NOTE: Of the seven presentations received on May 22, two have not been included in this transcript at the request of the presenters.

May 22, 2015

Honourable Steve Kent:

Good afternoon, ladies and gentlemen, and welcome. Thank you so much for coming. I have a few opening remarks and then we're going to get right into presentations. My name is Steve Kent. I am the Minister of Health and Community Services and Chair of the All-Party Committee. I would like to begin by introducing the members of the Committee and I will actually ask them to introduce themselves, so.

Gerry Rogers:

Hi, I'm Gerry Rogers and I'm the MHA for St. John's Centre, and you are sitting smack dab in the middle of St. John's Centre. So welcome.

Andrew Parsons:

Hi, my name is Andrew Parsons. I'm from Port aux Basques and I'm the MHA for Burgeo - La Poile and pleased to be with you this afternoon.

Kevin Parsons:

I'm Kevin Parsons and I'm from the beautiful District of Cape St. Francis.

Felix Collins:

My name is Felix Collins, District of Placentia and

St. Mary's.

Honourable Steve Kent:

Thank you. And there are other members of the Committee as well. We have a number that alternate because we all can't be everywhere at the same time, but we have good representation today from all three political parties and it's been a wonderful of process of learning and discussion and dialogue so far. We were on the west coast a week or two ago. Feels like it was a long time ago but it wasn't that long ago. And we had a great public dialogue session last night here in St. John's. We met with some officials working within Eastern Health this morning: staff, doctors, psychiatrists, nurses, social workers.

And today is another, this afternoon is another important component of this process. We're inviting people to make presentations to the Committee. So this afternoon we're going to receive a series of five, six, seven public presentations. So, people have between 15 to 30 minutes to make a presentation to the Committee and hopefully we'll have a chance to ask some questions and have a bit of a conversation

with the presenters as well.

I want to let you know that we're all extremely committed to this process. We've got, as I said, representation from all three parties working together because we all believe that we can make the Mental Health and Addictions system in our province better. That's our goal. And at the end of this process, however long it takes, we're going to make recommendations to the House of Assembly on how to make improvements to the programs and services here in Newfoundland and Labrador. So that's what we're up to. It is a process that will certainly take several months.

We're going to do another full day of sessions like this in eastern region next month. There'll be more opportunities for public presentations, there'll be another dialogue session like we had last night, and if anybody wants to contribute in other ways you're all welcome to do so. This is not your only opportunity. You can write us, you can meet with us, you can call us, you can e-mail us, you can tweet at us. There are many, many ways for you to be part of

the conversation and I hope that you will all feel comfortable in doing so in whatever way you choose.

So without further ado, I want to get the presentations and again thank you for being with us to hear the presentations this afternoon. There are a couple of presenters who have asked not to be recorded. I don't see any media in the room at the moment anyway but our staff, and we have staff here from Health and Community Services and the Office of Public Engagement. They'll be monitoring that to ensure that anybody who doesn't want to be recorded, won't be recorded, so.

Our first presenter this afternoon is Colleen Hanrahan who has already joined us at the table. Welcome, Colleen. Colleen is the Managing Director of the Institute for the Advancement of Public Policy and she has asked to make a presentation to us. So, Colleen, thank you and we'll turn the floor over to you.

Colleen Hanrahan:

Oh great, thank you. Now I'm waiting for my slides to come up. Okay, great. Well, thank you very much

for allowing me to have this time -- now can you hear me? Okay. My interest in talking with the Committee is to make you aware of a group of people who are not covered under our mental health care system, although they have mental illnesses and this relates to the prisons. And I'm going to provide you with some background information and hopefully give you some food for thought as you progress through this process.

Just so you know, my background is social work and law, and I've just completed a doctoral dissertation on mental health services in prisons, so I know a little bit about the topic and hopefully I'll give you some information that you can think about.

Next slide please. I ask the members to think about, do you know why prisons have been called our new asylums? And that is not my term, it's a been term that has been used by Howard Sapers, the correctional investigator for Canada, and for many other people have referenced prisons in the world actually as our new asylums.

