

# **HANSARD**

**NOVA SCOTIA HOUSE OF ASSEMBLY**

**COMMITTEE**

**ON**

**COMMUNITY SERVICES**

**Thursday, February 23, 2006**

**Committee Room 1**

**IWK Mental Health Services for Youth**

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**COMMUNITY SERVICES COMMITTEE**

Ms. Marilyn More (Chairman)  
Mr. Mark Parent  
Mr. Gary Hines  
Ms. Judy Streach  
Mr. Jerry Pye  
Mr. Gordon Gosse  
Mr. Stephen McNeil  
Mr. Leo Glavine  
Ms. Diana Whalen

In Attendance:  
Ms. Mora Stevens  
Legislative Committee Clerk

**WITNESS**

IWK Health Centre

Ms. Susan Mercer  
Interim Vice-President  
Child and Adolescent Mental Health Services

**HALIFAX, THURSDAY, FEBRUARY 23, 2006**

**STANDING COMMITTEE ON COMMUNITY SERVICES**

9:00 A.M.

CHAIRMAN

Ms. Marilyn More

MADAM CHAIRMAN: I'm going to call the Standing Committee on Community Services to order. This morning we have as our topic the IWK Health Centre - Child and Adolescent Mental Health Services. We're very pleased to have Sue Mercer with us today. Sue is the Interim Vice-President of Child and Adolescent Mental Health Services. So perhaps we can introduce ourselves.

[The committee members introduced themselves.]

MADAM CHAIRMAN: We generally start by asking the witness if they'd like to do a brief overview or a presentation before we enter into questions and answers.

MS. SUSAN MERCER: I chose not to do a power point presentation, because I've been to six in the last two weeks and they've all broken before people started. The amount of time it takes to figure out how to get the laptop and the projector working, I thought I could talk that much and you would get more information.

I'm the Interim Vice-President of Child and Adolescent Mental Health at the IWK. I've been in that role for almost three years; prior to that I was Director of Speciality Services; prior to that I was the team leader of the crisis team in the emergency department; and prior to that I was in Ottawa. So my knowledge and experience come from about 1997 to now, personally.

What I thought I would do is give you sort of an overview of the IWK Child and Adolescent Mental Health Services. I know you were particularly interested in the Adolescent Centre for Treatment, but that is part of the continuum of what we offer, so I thought I would talk generally about what we do offer, and then if you have particular questions around the ACT program I certainly can answer those. If there are questions that come up that I can't answer, because I'm not there day to day in that particular program, I certainly can go back, find out and come back to you.

I sent you out some printed information, and what I thought I would do is just, first, start with the organizational chart. If you want to just look at the chart it gives you an idea of how our services are set out at the IWK. We have program-based care, so we work in interdisciplinary teams. The person responsible for running those teams is a director, but they have a clinician leader or a physician leader working with them to ensure that the clinical aspect of the services, along with the management, are where they need to be.

Right now we have two directors, one of specialty services and one of ambulatory and forensic services. We call our specialty services anything that's sort of the more intensive, so that would be our two residential programs, our in-patient unit, our intensive community-based treatment teams, our day treatment, anything where people have probably been through a lot of the system and require much more intensive service - that would be under that category.

The other area is the community mental health clinics and the forensic services. Our community mental health clinics are in the community, as the title indicates. We're in Sackville, Dartmouth, Young Tower, Halifax. Our forensic services are at the Waterville correctional facility and also at Young Tower - we do some rehab services there - and also on our in-patient unit. That's an area which I can speak to in a little bit that has expanded in the last couple of years with the changing of the Young Offenders Act and the transfer of some funding from the Department of Justice to the Department of Health. That's an area that we've been responsible for for quite awhile but, really, the numbers have increased since the Youth Criminal Justice Act has come into play.

That's kind of how we're laid out. We work together as a team. There are psychiatrists, directors, clinicians, and the team, the operations committee runs the operations of each of these teams, because we are quite spread out for a program. If you look at the IWK Health Centre, people always think of up there on University Avenue where you've taken your child or you've gone to have your baby, but actually the Mental Health Centre only has one of the teams in the health centre, everything else is out in the communities. We're very spread out, and we spend a lot of time travelling around to the sites, meeting with staff and running the program.

The other thing I wanted to talk about briefly was - I don't know whether it's good or bad - but the mental health program has actually grown since 1997. When I first started in the emergency department we were fairly small, and we've actually doubled since then which, in health care, I think is quite phenomenal. It also indicates that either there's more

awareness of what children and adolescents and family require in that area, or that people are dealing with more. I'm not sure what it is. I don't know whether there's more awareness, so there's less stigma, and families and children are okay with accessing help, or if just the situations and the illnesses people are facing are more difficult. I think it's probably a little bit of both.

A couple of weeks ago I did a presentation for a group called Reaching Out, which is a group of parents, families, and consumers, who come together to establish a chair for adolescent mental health at Dal, I did a presentation for them. I just included that. It's very high level and very generic, and I can answer more detailed questions. It does give you an idea from when the merger happened in 1995 to 1997 as to where we are now.

At that point there were three groups that came together, the ACGC, people may remember it was the old Atlantic Child Guidance Centre, which was very much an office-based, appointment, clinician-driven mental health program; the Nova Scotia Hospital, which had programs for adolescents and children; and the IWK. Those three programs merged and became the IWK Child and Adolescent Mental Health Program.

Every year since then, as a program, we've looked at ourselves, we've reviewed different areas, we've reviewed different aspects, we've taken teams that have been in existence for a while and said what is it about these that are working, what is that isn't working, how can we expand. Each year, if you start to go through this, you can see that things have expanded. We've always attempted to meet the needs of children, adolescents and families who are out there in the areas of mental health.

We're quite involved with the Department of Health, developing standards for mental health service in the province. Children's mental health is offered in the nine DHAs and the IWK. We are the tertiary, the in-patient, the specialty services, but there are components of children's mental health in all of the DHAs. We were part of working very closely with the Department of Health to develop the first mental health standards in Canada for how we provide mental health service. Out of that, we've been able to adapt or change or increase the way we do certain things. We've really expanded the way we work in the community. I think we've known for a long time that families, children, and adolescents who are in crisis are not always able to come to your office, to make an appointment, to show up at a certain time.

We've really focused our expansion in the last few years on being out in the community. So we have shared-care positions. We have a nurse and a social worker who work at the North End Community Clinic, J.L. Ilsley High School, Cowie Hill, out there working with family physicians, working with teachers to do shared mental health service. We have an intensive community-based treatment team, there are five or six youth care workers who have clinicians overseeing their work, a psychologist and a social worker. They're out there in the schools, in the classrooms, in the homes, working with the kids who really just have not been able to stay - you know, the track, when you're thinking of kids in school, these kids are outside of that.

We have our two residential programs, which I'll speak to in a minute. Then, most recently, we've hooked up or partnered with Dr. Pat McGrath. You may know his name, he has a column in The Daily News, and he's one of the world-renowned researchers in pain and anxiety disorders. He has developed a program, a treatment-based program that's distance, so it's by phone and Internet. We've recently partnered with him to have him as one of our treatment providers, so when a family is referred, or sent for a referral, that is one of the options that's offered. It works quite well, particularly for disruptive behaviour.

Sadly, a lot of the kids who sit on our wait list, our elective wait list, are disruptive behaviour, because if you're looking at a family, say you have two referrals and one is a young person who is suicidal or starting to become psychotic and the other is a young person who is pounding holes in the wall and his mother doesn't know how to deal with him, they're triaged a bit lower than the suicidal and the psychotic. That's our emergency, that's who our services focus on.

We've always recognized that these other kids, although they don't have an acute mental illness, there is nowhere else in this province or nowhere else in the city to get that help. It's not like you can say, oh well, you can just go over here and get help there, these are families that I'm sure you people hear from, because they're quite frustrated, they're quite upset, it's disruptive to their families.

In the last year we've developed this program called Families First, which is treatment groups, and Family Help, which is working with Dr. Pat McGrath. Again, looking at best practice across North America, different ways to work with these kids to meet the needs of these children and families without offering your traditional office-based help. So that's sort of the gamut of what we do.

The forensic services are very particular to a very particular group, which again, as I said, our court-ordered assessments are probably up 30 per cent just in the last few months. I think that's probably in relation to a lot of media focus around kids in the media who may or may not have mental health problems. Certainly, I think judges and lawyers are questioning it more, so we are asked more to assess - does this person have a mental illness in relation to their crimes that are being committed.

If, indeed, they find out they do, we are responsible for treating those youth if they are found non-criminally responsible in a psychiatric way until their 19<sup>th</sup> birthday or until they have an absolute discharge. We do that in our in-patient unit. We do it through our Adolescent Centre for Treatment, which I will talk about, and we have a rehab program. We have someone who follows the person in the community or works with the community provider in another community if, for example, it's Cape Breton, Lunenburg, or somewhere they would just be travelling all day.

So the forensic services certainly has challenged us in the last couple of years. It's a whole new way of thinking and working, and it's a very specific skill set, which there isn't a lot of in Canada. So if you look at our vacancies you'd see that we probably have a

couple of forensic psychology vacancies, because it's not like people don't want to work here, there's just not a lot of them in Canada. It seems that every time we have someone, either their partner gets transferred to another part of Canada or they get pregnant. So you're always dealing with trying to replace this very specific skill set.

We're getting there and we're working very closely with the Department of Community Services and the Department of Health to develop specialized places for these kids to be in the community when they leave our health centre. You also can't have a child living in a hospital until their 19<sup>th</sup> birthday, but there are big challenges to supporting them in the community. So there's a lot of collaboration work going on between the two departments and the IWK to provide this.

If you looked at our organizational chart, it would be all of our different teams. I can talk a little bit about our two residential programs which, I think, specifically, you had some questions on today, then I will just open it up to questions. We offer two, what you would say, psychiatric rehab residential treatment programs. One is the children's response program for children up to age 12, which up until probably a year ago was funded fully by the Department of Community Services, partially by the Department of Health and a small portion by the Department of Education. The funding for that recently transferred to the Department of Health. The program has stayed the same, it's just the funding that has changed.

