan supported by the Ministry of Health would pay for itself in the long run by helping people take responsibility for their own lives.

There are CSI agencies out there that are trying their hardest to reach people who are trying to help themselves. These agencies that believe in the strengths approach to recovery are pioneering client-centered educational skills programs that empower and enable people to begin taking a stand and taking responsibility for their own lives, in spite of a paucity of funds.

I find the inconsistency of funding by the ministry to various LHIN areas is inexcusable. For example, LHIN 6 is the least funded of the LHINs of the consumer/survivor

initiatives. An agency providing CSI services in Halton, with three times the population base of the Thunder Bay district, receives only \$129,000 per year, in comparison to \$619,000 for the Thunder Bay CSI. Where is the equality of service in that? How can such a travesty be justified by this ministry?

Last Tuesday, this fourth-year placement student started facilitating a recovery group, the beginning, if future funding allows, of a series of continuing, ongoing recovery groups. This program was developed after it became evident that one community had nothing to offer those who were in most need of developing a sense of self-worth. One participant spoke about the difficulty in seeing her psychiatrist, the months between visits because the doctor is so fully booked, the short time allocated to discuss her health concerns and receive a renewal of prescription for medications, and little or no time to deal with recovery. Her voice trembled as she said, "Thank God for TEACH and your support. I don't know what I would have done, what would have happened to me if you were not here." A moment of *déjà vu* on my part; is it any wonder that I too believe that the future for a more successful recovery lies with educational groups that supplement the standardized information that is rampant in our health system?

1720

A success story at TEACH is of a person who was agoraphobic and had lived in almost total seclusion for five years. After a year or so of support from Support and Housing Halton, this person found the courage to attend a recovery group, then a self-esteem group. Presently, this person is looking forward to the facilitator training group with the hope co-facilitating a recovery group in the near future. That is what the future can hold for someone attending these strength-based educational groups.

Ladies and gentlemen, I speak from my heart as a caregiver of a family member with mental illness. I speak about what I have experienced as a beneficiary of the health care system. I speak about what I've seen and heard as a placement practitioner of support services and what I have been taught as a student of family and community social services. That is also why I am here to advocate for hope, to give those with mental health and addiction illnesses hope. Help them more generously with their food, prescription drug, transportation and shelter needs. Give them the chance to gain the knowledge they need to learn how to help themselves. Present them with the choices to assist in their own recovery. It will pay off in the long term.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. You have left time for at least a couple of questions. Anybody from this side? Christine, do you have a question?

Mrs. Christine Elliott: Thank you very much for your presentation. You have raised a lot of things that give us serious food for thought.

I'm particularly interested in the groups that you're speaking of. We've heard a lot about the importance of peer support. You're indicating very clearly that it's not

to supplement what you normally get in life skills training and that sort of thing. Could you tell us a little bit more about how you get the groups together, how they work, if they are ongoing, and what kind of physical needs and monetary needs you need in order to be able to successfully work in the groups?

Ms. Ewa Zakrzewska: That's a good question because at this point it's just beginning and there are very little funds. I'm a placement student at TEACH. Their funding for three people and rent is \$129,000 a year. Because I am there and I'm not being paid, they were able to put on two more recovery groups. I have facilitated in the past, but it's an ongoing process because the strengths approach is relatively new. What we do is advertise in the North Halton Mental Health Clinic, which is the area where I was working my groups, but we also have support groups in Oakville and Burlington. Acton is very poorly represented in the mental health support field.

When I started school, I spoke with my future field supervisor and she said she was appalled by what was happening. So that weekend I put together a package, because I had been researching recovery groups, and by Monday we had a plan for a six-week recovery group for those who had never been given an opportunity to be educated. These are for those less able to keep their attention. Over an hour period, they can learn one piece at a time. It has never been done. From what I've heard from outside of Acton, when I've mentioned it, as an example, to an emergency care nurse in Toronto, she said that it has been a long time coming. I personally see that as a wave of the future, a second tier for those who have been considered in the past less able to learn. They've never been given an opportunity to learn, and they're coming—as I said, on Monday morning, I presented this to my field supervisor; by Monday afternoon it was posted in north Halton, and by Monday evening I already had six people. There are 14 people in that Recovery 101, which is what it's called. This time around, we're doing bullying and assertiveness; in the next six weeks, hopefully, we'll be able to do a wellness kit, slow and steady progression, with the hope that they will eventually join the bigger recovery groups. But TEACH only has three major groups going. We lack the resources for putting on more groups. We have the people; we don't have the space.

