HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

COMMUNITY SERVICES

Tuesday, June 1, 2010

Committee Room 1

Department of Health
Re: Children's Mental Health Services

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COMMUNITY SERVICES COMMITTEE

Mr. Jim Morton (Chairman)
Mr. Gary Ramey (Vice-Chairman)
Mr. Leonard Preyra
Ms. Michele Raymond
Mr. Maurice Smith
Mr. Leo Glavine
Ms. Kelly Regan
Hon. Chris d'Entremont
Mr. Alfie MacLeod

[Mr. Leonard Preyra was replaced by Mr. Mat Whynott.]
[Ms. Michele Raymond was replaced by Ms. Becky Kent.]
Mr. Leo Glavine was replaced by Ms. Diana Whalen.]

In Attendance:

Ms. Kim Langille
Legislative Committee Clerk

WITNESSES

Department of Health

Ms. Patricia Murray,
Director - Children's Services

Dr. Linda Courey, Director
Mental Health and Addiction Services -
Cape Breton DHA

Ms. Susan Mercer, Sr. Director
Mental Health and Addictions Program
IWK Health Centre

Mr. Faizal Nanji,
Acting Executive Director -
Mental Health Children's Services
and Addiction Treatment Branch

HALIFAX, TUESDAY, JUNE 1, 2010

STANDING COMMITTEE ON COMMUNITY SERVICES

1:00 P.M.

CHAIRMAN
Mr. Jim Morton

MR. CHAIRMAN: Good afternoon, I think we'll begin. It's a moment after 1:00 p.m. My name is Jim Morton, and I'm the chairman for the Standing Committee on Community Services. I want to welcome our guests and witnesses from the Department of Health, and you'll have time to introduce yourselves in a moment. I think to begin with, we should go around the table and introduce ourselves, and begin with Kim.

[The committee members introduced themselves.]

Thank you. I'd like to also welcome the observers and staff members and press who are here today.

We are pleased to have witnesses from the Department of Health. I know Ms. Patricia Murray is here, who is the Director of Children's Services. I wonder, Ms. Murray, if you could introduce yourself and members of your team.

MS. PATRICIA MURRAY: Sure, it would be my pleasure. On my far right is Susan Mercer and she's the Senior Director of Mental Health and Addictions at the IWK. On my immediate right is Dr. Linda Courey and she's the Director of Mental Health and Addiction Services in Cape Breton, DHA 8. Behind me is Krista Higdon, who is our communications representative; Faizal Manji is our Acting Executive Director for Mental Health Children's Services and Addiction Treatment; and Laura Oxenham is a student who is observing the proceedings today.

MR. CHAIRMAN: Thank you. I can see from the handout and from the slides that you do have a presentation to make, so I think what we could do it begin with that, if you're comfortable with that way of proceeding, and then we'll have an opportunity for questions.

MS. MURRAY: Okay, that would be great. Thank you very much, Jim, and thank you ladies and gentlemen for being here. It's certainly my pleasure to be providing you with some information on child and youth mental health services in Nova Scotia. Perhaps, just as I'm beginning, we don't separate out children - so it's children and youth, and we see children and youth in the child and adolescent system up until their 19th birthday.

What I'll be speaking about today is putting the child and youth mental health in context, so that's sort of prevalence and frequency of mental illness in children and youth and the importance of intervening early. I will go on to discuss the delivery structure for child and youth mental health, how it's offered throughout the province, and the DHAs' responsibility for that.

We did develop standards approximately 10 years ago and as part of that work, we developed five core business areas and I will be reviewing those in the context of children and youth. They actually apply across the life span, but I'll just highlight some of the areas that are particularly relevant to children and youth.

I will also review the piece of legislation that was introduced approximately three years ago. I will then go on to talk about specialty services for children and youth and how these are offered around the province. I will have a brief financial summary of mental health funding over the last eight years or so and then the portion of that which is funding for children and youth. Then I will discuss some enhancements to mental health services for children and youth that we have received over the years, and finish up with some collaborative work across departments.

First of all, the child and youth mental health context. It is recognized that intervening early is the best way to go. That is why having adequate services available for children and youth is critically important. In fact, 80 per cent of all psychiatric disorders emerge in adolescence and that would be the single most common illness that onsets in the adolescent group. For things like autism, it actually onsets much earlier - that's in the preschool age group, so in both cases intervening early is critical.

In Canada, about 300 children and adolescents commit suicide each year and suicide is the second most common cause of death for people between the ages of 15 and 24. Mental illness is often a factor in that so, again, it's very critical to intervene early and make sure those adolescents receive treatment in a timely manner.

Particularly related to Nova Scotia, the prevalence rates are 17 per cent of Canadian children and youth are affected by mental illness at any given point in time. According to the 2006 census, there are 267,000 youth between the ages of 15 and 25 in Nova Scotia. Of these, 45,000 of them would require assistance through mental health and 40 per cent

of those - which would be about 18,000 - do not seek any sort of assistance. When I say assistance, I mean they may go to their guidance counsellor, a youth health centre, their GP, they may use non-NGOs within their community and also the formal system. The concerning thing is that between 18,000 and 20,000 are not getting service at all.

I've just provided some mental health stats that we have for our most intensive service, which is the 4-South Acute Psychiatric In-patient unit at the IWK Health Centre. There are two tables here, one shows where children are treated in Nova Scotia and you'll see not all DHAs are involved in that because we have one child and youth mental health unit and that's the one at the IWK.

Now you'll notice in DHAs 1, 2, 6, 7, 8 and 9, they also admit this age group to other units. Depending on the mix on the unit in those other DHAs, they may admit an older adolescent to an adult unit, or they may admit a younger person to a pediatric unit, and perhaps even general medicine if that seems appropriate.

MS. BECKY KENT: Mr. Chairman, may I ask a question just to understand the slide?

MR. CHAIRMAN: Yes, of course.

MS. KENT: Can you just tell me what SEPS and ALOS mean?

MS. MURRAY: Sure, SEPS is for separations - so that's how many discharges there are from the hospital, so that represents the number of stays. The ALOS is the average length of stays, so that's how many days they've stayed.

MS. KENT: Thank you very much.

MS. MURRAY: Thanks for asking, that's an important clarification. Where Nova Scotia children are from, they're literally from all of the districts across the province and you can see there the numbers.

This just shows the types of disorders that are treated on the in-patient unit, the majority being mood disorders and bipolar. Next are adjustment disorders, schizophrenia and anxiety disorders, those would be the biggest.

In terms of how services are provided, some government departments are actually directly involved with the service provision piece; that would be departments like the Department of Community Services and the Department of Justice. I think they have a hands-on role in that, whereas departments like Health and Education actually operate at arm's- length. Education has school boards and we have district health authorities and the IWK.

The Health Authorities Act which was introduced some time ago outlines fairly clearly who is to do what. The Department of Health, I won't go through all of the detail, but we're responsible for setting the strategic direction, developing standards, evaluation and measurement, the funding piece - those sorts of higher-level oversight pieces. The DHAs and the IWK are responsible for the governing planning, managing, monitoring, evaluating and delivering of the health services. So they are the actual health service delivery system and they determine - depending on their population - what particular services they may require and they have the authority to set those up and provide them.

They also participate in work that's done at the department in order to be consistent with anything that we may be introducing. We work very closely in mental health with our system across the province. We meet monthly with our directors of Mental Health Services and with the chiefs of psychiatry and some of the VPs.

There are nine district health authorities in the IWK responsible for the delivery of these services. Each district and the IWK have a Director of Mental Health Services and they oversee a broad range of mental health services. Now in four districts, as you will note, with Sue and Linda, they oversee both mental health and addictions and there are two other districts in the province that do that - District Nos. 2 and 3. The rest just have a director for Mental Health Services.

For children and youth, the IWK has the provincial responsibility for tertiary care and so many of these specialty services are located at the IWK, the most intensive treatment services.

The last bullet is just describing what a multi-disciplinary team may consist of; we offer our services that way. I wouldn't say that all teams consist of all of these professionals, but teams can consist of any combination of these professionals and it's just to show that there are quite a variety of professionals involved with this work.

This shows the shaded areas that outline the different district health authorities. This is a bit of a work in progress, so currently we have most of our outpatient mental health clinics - there are approximately 50 and I would say we are short a few on this map, but mostly they are there. That's to show that we have clinics organized and available around many areas in the province. The H's distinguish that it's a hospital and those hospitals have in-patient units, the one exception is DHA No. 5. As I noted earlier the only one specifically focusing on children and youth is the one at the IWK.

These are the five core business areas that were determined between eight and 10 years ago. The first one is prevention, promotion, and advocacy. In terms of what we've done around that to address children and youth, we introduced a depression strategy approximately four years ago and the idea was that it would take up to about 10 years to implement it all. The first part of it was to be raising awareness and the second part was to be providing some education around mental health issues and the last component was to provide cultural shift, so that there isn't so much stigma attached to mental health issues.

In terms of youth, what we did was develop a teen booklet that addresses depression. It talks about what it is to be mentally healthy and how to recognize symptoms within yourselves or possibly your friends that may show that you're having an issue and places to go to seek assistance with that.

We produced a calendar last year that was all art from youth mental health consumers - it was probably our best calendar, we've done it three years in a row. We also got some quotes from the youth in terms of what they wanted adults who are interacting with them to know, so that's been a very popular calendar that we've provided to various folks across the province. There's also a bookmark that we've produced that outlines some of the symptoms to be looking for and some Web sites on the back so that youth can access those services in a way that they're most comfortable.

Outpatient and Outreach Services - these would be where we see the greatest bulk of the clients that we serve. They focus on early identification and intervention services and assessment and treatment on an outpatient basis. There may be other services involved - that's folks going to the emergency room. We have Mobile Crisis Service in metro. Shared care, children and family and adolescent day treatment programs are also available here, but provided on an outpatient basis.

Community Supports - they're designed to help children and youth and families and their support networks manage the demands of daily life. The services may include case management or intensive community-based treatment teams, and we'll be talking a bit about those in a minute.

In-patient Services - they include the acute treatment, which is on 4-South, and then we have rehab and forensic services, and the rehab services are 24/7.

Specialty Services are generally attached to an academic centre, so most of them are located here in HRM Capital District, but we do provide them through a network and those are some of the speciality services that are applicable to children and youth - eating disorders or sexually aggressive youth. You can read the rest.

Previously, mental health legislation was embedded in the Hospitals Act, which was created in 1977. On July 3rd, 2007, the Involuntary Psychiatric Treatment Act was proclaimed, which addresses the needs of those who are most critically ill or who are at risk of becoming very critically ill, and they are admitted to hospital on an involuntary basis. I guess what is important to note here is that those do apply to youth. Some people may not realize that they apply to the youth population as well.

