MH-5

ISSN 1918-9613

Legislative Assembly
of Ontario

Second Session, 39th Parliament

Assemblée législative
de l'Ontario

Deuxième session, 39e législature

Official Report of Debates (Hansard)

Wednesday 5 May 2010

Journal des débats (Hansard)

Mercredi 5 mai 2010

Select Committee on Mental Health and Addictions

Comité spécial de la santé mentale et des dépendances

Mental health
and addictions strategy

Stratégie sur la santé mentale
et les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
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Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

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

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 5 May 2010

Mercredi 5 mai 2010

The committee met at 1550 in committee room 1.

MENTAL HEALTH AND ADDICTIONS STRATEGY

YOUTHDALE TREATMENT CENTRES

The Chair (Mr. Kevin Daniel Flynn): I call this meeting to order.

Why don't we ask you gentlemen to come forward? We've kept you there, hoping we'd have a few more members.

We had actually hoped to come and see you, because Christine told us about your facility and said it was something we should all see. It was our intent to come and see it, but fate conspired against us with the way the legislative schedule has been working lately. We thought, "We're going to be at the stage where we have to write our report." So we thought that if we couldn't see you, perhaps you'd come and see us instead. I want to thank you for doing that today, and turn the floor over to you and ask you to tell us all about Youthdale.

Mr. Paul Allen: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Please introduce yourselves as well, for Hansard.

Mr. Dan Hagler: My name is Dan Hagler, and I'm the executive director of Youthdale. I will start the presentation.

I'll come forward and invite each of you, any group at any time that you want; you just have to call me, and I'll make the arrangements. I think that this kind of visit not only will give you more because we will be able to give you ample time, but you also will enjoy the fact that you'll see that some of the work that you do behind closed doors has an effect on children. I think you will love it. You have an open invitation, any time you want. Just make a phone call. It's marked on my card.

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

Mr. Dan Hagler: I want to thank you for allowing us to speak with you about the work that we do with children and adolescents. I hope it will be of some kind of merit in your deliberations.

We have, at this particular stage, two units in downtown Toronto which are a hospital type. One is an intensive care unit, almost like a schedule 1 hospital for kids who are dangerous to themselves and others. Another unit is an intensive psychiatric unit that is intended to continue with children who feel that they need to stay a little bit longer until a time when they will settle and be able to integrate and go back with their families or to some of the other facilities that we have.

In addition, we have a few houses in the community. In each house, you have a few kids, sometimes eight, sometimes 10; it depends on the size of the house. At the houses, care is covered by psychiatric and psychological consultations, medical staff as well as child care workers and social workers. We try to help the children in the long run to integrate with their families. Sometimes the children don't have a family, so we'll refer them to the guardian.

The reason that we opted to have houses in the community rather than having an institution is because we'd like, as much as possible, that the lives of the children will be normalized. Not only will the children enjoy other friends on the street, but when the children are capable, they'll go to a regular school in the community. In this kind of arrangement, the transition from our treatment homes to the houses is much easier for the children and the parents.

Many of the children that we have, besides the fact that they have emotional problems, also have learning problems and various other problems. Some of the kids are very complex—maybe my colleague Dr. Scharf will speak about it—and some of them are not doing too well in school. To overcome this kind of thing, we created our own special classes with the collaboration of the board of education. As a matter of fact, many years ago we spearheaded this kind of an idea.

The kids are usually going to our special classes. Within a reasonable time, they are able to integrate within the same school where our classes are because our classes are just in a regular school.

Sometimes the kids find it too difficult to function in their community and they need a school on the premises. For these fortunate, or misfortunate, kids we have a beautiful facility. The facility is about 150 miles north of Toronto on a beautiful lake. The name of the lake is Lake of Many Islands. They live there for some time. They have a school program on the premises and also some kind of a lifestyle with the staff that hopefully will be able to bring them back to the community.

We have an arrangement with all the boards of education wherever we are and those classes are really a great help for the kids to integrate. I know with mental health patients, many of whom you are probably well acquainted with by now, the issue is work; for the

children, it's the issue of school. If the children are able to integrate within a regular school system, even part-time, for the children and the families this is a great success. Needless to say, we also enjoy it a lot because we feel that we are partly responsible for this.

We are about 40 years old. I started as a young fellow with this institution. Sometimes I feel about 100 when I count the overtime, but I wouldn't complain because I notice when meeting some of you that you do the same.

However, the Youthdale development story is going parallel to the vision of the ministry of the government of Ontario for the children. At the beginning, we started with the Ministry of Health. After that, for various reasons that I wouldn't elaborate now, we moved to the Ministry of Community and Social Services. Recently, we moved from community and social services to the Ministry of Children and Youth.

In 1982—yes, I believe it was in 1982; as a matter of fact, I'm sure about it—we were asked by the government at that particular time to develop a hospital for children. In 1981, for those who are not familiar with what happened in the past, there was a concept that children ought not to be treated in a hospital. They looked at the experience that we had with the children and we were asked to develop this kind of concept. The idea at the beginning was to develop 30 beds. As of now, we've developed 20 of them. Problems of budget aren't new to any kind of a government and in 1981 we had similar problems. You are visiting today a similar situation that we had then, with interest rates much lower. I remember when we built it and we wanted to borrow money, interest was about 18% of 19%.

The reason for the hospital is because, in addition to some kind of a support system and their experience in school, it's very important that some of the children who have medical and complex issues and who need an institution go there to deal with them. Even the concept of developing a hospital for 20 kids or 30 kids in itself is unrealistic because what happened is, we were lacking in terms of support for other institutions. With a lot of public relationships, we were able to seduce or encourage the Toronto General Hospital, or what we call now the University Health Network, to become a partner with us. Early in our development we had a relationship with St. Michael's Hospital. As well, we now have a relationship with the school of medicine's department of psychiatry. We are very proud to announce that we are a major partner with the university and with these hospitals and we've become not only a major centre, probably the largest centre of child psychiatry in the province, but we also have become a major place for the training of residents in psychiatry and fellows in psychiatry.