They're located at the APSEA building on the 4<sup>th</sup> floor. It's apartment-style living for 16 kids up to age 12. Kids who have been through every part of the system - all types of help hasn't provided help to that family. A lot of disruptive behaviour, conduct disorder, very serious behavioural problems, most likely not in school. We provide very intensive treatment to these children in that program. We have a therapeutic classroom, full-time psychologist, social worker, nurse, psychiatrist two and a half days a week, so it's a very intensive program. The program is designed to treat and stabilize youth, to help them move back into the community, whether it's to a foster home, their family, or whatever else was worked out, working with the referral agency.

The second residential program we have, which is the Adolescent Centre for Treatment, is for ages 12 to 19. That was set up, I would guess, four or five years ago, maybe three or four years ago. It started a few years before that on an as-need basis. There were a couple of youth who required this 24/7 intensive, supportive treatment. We started this program with per diem funding from the Department of Health. You would have a youth who had this, this, this, and this, and you would sit down and say, okay, where do they go? One by one, this program set up. Then we started to realize there's a lot of youth being sent out of province and a lot of youth receiving treatment that could be provided here in Halifax or here in Nova Scotia. As part of the Department of Health's continuing care and developing the standards, we received funding to expand that program to 12 beds.

We are located at the VIA train station. I don't know if anyone has been down there but it's a beautiful program up on the third floor. You wouldn't know that by looking

outside VIA, you wouldn't have known that when you saw it when it was an empty shell, but they did a really good job of renovating it.

There you have 12 beds and, again, they're apartment-style living. It's a very intensive rehab treatment. It's a voluntary program, so kids volunteer to come into it and they can volunteer to leave. We have psychology, occupational therapy, social work, nursing, a therapeutic classroom, psychiatric services, and it's operated 24/7 by youth care workers.

[9:15 a.m.]

The bulk of the kids being referred there have, again, quite severe behavioural problems, probably with other additional issues like depression, schizophrenia, eating disorders, anxiety disorders - definitely a lot of conduct and behaviour problems. Again, the focus is to stabilize and treat the youth in that treatment facility, but to move them back into the community as quickly as possible. Best practice says six months to a year, and we're running probably nine months to a year, depending, again, on next-step placement, which is often a bit of a stumbling block for any of these youth as they've sort of burned their bridges everywhere before they reached us.

Even the best well-meaning families, foster families, are a little shy about taking these youth back. So we really try from the minute they're admitted to work with wherever they're going, next step, to find somewhere for them to live. That sometimes breaks down. We're working quite closely with the Department of Community Services right now to look at, again, how do you support - you know, some of these adolescents are 17, 18 and 19 and have been on the streets or have been on their own, so they don't fit into the happy foster family, that's not what their needs are, so how do we look at working with agencies like Metro Community Housing or specialized foster homes? How do we create something that meets the needs of the youth rather than trying to fit them into existing circles, square pegs, that sort of thing?

We also have attached to those two teams the intensive community-based treatment team, which I talked about earlier. They will provide the ongoing support for these kids and families after they leave, either after CRP, which is a very huge component of what we do - I think we learned lessons over the years that you can have a child in treatment and they do amazingly well, and then they go back into the community or back into the family and, unless there's some ongoing support and a team approach, things break down very quickly.

This is long term, this is a continuum of care. People don't need this residential, 24/7, very confined treatment all the time. You think of any adolescent you know who may not have any problems, they certainly don't want to be treated or confined 24/7. People need their freedom. So it's a fine balance between how do you work with these kids and families in treatment, and then provide the same support after.



One of the things that I think will help a lot of these programs - but also the programs, the kids and families we're not meeting - is our mobile crisis component. We've had an existing crisis team within our emergency department since 1997. Hopefully, as of this month, we will be expanding that to a mobile crisis component working with the police, EHS, Capital District, and the IWK. It will come together as a team to provide outreach and mobile crisis to kids, families, adults in crisis out in the community to be triaged, stabilized or, if necessary, brought to the emergency department.

I think that has been a huge gap in our system. I even remember when I worked in the emergency department, families would come in with children, and getting them to the hospital was the most traumatic part of the whole crisis, so having someone able to go out and assess and see how things are will take away that sort of in-between, how do you even get someone to a hospital to see a professional?

Gradually, over the years as we expand, each year we take a look at what we're doing and what works and what doesn't work, and each year we've reviewed, by external reviewers, one of our programs. We take that very seriously, we involve families, we involve consumers, community partners, and we review the program, we look at best practice and where we need to change that, if we do.

Out of that we always have a plan as to how we change things to meet the needs, and the most recent being last year we reviewed the in-patient psychiatric unit because it was time to review it, but also because we noticed with the increase in autism services that things had shifted on the unit and we wanted to know how to change to meet the needs of people using this unit. So we recently completed that review and we are just in the process of putting together a committee, including parents and consumers, as to how we roll that out.

So that's us in a nutshell. It's a lot to take in. I'm always amazed, when I talk about what we do, how spread out we are and how much we do, and it never seems to be enough. You have the printed information in front of you, and certainly I will be willing to answer any questions that I can.

MADAM CHAIRMAN: Thank you very much. To this point I have Gordie, Mark and Leo on the list.

Gordie.

MR. GORDON GOSSE: Thank you for your presentation. I understand the level of work that the agency does at the IWK, but when you began you said you were interim director.

MS. MERCER: Yes.

MR. GOSSE: Okay. I'm just wondering, how long have you been in that position and why hasn't the position been filled on a more permanent basis?

MS. MERCER: That's such a complicated question with the IWK. The Vice-President of Child and Adolescent Mental Health left almost three years ago, and at that point I was asked to be interim for a very short period of time. So I did. A new CEO was hired, who posted that position as permanent. That CEO quickly left. So the position was sort of put on hold, and they said, could you just stay in it. I said, yes, of course. It took a while to get another new CEO, Anne McGuire has since then started and has actually restructured the whole senior team. So the VP of Child and Adolescent Mental Health is no longer in existence, it will be combined into one clinical VP. That has been posted for, and they're in the process of being interviewed. Right now at the IWK there's a vice-president of children, there's a vice-president of women, and a vice-president of mental health. The three VPs are part of the senior team. So that's being amalgamated to be one clinical VP position.

MR. GOSSE: The mental health treatment you were mentioning for youth, are you still receiving referrals from, say, probation within the Halifax area here? How long is the waiting list? Would you have any idea of how long it is for somebody who is referred from probation to the service?

MS. MERCER: We do receive referrals from probation, and we actually did sort of an assertive outreach to probation officers, as part of forensic services, to say, we have social workers and psychologists that are particularly part of the forensic rehab team and can work with particular youth. So it's not that they're fast-tracked in, they're referred through our regular central referral process, but if there is probation involvement and if there are requirements, they certainly can be seen quite quickly. All of our referrals to the IWK are triaged through central referral, using a standard triage system to look at the acuity. So whether someone's on probation or not wouldn't matter if someone was suicidal or psychotic and needed to be seen right away.

Certainly we have services that are dedicated to probation, and we work quite closely with Probation Services. There's a joint forensic committee, with the Sheriff's Office, Probation Services, IWK, everyone comes together, and we're constantly looking at that.

MR. GOSSE: The reason I asked that, the recent events in the news lately with car thefts and behaviours of young people and the way things are going with young people in society today.

MS. MERCER: It's always a challenge, because if the young person doesn't want to get the help or doesn't want to access the services, you're kind of in a bind then because what we have are voluntary services unless they're . . .

MR. GOSSE: Court ordered.

MS. MERCER: Court ordered or incarcerated. Even then someone can just refuse and just sit there.

MR. GOSSE: We just talked about your being the interim director. How is the department doing recruiting psychologists and therapists to the IWK? I've noticed on the Web site that there's still probably seven or six jobs.

MS. MERCER: For psychologists. It's quite interesting, because if you had asked me a year ago I would have said, hey, all our positions are filled. It kind of goes up and down, but right now we do have a couple of forensic psychologist positions vacant. I believe there's a couple of autism, which I'm not responsible for but I believe there's some autism psychologists - it's a very specific skill. We actually met yesterday to look at - for court-ordered assessments only psychiatrists or psychologists can submit the assessment, but we're looking at how we can hire maybe some forensic social workers, to work with less psychologists, to still do the same assessment, but have it as more team-based, to again rethink how you do things with a market demand and only so many resources. We're doing aggressive recruiting, but it's very competitive across the country.

MADAM CHAIRMAN: Mark.

MR. MARK PARENT: Thank you for your presentation. Leo and I, having worked with Anne McGuire before, we know that you'll be pleased. She's a wonderful person . . .

MS. MERCER: Excellent, yes.

MR. PARENT: . . . and did a great job in Annapolis Valley Health, I'll tell you that much. I have a few questions for you. One of the concerns I have is the centralization of services at the IWK. For my riding, that's okay, but for ridings in Yarmouth and Cape Breton, how do you handle services there? Do they all have to come in to the central core?

MS. MERCER: Each of the districts - again, I don't know the details - do receive funding from the Department of Health for child and adolescent mental health clinicians.

MR. PARENT: So you're the secondary referrals.

MS. MERCER: We're secondary, consultation or in-patient. There are no other in-patient beds, so we certainly do the in-patient. Our psychiatrists go to Cape Breton, P.E.I., Amherst and work with the clinical teams there. We also do telehealth to all those areas.

MR. PARENT: But all the in-patient beds are here.

MS. MERCER: The in-patient beds are here, but the follow-up will go back to their home community.

MR. PARENT: It presents a bit of a challenge if you have - how young would they be, they could be fairly young.

MS. MERCER: Again, you always have a challenge, because you want expertise in a clump. So they've tried putting a couple of child beds in various areas, but if you don't have the expertise and you don't have the clinical staff working, then it's almost like you've just warehoused or just said this is a child bed, but the psychiatrist is still in Halifax. That's a challenge in New Brunswick, P.E.I., Newfoundland and Labrador. You see that everywhere, and it's not just psychiatry, I'm sure you would see it with cardiology, you need . . .

MR. PARENT: I'm just thinking of the age of the children.

MS. MERCER: Definitely.

MR. PARENT: Is there any help for the parents who may be living in Yarmouth and have their child at the IWK to help them visit and maintain frequent contact?

MS. MERCER: We certainly encourage families to room in, to stay at the health centre with their child if they want to. A lot of families will use Ronald McDonald House, and we're actually in the process of building a Ronald McDonald room at the health centre, where families can stay there also. The bulk of our in-patient admissions are older children. We don't have a lot of little kids on the in-patient unit for various reasons, not a lot are referred, and you also don't want little kids away from their families. You try to have the treatment in the community. So certainly our social workers work with the families as much as they can, to do that link back and forth so it passes back to the family as soon as possible to try to establish the treatment back in the community.