There is a review board attached to that, and the purpose of that is to ensure that all patients being held involuntarily in Nova Scotia have their rights protected. The review board reviews the status of the involuntary patients at regular intervals and as they are requested to do so. This chart shows all of the involuntary admissions across the province, and there were 60 at the IWK, which represents the ones under 19.

[1:15 p.m.]

Sorry, just back to the provision of specialty services - this is the network model template that was approved by the senior leadership team at the Department of Health in 2003. It breaks things up between provincial, shared districts, districts, and local, and again, these are the specialty networks that are currently in existence - I've populated some of these boxes just to let you know what those services may look like. This template may look different depending on the specialty service involved, but obviously at the provincial level there's the Tertiary Care and the Speciality Services, which are attached to the IWK. The IWK is also responsible for Forensic Youth Mental Health Services in the province. They have those specialty services, 4-South and the rehab services.

Shared District Services would be the sexually aggressive youth. There are treatment programs provided in a few areas across the province, and some of those are across districts.

Child Psychiatry is fairly scarce. We have a reasonable complement at the IWK, but in terms of rural psychiatry, it's harder and harder to get those physicians in place, so there are psychiatrists who travel from the IWK to different areas in the province. There is also a psychiatrist in the Cumberland area who travels to at least the northern region. I believe she goes to Truro and Pictou County and sometimes to Cape Breton, so she's very active. At the district level we have the directors and identified ERs - and that's where emergency services are provided. Then at the local level we have primary care, satellite clinics, and NGOs.

I'm just going to review some of our specialty services. The Autism Treatment Program, affectionately known as EIBI, was introduced in 2004 with $4 million. It's one year of intensive service provided by multi-disciplinary teams with a period of follow-up until the child starts school. Currently we are not funded to serve all eligible children. It's a very cost-effective model. We have train-the-trainer training in place, so we have one FTE funded to provide training to all of the teams around the province, and they are in place and available on a regular basis to ensure that support is available as it's needed in the various districts. We had a final evaluation completed a couple of years ago and the outcomes are very positive for this program.

We are currently in the process of enhancing the diagnostic capacity across the province because one thing, as I noted earlier, is that it's very key to catch these children early and to identify them as young as possible. We want to make sure that children throughout the province have access to a good diagnostic assessment.

The Provincial Youth Forensic Services are the designated responsibility of the IWK. The services consist of court-ordered assessments, designated mental health beds. The 4-South unit has 17 beds; two of these are designated for forensics, if necessary. They can be used for regular patients who are admitted if those beds aren't required for a forensic purpose but they are there if they are needed.

There is a clinical team available at the Nova Scotia Youth Centre in Waterville, which consists of psychology and social work and a consulting psychiatrist. There was a Halifax Youth Attendance Centre introduced a couple of years ago and, in conjunction with the Department of Justice, we've provided a social worker and a psychologist to that service. That is basically one-stop shopping for youth who have been involved with the law. They have employment counsellors, teachers, probation officers and our mental health folks and a variety of services that they may require to help them stay on track or to set them on track. Then we have the treatment for sexually aggressive youth, which is available at various points throughout the province.

The Adolescent Centre for Treatment - known as ACT - provides rehabilitative mental health services in a 24-hour setting. It serves ages 13 to 19 with severe, profound functional impairments and/or severe disruptive behaviour disorders. These are very challenging youth to serve and we've recently expanded that from 12 to 18 beds. The length of stay is based on their needs. It can be from three months upwards. Staff work with the clients and families and offer a variety of interventions.

We have Compass, which is the younger version of that. It was formerly known as the Children's Response Service. It is a 12-bed, community-based, residential program for children between the ages of 5- and 13-years old, predominantly. These children receive intensive care when they're admitted to the program and work is done with their families or foster families or whoever they may be returning to, to ensure that they can be integrated back into the community successfully. The team consists of psychologists, a teacher, consulting psychiatrists, working closely with the families and communities and child care workers also provide some of that care.

The intensive, community-based treatment teams, of which there are two - one at the IWK and one in Cape Breton - provide home and community and school-based support for clients up to 19 years of age. They tend to have very small caseloads because they provide quite intensive services for these families. Again, they may be a step down from an ACT or a CRP program or an in-patient admission, to ensure that the gains that have been made are maintained. Sometimes the families need a lot of attention in order to ensure that, so that's the kind of work they do. They go out to the families' homes and they go into the schools and they go to community settings, as need be.

This is the financial picture. It shows kind of the total health budget, which you know is very large, and then the percentage of that, the mental health budget in actual dollars and the percent of the total budget that is devoted to mental health. They we have the money dedicated to child and youth services. Our MIS information just goes back to 2003-2004, so that's why it's not there for earlier.

You'll see that the total budget hovers around 3.5 per cent but you'll notice that with the children and youth - because we've recognized within the department that it's very important to ensure that there are services available to young people, because of the

prevalence of onset at that age group, we've increased it from 23 per cent to 30 per cent over the last several years.

These are some of the enhancements to mental health services for children and youth. I've put the year, so they've started in those years but they're part of the base budget now, so they continue to be available. Some of these will be programs I've already mentioned. The intensive, community-based treatment teams were introduced in 2003-2004. We said the autism program began in 2005. The BEST program is in Cumberland and it began in 2003, it is an acronym for behaviour, education, support and treatment. It is school and home-based and it is basically meant to decrease the number of serious behaviour problems either at school or at home. Parents, school boards, mental health, DCS and Dal Research are involved in that program.

There is a youth navigator service at the IWK. That is one position and that person is responsible for connecting the youth involved with the mental health program within the IWK, with the various services that might best meet their needs within the program and also within the community, once they are discharged from the program.

We have reproductive psychiatry which looks after possibly mothers if they're suffering post-partum depression and that sort of thing, or attachment issues. So it impacts on our youngest citizens.

Family Help was introduced in 2006-07 at the IWK and then in 2008-09 in Cape Breton, and it's proven to be a very popular service. It's telephone-based coaching, basically, so for those families who have a hard time accessing traditional office-based services, it really meets their needs quite well. In rural communities, it also helps if transportation is an issue. Resources are sent to the families and they're able to review them and then there is coaching available for them, so families can call and receive assistance, perhaps right at the time that the difficulty is happening. These coaches are available, I believe, into the evening so that families can access them when they are actually having the difficulties. That's been evaluated and it's been proven to be very effective.

Crisis Emergency Response and Early Response - all DHAs in the IWK have had these services enhanced over the years. The Mobile Crisis Service here in Capital District began when it wasn't completely 24/7, and it basically served, I believe, the peninsula, a bit of Dartmouth, and a bit of Bedford. It's a partnership between CDHA, the IWK, EHS, and police, so it provides services across the lifespan, and I believe approximately 20 to 30 per cent of their involvement is with youth. It was recently expanded in the 2009-10 budget to cover all of the Halifax Regional Municipality. As I noted, the Adolescent Centre for Treatment went from 12 to 18 beds.

Youth Forensics - this has grown over the years as well. The Sexually Aggressive Youth Program was introduced in 2003-04 and continues. The Mental Health team at the Nova Scotia Youth Centre was put in place in 2004-05. Halifax Youth Attendance Centre, those two clinicians were put in place in 2007-08.

On the court ordered assessments, the demand for those expanded considerably after the release of the Nunn Commission, so I think the requests were tripled within a very short space of time. We didn't have the capacity to meet the court deadlines for completing those assessments, so we've had to enhance that service a couple of times to ensure those court deadlines are met, and currently we are meeting them in a timely manner.

Finally, our collaborative initiatives. There's lots of talk about working more collaboratively across government departments and getting rid of silos and that sort of thing. This is just a list of all of the initiatives we have that we work with other departments on, and they're listed there so we won't go into great detail.

Just to note that the Mental Health Commission of Canada is in the process of developing a mental health strategy for the country, and hot off the press, which you may have seen today, our minister has just announced the two co-chairs who will be leading the development of the Nova Scotia Mental Health Strategy, which was announced in the Speech from the Throne this year. Thank you.

MR. CHAIRMAN: Thank you, Patricia. I'd like to take a moment to welcome Alfie MacLeod to the room. He came in while the presentation was underway - at the beginning of it, actually.

This is an opportunity for questions, and I see Mr. Ramey's hand in the air first. There may have been others, but that's who I saw first.

MR. GARY RAMEY: Thank you, Ms. Murray, for coming in, and your colleagues as well. Just to get this into some kind of context in my own mind, do you have any stats on how we here in Nova Scotia compare to other jurisdictions with regard to the efforts we're putting forth in the areas just discussed, related to mental health issues and youth?

MS. MURRAY: I don't have the detailed stats with me, and I may be able to get some of that information for you. I would say that everybody is struggling to provide adequate mental health services across the country. It's chronically underfunded in any part of the country, I would say. We're probably not keeping up with a number of them and we may be on par with others. Would either of you know anything more about that?

MS. SUSAN MERCER: I know that in discussions with other mental health providers across the country, talking about wait lists, a lot of them don't even accept the kids on the wait lists. So when we talk about our pressures of access for the IWK - because we accept referrals from anybody and we are sort of it for everything in Halifax and HRM - the other provinces often say that they just don't have a wait list because they don't even get the referrals. The schools are seeing a lot, the GPs are seeing a lot, so a lot of the same pressures. Budget-wise, I don't know the comparison across the country.

MR. RAMEY: Ok, thank you.

MR. CHAIRMAN: Ms. Regan.

MS. KELLY REGAN: You mentioned children and youth. For the purposes of your presentation, what is the definition of a child versus a youth, in terms of age? Is it the 13 demarcation or what is it?

MS. MURRAY: I would say when we look at the Compass program that goes up to 12-years old or 13 years old and then adolescence starts then. I included up to 24 for some of the stats I gave because these disorders often start in early adulthood as well, so some of them are relevant to that age group but I would say children go up to about 12-years old and then youth to 19- years old.

MS. REGAN: Mr. Ramey mentioned wait times. Whether it's even just at the IWK, do we track at all what happens? How long does it take a child to access treatment when they come into the IWK, say, for an addiction? Do we know how long the average wait is?

MS. MURRAY: Yes, we do have a wait time project underway within the department so that's been meeting for about a year and a bit. We're just getting reports now so we're starting to be able to track wait times across the province for the services of outpatient mental health and for urgent, semi-urgent and regular referrals. Our backlog seems to be with regular referrals. Those would be the ones that wouldn't be determined to be needing more urgency. The urgent ones tend to be seen in a very timely manner and the others tend to wait.

I'll let Sue respond to the question in terms of the IWK.

MS. MERCER: Yes certainly at the IWK we track our wait times for access to all of our programs. As Patricia mentioned, our pressures are with our community mental health, which primarily serves the HRM and some of the rural areas that fall under HRM where we have between 800 and 900 children and families waiting right now, beyond standard. The standard for those referrals is 28 days because as Patricia pointed out, they are the non-urgent referrals and they are waiting upwards to between seven months and a year and a year and a bit. [Interruption] Oh, the standard is 90 days. We do have some of the 28 days in there, it's a mixture between 28 days and 90 days, the standard for either of those, sorry about that.

