
MH-22

ISSN 1918-9613

Legislative Assembly
of Ontario

First Session, 39th Parliament

Assemblée législative
de l'Ontario

Première session, 39e législature

# Official Report of Debates (Hansard)

**Wednesday 21 October 2009**

# Journal des débats (Hansard)

**Mercredi 21 octobre 2009**

## Select Committee on Mental Health and Addictions

## Comité spécial de la santé mentale et des dépendances

Mental Health
and Addictions Strategy

Stratégie sur la santé mentale et
les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
Greffière : Susan Sourial

**Hansard on the Internet**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

**Le Journal des débats sur Internet**

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

http://www.ontla.on.ca/

**Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-3708.

**Renseignements sur l'index**

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7410 ou le 325-3708.

---

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

# SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

# COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 21 October 2009

Mercredi 21 octobre 2009

*The committee met at 1605 in committee room 1.*

## MENTAL HEALTH AND ADDICTIONS STRATEGY

### SIMONE USSELMAN-TOD

**The Chair (Mr. Kevin Daniel Flynn):** Okay, ladies and gentlemen, if we can call to order this meeting of the Select Committee on Mental Health and Addictions.

Our first delegation today, at 4 o'clock, is Simone Usselman-Tod. Simone, if you'd come forward. Make yourself comfortable. Use any one of the microphones you'd like. There should be some clean glasses there with the water.

You're our first delegation of the day, so I'll just explain the rules a little bit; they're not complex at all. You get 15 minutes. You can use that any way you see fit. It's always better if you leave a little bit of time at the end, if you're able to, for any questions and answers that the committee may have, but that's entirely up to you. Please feel free to sit. Other than that, the time is all yours.

**Ms. Simone Usselman-Tod:** Thank you very much, and good afternoon. I want to say thank you for making the effort to address addictions and mental health care in Ontario. Thank you for giving me the opportunity to speak on a topic I feel so strongly about, and which has been a significant part of my life for the last five years.

My name is Simone. I am an X-ray technologist and a registered massage therapist, and I run an equine boarding facility for 27 horses. I am a wife and, most important of all, I am a mother of two beautiful daughters, aged 17 and 19 years old, who I am pleased to say are both alive and well.

This is a success story about my youngest daughter. She did not have cancer, she did not have a heart defect and she did not have a blood disease. She was diagnosed with mental health disorders in the form of social anxiety, depression, eating disorder and self-harm issues, which escalated to substance abuse because we could not get her complex issues addressed here in Ontario.

**1610**

Katie started struggling with her mental health issues at 12 years of age, symptoms of which would be considered relatively normal or at least within the normal parameters of teenagers these days. During puberty she became withdrawn, had angry outbursts and had difficulty dealing with transition. All could be blamed on hormones.

Her symptoms started subtly but increased in severity over three years until she was 15 years old and came very close to losing her life when her issues became life-threatening, a potential death sentence. "Death sentence"? Strong wording, you might say. It is a potential death sentence when appropriate care cannot be accessed. Our journey through the caverns of the mental health care system left us frustrated, scared, distraught, distressed, angry and hopeless. The toll on my daughter as well as her family is immeasurable.

She was assessed by our family doctor as well as four social workers and counsellors, and it was decided that she was dealing with depression. Of that we had no doubt. We were told she was a teenager and was experiencing depression, as if it was not a huge deal. Her behaviour fluctuated between withdrawn, angry, lashing out, swearing, belligerence, self-destructive, self-sabotaging behaviour, restricted eating and impulsivity—an extreme teenager, you might say, or a youth with mental health illness.

Her behaviour escalated over the next few months. Home life was stressful and filled with tension. I began getting calls from other parents, who were concerned about Katie's behaviour with her friends. She was scaring her friends because of talk about taking a bottle of medication, as well as cutting her wrists.

She became less social, more irritable, and intolerant of everything and everyone. We became suspicious of her interactions on the phone as well as the computer. It was a full-time job looking after her. Out of concern for her safety and for our peace of mind, we started taping any incoming and outgoing phone calls as well as her MSN use. Her behaviour was becoming more erratic and she became rude and obnoxious. Our home was a very unpleasant place to live. We had tried being stricter, talking about our concerns, and we were met with denial, anger and defiance.

We had seen four counsellors, whose suggestions ranged from getting firmer with her—we had difficulty physically getting her to school, which she absolutely refused to attend. It was suggested that we get more restrictive if necessary or cut her more slack, that we were to blame for her symptoms because of our upbringing and the way we dealt with her, and that we were being too fair. Needless to say, we were not bestowed with any kind of confidence.

Friends said to kick her out; she was an unruly teenager. What I saw was my child struggling severely emotionally, and she had developed a poor sense of judgment and was very disconnected. My child was ill. If she had brain cancer and her behaviour had changed because of the effects of the disease, I would not stop taking care of her. If she had broken her leg and was having difficulty doing the things she used to do, I would not kick her out. But now, because she was coping poorly and was negative, angry and threatening suicide, it did not mean I was going to desert her.

I knew she was ill, and on some level I knew there was more than depression going on but I could not identify it. It was not until she entered the US mental health care system, in desperation, that she was diagnosed with a severe generalized anxiety disorder. Our search for assistance within the mental health care system in Ontario was anything but successful.

As my daughter's symptoms continued to escalate, we became distraught at our inability to help to relieve her symptoms and became more desperate as she continued to cut the flesh on her wrists, forearms, abdomen and thighs with blades. We were told there was nothing we could do to make her stop. I was horrified that this beautiful child of mine was cutting her flesh and couldn't believe that there was nothing we could do to help our 13-year-old girl.

Her sleeves were often bloodied. She began to show others at school what she had been doing to her body. She was desperately asking for help and for someone to notice her pain. My daughter still carries these scars today. Not three or four—no, her left arm carries about 100 two-inch scars that can't be missed, a clear reminder of where she was mentally and emotionally just two and a half years ago.

As parents, we have had to deal with the pain, embarrassment and shame that go with the stigma of cutting and mental health disorders. I work in the medical field. I know what others will assume about my daughter's judgment and her perspective: fear, horror, disgust and recoil. I know; I have felt the same way when working with patients with multiple self-inflicted wounds and scars.

All approaches we had taken with the Ontario mental health care system had been relatively unsuccessful. Treatment through our family doctor and counselling did not relieve my daughter of her endless pain. The disassociation resulting from cutting her skin did not give her enough relief from her emotional pain.

Katie deteriorated and became more and more desperate. We could find no way to offer her relief. She had constant headaches, was too tired to get up and was not hungry. She became thin and more anti-social. We felt we were at a wall. Then, almost overnight, there was a sudden change in her mood. In fact, she was actually pleasant, with fewer intervals of obnoxious behaviour, and we were offered some relief. Then we started to notice money going missing. Horrified, we realized she was probably using some sort of drug to relieve her discomfort. We searched her room and came up with ecstasy pills. With this, she ran away from home and we could not find her for over 24 hours. I realized at this point we could no longer keep her safe; in fact, she may not survive this ordeal.

Pictures in my head of all the addicted and overdosed patients who I'd seen over the last 25 years in emergency at the hospital came to mind, as well as those who left emergency for the last time in a body bag. "My God," I thought, "We may have lost her for good. What if there was something else we could have done? What if she doesn't survive? We may never see her make her 15th birthday. What if my child is dead?" Do you know what it's like to have to come to terms with the fact that your child may die or be dead because you couldn't get help for her? Talk about the ultimate failure as a parent: How could I ever live with myself? I felt completely lost and defeated. My daughter started with a mental health disorder and had ended up with an addiction.

What is a concurrent disorder? Concurrent disorders describe a situation in which a person experiences psychiatric disorder and a substance use disorder or addiction. It is important to keep in mind that there are many different kinds of problems that are covered by these various terms. As a result, concurrent disorders present themselves in many different forms. For example, someone living with schizophrenia or depression who has problems with cannabis use has a concurrent disorder, and so does a person who has problems with alcohol use and has clinical depression.

In my daughter's case, her concurrent disorders were complex. She was diagnosed with more than one mental health disorder, being an eating disorder in the form of anorexia nervosa, as well as clinical depression, generalized anxiety disorder and self-harm. The other part of the concurrent piece was substance abuse in the form of alcohol, ecstasy, ketamine and cocaine. She was 15 years old.

Her multiple issues limited access to appropriate care. For instance, addressing the eating disorder was frustrating. Her multiple issues restricted her from being accepted into the eating disorder clinic at McMaster Hospital. If she just had an eating disorder she would have been accepted into the program. Instead, we were turned away because she did not meet the limitations of the criteria set for the program. It was felt that if her eating disorder was addressed it would cause other issues to escalate. There was no comprehensive care available at one location to address her multiple needs. Her complex combination of disorders didn't fall within the parameters of services within Ontario.

Foremost, I am a mother, as many women are. I also have the advantage of working in the medical field in a children's hospital in Hamilton. I have connections and I'm not afraid to ask for help. I am educated, I speak English, and my father is a doctor. I could not navigate the Ontario mental health care system for my daughter. How on earth can someone who does not have my background, is not educated and who does not speak English ever hope to do so?

By chance, my sister found a place called Recovery Counselling Services in Toronto. I have some information in the package that I handed out. Recovery Counselling Services saved my daughter's life. After my first conversation with the intake counsellor, I felt there was actually some sort of glimmer of hope, perhaps a slight possibility that my daughter might have a chance—maybe. We were coached on how to encourage her to come for a meeting with one of the counsellors and for the first time we actually felt support in our quest to help our daughter. After three counselling sessions, Katie agreed to attending residential treatment. The recommendation was at Caron in Pennsylvania, as there were no residential treatments available here in Ontario for the severity of the problems Katie was facing, as well as her age issues. From this point on, we have never looked back. My daughter spent 10 months in residential treatment and then 10 months in a transitional program in Utah, where treatment is comprehensive and continuity of care is a priority, amongst many other aspects.