MR. PARENT: Good. Have you noticed an increase in gambling addiction problems with adolescents and mental health? It's a concern I've had for quite a while.

MS. MERCER: As you probably noticed on one of the forms I gave you, the Addiction Services is in the process of being transferred from Capital District, an adult service system, to the IWK. So the CHOICES addictions program, which is for age 12 to 19 will come under the IWK as of April 1<sup>st</sup>. Up until now, we haven't been treating or working with addictions. We certainly see them, we have a psychiatrist who works at CHOICES who is part of our program. I've heard through various meetings that gambling is increasing. I certainly know that will be something we'll be focusing on once the program is part of the IWK. I think there is a general concern and awareness that this is increasing.

MR. PARENT: How about mental health illnesses as a whole, are they increasing amongst the adolescent population, or is it just better diagnosis?

MS. MERCER: Well, that's what I was saying earlier, it kind of depends on who you talk to. There are certainly better diagnoses, but we are seeing more cases being

identified, too. So we don't know, is it because stigma isn't - when you look at mental illnesses, it's immediately the butt of jokes, or immediately the parents are blamed, and even though there's a lot of work done by agencies, such as CMHA and the Mental Health Foundation, around reducing stigma, it's still quite out there. I think as that reduces a bit, maybe families and adolescents don't mind seeking help as much. We also have teen health centres now. We have, as I said, shared-care workers in the communities. So there are more places for people to access health. We do a lot of work with Phoenix House, with street youth, so they're able to identify some of their youth as also having mental illness.

So it's probably a combination, I think, of more identification, better practice, but also people dealing with a lot more. Things like schizophrenia and depression, which have a stronger genetic base, it's hard to say whether that has increased or not, but we're certainly seeing more of it.

MR. PARENT: Are there environmental factors with certain diseases like that?

MS. MERCER: I think there are certainly environmental factors with a lot of things. If you have a child who is facing those issues and they're in a school where it has gotten bigger or there are less services or they're in a family where someone has lost a job and there's more strain at home, that's definitely going to impact what they're experiencing and what they're dealing with. I know there's a lot of work being done right now on resiliency by some researchers and how is it that when you have two kids dealing with the same thing, one seems to do just okay, and for the other one things fall apart. That's quite a big area of research right now. That will help us, because that will help us back up a bit and say, okay, how can we work with schools or the Boys & Girls Club, or whatever, to help develop these resiliency strengths for youth.

MR. PARENT: That was really where I was leading, because it's always less expensive to do health prevention than acute treatment on the end. So that's an area that you're looking at.

[9:30 a.m.]

MS. MERCER: We had a prevention education program many years ago that we cut when things were a lot leaner. What we said was it's kind of everyone's responsibility now to do that. Our funding and our purpose is treatment and, certainly when you have schizophrenia or depression or eating disorders, things where it's not really sure whether prevention would have helped it or not, you still have to continue to treat that, but we are definitely recognizing that you need to intervene earlier. For example, the work we're doing with Dr. Pat McGrath, by intervening with these families where kids are experiencing really disruptive behaviour, although at that point it may not be considered quite high on our triage list, if they just sat without intervention, then maybe a year or two down the road they're in jail, they're doing other things that if you had intervened earlier then you may have prevented that. So we're really trying to back up a bit in looking at early intervention.

We're not in the schools yet. There's some research out there that says you should be out there aggressively treating or seeking out kids of parents who have depression, because, genetically, that may happen. We're certainly not there. We're still very much working with kids who have been diagnosed, and also trying to look at early intervention.

MR. PARENT: Thank you very much.

MADAM CHAIRMAN: Mr. Glavine.

MR. LEO GLAVINE: Thank you, Sue, for being here today. It is always both a fascinating and challenging area. As an educator in a large high school, I know . . .

MS. MERCER: You saw your fill.

MR. GLAVINE: We saw our fill. Certainly that whole area and domain of talking about prevention is an area today where the traditional counsellor in a high school has become much more dealing with vocational and career and assessment of children, and not as much counselling, and the needs are terrific.

The area that I would like to go to today with you, Sue, is taking a look at the ACT program. You have fairly similar delivery under the mandate of the social community services with the Wood Street Centre. I'm just wondering, even though the IWK doesn't deliver that program, if you get referrals from the Wood Street Centre, and if you have, how many, and what kind of pattern or trend is developing there?

MS. MERCER: You're right, we certainly don't run the Wood Street Centre. It's my understanding that that's a short-term crisis stabilization locked unit. So it would not be considered the same treatment as our two programs. We certainly have many kids who go back and forth between us and Wood Street Centre. There is a relationship there. We don't do their crisis service, but we were certainly part of helping set up and train their staff. I know they do receive their crisis service from Truro. In the beginning, we were part of helping them set up what may be needed. It's the same kids. Under DCS, when they're in that time of very serious crisis and need to be locked and stabilized for a short period of time, they do access the Wood Street Centre, and we do get referrals back and forth. Beyond that, it's not part of our continuum.

MR. GLAVINE: Therefore, you wouldn't have a continual relationship with them, but rather more on a need basis, would that be fair to say?

MS. MERCER: Yes, and certainly I think professional people consult back and forth because Truro has a mental health clinic and has psychiatry, they are the main provider to the Wood Street Centre.

MR. GLAVINE: I remember, I think it was the Summer of 2004, in fact it was after one of our committee meetings here that the next day the newspaper headline read: Woman,

teen centre fails son. The mother at that time indicated that the Wood Street Centre model needed more mental health. I'm just wondering, again, having to look after our youth and adolescents who need mental health, have more of those needs been met, or do we still have gaps there that need to be filled?

MS. MERCER: Overall in mental health?

MR. GLAVINE: Overall, yes.

MS. MERCER: I think you'll always have gaps. For example, if you look at the crisis team, you could probably triple the number of people working on the team, but it's a start. So the fact that the police and the HS and the IWK and CDHA have to come together to work together and start that will give us a really clear indication of what's needed out there. Personally, I believe supports in the community and supports in school - a lot of the youth we have, placements are a huge issue with us, kids who are in hospital or in our residential treatment program who need to be out, there's nowhere for them to go. And a big part of that is figuring out how you support these families in the community. So you may have a child who can go home, but the school is saying there's no way we can take this kid in school, the family is saying we can't take this kid home, or the foster family is saying we can't take this kid if they're not in school. Then you need resources; you need to place somebody in that school with that child, for those teachers.

I think there are always going to be gaps, but I think it's important, too, to always look at how you're doing, what you're doing, and making sure you're doing best practice. We have a system where there is still, in this province, a lot of private practice people working with families in isolation, so there's no sort of accountability or no framework. You want to make sure that the service that families and youth are getting is researched and best practice - and there's an end to where you're trying to go. You can throw money at mental health forever and it may still not fill that gap unless you have it in a continuum and have a clear understanding of where you're going. That's why we took a real look at what we were doing with our in-patient unit, because the way in-patient services operate now is very different than years ago. You'll always hear people saying we need more beds, we need more beds, when in fact the bed part is such a small part now of treating mental illness. You need it in the community, because you don't want people inside a hospital for months on end.

MR. GLAVINE: Can I just stop you there for a second?

MS. MERCER: Yes.

MR. GLAVINE: That's exactly where I wanted to go, and if you take a look at the high-profile cases that have been in the media in the last months and the last couple of years, there's a very common theme that's unfolding there and that is that in the communities right across, from Sydney to Yarmouth, from Bridgewater to Amherst, we don't seem to have enough supports in the community. Is that a fair assessment, and how

can the IWK in its program do the branching that may in fact be the real strong support network that we do need?

MS. MERCER: I think if you look at the cases in the communities, you'd see that there's probably responsibility for everybody there, so it's Education, IWK, Community Services, Department of Health, the Boys & Girls Club. That old saying, "It takes a village to raise a child" - these kids need support in a community, you're right. But there may not even be a mental illness, it may be that the dad was unemployed and the child couldn't afford to go play baseball. It's so much bigger than mental illness - that may be one component to it - it may be parenting support, which can be offered at the Y, can be offered through schools, and it may be that the teachers need support in how to deal with this child, rather than immediately going the suspension route.

I agree, yes, we have to look at supporting youth more in the community, but it really has to be a collaboration, and it really has to be all of these programs working together, because I don't think it's one particular person's responsibility. Sometimes there's not a reason, a mental illness reason why that child is there. I know that's not a really clear answer, but . . .

MR. GLAVINE: That's part of the picture, yes, thank you very much. What about in terms of the wait list for the adolescent day treatment program, do you have a wait list?

MS. MERCER: Our wait list for adolescents isn't too bad - the day treatment or the residential component?

MR. GLAVINE: Well, both, really, since you've addressed or talked about both of these.

MS. MERCER: I don't have the numbers here. Our big wait lists are certainly in elective outpatient, which I said we're addressing with the Families First and Family Help, and the residential program does have a wait list. There are only so many beds. So what we're trying to do there is look at how we reduce the amount of time a youth stays in the residential program, and increase the community supports so more kids can come through. I think you could have many residential treatment programs and they would all be full and there would still be a wait list. Yes, we do have a wait list there.

MR. GLAVINE: Okay, that's good for now.

MADAM CHAIRMAN: Jerry.

MR. JERRY PYE: Madam Chairman, through you to Ms. Mercer, you had made comment with respect to the VIA Rail train station and the 12-bed unit that is there. I believe that 12-bed unit was introduced by the former Minister of Health, Jane Purves, back in 2003, as a result of reducing the number of children who leave the province for treatment. My question to you is, the 12-bed unit would not have satisfied the 2003 issue



of addressing the number of children leaving the province - I believe I should say out of province, because I believe there were some 28 to 30 children out of the province at that time receiving treatment that could not be given to them at home, in the Province of Nova Scotia. My question to you is, how many are out of province today?

MS. MERCER: I couldn't answer that because that would be under the Department of Community Services, that's who is responsible for the out-of-province treatment.

MR. PYE: But wouldn't you have some handle on that since you're a part of the program out of the Via Rail station as well?