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So this kind of a partnership with the board of education and the health institutions allows us to go on to achieve a lot of things that many other organizations were lacking. As a matter of fact, a few years ago, the American Psychiatric Association gave us a gold award—unfortunately, those of you who wouldn't visit wouldn't be able to see it, but it's mounted in my office—for having the best psychiatric services in North America in terms of comprehensive services for children. And I believe we still do.

In addition, we have a board that raises money, because there is only limited money that the government can go and support all those noble causes. We opened a chair of pediatric and neurodevelopment psychiatry. We work in collaboration with a few professors in research and other things that hopefully will be able to help our children.

Above all, those things that happened, above and beyond all the nice things and all the compliments, I am most gratified that for about 7,000 young people, we touch their lives annually, some of them with as much as a phone call; others in terms of admission to crisis; others for a longer stay in our residential program, and we're able to make a dent.

This is, in some kind of a nutshell, some description of the agencies, some historical review of what happened, what developed. We have some, however, very interesting features that I'd like to share with you, and maybe you'll be able to share it with other institutions.

First, and one of my most favourite topics that I like to speak about, is emergencies. When we look at emergencies, particularly for children and adolescents, but also emergencies for other people who have problems with mental health, what happens is, we usually rush them to a hospital. We rush them to a hospital, and the people are sitting there for hours and hours because those people who have a mental health issue, they don't bleed and it doesn't look like an emergency. Then, some of them will be discharged and other people will be admitted for the short term.

We didn't like this kind of system, so we came up with an idea: that we have paramedics 24 hours a day, seven days a week, and there is a psychiatrist on call or on duty. What happens is, when you have a phone call, and a child or a family have a problem, the first thing is, we speak with the child or with the family or both on the phone. After that, we go there—we have a mobile service. It means that the people, who are almost like paramedics, go to where the crisis is. They are able to see what the crisis is with their own eyes. Second, they usually find some kind of a resolution; however, sometimes the child ought to be admitted. At that particular time, they'll speak on the phone with the psychiatrist and they'll say, "You're going to be admitted to the hospital." The parents ought to agree. The child ought to agree, but at that particular time there is no waiting time, because once the child is being brought to us, he or she is being admitted immediately. I think it's quite impressive in terms of saving time and not torturing families and children, or any patient, with a long wait in the hospital.

The other thing is, though we are very small, we were able to provide a whole range of medical and some imaging services that the child needs. This means that we can deal with any kind of medical or psychiatric problem the child will have, so we don't have to screen and say,

"This child is too difficult," or "We can't accept this kind of a child." When it comes to MRI and other imaging, because of our relationship with the hospital—St. Michael's, which is just beside us, or sometimes, when we have the time, we use Toronto Western—we are able to go and get the best equipment, and often they consider the child as part of the hospital. If someone is unfortunate to have a child that needs all the medical services and all the attention, they are very lucky to be involved with us.

Now—and Paul Allen will speak a little bit about this—we have an option to admit a child in any part of the organization. If the child has a crisis, we have a secure unit where the child can be admitted. However, if the child has a problem with the school, we don't have to admit him first; what we have to do is make an appointment with the teacher or the people in the department and the child will go to school. If the child needs a school or premises or other situations, we will introduce the child to where the child will be best suited.

However, any one of those children—and some children are very complex—at some time or another during their life, they will be required to be admitted to one unit or another. Let's assume that the child is on some kind of medication and he is going to this beautiful camp that we have, and the medication doesn't help. So we would like to go and review it. You need to do it in a hospital setting. So you ask the child to go and move to a hospital setting, and then he or she will stay for some time. When they are stabilized—sometimes two or three days, sometimes a week, sometimes even longer—then the child can go back.

This kind of a possibility and flexibility allows us what most other organizations aren't able to do, and that's to go in and help the kids, I would say, no matter what the problems are. So the children are moving within the same kind of organization, though they're in a different kind of location based on their needs, and if for a short time they need to be admitted to one part or another, then it's a smooth transition for them, in and out or to another setting.

The other thing that is very important is that we are a community-based service. I agree with the concept—how can you not agree with the concept?—of having children in a normal environment, playing on the street and going to a normal school. We push the envelope up to a maximum in terms of making sure that the children's lives will be as normal as possible. I remember many, many years ago when I had a dialogue with the board of education. They said, "Why don't make a special classroom for those kids?" And I said, "No. It will be easier in the short term, but when you create a special classroom for the children, the children will stay in this classroom and their ability to integrate back to the school will be harder, if any." Therefore, we push all the time, as much as possible, the envelope to create some kind of a normal life for the children.

This is, in some kind of a broad description, some of the things that we do.

I want to tell you something. I have travelled far and beyond this province and beyond the country, and I'm proud to tell you that the service that we have, at least at Youthdale, can compete with any services in any other place in the world. I've been to Europe many times, and I think that we all should be proud—even with some financial troubles—that we are able to have some places of excellence, where the children who are lucky enough to be admitted get the service that they need.

Again, I plead with you—and I'll make arrangements for you to come and see with your own eyes, because someone told me that one picture is better than five hours of me talking.

However, I'd like to go on. I'd like you to be mindful of some issues that we have a problem with, but I won't elaborate too much. We have a problem with time and with age. Who doesn't? But this is for the children's sake and not for us. When I'm speaking about time, it's that the current arrangement that we have under the legislation is that we are not able to keep the child more than 30 days. You see, this kind of movement from one ministry to another changed a lot of regulations for us. When we were under the Ministry of Health, we were a schedule 1 facility, so if the children needed to go and stay a little bit longer, we could keep them. The law, under the Ministry of Children and Youth Services, is 30 days, come hell or high water. You have to discharge them, sometimes to a place where they wouldn't be able to function. This is an issue that we have in terms of time.