After 20 months at Vista Treatment Center, Katie returned home in January 2009, just before her 17th birthday. She is currently attending an outpatient program in Toronto, Ontario, Recovery Counselling Services, a private business which involves three hours of commuting. She also sees a psychiatrist in Toronto once every six to eight weeks for medication assessment. Katie has been home for nine months, properly medicated to address her mental health issues, and has learned many techniques to help her cope on a day-to-day basis. She has not relapsed and is doing well. When my daughter said "Thank you, Mom. Thank you for saving my life," I cried and cried with tears of joy.

Again, this is our success story. My daughter is alive and well today.

Thank you.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Simone. You've left a few minutes for questions, starting with Sylvia or Christine.

**1620**

**Mrs. Christine Elliott:** Thank you very much for your presentation today, and I'm glad you had a happy ending, but it sounds like it was a huge struggle to get there. You mentioned that your daughter was not able to get into an eating disorders clinic because she had such multiple problems. Is that something that you would recommend, that we have a more comprehensive system? And is that the nature of the programs that you entered into in the US? Is that what made the difference for you?

**Ms. Simone Usselman-Tod:** Absolutely. It was the ticket. The problem that I find in Ontario—it's like if you want to make a sandwich: you have to go to one place for the bread, somewhere else for the mayonnaise, somewhere else for the mustard, somewhere else for the turkey, somewhere else for the lettuce and somewhere else for the tomatoes. If you don't hit all those places, you don't have a sandwich. And here—you know what?—the piece of lettuce wouldn't have cut it. Most kids with concurrent disorders have one mental health issue with substance abuse; she had multiple.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Simone. Michael?

**Mr. Michael Prue:** I want to just follow along on that. This is a real hard struggle; I realize how difficult this is for you to talk about this. Are there other parent groups or people with whom you can talk? Is this recurrent, or is this just something that happened to your family because of the multiple disorders?

**Ms. Simone Usselman-Tod:** This is recurrent. My daughter attends a support group with Recovery Counselling Services, which I have listed in the papers there. For two years, I attended parent group meetings, and it was not uncommon. I think a lot of people get lost in the system. I was very fortunate to find Recovery Counselling.

**Mr. Michael Prue:** And did they all have to go the States?

**Ms. Simone Usselman-Tod:** Not all of them, no, not necessarily.

**Mr. Michael Prue:** But some?

**Ms. Simone Usselman-Tod:**. It depended on the use and the risk of the youth. My daughter was at very high risk. Her use, as far as substance abuse, went from nothing to pretty much all day within three months.

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

**Mrs. Liz Sandals:** I'm just trying to sort out in my own head here what Caron did, and what role Vista played, because if I understood you, she was at both and they're, given the addresses, obviously two quite different programs.

**Ms. Simone Usselman-Tod:** Right. Caron is a primary care. She spent a month in that program, and then they're assessed and they move on to either a longer-term process within Caron or another facility. It was deemed, through a lot of discussion, that Vista Treatment Centers was a more appropriate system for her; it was potentially more long term and her issues were complicated. She went to residential treatment at Vista Treatment Centers for 10 months, and then we explored a transitional program, which is not available in Ontario. We have either residential or outpatient; we don't seem to have anything in between. They provide a transitional program so that she can be worked at a level system to be more integrated into the community again. Since she's been in the outpatient program here in Ontario, she has done very well.

**Mrs. Liz Sandals:** So was she in a transitional—partly in-patient, partly outpatient—in the US, or is it that Vista organized transitional support here?

**Ms. Simone Usselman-Tod:** No, transitional support is in Utah, at Vista. What happens is they start with a lot of fairly high monitoring, especially as a transition from the residential program into the transitional program, because the transitions are hard for them anyway. As they prove themselves to be more responsible, they have more and more freedom and choice. So it's an earned program. It worked very well for my daughter. If I gave my daughter the choice of harm reduction and, "It would

be nice if you stayed clean," I would have lost her. She's a high-risk teen; she's not going to take "maybe." "Maybe" means "I'm not taking part in it."

**Mrs. Liz Sandals:** Thank you very much for helping us sort that out.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Simone. I have a short question. I visited Caron about a year ago because it seemed that a lot of kids in my constituency were ending up down in Caron, and I was quite impressed with the facility. Where there seemed to be a shortfall, and you may have addressed it—had your daughter come home from the treatment she received in the States and had to rely on the public system to get aftercare, would she have gotten it?

**Ms. Simone Usselman-Tod:** Not adequately.

**The Chair (Mr. Kevin Daniel Flynn):** Not adequately, so it probably would have all fallen apart?

**Ms. Simone Usselman-Tod:** I was not willing to risk that.

**The Chair (Mr. Kevin Daniel Flynn):** Was Father Bill at Caron when she went down there?

**Ms. Simone Usselman-Tod:** Yes he was.

**The Chair (Mr. Kevin Daniel Flynn):** He's quite a character.

**Ms. Simone Usselman-Tod:** He's amazing. I'm very impressed with the system down in the States, and what I've left you too is, they've got a system that works there. Basically, in Ontario we have a harm reduction system; they use an abstinence system.

The other issue is age. At 16, if a youth wants to walk out here, they can; they have to be 18 in Utah, which gives you an extra two years to work with. Interestingly enough, my daughter chose to stay in the transitional program for the whole 10 months. She was very interested in becoming clean.

**The Chair (Mr. Kevin Daniel Flynn):** Okay. Did you go down for one of the Sunday morning services?

**Ms. Simone Usselman-Tod:** Oh, yeah. I was down every month with my daughter, and we went down for the three-day education program that they had for the parents there. It was fabulous—priceless.

**The Chair (Mr. Kevin Daniel Flynn):** Great. Well, thank you very much for coming today and telling your story. It certainly is appreciated.

**Ms. Simone Usselman-Tod:** Thank you. I've also left my contact information in the paperwork that I gave you. If there's anything else I can do to help the system—I'm also in discussion with the Ontario government right now about funding transitional programs down in Utah. I'm happy to add anything else I can at a later date.

**The Chair (Mr. Kevin Daniel Flynn):** Perfect.

**Ms. Simone Usselman-Tod:** Thank you.

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

## ELEANOR BAKER

**The Chair (Mr. Kevin Daniel Flynn):** Okay, our next speaker after Simone is Eleanor Baker. Eleanor, if you'd like to come forward and make yourself comfortable. You were here when I explained the rules—

**Ms. Eleanor Baker:** Yes.

**The Chair (Mr. Kevin Daniel Flynn):** —so I don't have to explain them over again. It's all yours. Just relax, pour yourself some water if you'd like, and I'll get the clock going.

**Ms. Eleanor Baker:** Thank you. My name is Eleanor Baker, and I am the mother of a young man with a serious persistent mental illness. He was diagnosed with schizoaffective disorder in 2000, when he was 17 years old.

Feelings of anxiety, stress, guilt, shame, self-blame, fear and anger are often experienced when a family member learns they have a loved one afflicted by mental illness. Life becomes chaotic and unpredictable.

My son had learning disabilities which were identified when he was in grade 1. He always struggled in school and was in special education classes. He was not well integrated in our community schools.

He was seeing an adolescent psychiatrist in the community for motivational counselling, so he was already in the system. Even then, it was so very difficult to get him much-needed help. He was becoming increasingly depressed and was hardly sleeping.

Things were getting much worse at home. He was becoming increasingly agitated, hostile, had marked distortions in his thinking, disturbances in his behaviour and was beginning to experience hallucinations, which were terrifying for him. He was non-compliant with his appointments as well as his medications.

It was after my husband developed a serious cardiac condition that it was recognized that things needed to be done quickly, and a referral was made to the First Episode clinic at CAMH.

Once he was diagnosed, there were still significant issues in commencing the necessary treatment he so desperately required. He was psychotic and didn't believe he was ill, and consequently refused treatment. People who are psychotic often have no insight and are trapped by their illness. They can be allowed to avoid essential care, which may result in lengthy treatment delays. These individuals frequently do not want their family involved. If this is the case, it should not be assumed that the family is not in need of support and education.

He requested that his case be heard by the Consent and Capacity Review Board where I gave testimony. This was the hardest thing that I had ever had to do. I did not want him to be hospitalized and formed, but he urgently required medical treatment to begin on his road to recovery, and I became his substitute decision-maker. This experience demonstrates the importance of having families actively involved as partners in care to provide vital information when critical treatment decisions are being made.

When he was discharged home six weeks later, and my husband was recovering from cardiac surgery at the same time, I realized that I desperately needed support. I

required this so I could cope and subsequently support my son in his recovery. I didn't know where to turn and was shocked by how cumbersome this process was.

His case manager felt that it was a conflict of interest to provide support to me, because my son felt that he was well and everything would be fine as long as the mental health system and everybody in it would just simply leave him alone.

**1630**

After many attempts and multiple inquiries, things finally turned around. I was invited to participate in a focus group which was sponsored by the First Episode clinic at CAMH, to develop and design a community-based program for early intervention clients. Here we discussed the enormous need for family support and education. A family support group was started for First Episodes in Psychosis family members at CAMH. At one of these sessions, a family volunteer from the Schizophrenia Society of Ontario spoke, and I became a member of the organization the following day.

SSO has truly been my lifeline over the last several years. SSO strives to improve the quality of life for those affected by schizophrenia and psychosis through education, support programs, public policy and research. They also work co-operatively with organizations for allied disorders. They support, educate, engage and empower families.

Advocating on behalf of people affected by schizophrenia is an important part of SSO's work. The number of people in the justice system with mental health and addiction issues is increasing annually. The justice and mental health program was developed at SSO a few years ago to support the families of people with mental illness who have come in contact with the law, while promoting change in mental health and justice.

My son was admitted to CAMH once again three years ago, after he stopped taking his medications and became ill once again. He was formed, his case was taken to the Consent and Capacity Review Board, and once again I testified. He was in hospital for three months, until he was stabilized. He now continues to be compliant and is presently taking a college-level course once a week.

Last year he had the best three months since he became ill, when he had a job placement at a bank. This was the result of vocational support, which is an imperative part of the recovery process. Unfortunately, this placement came to an end because he was no longer able to work when he developed involuntary movements due to side effects of his medication.