MS. MERCER: Not really, because a lot of times those referrals, the out-of-province placements, are through the Department of Community Services and have not been involved with the IWK, or we're not aware that that's the route they chose to take. Certainly, I know that - well, I don't know, I couldn't even guess a number because we're not involved with that. The only time we would look at out-of-province placement through IWK or Department of Health is if we have tried everything we can within our system and that hasn't worked. I know in the last year or two we may have had one or two, particularly around eating disorders, who we had to request out-of-province treatment for, but that's very particular - all treatment within the IWK had failed that person.

MR. PYE: Can I ask you as well, some of the youth who have severe emotional problems and mental illness leaving this province, is that a result of the lack of professional services that we have available in this province, or the expertise?

MS. MERCER: Through the Department of Community Services, putting them outside the province?

MR. PYE: No, through the programs that are delivered by the IWK, because you did indicate that you indeed referred a couple of individuals who may have to go out of the province, because . . .

MS. MERCER: Yes, and they were treatment-resistant youth who went to a very specialized program in Toronto - one maybe two - around a particular illness. The ACT program, as I said earlier, sees mainly severe conduct disorder and disruptive behaviour. We do have a wait list there and, again, if you had more beds you could fill them. I don't know how many of those youth who get referred to us are waiting, because we also provide supports while they're waiting, so it's not like they're just waiting with nothing, they have the intensive treatment team or an existing clinician. What we try to do is maintain and stabilize in the community until there's a position open. I don't know how many of those are referred out of province by the Department of Community Services.

MR. PYE: How many youth are on the wait list for the ACT program?

MS. MERCER: I don't have that number right now. I would guess six, but please don't quote me because I don't have the latest stats in front of me.

MR. PYE: The single most important issue that comes through my constituency office is around children who have severe emotional/behavioural problems in school. The parent is at a loss as to what to do, the education system just suspends them from the school, and they're sent out into this wilderness of nowhere. The parent might be working, they don't know where their child goes once the child leaves the school grounds. The community constable in my area, it was just two days ago, came and talked to me and said, look, it's impossible to address these issues, because when we want to refer the children to the IWK, there seems to be such a long wait list. Now you tell me that there's a Families First program, and I would imagine that's the initial step that some of these children will take, or should take, to go through - right?

MS. MERCER: Certainly, if their needs could be met by that, they would be triaged through central referral and referred to that.

MR. PYE: What is the wait list for children who have severe emotional/behavioural problems and who are coming directly to the IWK for an assessment?

MS. MERCER: Again, it depends on how they're assessed and their triage. Our wait list is our elective triage, someone who's referred, it's not urgent, it's not an emergency, it's elective. The standards in the province say an elective can wait, I believe, six to eight weeks before an appointment - and don't quote me on the standards, I don't have them in front of me. That's where our wait list sits.

Since we've introduced the parenting groups, the Families First, the Family Help, in the last three or four weeks we've had 17 of those kids, sitting on our wait list, taken off the wait list and receiving treatment. What we're doing is looking at what we have and working with resources to try to meet those needs, because when you triage a youth with disruptive behaviour, as you said, a kid who's getting kicked out of school, it's not an acute mental illness, so it's not an emergency, it's not urgent, but it's causing a lot of family disruption, we try to figure out how we meet these needs, and that's what we're focusing on, our elective wait list.

[9:45 a.m.]

MR. PYE: I guess there are three levels of needs, urgent, emergent and non-emergent, just run me through a process of someone coming in, how you do that assessment.

MS. MERCER: A family or a doctor or a teacher or the people themselves could phone central referral, which is our central intake for all of our programs, and they are triaged by master's-trained clinicians and asked a number of questions and discuss what the issue is. From that, they are assessed. If it's urgent, please go to the emergency

department right now, emergent; if it's urgent, they'll receive a call and get an appointment within five days; if it's elective, then they're referred to the next slot, wherever that is, in one of our outpatient treatment programs. Again, the appointment could be many months out there, because that's where our wait list is elective.

MR. PYE: Some of the numbers that I've asked you for today and you were unable to provide them, is it possible to provide them to us?

MS. MERCER: Totally, I could have them with the press of one button. I can get you that.

MR. PYE: Thank you. The final question is probably not something that you might want to answer but I'm going to ask you anyway.

MS. MERCER: That's always a good warning, isn't it?

MR. PYE: It's around the Young Offenders Act. I know that you've made comment with respect to working within the framework and the structure of the Young Offenders Act. Is there ever a need for a young offender who has a mental illness or has a severe emotional/ behavioural problem to be charged in an adult court, in your opinion?

MS. MERCER: You're right, I can't answer that.

MR. PYE: Who should? If the professionals cannot answer that, who should answer that?

MS. MERCER: I don't know. I think the whole young offender forensic is a very complex issue, which is why we have very specifically-trained people in that area. I wouldn't even want to hazard a guess at that, because I'm not trained in forensics, psychology, psychiatry, mental health, at all.

MADAM CHAIRMAN: Does anyone else want to speak in round one before I leave the chair?

MR. GARY HINES: Madam Chairman, I just want to ask some questions around the VIA train station project. You indicated, initially, that they came and went voluntarily.

MS. MERCER: It is a voluntary program, yes.

MR. HINES: Can you give me a little bit of an overview as to what kind of retention level there is opposed to those who would come in and determine for whatever reason they're going to move on? Is the door revolving?

MS. MERCER: No, we have a fairly good - kids seem to stay. The whole idea is that it's supportive and it's treatment, and you work with these families and kids before

they come in, also. There's a recreation component, there's a school component. Even if a youth says I'm leaving, you really try to work with them to say, okay, where are you going to go, what would be the next steps. We will still provide treatment and support if they choose to leave, because, again, confinement doesn't work for all adolescents and families.

MR. HINES: Thank you, Madam Chairman, that's all I wanted to ask.

MADAM CHAIRMAN: Ms. Whalen.

MS. DIANA WHALEN: Thank you very much for being here today. I can certainly say there's a lot of people in my constituency and many people I know who've had need of the services of the IWK Mental Health, and it's been there for them, although sometimes they have to wait. I know that when people do get through the wait list and they're taken on, it's a huge relief to a family.

There are a number of things you've mentioned today that I think are really positive, the crisis team that can go out and intervene before the families have to go through a lot of trauma to get the child to the hospital is good. As I say, I think you're doing a lot of things. I'm concerned about your funding. I'm just going through some of the old media clippings and so on, as well. One was from the Canadian Mental Health Association a year after the standards were put in place. It said yes, now you have really good standards and, as you said, you're first in Canada to do that sort of thing, that's an accomplishment, but where's the funding. It said they gave an E for effort in terms of the government funding to help you achieve what has been laid out.

I noticed, as well, the funding seems to have gone about \$1 million each year for the last few years, but the need is still so acute. I'm wondering, is there a best-case scenario that the hospital has looked at about what you need to take these services to the community?

MS. MERCER: The Department of Health asks each of the DHAs and the IWK to do a self-assessment each year on our standards. We look at the standards, we look at what we're offering and what we need, and we put a dollar figure to it. It's in the millions and millions. We constantly question what we're doing. I agree, you could throw a lot of money at it tomorrow and it still wouldn't solve it.

Our approach is we take what we're given and we try to do the most we can with that, which is why the most recent programs we've done are less intensive and more community based, because you can treat a lot more people, just offering support groups and parenting groups and anxiety groups as a part of treatment. Families often say, well, I can't get help and you'll offer a group, and they'll say, no, I want to go in an office where someone closes the door and talks to me. But that may not meet the need of that child and family. So we've incorporated the treatment groups as part of the treatment.

So when you're referred, we've studied and researched and said, okay, for this particular disorder, this is the best treatment available and offer this. We're really trying to

look at expanding and offering treatment that meets the needs without being as expensive. Your residential and in-patient are very expensive, but they're just a small part of treating that illness.

MS. WHALEN: I think you're doing a very good job without the resources that you need. Are you looking at other provinces for best practices, things that they're trying to do, as you say, in terms of utilizing other professionals or getting maybe the team approaches?

MS. MERCER: Certainly. Even with the mobile crisis component, we've looked to Toronto, B.C., to see what they've set up and how they do it. I think the fact that we're doing it in conjunction with the police and EHS is quite positive. The last thing you want is four different people out there doing crisis intervention on their own. We're not a big city and we're not a rich province, so you have to look at how you do what you do with what you can.

MS. WHALEN: I think the coordination part is very important.

MS. MERCER: It's huge.

MS. WHALEN: It's a good thing that you've moved on. On the idea you mentioned earlier about not wanting young people hospitalized, that you want to get them back into the community in one form or another, do you have any now who are hospitalized, not in your intensive in-patient program but who are simply holding hospital beds in psychiatry? There have been stories in the press before about people who have sat there for a long time.

MS. MERCER: Yes, we have, and that's where I referred to as the placement as our big challenge. We're working very closely right now with the Department of Community Services, probably on two or three youth who could be in the community, and what they need in the community isn't available. So we're figuring out how to create that. You have places like Phoenix that offer excellent community-based housing, but if you have a young person with certain crisis needs, you have to add something else to that so that they can stay in the housing and not lose it if there's a crisis. That's one of the things we're looking at, how do we provide staff to places such as Phoenix House to support these youth so they can stay there.

MS. WHALEN: Can you tell me what your relationship is with Laing House? That's sort of the upper end there, apparently they're 17- to 24-year olds who specifically have mental health issues.

MS. MERCER: That's a day program, that's not housing. Laing House is a day supportive program, voluntary, for youth with severe mental illness. They come to our in-patient unit and do outreach. We refer kids down there, that sort of 17- to 19-year age. We do have a relationship with Laing House.

MS. WHALEN: Certainly on your question of housing, that's something that's come up when we've discussed mental health for adults, as well, that it's so difficult and that we need supportive housing, we need places where people can live independently but with a lot of support around them.

MS. MERCER: I think the ideal is support when they need it and not as a criterion to where you live and not having to move once you get better. That has been the history of mental health housing, that when you get better you have to move because you don't need the supports anymore. None of us would want to lose our housing because all of a sudden we feel better.

MS. WHALEN: That's right. You really want to support them so that there is no regression. I wanted to ask you about the comments you made about so many people seeking private help. I know that comes up with constituents who come in and have problems. They've explored that, but that costs about \$120 an hour and it's really not available to a lot of people. You could go once or twice, but to set off on a program of treatment that meant you would be paying \$500, \$600 a month is just not possible. How can we integrate the kind of care that some of those people are getting, and maybe they're just getting a bit of it because they can only afford to go once or twice a month - how can you integrate that? Is there any way? You said that's happening independently, and there's no team support.