Next slide, please. Also, did you know mental health services delivered in prisons are not equivalent to those delivered in the community? And I want to talk a little bit about that as well.

Next slide, please. So the purpose of this presentation is to inform the Committee about these issues, and I want to help you understand why I'm saying prison mental health services are not equivalent to the services delivered in the community, why services should be equivalent and how equivalence can be achieved.

Next slide, please. Now, the term "equivalence," actually and I hate to digress, I know this is a Friday afternoon and the last thing you want to hear about is the law, but, unfortunately, I have to talk a little bit about the law. Equivalence is a term that's used in human rights standard, international human rights standards, and it relates to the treatment of prisoners. They should have equivalent health services as they would have in the community.

Now as it turns out, this standard is very

challenging to apply because reality as a lot of research has shown prisoners do not have the same level of health status as people in the regular community. So it is much lower and health problems can be more severe.

And secondly, unlike someone in the community, you can't just walk into, if you're a prisoner, you just can't walk into and say I need health services and I need to go see a specialist to get a hospital. There is a whole process. You're in a prison. You have to get access. The correctional staff have to help you get there. You need to be supported by the vans and get the resources mobilized to get you there. And not every person, even though they may be in need of health care in a hospital, will actually get there. If I have a chest pain it is one thing. If I have, I'm claiming I have mental health condition that needs me to get to a doctor in a hospital, there is a bit more of a process it has to go through. In fact, you night have to get approval from the Deputy Minister. So, it is a more complicated process.

So I guess what I'm trying to say is that

equivalence is not straightforward. It is not an easy concept to apply. However, you'll notice I'm referencing a man by the name of (inaudible). He's a lawyer and a psychiatrist working out of the UK. And he's proposed that we use the right to health which is considered to be or in fact is a right that's in our international treaty which Canada has signed. We all have a right to health. And what is a right to health? It means services are available. It means they are accessible. Barrier free. That you can access those services and services are acceptable, culturally and language and many other ways, privacy confidentiality and good quality (i.e. standards). The same standard that you would expect in the hospital or in the community, you should be able to access as if you were an inmate in prison. So those standards are why, when I say right to health, those are the four things I'm talking about.

Next slide, please. Okay, so background, why are prisons considered to be our new asylums? And I don't know if people are aware but internationally the inmate population has grown considerably. Right now, there are over 10.2 million people in the world

who are incarcerated and that increased over a million people over the past six years. Since over the past 15 years, there's been at least a 20 to 30% increase in the number of inmates in worldwide prisons. Now, why is that? Well, a lot of it has to do with our changing world, you know, internet terrorism. And of course, the value we all have now seems to be a heightened value in public safety. A concern for public safety. That's one aspect.

In Canada, between 2012 and 2013 there was a 19% increase in our prison population. So, it may seem sometimes that we are distant from that but in fact this is the trend and it seems like we might be getting a bit more of an increase in population given the new laws that are expected to come down federally.

Next slide, please. Okay. The changing profile of prison population has also been really of major concern because one of the things that has happened is that, even though there has always been a presence of people with mental health issues in prisons, there seems to be a significant increase in people with

mental illnesses and mental health concerns. Now, it could be that some of the standards and understanding and recognition of new mental illnesses may be one thing, but the other thing is the impact of public policy changes. In the 1960s and 1970s, there was a significant move toward closing psychiatric hospitals where people would be living there for quite some time, for extended periods, in favor of putting people in the community and that they would be able to medicate themselves and have more freedom. Unfortunately, that assumed that a lot of the resources that went inside the hospitals would be transferred to the community. Unfortunately, that didn't happen. We now have a result, and you will probably remember in the 1990s for sure, I remember in St. John's, all of a sudden we had a whole lot of homeless people and we had people who didn't have, seemed to be in and out of the prison system and we still have that. And it hasn't really changed and it is a problem that's been recognized right around the globe. In fact, a lot of people are cycling through the prison system, the community, psychiatric facilities and back and forth. It's called transinstitutionalization. So it is a problem and it

is a very real problem.