I now dedicate a fair bit of time to volunteering, helping other families and also providing a voice for families in the mental health and addictions system. I am actively involved in family education programs and facilitate peer support groups for families at the Schizophrenia Society of Ontario. I am co-chair of the Toronto region chapter leadership committee of SSO.

I am a family member on the Ontario Working Group for Early Psychosis Intervention. The group is made up of individuals and organizations that share the goal of developing an effective treatment and support system for the early stages of psychosis. The working group is focused on bringing the benefits of early treatment to all citizens of Ontario who experience the onset of psychosis, and on providing support to their families.

I am also a member of the Toronto Central LHIN mental health and addictions family advisory working group, as well as the family member on the Toronto Central LHIN mental health and addictions steering committee.

I do this work because, as a result of my experiences, I firmly believe that it is of vital importance to have families involved as partners in care. I am providing two documents for all of you which support this.

I would like to mention some of the things that I feel should be included in Ontario's provincial mental health and addictions strategy.

There needs to be in-service training in all levels of the school system so that teachers and auxiliary staff can recognize when a student has a mental health issue, and they know when and how to communicate this very sensitive subject to families.

There should be more in-service training in mental health and addiction for family physicians and pediatricians so they can make referrals to first-episode programs or other appropriate programs in a timely manner.

There should to be trained professionals, specializing in family work, to work with families to support them through all phases of the illness. Supports for the family, as well as for the client, change in focus as recovery progresses. Structured family support should be incorporated into the recovery plan of the individual from the beginning, and it should become a formalized component of working with clients who have a mental health and addiction issue.

The needs of francophone, aboriginal, and ethnic minorities must be considered and supported.

There is an urgent need for increased support to family and consumer organizations. Existing and new consumer and family organizations require funding at an annual and sustainable level.

I would like to sincerely thank all of the committee members for your dedication and hard work in the process of improving the mental health and addictions strategy in Ontario for all of its citizens, and for the opportunity of speaking to you today.

**The Chair (Mr. Kevin Daniel Flynn):** That's great, Eleanor. Thank you very much. You've left lots of time for questions. Michael, do you have a short one?

**Mr. Michael Prue:** I'm sorry, I didn't have a chance—I apologize. I just came in, so I'll pass it to my colleagues.

**The Chair (Mr. Kevin Daniel Flynn):** Anybody on this side have a question? Helena?

**Ms. Helena Jaczek:** Thank you very much. I think you've really summarized very well for us what we've been hearing over and over again. The issue you described around early recognition I think we're very

conscious of; also, the fact that family doctors quite often don't have the expertise to assist and recognize and make appropriate referrals and so on. We've also heard a lot about housing and that kind of issue, as well as the job and vocational training.

I may have missed it, but could you describe what's happening with your son at this point?

**Ms. Eleanor Baker:** My son lives in our home. He's 26 and he is living with us.

**Ms. Helena Jaczek:** So this is something you haven't had to face—

**Ms. Eleanor Baker:** I haven't, and that was the main reason why I didn't address it, although I do have a great deal of knowledge of this from the families that we've spoken to at SSO and through my work on the Toronto Central LHIN.

**Ms. Helena Jaczek:** And do you have any particular recommendations around what type of housing or—

**Ms. Eleanor Baker:** More affordable housing units that have support for these types of individuals.

**Ms. Helena Jaczek:** Peer support—have you had any experience there?

**Ms. Eleanor Baker:** Peer support, yes. Actually, I do—well, peer-family support, and there is peer support also that is being done now for consumers at the Schizophrenia Society of Ontario.

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

**Ms. Sylvia Jones:** Thank you, Eleanor. You made reference to vocational support. It's not an area that we have talked a great deal about or had a lot of presentations on. I wonder if you could expand on who was doing that vocational support with your son and how the process went.

**Ms. Eleanor Baker:** My son's case manager that he's now seeing because he's no longer first episode. He's now being seen at a continuing-care facility, Spectrum, out on the Danforth, which is under CAMH's umbrella.

But there is also a lot of vocational work that is being done by LEARN. I'm not sure if you're familiar with LEARN. It's also part of CAMH. It's located on St. Clair Avenue West at Oakwood. They deal with education and advocacy, and students who have not been able to finish high school have the opportunity to do so there.

When there isn't vocational support, my son would go for jobs and would get hired, but what constantly would happen is he could be easily distracted and he would be let go because it was often said that he was too slow. This was devastating. It makes things even worse and it makes it so difficult to move on with recovery.

When I mentioned those three months that he was at the bank—the other thing is, sorry to backtrack, a lot of these jobs for these young people are very menial tasks. When he was at the bank, his self-esteem was just right up there. He was respected there and he felt so good and told all our friends and family that he was working for the bank. It's the best he has been.

**Ms. Sylvia Jones:** So the vocational support was through CAMH?

**Ms. Eleanor Baker:** Yes.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Eleanor. Christine, a brief question?

**Mrs. Christine Elliott:** Thank you very much for being here today and for the terrific advocacy and volunteer work that you do. It's very time-consuming and obviously you've got a real passion for it.

If you could comment a little bit more on your experience with the Consent and Capacity Board, we have been hearing from a lot of parents about the problems that they have in accessing treatment for their children in situations where their children actively don't recognize that they're ill and don't want to be treated. You mentioned that you became your son's substitute decision-maker. My understanding is that's a very difficult thing to achieve. Could you maybe comment on how that process was for you?

**1640**

**Ms. Eleanor Baker:** The reason why this was done is because the form was upheld. He was actively psychotic at the time. I didn't want to testify but I was encouraged to do so because it would help to get him the treatment that he needed. As I said before, it was the most difficult thing, as a mother, I've had to do.

Because the form was upheld, and my husband was ill at the time, I became the substitute decision-maker and treatment was commenced.

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

## FRONTLINE PARTNERS WITH YOUTH NETWORK

**The Chair (Mr. Kevin Daniel Flynn):** Our next delegation this afternoon is Frontline Partners with Youth Network. Is Jenny Katz with us? Make yourself comfortable, Jenny, and introduce your colleague.

**Ms. Jenny Katz:** Thank you. I'm here with Neemarie Alam, who is also from Frontline Partners with Youth Network.

**The Chair (Mr. Kevin Daniel Flynn):** Wonderful. Make yourself at home there. You have 15 minutes, like everybody else. Use that any way you see fit. If there's any time at the end, we'll see if we can share it amongst everybody.

**Ms. Jenny Katz:** Thank you. I think we're kind of hoping for a bit of a conversation, actually, so I can speak at length but I'm going to try not to and really invite questions and discussion.

I believe we're bringing a perspective that you might not have heard before. I'm here today, and I don't know if Neemarie might—she'll jump in at any point. We're used to interrupting each other.

I'm here today because I could not be here if something like this was happening two years ago. I was an employee at a children's mental health centre. In fact, I've worked at a lot of different children's mental health centres, as well as—oh, am I too loud?

**The Chair (Mr. Kevin Daniel Flynn):** When you get too close to the microphones, they tend to feed back. Just stay about a foot away and you'll be great.

**Ms. Jenny Katz:** Okay. The reason why I can be here today is because I quit my job. I quit my job because I wanted to be able to do a level of speaking that I wasn't able to do when I was employed in the systems.

There are a lot of front-line workers who have excellent things to say about how things could be changed, but they're not able to speak for fear of losing their jobs. These are front-line workers working in all different kinds of organizations, including a lot of provincial transfer payment organizations.

That is partially why I want to leave a lot of time for discussions, because we are going to bring a perspective that you might not otherwise have access to, because front-line workers cannot speak freely.

The reason why we started as a network is because we were losing so many young people to gun violence in Toronto. Front-line workers are dealing with grief and trauma and are losing young people that they're working with. Additionally, they're losing family members and community members, because front-line workers live in communities and work in communities as well.

Front-line workers, many of whom are dealing with their own historical trauma, their own current trauma and grief, aren't able to access support through their organizations and are starting to come together to meet with each other in order to get that kind of support.

But what has been recognized, in terms of getting that support, is that there are systemic issues that are contributing—oh, I keep moving closer and closer to the mike; I'm so excited—to violence and particularly youth violence in the GTA, and we're very concerned about that.

Our loyalty is generally with young people and families and communities, and sometimes we're asked to split our loyalty between our organizations and the communities that we're working in.

I invite you to look at our fancy handout that we brought. We got a little excited with text boxes.

I guess something that might illustrate some of the points that are in our paper is that for the last position that I held—and I just want to say that I was a clinical therapist. I went back to school and I became a clinical therapist working with young people who were mandated to see me through the court system for anger management issues.

These were young people who all had assault charges, and every single one of them had histories of trauma. Many of them had nowhere to live. And I was supposed to be doing anger management counselling with them.

I ended up focusing on working with young women with assault charges. Many of them were mothers. Many of them were soon to become mothers, I would later find out, but they were there to see me for anger management.

So there's a real disconnect, because what we know in best practice is that you do not treat trauma when people are in the throes of it. People need stability and security in order to start looking at these things.

That put me in an ethical dilemma: Why am I doing anger management with young people who have every right to be angry? And the other question was—actually, I'm just going to ask Neemarie if she wants to jump in, because I know she probably does. Does she need this turned on in any way or does it—oh, it just happens magically.

*Interjection.*

**Ms. Jenny Katz:** You don't? Oh, okay. So I'll just keep talking.

The other issue that we were seeing was that the young people who were mandated to see us would never have otherwise entered the children's mental health system, yet all of them had had experiences of trauma.

The children's mental health system is—basically, if we look at a lot of the executive directors and senior management in these organizations, they're mostly white. In fact, they're almost all white in Toronto. But when we look at the young people who are coming in through the system, who are mandated to be there, they're often not. So the services are not reflecting the needs of the young people who are there, and are framing problems in a particular way that doesn't connect with a lot of young people and their families.

This brings us to the first page of our handout, which is "Stress, Trauma and Unequal Distribution of Wealth." I'm not sure about the other presentations that you've heard here, but the social determinants of health are a very useful way of understanding mental health and addictions. And there's growing research that shows if we do not address housing and access to good recreation, if we don't address education, if we don't address the unequal distribution of wealth, then we will see a growing number of young people in jails, in hospitals and in our children's mental health centres, which are really expensive, by the way.