MS. MERCER: We encourage people, if they have insurance or if they have EAP programs to use those if there are problems they can deal with. We often find there's an overlap, too, and we will get referrals from the private practice group because things are much more complicated. I don't know how we integrate those two systems. My concern has always been that the people who are licensed, it's okay, so if you're a registered psychologist or a social worker and you're licensed, but there are also people in private practice and it's not a licensed body. None of us have any control over what they're doing or any awareness.

MS. WHALEN: Exactly. That's a bit of a concern. I have one other question, if I could, and that's the idea of early intervention. With a lot of mental illness, and a lot of it does strike in the early teen years or the adolescent time, when that begins, a lot of times parents or perhaps teachers don't recognize the signs and the behaviour. It might get a lot more acute before they finally seek help. This, of course, would create more work for you, in the sense of identifying earlier, but it's also easier to treat if you can have the intervention early and identify what the problem is. So I'm wondering if you're doing any of that kind of early identification either through schools, working with school boards, to identify mental health - train the trainer, kind of?

MS. MERCER: We certainly do public talks, and we offer public talks at the IWK, in their telehealth, around different areas. There was one on self-harm behaviour a couple of weeks ago, which I believe 55 people attended. We do education with schools when they ask. Again, to me, it's part of that going back to we really need to strengthen our

collaboration and work with existing systems. There's the teen health centres, there's PTAs, those types of things - the more awareness they have. The Department of Health recently released a depression strategy for teens, so there are booklets and posters being put up. A lot of it's about awareness and education. Places like the Canadian Mental Health Association are also important in that.

I'm a firm believer that it's not one person who can do all this, we really have to be working together. A lot of our programs work very closely with the schools around particular youth, and out of that there's an overflow and teachers learn about other issues.

MS. WHALEN: Have you worked directly, say here in Halifax, with the Halifax Regional School Board to do any in-servicing of teachers, counsellors?

MS. MERCER: We do, yes. It's not a regular, set thing, but we certainly when asked, do in-service with guidance counsellors and teachers. They attend a lot of the community stuff we offer, too.

MS. WHALEN: Thank you very much.

MADAM CHAIRMAN: Stephen.

MR. STEPHEN MCNEIL: Susan, I apologize for being late. If these questions have been answered, you can tell me to talk to one of my colleagues. It's around the intensive community-based treatment team. Do you just have the one?

MS. MERCER: Yes, there's one here, and there's one in Cape Breton.

MR. MCNEIL: Are there plans to have more, throughout other parts of Nova Scotia?

MS. MERCER: I don't know that.

MR. MCNEIL: What happens to youth in rural Nova Scotia who require that treatment?

MS. MERCER: I believe when - and, again, I can't speak to the funding to the other DHAs - the two ICBT teams were set up in Cape Breton and in Halifax, and the other DHAs received funding for additional child clinicians. Cape Breton and Halifax were chosen because we have the numbers for that type of work. It's a community team, so they're going out to the schools, and we have the numbers of youth and kids. There aren't a lot in the other communities. I'm not sure why they chose not to set up intensive community-based treatment teams.

MR. MCNEIL: I think you alluded to it a bit, to my colleague, the member for Halifax Clayton Park, but around the high schools and the health centres that are in the

high schools, does somebody go out on an annual basis to talk to the people who are actually providing the service in the high schools?

MS. MERCER: We work with the teen health centres. The teen health centres are not run by us, they're run by Public Health, I believe. We work quite closely with the teen health centres, and we do have a shared-care nurse who goes to J.L. Ilsley and works with that particular population. There's regular collaboration. We're aren't particularly stationed in the schools.

MR. MCNEIL: Again, I'm thinking of rural Nova Scotia, and The Gold Door, for example, in Middleton. Are there people from your program who would go out or would be able to go out?

MS. MERCER: Not to the rural - well, we do for some of the forensic, we do training in other areas of the province, but each of the other DHAs have child and adolescent clinicians in their health centres, so they would do that support work with schools there. If they needed a consultation from us, we would certainly provide that.

MR. MCNEIL: So what happens if somebody in a rural school believes there's a mental health issue that someone needs some support with? Where do they go?

MS. MERCER: They would call their local health authority, and they do have child and adolescent mental health workers and clinicians.

[10:00 a.m.]

MR. MCNEIL: And then they would end up being funnelled into your program?

MS. MERCER: Not necessarily. They do treat in their local community. The only time they would come to ours is if they would need an in-patient admission, or if they needed a second consult by a specialty clinic. Then that's done through . . .

MR. MCNEIL: I guess one of the challenges and one of the things I'm trying to come to understand a bit, the health centres that are in the schools deal with a variety of issues but as you alluded to earlier, mental health is one of those things that it's tough enough to get somebody to talk about and it's 10 times harder, I'm sure, for someone to even consider there's a mental health issue if they don't know anything about it. I'm wondering, are we branching out to those health centres in trying to at least provide some support for those teens that are struggling?

MS. MERCER: I'm not sure of the status of teen health centres in the schools and the rural areas. I know in Halifax there is one in each of the high schools. I don't know about the rural areas. But in each of the DHA health centres, like hospitals and clinics, there are adolescent and child/youth clinicians that the schools could access there for



support. It doesn't necessarily have to come to the IWK. We're sort of the next step after - if they haven't received the help and the support they need in their local community.

MR. MCNEIL: Would you say there's a gap in mental health services in rural Nova Scotia?

MS. MERCER: I don't know. I work in a professional basis with clinicians and other administrators in the rural areas. I certainly know, for example, Bridgewater, Cape Breton, you know, they would say they have child and adolescent youth workers or clinicians. I don't know if they would consider they have a gap or not. It's run independently for each of the DHAs and we are sort of the next step, or tertiary treatment. You don't have to come to the IWK to get that help.

MR. MCNEIL: Thank you. Also around the alternate funding agreement for psychiatrists, it was suggested that perhaps that funding program would help fill some of the void that we had and encourage, I guess, psychiatrists coming . . .

MS. MERCER: With psychiatrists?

MR. MCNEIL: Yes.

MS. MERCER: It has. It certainly has for child and adolescent. Psychiatrists were - you know, if you had asked me a couple of years ago, I think we were at 12 out of 17 and we are probably 15, 16 now.

MR. MCNEIL: Out of 17?

MS. MERCER: Yes. Which is our complement.

MR. MCNEIL: And you attribute all of that or most of that to the alternate funding program?

MS. MERCER: I don't know but it certainly was coincidental that around the same time - I think we're fairly competitive now and we've been able to hire some new psychiatrists. I think we're quite fortunate because right across the country, again, there's not a lot of child and adolescent psychiatrists. It's not just Nova Scotia that are looking. We're doing okay. You know, I'm sure many people would say, well, you have a complement of 17, you need 35, but of the complement we have, we're getting up there to filling complement.

MR. MCNEIL: Thanks very much.

MS. MERCER: No problem.

MADAM CHAIRMAN: Thank you. I'm going to ask the vice-chairman to take the chair.

[10:03 a.m. Mr. Mark Parent took the Chair.]

MS. MARILYN MORE: I have a couple of questions I want to ask you. One is fairly broad and I will wait a minute to get to it. But what I wanted to clarify is the voluntary nature of the youth and children in the residential programs. I understand, because a couple of my constituents have been personally involved, that these youth can actually contact a medical professional and sign themselves out at any time, including the middle of the night.

In one case it involved a very developmentally-delayed young woman. Basically, she was out on the street without her parents' knowledge. She had the coping abilities of almost a preschooler. I'm just wondering, are there any protocols that can be put into place to safeguard the physical safety of those residents?

MS. MERCER: Well, before anyone would leave their in-patient or residential program in the middle of the night, they would be assessed by the psychiatrist on call. The only way you can hold someone against their will is if they're a danger to themselves or others, under the Hospitals Act, or under the mental health legislation. That's around their competency and their abilities, to be aware of what their own needs are, and also, whether or not they're a danger to self or others. I don't know that particular case but, certainly, someone would have been assessed before they leave. Every effort would have been attempted to ask someone to stay but you can't hold someone against their will unless there is a danger to self or others, a component of that, if they're competent.

MS. MORE: There can't be a rule though that they're released to an adult? I mean, they can just actually, physically go out the door if they're judged competent?

MS. MERCER: Well, it would be no different than a 16-year-old who is, say, at home and in the middle of the night decided that they were going to go off to a friend's house. You can't physically hold someone against their will if they're not a danger to themselves or others. They would be assessed by a psychiatrist. We have psychiatrists on call 24/7. Again, every effort would be made to encourage that person to stay until the next morning. If they're adamant they're going, we work with them, okay, where can you go? You know, can we call a friend? It doesn't happen a lot.

MS. MORE: No, I'm sure it doesn't.

MS. MERCER: But, again, you can't hold someone against their will.

MS. MORE: Well, it's interesting because I know I've taken several family members over to the QE II for different medical procedures. They're told on the spot that unless another person actually comes up to the floor and escorts them down and takes them home, that they won't release them from the hospital.

MS. MERCER: Oh, they're probably under anaesthetic or . . .

MS. MORE: Perhaps, perhaps not.

MS. MERCER: That's very different, yes.

MS. MORE: But if you can do it on sort of the physical treatment side, I'm just wondering why there can't be enhanced safety protocols, where the . . .

MS. MERCER: Believe me, it's something we look at every single time and looked at it over and over, but really the bottom line is that if someone is competent to make a decision and they're not a danger to themselves or others at that point for psychiatric reasons, you can't hold them against their will.

Again, as I've said, because of the way the environment is set up, fortunately, this doesn't happen a lot because people are in a supportive environment. When someone does do this in the middle of the night, every effort is made to try to ensure that they're going somewhere safe, whether it's Adsum House, Phoenix, Metro Turning Point, or somewhere, or another family member is available to pick them up. But people have their own rights and it's a balance between that person's rights and the rights of the community.

MS. MORE: I just want to touch on the other issue and I may come back to this in round two, as well. From my casework and my work as the critic for the Department of Community Services, I sense - how can I put this? - some stress between the Department of Health and the Department of Community Services, especially around children in care. There seems to be a tendency to want to off-load responsibility on the other department. A lot of these cases involve very difficult situations that are complex, multi-layered and there's no easy answer in terms of treatment or help for the individuals.