For addictions we do much better. We don't have a wait list for addictions right now. We are a provincial program and we're just in the process of redeveloping the program. We inherited it about four years ago from Capital District and we've moved to a much more multidisciplinary model in addressing both mental health and addictions because we found that working with adolescents, about 80 per cent of youth coming into the addictions program have both mental illness and addictions. It is hard to say which comes first, so we treat both. We don't have a wait list for that program.

[1:30 p.m.]

With urgent, if somebody was suicidal or severely depressed or hearing voices, that we are meeting the time frame of either seeing them immediately, in an emergency, at the Emergency Department or with the crisis team or within seven calendar days for an urgent referral.

MS. REGAN: I'm not quite sure that I understood. You mentioned a number of different times; 28 days, 90 days and seven months.

MS. MERCER: Yes, sorry about that, it was a little bit confusing. We have various categories and the standards are set by the province, in working with the director. There is emergent, which if you were to show up in the Emergency Department or if you were to call our central referral number and describe the situation, if our clinician deemed that was an emergent, you would go straight to emergency and be seen. We have a team on there 24 hours a day, seven days a week. If they did a screening - you explained your symptoms or your child's symptoms or the teacher explained and they did a screening and found that it was an urgent referral, they would be seen within seven calendar days. So we'd say you have an appointment and we'd give them that date.

The next two categories are semi-urgent and regular and that is 28 days and 90 days. Sorry about that, it has just recently shifted. Those are our two pressure points, the 28 days and the 90 days. Depending on what their situation is and what their symptoms are and what they are experiencing, the standard says they should be seen within 28 days or within 90 days. We are challenged to meet both of those targets.

MS. REGAN: Can you give me an example of what a 28-day person might be dealing with, versus a 90-day person?

MS. MERCER: Well I'm not a clinician but it would be - you could have, say, if we looked at depression and what a young person who is experiencing symptoms of depression, and feel free to jump in here, my Ph.D colleague, the psychologist. The symptoms and the impact on their life, how urgent they were that they need to be seen would be whether the clinician would determine okay, what's happening here, because it is a clinician that judges this, what is happening here. They should be seen in about three months and there would be no life impact to them or their family. Or it's a situation where really this is stressful and it's difficult but it could be - within 90 days if they were seen, it wouldn't have a negative impact on their life or their families.

So that is how it would be triaged. Very similar to a medical procedure if you were going for something and the physician said, you need surgery but you can wait three months or you need to have it tomorrow.

DR. LINDA COUREY: It relates to level of risk. The standards were developed several years ago for outpatient referrals and the standards give particular examples about

what symptoms would be considered requiring intervention within the seven-day period. So some young person who is developing psychosis for the first time or beginning to show symptoms or talk about suicide - not necessarily just talking about suicide but having an assessment that suggests that they are at risk - then yes, those folks would be offered an appointment within the seven calendar days.

If a young person was recently discharged from an in-patient unit - and, of course, in-patient admissions are used to help stabilize patients but certainly not to cure them - so many individuals who are discharged from in-patient units would require close follow-up and monitoring after that time because presumably they would still have continuing symptoms. They may have been started on medications and would need to be followed up closely. That would be one example of the type of patient who would need to be offered an appointment within the 28 days. The rest is a grab bag of anxiety disorders, disruptive behaviour disorders, a range of different presentations that are admittedly challenging for families and for the individuals but are not at the same level of risk as those other categories - the emergent, semi-urgent and emergency cases.

MS. REGAN: I have to say that I'm surprised that anybody who was deemed to be at risk of committing suicide would have seven days.

DR. COUREY: No, there are different levels of risk. If there was any suggestion that there was a clear risk of danger and that the young person was considered to be at risk to kill themselves, obviously they would be seen right away in an emergency department. That would be considered an emergency referral - the standards suggests they're seen and assessed within 24 hours. I think that we can safely assume that those services are in place across the province. The emergencies get seen, the children that need to be seen within seven days are getting seen. In Cape Breton, we know that we are also able to see those youth within the 28 days that are deemed to be semi-urgent. However, we are also challenged to see the regular referrals - those who are less at risk.

MS. REGAN: I recently had a situation that came to my attention where it was a young man, a teenager who was using drugs, had tried to commit suicide and his family was frantic because it was taking weeks to get him into the system. They had to have him cleaned up, they got him cleaned up, they brought him to the IWK, they thought that something was going to happen that day, there was an assessment done, then you wait another week. For this family, having had a son who had already tried to commit suicide, they were just quite frankly flabbergasted that they were told to wait and I don't understand that.

MS. MERCER: Certainly when alcohol and drugs are involved with young people, it becomes very complicated because it's a balance between getting help and having them participate in the help. I think we're all well aware of that and that can be very challenging for families.

Again, if that young person showed up at the emergency department with their family and there was imminent danger of suicide or quite serious, they are assessed there on the spot. Out of that assessment sometimes it's - for example the Choices Program, which is addictions within the IWK, we feel that this would benefit. There is a period then where that young person in the family talk about that, they may attend the appointment or they may not attend the appointment. Sometimes, I agree, that is very frustrating for families if things take longer than they should. It's always a fine balance, particularly with addictions, of having that young person involved with the decision making. That's probably the biggest challenge that I hear from families when they're calling - they say, please just take my kid and fix him in the addictions program and then the young person gets to the appointment, if they get to the appointment.

We're introducing a huge component of outreach within that program, so we're really starting to go out into the schools more, out to different places where young people are - to reach out much more to families so they don't have to come in to appointments. I appreciate the challenge and it's such a balance, I think, between what they need and what you can pressure them into doing.

MS. REGAN: My concern around that is there is now scientific evidence that shows that at 17, a child's brain is not fully formed, and we're giving them a whole lot of control over their outcomes when their brains are still growing. I really felt for those parents because they knew what their son needed. He may not have liked it, but he wasn't grown up yet. I'm wondering if there is concern among the health community about the fact that at 17, a kid's brain is not fully formed yet, and we're giving them a whole lot of power over what they do?

DR. COUREY: The law in Nova Scotia is that we assess capacity to consent, to treat them. If there is a determination made that this 17-year-old has the capacity, we are not permitted to treat them against their will or hospitalize them against their will, whether they are 17 or 14 or 37. We are stuck with that and that is the challenge of working with this population - to try to engage them and that's a complicated dance.

MS. MERCER: We will continue to work with the parents and the family as much as we can to support them in helping their young person change or come to terms with what they need to do. Several times they will come in, try the program and leave. The addictions program has a huge recreation therapy component to it because we realize there is a narrow gap to grabbing that kid and getting an interest. You can get them to show an interest all of a sudden in basketball or in a music instrument, then all the other treatment around the addiction can happen because you sort of had a hook to get them into treatment.

MS. MURRAY: I was just going to say that the treatments in Nova Scotia, except those under the Involuntary Psychiatric Treatment Act, are voluntary. We often get the request, well couldn't you just lock him up, or couldn't you just create a service where they can't get out, they don't have a choice? That's not considered best practice, and in short of

being involved with the law, they do have to co-operate and they do need to be there willingly. So that poses the challenge you noted, but that's the way the system operates.

MS. REGAN: I just want to say that this child was involved in legal issues as well. This is why the parents were beside themselves, because it seemed to them that boom, boom, boom, there were all kinds of red flags all over the place and yet they had to wait. I should let other people move on.

MR. CHAIRMAN: I think we should, but do you want to respond to that?

DR. COUREY: Just one final point, there is a careful assessment that has to be done when someone engages in some sort of act of self harm. Not all of those acts are evidence of a risk for death or a risk for suicide, right. Many folks - whether they are adolescents or adults - engage in suicidal behaviour and put it in quotes, and their intent is not to die. Their intent is perhaps to just say, look, I'm drowning here.

It is important that we do that assessment to determine - look, is this a situation where the person has an immediate safety need - we have to hospitalize them right away, involuntarily, they are obviously whatever - or is this a symptom of a longstanding problem that's going to need some treatment over time, in the community, probably involving the family, and that's where our solutions are going to lie? Yes, it's going to be uncomfortable and yes, there are safety risks, but the solution is treatment on an outpatient basis, not a quick fix on an in-patient unit. That's a message that many folks have a great difficulty appreciating, certainly when it comes to their loved ones, and yet that's our reality.

MR. CHAIRMAN: Thank you, it's important to draw things out. I think I do want to move to someone else and perhaps there will be opportunity for a second round of questions if they do have more. I think that takes us to Mr. Whynott.

MR. MAT WHYNOTT: Thank you very much, Mr. Chairman, and thank you for coming today. The whole issue of mental health services for youth and children has certainly come to light for me over the last number of years. My wife-to-be is doing her education in Child and Youth Studies and just graduated from her B.Ed. program, but her big passion has been the whole idea of early intervention services for children. Because of that, I've become an advocate for that as well, and certainly understand the importance.

I just have a question around the whole mindset of mental health services in the province. Have we seen a change in the way that the ordinary Nova Scotian, or Nova Scotia families, have seen mental health?

MS. MURRAY: Well we certainly like to think so. Part of our job is raising awareness so that there is a greater comfort around acknowledging that families are having difficulties and that they need to seek mental health services. Now the sad thing will be when they let things go on and they just don't feel comfortable doing that. Even though

there are challenges accessing the service, it is there, and it is there certainly for the more severe in a very timely manner, so that's important.

We don't have any way to really measure the shift. I think anecdotally we hear that and we hear it in various settings. Teen health centres have been set up, or youth health centres within the schools, and I think more folks are accessing those. They're really very youth-friendly and they really try to get kids in and then they can refer on from there if they identify it. Then we have other folks who are very unhappy to have a program in their area, or whatever, so we also see that there's a lot of stigma still attached, so it's just very hard to measure that. But I think, anecdotally, we certainly see patches of light. Would either of you have comments to make on that?

[1:45 p.m.]

MS. MERCER: I'm not as optimistic, unfortunately, having just been through the process of trying to move a program into a neighbourhood. I agree, I think part of the reason our referrals are so many is that there's more of an awareness. People ask for help, so that isn't as bad, but I still feel the stigma is very strong. I know at the IWK, we've recently looked at ourselves and said, even within this health centre, what can we do here? The number of times somebody will come to me and say, I have a staff person who is experiencing this and what should I do? I'm coming to you because I don't know who else to ask.

Even the basic understanding of what mental health is, and mental illness with young people, the stigma is huge. You see young people come into the in-patient unit on the 6th floor, which is Oncology - there are friends and family visiting all the time. On the 4th floor, which is our in-patient unit, you don't see that. It's sort of out of sight, out of mind and I think we have a huge amount of work. I think each and every one of us has to do something around stigma because people will talk the talk, but then when it really comes down to having someone in front of you who is dealing with this, or how your family deals with it, people don't ask for support, or it's still seen as they're "getting help".