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The other issue is in terms of age. Someone was talented enough, in the legislation, to develop some kind of an age range for the children. For one reason or another, in between the all-conflicting rules and regulations, we aren't able to treat kids, in many circumstances, over the age of 16.

We are integrated within a vast empire of children's mental health centres and we are able to admit the kids at any kind of age, but if we or another agency or another hospital would like to use some of our services when the child is 16 and one day, we aren't able to do this kind of thing.

I'm sure, in your deliberations—by the way, we are speaking with the two ministries at this particular stage, with the Ministry of Health and the Ministry of Children and Youth Services. I see some kind of interest with this. But if in your deliberations you find that our case merits something, I'd like to think that you will at least pay attention and put your mind to this, because this will be of such great help, and Paul will speak about it.

I'd like to rest now, because it's very hot. I'd like to ask Dr. Nathan Scharf, who is the chief psychiatrist with us, to speak a little bit about the kids. It's much more interesting than institutions.

Dr. Nathan Scharf: Thank you, Dan. I would also very much like to thank the committee for having us here today. For me, it's an unusual opportunity to be able to speak directly with the committee and with people who directly may influence or impact the ability to shape health service delivery to kids. It is something that per-

sonally interests me in some of the career choices that I've made along the way, so I'm very pleased to have the opportunity and I want to applaud the committee for the work that they're doing.

Dan said he would speak about the organization and Paul could speak about some of the other things. He said to let me speak about the kids, and I was trying to think about what I should say. Knowing that time is precious and, if anything, it's better to let you ask questions, I decided I would talk about myself as a kid, which is not anything that they're expecting.

As I was thinking about it, I thought that really what my issue is and what my concerns are, in providing service to the young people I work with—the experiences of how I found myself in the position where I am right now sort of reflect, I guess, what my personal agenda and interests are.

I went to medical school in the early 1980s. I was very young; I was very naive. I came to believe—so I was told—that the key to being a doctor was to do internal medicine, because that was the golden flower of understanding what was wrong with people.

I did do internal medicine. I did a couple of years of internal medicine residency in Montreal. By the end of the first year, I was very disillusioned, because what I found—and this was the 1980s; I think things are a little bit better now—was that there was a real emphasis on diagnosis and treatment interventions. What there was not—at least in internal medicine; at least in Montreal at that time—was any integration of services and service provision, and there was really no opportunity to talk to people as people. I became very disheartened by that. I left the program.

I did a little bit of front-line street medicine work, ambulance work, having already decided I was going to go into psychiatry. My interest in psychiatry came via some passing interest in community and social medicine, because I felt that this business with internal medicine had to be broken down. It wasn't human and it wasn't humane. It was, I guess, a sort of rebellious period for me.

What happened, though, was that I found that when approaching medicine just from community and social medicine and public health, you didn't speak with people—at least, you didn't work with people directly—and I love people's stories. Psychiatry, for me, was something that would give a balance between providing active, intensive service and working with people.

The funny thing is that, of course, I wound up in child psychiatry, because this is where I came to work with systems. In adult psychiatry, you deal with adults. Absolutely, in the context of chronic care, it's necessary to work with community and social service agencies. But it was most intensively and most clearly in dealing with kids that service integration and continuity of care were most relevant, because of course the kids were the patients but they weren't usually the clients. The clients were somebody else: It was the parents; it was the schools; sometimes it was forensic and police work.

What drew me to child psychiatry was not a love for children per se, but a real interest in working with and developing systems in service provision and systems in mental health.

I have felt very privileged over the years. When I finished my training, I was very influenced by Paul Steinhauer, who was the head of academic child psychiatry at the time and very interested in families and advocating for families. I was really moved by this. Psychiatry shouldn't be about drugs and pills. It should be about families and providing service to kids in need and at risk in the community.

I felt very fortunate to fall into working at Youthdale, where I have worked ever since—it has been about 20 years plus, now—because what I found in the agency was not only a lot of forward thinking and a lot of interest in systems and system developments but, certainly within the agency, an interest in approaching kids holistically and providing a spectrum of services that go far above and beyond merely addressing psychiatric diagnosis, medication management and treatment.

Dan spoke a little bit about neuropsychiatry services—maybe he mentioned it, maybe he didn't; I don't recall now—sleep clinic and neuropsychological services. We've developed a very rich stew of specialty assessment resources within Youthdale. But that's not really what the agency is about, or at least if it is, that's not why I'm there. I'm there because I'm really more interested in—and over the years have been—providing consultation to the outpatient residential treatment programs, to the community at large. I have, throughout that duration, worked on the crisis unit, which is the intense in-patient unit.

People should be aware: It's a quarternary referral centre. About 40% of our admissions come from other hospitals. Sometimes those are general hospital settings; sometimes those are child psychiatric hospital settings. We don't discharge to other hospitals more often, typically, than about once a year. We've tried to provide a more definitive take and to work more intensively with the community resources to be able to develop discharge pathways and treatment plans so that the kids can be reintegrated into the community and ideally, where possible, go back home to their families. To be able to do that, to take probably about 40 or 50 kids from hospitals—never mind the other 70 or 80 who come from the community or from homes—and to take 98% of them and return them to the community without a need to send them back to another hospital, I think, is really quite remarkable. But we don't do it on our own. We do that because we are partnered and integrated in community service systems. Over the years, we have developed models to effectively engage with and relate to them through partnerships. That's one thing.

Another part of it is, of course, that we do have this comprehensive range of services that Paul will speak about. We have the opportunity, as a crisis unit, to keep kids for 30 days. It's not always long enough, but it's long enough to do a lot more than most of the in-patient psychiatric service hospitals for kids will do.

Where we need to, we can step down on to our transitional unit, which is still secure in terms of the intensity of supervision and support that's available, but it does allow freer access to the community. It does allow kids an opportunity to integrate directly from the unit into school programs in the community. So it provides that continuity of care. The rest of it, of course, falls out through residential programs, special school programs, after-care, family therapy and so forth.

