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Wednesday 8 April 2009

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Mercredi 8 avril 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
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 8 April 2009

Mercredi 8 avril 2009

The committee met at 1605 in committee room 1.

MENTAL HEALTH AND ADDICTIONS STRATEGY

The Chair (Mr. Kevin Daniel Flynn): Ladies and gentlemen, if we could all take our seats, we can call the committee to order.

Committee members will have something in front of them that is information on some things that have been happening in the Fredericton area of New Brunswick, something that came across my desk from somebody who wanted us to know that.

Today is the first time we're hearing from some members of the public. We're hearing from the experts in the field first, people who have a more-than-intimate knowledge of the current shape of mental health and addiction services in the province.

PARENTS FOR CHILDREN'S MENTAL HEALTH

The Chair (Mr. Kevin Daniel Flynn): Today, we have with us Parents for Children's Mental Health. We've got Sylvia Naumovski, Sarah Cannon and Sean Quigley. Please come forward.

As I said when I came in, you're our guinea pigs; you're our first. We're experimenting with you here today. The committee met previously and decided that the rules would be that each delegation would get 30 minutes. If you want to leave a little bit of time in there for any questions from the committee, that would be wonderful. You're the only delegation today, so you may get a little bit of latitude from the Chair, but if you could keep it around that time, it would sincerely be appreciated. The floor is yours.

Ms. Sarah Cannon: I think we can probably do that and keep it very concise.

The Chair (Mr. Kevin Daniel Flynn): Just before you start, please identify yourself for Hansard so we can get it in the official record.

Ms. Sarah Cannon: I'm Sarah Cannon.

I think we want to present to you the information that you want to hear, so I think it's more important for us to answer your questions, but we will give you a little bit of background.

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We have met with a lot of you in person, so we have been able to share some of our personal stories with you, but Parents for Children's Mental Health is a non-profit provincial organization. Our mandate and our goals are to educate, empower and support families and their children who struggle with the daily, unique challenges of having children with mental health issues.

All of us involved with Parents for Children's Mental Health are families; it's a family-driven organization. We all have children who have mental health issues. So we're coming at this from a very personal perspective, and that's really important to families, because one of the biggest problems there is surrounding the issues of menal health, especially children's mental health, is the stigma, isolation and discrimination that families feel.

I think one of the main things that we're trying to promote, especially to this committee, is that we are the true front-line workers with our children. Parents are an untapped resource when you are dealing with the crisis of the mental health system, and we are offering our expertise and collaboration with you, with the government, with our agencies, because there is a huge need to fill in these gaps and the deficits in our system that are seriously affecting our lives. We're very willing to step up to the plate, offer our assistance and offer to be resources. We come at it with a lens that no one else can offer and which isn't taught in curriculum, and that is that we can tell you precisely how these issues translate in real life, in real time, and what the outcomes are of some of the serious deficits of our system.

I don't think I need to list what all of the deficits of our system are. One of our comments is that there have been numerous, numerous reports, especially recently, about what all of the deficits are in the mental health system. This is not a new issue. This has been going on for decades.

I think the point has come that we as parents are saying, "Enough." We have asked nicely, and now we're sort of demanding that our voices are heard. We're three, but we're representing hundreds and thousands of families. Currently there are 654,000 families in this province who are dealing with this. That's unacceptable.

This morning, I was looking at an old report of the mental health implementation task force that was established in 2000. The report that they put forward is called The Time is Now. That was nine years ago. My personal

request of this committee—and after meeting with most of you, we recognize that we do have some true champions here, but we would like to see action and a plan. We don't want just another report that, nine years from now, we're going to be referring to, that says the same thing we've been saying decade after decade. We need parity, we need equity, and we need our children and our families to be treated respectfully by the system.

I think that sums it up. We'd like to take your questions because we really want to give you the information that you need, we want to give you our perspective, but we want to give you the perspective in the areas that you want to hear it and that you're prepared to discuss and put into action.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you very much for your comments. Why don't we give 10 minutes to each of the parties, maybe starting with Christine and Sylvia, and just go around?

Mrs. Christine Elliott: Sure. I know we've talked about some of the issues, but if you could—there's a stigma issue that's still associated that we need to be dealing with and, of course, there's just the under-resourcing of children's mental health services that we've talked about. Could you give us sort of the top three priorities perhaps, Sarah, in terms of what you would like to see addressed immediately, and then perhaps what could be more of a long-term strategy?