Next slide, please. So why are services not equivalent? Now this is where we get a bit testy. And I'm going to try to make it as simple as I can. Our system of government has been based on the UK model where there is a unit, one system, so, and all services are united, a centralized system. So they had people, the prisons, and then under common law you're responsible for the care of people in your custody. So those two were merged and in the UK prison administrators were responsible for providing health care to people in their care, custody.

Now, when we come to Canada, we carry over that tradition and in the way the powers of governments have been divided, the federal prison system is responsible, the federal government is responsible for penitentiaries where people serve two years or more, and the provinces are responsible for prisons where people serve two years less a day.

Now, in the federal service, the federal correctional services is responsible for providing

health care in the prison system. That is their job. In our system, prison administrators, because of the way our system has evolved, the health care system, even though it is a provincial health care system, prison administrators, not the health care system, are responsible for providing health care in our system.

So, Mr. Minister, that would mean that basically, even though you are administering universal health care system, it doesn't touch the inside of the services that the penitentiary offers. So, therefore, you have two systems that are operating at one time.

Next slide, please. So, the delivery of mental services prison administrators, while they have the responsibility, so this is their job and even though their job, really, and they're trained to provide services for management administration of a prison, they have become responsible for health care. So they have employed staff like nurses or entered into contracts with physicians to provide these services. But primary care is one thing. You're getting an

inmate who needs, has an infection or basic primary care is one thing, but, increasingly, with the pressure on prisons to respond to mental health and mental illnesses, it became a greater pressure and around the world there have been different types of interventions. And one of the things, for example, in the UK there was a huge study done by the inspector of the prisons and they recognized that the title was called prisoners or patients because they realized that the two of then oftentimes were combined. And that, really, the prison system was not equipped or able to deal with the health care services, so they transferred it to the health care system. The same is true from many of the countries in Europe, some Australian states and some American states.

The World Health Organization for regional office for Europe established a health and prisons project a number of years ago, and they've doing a lot of work advocating for the need to get health care in, more in the health care, in the health field as opposed under the responsibility of the prison administrators.

In Canada, there have been some changes in other provinces. For example, in BC they contracted out and they have called tenders and, basically, private sector companies provide the service to the penitentiaries.

In Alberta, because, primarily because of the pressure on with the mental health issues, basically the government has transferred responsibility to the health care system in Alberta.

In New Brunswick and in Nova Scotia, the prison administrators have entered into contractual arrangements with health care authorities to deliver those services and there is different arrangements for that.

Obviously, in Newfoundland, we're still where the prison is responsible for providing health care services.

I will let you know that the Canadian Medical Association 2013 ran a series of articles (I think there might have been 13 in all), and they were

strongly advocating for the health care system to get out of jail. Basically, they want to see the health care system inside prisons to be run and managed and operated by the health care system.

Next slide, please. Okay, so, what is the challenge here? Why is this such an issue? Well, for starters, I mean the prison's job is to manage a prison. The security and safety of everyone inside that prison is the responsibility of the prison administration. Not only the prisoners, it's the staff, anyone visiting, they are totally responsible and that is what they're trained to do. That is their competency. That is what they are supposed to do. The whole structure is generally run on a paramilitary model. And in order for people to become correctional officers in most jurisdictions you enter with high school education. There is some training. You might have a college diploma, you might be training, as in Newfoundland and Labrador, the training is provided by the Department of Justice. But the bottom line is, is that it is a different orientation and a culture that's developed out of that.

Now, compare that with the mental health care system. The focus of people involved with the mental health care system and providers is patient care. They're not concerned what you did or why you're in there. They're concerned about your health. Basically, the mental health system and services are delivered through multidisciplinary teams. They are not involved with military structures or command and control or. Their job, really, is to work with one another to try to develop a plan of care for a patient. So, they are two different worlds operating. Then on top of all that, you have licensed professionals. You don't have, you have people who generally have years of university training and expertise developed too to provide the services.

So, sometimes this leads to conflicts between the two. Certainly, when the bottom line is the budgets the prison health services are paid for by the prison. They are not paid for by the health care system. So, basically, if there is money come forward, I mean the prison has to set its priorities and one of the priorities may be health care, may be

other priorities. So, it is not the primary mandate. Okay.