There are limits to the model. I've had the ability in the last few years at Youthdale to be a consultant to the intensive support and supervision program, which is in essence an alternative treatment program or resource program for kids who are young offenders—essentially an alternative measure to provide for kids who have very clear mental health needs. Rather than time in detention, jail or custody, we get them back with their families; get them integrated into the community and provide community-based intensive support. We give them support workers who will see them at home, take them to vocational programs, take them to school and help them get social insurance numbers.

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The idea of providing ongoing care to these young people is critical to their success. At Youthdale, because we provide our focus in terms of in-patient services to kids before their 16th birthday and because those kids will all have legal guardians who are looking out for them, it's relatively easy, given the structures that are in place right now, to provide comprehensive service treatment plans.

Lack of resources is a separate issue. I can't get into it over here. It's easy to come up with plans that would be effective—finding resources is an issue—but the problem is doubly multiplied in kids who are above and into that transitional age: 16, 17, 18 years old. The ISSP program provides community-based support with psychiatric consultation, social work support and psychological services where they need it.

What we can't do at Youthdale is take kids who are over 16 and know where to send them in the community to provide any kind of comprehensive, integrated, holistic kind of treatment. To my knowledge, however good the services may be in Toronto, they're not adequate to the task because those transitional-aged youth, 16, 17, 18—18 is a little bit better already. When they turn 18 or 19, it gets a little bit better.

There are community programs in place—ACT teams; COTA, community occupational therapy—that can provide community-based support for kids and families, young adults in high need. But in that kind of twilight zone between 16 and 18, I am generally at a loss knowing where to send a child who I'm working with, either in our residential programs or because I follow many of the kids after their discharge from the services at Youthdale—where to send them and who they should turn to to provide comprehensive and holistic care until they're 19 or 20 years old, because the services are really very hard to come by.

So, if I want to speak about the kids and speak about advocacy, what I'd say is that I think that there's been a lot of foresight and thought put into the integration of services, at least at Youthdale, for kids up to that age range, but we are shortchanging the needs of kids who are kind of beyond the cusp. That's an area that I would hope this committee would really look to putting additional resources in for service development.

The kids and the adults are better served than those transitional-aged youth and a comprehensive treatment model that can provide continuity of care for that group, I think, is really sorely needed.

I'll be quiet now.

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

Mr. Paul Allen: Okay. I, too, am mindful of the time, so I will try to be brief. My name is Paul Allen, and I'm the clinical director of Youthdale.

Dan and Nathan have touched upon elements in a graph that has been distributed. It's titled Youthdale Treatment Centres: Sample of Continuity of Care. I thought I could just very briefly take you through a fairly typical intervention for Youthdale.

I would first note that Youthdale's psychiatric crisis service is a resource that's used by mental health and child protective agencies across the province, so those 7,000 calls a year that we receive are probably 50% in the GTA and 50% from well outside. With that sort of ongoing contact with various communities in the province, we begin to develop a sense of what the needs of kids and families in particular communities are, what resources are funded and are easily accessed by children and families and where Youthdale, as a provincial resource, needs to step in and take care of the highest-risk situations where the gap between the need of the child and the parent is most great, compared to, say, what the local hospitals, local children's aid, local children's mental health centres are able to provide.

Youthdale is not generally a well-known program. It's not, say, like the kids' helpline where children themselves or their friends would know to call Youthdale. We tend to be a service that's accessed by families upon the final decision of, say, the family doctor, the children's mental health worker assigned to the family, or often a counsellor or a vice-principal in the school setting who has been concerned about this student for many months, in most cases.

Youthdale is generally not the first place that the child and family turn to for assistance. It may be the third, fourth or fifth stop along what turns out to be a fairly long journey for many of these kids and families as they struggle, usually with multi-generational mental health issues, substance abuse, poverty and other social disadvantages that many of these kids and families bring when they come to Youthdale for help.

For the highest-need kids, the entry point is the psychiatric crisis service. This is staffed by the paramedics that Dan referred to. It's a telephone line that we operate and staff 24/7. It provides a pretty immediate assessment on the telephone to a parent or a professional

who's calling with a concern around a child's suicide risk or a risk that they might present to another family member or a student at school. That team has 24/7 access to a psychiatrist. After they have gathered information and have an idea themselves of how to triage this case, they can always access an opinion from a child psychiatrist to be sure that they have the right level of concern and that the safety plan that they're now going to share with the people looking after that kid will take care of the immediate risk.

Within Toronto, we have a mobile crisis response. Again, this is a service that, as Dan said, operates 24/7. For families, say, who would have difficulty getting their child back to the hospital, maybe where they have been a couple of times—they've had to wait; they were assessed briefly and discharged; the kid and the family are kind of tired of that route—this team will go out to the family home and meet with all members of the family. They're often much more forthcoming in a setting like that in terms of how troubled they are, and their interest in finally getting help may be able to be clarified with the kid and the family, because there's often a big disagreement that has been going on between the kid and the parents about whether they need help at all, what kind of help and what's going to be the bottom line in the household.

After that mobile crisis assessment, we always have a consultation with the psychiatrist. At that point, what we have is usually a pretty good record from four or five professionals who are involved with that kid and the family. We've laid our eyes on the kid and the family ourselves, and we're consulting with the psychiatrist. Out of that, we have a very good clinical sense of the child.

For those who need to be admitted to Youthdale, we have access to the 10-bed secure treatment unit, which is very much like a psychiatric schedule 1 facility. It will take kids involuntarily. Many times, these are kids transported by ambulance from hospitals, or police may end up transporting the child. Large members of the family will gather together to get the kid out of bed, to get them to Youthdale. The kid will often be protesting, sometimes quite loudly and explicitly; other times, they're just very withdrawn and avoidant of getting any treatment. They'll start on that base at Youthdale, at least.