I would encourage everybody to get behind any kind of poverty reduction strategies. I would also encourage people to learn about the social determinants of health.

I'm going to back up for a minute and quickly say who Frontline Partners with Youth Network is, because I got really excited and I realize that I didn't actually explain who we are. Frontline Partners with Youth Network is a network that is comprised of people working with youth across the city of Toronto. They don't represent their organizations; they represent themselves as people. There are over a thousand people involved in our network and they touch hundreds of families—well, actually, thousands of families. We interact with them through social networking websites, through our own website, through newsletters, through our listserv and through several activities. We offer free training that no one else will offer and we offer support that no one else will offer to front-line workers, recognizing that they are dealing with overwhelming stress and they can't necessarily do anything about it because their employers, who do their performance evaluations, can't hear about it.

I think I'm going to stop and see if there are any questions, based on all the stuff that I just said. There's a lot more but I'm just going to see if there is anything else.

**The Chair (Mr. Kevin Daniel Flynn):** Well, you've left about six minutes, so that's a couple of minutes for each party. Let's start on this side. Maria, Jeff, Helena, Bas? Anybody on the—Liz?

**1650**

**Mrs. Liz Sandals:** Yes, I'm curious about how the group that you've got—is it just an informal support group, or are you funded somehow? You said that you had quit your job as a front-line worker to work with the group. Are all of the people who work with the group in that situation, or are you the unusual leader?

**Ms. Jenny Katz:** I'm definitely an unusual leader. We work non-hierarchically. So, yes, I'm an unusual leader. Actually, Neemarie is the only other person who is working with us full-time. We have a lot of part-time workers; we're doing focus groups to look at male youth workers in particular, and their experiences around grief and trauma. We're using our informal networks to do that, but we do have a listserv of over 1,000 front-line workers whom we connect with regularly. We have some part-time staff and we have a number of volunteers. We have a stewardship group of front-line workers who represent the entire city.

I think Neemarie wants to add something to that.

**Ms. Neemarie Alam:** We're funded by CHEO through the provincial centre of excellence in mental health; we also receive Laidlaw funding and we've recently gotten a grant from the city of Toronto through their social development investment program to fund me to come on to support the infrastructure and capacity-building. So, similar to Jenny, I started out as a youth worker in a children's mental health agency and kept struggling because there was just so much work to be done. The expectation was that you'd be everybody for everybody all the time, and there was no support system to sustain that. It became so unsustainable that I had to leave, and I started here.

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

**Ms. Sylvia Jones:** First a quick question and then a follow-up: You mentioned that you have about 1,000 workers in your network—

**Ms. Neemarie Alam:** Yes.

**Ms. Sylvia Jones:** Sorry, I may have missed it. Is it province-wide or GTA?

**Ms. Jenny Katz:** It's Toronto, and now we're expanding into Peel, although someone heard of us in Montreal, which was kind of odd. I'm also a part of the Sparrow Lake Alliance, which is a province-wide initiative. We sit at some policy tables trying to represent the truths of the front lines that don't otherwise get heard.

**Ms. Sylvia Jones:** I want to ask you more questions regarding the recommendation on the last page: "Develop a mechanism to engage with front-line workers from across sectors so that they safely share their knowledge about what is and what is not working...." I'm interested in having a little more in-depth on that. It's something that comes up a lot with families in particular, particularly as they transition out of the post-18-year-old. Can you talk about how that recommendation came about?

**Ms. Neemarie Alam:** The recommendation, to my understanding of it, came about because youth work itself is really nebulous; it's kind of undefined, and there are these small subsectors that people are employed into, so it's arts or it's recreation or it's mental health. But what happens is, because you're working front-line and you develop these really strong, trusting relationships with young people, they come to you with more than just arts or recreation or mental health issues, and most organizations don't support their front-line workers supporting young people in accessing services in these other areas.

**Ms. Sylvia Jones:** But is that a privacy issue that they're running into or is it just, "We deal with this and we don't want to talk about anything more than what's in this box"?

**Ms. Neemarie Alam:** It's about trying to get as many referrals as possible; it's about just rotating people out as quickly as possible because it influences funding and it influences statistics. Unfortunately, our organizational systems are not set up to sustain trusting relationships with young people. So young people who have had this long history of not trusting people finally start to trust somebody who's a worker but can't utilize them completely for all the resources that they may be able to offer.

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

**M^me^ France Gélinas:** Do you see your model as something that could be repeated elsewhere?

**Ms Jenny Katz:** Yes. In fact I've met with front-line workers from other sectors, particularly around the homeless sector, as well as people working with seniors and people working with small children. All front-line workers seem to feel like they're silenced when they want to talk about what's going wrong in the systems, and that they can't offer their truths because it will compromise the funding to their organizations. It's a massive problem.

**Ms. Neemarie Alam:** It translates to guilt and carries over.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you very much for coming today. Great presentation. You got a question from each of the parties in; wonderful.

**Ms Jenny Katz:** Thank you, and our contact information is on the back.

**Ms. Neemarie Alam:** Thank you for having us.

**The Chair (Mr. Kevin Daniel Flynn):** Our pleasure.

## FETAL ALCOHOL SPECTRUM DISORDERS STAKEHOLDERS FOR ONTARIO

**The Chair (Mr. Kevin Daniel Flynn):** Our next speaker today is from the Fetal Alcohol Spectrum Disorder Stakeholders for Ontario: Sheila Burns, the

chair, and Valerie Temple, the lead with the diagnostic working group. If you'd like to come forward, make yourselves comfortable. I think you were here at the start of the meeting, so you know what the rules are.

**Ms. Sheila Burns:** We do.

**The Chair (Mr. Kevin Daniel Flynn):** The time is all yours.

**Ms. Sheila Burns:** Hi. It's a pleasure to be here, and an honour to speak to the committee today to identify issues and opportunities that can address some of the systemic challenges associated with mental health and addictions in Ontario.

**The Chair (Mr. Kevin Daniel Flynn):** I'm assuming you're Sheila, are you?

**Ms. Sheila Burns:** I am. My name is on the next line.

**The Chair (Mr. Kevin Daniel Flynn):** If you would just identify yourself for Hansard, these folks have to get down everything you say, and then perhaps, Valerie, when you start speaking you could identify yourself too.

**Dr. Valerie Temple:** I will indeed.

**Ms. Sheila Burns:** My name is Sheila Burns, and I chair the FASD Stakeholders for Ontario, a volunteer collaborative of researchers, agency staff, specialists and parents who are advancing awareness regarding the needs of individuals with FASD and addressing the prevention issues for this neurological disorder. We focus on five areas, including diagnostic capacity, justice issues, prevention, intervention and support, and urban aboriginal. Our aim is to inform the government and the service sector about FASD so service provision can begin to more effectively accommodate those living with the disability.

**Dr. Valerie Temple:** Good afternoon. My name is Valerie Temple. I'm a psychologist. I'm also the co-lead on the Ontario stakeholders' diagnostic working group and I'm the clinical lead of the Surrey Place Centre adult diagnostic clinic. Our Surrey Place clinic is the first clinic in Ontario that's focusing specifically on diagnosis and intervention for adults.

I am aware that others have made presentations to the committee regarding FASD and its impact. I don't want to duplicate their presentations, but a quick recap: Fetal alcohol spectrum disorder is a disability caused by prenatal exposure to alcohol. Alcohol primarily impacts fetal brain development by causing cell death, dehydration and impairment in multiple areas of the brain. The degree of impairment depends on dosage, timing, and maternal and fetal factors. FASD occurs in 1% of the population, according to Health Canada, meaning it affects approximately 130,000 Ontarians.

You have heard that individuals with FASD are heavy users of services in Ontario, with high rates of mental illness, addictions, school failure, homelessness, unemployment, conflict with the law and having children they cannot care for.

The rates of failure are not intrinsic to the disability but reflect the absence of care that individuals require. Our lack of knowledge of FASD has not been benign. It has resulted in some of the trauma that underlies the exceptionally poor outcomes. It is exacerbated by the fact that few, if any, services are set up to accommodate the addiction and mental health treatment needs of this highly vulnerable population. Yet there is no plan to address this underlying disability that implicates so many services in Ontario.

We know that there are high rates of mental illness in youth with FASD, and studies indicate that at least one quarter of youth in custody have the disability. Two studies, one cited to this committee by Judy Kay from Sioux Lookout, and another by the Children's Aid Society of Toronto, show that more than 50% of crown wards have FASD or prenatal alcohol exposure and the behaviour phenotype indicating the disability. These studies reflect other findings that indicate that 80% of children with FASD are not raised by their biological parents.

**1700**

This year's Ministry of Community and Youth Services' Results-based Plan Briefing Book shows that more than $500 million were invested in mental health services, allocated to 260 agencies and 17 hospital programs. In spite of this investment, 25% of the children didn't show improved functioning at exit. The report also highlights recidivism rates for youth in trouble with the law. While there will be a review of practices, the current system offers 69% and 35% recidivism rates for youth in closed custody and community-based programs, respectively.

Without examining the role of brain-based impairments and problematic behaviour within these service delivery systems, we will invest funds in programs that are ineffective for at least one quarter of children and youth in crisis. I suggest that captured in the failure rates are the children with FASD. We are missing a critical opportunity in addressing the special needs of these troubled children. We are missing a vital opportunity to assess and then provide supports that can best meet their developmental, learning and social challenges. We are also failing to provide the information, training and support to adoptive, foster and kinship families.

You have heard from parents who have struggled to find the genesis of their children's challenges and then programs to meet their needs. You have heard from service providers who are struggling under the weight of growing demands for service and the need for funding. You have heard about small FASD initiatives that are trying to bridge the gap to bring information to community services so they are more effective.