Now next slide, please. Now, applying the right to health and how does this all fit? What does this matter with prisons? Basically, I guess we'll start at the available services up in the upper right-hand corner there. We talk about available services. Well, yes, it's true that many services are available but the literature shows and research is showing that really it's underresourced. For the amount of demand and the need of the inmates, there is a great deficit in terms of the kinds of services and demand given the demand for services.

On the right-hand side accessible, it is looking at the barriers and the question, really, is how much information do we really have about the patient inmates? How do you know the profile, what their needs are and what the barriers may be for them to access the services? And using the determinants of health model, prisoners are considered to be very vulnerable and certainly are at the lower socioeconomic levels generally, not always. Now,

there are not too many Lord Blacks running around the prisons but there are a few. And the bottom line is, is that many prisons, in terms of managing the correctional facility and the offenders, they will have information systems and computerized databases. Health care records usually are by records are by paper records, not connected with each other. The many providers just don't have the interface with one another, and certainly not an interface with the health care system. So, basically, on an individual planning level, that's one thing, there's lack of coordination; but on the other side of planning services, that the data just isn't available. So it's a real challenge to provide that.

The next one is appropriate. Now, I don't have a lot of data here about what the inmates themselves will say about if it's appropriate culturally, language or. I can tell you in a lot of prisons one of the big challenges is lack of confidentiality and privacy. That's definitely a challenge in those prisons. And then finally good quality. And this is one that really comes down to the standards and the standards, usually we do have mental health,

qualified mental health providers but we do not have the same standards that you would have in a hospital in terms of multidisciplinary care, the integration of services or connection with the larger health care system, which is very important for continuity of the care. And that is the critical thing. Continuity of care so people know that when you're -- whatever is happening inside my health care in the community go to the prison, in the prison are going back to the community is connected. Well, unfortunately right now the way it is, it is not.

So next slide, please. So, why should services be equivalent? Why does it matter? Well, this depiction shows the cycle of services that most mental health services, and this is a model that's used by both the health care system and the correctional facilities. So this is one that's appropriate to all. So if you're not possibly properly screened and assessed (i.e. if your mental health needs are not identified), if you don't have treatment, if you're at risk for suicide, well how are you going to go back into the community if you're not treated? How are you ever going to reintegrate?

How can you ever say that you can't, you won't have contact with the criminal justice system? The chances are that recidivism is a likelihood. If you don't have the proper supports in the community. If you don't go away and you're out on the streets and you don't have the mental health services and supports you need, that's going to happen. So, really, we're talking about continuity of care and the fact that hopefully the goal of the prison would be to keep people, to help them get through the correctional system and not come back. And that is the goal or should be the goal.

Now next slide, please. So how can equivalence be achieved? Well, I think one of the things that's obviously to get the prison health care services must be part of the universal health care system; i.e., right now connected with the Canada Health Act. Right now, prisons are not covered under the Canada Health Act. Hospitals are and physicians are but prisons are not. So this is, this is part of the challenge here. So, first of all, it's for the province to sort of accept that the health services inside that prison become health services that are

covered or at least extended and integrated with the main health care system so that there is not just this divide.

And finally, it is very important that the health care system must work in collaboration with the prison system because after all when they are running two systems but the point is the prison still has a role and it is a role that in our society right now we're still, this is the way we deal with offenders and it has to be supported.

And now, I know that there are efforts ongoing at the moment to try to help our systems here work together more collaboratively, but I would like to quote the Honourable Anne Derrick, who's a judge in Nova Scotia, who was a commissioner at the death of Harold Hyde who was arrested and died in custody, and she -- her observation was we have two systems that are serving the same people but they're operating in two different silos. They are not communicating with one another and, I guess, that's the goal. That's the challenge is to try to bring that together. Although it is working, they are trying to do that

now.

Now, next slide, please. So, the conclusion is, is that the prison health care system needs reform to meet the right to health and to achieve equivalence. And the result could be or should be, that's the goal, continuity of care, improved health care system for prisoners and hopefully that would inspire this committee, perhaps, to consider at least that prisons are part of the health care system and should be part of the universal health care system and integrated with it. Thank you. That's all.