A psychiatrist is part of the interview with the child and the family. We give them some sense overall of what our understanding of their crisis is and how we're going to go about, from the very beginning, not just fixing the kid, who may be identified as the problem, but trying to respond with the family, trying to respond by intervening with their community so that if they're going to go back home, there will be additional supports from mental health providers in their community so that they don't need to go back into a crisis.

At the end of the 30 days—and I'm now sort of looking at step 4—we can transfer the child from our secure unit, where we're limited by the 30-day stay, to another psychiatric unit, where we can take a little bit more time with the child to make plans and to move the child back on to a longer-term resource.

One of the very frequently used options for the most high-risk kids—these are kids who have depression, who are abusing substances, who have maybe been placed in foster care or residential programs in the Toronto area but have run away from those programs and gone back to high-risk behaviour on the street. With those kids, one of the options that we have at Youthdale that's quite unique is a treatment camp, which is about an hour northeast of Parry Sound. We have three cabins with a total of 24 beds there. For the kids coming out of the hospital settings, where they're agreeable to treatment but we're really concerned about their ability to keep themselves safe if they were placed back in a city-based program, we can start them out in the wilderness, where we sort of have environmental security; where we take away a lot of the temptations; where the school that they'll attend is on-site; where there's a lot of outdoor project education and a working farm program to get them back to basics. Many kids might spend a month in the secure unit, another month in the voluntary psychiatric unit, and then maybe nearly a year in the wilderness program to settle down, get back in school and have the relationships with their family established so that they're not in conflict all the time.

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At that point, we can transfer the child seamlessly to one of our homes in Toronto, where they will be nearer to their families; where we can begin to integrate them into the regular school system; and ultimately where we're going to be able to graduate them back to their family's home, perhaps with after-care support that either our psychiatrists would provide or which we would provide through our family therapy department or perhaps through one of our special school programs that would not need to have the kid in hospital or living outside the home, but will have enough mental health support so that the kid can hold on to the gains they've made and the family can feel secure and able to parent this kid in the next stages.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We're actually at the time when we had planned to go into the report-writing stage. If we do ask questions, I'm sure everyone will have questions. So it's entirely up to the committee.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Sure. Let's start with Liz, then Christine.

Mrs. Liz Sandals: The referral mechanism, I think I hear you saying, would be from various sorts of other professionals all around the province.

Mr. Paul Allen: That's right.

Mrs. Liz Sandals: Obviously, there must be, if not triage—the answer a lot of the time must be, "We're already full," especially if it's a crisis situation and crisis beds are already full. What would you then say to the person who says, "We're full"—and I'm not trying to be

argumentative. I'm thinking this is wonderful. But you can't possibly be handling everybody who has the need for this track of service. What are you saying to all the people who call in a panic when you're already full?

Mr. Dan Hagler: Nathan was speaking about integrating with other services in the community. Sometimes we are full. First, because of our relationships with other services, someone will pick up the phone and say, "Listen, I would like you to accommodate this child for three or four days," and they do this comfortably.

Often, when the child is being admitted to us and the child doesn't have parents who are able to co-operate, we try to hook up with another social agency that will provide the services with us.

I can say to you with assurance that we deal with any kind of crisis. Under the circumstances, we are not always able to provide the ideal situation, but we carry the child so there will not be any kind of disaster while the child is waiting for service. This is why Nathan was speaking a lot in terms of integrating our services with the total community.

Mrs. Liz Sandals: Are there other services in the province which are similar to this in structure? You mentioned that you're getting calls from all over the province, which actually doesn't surprise me. Are there other similar services elsewhere in the province?

Mr. Dan Hagler: Not quite as comprehensive as we are. I was part of the committee in 1981. The ambition of the legislators at that time was to provide four or five centres like this. They established Youthdale as the first experiment. After that—I don't have to tell you what happened—in 1982—

Mrs. Liz Sandals: So you're still a pilot?

Mr. Dan Hagler: Yes, we are still a pilot. As a matter of fact, every day I figure it's another experiment.

Mrs. Liz Sandals: The other thing that's confusing me slightly is because at the beginning of the program you're very much like a hospital, but we'll leave that aside.

You said that you're funded by MCYS, and I'm wondering how you get funded by MCYS. What does MCYS think it is funding?

Mr. Dan Hagler: For the social worker and the child care worker, we are funded by the Ministry of Children and Youth Services. For the psychiatric and some of the medical, we are being covered by OHIP or the Ministry of Health. So it's two ministries—

Mrs. Liz Sandals: So some of it you would get by billing OHIP. For the people who are actually medical practitioners, you would bill OHIP.

Mr. Dan Hagler: Yes.

Mrs. Liz Sandals: But you're not getting a hospital bed per diem, because you're not really a hospital.

Mr. Dan Hagler: We get grants, however, for some of the non-medical services that the medical staff are doing, from the Ministry of Health.

Mrs. Liz Sandals: Okay. This sounds like a complicated dog's breakfast of funding, so I won't go any further.

It's a fascinating structure, though, you have in being able to move children through. You said up to 16 years?

Mr. Dan Hagler: Correct.

Mr. Paul Allen: As far as the hospital units are concerned, yes, up to 16. The longer-term programs are admitting kids up to the age of 18.

Mrs. Liz Sandals: Oh, okay. And you might have somebody start off with you when they're 15 in the hospital program, but they could still continue in the program even past age 16, and by then they're in one of the more residential parts of the program.

Mr. Paul Allen: That's correct.

Mrs. Liz Sandals: Thank you very much. Fascinating.

Mr. Paul Allen: You're welcome.

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

Ms. Sylvia Jones: Just a brief question, and I apologize because I did come in after you'd begun. You mentioned that 40% of your patients are coming from other hospitals.

Dr. Nathan Scharf: Yes, I think so.