DR. COUREY: There's still so much more work to do in terms of building capacity in our communities - whether it's the schools, the youth health centres, the family doctors, wherever - to be able to be aware of the early signs, and to work with us collaboratively too, so that they know who to call when those signs make themselves evident in situations and not to hesitate, just to make the referral. Stigma is alive and well in Nova Scotia, no doubt about it.

MS. MERCER: And across Canada, the Mental Health Commission of Canada have launched a whole anti-stigma campaign. We're not unique in this.

MR. WHYNOTT: I know Ms. Regan talked a little bit about the whole issue around mental health services and also addictions. Can you explain what's being done to treat those youth who have both mental health illness and an addiction, somehow?

MS. MURRAY: Early on we established standards for concurrent disorders, which is how we refer to mental health and addictions together, and that work has come to the fore in the last while. There is a whole culture shift required to treat the two together, mental health and addictions - they are two very separate cultures. Sometimes they disagree in terms of how to best approach this, so it is a bit of a challenge.

One positive step is we do have some directors that share both portfolios and we're working toward that. Currently we have a group in process that will be working on the concurrent disorder standards and how to best proceed with that work so that these youth get the services they need. Faizal sits on that group - do you have any comment you wanted to make?

MR. FAIZAL NANJI: I would just say that there is a whole group being led by Health Promotion and Protection - we're certainly supporting that in Health - that is looking at concurrent disorders across the lifespan, but more than just the standards, that's a component. What we're looking at is really what are best practices dealing with concurrent disorders across the lifespan and what models exist to address it in a comprehensive way. Some of that work is currently underway, which will lead to recommendations for how to proceed in terms of a model and also looking at the standards.

MS. MERCER: I think we're more fortunate at the IWK because I believe with youth, it's a much higher occurrence. When I speak to some of my adult colleagues they will quote sort of 20 per cent to 30 per cent, but in youth, as I said, in the last four years when CHOICES became part of us we have seen 80 per cent of youth. We have a consulting psychiatrist with CHOICES, and we're working with the other teams in the IWK Mental Health Program.

It used to be that if you called central referral and you said, my kid is dealing with this, they would say no, that's addiction, you have to call CHOICES. We're now moving toward one intake so it will be a holistic approach. We consult back and forth across teams, but it's very much looking at the child and what their issues are. Sometimes it's very much the chicken or the egg - are they drinking because they're depressed or are they depressed because they are drinking? - so it's better to treat both. All of our staff are trained in both.

MR. WHYNOTT: What is being done to ensure that police and teachers are trained? That's obviously where a lot of kids are spending the majority of their days, in school. Have the police and teachers been trained to react appropriately to situations where children with mental health issues may act out?

MS. MURRAY: We do have police involved with our mobile mental health service within HRM. They work very closely with the clinicians who go out on call and they've received some training prior to being a part of that service, so that's happening. I also know across the province - and I don't know a lot of the detail of this, but I know through CDHA they have developed a way for the police to collaborate well with mental health services, so they're working with all of the police services across the province to enhance that.

I know there is also an on-line program that I believe all police are now required to take. That gives them some background information on mental health services, because the police themselves have identified that they're not always adequately prepared and they have asked for this. So there is a very good on-line course that they are now required to take.

In terms of teachers, that's kind of an ongoing thing. I know through the Child and Youth Strategy, some initiatives have been introduced in schools, including Schools Plus and Health Promoting Schools. Those look at more of a culture within the school to cut down on some of the violence and bad behaviour that they see, but it also is to enhance a healthy school environment and to support kids who may be having difficulties. They work collaboratively with others in the community, including Mental Health and DCS. Those are pilot projects at the moment, but there's always an appetite to see how broadly we can spread that, because it's very helpful.

There's also a curriculum that has been introduced in the school system - it's not mandatory but it is available - it is at least available at the junior high level and some at the elementary school level. I believe it's called Healthy Minds, Healthy Bodies. It is being introduced across the province and so teachers can teach that and children can learn at a very early age what mental health is and how to stay mentally healthy. It is very age appropriate and it's quite a good curriculum that has been introduced.

MR. WHYNOTT: Thank you very much.

MR. CHAIRMAN: Mr. Whynott, I know you have other questions, but perhaps there will be a second round. Next I have Ms. Whalen and then, just so you know, Ms. Kent is next on my list.

MS. DIANA WHALEN: Very good, thank you very much and thank you for being here today. It really is a very broad subject. I realize it touches on a lot of other departments. We've already talked about schools and justice and we know there's a great interface with the community in so many ways.

I'm a little bit interested in the share of the budget that is spent on mental health services. We know it's really small - 3.5 per cent is what I think the figure was that you gave us, out of the total health budget, which is probably 45 per cent of what we're spending overall. I wanted to look at the percentage that goes to children, because I think what you're showing there from this 2008-09 is 30.7 per cent of the health care budget is spent on children.

MS. MURRAY: No, no, sorry, of the mental health budget. MHB is Mental Health Budget, I didn't have enough space, sorry, just to be really clear.

MS. WHALEN: Oh, all right. Do you know, out of the total amount spent on children and youth, whether we're doing better than 3.5 per cent? That would be my

question because 3.5 per cent is the global amount of mental health and addictions out of our whole global budget.

How are we figuring with children because as you said, for mental illness, 80 per cent of the mental illness that we see throughout life exhibits itself when you are a youth or younger, so would we put a higher percentage of our funds into it in the child and youth level, at that age group? I'm just wondering if you have a relative figure of the 3.5 per cent out of the total budget and then just hiving off children and youth?

MS. MURRAY: Well I guess what I have is what is stated there, so 30 per cent of the 3.5 per cent is children and youth.

MS. WHALEN: Would you guess that 30 per cent of the overall health budget is spent on children and youth, which would show that it's in proportion?

MR. NANJI: You mean for the mental health?

MS. WHALEN: Yes.

MR. NANJI: That represents 1 per cent, right, of what is there, in terms of the overall health budget.

MS. WHALEN: I think you know what I'm asking, though. I want to ask whether we're in the same - are we in relatively the same ratios or are we putting more than 3.5 per cent of our medical budget for children and youth into mental health?

It's clearly an age group and a category of kids, people in our population, who are more prone and who are exhibiting these early signs of mental illness. If we can address them early, then we've made a huge difference for the rest of their lives. So I'm going to that and wanting to drill down a bit more on the numbers, if we could, and I would appreciate if you can't today, if maybe somebody could do them, even if it's a ballpark, are we in the right ballpark, or we actually putting more resources into these young people for mental health? That's what I'd like to see.

I did have a meeting with Anne McGuire not too long ago; I was trying to look at my notes; I believe she was saying that at the IWK, they spend more than 3.5 per cent on mental health out of the IWK's budget, as a complete district. So could you provide that perhaps later to the committee? I realize today we won't find it if you don't have your accountant with you today.

MS. MURRAY: We will look into that.

MS. WHALEN: I think it would be encouraging for us in the committee to know that there's a higher percentage and if we see that it's just static with what it is for the total population, then we'd have a reason to push for more with youth.

DR. COUREY: I think we have to also be clear that the prevalence is always going to outstrip our ability in the formal mental health system to respond. There is no way that you will ever have enough money to build up our system.

Now, strategically, there are places to put the funds, particularly in areas where we're building capacity in the schools, in the youth health centres, with the family docs, within addiction services, so that we can catch these problems earlier on, so that fewer and fewer are going to end up in the mental health system. Just the work on early psychosis, we know that if you can identify these symptoms before the first psychotic episode, then the major decrease in functioning that these kids will experience over the course of their lives and the subsequent demand on the health care system, you can prevent that. You can have a massive impact, so that has got to be an area for enhancement in the future, if there is going to be any.

MS. WHALEN: Very good, and I appreciate that. Your first statement was kind of depressing - we'll never be able to do it all - but the idea that we can give more capacity to the family doctors and schools and so on, I was going to mention Stan Kutcher who is a research chair at Dalhousie in child mental health, I believe. He has a pilot project in Digby that I believe the health board is involved within one of the schools, perhaps more than one, where they're working with - you talked about training the trainers, but they're training the school teachers.

MS. MERCER: When Patricia was discussing the schools, I was going to mention that the Sun Life Financial Chair is doing work with teachers, in addition to the pilot projects, also does training in modules at the Mount in their summer institutes. With Stan, we're working quite closely around building capacity everywhere so as a researcher he can develop these modules that can assist GPs, or family physicians, to have the knowledge and the ability to either refer on or to help people treat them as part of their work.

That's where we have to go because there's no way we could see the number of kids, as Linda said, who need the help directly from us, but there are a lot of other places, and a lot of youth we don't even see. You talk about the schools, there are groups that are on the streets or go to school, but they're not really going to schools, and would not access a teen health centre even if it was put right in front of them. How do we build a capacity with teachers, with physicians, coaches on teams, so that everyone is aware of what the needs are for these youth?

MS. WHALEN: I think that's very important and that we talk about - not everybody with mental illness needs to see a psychiatrist, there are a lot of other levels of intervention that can be very effective. We can't afford a psychiatrist for everybody with mental illness; I agree with that.

Could I just ask about the mental health strategy, whether you will be fully involved - Children's Mental Health Services will be very much a part of that Mental Health Strategy?

MS. MURRAY: We don't know a lot about the strategy yet. Just the co-chairs have been announced, so I think they would say that, certainly, we will be co-operative with whatever we're invited to be involved in, as part of that process. It will be addressed across the life span, if that's your question. It will certainly include children and youth. It's meant to be across the life span strategy.

MS. WHALEN: With the differentiation with the IWK and all the other districts, it's just important, I believe, that children be very much a part of that. With the Auditor General's Report that was just done, were you included in the audit of mental health services?

[2:00 p.m.]

MS. MURRAY: Yes, we were, but can I just back up about one of your budget questions? We can certainly tell you what's provided through the Department of Health in terms of percentages, but the DHAs and the IWK also have the capacity to enhance that within their own budgets. We provide a non-portable budget, which means it has to be used for mental health services. It can't be used for any other types of services, and so that protects it.

If within the district, they have finances available or it's deemed to be a priority for them, then they can also build on that. As Anne McGuire said, we will give them a portion of money and she may be able to enhance it through their processes within the IWK, so we'll give you some of the picture, we can't give you every DHA.

MR. CHAIRMAN: Thank you, Patricia and Ms. Whalen, your time is up for now. Hopefully we'll have time for another round. I'm just thinking, as I watch the time, because we have a bit of committee business, we probably have until about 2:45 p.m., just to give everybody a sense of our time frame. That takes us to Ms. Kent.