We know that we can prevent some of the mental health issues, substance use and poor outcomes associated with FASD. Research indicates that outcomes significantly improve with six factors: early diagnosis, a stable and nurturing home life, not being a victim of abuse, absence of witnessing abuse, appropriate education and mental health services, and access to developmental services. These factors help define the next step, the action items needed by the province and our service delivery system to begin to address the needs of this

vulnerable group: individuals who make up a significant portion of the systems' users and clients, those whom the system is failing to serve in spite of the allocation of significant resources and the best intentions.

During discussions in the 1990s there was debate whether we should diagnose a disability for which there was no cure or treatment and one that implicated the mother so explicitly. By avoiding defining the problem, it would only grow, and no solution would ever be found. The Stakeholders has worked towards defining the problems and exploring solutions through the advancement of awareness, diagnosis, care support, and prevention of FASD.

**Dr. Valerie Temple:** I'm going to talk to you a little bit about diagnosis. Diagnosis of FASD is not a matter of a simple blood test or a CT scan, although these things might be part of the process. It's not like Down's syndrome, where there's a chromosomal abnormality that you can locate. Diagnosis of FASD requires a medical physical examination, a cognitive and skills assessment, and investigation of prenatal and medical and psychiatric history. It requires a team of clinicians, all with specialized training in FASD. In many regions of our province it's a great challenge to bring together the multi-disciplinary team necessary to make a diagnosis of FASD.

Diagnosis also takes a great deal of time, and the fact that there is no OHIP billing code for FASD diagnosis presents a significant challenge for physicians, as their time isn't recognized and it's not captured in the broader context of the medical system.

In addition to challenges, however, we also have opportunities—opportunities to recognize and utilize the resources already available to us across the province. Multi-disciplinary mental health teams do exist in many regions, and training these existing teams to identify and diagnose FASD would be a very valuable first step.

We're beginning to know what to do to address the complex needs of this significant subpopulation who are heavier users of the system, are at high risk of mental health and addictions and who have thus far had their needs unmet. We know that people with FASD often receive a variety of mental health diagnoses across their lifespan. Attention-deficit disorders, conduct disorders, borderline personality, post-traumatic stress and psychosis are a few of the very common ones.

Although there are effective treatments for these disorders through existing mental health systems, for people with FASD, treatment using traditional means is often ineffective. Clinicians working in this field will tell you that individuals with a brain injury such as FASD require specialized interventions and accommodations in order to be successful. Sending people with FASD, over and over, to traditional interventions leads to a sense of failure for the individual, frustration for the service provider and despair for the family. And it wastes valuable resources by applying interventions and treatments that we already know are unlikely to be effective. That is why increasing access to accurate diagnosis, coupled with education, is key.

We know the types of interventions that work in FASD. We know that environmental changes and supports, educating staff, support workers and teachers, and comprehensive long-term support plans are what are needed.

**Ms. Sheila Burns** I wanted to talk a little bit about prevention. Prevention strategies need to resonate with the general population who just need information regarding the impact of alcohol on the developing fetus. Women need to know they should avoid pregnancy if they drink alcohol. Fetal alcohol spectrum disorder can be prevented. But there is a population of women who are alcohol-dependent. These women need specialized supports to cope with the complex issues in their lives. Toronto's Breaking the Cycle program is geared to help these women. A dozen agencies collaborate to bring the supports and services vulnerable women need to enhance their ability to deal with drug and alcohol dependency, to address trauma and abuse, to stabilize their lives and to learn good parenting skills. We know that if we support this group of women, we can reduce the incidence of FASD and provide early intervention programming for their affected children.

Breaking the Cycle also identified a group of women who themselves have FASD, who stumbled through their lives having experienced failure, trauma, abuse and mental illness, and an undiagnosed disability. Those women need the supports offered other adults with developmental disabilities. Both men and women with FASD need access to supportive housing, employment and daily living so they can contribute to their community to their fullest capacity. They need a lifetime of support and a continuum of care.

Bill 77, the act to provide services to persons with developmental disabilities, offers an opportunity to address the needs of these vulnerable adults. It adds executive and adaptive functioning impairments to the criteria for accessing services. A flexible service provision will assist individuals to work, parent and live with respect and dignity.

In a recent study, FASD is estimated to cost Canadians $5.3 billion annually. In Ontario, we would see huge savings and efficiencies if we ensured that the services these individuals receive were appropriate to their disability and weren't contributing to the problem. With awareness, diagnosis and training, we can begin to align services more appropriately and see better outcomes.

Ontario is the only province that does not have government staff assigned to this issue. The western provinces and territories have worked together for years exploring facets of the disability, providing training opportunities, conducting research and defining and advancing best practices. Ontario is not at that table, which leaves no one to ensure appropriate service provision for the 130,000 individuals in this province with FASD, nor is there a strategy to reduce the incidence rate. We need ministry and government leadership in a collaborative approach, as is demonstrated by this standing committee, to take the lead on this issue. It requires more than the dedication of a few dozen volunteers across the province.

Those with FASD are heavy users of our system's mental health and addiction services. They do not have to be: Appropriate services. Thank you very much.

**1710**

**The Chair (Mr. Kevin Daniel Flynn):** Thank you for a very good presentation. Unfortunately, there's no time for questions and answers, but I think you did a very good job.

It's interesting. I just wanted to point out a thing that I think that most of the committee members would have heard: that if you become pregnant, you should avoid alcohol. What you're saying here is that if you drink alcohol, avoid pregnancy, which is turning it around a little bit.

**Ms. Sheila Burns:** And I think that's a really valid point. I think we do have to look at this differently; that so many women drink and so few—only 50% of women—plan their pregnancies. So the risk of overlap and early complication exists, and that leaves women to worry. I think that if we look at it through a different lens, we can effect change.

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

## CARITAS

**The Chair (Mr. Kevin Daniel Flynn):** Okay, our next presentation today is from an organization, Caritas. Elio Sergnese?

**Mr. Elio Sergnese:** Good enough, sure.

**The Chair (Mr. Kevin Daniel Flynn):** The executive director. You've brought somebody with you today; if you would introduce that person and make yourself comfortable. I believe you've been here since the start of the meeting, so you know what the rules are.

**Mr. Elio Sergnese:** Actually, I didn't, but I think I have 15 minutes.

**The Chair (Mr. Kevin Daniel Flynn):** Yes, 15 minutes. Use it any way you see fit. If you can leave some time at the end for questions, that would be great as well.

**Mr. Elio Sergnese:** Okay. Good afternoon, everyone, and thank you for the opportunity to make this presentation. My name is Elio Sergnese, and I'm the executive director of the Caritas Project, a therapeutic community here in Toronto. This is my colleague Dr. Norma de Castro, and she is our mental health specialist.

I'd like to start by giving a very brief overview of what Caritas does and then move on to more general themes, including what needs exist in the sector, what is working and should be expanded upon, how service providers can be coordinating with other sectors, and the role of the justice system. I'll leave about half my time for questions.

Caritas is a registered charity with over 20 years of experience rehabilitating clients who have the most challenging problems. Our 25-month program is the only one of its kind in Canada, and we have served clients from all over the country. For many of the men we serve, our care is the last chance they have of leading healthy lives. Residential clients start at our therapeutic community in Toronto and, when they're ready, they move to the next phase of the program at the farm in King City. Unlike typical relocation programs, ours takes a holistic approach, addressing the physical, mental, spiritual, social, emotional and vocational needs of clients in a family-like environment.

Our funding is broken down fairly evenly from three sources: We have client fees, the Ministry of Health and some very successful fundraising programs. Our operating budget is $1.6 million. We also offer weekly family support groups, and we do prevention in schools. As I'm sure you are all aware, there are many needs in the system, not the least of which is more money, but I'd like to focus on a few specific items we've identified over two decades.

By far the most crucial need is for more semi-independent long-term housing for clients who have completed our program, and what I mean by this is a place where clients can live mostly independently but under the caring supervision of doctors, social workers and, in some cases, parole officers. This is especially important for seniors who are not ready for a retirement home. Oftentimes, clients will graduate from a program and then end up in an environment that is not good for them, where they are not taking their medication or where they have no support system. Often, this includes unhealthy family situations. There is a program in Toronto called Reconnect that does some work like this, but they are overwhelmed, and in at least one case they were forced to place a client in an apartment across town and away from existing support networks. If there is only one suggestion I can make, it is that the government provide more post-program housing.

Another important need is for additional employment and training services in general—and certain clients, especially those with mental health issues, require specialized placements. Naturally, we want clients to reintegrate into society after they defeat their addictions, and this is made much easier if they are able to find work or upgrade their education. We have a teacher come to our site a few times a week, but this is not enough.

There is a service in Toronto called Fresh Start that only hires clients with mental health issues to do cleaning. This is great for the clients, because it takes away the stress of wondering whether they are going to be fired. If they miss a day, for example, they won't be let go. The employer understands and there are special circumstances here.

Youth have special needs in that they require assessment and intervention as early as possible. An untreated mental disorder in a young person can quickly become severe at a young age. Serving ethnic minorities sometimes poses a challenge. Often, family members from outside of Canada do not understand mental health issues or what we are trying to do. In one case I dealt with, the client's mental health issue was seen to be shameful and being in our program was seen as a punishment. Lan-

guage barriers also crop up and can be averted by making translators readily available for use.

Lastly, on the topic of needs, emergency room staff have become more sensitive to the needs of mental health patients, but there is still room for improvement.

What works when it comes to treating mental health and addictions? It's important to avoid the typical institutionalization where everyone is confined to their rooms. Caritas has tried to create a sense of family within the program, which has been highly successful. Giving everyone a role and a purpose helps us do our work, but it also gives clients life skills that they can use after they leave us. However, this kind of a support network should be made available or replicated post-program. For many of our guys, the reason they got into drugs in the first place was because they didn't have somewhere they felt they belonged.

The next thing I want to talk about is how to improve coordination between service providers like Caritas and other sectors or actors. Agencies should develop strong relationships with GPs and psychiatrists. Many clients, when they go to see their doctors, report that everything is fine and that they don't need help—or, more specifically, their medication.

In these cases it would be helpful for the doctors to come to us and say, "Are there any problems you've been noticing?", and so on. Strong communication with service providers can give doctors context and history, ultimately allowing the doctor to better help the patient.