Mrs. Christine Elliott: Would you be able to share that outline with us, that you've developed for the modules for the group that you're leading?

Ms. Ewa Zakrzewska: At this point in time? My assignment this year, as placement, was to have a skeletal recovery group where the components would be added as needed. With Recovery 101, the six-week program would be what would be in a two-hour session, for a 12-week program. So Recovery 101 would contain a lot of Recovery Is Discovery, which is the other recovery group that goes into anger and anxiety and self-esteem issues—so these are all offshoots based on the same recovery core.

Mrs. Christine Elliott: Thank you very much.

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

ONTARIO COALITION OF MENTAL HEALTH PROFESSIONALS

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is the Ontario Coalition of Mental Health Professionals. We've got Rod Cohen and Bob Bond joining us. If you'd like to make yourselves comfortable, I think we've got clean glasses up there; there's some water.

Like everybody else who's appeared before us, you get 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll do what we just did and we'll split that time. It's all yours.

Mr. Rod Cohen: Thank you very much. That's a hard act to follow. My name is Rod Cohen. I'm the chair of the Ontario Coalition of Mental Health Professionals and I'm also the past president of the Ontario Society of Psychotherapists, which is the organization that I represent within the coalition.

Mr. Bob Bond: I'm Bob Bond. I'm the chair of the advocacy aspect of the coalition. You may remember seeing me before, because I presented in June for the Canadian Association for Pastoral Practice and Education, which is the group that I represent on the coalition.

Mr. Rod Cohen: I certainly appreciate the incredible volume, intensity and breadth of information and passionate presentations that you've been hearing over the past couple of months as you've been travelling around with the select committee, so I just really want to focus and make a few points. To begin with, I'd like to introduce the coalition to you.

The Ontario Coalition of Mental Health Professionals is an umbrella organization whose members are professional associations in the field of mental health. Founded in 2002 and officially convened in 2004, the coalition is an organization of non-statutory, self-regulated, like-minded partners dedicated to the recognition of the psychotherapy and counselling professions in Ontario. There are 13 member associations in the coalition, representing psychotherapists; counsellors; marriage and family therapists; art, music and child therapists and analysts; and spiritual therapists and chaplains.

The coalition was specifically formed to address the issue of the incoming regulation of psychotherapy and counselling in Ontario. It strives to understand the needs of the diverse community of its members in Ontario and aspires to be inclusive in its membership and a strong voice for the promotion of psychotherapy and counselling in Ontario. Our goals include promoting the development of policies and practices for the provision of accessible, competent and accountable psychotherapy and counselling services throughout the human life span, in a manner sensitive to the pluralistic nature of Ontario's society; to seek government regulation of non-statutory,

self-regulating mental health professionals as indispensable members of the health care system in Ontario; and to research awareness of the issues and their implications among professionals, government and other stakeholders.

We are pleased that the Legislature is taking a comprehensive approach to reviewing how the mental health of Ontario's population can be improved. Improving a society's mental health is about more than simply expanding access to Ministry of Health and Long-Term Care funded services. It is important for the committee to hear from those across the care spectrum who can identify opportunities for reducing gaps in care. As mentioned earlier, our coalition represents a broad range of therapeutic modalities in a vast variety of settings.

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As one example, in my own professional role I am the founder, executive director and lead therapist of a non-profit, community-based therapy centre for high-risk youth and families in Toronto called Blake Boulton Youth Outreach Service. Our mandate is to make accessible, intensive and long-term psychotherapy and counselling to a most vulnerable population who would otherwise be unable to access and afford it. Every day we receive referrals from traditional government-regulated youth and family treatment centres such as hospitals, shelters and child welfare agencies. They send their clients to us for a number of reasons. They lack the skill and expertise to work effectively with this very difficult clientele, they admire our model of long-term treatment and do not have enough staff to handle the demands upon their services, and therefore reach out to community agencies. This, I believe, highlights the importance of expanding government-assisted psychotherapeutic services especially to those who are most vulnerable.

Mr. Bob Bond: Within our current system, access to psychotherapy has characteristically been limited to either people who can afford to purchase it; people within their workplace employment assistance programs that happen to cover it; or people whose extended health coverage, under an extremely liberal and generous third party agreement, allows them to access it. What we celebrate and hope is that the establishment of the College of Psychotherapists and Registered Mental Health Therapists can broaden systemic access considerably and, with that access, shorten wait times in mental health and addictions.