MS. BECKY KENT: Thank you very much, Mr. Chairman and thank you for coming in. This is so important, recognizing that you have a lot of challenges ahead of you. As MLAs, people come to us with a multitude of issues and challenges and for me, I think this is one of the more difficult ones to help with. We can't take a role that's directive, but you certainly want to offer direction to services.

As things roll out, it's encouraging to hear that there are improvements coming along and I would certainly enjoy the opportunity, later, to follow up with you and get a little more resources for us on that level, at an office level, to better serve the constituents who come in. I don't have to tell you the state that they're often in when they get to the point where they may actually come to an MLA for help in these situations.

I've had the benefit - and I very strongly consider it to be a great benefit to myself and my family - to have had very direct and personal contact and experiences with children with autism, the families and the caregivers associated with it and the challenges that they

face and the experiences that they have. The EIBI program is well talked about; it's for those families that are in need of help or those that are, in fact, part of that program. There's a multitude, a spectrum, of experiences and successes with it. There are emotions attached to it regarding what it took to get selected or not selected.

You mentioned today that not everyone is able to take advantage of that, but clearly the information that we're getting is that it is very successful. It has made such an impact and a benefit to many children with autism and then directly to the family, because it's a greater experience and a greater benefit - not just to that child, because the whole extended family and the community around them is experiencing that.

I'm wondering if you can give us a little more insight into that program and a little more detail for the committee on those benefits, how it rolls out, and how it is affecting these children, and perhaps explain what is being done around the fact that not all of the children in Nova Scotia - who, one, are identified because not everyone has been identified, we don't have that database - what's being done to support that program or expand that program?

MS. MURRAY: Well, how long do you have? (Laughter)

MR. CHAIRMAN: Maybe three or four minutes. (Laughter)

MS. MURRAY: Actually, my first job going into the department was to get that program up and running, so I know it quite intimately, or I feel that I do, so I've been intimately involved with it, as I said.

It was developed using best practice at the time, and it continues to be best practice. We had a set amount of money and so we tried to introduce something that would take the most advantage of the resources that we had. We made decisions around the levels of service providers that would be offering the service. We decided to do a train-the-trainer model because that would increase capacity within Nova Scotia and we wouldn't have to do the expensive hiring-out of folks coming in from California to provide that.

Our model consists of a Pivotal Response Treatment, SCERTS - which is a long name which I probably couldn't recall right now - Positive Behaviour Support and PECS. It's kind of a hybrid model that the team has put together and we have excellent clinical leadership in Dr. Susan Bryson, so we're very lucky to have that calibre of expert in the province. She has taken responsibility to oversee the clinical implementation of this. We have teams trained in every district health authority under the IWK.

We knew when we started that we wouldn't be able to see all children who required it. We were mandated with getting it up and running as quickly as possible, because as you say, these families were desperate for it. Frankly, they were just hanging on waiting for it. We were to evaluate it to see if it was effective and we have completed that evaluation. It is very effective, and basically the evaluation shows that children were divided into higher-

functioning and lower-functioning. For everyone it is effective. Everyone has benefitted to a degree.

For some of the higher-functioning kids, it's amazingly effective. Some of them made gains of two years in the period of one year, faster gains than regular typically-developing kids might make. There have been very heartwarming stories. I hope you've heard some of them, and trust the others of you have. I think that there are families everywhere who have just been very grateful for this service, are thrilled that their children are making advances and gains and maybe better equipped to deal with school when they start, so it can be very life altering for them and that's terrific.

For the lower functioning, it still has a positive impact. These are kids who are probably going to require support for life. This is a neurological disorder and it's not curable, so you manage it as best you can and you implement the treatment as early as possible, because brains are still developing and that's when you can have the greatest impact. That is why we're keen to get these kids identified as early as possible and into this treatment program.

It consists of one year of intensive treatment, so it's 15 hours for first six months, 10 hours for the next three, and then five or six hours for the remaining three. There are booster sessions or check-ins with the family as resources are available. If they have questions and get into further difficulty, there may be an opportunity to shore them up a bit while they're waiting to start school.

We have identified that we're serving approximately 60 per cent of the children and we need additional resources and additional human resources to serve the rest. We've put that forward as part of our business planning process on a regular basis, so we've identified it within the past couple of years at least, to say that we aren't able to serve everyone within our current resources.

People have suggested, why don't you just give everybody two or three hours a week and then you can serve everyone? Our fear is that we don't want the model to be watered down so much that it's not really effective with anybody, so we've held fairly fast to that, that we want to make sure the model is consistent. We look at the fidelity of the model and we keep track of that to make sure that children all over Nova Scotia are receiving the same level of treatment and that isn't watered down too much so that it won't be effective. I think we really are serving the most kids that we can, given the resources that we have.

MS. KENT: Do I have time for one more, just a quick one?

MR. CHAIRMAN: One more brief question.

MS. KENT: Very quickly, that program is up to age five, if I recall?

MS. MURRAY: It's until they start school.

MS. KENT: Until they start school, okay, so then we have the rest of their lifespan and certainly based on the presentation today, up to age 19 - what is being done, what are the thoughts around the next stage? That's one of the things that advocacy groups have brought to us, that life continues past and those with autism, young teenagers with autism, are facing very different challenges through school, for instance, because we want them to be part of a school program. What are your thoughts on that?

MS. MURRAY: I know that the school system has worked really hard to put services in place for this. They've developed autism support teams in all of the school boards and they've supported the transition into school, to make sure then know well in advance when children are going to be starting school, to ensure they have the supports they need as they start school. They connect with the EIBI team to make sure they benefit from the strategies that have worked with these children, to make their entry into school as successful as possible. As they go along in school, they continue to try and develop services for them.

It is difficult, once they are of an age, and generally then you are basically managing their behaviours and trying to teach them better ways. But some things are already, sort of - that's the way they're going to be, so you need to really look hard to manage some of those behaviours.

They are seen through our mental health clinics across the province. Depending on the staff available, some have more interest and expertise than others, so that's not a consistent thing in every district health authority, but generally clinicians are trained to address the needs of children and youth with autism.

I would say it gets a bit sketchier when you get to the adult system. I can't speak directly for that, but I know that we've heard concerns that it's very difficult to get adults treated. Do you want to speak about the work that was done?

MR. NANJI: Just quickly, I would add that government has recently received a report from an interdepartmental working group that had representatives from Education - which was the lead on this initiative - but also representatives from the Department of Community Services and the Department of Health, working together with a number of advocacy groups in autism. They looked at the needs of individuals and families across the lifespan and provided about 52 recommendations to government. That report has been produced and has been received. It is publicly available on the Department of Education Web site. As I say, it has been received, so there is still more to follow on that.

MS. KENT: Thank you very much.

MR. CHAIRMAN: Just so you people know how my list is looking at this point, I've got Mr. d'Entremont next, followed by Mr. Smith and then I'm back to Mr. Ramey. That's the way it will go, so Mr. d'Entremont next.

HON. CHRISTOPHER D'ENTREMONT: Thank you very much. I'm going to try to be very general on this one because I think we're moving into an exciting phase, which is the development of a mental health strategy. For many years, we've sort of - all right, we have this much money, we're going to address this program or we're going to address that program. But knowing that a strategy will take some time to develop, and knowing that we probably still need some beds at ACT, we will still need some programming at Choices, we still need things like that, what would be your top-five list of issues that we should be investing money over the next year or two years, until a mental health strategy is put in place? A big question, but it's easy.

MS. MURRAY: Well we do have a process in place where we determine the priorities that are needed within our system and based on our standards, how can we better meet those. So I would say our three top priorities are - in the past, they've been crisis response service, but we have done quite a good job of shoring that up so it's community supports. It's really not considered ideal care to have children and youth, or in fact anyone, in a hospital for longer than they absolutely have to be there.

We would like to see more supports in the community, that's where we're going to get at the greatest need - I think, with children and youth, that's especially appropriate. So we would like to see those services shored up. Seniors will become an issue if you're talking just generally across the life span, if we're looking at priorities for our entire program, because of the growing number of seniors and the issues.

Children and youth have actually been a top priority, basically, since the standards were developed, and they continue to be, which is why we've put new resources into programs to serve them but there is more to be done.

With access to services, as Sue has alluded to the thousand that are waiting at the IWK for outpatient mental health treatment, we don't have the capacity to see a large group of what we consider regular referrals - significant behaviour problems, those kinds of things - so if we had additional clinicians and perhaps program-specific things around behavioral difficulties.

MR. D'ENTREMONT: And that would be my follow-up. There's always the ask of more dollars, but there's also the actual visibility of clinicians and health professionals to actually administer the programs and provide the services.

Where do we think we are in that crunch? I mean, we know that this outpatient issue really revolves around the availability of people, but is it something that we're going to see an end to in a short term, or are we going to see this for some time until we can either

have a new training course somewhere or entice people from other parts of the country or the world?

MS. MURRAY: It's going to be a chronic problem; I think it's only going to get worse. We've certainly noticed it; we've noticed it in rural areas more than in the Capital District but it's still even an issue here and so vacancies can sit vacant for quite some time. Even if we were to get an influx of large amounts of dollars, we would not have the health human resource available to do that. We would need to introduce things gradually and try to, as you say, entice and hire folks from other parts of the country. Our wages are somewhat comparable, but sometimes lower, so we're not able to attract all of them. I think there aren't as many being produced and it's not going to go away quickly. Would either of you like to comment on that?

[2:15 p.m.]

MS. MERCER: As I think a lot of people in the province are looking at models of care, we're looking at different ways of doing things. We're less challenged with recruiting in Halifax. We have some very skilled staff but we've recognized, even if you gave us millions of dollars tomorrow, how would we address those thousand kids? It would be done differently. We'd be building capacity with the family physicians, having other workers doing the work in the community, in the homes, with more senior advanced clinicians supervising them. I think it's doing it a little bit different but, again, building the capacity outside of the IWK alone and working in partnership.

MR. CHAIRMAN: Before we go to Mr. Smith, as we're talking about children, one of things that keeps coming to my mind is that - at least it's difficult for me to think about children without thinking about the context in which they live - particularly their families, but the broader communities like schools and so on. As Mr. d'Entremont was asking questions about recruitment, I was just wondering to what extent you have looked at recruiting people with expertise in treating couples or families as a part of that process that you're engaged in.

MS. MURRAY: Unfortunately we're not really able to take that on because within the resources we have, we can barely see the children and families that need the most critical care. I think working with families it just goes without saying, when you're working with children and youth, and often working with teachers as well, there are often several people involved with that just as part of the regular services provided in the regular treatments. But to sort of say, do we do specific couple counseling or do we do specific family counseling? Not necessarily.

DR. COUREY: We do it as required so that if a young child or a youth is identified as the patient, most often, wherever possible, the family is involved in the treatment. We do train and we look for an ability and a comfort doing family therapy as a basic competency when working with kids. I think that it is another recruitment challenge in relation to this, that much of the clinicians' training doesn't adequately prepare them to

work in a mental health setting that requires expertise in a range of therapeutic interventions, both individually and with family.