There's also a strong need for building relationships with groups that provide employment, apprenticeship training and education. A volunteer of ours has been in contact with Employment Ontario for several months now seeking support for our clients, but we have had little success.

The last topic I'd like to discuss is the role of the justice system. For the most part, those in the system have accepted that treatment is superior to punishment when it comes to mental health and/or addictions. Probation officers can provide us a lot of support as long as they share this belief. They can reinforce for some of our more troubled clients that if they don't want to be in our program, the only other alternative may be jail. Probation officers, like psychiatrists, need a better understanding of what service providers like Caritas are trying to do. There is a great potential for all parties to work together as long as professional boundaries are accepted and respected.

Thank you for being here today and listening to what health providers have to say. I'll leave you with one thought before I open it up to questions. In Ontario, we attempt to ensure that those in wheelchairs have the same access to things that the rest of society enjoys. Mental health and substance abuse sufferers deserve the same treatment. If we do not give them the skills and support they need to feel part of a community, we are simply fuelling whatever mental health issues exist.

Thank you again, and I look forward to your questions.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Elio, for your presentation.

Christine or Sylvia, we've got about seven minutes, or about three minutes each.

**Mrs. Christine Elliott:** Thank you very much for your presentation today. I'd like to just ask you some questions regarding the justice system, if I could, because we've certainly heard the frustration of many families, in particular, about accessing assistance for their family member who may have a problem with mental illness but they refuse treatment or they don't have the insight to recognize that there are problems. Do you have any specific recommendations around possible solutions to that dilemma?

**Dr. Norma de Castro:** Yes, some, because quite a few of our residents come from jail, and they are the most difficult people to deal with in the first five months because of their anger—coming from the jail, and their mentality. They have some kind of jail mentality, so it's very hard for them to even agree and co-operate with our rules and regulations.

**1720**

So what can I suggest? What I have been doing since being in mental health is, I deal with the residents quite a bit. I have a group with them dealing with their own issues, not so much with the addiction per se, or mental illness, but just adjusting to the environment. That's the first approach before they can become collaborative with it, whatever we do in the program. Is that what you're asking?

**Mrs. Christine Elliott:** I guess I'm just wondering if there's someone that—often families say, "I can't get my family member into any kind of treatment program because they don't think that there's a problem." There seem to be many impediments to getting assistance for someone. Of course, we're talking about balancing people's civil rights and civil liberties against the clear need for treatment, at least in the eyes of the family. We're really interested in any suggestions you might be able to offer us to how we can deal with that.

**Dr. Norma de Castro:** What has happened in our situation is that if the family understands the whole condition—we give a lot of support to the family, number one. That's very important. Once the family understands our motive or our philosophy about the program, they become very stern and firm in telling their sons or their daughters, "You need to go into the program or you are on your own." So, there, the family poses a threat to them: "You cannot come home unless you go into the program."

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

**M^me^ France Gélinas:** I'm sorry, I missed part of the presentation, but I'm curious to see: How many clients can you accommodate at once?

**Mr. Elio Sergnese:** We have the capacity to hold 50 people right now.

**M^me^ France Gélinas:** And this is in your Toronto and your King City—

**Mr. Elio Sergnese:** A combination of the two; that's correct.

**M^me^ France Gélinas:** The combination of the two. And do most of your clients stay the full 25 months with you?

**Dr. Norma de Castro:** Some 95%.

**M^me^ France Gélinas:** They will stay for over two years with you?

**Mr. Elio Sergnese:** They don't necessarily agree to doing that in the beginning, but we divide the 25 months up into four phases. We ask that they commit one phase at a time, where the first commitment would be five months. So that gives us five months to explain to them and help them understand why they would need the other 20.

**Dr. Norma de Castro:** And usually the first five months is adjustment to the whole program, and you have to deal with their anger and frustration and so on.

**M^me^ France Gélinas:** And is it solely men?

**Mr. Elio Sergnese:** Yes.

**M^me^ France Gélinas:** And what are your main areas of referral? How do they get to know you exist?

**Mr. Elio Sergnese:** In short, I can tell you: from everywhere. We are the last resort. Nobody wants to do a 25-month program. So when you're desperate, we have referrals coming from doctors; we have referrals coming from the justice system—a lot of people will accept conditional sentences, so instead of going to jail, they'll come to our program for, I believe, it's two years minus a day; schools—we've had schools refer their students to us—rather, students who have been suspended, that is. Where else?

**Dr. Norma de Castro:** We have clients, too, from all over the world. We have one from Russia, from Italy, from France, from Portugal, from the States.

**M^me^ France Gélinas:** Do they all have a serious mental illness?

**Mr. Elio Sergnese:** No, not all of them. It's the combination. We have people who have just strictly addiction problems. Right now, 48% of our population has concurrent disorder—mental health and addiction.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Elio. Any questions? Helena?

**Ms. Helena Jaczek:** Did I hear you right? You have space for 15 or 50?

**Dr. Norma de Castro:** Fifty.

**Ms. Helena Jaczek:** Fifty. How many are in Toronto—King City is in my riding, and I feel very awkward because I've never heard of Caritas.

**Mr. Elio Sergnese:** I hope I didn't cause problems for myself.

**Ms. Helena Jaczek:** How large is—

**Mr. Jeff Leal:** She's coming for a tour this week.

**Ms. Helena Jaczek:** I definitely will be.

How many are in your King township—

**Mr. Elio Sergnese:** In King City, we have 88 acres of land. Unfortunately, our house can only accommodate 16 people.

**Ms. Helena Jaczek:** Sixteen?

**Mr. Elio Sergnese:** Correct.

**Ms. Helena Jaczek:** Is that, by any chance, on Dufferin Street?

**Mr. Elio Sergnese:** On Weston Road.

**Ms. Helena Jaczek:** On Weston Road.

What I actually wanted to ask was: In terms of the ancillary services—Fresh Start and some of the other programs—do you notice a difference between services—accessibility of these services and availability? How does York region compare with Toronto?

**Dr. Norma de Castro:** How does—I'm sorry?

**Ms. Helena Jaczek:** How does York region—you must be referring to programs in York region as opposed to in your Toronto facility, you would be referring to Toronto ancillary services, Fresh Start or any other services. Do you notice a difference?

**Mr. Elio Sergnese:** We've had more success with the Toronto services.

**Ms. Helena Jaczek:** So you're finding some difficulty accessing services in York region?

**Mr. Elio Sergnese:** Accessing; identifying, even, whereas it's easier to identify the services that exist in Toronto, perhaps because they're either larger or there are more of them. While it's always difficult to have access to those services, it's easier to get to the services in Toronto. Transportation is always an issue as well for some of those services.

**Ms. Helena Jaczek:** Could I just follow up? Did your organization purchase the property on Weston Road?

**Mr. Elio Sergnese:** Yes.

**Ms. Helena Jaczek:** I see.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you very much for coming today. Great presentation and great questions. It sounds like you've got a wonderful organization.

**Dr. Norma de Castro:** And we do a lot of school presentations. I believe that this is really the best first step in terms of prevention, as you probably all know. There's a lot of addiction among youth, and we are in great demand to do school presentations in different schools all over.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you for what you do.

## EVA'S INITIATIVES

**The Chair (Mr. Kevin Daniel Flynn):** Our next presenter today is Eva's Initiatives: Maria Crawford. Maria, if you'd like to come forward.

As you're settling yourself, to the committee, I just wanted to talk to you about a few things. One is that the Ontario College of Family Physicians sent a response to the Ministry of Health and Long-Term Care's discussion paper. It's about this thick. I have a copy and I wondered if other members had a copy.

**Ms. Sylvia Jones:** I think you should read it—

**The Chair (Mr. Kevin Daniel Flynn):** I'll read it and tell you what they said?

It literally is about this thick, and everybody else didn't get one so I will give it to the clerk. And there is

an executive summary that's maybe four or five pages. I'll make sure that you each get a copy of that. It looks like it's very well done.

The other thing is, there's a presentation November 3 in Toronto. It's called Making Gains in Mental Health and Addictions, and I'm presenting on behalf of the committee. The staff are going to attend as well, so just so that the other members are aware of that, and if any other member of the committee wants to attend.

**M^me^ France Gélinas:** At what time?

**The Chair (Mr. Kevin Daniel Flynn):** I can get you the details. I think it's an all-day conference.

**M^me^ France Gélinas:** And what time do you present?

**The Chair (Mr. Kevin Daniel Flynn):** It goes from the 2nd to the 4th, but I'll be presenting on what we've done as a group on November 3.

**M^me^ France Gélinas:** Okay. Let us know when you present and we'll go cheer you on.

**The Chair (Mr. Kevin Daniel Flynn):** All right. Apparently I'm on just before Mary Walsh, which is a lot better than following Mary Walsh, I'm sure.

Sorry about that. I just wanted to get some business out of the way while you got settled. Our next presenter, as I said, is Eva's Initiatives. Maria, thank you for coming. If you'd introduce your colleague, you have 15 minutes like everybody else. If you can save a little bit of time at the end for questions, that would be great too.

**Ms. Maria Crawford:** I'd like to start by thanking the honourable members of the select committee for granting us the opportunity to come and speak to you today on behalf of Eva's Initiatives for homeless youth. I'm Maria Crawford; I'm the executive director of the organization. With me today is Sondra Marcon. Sondra works at Eva's Place, one of our three shelter facilities, and she works directly with the young people that we're here to talk to you about today. Just by way of context, there's certainly a more fulsome summary in the package that we've provided, but Eva's Initiatives is a not-for-profit organization that works with homeless and street-involved youth. We operate three shelter facilities in Toronto as well as a wide range of specialized programs and services to assist homeless youth. We accommodate up to 114 youth every night. I'm going to turn it over to Sondra at this point to speak to you specifically about the young people that we work with.

**Ms. Sondra Marcon:** We are speaking to you today to stress the dire need for a youth-specific mental health system, and to highlight the fact that there is no such system existing in Ontario. We have a children and youth mental health system that effectively ends at the age of 16, sometimes 18; and we have an adult mental health system. There's no system in Ontario that deals specifically with youth mental health.