Ms. Sylvia Jones: Are you doing any diversion from the justice side, young offenders before they actually get charged, any of that kind of—

Dr. Nathan Scharf: The only program that is named specifically as forensic within the agency is the ISSP. That's the intensive support and supervision program. Youthdale was named one of a number of programs within the province that were initiated to provide multidisciplinary support—MST, we say for short; it's a model from the United States—or wraparound services to provide comprehensive support for youth who had already been convicted of offences within criminal justice. One can say that anything that will provide for greater family cohesion, success and so on and so forth will be useful as primary care prevention or tertiary care prevention.

But, no, we don't have any sort of pre-conviction services. There are limited, within the province and within Toronto, programs that are asked to do forensic assessments for court purposes for young offenders. The old Family Court clinic in Toronto would do young offender assessments as part of predisposition hearings, but we're not doing that.

Mr. Paul Allen: I would certainly say, in my experience, that police are often involved with these kids, whether it's addressing their offences or just giving families a hand trying to control their kids and protect members of the family. They're very reluctant to charge these kids with offences. They assist the family. Many times, the police are involved in recommending a place like Youthdale. They assist families very regularly in getting the kids to Youthdale in a humane way, I would say. You see a lot of effort in the community on the part of police and probation to provide mental health interventions for these kids as opposed to criminalizing their behaviours.

Ms. Sylvia Jones: Thank you.

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

Mrs. Christine Elliott: Thank you very much for your presentation. Even though I've had the pleasure of visiting Youthdale, I learned a lot again. I certainly would encourage members of the committee to visit, if they're able to do so.

Just a couple of questions; one is: Is there any other agency that offers the level of intensive service that Youthdale offers, or are you the service of last resort for the entire province?

Mr. Dan Hagler: No; as far as I know, there isn't. Part of the reason, I suspect, is that the American Psychiatric Association gave us their gold award for the best integrated psychiatric service, because I don't know any services—and I travel in the United States often—that have this kind of a thing.

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The province, at that particular time in 1981, was very ambitious and allowed us to develop an absolutely superb service. When they found that they aren't able to go and to develop other places, they declared us a provincial facility. So, this is why we serve the total province.

Mrs. Christine Elliott: Another quick question that I had is: You indicated that you can only have children stay in a secure facility for 30 days. What would be the optimum time if you could choose it? Do you think 30 days may not be enough, or would you rather just have more of a discretionary option as to how long?

Dr. Nathan Scharf: It's a problem to not have that discretion. Having said that, it certainly is not optimal to have kids admitted for 30 days. Our average duration of admission probably runs about three and a half weeks, and by virtue of having four weeks and a couple of days—I say frequently to the people whom I'm supervising or teaching that it's always a failure when a child is admitted for 30 days, because then they recognize that they're being discharged because of legal requirements rather than because of progress or gains made. So you work very, very hard to try to create resourcing within the community to get the child out well before the last moment. A child being there 30 days, given the context, is something of a treatment failure, or it could be construed as such.

Absolutely, there are some kids who will require more than 30 days for stabilization and for treatment. Typically, those will be the kids who have a clear axis I major psychiatric diagnosis. Primarily, work with adolescents is psychosocial intervention: a lot of conduct disorders, a lot of substances, a lot of depression, a lot of trauma. Now we're seeing more and more neuropsychiatric kids, but even leaving those aside, because those will often present younger, when you're dealing with transitional youth, the kids who are older—15, 16 and especially 17 and 18—you are seeing the first onset, for most individuals, of major psychiatric illness: schizophrenia, bipolar disorders. Unfortunately, the major initial gist of intervention is going to be psychiatric and medication management. The psychosocial supports and networks and working with family are extremely important—just as important in terms of long-term care. But that's down the road, and more community-based.

To treat a new-onset psychotic individual will usually take more than 30 days. When I mentioned that 49 out of 50 kids—or actually, it's probably closer to 79 out of 80 kids—we'll be able to discharge back to the communities: The once a year when we're phoning around to other hospitals to transfer is almost invariably in a child who is psychotic; you need more time for that.

Mrs. Christine Elliott: If I could, just one more question: Dealing with a reluctant patient, what do you do in situations where you, say, have a 15-year-old that really doesn't want to be there? I think at my previous visit we've touched briefly on that, about an equivalent to the Consent and Capacity Board. Could you just speak about how you deal with that and what happens in those instances?

Dr. Nathan Scharf: Certainly the first, primary goal of the psychiatrist and the treatment team when these kids come to the unit is trying to find something—and it can be almost arbitrary; it doesn't necessarily have to be what the parents or guardian is most concerned about—that you can hook the child into to form a meaningful therapeutic alliance with him, because you can't provide any meaningful work if you're fighting with a child for 30 days. One of the skills that people develop—if they're going to be satisfied doing this work; if you can't do it and you're not happy with it, you won't be in the field very long—is finding something—and I would say that you have a window that generally runs about 48 to 72 hours—that can be meaningful for this child, essentially forced into a psychiatric setting against their will, that they feel they can meaningfully get out of being there. Sometimes it's just, "You need to work out something with your parents so they don't keep on feeling that you need to come to places like this." But even that is something to start. If you can establish that, you can get contact with the child and parents around treatment goals. That, we are able to do probably 90% of the time.

The other 10% of the time, we have kids who will—because they all meet with advocates within 24 hours of coming to the unit, and the advocates will explain to them their rights, as we ourselves do at the time of admission, that if they absolutely feel that they don't need to be here and that admission is unjustified, they can request a legal review. There is a process of legal review board hearings which are similar but not the same as hearings under the Mental Health Act. Those hearings will take place within five days of a request. So if a child absolutely is adamant that they don't want to be at the setting, it may take them somewhere between five and seven days to be able to activate the mechanisms to try to force the issue of an unplanned discharge.