Now, I know the IWK is not part of capital health. I'm just wondering, what sort of liaison and coordination or collaboration mechanisms are in place, especially between those two departments, but also with Capital Health and the other district health authorities, especially with these difficult cases of children in care?

MS. MERCER: Certainly, it's a lot better than it was. As I mentioned, I don't think it's for lack of anybody trying but what these kids need doesn't exist. So you have a child who is in care . . .

MS. MORE: Doesn't exist here or anywhere?

MS. MERCER: Anywhere, because it's particular to each of those children's needs. What we found works best is that we pull together a team when we come up with a child who is in this situation and we create what's needed for that child with the IWK, the Department of Health and the Department of Community Services, in a room, meeting and working together to look at their needs. You know, DCS has certain programs; they have

the group homes, foster homes, community service for adults. We have a child here whose needs just aren't met by that, so we have to create something. That's not an ideal situation but it's where we are now.

Yesterday, we had a meeting with the Department of Community Services and the IWK because we have several youth right now who are ready to be discharged and there's nowhere for them to go. One of the examples I gave you earlier was a young person who, probably, we're hoping will go to Phoenix House and we will provide extra support. Phoenix is excellent for the population they serve. When you take some of the problems our youth are experiencing, it could just destroy their whole program by one person so you don't want to do that because then you've disrupted the lives of 16 other youth for one youth. So you have to work together to meet those needs. It's not ideal but it's what we're doing now and really trying to figure out what the needs of these youth are and create that.

MS. MORE: Well, youth in temporary or permanent care of the Minister of Community Services often have low, medium and high levels of mental health concerns. Are they put on your elective wait list the way every other young citizen of Nova Scotia would be, or are they given any special access to mental health . . .

MS. MERCER: They would be triaged. Their care status wouldn't be taken into account. Their mental health would be triaged, is how you would look at that.

MS. MORE: So if they were just acting out or misbehaving in a very strong way, that would not be considered an emergency situation at all?

MS. MERCER: It certainly would depend on what that particular case was at that time. We work with a lot of kids that are in care and provide the support to the families, the group homes, so they are receiving some treatment from us. We have our day treatment program that a lot of the kids that access that and come through that are involved with the Department of Community Services or Children's Aid. When they're triaged around where their acuity is and mental illness at that point, yes, their care status would not be what would be looked at.

MS. MORE: Do you have any suggestions on how the two departments can work more closely together, even on some of these issues, in terms of sharing or adding to each other's resources?

MS. MERCER: Well, there are several committees that I sit on with the Department of Health and the Department of Community Services. I think we need to continue to look at mandates and look at the children and families, and what their needs are and how we marry those. I don't fault DCS. They only have so much to offer and often, what the child needs that we are looking for, they don't have. So it's, again, how do we adapt what we have in existing resources? If we had tons more specialized foster homes, that would help, but there's only so many families that are willing to take these children.

MS. MORE: But isn't it true that if the issue of where the money is coming from was off the table, it might be easier to get a lot of these situations resolved?

MS. MERCER: I don't know. You know, I look in some other provinces where there is one ministry or one funding source and they have the same difficulties. It's often that the child needs the services that aren't there and you have to create something that's particular to the needs of that child and family. I don't know if that would be the answer.

MS. MORE: Okay, thank you.

[10:12 a.m. Ms. Marilyn More resumed the Chair.]

MADAM CHAIRMAN: We have round two and I think Mark is first.

MR. PARENT: Thank you very much. I just want to ask, in 2003-04, the Waterville correctional centre and the youth facility, I guess, the year afterwards came in under . . .

MS. MERCER: Sorry, the youth facility - I didn't hear the second part.

MR. PARENT: The youth facility.

MS. MERCER: In Waterville?

MR. PARENT: Yes. It came in under your umbrella.

MS. MERCER: The clinical services, yes.

MR. PARENT: How has that worked out?

MS. MERCER: We're responsible for the clinical services, not the correctional components of that.

MR. PARENT: No, I know that, yes.

MS. MERCER: Yes, okay. It's progressing. You know, we have a clinical team down there. We've had a couple of turnovers with vacancies and taking a while to fill the vacancy. The clinical team is coming together. We're just in the process of finishing construction so that they have one area to work in. It's moving ahead.

MR. PARENT: So it's a good fit.

MS. MERCER: Yes.

MR. PARENT: This may be an unfair question and feel free not to answer it, but considering that the youth facility is under your purview right now and there's tremendous

talk about youth crime, youth violence and all this sort of thing, in your considered opinion, is the best way to go in stiffer legal penalties or in more resources to the youth, in terms of counselling, intervention at an earlier stage?

MS. MERCER: Again, not being a lawyer or a judge, I'm not going to touch the stiffer penalties. I certainly think moving to provide more support and clinical services to this population is a move in the right direction. Again, your hope would be that you get to them before they reach the criminal justice system which, again, is working with their probation officers and that. I don't think it's an and/or. That's my answer.

MR. PARENT: Yes. Probably it's not fair to put an and/or on it. Although, I guess the parallel is drawn in that prevention is always better, whether it's on the criminal justice side or whether it's on the health side. It's always less expensive and it's always better for the individual and for society as a whole.

MS. MERCER: Again, I think it's everyone involved; it's the Department of Education, Department of Community Services, Department of Health, the local community. These kids don't reach this point because of a failure of one component of their lives.

[10:15 a.m.]

MR. PARENT: And in the Annapolis Valley, they have CAYAC, which my colleague would know about, which is an innovative sort of approach to try to bring together those various organizations.

MS. MERCER: We have CAYAC here. There's a CAYAC in each of the regions.

MR. PARENT: How would you assess how those work?

MS. MERCER: Well, the CAYAC in the central region, we come together monthly and meet to look at these issues and how you work more collaboratively. Actually, right now, we're supporting a social worker, working out of St. Pat's High School, working with youth who are suspended, and doing a research project on, okay, why are these youth suspended, what could have been done before this, where are the interventions that have taken place in getting these kids back into their schools?

MR. PARENT: Thank you very much, I appreciate that.

MADAM CHAIRMAN: Is there anyone else for round two?

Mr. Glavine.

MR. GLAVINE: Just a few areas of comment where perhaps I didn't feel that you went far enough, or should have possibly shown some of the weaknesses that government

should be responsible for in the area of mental health. Let me just throw a few of them at you.

Talking about the alternate funding agreement, yes, it certainly does help in some regard, but we have a considerable number of deficiencies with psychologists, psychiatrists around the province, not just here. I was told this week by a psychologist working at 14 Wing Greenwood, who has some scope across Canada, who says that we will never be able to provide the full complement, because, for the most part, we are \$40,000 to \$50,000 behind in salary right now.

MS. MERCER: For psychologists?

MR. GLAVINE: Psychiatrists, psychologists, yes.

MS. MERCER: I don't know about psychiatrists, I think with psychiatrists we're probably doing much better. Psychologists, I don't know the particulars of salaries in other provinces, but I think you're right. We're certainly lower paid than in other provinces, as we are with nursing and social work, too. Psychology is such a specific discipline and skill set, I think that's why that's much more noticeable.

MR. GLAVINE: And the competition, of course, is so extreme for that. You have constituents who come to your office with issues around the provision of mental health, but you also have constituents who deliver mental health programs. There's a fairly prominent one in my area, obviously nameless in this context. I said, basically describe the Valley District Health Authority delivery of mental health for those 16 to 19 years of age. His one word was, it's a wasteland. He said we just are not providing the kinds of services and so forth that we need.

He also pointed out, and it just dovetailed perfectly with two recent visits to my constituency office, that they will often leave correctional centres, and I have one coming back, in fact, today to my riding from another part of the province, and the parents said he just cannot be at home because of other siblings, he has no shelter, nothing provided for addiction services, and the third area is around a Grade 10 level of schooling. So he's leaving with absolutely nothing in place. We know what the outcome is going to be there. Another couple visited my office with a 20-year-old in Springhill, asking me to write the Minister of Justice to get the kind of help that he needs.

Why this lack of coordination? I'm hearing it from the schools. I've been before a board to suspend a student, so I know that side of it. I know that these multiple suspensions from school, junior high right through to high school, many of them are not just the bad boy syndrome. They have serious to very serious psychological problems. Our schools have inadequacies, our correctional centres have inadequacies, and then in the communities.

What kind of advocacy would the IWK be doing to government to say, gee, we need to get a coordinated program, we need to do a lot more on prevention? Are you in that ball game of doing that as well as . . .

MS. MERCER: Everything else that we do?

MR. GLAVINE: Yes.

MS. MERCER: I think certainly we're advocating all the time. You've heard me mention over and over here that I believe collaboration is a huge component of this. The treatment of mental illness is a very small part of it. You're right - unless when someone is leaving Waterville there is a next-step placement ensured, things are going to fall apart. The probation officers have caseloads that are huge; attached to the new Youth Criminal Justice Act, there are support services attached to the probation office. So I think more collaboration has to happen.

If the young person is not willing to partake in all that, it's a real gap. If they choose not to go to school or not to attend addiction treatment, it's a challenge and it's frustrating. Housing is huge. If you looked at the kids of Phoenix House or the street-involved kids, a lot of them would have that history you described because there isn't available housing out there. I think that's a big component of this.

So I don't have a magic answer, but I agree I think it's a lot of collaboration with a lot of these agencies.

MR. GLAVINE: We're without a major preventative kind of program. I see the first steps with autism where a \$4 million line item in the budget is going to help with ABA and IBI treatment programs and so on. We know the child without that treatment who goes on to be a teenager is one that's very, very difficult in terms of providing the kind of mental help, possible work, training and so on.

What do we need to be doing, do you think, in the early years of schooling and when children first come in touch with the legal system? We know some of their problems are certainly mental health issues - what more do you think we can be doing? It's fine to talk about collaboration, but where do we need to place and invest our dollars to try to prevent that quadrupling or whatever down the road?

MS. MERCER: I'm a firm believer in supporting the families and getting into the schools and in the families, helping them deal with these situations. Mental illness and mental health support and treatment in children and families would be so much easier if it were like a pill, but it's not. It's parenting, understanding the illness, friends. Then throwing in their adolescence, even an adolescent without all these issues is going to tell you to get lost and not be involved in their lives. It's really ensuring services are out there to meet the needs when they're identified. It's not, I think, that we just have to keep offering it over and over.