Honourable Steve Kent:

Thank you. Committee members probably have some questions for you, Colleen. So we'll it up for them.

Colleen Hanrahan:

I hope it's not the constitutional questions.

Honourable Steve Kent:

No, we've got one lawyer at the table, that's plenty.

Colleen Hanrahan:

You got two.

Honourable Steve Kent:

Two. Oh two, right.

Colleen Hanrahan:

You got two. You're surrounded by three.

Honourable Steve Kent:

That's one too many at least. Okay, who wants to go first?

Gerry Rogers:

I have a question. So, Colleen, now sort of drilling down, how concretely should this work in terms of the collaboration, the integration of mental health services, the health care services in prisons? And so, for instance, if John Smith has an outside psychiatrist and has been under the care, he's got continuity care there, and then he is sentenced to Her Majesty's, what's the best way for going forward?

Colleen Hanrahan:

Well, I can say that there is an effort now, I believe, to start the collaboration, so I think that's opening up and happening. But I think the reality is the province needs to look at how these services become integrated. So, there has to be a -- if John Q. Public is out in the community and dealing with psychiatrist, I mean I can't really say that that psychiatrist, it is not my place to say that. But at least some communication ongoing between

what's happening inside and in the prison and opening up that communication which right now it is problematic because it's a setting that is challenging, and, again, the practice of psychiatrists are not really, I can't say I'm really up on that but I know that there is openness. The need for communication is certainly the big one.

Gerry Rogers:

So if you're saying, if I understood, then the ideal situation is for the health of prisoners to be coordinated and provided by our health care system and the same with the mental health aspect of that. So, how do you balance the potential conflicting needs there? So, if you have a prison where basically you've identified what the priorities are for a prison system and how does that work together if there are conflicting needs in terms of the mental health and wellbeing of someone who's incarcerated?

Colleen Hanrahan:

Well, I mean there is no question that one of the big challenges is going to be trying to get the two systems to work together. They have to collaborate and there is always a tension between the two systems. And I guess the reality is, it's got to be

a way to engage in communication but prisons historically have been insular, very insular and it's been a real challenge even to get research conducted inside of prison. I mean it is a real challenge to do that. And, so, there has got to be openness on both sides and certainly I think if it was an opening for the prison system to have support, shall we say, through the health care system as opposed to the way it is operating now. I mean let's face it. With all due respect to the prison administrators I've met who are doing their best, they recognize that they are not competent to deliver health care services. And they really, they have to be concerned about the prison but they have to be more concerned about, well I won't say liability but yes that's one of the things, but I mean the bottom line is it should be driven by the needs of the inmates, the health needs of the inmates. And that, to me, from the work I've completed, most of that would be based on looking at getting the health care system who, and people who are competent, to deliver health care services. Now there would be times when there would be challenges with the correctional system but the other side of that is that the correctional officers have a big

role to play in the informal role in the mental health services of a prison. And in spite of the fact that they have relatively limited education, they are expected to do an awful lot. They are expected to identify when someone is having a challenge, they are supposed to expect, they are expected to identify the fact that someone is having a hallucination and they need intervention but yet they are not trained. They need training and they need training on an ongoing basis and that has not been happening. And that's throughout the literature.

Kevin Parsons:

That was going to be my question. What kind of training is available to our (inaudible) in the prison system to identify if I got a pain in the chest I know I got a pain in the chest and I know I have to go to emergency. So what's there? Right now is there any training available for people to understand the mental health issues that are ...?

Colleen Hanrahan:

Well, I guess, depending on the prison, there is a little bit of training and I know that certainly in this province it has been an effort to do that. But

the point is it's got for be ongoing. It can't be one off. Like, okay, we did three days of training this year and it's got to be something ongoing and it's got to be something that made people aware that mental -- see a lot of people, as you well know, as you would have heard, there is a great stigma associated with mental illness. So, it's one thing if I have chest pain, yes get you to the ER ASAP, but many people who are having auditory hallucinations, for example, some people might interpret that as oh, well, that's just him acting out. Boy, put him down in the seg. And that is not necessarily the answer. So, I mean and other side of it is you can't expect to turn correctional officers into psychiatric nurses or, but the point is sensitive them at least to yeah, there is a red flag here and I have to do something about this.

