



***OFFICE OF SENATOR LUCIE PÉPIN***

**INTRODUCTORY ADDRESS**

***2<sup>ND</sup> ANNUAL SUMMIT ON CHILD AND YOUTH MENTAL HEALTH***

**DELTA CHELSEA HOTEL  
33 GERARD ST. WEST, TORONTO**

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Fellow participants,  
Ladies and gentlemen:

Thank you for inviting me to this second Annual Summit on Child and Youth Mental Health. My sincere congratulations to Children's Mental Health Ontario, for the initiative it has shown in organizing this important gathering.

If I may introduce myself, I am here as a member of the Senate Standing Committee on Social Affairs, Science and Technology, which is better known under the name of its chair, Senator Michael Kirby.

Two years ago, shortly after our study of the public health care system, the Committee began an inquiry into mental health, mental illness and addiction. From February 2003 to May 2005, we held a number of public hearings in Ottawa and across Canada. These enabled us to listen to hundreds of Canadians working in the area of mental illness and addiction. Other people and organizations, with an interest in the subject, gave us their opinions and suggestions in letters, briefs and through our Web consultation facility, the volume of responses to which greatly exceeded our expectations. I must admit that some of this personal testimony touched us deeply.

Throughout our inquiries, the Committee received much-appreciated support from members of the mental health and addiction community. The positive response to our three interim reports of November 2004 is an example of this support. My presence here this morning, to talk to you about some of the ideas to be addressed in our final report, is a sign that this interest continues, or at least I hope it does.

We feel this support is most important. In undertaking this study, the committee wanted to make a modest contribution to needed change, in conjunction with those principally concerned. Most of our recommendations will be based on the testimony of numerous experts, and a searching review of the documentation received over the last two years.

It is also by listening to Canadians that the Committee has identified the following vision and overall orientations which will underpin our final report, release of which is expected in January 2006.

The status quo is not an acceptable option as far as mental health and addiction are concerned. We need a genuine system based on recovery. In our opinion, recovery must be the main objective around which we organize the delivery of services and support for mental health.

The Committee is well aware that not all of those suffering a mental illness are going to recover. Nevertheless, we believe the central goal of our mental health policy must be to encourage recovery. By stressing recovery, we place the accent on wellness rather than on the illness itself. Therefore, we make it our objective to help people with a mental illness to confront in an active way the limitations imposed by their condition, and to lead more gratifying, promising and productive lives.

Promotion of mental health and recovery from mental illness demands action focused on the social determinants of health - particularly those related to adequate income, shelter and employment, and

participation in social networks. It is important to note that a great number of Canadians enter the system because of poverty and an absence of social services.

An approach based on the idea of recovery acknowledges that it is an active process during which they assume responsibility for their own recovery.

Any recovery-based system will require a reorientation of mental health programs geared to choices from a broad range of services available in the communities people live in, and on the integration of all kinds of support and services, regardless of distinctions between public and private, or professional and non-professional.

The development of a recovery-based system is, admittedly, a complex undertaking, but it has the advantage of prompting coordinated action from people working both within and outside the official mental health care system.

In practice, one attractive aspect of a focus on recovery is that it could help establish a framework for the assessment and evaluation of services, which is not sufficiently being done at this time. This approach centered on the person inspires all our recommendations that we will submit to governments.

Since we adopted a very comprehensive approach designed to address mental health and addiction at several levels, the Committee heard briefs on a number of special needs, including those of youth and children.

Mental health is often treated as the poor parent of our health care system. In our view, mental health services for children have been the “poor parent’s poor parent”, so to speak. Experts and other witnesses confirmed to us once more that our youngest citizens are not always well served by the mental health system.

Mental health services for young people are delivered very much in a piecemeal, uncoordinated manner. Most mental health policies and programs are still designed mainly for adults.

It is difficult almost everywhere to obtain mental health services and support for children and adolescents. When such services are available, the waiting lists are usually lengthy.

Aware that it is impossible to change things quickly and all at once, the Committee has focused in its final report on what we feel are key areas where corrective action is possible.