A lot of work, I think, could be done between Health and the schools and outside. The CAYAC project that I spoke of earlier, that's why that research is quite interesting. It's looking at these kids that have been suspended and end up in this particular classroom at St. Pat's, what has been the previous intervention and where could any of us have intervened differently or more assertively, or not, to see what the outcome is.

There is no easy answer, it's always a very complex situation and I'm sure if you look back over each one of those people who come into your office, there has probably been tons of intervention and tons of attempts and for whatever reason, it has failed all the way through. The question is, how do you not repeat that with the next person?

It's no easy answer - no matter where you throw money at it, there are still going to be other areas that are identified. People just really have to keep working together.

MR. GLAVINE: Thank you.

MADAM CHAIRMAN: Gordie.

MR. GOSSE: You're talking about a collaboration and early intervention. The reason I bring this up is because you mentioned this earlier and you talked about Boys & Girls Clubs being a part of the full scope of treatment. Again, we see four departments within this government - Justice, Education, Health and Community Services - and the 16- to 19-year olds have been falling through the cracks on a continuous basis for x number of years.

I can go back to the previous government before this government and many letters I have written to Francene Cosman back then, Peter Christie, David Morse as we sit here today. As a person who worked in an adolescent treatment centre and an executive director of a centre, I'm still hearing the same thing over and over again from all four departments and all four levels of government. Talking about funding, you mentioned you can throw all kinds of funding all the time and not correct all the problems. But if there were an adequate amount of funding in some of the areas such as Boys & Girls Clubs, Whitney Pier Youth Centre, and other youth organizations like this, like up in Pleasant Bay in Cape Breton where they have a youth centre and all these different things.

You have the Department of Health that decided years ago - I sat in Cape Breton for years on getting the teen health centres in the high school, Sydney Academy, and working with all these organizations for years and that's the reason I'm sitting here today because I got totally ticked about the lack of funding, you know, it's the same thing over and over again.

The day before yesterday, I received a call from the Minister of Community Services telling me, you'll be happy to know that we're going to give \$15,000 to the youth centre, Gordie, for a capital project. I say, well, that's lovely, I really agree with that, but what about the actual core funding for the staff, for the youth workers and for the people who work hands-on on a daily basis with these young people - a place like the Family

Resource Centre that do programs within the Boys & Girls Clubs and within these facilities. What about the actual core funding for those people who provide that, you know, these are the people who work hands-on on a daily basis with these young people and there's no funding. For seven years I've written to every minister who has been in here since 1998 and even beforehand looking for adequate funding to provide these services for these young people with mental health issues and other issues.

I mean I've been the guy who has been on the plane that has transferred these young people to Ontario, but I will give you an example of transferring a juvenile psychopath or a multiple personality disorder to a private centre in the Quinte Bay area of Ontario, and know what it's like with not having the adequate funding. The school teachers who actually know in Primary that there's a problem with this kid, whether it's ADHD, whether it's ADD, whether it's autism, whether it's some kind of seizures, I mean they know this at an early age, but yet we continue as a society never to put the appropriate funding. You kept saying earlier we can throw all the funding at it we want, but we never put the appropriate funding and redirect it to the people who are actually working hands-on on a daily basis with these people.

I did tell the minister this week, well, that's really nice to put \$15,000 into capital for a facility that has 130 youth on a daily basis, that provides breakfast to these children, provides dinner for these children, provides all these programs, sibling rivalry and all these different things, but in seven years of writing to him, as an executive director myself and then as an MLA, and I asked, well, what about the core funding for their staff? Well, that's in the regional area, you have to bring that up. Well, I've seen the regional guy so many times that I would much rather not mention it here today, because I'm sick and tired of going on behalf of these organizations to the minister all the time looking for the appropriate funding for these organizations.

MADAM CHAIRMAN: Excuse me. Is there a question here? (Laughter)

MR. GOSSE: Well, the question, no, I'm just really totally- I would say it on the mic, but I better not.

MADAM CHAIRMAN: We appreciate that.

MR. GOSSE: Yes, I'm just saying again, we have those four government agencies - Justice, Community Services, Education and Health - and they're still falling through the cracks.

MS. MERCER: Are you aware of the latest initiative for youth at risk?

MR. GOSSE: Oh, yes, I'm a know-it-all. I shouldn't say a know-it-all, but I do have it on a daily basis in the riding that I represent, and such a high unemployed area and many, many problems with drugs and alcohol, but just frustrated. So I'm just asking you, could you recommend any specific measures to the committee today, you know, what we can do

to alleviate these problems that I've just ranted and raved about and maybe I shouldn't have?

MS. MERCER: Well, I think you have to look at initiatives like, you know, I worked in Ottawa for years and Ottawa is a very flush city. I complained every single day. I worked with street youth with mental illness, and I complained every day about the lack of resources until I moved here. So I think no matter where you are and how much resources are out there, it's not always going to meet the needs. I don't mean that we have to, you know, just lie down and roll over, but we have to go at this in strategic ways and make sure that where you're putting your money, you're getting good services and good supports.

Right now those four agencies you just talked about, or four departments, are coming together to look at the 16-year olds to 19-year olds because not only you, but all of us have been saying for years, you know, the 16-year olds to 19-year olds, at 16 you're cut off from child welfare and you're 19 before you can get welfare. So you're in a huge void. So right now we're coming together to look at, okay, what are those needs? There are services out there that are being provided. So there are certain people being met and their needs are being met, but we need to do it in, I think, a really clear strategic way that we're all working together. You didn't like that answer, did you?

MR. GOSSE: No, I'm not going to comment on that, but I guess I'm finished, am I, Madam Chairman?

MADAM CHAIRMAN: I think we're going to move on to Stephen.

MS. MERCER: They also did the same type of self-assessment that I talked about of the youth health centres in the province under the Department of Health Promotion and the Department of Health to look at standards for care for those services and what they're providing and if they needed to, and if they could, fund them to provide what's needed. So I think there are attempts and I think we're moving in the right direction.

[10:30 a.m.]

I have to say that from when I moved here in 1997, I think we're a lot further ahead than we were. I know it's not perfect and I hear this all the time too because the same people who are in your office are phoning me. We just have to keep moving ahead and we can't get frustrated and we can't just stop doing what we're doing and we have to just work together and that's, I think, the answer.

MR. GOSSE: Fifteen years as a youth worker and an executive director working in the field.

MADAM CHAIRMAN: Thank you. Stephen.

MR. MCNEIL: Since 1997, you were going to say the greatest strides you made were from 1997 to 1999, right? No, I'm just kidding, I don't want you to . . .

MS. MERCER: Were you a part of that? (Laughter)

MR. MCNEIL: No. The mental health legislation that was passed more recently. Has that had an impact on how you provide services, and has it enabled you to provide services better to your clients?

MS. MERCER: I don't believe it has come into play yet. I think it's still in the process of being rolled out. Components of it will probably change the way we do things or help us with the more sort of non-compliant or more difficult situations in the community, but I don't think it will have as much of an impact with us because we work with the younger population. We already have one of the recommendations, to have a rights adviser in each of the health authorities. We already have a youth consumer navigator - that's his title, but his role is to advocate for the rights of young people going through the mental health system and he works out of the IWK.

MR. MCNEIL: That is for the Capital Health Authority?

MS. MERCER: For the IWK, up to age 19.

MR. MCNEIL: Okay. You also mentioned earlier, there are just not enough foster families to provide the kind of support for everybody who needs it. In some areas there are smaller group homes, where three or four kids are brought together. Has this approach worked well?

MS. MERCER: It certainly works for some youth, but I guarantee you that every one of the kids - you know, I meet with DCS and Health and all the workers, and we all come together - they have been through that whole thing and their needs at that point, the group homes or the special options, small options homes or the foster homes, are meeting their needs.

MR. MCNEIL: The challenge that sometimes you're faced with is you have a constituent who comes to you and they literally have run into the wall. They have been emotionally drained and they have a child who - in some cases it's frightening, because they have other children and they have nowhere to go. I mean, what do you tell them? What do you say? It looks to me like, ideally, yes, we would have liked to have anticipated and we would have liked to have cut all the stuff off when the children were very young and would have been able to put all the supports in place, but the reality of it is, we didn't, and now we're faced with that challenge for that family. Where do they go?

MS. MERCER: That's really where the existing systems have to work together. If they are under 16, they have to work with DCS, and if there are mental health problems, they have to figure out how they work together. If they are over 16, it's much more difficult

because there is much less structure out there for that population and I know, we've had those kids who have been in our in-patient unit, gone through our residential program, gone back home and things fall apart again, for whatever reason.

MR. MCNEIL: Everybody says how great life would be if we could knock down the silos in government. It is a simple concept and there's probably a lot of truth to it. But to get a meeting with four people from four departments, on any issue, and then try to get them to come together and be willing to allow the areas that each of them represent to be greyed a little bit so they could provide a better support, I have tried to do it for adults with addiction problems in my constituency. You get them to the table, then after a long battle they all become protectionists of their turf because it becomes a budget issue, who is going to pay?

MS. MERCER: And you're right. We duke that out on a regular basis with the IWK, the Health Department, Community Services, we're meeting regularly and saying, okay, we have to make a placement for this child. They cannot live in the IWK, and it's one-offs, but there is a process in place. There are standing committees, continuum of care, continuing care networks, to move those forward and they are on a case-by-case basis. It's a challenge.

MR. MCNEIL: And those challenges, quite honestly, are ours.

MS. MERCER: Yes.

MR. MCNEIL: In my view, people should not be asking you for advice on how we make it happen, that it's our collective responsibilities as elected persons, regardless of what Party, to try to work to solve those problems. Any experiences that people like you have had dealing with the system certainly gives us a better sense just to move forward, so thanks very much for coming in and for all the work you're doing with the youth of Nova Scotia. Having had parents come into my office on a very limited basis, the service you're doing is wonderful.

MS. MERCER: You're welcome. I get the same families calling me too saying, you're not helping my child - it's really hard to remember there are a lot of kids out there who did recover from an eating disorder. I had a mother come to me the other day, her son just received the highest award in engineering from a university and she said he had been in the in-patient unit when he was 12 and I didn't think he would live. He was suicidal, he was this, he was that. He is now getting an engineering scholarship.