Unidentified Male:

Colleen, I certainly accept a lot of the things you said. There is no doubt we overdo it in the sense of criminalizing mental illness. A lot of our prisoners in our prisons, a lot of our inmates in our prisons have committed crimes basically because of mental and socially mental illness problems. And I guess the

ideal world, we wouldn't have these people in prison. But we will and we continue to have people in prison with mental illness problems. We have mental health court in this province that does great work in that respect. And with respect to training, Kevin's question, we've done a fair significant amount of training for correctional officers in the last two to three years. And as well, we have a multidisciplinary team in place that's responsible for the mental health project in HMP. It does a really terrific job. But having set all that aside, we still have major problems with mental illness problems in prison.

But you're suggesting that there should be an equivalence between the level of mental health care, mental health care in prisons with mental health care on the outside. And certainly, that's a goal that we should look towards. But do you not agree that there are some aspects of delivering mental health services in prison that have parameters around them that don't exist outside of prison?

Colleen Hanrahan:

Oh, yes.

Unidentified Male:

I'm thinking of such terms as psychiatry, perhaps in psychiatry, prescription of drugs, given the culture of prison culture and safety issues and whatnot, would not agree that there is a major difference in that line?

Colleen Hanrahan:

Well, I will answer that two ways. Okay, first of all, in the literature, the setting makes a difference in the literature. Okay, so you have in a prison setting, generally, due to exactly what you're saying, the potential for inmates to drug seeking behaviors, violence that kind of thing, there is a challenge versus in the community it is a lot different. Even at the hospital it is a lot different than dispensing medication.

But I do wonder, having been in several prisons in the province and elsewhere, I do wonder if a lot of it has to do with our facility. And I know there is not much we can do about the budget but if there had been a new facility, because I mean the privacy issues, I mean I know for example, yeah, there is no privacy. There is no way to offset some of those

challenges. I just wonder would it have made any difference? And I don't know the answer to that. But I just think that just having been inside HMP and some of the other prisons that it's pretty pathetic.

Unidentified Male:

I totally agree with you, that there has to be major collaboration between services inside and outside. I think that's essential. We have to have a……I think we're moving, we've moved towards that quite a bit since the peer review was done on psychiatric services. We still have a long ways to go. We've had some improvements but certainly the whole principle of criminalizing mental illness is a serious one and I'm delighted you made the presentation here this afternoon.

Colleen Hanrahan:

Yeah, I think we have to move toward trying to get it as equal as we can, but I mean the other big challenge is you're not starting off with people at the same level, and I mean you're talking about, really, the most vulnerable, generally speaking, the most vulnerable populations.

Honourable Steve Kent:

You had a question for Colleen?

Paula Corcoran-Jacobs:

Actually, I just want to respond to the prior question around training for staff at HMP in particular. They actually have one individual on staff who's trained to deliver a course - Mental Health First Aid - and it is an adequate course that provides staff members and the general public with the skills to help someone through a crisis emergency as well as standard mental health issues. So that is happening and they have begun delivering that training to the corrections officers. So I just want to provide that information.

Honourable Steve Kent:

All right, thank you.

Gerry Rogers:

I had one question.

Honourable Steve Kent:

Go ahead, Gerry.

Gerry Rogers:

And Colleen, do you know of any prisons particularly in Canada, but or even elsewhere, that are using the recovery model within their mental health services within prisons?

Colleen Hanrahan:

I know that in certain provinces, it's certainly a priority. And I know that they're trying to move that toward that model here. I can't tell you an example of a model that you would be good to review, but if the Committee is talking about bringing any people in, I can certainly give you some names, and one of the big names would be Andrew Coyle who is a former prison administrator in the UK. He is, laterally he left that after 30 years and became a legal scholar. We're all around everywhere. And I heard of him because he was an expert witness at the Ashley Smith inquest and I heard him speak in Toronto. So, I mean he'd be very, someone that would really inform the Committee.