Mr. Rod Cohen: There's the potential for improving the outcomes in Ontario by better leveraging the full diversity of expertise that is available now in the province. For a mental health strategy to succeed, it's important to recognize that not all people want to receive or benefit from care within a traditional medical model. Our members make an essential contribution to the overall care mix of mental health services available in our province. Again I refer to my own personal example. My agency alone last year met with over 225 clients, individual and family, from 31 different cultural ethnicities that were referred to us by 35 different sources such as

courts, hospitals, schools, police, traditional treatment centres and private practitioners. A diversity of practice models both complements and takes pressure off the OHIP system.

Mr. Bob Bond: For lack of accessing psychotherapy, many people with addiction and/or mental health needs currently cycle through our emergency room and hospitals, our courts and prisons without ever getting to, let alone actually addressing, their underlying stuckness, hurt, injury, loss, upset, trauma, anxiety or whatever other issues. This ends up costing huge amounts of money warehousing people and treating them in systems and in modalities that don't and cannot work instead of spending appropriate amounts to heal people and improve qualities of life.

Mr. Rod Cohen: This government's action to regulate the practice of psychotherapy through the Psychotherapy Act of 2007 was welcomed by our coalition, but we are now keen to see this legislation implemented. We strongly urge the government at this point to move quickly to bring the college of psychotherapists and registered mental health professionals to life. We know that the registrar is in place and we are in regular communication with her. We know that the transitional council has been selected and that the members are just waiting to start their work. We look forward to this very exciting phase of our profession to get underway.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left quite a bit of time for questions. Let's start with Christine. There's probably about two minutes each.

Mrs. Christine Elliott: Thank you for your presentation. We certainly have heard a lot in the course of the hearings about people who are being inappropriately caught up in our criminal justice system, for example. I'm wondering if you could give us some examples of how, if your role were expanded and more available, that could work in getting people out of that system or not getting into it in the first place.

Mr. Rod Cohen: Into the—

Mrs. Christine Elliott: —criminal justice system.

Mr. Bob Bond: One of the areas where that is possible has been referred to today: increasing the amount of psychotherapeutic resources available within primary health care settings like family health teams and community health centres. That immediately comes to mind, but anyplace where psychotherapy can be inserted alongside and be supportive of primary health is a boon.

Did you want to—

Mr. Rod Cohen: I just would add to that, Christine, that it's the kind of circumstance that I personally deal with on a regular basis. On any given day I will get a call from the court system, whether it be duty counsel or a mental health worker, asking if there are mental health services, psychotherapeutic services, available for people who are dealing with issues and are in the court system, looking for resources which would be far more effective and less costly than incarcerating people.

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

M^{me} France Gélinas: I think you were here when the presenter was saying that putting psychotherapists in family health teams and certainly community health centres is a good way—I'm aware that quite a few community health centres offer mental health services; I'm not aware that very many family health teams do. There are 150 family health teams in Ontario. Would you know how many, if any, have psychotherapists on staff?

Mr. Bob Bond: I don't have statistics, but I know an example of one in Hamilton that does. They not only have some psychotherapy, but it comes in the form of several different kinds of practitioners. But I don't have statistics; I'm sorry.

M^{me} France Gélinas: That's okay. Thank you.

Mr. Rod Cohen: I'm also not aware of statistics. With regard to an example, I work in the lower east end of downtown Toronto, at the South Riverdale Community Health Centre. They have a family service team and they have social workers on staff providing psychotherapeutic services, who then refer out into community organizations like mine, for instance, because they have such a limited amount of time and resources. So it's emphasizing the importance of having greater accessibility, more than band-aids.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Rod. Questions from this side? Bas?

Mr. Bas Balkissoon: I wonder if you could just help us out, based on the previous presenter, and educate us on how one becomes a psychotherapist and what the prerequisites are.

Mr. Rod Cohen: One of the interesting things about psychotherapy is that it's, as I'm sure you're well aware, not a singularly identified profession or skill. The organization, for instance, that I'm involved in, and that Bob is as well—to be a psychotherapist requires a combination of extensive academic theoretical training, a very long period of clinically supervised work with clients and patients, as well as the mandatorily having performed your own or been involved in your own psychotherapy to understand yourself and the process.