There is an obvious need for mental health professionals, particularly to work with children, so as to increase system capacity and shrink the waiting lists. The training of pedopsychiatrists is a long process. Due to the circumstances, however, we have to look elsewhere in the meantime. Our Committee advocates a few transitional measures to relieve pressure on the system, while the required corrections are under way. In this connection, distance care, alternative treatment models and case conferencing can be very helpful.

Distance care provides support to many families coping with real problems of access.

Distance psychiatry could be increased in rural and remote regions, where shortages of professionals are more marked, in order to facilitate the sharing of resources among poorly served communities.

When clinically appropriate, we suggest the use of group therapy to reduce waiting times. Instead of leaving patients and families waiting for care, they can be grouped to at least talk about mental illness. A prerequisite, of course, is that waiting lists be properly quantified and prioritized. Health professionals should receive training in this area.

Since all options must be considered in the effort to improve the level of service, case conferencing is another transitional means that the Committee supports, to increase the efficiency of the health care system and, ideally, to reduce costs. More sustained cooperation is needed between our health care, education and judicial institutions.

To cope with the emergencies that arise in the delivery of care to children and youth, we propose these few transitional measures to relieve the pressure on the system in the short term. Its survival depends, however, on a more thorough redesign to bring about the needed changes.

The Committee sees as a priority the whole question of the transition from systems and services designed for young people, to those for adults. We noted serious shortcomings that must be carefully considered to ensure uniformity in the transition from the system of health care and social services for children to the adult system. We are proposing care and social services that anticipate and allow for the transition from adolescence to adulthood. The key is to ensure that there is no longer a gap, and that the systems are seamless at the point where individuals become eligible.

The Committee places much emphasis on the importance of early detection in children affected by mental health problems. The fact that most adult mental health disorders occur during childhood reminds us, once again, of the importance of devoting more resources to early detection and treatment.

The Committee understands that as far as possible, services should be available where young people spend most of their waking hours: in school.

In this connection, the involvement of teachers should be encouraged and endorsed. To help them make an appropriate contribution, teachers should be trained in the early detection of mental disorders in children and youth. A profile of such training could be incorporated into teacher training curricula.

We do not expect teachers to make diagnoses, just to be able to acquire knowledge that will enable them to identify and understand the condition and types of behaviour in students that can be caused by mental disorders.

The schools must be better equipped than they are now to manage mental health problems in children. In our view, there are more pros than cons in recognizing the school as the main point of contact in relation to mental illness in school-age children. One way of achieving this might be through the administration of mental illness detection tools. Although we favour this method because of the potential benefits it offers, we do nevertheless realize that there are a range of approaches for the population groups that concern us, procedural

differences and legal obstacles that currently impede the rapid introduction of such early detection programs into the schools.

Any decision go forward in schools must be accompanied by education programs to reduce the still too negative perception of mental health and to encourage a wider acceptance and understanding of mental illnesses. Such programs may be essential to encourage students to seek help.

Generally, combating the stigma and preventing discrimination against the mentally ill has to be a priority. We have noted that the intensity of the stigma and discrimination inflicted on persons with mental disabilities, whatever their age, is one of the most tragic realities of mental illness in Canada. The stigma attached to mental illness is a major obstacle not only to diagnosis and treatment, but also to community acceptance. It drives people to remain silent about their mental illness and, in many cases, to put off seeking health care, avoid taking the recommended treatment, and refuse to share their concerns with friends and relatives or with health service providers.

Educating the public and the media about mental illness through a national campaign to remove the stigma is an important step.

Getting back to children, our Committee stresses the importance of early intervention in the schools, but without overlooking the fact that many problems arise long before a child starts school. On this point, we make the suggestion from the outset that the public should learn that the prevention and treatment of mental illness is a lifelong undertaking.

Families may have to make difficult decisions about treatment, hospitalization, accommodation and the level of contact with a family member suffering a mental disease.

We defend the elaboration and application of models in which families and children are collaborators and partners.