Often you'll have, for example, a Master's of Social Work apply for positions with Mental Health Services, and they're coming with very little background. So I think there is work to be done in the longer term and looking at university clinical training programs to ensure that those individuals come to us with at least basic competencies and the kinds of interventions that these kids need.

MR. CHAIRMAN: Thank you. Mr. Smith, sorry for taking some of the time.

MR. MAURICE: Thank you. I guess I want to thank you people, but on a different level. I don't know how you can cope with what you're dealing with on a daily basis. When you tell us things like there are 45,000 young people out there who need service and 18,000 aren't getting treated, to me that just seems daunting and I don't know how you get up in the morning and face that.

My question, when you first started to speak, Patricia, was around the lines of, well, what are you doing to try to address or to outreach, to get these people who aren't getting the service. But you're telling me that you can't even cope with, I think you said, the regular referrals that you have now. If you added these 18,000 to the list - we've got less than 1 per cent of the total health budget goes to youth issues, and even with more money you can't find the people to do the work.

MS. MURRAY: Thank you. That's a very good summary.

MR. SMITH: I just find it overwhelming. I'm amazed. It seems to me almost like a crisis kind of situation.

DR. COUREY: It's so helpful that you realize that and that more people are talking about that. That hasn't been the case, up until recently.

MS. MERCER: It is a crisis, you're absolutely right - child and youth mental health.

MR. SMITH: I don't know the point is of doing outreach to get at these other 18,000 people, because you can't handle what you've got now. Having said that - and you're telling us that you need to get them early and the rest of it - just in the last weekend, my community had a suicide of a 45-year-old person and the weekend before, we had a suicide of a 40-year-old person. These were people who were well known in the community, well established, but obviously didn't get help early enough. I'm just finding this - what do you do for outreach? I guess you don't need to go looking for people - you can't handle what you've got - but what do you do?

MS. MURRAY: That's part of the challenge. That is, we reduce stigma and increase the demand for our services, which are already taxed. I think part of what both

Sue and Linda have talked about is the fact that building capacity within schools and community - we generally have an open referral policy across the province so if anyone has a concern about a young person they can call with a referral. We obviously encourage the people we work with to do that, in terms of the school folks, the Department of Community Services. We just have places that we know we'll be running into these young people who will need assistance, and I guess we would encourage them to take an active role and make sure that they're brought to our attention.

DR. COUREY: It's all about relationships. We work with child welfare, we work with First Nations mental health or health services wherever possible, again trying to assist them to intervene at the level that they can. Again, of those 18,000, the vast majority are not going to need a psychologist and a psychiatrist, but if they don't get the intervention earlier on and if the family doesn't get the supports in place and if they're already compromised in dealing with housing and employment and income problems, then what is going to happen? Things are just going to clearly deteriorate and then they eventually end up in our service, with multiple problems requiring all sorts of intervention from the experts.

MR. SMITH: I guess my other question is a little bit like a follow-up to that. I spent 34 years in Legal Aid and a lot of time with young people in courts, and the co-relation between criminal problems and young people with mental health issues is strong. Is there any way through that system of attracting attention to it so that the treatment can get - because we talk about these forensic studies and things that get ordered, but they're really rare in the sense that not as many perhaps as needed are done. Is there any kind of way of connecting these?

MS. MURRAY: Well I think we actually do have a pretty good forensic service in place in Nova Scotia. We've worked very closely with Justice and they knew that they had a need within the centre in Waterville and so we have put a team in there. They function as an outpatient mental health team for that population of youth. They work very closely with the correctional officers and the teachers within the facility, so they actually get quite a good service while they are incarcerated.

Then the idea is, at least in the Halifax area, I think they will be looking to open additional attendance centres and if possible, in Cape Breton, but right now we only have it in the HRM. That kind of tracks these youths so that they do get support once they're out of the correctional facility, or perhaps they're not going in but they need some support, so they're tracked that way and they get mental health support through that.

There are a lot of assessments being completed and suggestions are made for things that might be helpful for these youth in the community. The sexually aggressive youth treatment is provided across the province, so again, that's a particularly difficult population to work with, but we do have very well-trained clinicians in that field and they're accredited with the training model that they implement. Justice is always very keen to involve mental health and they do recognize the need, so they shifted to including mental health and the

development of services, recognizing things early and making sure that they get the support so that they can get back on the right track.

It tends to be that there are a handful of youth who are a revolving door within the system, but sometimes if you can catch them early and they've made some bad choices or bad decisions, that's enough to correct them. Otherwise, they are difficult to deal with but there are services in place specifically for them.

MR. SMITH: I have some other questions, but I know it's somebody else's turn.

MR. CHAIRMAN: I'm not sure that we're going to get back to you, but we can try. That takes us to Mr. MacLeod, who will be the last questioner in our first round and then I think we will go then to Mr. Ramey, who had been waiting not all that patiently for his next opportunity.

MR. ALFIE MACLEOD: Thank you Mr. Chairman and thank you for being here today as well. Dr. Courey, I'm interested in relation to - we've been hearing a lot about what's going on in Halifax and the surrounding area, but I'm a little curious about how you see things happening in Cape Breton, in particular with the First Nations communities. As you know, in Eskasoni, over the course of the last year there have been a lot of challenges and the community has stepped up to the plate to a certain degree. I'm just wondering how you feel the resources and the ability for you and the Cape Breton District Health Authority to deal with some of these things compares to where we're in the overall picture?

DR. COUREY: I would say that there are some good things happening. In Eskasoni, they have managed to consolidate services that in the past were fragmented into one system. There is Health Canada funding for what they are calling mental wellness teams and some case management there that we are connected with them on that. I sit on a steering committee that's going to oversee the implementation of that model which seeks to try to engage more First Nations, identify individuals who need mental health services and connect them with the formal system.

This is a very high-risk population and I think that there are a lot of issues that are going to need to be address over the next little while. Even if those teams work with us, there is still a reluctance to participate in outpatient treatment through the formal mental health system, so I think there's a lot of work to do.

Also, there is a lot of work to do in terms of early identification. It's not just First Nations youth, but because they are at such high risk and because they often come challenged with multiple family problems and challenges in relation to all of the determinants of health, they are complicated cases. So you add all the same challenges that the rest of Cape Bretoners face in terms of accessing services - culture, language, geographic distance - you know, there are quite a few challenges in our ability to respond to the needs of First Nations communities. That having been said, I think the recent moves

of the development of these teams and having us more formally connected is going to go a long way to making some improvements.

MR. MACLEOD: When you say there are more challenges - and there are challenges within Cape Breton, there's no question - when it comes to the ability to have in-patient service in Cape Breton, do we have specific beds identified for youth and for adolescents in the program? I noticed in the stats there, six days for the average separation. I'm just wondering, compared to the overall waiting list, what does the waiting list in Cape Breton look like for services for young people?

DR. COUREY: First of all, with respect to in-patient services, we do not have a unit for adolescents. If we have adolescents who require admission, they are admitted to a pediatric unit, and we have a psychologist and a psychiatrist who provide consultation to the pediatric unit should they admit a young person with a mental health problem. The older adolescents may occasionally be admitted to an in-patient or short-stay unit, and that would be the only unit that they would be admitted to.

Our expectation is that the admission would be a matter of days; certainly, if an individual required an extended admission because they are psychotic or have a major psychiatric illness, we would refer them to the IWK. We would refer a handful of those a year to the IWK and they would be treated and we would work with them on the discharge plan and follow them up when they're discharged back to us.

[2:30 p.m.]

I'm often asked about in-patient services for adolescents in Cape Breton, because there seems to be this idea that maybe we should have an adolescent unit. Our feeling is that if we had our druthers in terms of where the money would go, it would be into community supports and outpatient mental health clinicians following families and youth on an outpatient basis, because that's where we're going to have the most impact. We can manage the occasional in-patient admissions to the adult unit or to pediatrics, with the support of the IWK, but what we really do need is the support in the communities. That means in Cape Breton, not just the industrial area, but trying to provide services in Inverness, Cheticamp, north of Smokey, all of that.

Our wait times for outpatient services are not too bad considering we've had a massive increase in the number of referrals over the last few years - referrals of individuals who actually attend the first appointment. As I think I mentioned before, all of our emergency, urgent, and semi-urgent referrals are able to be seen within the established time frame set down by the standards, but we do have larger numbers of families and individuals waiting if they are called a regular referral. Our median wait time for that group is 60 days, which is pretty good, but again, we're having more and more individuals waiting past 90 or 100 days.

We also have longer waits for the Autism Intervention Program, which is EIBI. We're just losing a Ph.D psychologist who is drawn to the joys of private practice, so that is going to be a challenge for us. Our Intensive Community-Based Treatment team is just beginning to have a wait list of a matter of weeks at the moment, so we are managing.

I should say one more thing, which is the investment that was made in the Family Help Program in Cape Breton has been extremely positively received by the community. We are able to see larger numbers of kids with mild to moderate mental disorders through that program and the evaluations are very positive.

The other thing we've used Family Help for is to do a telephone screening of all central intake systems, so if anyone would call, they would get screened by the Family Help folks. That screening has resulted in an increase of about 50 per cent, in the last couple of years, of people who actually show up to the first appointment. So there's something that they're doing right in terms of people wanting to come and see us, at least for one appointment.

We still have challenges. We still have access problems, stigma problems. We have challenges with multi-problem youth before they get involved with the criminal justice system. We don't have access to the Youth Attendance Centre that exists in Halifax, like many other parts of the province, and we certainly need those resources. There is a range of services that are more difficult to access in Cape Breton than they would be, certainly, in Halifax-Dartmouth.

MR. CHAIRMAN: Thank you, Dr. Courey, thank you Mr. MacLeod, I think that will take us back to Mr. Ramey finally.

MR. RAMEY: I will be brief and I do thank Mr. MacLeod and Dr. Courey because you addressed one of the questions I was going to ask, if there are any special services targeting Aboriginal populations. I think you already addressed that, to my satisfaction anyway.

The other question, I noticed when I was looking at the enhancements to mental health services for children and youth, one of your slides said, the BEST program in Cumberland County, and I noted that it was in Cumberland County. I was just wondering, in terms of the nine DHAs, you obviously - and I think Mr. Smith mentioned the number of people who haven't been seen, too, so I'm piecing disparate parts of information together as a result of the conversation.

You have a template, I take it, of where the folks are coming from, which DHAs they're coming from, and in what numbers, I assume. Do we then take that information and try to get the services targeted into those specific communities where the need is the greatest? Is that what we're doing?

MS. MURRAY: We tend to try and locate the services where there is the greatest population, so proportionately you'll get your biggest bang for the buck in those areas. Obviously Capital District is the biggest and DHA-8 is the second largest, so when we're divvying up resources it tends to go there. If we're developing a specialty service, what we try and do is make it available across the province. It tends to be housed here, but then folks can access it from across the province, so the Choices program for addictions, the in-patient unit, the ACT Program, CRP - they can come from all across the province to access those services.