Because there's so much stigma attached to mental illness, I think when it's cured or when you have gotten past it, it's much easier just to forget it rather than to celebrate it.

MR. MCNEIL: Those are the stories that need to be told. Unfortunately, we're telling you the worst-case scenarios and there are many victories that I'm sure you have had.

MS. MERCER: Oh, I believe you and I hear the worst-case scenarios. We have a challenge, when you look at the telethon every year we always ask can you get a family who has gone through your mental health program who want to celebrate what has been done - people don't want to. It's a stigma, they see it as an embarrassment. We have amazing stories of kids who were 70 pounds, who are now in university and doing quite well or had numerous suicide attempts and who now have a job and are doing quite well in treatment for their depression. So much anxiety that they couldn't go to school and through our day treatment program, they got through their school phobia.

But rightly so, people just want to put that behind them when they're done. It's very different from cancer or cardiology where people are very proud to say that they got through that because there's not the same stigma attached.

I too have to remind staff of that because, especially where we have a long elective waiting list, all the people hear is you're not treating my child when they know they've just spent a day treating very severely ill people and helping them get through it. Not to fault that because I think we have to continue to carry the voice of the people not getting the service and are feeling frustrated. When you go back through what they've been through, I think there have been a lot of interventions and we need to look at why it didn't work and take it from that angle and start to change the way we're doing things. I think the only way to do that is by bringing those four departments and service providers together.

That's part of what this youth-at-risk project is doing. The Department of Community Services, Department of Health, Department of Education, Department of Justice - they all met in a room, there's now a project manager and they're going to move forward. That's my soapbox.

[10:39 a.m. Mr. Mark Parent took the Chair.]

MS. MORE: Thank you for that reminder because every day we hear from families in our constituency offices and they're the families that are on the wait list and have fallen through the cracks. Their stories are such horrible experiences you can't help but feel their pain.

I'm proud to say this committee has taken a very special interest in the topic of children and youth at risk over the last couple of years. We've had a number of organizations and department representatives before us trying to get a handle on what we can recommend, how we can be proactive. I'm really encouraged to hear about the youth-at-risk project and I know we would certainly endorse that kind of collaborative approach.

I'm thinking, in analyzing the information that has come out today, that there might be another approach. I'm just wondering, has your division or section done much work in terms of providing in-servicing to the child care sector?

MS. MERCER: Child welfare?

MS. MORE: No, child care. The early childhood educators, before the age of five.

MS. MERCER: No, we haven't done a lot with them and a lot of it is resources, if you have clinicians who are seeing clients and families, they are not also doing a lot of work with that. Our main in-services or education have been with the schools. There are some with preschools, but it hasn't been a lot.

MS. MORE: I've seen some really interesting models in other provinces where because they have early childhood learning opportunities, they are not only able to identify and intervene at a very early age and turn just slight misbehaviour into something that is healthier, but they have also been able to involve the parents, so that the parents take on more positive parenting techniques and roles and the difference by the time these children enter school is quite phenomenal. I remember a case of identical twins, where one child was having problems and the other one wasn't and they both went through it and the parents were able to deal better with both children and they are succeeding in elementary school very well. That was in Ontario.

I'm beginning to realize that an investment in early child care and learning in Nova Scotia, might be a way to turn this huge treatment problem around and have a positive effect on future generations. But you are saying you wouldn't have the resources to actually be able to do in-servicing with early childhood educators?

MS. MERCER: Certainly, the way we are set up right now, it wouldn't be something that we could do regularly. I guess you would also have to look at the child care providers too and what their needs would be and where they would like to see putting their energy with staff and parents. We do parenting groups with children who are quite young. They are not from a particular child care agency or any particular place. You would almost have to look at that as a huge overall picture, given the number of child care facilities that are out there.

MS. MORE: Well, they do have provincial training and professional development days through some of their organizations so it might be interesting if the early childhood division of Community Services talked to some of your people, just to see if they could be a little more proactive on those issues.

Who should be taking the leadership role in doing more on the prevention and mental health promotion side for children and youth, in this province? I mean, I realize it is not part of the present mandate of any department, any agency, any organization. We've talked about how they have to work across all those sectors and across different levels of government, to actually have any positive movement on this. Who needs to start that ball rolling?

MS. MERCER: I think it's like anything else. I think if there was a decision made, okay, we're going to start doing early intervention, you need to make sure that what you are doing has an end to it. You know, there are some illnesses that early intervention doesn't

make a difference. Schizophrenia is going to happen anyway. So, I think, certainly, it could be part of the mandate of the IWK at some point. It isn't right now, other than we all do it as part of our day-to-day running. Anything that happened, I think, needs to be structured and resourced so that it has a point to it and it's not just, okay, we're going to start inservicing this because we think it would make a difference.

MS. MORE: Well, you've talked several times, and we have as well, about how vulnerable the 16- to 19-year olds are in Nova Scotia, who are at risk. I don't know if you are familiar, this is Homelessness in HRM: A Portrait of Streets and Shelters Volume 2, and I was stunned to find out that not only is youth homelessness increasing in HRM, but a quarter of it, 25 per cent of them, are youth who say that they have either been in institutions or foster care, in temporary or permanent care of the Department of Community Services. I mean, I was stunned with that figure. Now, I realize that these are the most at risk, but it's obvious that in the past we haven't been able to provide the programs and services that they need to help turn their lives around. That's frightening.

[10:45 a.m.]

MS. MERCER: I thought it would have been higher. No, I think you will find a lot of studies that link children in care in earlier ages and going through many foster homes, or various homes, to have problems later. Tim Crooks, who's the executive director of Phoenix, and I work quite closely together around serving this population and, you know, how mental health and how the IWK, as a health centre, can work with his agency to meet the needs of this population.

They're going to be very much involved with this youth-at-risk project because, again, it's not just throwing resources or money at what's there now, it's looking before that. So if a child hits the street, there is Phoenix House, there is a shelter, there is this, there is that, but you need to back it up a bit to say, okay, what about before they have to leave home, or what about when they were in a foster care system, or in a child welfare system, what could have been done then to prevent them from leaving it at 16?

MS. MORE: Well, I don't want to be oversimplistic, but I guess I'm suggesting that if this province - and that means all of us - invested more in regulated child care and early learning in this province, you know, I think we could prevent and avoid some of this happening, perhaps not the chronic mental health conditions, but certainly many other levels of mental health problems and acting out, you know, inappropriate behaviour. So thank you.

[10:47 a.m. Ms. Marilyn More resumed the Chair.]

MADAM CHAIRMAN: Gordie.

MR. GOSSE: Just one question.



MADAM CHAIRMAN: Oh, I'm sorry. Leo asked to speak and I said round two, you both spoke in round two. So let me just check. Does anyone else want to speak in round two?

MR. PYE: I don't want Gordie to speak. (Laughter)

MR. GOSSE: I have a question right away.

MADAM CHAIRMAN: No, but just a second. I'm going to give a quick question to Leo because he did ask first, then Gordie, and we'll probably finish up the questions at that point. Leo.

MR. GLAVINE: Just very quickly, I've been trying to think about a more complete use, I guess - not a better use but a more complete use - of the Waterville facility which, you know, physically and so forth is an underutilized facility now. There are only about 50 or 60 clients who are there which is about half to one-third capacity, certainly less than half.

As an educator, I've often wondered about when you do identify children, the ones that you're involved with suspensions and, you know, dysfunctional family elements and so forth, if that were to become like an assessment centre - I mean, there almost seems a time for many families and the adults dealing with children who are out of control, you know, what are the reasons for them being out of control? I wonder if you would consider that to be a realistic type of approach where you take an adolescent for a couple of weeks, give them the battery of kinds of tests that would help identify certainly some of the - either they're deep-seated or, you know, not so serious psychological problems, home problems, educational.

Within the educational framework of the province now we have children who wait a year to two years to get tested - testing of any sort let alone those that would be more revealing on psychological processes. So I'm just wondering, do you think that that kind of concept would have some better use of that underutilized facility?

MS. MERCER: Well, I'm not a practising clinician, so I don't think I could answer that. Personally I think to do a full assessment of what someone's going through, they probably need to be in the environment they're in. We often find that sometimes when children are admitted to an in-patient unit with a certain problem, then nobody sees it for two weeks until they go back home. So I wouldn't want to stab a guess at that because I'm not a clinician right now. So I don't know. It's a beautiful facility though.

MR. GLAVINE: That's why I say it's underutilized.

MS. MERCER: Yes.

MR. GLAVINE: Thank you.

MADAM CHAIRMAN: Gordie.

MR. GOSSE: My question to Susan is, these children who are coming out of care with such high needs, what would your opinion be, you know, foster care may be in crisis, I think we got in trouble in this committee for calling that at one time, and these children with high needs coming out of the mental health treatment facilities. What is the solution for these children to get back in society and have a proper environment, to have a support network to help them get back into the community and be productive members of society?

MS. MERCER: I think the important part is that the residential treatment is one part of the continuum of care. What's needed upon discharge is that care continuing either with their home treatment teams - maybe they're going to Cape Breton where the child team there will take over and some follow-up from the existing treatment. It's not a snapshot where they go in and they're fixed and they go. I think the idea is continuing and not let it drop until the family and the child feel they don't need it anymore.

MR. GOSSE: The ones that are going into foster care, is there any special training for the ones in foster care who are receiving these children with high needs? They're coming out now with more high needs.

MS. MERCER: I don't know, because I'm not responsible for the foster care system. I assume there is, but I don't know. Sorry.

MR. GOSSE: Thank you.

MADAM CHAIRMAN: Thank you. Are there any other questions? If not, I think we'll bring this part of the meeting to a close and then we'll continue on with our committee business.

We really appreciate you coming here today. This is a very, very difficult issue and we want you to know that we appreciate the leadership and the work that you and your colleagues are doing for the youth and children of this province. Our questions are meant to try to help us understand where we can play a role in supporting that work. It's essential and crucial and obviously we have to be more proactive, but we also have to make sure the resources are in place so that you can do what you need to do.

Thank you very much for coming today, we appreciate that very, very much.

I will just remind the committee - I'm going to let Sue go - that we're going to deal with the correspondence from the ministers regarding our forum on policy. So a two-minute break.

[The committee adjourned at 10:53 a.m.]