Ms. Sarah Cannon: Stigma is definitely the number one thing for me, personally. I don't know if you might want to ask all of us what our top three are, because that's something that might not be consistent.

But for me, it's stigma. I truly believe that that's sort of at the heart of what is wrong, because there isn't a big enough public outcry about what's going on. I really, truly believe that a lot of that has to do with the stigma of it. So, yes, for me, that's a huge thing.

The other thing for me, personally, is the number of ministries that are involved and the way that translates in my life. It is indicative of what a lot of families go through. Our children go to school; they have mental health issues while they're in school; schools are not resourced to help them. My child goes into a crisis; I'm told to go to the hospital with my child; I get to the hospital and they don't have the resources to help. My child needs service acutely because they have a mental health issue; our child and youth agencies are so overburdened that they don't have the capacity to help me. So I would like to see a defragmented system and an interministerial collaboration.

Third, I want to see equity not only in funding, but in the approach that the government, the public and everybody takes. When I go to the hospital with my child, I want my child's mental health issues to be as serious and as important to that hospital as if they had a physical health issue. I want every discussion around my child's mental health to have that parity and that equity with their physical health.

Those would be my three.

And I want my child and youth workers recognized for what they do, because they're the ones who are saving my daughter's life.

Ms. Sylvia Naumovski: I'd like to see a bigger concentration on prevention and early intervention; the reason being, in prevention, we have to have—

The Chair (Mr. Kevin Daniel Flynn): Excuse me, Sylvia, I know you're on a roll, but could you identify yourself as well? Sean, when your turn comes around, could you do the same? Thanks.

Ms. Sylvia Naumovski: Sorry, it's Sylvia Naumovski. Where was I?

Ms. Sarah Cannon: Early intervention.

Ms. Sylvia Naumovski: Prevention and early intervention.

I truly believe that we're going to have to look differently and work in that mode, that we have to look at prevention, and that we've got to educate the whole public. We're going to have to go into the schools so that we can touch not only the children, but the adults, because everybody is affected by mental illness. It may not be when they're five or seven because they have ADHD, but maybe they'll have a life-threatening thing that happens to them when they're 13. Why are we waiting to help these people? Why don't we have a program that's put into place early so that it becomes part of the norm, and so the prevention component is there, and then everybody knows what is expected?

When I talk about early intervention, it also has to be taken early at the kids' level. We don't want it to be that the child is in crisis. We want him to be caught before he gets in crisis. What's happening now is children who are 14 have something happen to them and they're in crisis and they have to wait eight months for help. So what happens is that things get worse and worse. It gets deferred, they break the law, become homeless. We could eliminate some of this if we just intervened early.

Mr. Sean Quigley: Sean Quigley.

A couple of things are really key. The first one is to recognize that it's not enough to recognize that there's an issue. Everyone around the table here recognizes that there's an issue. That's why we're here.

We had a meeting earlier with MPP Gélinas, and I was telling her the story—I was sitting outside in the park, and I was looking across here at the building, and I said that I'm not really feeling the love. These families, my family, my daughter, and the thousands of families across the province need to feel the love, the love being in terms of how children's mental health is funded, which we know hasn't happened for the last 14 years. There has been no increase, and that needs to change as far as services go.

We know that if there are peer-supported programs, they are really effective. There is study after study in the United States and in Canada that back this up.

We're here to offer our help to you. My goal is to get you all to succeed, and in order to do that, we have to have a conversation. The conversation is about how somebody like myself, who's an expert when it comes to

my child and her care, can give you information that will help you make decisions. The bit of information that I want to give you is to recognize that we families are experts in this care. We have dealt with a number of ministries and a number of programs: health, education, justice, child and youth. It goes on and on. From dealing with all of those different departments, we bring to you a unique perspective that is not easy to duplicate by talking to one agency or even the largest agencies in the province.

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The next thing I want to say to you is that talking about community and engagement is a very interesting concept. What does engagement mean? From my point of view, engagement means that right now you're doing it; you're talking to us and asking for our input. That's great. But engagement also means that when you come to make recommendations, you talk to us before putting those recommendations out, in order to get our input on those recommendations. When you make those recommendations, you ask us to be a part of their implementation, and then when you implement those recommendations, you ask us to be a part of how those implementations get put into place. That is engagement, and because these problems will only be solved through community and we are leaders in our community when it comes to child and youth mental health, we're good people to tap into, and we want to help you.