MR. RAMEY: Can you give me, again, the acronym BEST was for something - Before School, or something like that?

MS. MURRAY: Yes, Behaviour Education Support and Treatment, BEST.

MR. RAMEY: How did Cumberland land that?

MS. MURRAY: They would have submitted a proposal. Sometimes, if the Health budget allows, the district health authorities and the IWK are invited to submit proposals and if they address one of our key priorities - as I noted they are children and youth and emergency services and that sort of thing - if they address that, and if they fall within our parameters in terms of accepting them, then they may get funded. There are the odd programs across, like the Youth Navigator System at the IWK and the BEST program in Cumberland.

As I said, typically the services land here and in Cape Breton, but we're also aware that services are needed across the province and so if there is an opportunity to fund them elsewhere, we do, and so we were able to give them a small amount of money to be able to keep that going.

MR. RAMEY: Okay, thank you very much, I appreciate that. Thank you, Mr. Chairman.

MR. CHAIRMAN: Thank you Mr. Ramey. Ms. Regan.

MS. REGAN: I wanted to go back to the EIBI program. According to a statement on a fact sheet produced by the Department of Health in January of this year, government recently stated in the Legislature that over the current year, they will be reviewing their ability to enhance the EIBI program. Now that we're in a new budget cycle, has the EIBI program been enhanced? I know we know that about 60 per cent of the kids are being served - what is the number of kids that are not?

MS. MURRAY: The EIBI program was not enhanced, and the number fluctuates - I would say it's between 90 and 100 who are not being served.

MS. REGAN: I'm just wondering if we can move to the Schools Plus Program because we're not going to get very far. Last May, Nova Scotia Health Research Foundation issued an RFP to review the Schools Plus pilot program and the deadline for the evaluation is June, this month. I'm just wondering, have you received the evaluation yet? If not, is the evaluation on target for completion this month?

MS. MURRAY: The lead for Schools Plus is actually the Department of Education, so we wouldn't be aware whether or not they received it. We are working in collaboration with them on that program and we have ongoing meetings so I may be hearing about that in the future, but I wouldn't be able to speak to it now.

MS. REGAN: You wouldn't get a copy of it as soon as it came in?

MS. MURRAY: We may or may not but I just wouldn't be aware of its arrival because that would be something that the Department of Education would be responsible for.

MS. REGAN: So you're not aware of its arrival at this point?

MS. MURRAY: Right.

MS. REGAN: Are you aware of who is doing the evaluation and how much it is going to cost or anything like that?

MS. MURRAY: I'm not aware.

MS. REGAN: And you probably don't know if they're planning to expand the Schools Plus program or anything like that.

MS. MURRAY: I'm not aware. I am aware that it's certainly viewed very positively and the pilot projects, I think, anecdotally certainly are going well, so it's getting some attention and there is discussion about it. That's about what I could say at this point.

MS. REGAN: Do you know if they're planning to release the report?

MS. MURRAY: Again, that would be up to the Department of Education so I can't speak to that.

MR. CHAIRMAN: Good try. (Laughter) That will take us to Ms. Whalen. We have about four minutes left so we'll see where this goes.

MS. WHALEN: Very good, I just wanted to pick one area then. I'd like to go back, Ms. Mercer, to what you were saying about the program that the IWK is looking to move to Joseph Howe Drive, to the building there. Again, I think that what we've heard today has been about bringing services to a community, taking it out of the hospital setting,

working with families in more of a community setting. I realize that's a building, it will be a bit of an institution, but was that intended to be a residential program? I apologize, I don't know much about what you are proposing.

MS. MERCER: It is a residential - a portion of it is. The Choices addiction program, which is located right now at Dalhousie University residence, O'Brien Hall, so it is three components to that program which is an out-client, a day treatment program and 14 beds. So we are relocating in early July to Craigmore, which is on Joe Howe Drive.

MS. WHALEN: I did wonder if it was an expansion but now you're just relocating?

MS. MERCER: It's not an expansion, no, just moved location.

MS. WHALEN: My question would be, if it has been existing in O'Brien Hall, could you not address community concerns by showing that it hasn't had those impacts where it is now?

MS. MERCER: We certainly provided a lot of education and facts and addressed the concerns as they've come in and we've offered to meet with a small group of neighbours in the community on an ongoing basis, so that information is certainly flowing back and forth. We haven't had any problems at O'Brien Hall.

MS. WHALEN: That's really what I wanted to know - how long has it been there and did you have any problems.

MS. MERCER: We were there for four years and we haven't had any problems.

MS. WHALEN: You know, I think a lot of times the concerns people have, as you say, are based on misunderstanding and just fears, really.

MS. MERCER: Totally understandable, which is why we had the community meeting with them and which is why we're offering to continue meeting with them.

MS. WHALEN: I was impressed and I did see the CEO, as well, attended that meeting and was willing to talk directly to the neighbours in that area. I think that's the way we will start to break down those barriers. I wish you luck with that program. I'm going to stop.

MR. CHAIRMAN: Okay. I don't have anybody else on my list. We might have another minute if there's anybody who has one burning question. I don't see any hands so Patricia, do you or any members of your team have a summary comment that you'd like to make?

MS. MURRAY: I might just say a couple of things. First of all, I'd like to thank you all for your very careful attention and your very thoughtful questions. Clearly you've

considered our presentation and you're all well aware of this issue at some level or another, so we do appreciate that.

I did want to say that when anyone comes into our system, we are well aware that it is almost a crisis by the time they are bringing it to our attention. So when we talk about divvying up in terms of urgency, that's a clinical call and we have to make it within the resources we have. We are painfully aware that families are suffering, regardless of when they are being seen and how long they have to wait.

Dealing with the adolescent population is most challenging. As both Dr. Courey and Ms. Mercer said, getting them engaged is key and while their brains aren't completely developed, may even be a little sketchy if they've been indulging in a lot of drugs or alcohol, they may still have capacity and they don't agree. That's very frustrating for families and we all hear about that.

I did also want to pick up on the comment that not everybody needs to see a psychiatrist. We're working very hard with multi-disciplinary teams, and with the new models of care, so that people see who they need to see. That stretches the resources as far as we can and makes sure people actually get the appropriate care they need, and we save our most experienced specialists for the people who need them.

I also wanted to say that there's a very hard-working system behind all of this. Mr. Smith noted that it's very hard to wake up to this every day - it's very hard for them to wake up to this every day. They see those families; they hear those concerns. In every area, when referrals are made and they're told the approximate length of the wait, they're also told, please call back if your situation changes and it can be re-evaluated. These families, regardless of how we determine it, are certainly suffering and the clinicians hear that and they work very hard to make sure these families get the services they need. They don't have enough resources, it's more a system thing, but they certainly carry that, and so I want to acknowledge all the hard work that they do.

I'm hoping that the environment is right, or the culture is right, to shift to more collaborative care. As both my colleagues have said today, it's about increasing capacity elsewhere rather than enhancing - well, it's both, actually, but it's also important to increase capacity elsewhere and so we're encouraged, hopefully, by the appetite to do that and we'll keep working in that direction.

I think that's what I wanted to say, but I do thank you all for your attention and I thank my colleagues for their thoughtful answers to your questions.

MR. CHAIRMAN: Well thank you all for being here today. You can tell from the questions, there has been a lot of interest and it's been very helpful. We do have, just for the Committee members, some other business to take care of, so please don't rush out of the room as we enter into this. Maybe we'll just take a minute to allow the transition to occur.

[2:44 p.m. The committee recessed.]

[2:45 p.m. The committee reconvened.]

If I can call us back to order, I think everybody has an agenda in front of them or somewhere among their papers. Under Committee Business, there are several items that we should address, the first relates to correspondence. We had a letter that we referred to in our last meeting from the Faces of Poverty Consultation in which - and that letter is being distributed, as I speak. There were several comments or requests that were made in that letter that we at least referred to at our last meeting but did not reach decisions on, and I thought we should come back to that.

My summary of those requests is - the first one was that we were asked if presentations planned for the committee could be circulated to members in advance of committee meetings. It's been at least the practice in this committee, during my experience, that the presentations that we get access to, at this moment, have been brought to the meeting. We haven't seen them in advance of the meeting. We could certainly consider changing that procedure, but some of you have more experience than I do with this and I guess I'd just be interested in any thoughts that members of the committee might have about the appropriateness of that request.

MR. SMITH: I think it would be an excellent idea if they, obviously, have it presented at least a few days in advance in order to give it to this meeting. It would be nice if we had it to read over and then our questions can be readied in advance and perhaps save some time and that kind of thing.

MR. CHAIRMAN: I'm seeing some nods. Does that seem like an acceptable practice? Ms. Whalen.

MS. WHALEN: I would just like to point out - and I know Mr. Whynott is on our Public Accounts Committee - we get an extensive amount of information provided to us prior to - in fact, too much for us to read. If you were to have something like the presentation, which really sets the stage for your questioning, I think it would be very useful. I think then you're able to just focus your questions and be better prepared, and that makes better use of the committee time.

MR. CHAIRMAN: Just for clarification, of course we all do have access to quite an extensive amount of information, as prepared by the Legislative Library. So I think what is perhaps being requested in this letter are those specific presentations like the one we saw today . . .

MS. WHALEN: I think that might actually helped to focus it.

MS. REGAN: I was just going to say we did get an extensive amount of information in advance of this, about 367 pages worth. (Interruption) I did, I read it all - no. (Laughter)

The thing is that you could take one little bit and start focussing on that and it might not even come up at this meeting, so I really think that something like this would be of much more assistance.

MR. CHAIRMAN: I think we have some agreement that it would be reasonable to ask our witnesses to present whatever briefing notes they are going to bring with them several days in advance of the meeting. Would it be acceptable - we have already agreed that documents like this that are made available are posted, so that an observer who may be coming would have access to them in advance as well. Assuming we can manage that, is that an acceptable plan? Okay, I think we've got agreement. I don't see any . . .

MS. KIM LANGILLE: Do you have an idea of how much in advance you want the presentation? The same as a research package, a week? Is that sufficient?

MR.CHAIRMAN: It has to be reasonable to the presenters as well, but I would think . . .

MS. REGAN: At least the weekend before, but a week before would be . . .

MR. MACLEOD: I would just say that in some cases, sometimes the presenters aren't going to have the ability or the manpower to do that, and we should understand that, but being reasonable, if they can do it within the week, that would be great.

MR. CHAIRMAN: Okay, so we'll aim for a week, understanding that there will be times when that may not be possible. Okay, thank you.

The second request was, and this is again from the letter from the Face of Poverty: We have not always been aware that follow-up has been received and/or recorded when a lack of information. I guess sometimes we were requesting additional information. Observers may not know how to access that, but I think probably - Now I'm just trying to think, how do they know? They don't know. They don't have a way of knowing.