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As we've been saying, it is a non-statutory, self-regulated field at this point. The self-regulated bodies that are in the coalition have a pretty much standardized definition that requires extensive academic training and practical clinical training, which really looks at the importance of core competency of skill in combination with academic training.

Mr. Bas Balkissoon: What would be the prerequisite to get into the program? Do you have to be a general practitioner—

Mr. Bob Bond: Do you mean academically? Academically, across our coalition folks are schooled at a master's level, and then clinically there are between 600 and 1,500 hours, depending on whether you're an art therapist, a music therapist, a child therapist—there's that

long set of hours of supervised clinical practice, to discover one's trade.

As Rod mentioned, there is a track of critical self-awareness and practice. In some organizations, that is through doing one's own therapy, and in some it's through other self-reflective means, as one trains.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Bob. Unfortunately your time is up, so will you be really brief?

Mr. Bob Bond: Very brief. One of the exciting things about the formation of the college will be, hopefully, a standardized level of practice involved in becoming a psychotherapist.

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

Mr. Rod Cohen: We appreciate it. Thank you very much.

ONTARIO SOCIETY OF PSYCHOTHERAPISTS

The Chair (Mr. Kevin Daniel Flynn): Staying on the same theme, we've got the Ontario Society of Psychotherapists coming forward. We've got David Schatzky and a mystery guest, who I'm sure you will introduce, David.

Mr. David Schatzky: I will introduce myself. I'm here for the organization.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else who is appearing before us, you have 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll do what we just did and see if we can't split it evenly amongst the three parties.

Mrs. Liz Sandals: Just a point of order, Mr. Chair, to explain to our guests that it's entirely possible that that bell is going to start to ring while you're talking. We're all going to get up and walk out and go and vote, but we'll come back.

Mr. David Schatzky: I won't take it personally. I've had enough therapy not to. Thank you.

Laughter.

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

Mr. David Schatzky: My name is David Schatzky, and I represent the Ontario Society of Psychotherapists. I'm a past president of the OSP and a co-author of its standards of practice. I've been in private practice myself for about 15 years. Of course, you've just heard from Rod Cohen, who, by coincidence, is a clinical member of the OSP, my professional association.

I had written down that there's no way you would know that as part of our training, both Rod and I were required to see a psychotherapist for many hours ourselves, but in answer to one of your questions, he just revealed that. All members of the OSP have that as a very important prerequisite to getting into practice.

Having been in therapy ourselves, we appreciate not only what it feels like to be a psychotherapy client, but we also are much more aware of our own biases, patterns

of behaviour and the nooks and crannies in our own character that could get in the way of providing safe and effective treatment for our clients.

To be very personal for a moment, I first saw a psychotherapist when I was 15 years old, and I've used the services of psychotherapists on and off ever since. For example, even a few years ago my life felt very dark indeed for a while. A very important relationship came to an end. I was having difficulty letting go of it, and I was causing problems for myself and for others.

One day I spent a whole session with my therapist, complaining and whining and unburdening myself of some very, very deep and troubling thoughts I had about life and the problems I thought I was facing. I went on and on. My psychotherapist listened intently to my very negative rant, and with less than a minute to go until the end of the session, I paused to take a breath, and very quietly he said, "Well, that's one way to look at it."

Well, I burst out laughing, because with that one comment, he changed my perspective, and I was able to get through the next week. He didn't send me for tests. He didn't criticize my bad behaviour. He didn't tell me to change my diet. He didn't prescribe antidepressants. He simply listened, and what he said stayed with me, so that even now, whenever I feel discouraged, those words come back to me and it helps me—one part of the things that help me to carry on. That's just one tiny example of what therapists do and what can happen in a therapist's office.

Well, the OSP itself is a professional association of 300 psychotherapists. We provide mental health services to 15,000 Ontarians a year, many of whom find their way back to living a full life, without costly medication, without using hospital facilities and without other expensive medical interventions.

From the outset, OSP put into effect rigorous entrance requirements for our members: a master's degree or equivalent, specific training in psychotherapy theory and techniques, supervised clinical practice for hundreds of hours, and as you've heard, personal psychotherapy. We created a standards of practice; we adopted a code of ethics and put into place compulsory continuing education requirements. Over the last decade, OSP has enthusiastically, even passionately, participated in the process leading to the establishment of the College of Psychotherapists, and we did all this voluntarily because we're committed not only to our clients, but also to our profession.