That's what I would say is really critical here. We need to deal with the funding issue. It's the elephant in the room that needs to be sorted out. You need to deal with how people are engaged and you need to recognize the expertise that has come about from some fairly hard-won struggles. Our stories—a number of you have heard them—are not unique; they are commonplace. That is a sad, sad thing.

The Chair (Mr. Kevin Daniel Flynn): One short question left. I think we've got about a minute or two.

Ms. Sylvia Jones: I'm not sure if it's a short question, but it will be a short question; you decide with the answer—

The Chair (Mr. Kevin Daniel Flynn): It'll be a short question, long answer.

Ms. Sylvia Jones: I am interested in your experience, as an organization, in dealing with the magic age, 18, consent and families, because you're talking a lot about how families are so important to the care, but I need to know what happens at 18 and what your group has been doing for that.

Ms. Sylvia Naumovski: My name is Sylvia Naumovski. The care doesn't continue on, and it is a big concern because children grow up. A lot of times, children suffer from psychiatric problems later in their teens, so when they finally do get service—let's say they're 16 and they wait eight months, so they're 17 and get serviced. They're almost 18 and have to move into the adult system. There's no continuity. My son is actually going through that right now. There are no programs particularly for that age group. What I think happens is a lot of them go homeless because the parents can no longer deal with them at home, because a lot of them become dangerous—I'm talking about some young kids—and the advice that I got was to lock my doors.

Ms. Sylvia Jones: Even with families and parents who want to continue—

Ms. Sylvia Naumovski: There's no place for them to go, and then if you do find a place, it probably costs a lot.

Also, I think parents are exhausted. They also say, "Well, he's 18 now; maybe it's time that he's on his own," and what ends up happening? The child cannot cope. He hasn't learned coping skills and he ends up going on the street.

This is something we were talking with France about. We really have to think about a different approach, and maybe family-driven care or family-centered care might be the way to go. We've got to think of a different way. Parents need to be trained, or they can help out the system by having training. Funding needs to go towards them so that they can at least provide other sources for them, or housing. If the child can't live with you, at least you can put them in a safe place and help subsidize, instead of just dumping them. They need assistance. Parents can provide policies and advice on policies.

The Chair (Mr. Kevin Daniel Flynn): Actually, I'm going to move on to the questioner, but I'm sure you can continue on that train of thought in your answer.

Ms. Sylvia Naumovski: That's fine.

The Chair (Mr. Kevin Daniel Flynn): France, you're next.

M^me^ France Gélinas: No, I would encourage you to continue. I know that we've had conversations and not everybody had an opportunity to hear, but certainly, if you want to continue on some of the ideas you've shared with me toward family-centred care and how an organization like yours could make a difference in children with mental health.

Ms. Sylvia Naumovski: The two main things for mental illness are loneliness and not being connected. So what do you have to do? You have to change that. You have to make someone who suffers from mental illness feel connected, loved and not lonely. In my situation, my son is aggressive and threatens to kill me. I can't live with him. I put him in an apartment all by himself with practically nothing. All he wants to do is come home, but I can't have him at home. He's a risk. He threatens me and my family, so he sits in his apartment. He is miserable. We had him come home just for a very short period of time. He went from here up to here, and I felt so bad. I am doing exactly what is not helping him. He needs to feel connected. He's lonely.

Mr. Sean Quigley: This idea of feeling connected goes to a concept that many of you will have heard and will definitely hear in your consultations: the idea of resiliency. Resiliency is the ability to overcome a crisis quickly and move past it. Resiliency also refers to your ability to be connected to the community and feel supported. That's a critical component when we're talking about family-centred care. Sylvia's case is exactly

that. Because her son isn't connected to a community of care, a continuum of care, there is no resiliency, so the same issues come up again and again and again.

Ms. Sarah Cannon: We need to—very briefly, I'll tell you—have the services wrap around the families, not the families travelling all over the place, to different places trying to get service. The family needs to be treated as a whole and the services need to treat the whole family, because with an increased capacity to deal with it as a family, that child at the centre of that is going to have an increased capacity to overcome it. We're not just talking about the child affected; we're talking about the mom, the dad, the siblings, the grandmas, the grandpas, the aunts and uncles, and everybody in their lives—their teachers. Let us feel wrapped around.

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

M^me^ France Gélinas: I know that it will be a repeat, but I think it's worth saying: You've all had experience with a child who had mental health issues, but in your own way, all of you were able to succeed, in some form or another, where lots of other parents have failed. I wondered, if you're comfortable, if you could share some of your personal stories and some of the key—not decision points, but some of the key activities that really shaped the treatment for your sons and daughters, and where the system actually worked for you.