MS. LANGILLE: Sometimes they would, because the correspondence is brought here and it is talked about at the meeting, but not in all situations.

MR. CHAIRMAN: It's not necessarily recorded in Hansard if it's not discussed here. Mr. Smith.

MR. SMITH: Why don't we do the same thing with the responses that come in? Put them on in the same way that we're going to put the committees on the Web site, the written answers that come in.

MR. CHAIRMAN: I don't know if there's - I'm looking for some reflection on that. Is there any likelihood that kind of information might be confidential in nature, that it should not be public? Mr. d'Entremont.

MR. D'ENTREMONT: Well, in some cases it probably would be - it's a public meeting - but at the same time, how does that mesh with the Hansard, with that reporting service? That's basically where you're trying to have your connection to, so it's more us asking a question of Hansard, if it's possible to add these briefs as they come to us, after the fact. I mean, I don't know how that works in the whole thing.

MS. WHALEN: Again, if I could.

MR. CHAIRMAN: Yes, please, Ms. Whalen.

MS. WHALEN: We quite often ask for extra information at Public Accounts Committee, and it doesn't go into the public record. It is circulated to the members, and we often don't - well, we don't usually discuss it. It's simply circulated to say that those - similar to the request I made today about the financials. It would just come back to the members and it's up to us to act on it. Whatever you do decide might have a bearing on some of the other committees. As I say, as the Chair of the Public Accounts Committee, I'll be interested if you have a suggestion.

MR. WHYNOTT: What happens when it is tabled in the House? When it goes under the Mace, what happens there?

MR. MACLEOD: I was going to say we have the same - when we have estimates, sometimes ministers don't have the ability to respond right to a specific question on a specific line item, and that comes to your caucuses. It is nowhere to be found in the public record, unless you go and do that kind of research. Mat, I'm sorry. I was kind of thinking where I was, so I wasn't sure what your question was.

MR. WHYNOTT: I was thinking when Committee of the Whole House, when something is tabled there, is it public record?

MR. D'ENTREMONT: It's numbered and recorded because you're in session. This is received after the fact, right, so we're not in session, we're not in a recorded session.

MS. REGAN: Perhaps, when it comes to you, we could bring it to the next meeting and just say is this an appropriate thing to have go online? Yes? No? There may be cases where things are confidential and we don't want it out.

MR. CHAIRMAN: That seems like an interesting and helpful suggestion that if any correspondence received as follow-up could be added to the agenda for our meeting, and either referred to or discussed during the meeting, so that it is recorded in Hansard, anybody wishing to find that would then have the ability to know it has been received or tabled. Mr. Whynott.

MR. WHYNOTT: I would suggest maybe what we do is ask legal counsel, just for confidentiality purposes and just the whole process on how that works, that would be a suggestion from me.

MR. CHAIRMAN: Mr. Smith.

MR. SMITH: My answer to that is, this is a public meeting. If we ask the question here, and they have the answer, they're going to give it to us. All they're doing is deferring collecting the information to give it to us - it can't be confidential. I can't see how it could possibly be confidential, in any way.

MR. RAMEY: I don't know if this point is relevant or not then, the only thing that I would be concerned about is that somebody would be reluctant to give us the information that we requested because they didn't want it to be in the public domain, or something, and they wanted it for our eyes only. I wouldn't want that to impede us getting information we want. Having said that, I guess, if you check with legal counsel and they say there's no problem with it, then we're okay anyway. I think we've beat it up enough.

MR. CHAIRMAN: I think we've got a number of suggestions on the floor. Checking with legal counsel seems like a prudent idea, which may help us understand where to go next. We'll bring this back, once we've done a bit of research, to a future meeting.

We're not done with this letter yet - this is a thoughtful group. They're referring to our last meeting with the director of Maintenance and Enforcement Programs: This is a specific incidence where the standing committee should request a report back from performance. They were referring, I think, to the audit that was done. It does occur to me that is a good point, and it may well be one of the things we should look at in the future as we're organizing future meetings, about an opportunity to revisit that program to see how they're doing with that long list of standards that they've been pursuing. Ms. Regan.

MS. REGAN: Just in the information that has come to light for me since that meeting, I have a whole lot more questions, so I would love to have them come back again to answer them. I would also suggest that in the future, when we're going to deal with a huge issue like childrens' mental health, we could have just had one of those groups in. We should of just talked about, for example, EIBI, this afternoon. Trying to get across the whole breadth of youth mental health, we just scratched the surface.

MR. CHAIRMAN: That point is well taken. Maybe that takes us to the next item on the agenda, which is future witnesses. As a piece of information, when we prioritized our list of possible witnesses, one issue was the Residential Tenancies Act, and perhaps witnesses from Service Nova Scotia and Municipal Relations. That may still be something we could consider; that's the only thing we had on our list.

In terms of where we go from here, which maybe also involves whether we have summer meetings - is moving to the Residential Tenancies Act the next step for us to take? Is that continuing to be of interest? We could schedule that for our next meeting, probably, but we also need to think about what other witnesses are we interested in considering. Ms. Regan.

MS. REGAN: In terms of the Residential Tenancies Act - and forgive my ignorance here - do we just hear from government groups or do we ever have other groups come in who would have an interest in this area and make presentations?

MR. CHAIRMAN: We certainly have others come in. We have, and could, and in my opinion should, look at a variety. There may be either a different group from the department or a combination of . . .

MS. REGAN: I'm thinking about the sort of flip side of it, which would be the property owners and some of the tenants, property owners - everybody who is connected with that, if there are groups representing them. Would that be a problem?

MR. CHAIRMAN: I can't recall. Kim, you may have some information about that. When the list of witnesses was created, do you recall, was there a proposal?

MS. LANGILLE: Well, what it was, the proposal was Government Review of Residential Tenancy Act so it specifically mentioned the government, that's why Service Nova Scotia and Municipal Relations was contacted in that regard. There's no reason why you couldn't have another group if the committee chose to.

MR. CHAIRMAN: Are there specific suggestions at this point as to who we might invite?

MR. MACLEOD: I would suggest that we should look at some of the people who are living in mobile home parks. Because in mobile home parks, these people are charged property tax yet they have no say over any of the things that take place within their community. Their lot fees keep on rising - a really remarkable amount of money (Interruption) Well, it's under the Residential Tenancy Act and there's a whole section that deals with mobile home parks.

MR. SMITH: How did this topic come to the table?

MR. CHAIRMAN: We created a list among this committee about a year ago, probably just before you joined us.

MR. RAMEY: It's an area in which I have interest, big time.

MS. REGAN: Alfie, is there a group that deals with - is there some kind of an organization that these folks belong to?

MR. MACLEOD: Mat has a bunch of them.

MR. WHYNOTT: Yes, there's a group called - it's actually an Atlantic Canada group, I believe. I can find out the name for the committee but there is a group. Next time, we can bring that forward.

MS. LANGILLE: Perhaps when we have our next organizational meeting, that's when everybody can submit their requests again.

MR. CHAIRMAN: Maybe that's where we're kind of struggling over what to do next, that may be where it takes us. Just to clarify, I think there has been a long tradition of this committee not meeting over the summer. Does that continue to be an acceptable plan?

MR. MACLEOD: I'm a strong believer in tradition. (Laughter)

MR. CHAIRMAN: I guess that's probably why you're a member of the Progressive Conservative caucus. (Laughter) That means we would then meet in September. I can't remember when Labour Day is, I didn't check that before I came in today.

MS. LANGILLE: Our September meeting would be the 7th, right after Labour Day, I guess.

MR. CHAIRMAN: The Tuesday after Labour Day. (Interruptions) I'm hearing quite a bit of noise. Am I hearing that first Tuesday after Labour Day is not the best day? If we went to the next Tuesday, is that a possibility?

MS. LANGILLE: There is already a meeting that day, right? Yes, another committee meets on that day.

MR. CHAIRMAN: On the second Tuesday?

MS. LANGILLE: Yes.

MR. CHAIRMAN: I heard Ms. Regan say the 7th would be okay. Can we test that to see how many people are willing to meet on the 7th? Maybe a show of hands. I think I'm seeing the majority of people. I think we would meet at 1:00 p.m., again following tradition.

So then our next meeting will be on September 7th, at 1:00 p.m. The purpose of that meeting, I think, based on our discussion would be an organizational meeting. Perhaps if each of us can go back to our respective caucuses and think about what we'd like to bring forward, we'll use that meeting as an opportunity to create a list of witnesses. Does that sound acceptable?

MR. MACLEOD: That sounds very fair.

MR. CHAIRMAN: Ok, thank you. There is one other item on our list. At the end of the last meeting where we were hearing from - what did we discuss last time in addition to. . .

MS. REGAN: The Kings Regional Rehab folks were here.

MR. CHAIRMAN: Yes, along with some other people.

MS. REGAN: Yes.

MR. CHAIRMAN: The services to people who are disabled, I think, was our general theme. There was a suggestion at the end of the meeting that perhaps it would be a good idea to have a tour of the centre. I bring this back here to see if there might be some interest in that, and I'm not sure if that would be a replacement for a meeting, but it might be something that would be of interest to all or some of us.

MR. MACLEOD: I would be very much in favour of such a thing.

MR. RAMEY: I would as well.

MR. CHAIRMAN: So I'm seeing quite a bit of interest. Ms. Regan, I thought you might be going to add some other comment?

MS. REGAN: No.

MR. CHAIRMAN: Okay, that's a yes. What kind of time frame should we be thinking about, should we organize such a thing? Is that an activity for the Fall?

MS. REGAN: Would it be possible to do before the end of this month? Would members want to do that or would they prefer to wait?

MR. RAMEY: I think that's a good idea.

MR. CHAIRMAN: I would like to welcome you to the Annapolis Valley. It's not the riding I represent, but it's very close to it. It would be wonderful to have you. I guess then what we will look at is a possible time toward the end of this month and see what we come up with.

MS. LANGILLE: That is high graduation season. Everybody knows that.

MS. REGAN: I wouldn't do the last week of the month. My impression is that that's when most of the high school graduations are.

MS. LANGILLE: What about the first week of July? If we went beyond that, is that bad for people? If I can't . . .

MR. SMITH: The first weekend? That's the middle of a long weekend.

MS. LANGILLE: That first week - sometime that first week of July.

MR. MACLEOD: I think what we'll do is see what options you can come up with and then maybe circulate them around to see if we can get an agreement.

MR. CHAIRMAN: Okay, we will come up with two or three dates, perhaps, or an option or two and make sure that's available. I guess I'm assuming it may likely be the case that not everybody can manage it, but the majority of people who can will take a tour.

I think that concludes our business. Our next meeting will be on September 7th. Thank you for all your work both today and throughout the year.

The meeting is adjourned.

[The committee adjourned at 3:05 p.m.]