Mr. Dan Hagler: Sometimes kids leave, in spite of our best accommodations. There is some kind of legal process that they don't like to be labelled. It's so complicated that sometimes children, against their parents and against their guardians, are being sent back to the street because this is what the child wants. But most

of the kids, on the other hand, just to go and to suggest: First, we have a unit that the child can come to, a unit that is not secure. It's only when there is imminent danger for the child and for others that we'll go with admitting them against his or her will. Many of the kids ask to move to another intensive psychiatric unit in the same building, and they do it only if they volunteer to have it done.

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

Mr. Paul Allen: Maybe just a final comment?

The Chair (Mr. Kevin Daniel Flynn): Go ahead.

Mr. Paul Allen: In terms of the length of stay and, "Is 30 days sufficient in most instances?", besides the clinical work of stabilizing the dangerous behaviour of the child and bringing specialists together at the same time and in the same place to really figure out what's underneath all of these behaviours and emotions that are turning everything upside down, part of the calculation we have to make at Youthdale that's putting our average length of stay out to 30 days—and in many cases, we would prefer to have the flexibility to go longer—is not the clinical issue with the kid, per se; it's trying to match a resource in that kid's community, to advocate to the local children's mental health and the medical professionals in those communities to have a buy-in to the discharge plan that we're building now that we have the child stable and we've understood a number of the underlying reasons for their distressing problems. They'll still need ongoing help, and if it's not going to be through a program at Youthdale, many communities need time to get themselves organized, to align, to move these kids and families, if not to the top of the list, at least in a reasonable way, try to accelerate their involvement with this kid. They have to recognize that this kid and family is one of their highest needs or they wouldn't be at Youthdale. Rather than having a relapse, they need to do something differently from, say, 30 days before.

That length of stay is not just the clinical work with the kid and family; we also take the time, which many other programs won't—certainly in hospitals—to align local mental health providers to a plan to keep the kid well so that they can preserve the gains that they've made while in the hospital setting.

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

Mrs. Maria Van Bommel: Just a couple of questions: First, someone mentioned, in response to Sylvia's question, about forensic. Are any of the beds at Youthdale funded through the justice ministry at all if you're dealing in forensic?

Mr. Dan Hagler: The answer is no, and even if they were funded under the legislation, we are not able to go and deal with those children because we have a limit of 16 years old.

The Chair (Mr. Kevin Daniel Flynn): I think you need to speak closer to the mike so that Hansard can hear you.

Mr. Dan Hagler: The legislation binds us to go to work up to the age of 16. Those people that you're speaking about: Usually most of them are older.

Mrs. Maria Van Bommel: Your system uses residential treatment and right now I'm sure you may, if you've been following the news at all, know that in Sarnia–Lambton there is a girl's community home which is operated by the St. Clair children's mental health agency. The home has, at best, seen about a two-thirds occupancy rate, so the agencies board has decided to close it because of the underutilization of it. They're telling the families and the community that foster homes is the trend now in this.

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I'd like to know what you think about the foster home approach to children's mental health in terms of providing what we talk about as "normal" and having kids who are going to community schools and participating in the community be seen to be going to a normal home, or the whole issue of runaways. You mentioned runaways and what happens there. Is this the trend? Are we seeing a trend in this direction?

Mr. Dan Hagler: No. This is the most loaded question I was ever asked in any place. What happens over the years is we try to develop services, because of a lack of money, that require less and less money. Sometimes they don't make any kind of sense. It's like a child who's coming to us because we look as if we know all the answers, but the child and the issues are much more complex.

I don't know too much about the service that you are speaking about, but the reason that they are not full may be more to—yes, and I don't think it's just simply that the service is not needed. There is a pressure at this particular stage on children's aid societies and other institutions to cut their budgets to find a cheaper, less expensive way to deal with children, but having been 40 years in the field, I think it will backfire. I've seen it several times. I know that services are being closed not because they are not good and there is a new fashion to do it; it's because there are not enough funds to do it.

Dr. Nathan Scharf: If I could just comment. I think anybody who works with kids would have strong feelings about this kind of issue. To me, it never has been, nor should it be, an either/or. There are some kids—and I'll say most kids, probably, who, for whatever reasons, come into the care of the children's aid society or other agencies who can and should be placed in parent-model foster homes. The kinds of kids whom we are treating and who need these residential programs are kids who generally have been in one or more foster homes first and failed in those settings because the foster homes, while people will legitimately see them as being a more normal kind of family model than treatment settings, cannot provide the degree of structure, supervision and support that the foster homes can.

Nobody would be advocating against foster homes. Sadly, foster homes fail in providing adequate resourcing for many of the kids we wind up dealing with.

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Maria. I have a few really short questions. You said 30

days are granted to a child as a stay? That's the most that they will fund under MCYS?

Dr. Nathan Scharf: It's not funding. Legally, the Child and Family Services Act, under which we admit children to our unit, will only allow a single 30-day admission. It's a legislative piece, not a policy or funding piece.

The Chair (Mr. Kevin Daniel Flynn): So it's a single 30-day admission in their lifetime?

Dr. Nathan Scharf: No, no, no. You can readmit.

The Chair (Mr. Kevin Daniel Flynn): After what period of time?

Dr. Nathan Scharf: Twenty-four hours, 12 hours, 10 minutes.

The Chair (Mr. Kevin Daniel Flynn): Okay.

Dr. Nathan Scharf: I think, historically, over the last number of years, we've had about a 12% readmission rate. I think it was higher earlier on. Now we do have more resources. For kids whom we really don't feel are ready to go and who do need longer time in terms of the psychosocial rehabilitation piece—we're not talking about diagnosis or medicines. But for that piece, this is where the transitional unit, which opened up 12 years ago, has been extremely helpful. Nevertheless, some of the kids will get readmitted. I think in my career, the largest number of readmissions we've had to the service was five readmissions for a total of six admissions for one particular child. That's in the 20 years I've been there.