Imagine you're a youth service worker at a homeless youth shelter and you're six hours into an eight-hour shift. You think to yourself, "Things are going well," when suddenly a youth comes running into your office yelling for you to come quickly. As you turn a corner, you see blood coming from under a bathroom door and you hear someone screaming. You reach for your cell phone and dial 911. You try to speak to the youth through the locked door, past his gut-wrenching screams and loud banging on the wall. It seems like forever before the fire department arrives, followed by the police. The police hear the sounds coming from the bathroom and call for backup. Finally, they get the door open and a knife flies out of the hands of an 18-year-old male. A quick-thinking officer kicks it out of the way. The police officers use a taser gun multiple times to subdue the youth. In this situation, the young man I'm telling you about completely severed his penis and one testicle. This is one of many stories we could share with you about youth aged 16 to 24 who reside in our shelters and who are struggling with mental heath and/or addiction issues.

**1730**

In Toronto alone, it's estimated that 10,000 young people are living on the streets. That is anywhere from 1,500 to 2,000 on any given night. An informal survey by the Youth Shelter Interagency Network in Toronto estimates that 40%, or one in four homeless youth in Toronto, are struggling with mental health issues. This estimate is conservative.

Although the minister's report, Every Door is the Right Door, is comprehensive, it's lacking in a key area addressing the issues facing people who are homeless—in particular, homeless youth. As noted in the report, "Ontarians between the ages of 15 and 24 are three times more likely to have a substance use problem than people over age 24." The report also states that youth 15 to 24 are also more likely to experience mood disorders, depression and a first-episode psychosis. These youth are more and more often ending up at emergency shelters with limited supports, unclear diagnoses and exhausted families and caregivers. They are routinely discharged from hospitals to youth shelters with limited discharge planning or support.

Comprehensive mental health services are critical for these 40% of youth involved in Eva's Initiative's programs, and in all shelters across Toronto, who are also suffering from complex mental health issues. These youth experience symptoms and/or diagnoses of depression, bipolar disorder, post-traumatic stress disorder, first-episode psychosis, schizophrenia, attachment and personality disorders, obsessive compulsive disorder, attention deficit disorder, anorexia and bulimia, fetal alcohol syndrome, concurrent disorders, dual diagnosis, body dysmorphic disorder, acquired brain injury, Asperger's, autism and developmental delay, just to name a few.

The shelter system lacks the resources to appropriately respond to these high-risk, high-need youth. With a low number of staff per shift, with limited education and experience, and in addition to working with other shelter youth, these staff must respond to youth with challenging symptom presentations, including high anxiety, withdrawn behaviours, flat affect, inconsistent moods, unprovoked anger outbursts and acts of violence, eating disorders, problematic social skills and boundaries,

paranoia, inappropriate sexual behaviours, self-harm and suicide, and homicidal ideation. The only reliable funding that shelters receive is a per diem rate that, at present, covers only 60% of our operating costs for food and shelter.

Adolescence is the time when most mental health symptoms emerge, and yet the child and youth mental health system will often not intake a youth who is over the age of 16 years. To better serve this population, Ontario needs a youth-specific mental health and addiction system. It is important that this youth-specific system take into account the developmental needs and behaviours of adolescents, as they are key factors in the ability of youth to access and succeed in programs. A youth-specific mental health system must recognize youths' need for autonomy, their risk-taking behaviours and brain development, as well as the unique and unprecedented issues that youth are struggling with today. It is also important to consider the distinct determinants to successfully and productively engage youth in the process.

To better serve these youth, all staff involved in delivering services to this population, including teachers, child and youth workers and hospital staff, should be comprehensively trained and educated on the emergence of mental health in adolescence and the strategies to engage youth in this process.

Homeless youth have more urgent and unique needs, and they come to us because they have nowhere else to go. We were quite taken aback recently when a well-respected psychiatrist commented that youth shelters are fast becoming the new asylums for young people with mental health issues—a shocking statement, but there's a huge degree of truth in that.

Homeless youth access emergency health services more than the general population. The average homeless person has health care costs that are 50% higher than the health care costs of the average Canadian. Increased funding for community-based, youth-focused mental health and addiction programs is necessary to reduce emergency room visits and overuse of hospitals.

These community-based services need to include more youth-specific addiction programs, detox and concurrent disorder programs. Most in-patient addiction facilities have extensive wait-lists and require ongoing contact from the client to ensure interest in participation. This is particularly problematic for homeless youth who are transient. Often youth will relapse and, due to lack of contact as a result of their homelessness, lose their place on the waiting list.

Concurrent disorders are on the rise. A recent study from the Centre for Addiction and Mental Health found that one in five people treated for mental health disorders in Ontario's hospitals and mental health clinics have co-occurring substance use issues. The majority of mental health services that service youth aged 16 to 24 who are also struggling with substance use issues will not provide services until the substance use issue is addressed. This is not realistic or appropriate for most youth.

The image we leave you with of homeless youth with mental health and/or addiction struggles should not be one of self-mutilation. We should not have to share with you that this young man's story ends with his body being found in Lake Ontario two weeks ago—he committed suicide—that the lack of support and housing had contributed to his death. Unfortunately, this young man's experience is not unique. We have had a number of young people take their lives as a result of not being able to access the services and supports they require. In a province like Ontario, this is a tragic disgrace.

The image should be one in which youth are given the right opportunities and supports: help and guidance in transitioning from the shelter system; assistance in reconnecting with families and developing systems of support; job training and employment opportunities; and most of all, are healthy and actively engaged in their own recovery. All of this can be achieved with a youth-focused mental health and addiction system.

Until such a system is in place, we believe it's imperative that shelters for homeless youth receive funding for vital services they provide in attempting to address the increasing number of youth with mental health issues who end up in the shelter system. These services can be provided via the shelter system in a much more cost-effective manner than if attached to larger public institutions and can provide more appropriate and accessible services to these vulnerable citizens. We have developed a model and a specific funding proposal which is currently resting with the Minister of Health, but have had no response to date.

We thank you for your time, for hearing us today and for your thoughtful deliberations on this pressing issue.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you for your presentation. We've got time for probably one quick question and answer, starting with France.

**M^me^ France Gélinas:** So would you see mental health, addiction, all of the services like employment services, support services and transitional housing being for this age category?

**Ms. Sondra Marcon:** Yes—I mean, ideally. The age category has such a unique set of needs that aren't being met in either the adult or the child system, so it would be about creating a specific system that meets the needs of these youth. A 21-year old going into the adult system doesn't necessarily have the same needs as a 60-year old in the adult system, and often they're sitting in a room with a bunch of 40-, 50- and 60-year-olds, at 21, being expected to access services in transitional housing, in group facilities, in all of those places. It just doesn't fit who they are or what they're about.

**M^me^ France Gélinas:** Very good. Thank you.

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

**Mrs. Liz Sandals:** We've heard in lots of places about the gaps, particularly at this transitional age, but not so much, perhaps, from the point of view that you're bringing to us, which is the homeless youth—the kids who just haven't accessed services anywhere. Are the kids you're seeing in Toronto shelters Toronto kids, or are you seeing them from all over the province? I'm just wondering, are you the collection point for the province?

**Ms. Sondra Marcon:** Yes. I would say we see youth from all over. And some of the youth in our shelters do access services; they just haven't been effective for them.

**Mrs. Liz Sandals:** And that was actually my next question: Is the problem sometimes that the young person has chosen not to access services—because that's often what you get with mental health or addiction—or is it that there were no services to access?

**1740**

**Ms. Sondra Marcon:** I think it's a little of both. It's challenging for youth to access services, and walking into a big institution is challenging for any youth to do without support. But it's also the fact that wait-lists are eight, nine, 10 months long, and when you're dealing with homeless youth who access the homeless shelter—and they're bouncing from shelter to shelter because they can't be maintained or they're uncomfortable or their paranoia leads them to not feel safe. By the time the eight months comes up, you often don't know where they are. I had a phone call from a provider and I couldn't tell her where a youth was, so—

**The Chair (Mr. Kevin Daniel Flynn):** Thank you for that answer. Christine or Sylvia?

**Mrs. Christine Elliott:** Sure, just a quick question. Your reference to the Every Door is the Right Door strategy—I gather what you're saying is that your particular door hasn't been recognized as being as important as it is, that you're seeing youth and you're the ones who have access to them on the spot.

I really applaud you for coming to speak to us about it and I'd really be interested in more about your proposal that you have submitted to the Ministry of Health. Is there any way that we could get a copy of that?

**Ms. Maria Crawford:** I'd be happy to. If you'd just direct me if I do that through the clerk or—

**Mrs. Christine Elliott:** Thank you. That would be wonderful to have that.

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

## CITY OF TORONTO, SHELTER, SUPPORT AND HOUSING ADMINISTRATION

**The Chair (Mr. Kevin Daniel Flynn):** Our final presentation of the day comes from the city of Toronto Shelter, Support and Housing Administration—Phil Brown. Make yourself comfortable. Like everybody else, you get 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll try and share it out as much as we can. Thanks for coming.

**Mr. Phil Brown:** Thank you very much, Mr. Chair. Good evening, and thank you for this opportunity to speak to you. I'm here to represent the interests of the most vulnerable in our province who are mentally ill and have addictions. These are people who are homeless and those who are precariously housed.

I think you've just had a reality check from one of our valued partners, Eva's Initiatives for homeless youth.

I thank the Ontario government for working to create a long-term strategy for mental health and addiction services and for establishing this committee. I want to respectfully suggest that, in doing this work, you think beyond the matters of conventional health care delivery alone.

My name is Phil Brown, and I'm the general manager of Shelter, Support and Housing Administration at the city of Toronto. This is the division of the city that is responsible for funding and administering more than 90,000 units of social housing. We manage the emergency shelter system, and we coordinate services for homeless people delivered by local community agencies and funded by the city, provincial and federal governments.