Ms. Sylvia Naumovski: I feel that I cheated because—Sylvia Naumovski.

The Chair (Mr. Kevin Daniel Flynn): Actually, you don't have to introduce yourself every time.

Interjections.

Ms. Sylvia Naumovski: Okay. In a sense, when I'm saying I feel like I'm cheating—I took everything; I knew everybody; I would tell everybody; I would go to everybody. I would phone my mother's friend who was a principal and somebody who was a psychiatrist and ask them for their help—for my personal gain, to help my son—but that isn't how it should be. I speak English and I had connections to a few things. I beat on the door. I phoned every single person. I went through the directory and I learned lots, and that's how I did it. But a lot of people can't do it that way. I was persistent and I would keep on calling and I would keep on—I had said, "He is in crisis, he is in crisis, he is in crisis—you have to take him. He just has to be taken." I'd phone every single day. Well, he just got worse, and so, finally, they did take him, but that's how it worked, and I just kept on, for whatever it was—school or whatever; it was just persistence, persistence, persistence.

M^me^ France Gélinas: But your son also participated in a program that you ended up having to pay for yourself.

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Ms. Sylvia Naumovski: Yes. Unfortunately, he had oppositional defiant behaviour. Of course there's no buy-in, and every time you went to a program—there were programs offered—and he didn't want to do it, well, forget it: Out he goes. So we would keep on trying different programs.

He actually broke the law and was in jail. He had a choice: Stay in jail or his parents are going to send him to Project DARE, which was up in the north, where he's in complete isolation. He loved it, though. It was the best thing, but it was probably because he was there at a certain time in his life. His other choice was jail; what would you pick?

He got a lot out of it, but the sad part—well, for us—was we financially had to support it. There's no financial support like OHIP or anything like that, there's no other program within the province that I know of, and it cost us a lot of money. We were only able to keep him in for seven months. When he came out, there was no follow-up. He just reverted to drugs and everything else. It was good at the time, but if the program could have continued it would have been even better, and that's kind of sad. There are programs there, and excellent programs, but there's not the continuity to continue it on to help someone to succeed.

Ms. Sarah Cannon: Sylvia's not telling you what constitutes "a lot of money," but for seven months, that was $60,000. How many parents and constituents can you think about who could just hand over $60,000 for seven months? That's an issue.

Mr. Sean Quigley: With our child, my daughter, Erynn, the reason we're successful is my wife and I are fortunate. We're fortunate in that we're well-educated, we're fortunate in that we have a good livelihood, and we're fortunate in that we live in a good neighbourhood, so we're able to stand up for ourselves. But also, on top of that, we had to keep calling and knocking and calling and knocking. Persistence was key, and not being willing to just, as I say, sit in the bunker. The bunker is where we were when we were feeling cut off, unsupported, and we were days away from selling our house. We decided we're not going to do that; we're going to stand up and actually start to fight and advocate for ourselves.

It wasn't until that happened that things changed for us, and our daughter—respite care was critical for our daughter. It gave us the space. I would be called every day at school to pick her up from school. She'd arrive at school at 9, I'd be picking her up at quarter after 9, no exaggeration, four out of five days. Your job is affected by that, obviously.

Also, the fact is that we finally got to a point where we were so pushy that we got what we wanted: The squeaky wheel gets the oil, yes? That's what it takes. But I've said to a number of you—and I know Sarah and Sylvia have said this—what about the single mom who works in a call centre for $10 an hour and has two kids, one child has a mental health issue, and she's trying to live on something like less than $1,300 a month? How does that parent advocate for themselves that way?

The good news is my daughter is now in grade 7, she's on student council, and she's got the highest academic grades in the school. That's good news. But as many people in the agencies tell me, and I believe them, we're the exception; we are not the commonplace.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sean. Thank you, France. The government side: Helena?

Ms. Helena Jaczek: Yes, I'd just like to explore a little bit more the early intervention that I think, Sylvia, you mentioned—and Sean, perhaps you got some early intervention in your case. What is the problem there? Presumably—and I'm just speculating, so I'd like you to tell me, but I'm wondering, is it that the parent sees somehing is wrong, approaches a health professional perhaps, a family doctor? I don't know how this happens. Is there a recognition issue in terms of not acknowledging, not being able to diagnose, not being able to really understand what's happening? Is there an education issue here that people need to actually understand how to recognize? Is that part of it?