The threshold to readmit obviously gets higher and higher. We have less new to say or offer the second, third or fourth time around. We'll sometimes admit a child at 10 years old and can see them four or five years later for completely different reasons.

The Chair (Mr. Kevin Daniel Flynn): As we travelled around the province, one of the groups that talked to us a lot was the fetal alcohol syndrome people, saying there's a lot of misdiagnosis going on, in their opinion, and that things we're diagnosing as ADHD and other conditions are actually fetal alcohol syndrome. Would you agree with that statement? Are you seeing evidence of that?

Dr. Nathan Scharf: I would see evidence of that. I'd probably have to say I'm guilty of that myself. Certainly, in the last two, three, or four years, I am seeing a lot more cases, maybe because I was naive to it earlier on. We were all aware of it, but part of the issue is diagnostic. We'll see a lot of kids who have neurodevelopmental markers of intrauterine alcohol and drug exposure, but to make a diagnosis of fetal alcohol syndrome, you need certain specific physiological markers. It's an issue of morphology in addition to having a very clear history of intrauterine exposure. Very often, we have kids who look like it and feel like it, but we don't have the history, or we have a clear history, but you can't make the diagnosis by virtue of having lack of physical features. So you're left with, I'll say, a lesser category of alcohol-related neurodevelopmental disorder, which is really more speculative. But absolutely, we're seeing a lot more of it now—or I am, at least—than four or five years ago.

The Chair (Mr. Kevin Daniel Flynn): Okay, that's one. Are you seeing an increased incidence? You've been around in the business, you've said now, since 1981. Is it increased incidence or increased diagnosis?

Mr. Dan Hagler: It's very hard to say. They're in combination, but I'll try to say it straight.

First, the flavour of the last few years is to go and be involved with fetal alcohol syndrome. We are serving in a role with some work with Sick Kids hospital. On one hand, you have an awareness. So you know if the child is not this, not this and not this, and there is nothing else, maybe it's this kind of a thing. Then you look for some kind of information. Surely, with many of our children, we'll find that the parents were involved with drugs. The second thing is, over the years, the drug culture has become a much more prevailing thing.

The other aspect is, with the advance of technology in the medical field, we create children who have problems today that they never had before. The idea just a few years ago was that to have a child, you had to come to term or close to term. Today, after 20 or 22 weeks, you can deliver a child. You keep it in incubation, and this child will look cured until the time the child is two, three, four or five. There will be no cure, because there is something in the brain that wasn't developed.

So there's a variety of ingredients in this kind of a thing: first, the knowledge that we have; second, the technology, on the other hand, that the doctors develop.

Dr. Nathan Scharf: I'd like another 30 seconds, just because I think it's worth saying. There's an old expression, "If all you have is a hammer, everything starts to look like a nail." A lot of what happens in psychiatry is a function of political and advocacy waves and movements. Now, I think that there is a great need for additional servicing for kids with FAS, so I'll exclude that.

But I think that a lot of what has happened in psychiatry is that certain conditions have had explosive increases in numbers of diagnoses recently, because new treatments have become available that people are willing to give to treat conditions. If doctors are reluctant to make diagnoses for conditions that they can't treat, and as more treatment options become available, sometimes you find that the criteria around various disorders shift suddenly or dramatically. That has been most clearly the case in the last 10 or 15 years around bipolar disorders in children, but there are certainly other conditions where one might wonder about how diagnosis is following treatment resources rather than the other way around.

Mr. Paul Allen: One thing I would say on that issue, whether it's FASD or another factor, is the more Youthdale spends time working with the kids who are falling through the cracks of the systems that we have built—and Ontario, compared to many jurisdictions, is a very wealthy and well-resourced service system. Whether it's provided in health care settings or in community settings, it's very rich.

The kids who come to Youthdale are the ones those systems aren't figuring out and helping. More and more,

what we're discovering is it's not a matter of providing counselling, encouragement or psychosocial help for those kids. Even psychopharmacology doesn't give you the sort of benefit with these kids that you would want. We find they're on multiple medications, sometimes prescribed by different doctors over a long period of time. But what we're figuring out more and more—again, whether it's FASD, a genetic factor or an acquired injury—is there's something about the function and the structure of the brains of these kids that makes it very difficult for them to learn from experience; it makes it very difficult for them to learn from treatment, which is partly an educational experience for these kids. They don't understand a lot of spoken or written instruction. Their ability to remember things is difficult. Their ability to hold on to things that they might understand in one situation—when they're under stress, that understanding goes out the window.

What I would say is that the people who are raising FASD as an issue should get credit for raising the understanding that there are a lot of difficulties that these kids have in understanding how we're going about trying to help them. Their lack of response to those efforts doesn't mean that they don't care, that they don't appreciate or that they're not trying their best; it's that we have to bring together a different team around those kids, in a way, to understand all the challenges that they're facing—some of them are cognitive and neurological—and the strengths that these kids have.

Let their families understand—this is not a matter of bad parenting or neglect or parent-child conflict. There are factors here that are beyond the social and familial cycles. There are millions of dollars invested in services for these kids. You have to take a different account of that.

It's hard to replicate an institution like Youthdale, but part of what you see here is the evolution over time, where we've taken good community-based mental health services built in an institutional setting, when kids are really dangerous and out of control and either don't understand or won't accept that they need help, and where you can have the critical mass of specialists working together in one place to give answers in a quick way and then give people back in their communities enough time to build the discharge plan, to have the resources, and the backup of Youthdale in carrying out the continued work with those kids.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you. Are there any more questions? If not, thank you very much for the time you've given us today. Thank you very much for forgiving us for cancelling our visit to your facility. I think each of us, in our own way, if we're able to, will try to make it down, if you'll allow us to do that.

Mr. Paul Allen: It would be our pleasure.

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

We're going to recess and go into closed session for the report writing, and we're going to get France on the phone as well, so she can participate in that portion.

The committee continued in closed session at 1702.

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