For us, it is in the best interests of all concerned for the patients of mental health and addiction treatment services, and their families, to participate actively in the planning, delivery and assessment of such services. Young people and their families should be full members of the treatment team, on the same basis as the health professionals. Health care is too important to be left to physicians, psychiatrists and nurses alone.

This transition is admittedly not an easy one, but the health care system has to adopt a family-oriented care model in which family members can assume their responsibilities.

In addition to being involved in service delivery, families must be supported financially, as well as the volunteers in support networks and self-help groups, who play an equally important role. All of these people need help, and the parents of autistic children must not be left out. As the family caregivers, they are at their wits' end. This came up constantly at our hearings. Treatment is expensive, and not always available to all the children that need it. We have concluded that the problems faced by autistic children in Canada can no longer be ignored. The Committee believes that the ideal framework in which to search for solutions would be a meeting of all the parties concerned with autism, including the patients.

Those are some of the specific areas to which our Committee will suggest solutions to mental health problems in children and youth once and for all. We are conscience that we have not covered everything, as the needs are enormous. We do believe, however, that we have elaborated a concrete and specific list which should allow for young sufferers of mental illness to be quickly identified and placed within the system, and not outside the system's framework. This conforms to the vision that has kept us motivated through our long work - that of establishing a model based on people rather than based on illness.

The Committee recognizes the importance of giving our report a national characteristic, but not necessarily a federal one. This characteristic constitutes, for us, an essential mechanism for the implementation of the reforms cited and recommended in our report.

This independent organization, without lucrative goals, which we are promoting, would group together representatives from different governments and other experts on mental illness issues, including individuals who live with mental illness and their families. This entity would establish partnerships and would facilitate collaboration by uniting government representatives that will play a key role in the transformation of the system.

This structure will complement other existing structures, but will especially ensure that questions concerning mental health stay at the heart of debates of public policy in Canada for as long as we have not found and applied efficient solutions.

No level of government alone possesses the resources required to surpass the vast range of mental health problems. This independent organization will help all governments in this regard by facilitating the exchange of information and networking knowledge about the best mental health care practices from ocean to ocean. This could be accomplished by the creation of a National Centre for the exchange of knowledge, accessible by members via the Internet.

It is important to establish a satisfactory relationship between the financing of the physical health care system (medical care and treatment) and the mental health care system and the treatment of addiction. The problem of financial resources is another subject, however, the Committee is expecting a lot from the federal government that has not invested in mental health care in a long time. We will be asking for an injection of funds specifically dedicated to mental health and addiction treatment; funds that will primarily help people out in the field. These new resources will be channeled in ways that do not allow them to be redirected towards other programs, which is currently the case. It is important to note that after two and a half years of studying the mental health care and addiction treatment system, the Committee has not succeeded in determining exactly how much is spent annually in each competence sector for mental health services and support.

I could spend more time talking to you about the upcoming report, but time constraints limit me to expressing only the essential points.

Our Committee does not believe it knows everything about this imposing topic. Our report will perhaps not contain all the expected answers.

We hope therefore that our recommendations act as a catalyst for open and informed debate on the reform of the mental health care system and addiction treatment. Our Committee hopes that our conclusions will contribute in maintaining the winds of change that have blown stronger over the past few years, during which we have studied this problem. We also believe we have taken a big step in the direction shared by most individuals and groups involved in mental health care.

Due to the enormity of the challenge, the Committee truly thinks that it is impossible to transform the mental health care system in a single step. We can however advance, but only if we elaborate a pragmatic reform and if we adopt a gradual approach for the application of such reforms. In working together, we can make a difference in the lives of people living with mental illness and their families.

Through this Summit that begins today, participants in mental health care in Ontario have arrived at a crossroad, where enlightened deliberation will inspire a bright future. The conclusions to your work will without a doubt contribute to this deliberation and bring new solutions to previously unanswered or unasked questions.

I hope the work you accomplish during the Summit further feeds the action plan in mental health for youth and children that you hope to support, and that you hope all the provinces will support.

Thank you. Merci.