You probably remember the old country doctor before OHIP. Well, we like to think of ourselves as being a bit like them: connected to the people who depend on us, but without the security of guaranteed payment for ourselves. Most OSP members work independently, mainly in our own private practices. Third party insurance doesn't pay for our services, but we're very much in demand. Perhaps that's because we pay very close attention to every word our clients say, and we build a relationship with them of trust and understanding.

It's that relationship which has proven to be therapeutic to people who are struggling with the complexities

of the human condition. They may be facing difficulties like intense anxiety; challenges in maintaining relationships; impulsivity which gets them into trouble at home, on the job or with the law. We help people with undermining feelings of inadequacy, with profound disappointment, loss or betrayal. We work with their anger and their rage. We help them cope when they feel overwhelmed by the complexity of the world or completely alienated from society. All these aspects of being human can be so paralyzing that some people barely function or constantly fail to meet their own goals. Some are very self-destructive or seriously disrupt the lives of their friends, family, co-workers or even their own employees.

That's where the therapeutic relationship with a psychotherapist comes in. We facilitate a process that helps our clients take care of themselves, get on with life, with their work, with their relationships.

At this point, you may well be thinking, "So what? Why are you here? What does the Ontario Society of Psychotherapists have to offer this committee?" Well, we know that you want to make sure that every one of your constituents gets the kind of mental health treatment they need, when they need it, for as long as they need it. That treatment should be with a practitioner they want to work with and who can help them effectively, a professional who can and will refer them, if necessary, to the more specialized services of addiction, psychiatry or medicine, and someone who is willing to work collaboratively with those specialists.

From your perspective, it would probably be even better if our services were not paid for out of the provincial treasury. Of course, if they're not paid for by the taxpayer, then they need to be at a cost the consumer can afford, and that's who we are and that's what we provide. Given your mandate to ensure that all citizens get better access to mental health services, the OSP would like to suggest that psychotherapists be considered among the primary providers of mental health services in Ontario—the general practitioners of mental health, as it were.

The role that psychotherapists play in the provision of mental health services in Ontario is often unacknowledged or misunderstood, but it's not inconsequential. Self-regulating psychotherapists in private practice have been meeting vital mental health needs for thousands of Ontarians for more than three decades. We are accessible in urgent circumstances and are available in centres without hospitals or other health care services. In many cases, we're the only provider who can meet the client's need for privacy and cultural sensitivity. Where social stigma may prevent people from seeking help, our non-medical, non-psychiatric orientation allows people to ask for help or seek treatment before it reaches crisis proportions. In other words, they don't have to feel as if they're sick or crazy to come to us.

Psychotherapy is both therapeutically effective and cost-effective. The College of Psychotherapists, which is about to burst upon the scene, creates a vehicle to bring

several thousand private-practice psychotherapists into the web of inter-professional collaboration to meet the mental health needs of Ontario. And you're absolutely aware that most people don't know where to turn for mental health services, and, as someone mentioned earlier today, they're certainly confused about the names and the titles and who is who.

You know that access to an MD/GP is a real issue for many rural citizens, and finding a private-practice GP who is taking on new patients can be difficult even in the best-served urban areas. So people are very puzzled about who can give them the help they need and where to find that help.

For that reason, a publicly funded educational and advertising campaign which lets Ontarians know about psychotherapists, GPs and local agencies would be extremely useful. It would point them in the right direction. If they're in a crisis or if they want to prevent their distress from becoming a crisis, far better to seek help and find it than to commit suicide. A publicly funded campaign which points the way to mental health services that Ontarians need would be, at the least, very helpful and, at best, life-saving. Well, that's at least one way to look at it.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David. We've got about five minutes left. I think the bells may start ringing very shortly. I just don't know—how long is this vote?

Mrs. Liz Sandals: I think it's 10 minutes.

The Chair (Mr. Kevin Daniel Flynn): If it's a 10-minute, then we can question you for four. So let's start with Christine.

Mrs. Christine Elliott: Lots to think about here. The idea of having access so that people could come to almost normalize the seeking of therapy before it reaches crisis proportions—it seems to me that that would be very valuable and would save the system money over the longer term. Is that more or less what you're—

Mr. David Schatzky: That's one of the things that I've been trying to convey, for sure, yes. Many of the people we see in fact have that point of view. They know that there's something troubling them, there's something to deal with, and we're their first line of defence.

Mrs. Christine Elliott: And I guess just having it available through the system, whether it's part of a family health team or whatever, helps deal with the stigma aspect of it as well, because it's something that's available for everybody in that they can avail themselves of it, if needed.