Along with the Ministry of Health and Long-Term Care, we also fund Habitat Services, a program that provides housing support and subsidy in boarding homes and rooming houses for more than 900 people with psychiatric illnesses. We also operate a street outreach and housing program called Streets to Homes. This provides housing assistance and intensive case management supports to people who live outside or who spend their days on the streets, to help them find and keep housing.

My main message to you this evening is this: For the most vulnerable, mentally ill people in our province, housing is the first medicine to consider.

Many of the people who use the shelter system in Toronto do so for economic reasons. Most use the system for a short time. There is a core group who stay in emergency shelters for long periods of time, sometimes years, because their ability to earn a living or to live on their own is compromised by mental illness and/or addictions. For them, the shelter system, which was originally intended to provide only temporary emergency shelter, has become their de facto home.

Let me tell you about just one of our shelters. Seaton House is Ontario's largest men's shelter. It has 580 beds, but at least 280 of these provide long-term care for men with physical, mental and addiction issues. A recent survey of long-term residents by researchers from our partners at St. Mike's and CAMH documented the high-needs profile of this population. Forgive the statistics, but they outline a powerful story of how service systems funded by other orders of government are failing a group of people profoundly affected by mental illness and addictions.

The survey revealed this: 33% of long-term shelter users have a diagnosed mental illness; 35% have an alcohol addiction, and 50% have an addiction to other drugs; 18% have a diagnosed concurrent disorder; and a mere 17% were identified as able to maintain a home of their own without some level of support.

Seaton House is just a five-minute drive from the Legislature, and I would be more than happy to take you on a tour of this or other shelters.

While Seaton House, like other shelters in Toronto's system, provides a variety of health care supports to clients who should be served by the health care system, it

is funded as an emergency shelter facility rather than a health care facility. For each occupied bed, the province pays the city $33.25 per day. The actual daily cost of operating one occupied bed at Seaton House is $104. The city picks up the difference of $70. As Eva's just mentioned, the shelter system lacks resources.

Many of the men at Seaton House, as well as many of the women and families in our other shelters, are in homeless shelters because they have been referred from prisons, emergency rooms, psychiatric hospitals and long-term care facilities—publicly funded institutions that have been unable to meet their complex needs. So they are referred to an emergency shelter.

We do our very best to help our shelter clients find appropriate housing because we want to end their homelessness, not manage it. Why do we emphasize housing? Because we believe that whether you live in Scarborough, Guelph, Peterborough, Thunder Bay or anywhere else in this province, your first need is for a permanent home, not a bed in an emergency shelter. Only with the dignity, safety and security of a place to call home can you begin to deal effectively with the other issues, mental illness and addictions being among the most common. We believe home is where it starts. We use the housing-first approach throughout all our services. We see housing as a right.

In Streets to Homes, and elsewhere in the work we do, we have seen empirical evidence that housing with appropriate supports is good medicine. We are seeing improved mental health and fewer addictions among clients who we have housed.

Since we started Streets to Homes in 2005, we have helped more than 2,600 people move into permanent housing directly from the street. A critical part of the program is to provide people with follow-up supports for up to a year. These come in the form of a support worker who assists his or her newly housed client to get settled into their new home, connecting them to resources in the community, most often health care, employment training and resources. More than 90% of the people we help to find homes remain in their housing. Most live in private-sector apartments, not social housing or supportive housing.

A post-occupancy survey we did in 2006 shows that having housing also results in improved mental health and reduced alcohol and other drug use. Again, it cannot be housing on its own. There need to be supports in place that provide consistent and coordinated follow-up.

We've also seen the importance of post-occupancy support in the Hostels to Homes initiative. This is the Ontario government's pilot project that essentially uses shelter per diem funding to provide supports to newly housed people who were previously users of the shelter system. We are finding that with the assistance of their follow-up worker, long-time shelter users are able to remain in their new homes, deal with their illnesses and settle into the community. We thank the provincial government for this important pilot project.

Housing is not only good medicine, it's also good economics. We can demonstrate that having housing with appropriate supports not only improves the health and quality of life but also results in a clear reduction in use of costly emergency health and justice services. In our survey, a group of six high-needs clients on the street used an average of at least $36,000 each in emergency and health services in the last year they were homeless before they were housed. Had we not been able to help the six people in this group, we estimate that they would have cost the system more than $2 million in health and emergency services over the next 10 years. In comparison, it costs less than $15,000 dollars a year—$41 dollars a day—to house these individuals with supports. The bottom line is, do nothing and it costs you $2 million over 10 years; house them and it costs you $1 million over 10 years.

As I've described, at the city of Toronto we've already made many successes in developing innovative programs to help homeless and vulnerably housed people with mental health issues. But there's clearly more work to be done, and we're pleased that this committee will be advancing support for these types of innovative approaches and looking for ways to break down silos and integrate services across different jurisdictions and sectors.

In particular, and in closing, I would ask for your help in the following areas:

(1) Provide sustainable, ongoing funding for shelters which covers the true costs of providing services to homeless people with complex mental health and addiction issues. All shelters, including Eva's, across Ontario need more than $33 a day.

(2) Implement a new funding model for shelters which supports a housing-first approach and enables people to move more quickly from shelters back into housing.

(3) Invest funding in programs that provide intensive case management to help vulnerable people remain in their homes.

(4) Provide ongoing sustainable funding for the Hostels to Homes program and make it permanent.

(5) And finally, we need your help to make sure that there are affordable places to live for all people who are mentally ill and have addictions.

The Ministry of Municipal Affairs and Housing is currently holding consultations to develop a 10-year affordable housing strategy. This committee has a unique opportunity to ensure that your mental health and addictions strategy merges seamlessly with the Ministry of Municipal Affairs and Housing's 10-year affordable housing strategy so that there is a coordinated, collaborative approach to providing housing with supports to meet the needs of all Ontarians.

Recently, Toronto city council overwhelmingly voted to approve Housing Opportunities Toronto, and we've left a copy for you—an affordable housing action plan. Helping homeless and vulnerable people find and keep homes is a key strategic theme of the city's plan. However, unless we think outside the traditional lines of responsibility, we will not be improving access to services for homeless and vulnerably housed Ontarians with mental illness and addictions.

Investing in housing solutions is cheaper and more effective than having people end up in the emergency room at $212 a visit, a psychiatric hospital at $665 a day or in jail at $143 a day. Again, we can house clients for $41 a day and keep them housed, and happily so. If you're mentally ill or have addictions, having a home is the beginning of addressing these issues. Housing First is great for clients and great for taxpayers, a true win-win.

Thank you, Mr. Chair.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Phil. You've left about a minute for each side here. Any questions from the government side? Christine? Sylvia?

**Mrs. Christine Elliott:** I'd just like to thank you very much for coming and speaking to us today because I think you have just clarified for us what we've been hearing, sort of, from different groups, but it hasn't been really clearly stated—the high proportion of people who are homeless that do have mental health and/or addiction problems and the need that you have to have housing coupled with support, and that's key to success. Thank you very much for stating it in such clear and simple terms for us.

**Mr. Phil Brown:** Thank you very much.

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

**M^me^ France Gélinas:** I don't know if you'll be able to answer this: I certainly support the Housing First strategy. I think it is the way to go. Were you able to quantify this? You mentioned that you need $31.3 million in the shelter system in Toronto. But if you were to implement Housing First for everybody who needs it—any idea of a number?

**Mr. Phil Brown:** Thank you for the question. We don't have one number for that. But in the package that we left with you, we do show our cost-benefit analysis of housing somebody as opposed to putting them in jail or leaving them in an emergency room. So we do have that cost-benefit analysis. I'm happy to chat further if that's possible.

**The Chair (Mr. Kevin Daniel Flynn):** Final question from Liz.

**Mrs. Liz Sandals:** Yes, I was sitting here when you went by before, trying to reconcile this in my mind.

Thank you for your presentation. On page 3, you say the actual cost of operating one occupied bed at Seaton House is $104 a day, and then over in your final conclusion, toward the end, you talk about housing clients with supports for $41 a day. Is that the difference between shelter housing and permanent housing? Can you explain that discrepancy?

**Mr. Phil Brown:** Yes, indeed. Those are the figures for Seaton House; the $100 is for Seaton House. On average, across our shelter system, it costs about $69 a day for an occupied bed for a shelter client. We also say that it is cheaper to keep people in housing. Emergency shelter in and of itself is an expensive form of accommodating people. That's why we're saying housing first. Housing is the best solution for clients and it's also one of the cheaper ways of doing it.

**Mrs. Liz Sandals:** So the $41 a day, can you tell us what model that is, just so that we're clear?

**Mr. Phil Brown:** Yes. Again, there's a more detailed package in the cost-benefit analysis that we left with you, but that is the cost of an average rent, plus ongoing supports to help keep that person housed.

**Mrs. Liz Sandals:** So that's monthly rent plus some salaries for support?

**Mr. Phil Brown:** Correct.

**Mrs. Liz Sandals:** Okay.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you, Phil, thank you, Liz, and thank you, committee.

**Mr. Phil Brown:** Thank you very much.

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

We're adjourned.

*The committee adjourned at 1753.*

# CONTENTS

Wednesday 21 October 2009



**SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS**

**Chair / Président**
Mr. Kevin Daniel Flynn (Oakville L)

**Vice-Chair / Vice-Présidente**
Mrs. Christine Elliott (Whitby–Oshawa PC)

Mr. Bas Balkissoon (Scarborough–Rouge River L)
Mrs. Christine Elliott (Whitby–Oshawa PC)
Mr. Kevin Daniel Flynn (Oakville L)
M$^{me}$ France Gélinas (Nickel Belt ND)
Ms. Helena Jaczek (Oak Ridges–Markham L)
Ms. Sylvia Jones (Dufferin–Caledon PC)
Mr. Jeff Leal (Peterborough L)
Mrs. Liz Sandals (Guelph L)
Mrs. Maria Van Bommel (Lambton–Kent–Middlesex L)

**Also taking part / Autres participants et participantes**
Mr. Michael Prue (Beaches–East York ND)

**Clerk / Greffière**
Ms. Susan Sourial

**Staff / Personnel**
Ms. Elaine Campbell, research officer,
Legislative Research Service