Ms. Sarah Cannon: I'm going to try and answer all that. "Yes" is the short answer. I think there are a couple of really important elements that we need to make you understand. One of the deficits, when you know that there's something wrong with your child, if it's a mental health issue, is, first of all you're not educated. Mental health issues aren't well publicized, and no parent is going out thinking, "Oh, I think my kid has a mental health issue." That's not your first, knee-jerk reaction. You're noticing something's wrong but your mind doesn't go, "Psychiatric." You get there, but even once you get there—if you're lucky enough to get there, which takes years for a lot of families to do; not months, years. In my daughter's case it took years, and it wasn't until there was a witnessed psychotic break that the doctor went, "Oh, yeah. Maybe we're talking about a psychiatric thing," even though I'd been describing it for months and months.

Even once I was like, "Phew. Somebody's listening to me and now we're going to get help," no, that's not how it works. A social service worker is sent to my house. A social service worker spends maybe six hours a week with me for six weeks watching how I interact with my daughter, watching how she interacts with me, how she plays, how I discipline her. She talks to me about how to effectively listen to my child, how to positive-parent. I was sent to 1-2-3 Magic classes. I was sent to three different parenting classes that I had to go to. Then the social workers write up their report and go, "Mom's okay. She's not the one causing the problems. Now we need to turn our attention to the daughter." Okay, yes, we've recognized that the daughter needs help, so now I'm put on a wait-list to talk to an administrator who is going to decide where I go. So for six weeks I wait to have a phone interview. Then I have a phone interview with someone who's checking off boxes and says to me, "No, I don't think this is appropriate for you. You need to go here." And this is the cycle: six weeks, six weeks, six weeks, and then even when you find the box-checker who says, "Yes, you fit, but we're going to see you in eight months, okay?"

The way I like to illustrate this is if we take this and I now have walked into my doctor's office and my child is diabetic, I am not being sent to nutrition classes, cooking classes, calorie-counting classes and proper exercise. I don't learn all of that before they look at my daughter and treat my daughter and give her insulin. They don't say to me, "In eight months we'll give her insulin. Hopefully she doesn't go into a diabetic coma before then. If she does, make sure you hurry up and get to the hospital." So that is a key problem.

Do I know all the answers to why that happened? No, but that's how it plays out. I don't believe there's an awful lot of education. Even within our doctors' education system, I don't think they're trained properly in how to recognize it. Even the professionals and doctors who work in that system are stigmatized against, so people don't generally go there immediately. Logically, that makes sense to me, because 10 child psychiatrists a year are produced in Canada. How's that? Obviously doctors aren't going, "Woo, I want to be a child psychiatrist," and I think that's because they're low on the totem pole.

So it is a big cycle that has more than one element for sure, but I think the biggest part of it is, they look at it completely backwards. The parents are meant to go through all of these hoops and we're put under a microscope and we have to prove this isn't our fault. And when we've done that, then they'll go, "Okay. We're going to try now to fix your kid."

The Chair (Mr. Kevin Daniel Flynn): Thank you. Just a brief answer, and then we'll go on to Liz.

Ms. Sylvia Naumovski: Oh yes, it'll be brief. For early intervention, I think that it really has to be a prevention thing. In the schools, teachers have to be trained—they're not trained—so they can recognize it and pass it on to the parents. They don't just teach children; they teach the parents, and then the parents will have to go to whoever after that. So I think it has to start at a prevention level at an early age. For the other situations where a child is 14, before he gets into a crisis, early intervention before a crisis—basically money has to go to the service providers to help those families. That's the only way it's going to help, because they're in crisis. There's no other way it can be done, because they cannot do it themselves.

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

Mrs. Liz Sandals: That was actually where I was headed anyway because Sarah had mentioned prevention and early intervention. I wanted to know, and perhaps you can flesh it out a little bit more, what you think prevention looks like, because people mean a whole lot of different things by "prevention," and I'm never quite sure what they mean, so I'd like you to flesh it out.

Ms. Sarah Cannon: I personally don't like that. Sylvia and I debate about this.

Mrs. Liz Sandals: That's why I'm asking, because I bet you don't actually agree.

Ms. Sarah Cannon: For me, "prevention" implies there is something I could have done to stop the fact that my child had a mental health disorder. I agree that we have to prevent the crisis. I'll let Sylvia flesh it out.