Mr. David Schatzky: Absolutely.

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

M^{me} France Gélinas: I truly enjoyed your presentation. You're a very good presenter, so it made it very lively and interesting and made it very clear, as well. Your message is clear; your focus is on improving access. One huge barrier to access is the ability to pay. So your points are clear and well taken and I thank you.

Mr. David Schatzky: Thank you.

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

Ms. Helena Jaczek: Yes. Thank you for the presentation. I'm just wondering, if you do have a client who you feel is suicidal or perhaps psychotic and in need of medication, how do you refer back into the medical side of things?

Mr. David Schatzky: Very simply and directly. We talk about why it's maybe necessary and I try to facilitate putting them in touch with the right person, and sometimes I might even—I've even had occasion to make the call myself while they're in my office.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, David. It was a very good presentation.

Mr. David Schatzky: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Is Iris in the audience? You're going to feel a bit left out because we're going to leave and then we're going to come back. If you don't mind waiting, we're going to vote in seven minutes and then we'll be back here in about two or three minutes. So if you don't mind waiting 10 minutes—

Ms. Iris Kairow: That's fine. Just make sure you have your package read by the time you return so that I can quiz you on your homework.

The Chair (Mr. Kevin Daniel Flynn): Hey, we've got nothing else to do. As long as you're not offended, we're going to leave you. Thank you.

The committee recessed from 1752 to 1807.

IRIS KAIROW

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is Iris Kairow. Is that right? You've got 15 minutes like everybody else, and you can use that any way you see fit.

Ms. Iris Kairow: Thank you. Our story begins with a carefree child, designated as gifted, with enrichment at wonderful schools, successful at chess, track, soccer teams.

Grade 9 was nearly fatal when a 20-kilometre joyride crashed the teenagers into a pillar. Thank goodness for a smart judge who ordered a psychiatric assessment, but there is no test for schizophrenia. Many tools are based on what a patient says during an interview. When we walked out with a clean bill of health, I knew he had lied to these doctors, too.

Then he phoned me from Hamilton saying he was tired from roller-skating on the QEW from Toronto in two hours. Our child was attacked by the Crips gang in the Kingsway, so he believes. One neighbour witnessed teenagers dancing on my steep roof—waited three weeks to point out the insurance liability might become a financial issue for me, so I hired a housekeeper. But our son likes to cook in the middle of the night. He caused two accidental fires, totalling \$12,000—more sleeping medication for us, and we all wished he could live in a group home.

Truth is, our child slept in High Park as one of Toronto's 7,000 homeless. Our child gave out beatings and suffered beatings in seven shelters. Changing door

locks did not keep our younger siblings safe. Our child repeatedly used surprise by breaking into his own home via the dog door flap. With each stolen bicycle I brought to the police, I explained that he took instructions from specific younger boys who were ringleaders.

I helped the crown prosecute a break and enter just to take beer, but they happened to find an antique gun. "Mommy, what is bail money and why don't you just give it?" "Because, sweetie, the social worker advised us to leave him inside that place." After names were read out in court, I thanked a neighbour for supplying a witness statement, but they denied it. Another neighbour came onto my porch to tell me, "I think your family had better move off this street."

If schools had spotted him for an early intervention program, symptoms would have been less severe; his two younger siblings less shamed; fewer nightmares; I'd have spent more time, more hours, with my younger two children rather than dragging myself to seminars on parenting and substance abuse.

As it unravelled, from probation office, CTYS, George Hull, Breakaway, psychiatrist, two social workers that I arranged privately, no one told us that marijuana triples the risk of schizophrenia. I had no idea our son was losing 20% of his brain tissue. I should have been less strict about alcohol and more about smoking?

It was not until much later, after our son was called names—some of the 270 phrases for insanity—after his fourth high school, after living at Eva's Phoenix, that anyone mentioned the word "schizophrenia."

When his teacher mentioned that he was in hospital, classmates relayed several instances of swallowing metal screws. This will become a reportable event after the select committee's work is finished.

Our son's first two medicines were not very effective. He continued to chew wood off his bedpost and swallow pennies. When he explained his perpetual emotion waterwheel, the psychiatrist shrugged it off. If I had only known that schizophrenia patients lose cognitive function with each breakdown—dropping from IQ 100 to 65—and that they could recover some cognitive functions with brain tissue growth, called plasticity, with early medicine.

Let's recall a single fact that car rental companies enforce: A healthy person is not considered responsible until 25 years of age. When our son announced his AIDS cure with mini robots, the psychiatrist suggested university admission. Doctors recommended adjusting amounts or types of pills, but a 17-year-old enjoys prolonging debate. It's a waste to plead this decision with a three-person legal board.

Our son never refused to swallow his medicine for any health professional. Twice, CAMH psychiatrists took lawyers to the Consent and Capacity Board for the same purpose: to switch from one pill to another pill. They had to take several hours away from other patients to state that my son was incapable of appreciating the reasonably foreseeable consequences of a decision. When alternatives have not yet been experienced, no patient can foresee around a corner.

CAMH's social worker staff expedited ODSP approval. That made it impossible to persuade a paranoid person that living with less pocket money in a group situation would be more therapeutic for him. If our eldest child had been able to live in a group home, then he would not have kicked his little brother in the head. Unfortunately, his brother's concussion cost public expense two hospital visits. Waking up at the YMCA, he ran naked many blocks before police apprehended him. Annually, Toronto police log 10,000 responses for emotionally disturbed persons, six hours a call at \$36 per police hour. Back in the ER, physical restraints at all four points were required. This was worse than visiting in the jails. In the future, we can reduce the 19,000 ER visits made by schizophrenia patients.

In 2002, had we the fortune to live in New York, New Brunswick or British Columbia, access to standard treatment would not have been an argument. I would not have lost my argument with ER psychiatrists that setting fire to his own hair at midnight on December 24 was insufficient legal grounds. That doctor discharged my son on December 26. Seven years of medical training, and the doctor is talking legal matters. Ontario law is quite clear: A danger must be evident. Perhaps 72 hours' time allows substances to wear off; paranoia actually worsens.

Some mental illnesses do not cause incapacity, but persistent psychosis and paranoid schizophrenia are defined by irrational thought patterns, intrusive thoughts, disjointed ideas, random delusions and lack of judgment. Paranoia prevents patients from selecting a choice or trusting any advice. It's a no-brainer: These few patients should not decide their own health treatment.

I know this committee can set a clear destination on how matters should be. Like laws about jaywalking, bike helmets, school truancy, idling cars and clearing our snow, laws set out the ideal. Please leave the enforcement for specific situations. Please leave the wranglings of implementation to those who do practise medicine and law. His father and I spent hours reviewing how we could get publicity or legal action to remedy how our son was being denied appropriate medicine.

The same day that my son tells me a row of elevators is actually a computer hard drive, his psychiatrist asks his permission for switching to a third medicine. I ask this committee to revise regulations so that the legal right to refuse standard schizophrenia treatment only be presented to youth after they have completed eight months of that medicine. Where schizophrenia or suicide issues are confirmed, do not seek permission from youth under age 20. Where degenerative brain disease and other severe mental diagnoses are being treated, suggest to medical practice guidelines that they treat youth as minor children by involving the next of kin—only for paranoia and schizophrenia. For patients with a confirmed diagnosis who are treatment-naïve, the legal right to refuse medicine should not be suggested as their own choice until they are over 25 years of age. Your existing rules permit all patients to refuse standard pills for their mental disorder, which would only make sense for adult patients

who have maturity or who have eight months of experience on medicine on which they could base their judgement, or if the history of paranoia and schizophrenia is not yet confirmed. I'm talking only about standard pills, not injections or ECT or new trials, and I mean only for the mental disorder, not for other aspects of their health.

1820

Today I'll list 10 actions, each with zero cost. Elected members can start these immediately:

Talk with your local police to estimate how much money is devoted to respond, restrain and escort EDP, emotionally disturbed persons.

Track mental illness as a contributing factor to crime, major or minor, along with violence against women, hate crimes. These are tracked, and the statistics are published.

This very week, watch five videos: Jesse Bigelow in *FearLess*, *A Beautiful Mind*, *The Soloist*, *Fight Club*, *Benny and Joon*.

For the next two months, wear your watch on the opposite wrist, don't wash your hair, to see how this feels.

In your riding newsletter, print a poem or anecdote about a mental disorder. Award a certificate to a constituent who writes a short essay.

Tell your developers, landlords, real estate professionals, clubs and charities there is a high demand for basic accommodation. Renters with severe mental illness do guarantee monthly payments through electronic transfer of ODSP funds, and it is illegal to discriminate against disabled people.