Ms. Sylvia Naumovski: For me, "prevention" is that you look at the whole society, and you've got to teach the whole, not just a little part. I truly believe that everybody's affected by mental illness, so we have to be able to make them aware and educated so that they can see the signs and go for help. We also have to have anti-stigma campaigns so people don't feel ashamed.

Mrs. Liz Sandals: So is it really so much prevention as early recognition, which is slightly different than early intervention?

Ms. Sylvia Naumovski: That's true; there's a combination. "Prevention," I guess, would be a healthy society, but making sure they are kept healthy.

Mr. Sean Quigley: I want to steer you away from the idea of prevention. I want to talk about mental wellness instead. Mental wellness is where you set up a system within the schools, within organizations and in the workplace where the people within those groups feel like they are supported and that it's okay for them to go through a crisis and they know they'll be supported, in whatever form. That could be a mild depression, or it could be that my grandmother passed away and I need some time to deal with that grieving.

There is successful model after successful model when it comes to mental wellness across the world. New Zealand has a very successful model. Northern Ireland has built one. Great Britain has built one. The European Union has built one. We know that the idea of mental wellness is really important.

Where it was most effective, if you're talking about early intervention, is in the primary schools. You talk about mental health and wellness in the primary schools, and that leads to a word I discussed earlier, which was resiliency, and community. Those programs reinforce those ideas amongst the whole school. It's learned at a young age, and by osmosis, the parents in the community will hear about that, just as I hear about my daughter's adventures in her physics class. There will be an osmosis. Then you bring that out into the community.

I've said to a couple of you that if you're going to talk about educating, dealing with the stigma and how to present a message to the public, you shouldn't be looking at your standard PSA: "Let's all do this"; you should be taking a page from Coca-Cola. Coca-Cola markets really well. They hook in the young kids, they hook in the middle kids, they hook in us adults, and they hook people from all over the world. Coca-Cola is good at marketing. Take a page from their book when it comes to dealing with the idea of marketing against mental health stigma.

The Chair (Mr. Kevin Daniel Flynn): You still have a couple of minutes if there are any final words.

Ms. Sarah Cannon: I would like to add something around early intervention because, like you said, there are a lot of different connotations and ways that it can be interpreted. For me, what strikes me about this system is the fact that it is a worst-come, first-served basis. Because of the increasing burdens that are placed on our system, the criteria for "worst" are becoming worse and worse and worse. You almost have to be going in there bleeding for them to say, "Okay, yeah, we need to deal with you."

For me, early intervention and prevention is, let's start to back that circle up, give our services the supports and our families the capacity so that we can intervene before it's a crisis, before our kids are going to the hospital suicidal, before moms are finding their teenagers on the floor. I think it depends on which point in time you want to look at it from, if we're talking about acutely right now or how you want it to look in the future.

Ideally, what Sean says: I think about how absolutely adamant my kids are about recycling and energy prevention. If they walk by me in the morning and I'm brushing my teeth and the water is running, they turn it off and yell at me because it is drilled into their head at school—if I don't put my can in the right recycling box. It's possible. Let's start. Those kids are sponges and they're going to deliver that message for us.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for appearing before us today. I think you said in your opening remarks that you sensed that there may be some champions sitting around the table. I think you're absolutely right on that. This is the first time on a select committee for all of us, I believe, the first time going through this process. We're going to be hearing from an awful lot of people in the field. Some of those people we haven't heard from yet, obviously, we haven't been exposed to, but from what you've said today, I think we probably started with the right group.

Ms. Sylvia Naumovski: Thank you.

The Chair (Mr. Kevin Daniel Flynn): I think some of the comments you gave us will give us something to set that standard by because you're living this daily, aren't you?

Ms. Sarah Cannon: Yes.

Mr. Sean Quigley: Yeah, we are.

Ms. Sarah Cannon: I know that this committee is going to be travelling, and you've heard from three of us, but make your own commitment as a committee as you travel to try to listen to families everywhere that you're going—and youth, because youth have an even different perspective and spin on things than we do. They truly are the product of what they're living.

I'd also like to offer if we can try to get responses for you through e-consultation or whatever, asking pertinent questions of our parent membership, polls or whatever—we have polls on our website—if you want that kind of information gathered, then we'd like to offer that to the committee as well when you're looking at things from the true family perspective.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you very much for your attendance.

Members of the committee, we do have a full slate. Our next meeting is completely booked, and that will be two weeks from now. Next week is constituency week, and then the week after that, we have a full slate. We're adjourned.

The committee adjourned at 1644.

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