Ensure children's books about mental health are included with those that are already being published and purchased by schools and libraries. Buy some for your office waiting rooms. I've suggested a list attached in your package.

Switch to ordering snacks from the Raging Spoon Catering Company and similar businesses that are listed in the back of your list of alternative businesses.

Stop on the sidewalk to talk to people with mental disorders so you can discuss how stereotypes, prejudice and discrimination help stigma persist.

Ensure regulations are amended to encourage treatment so that Ontario law may keep pace with seven other provinces' mental health legislation.

And the number one way that you can start today with zero cost: Make severe mental disorders a priority by arranging the donation of your brain tissue for science.

The time is now for making it happen.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Iris. We've got a little bit of time left. Looking at my time here, you've left about a minute and a half. France, would you like to take that?

M^{me} France Gélinas: I want to thank you for bringing your story, and I think your top 10 ideas are all good.

You talked about early intervention. Do you see this as something that would be available in every school?

Ms. Iris Kairow: I live in the best country, in the best province, in the largest city with excellent schools. I

talked to the social worker, the guidance person, about the fact that my son is gifted, maybe a little mischievous. Nobody ever mentioned schizophrenia.

But please don't waste public money on advertising, because there has already been a lot of money wasted on anti-stigma advertising, and according to Canadian research that was done in Calgary, it was not effective.

The most effective thing, I think, would be more to increase our familiarity by a requirement for job placement as affirmative action. This increases the percentage that we meet every day—the mail person, the janitor—and then we understand better. Apparently, headlines and brochures and news stories don't really improve the problem of stigma.

Please don't rely on the police to be social workers. I have an MBA and in my day job, I work on the traumatic mental stress team of the Workplace Safety and Insurance Board. We have a lot of difficulties with suicidal police who are finding these youth suicides horrendous to cope with. They try to be macho and keep a stiff upper lip, but eventually—this is part of the iceberg, where there are hidden costs, a domino effect, and it really impacts a lot of other people when there are negative outcomes.

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

Members of the committee, that was our last delegation of the day. I want to draw your attention to a few points: You have a memo before you from Elaine, the research officer. It looks like this. That's something you can perhaps think about in preparation for our meeting next Wednesday at 12 noon. It's a lunch meeting in committee room number 2. It's something to think about.

On November 20, for the meeting between us and the minister's advisory group, out of the nine of us, we've had seven people who have said that they will attend. There are two people who are unable to attend, but does the committee still want to go ahead? Seven out of nine is pretty good.

Mrs. Liz Sandals: Maria and I are just saying that public accounts I think will be meeting at 12 to 3 as well.

M^{me} France Gélinas: Noon on Wednesday.

Interjection.

Mrs. Liz Sandals: That's now got another three of us.

The Chair (Mr. Kevin Daniel Flynn): No, this is November 20.

Mrs. Maria Van Bommel: No, no. We're talking about next Wednesday. You talked about noon Wednesday.

Interjection.

Mrs. Liz Sandals: Is it possible—oh no, because we're going 1 to 3.

Mrs. Maria Van Bommel: We've got a conflict.

The Chair (Mr. Kevin Daniel Flynn): From 1 till 3?

Mrs. Liz Sandals: How long were you thinking the meeting would be?

The Chair (Mr. Kevin Daniel Flynn): Well, it can be as long as you want. It's really informal. It's a chance for everyone to get together, but rather than rush it, I'd sooner not do it. You're not going to get it done in an hour, if that's what you're asking.

Mrs. Maria Van Bommel: I think we're supposed to start at noon next Wednesday.

Mrs. Liz Sandals: I was going to say, if I could ask—see if Norm would agree to leave it until 1—

Interjections.

The Chair (Mr. Kevin Daniel Flynn): How many other members can make it on that day? We've got to give this thing some priority.

Ms. Helena Jaczek: October 7 at noon.

The Chair (Mr. Kevin Daniel Flynn): Okay. Well, we're just going to have to go ahead unfortunately, unless public accounts wants to change its schedule.

M^{me} France Gélinas: This is for the report writing?

The Chair (Mr. Kevin Daniel Flynn): Yes. I just don't want to leave it any longer if I can help it.

The other thing you could do, Liz, is, if for some reason it doesn't work out that you can attend, if you would read Elaine's memo and if you've got anything to provide in writing or even if a staff person could come on your behalf, that would work as well. Okay?

Thank you very much for attending.

The committee adjourned at 1825.

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