Honourable Steve Kent:

Okay. Well, thank you for your presentation, Colleen. That's been very helpful and informative for sure. We appreciate it. Now our next presenter is Mr. Karen Todhunter who is the Director of Clinical Development with Fonemed North America. Is Karen here? There she is.

And Fonemed is actually the company that provides

our Health Line services currently here in the province. Welcome, Karen. And the closer the microphone is to you, the easier it will be for everyone. So if you can move it in a bit that would be great.

Karen Todhunter:

Thank you. And thank you for the opportunity to be here today and tell you a little bit about our company and what we're doing. And like you say, we are the current provider for the provincial health line service. So, we are present here in the province and we started our operations here, actually, in 1999. When we started, we were very small. At the time, we were downtown and we were, I think, about 12 nurses, all located here in the office. As we grew overtime we expanded our operations and, of course, with the oncoming of the Health Line we were fortunate enough to up three more offices here in the province. And we have current locations in Stephenville, Corner Brook and St. Anthony. And I believe our staffing right now we're one of the largest employers in St. Anthony. We employ 30 or, I think, actually, over 40 or 50 staff up there and the equivalent amount Corner Brook. And

Stephenville is a much smaller presence but we do also have some nursing staff there as well.

If we can just jump right into the slides, I think we can get going. So, as Minister Kent alluded to, we are a telehealth health service provider. We work closely with our clients to improve health outcomes and to support costs. And certainly one of the biggest goals is to minimize the cost on the health care systems. And our biggest goal with these services is that we keep beneficiaries well and offer behavioral counseling and that we guide them to appropriate care when needed. We manage their transitions from different levels of care and we also enable remote chronic management disease.

So, you can see here, we have a large variety of clients. We do also have a very strong presence in the US. We've got a lot of clients down in the States and a lot of different services that we provide for different clients. Many of our clients we started with were the physician practices and a lot of that started, you'll recall, of course, the difference in the health care system in the States

where it is much more private organization and they're mandated down there to provide access to their physicians 24 hours a day. So, of course physicians couldn't manage their practice all day and then be available all evening and they started contracting out services and using a nursing service similar to ours.

So that is kind of where we started with our client base and it really grew from there and we started and continued to offer more programs. Overtime what we noticed was particularly with our triage and health information, that it just wasn't enough. Our clients were asking for more and, of course, our patients were asking for more. So that's when we started really looking at expanding and enhancing the services that we offer.

Once we started looking at what we needed to do, we also recognized that we needed more support for our own staff, enable them to provide the services that we needed. So we undertook at that point to design our own software. And with the assistance of the federal government, we received some ACOA funding

in 2010 and that was a real great thing for us because it gave us the support we needed to be able to put the staff particularly into the design of the software. And we were really fortunate in that we were able to take clinical staff and the technology staff and put them together and work together to design a software that fit the needs of the frontline people and all the users of the software.

Next slide. So in saying that, you know, I don't want to dwell too much on what our company does but on some of the different things that we can offer and some of the things that are out there, and of course software being number one, because all of our services are offered remotely in the sense that where everything is telephone based or technology based, we're not in the office. We're not there. And of course that has benefits and advantages there in that it's much more accessible for people in remote areas or people who don't feel that they can go into the office and talk to their physician about certain issues. Or also people just want anonymity. They can call, they don't necessarily have to give their name but they can speak freely to a health care

professional.

I'm showing my age now. And of course the big benefit, we've been here really since 1999. We've built a tremendous management team and a very strong quality assurance program, and that certainly has been a guiding force for us over the years. Our medical protocols and guidelines, we also use our best practice. There are gold standards for the triage protocols. We're using ones that are well known throughout the United States and across all of North America. Many practices and organizations are using the same protocols and guidelines that we use.

Next slide. So just to touch real quick. I don't want to go into too much detail on the different services we provide, but, of course, nurse advice is pretty much anybody can call in, for example, to the Health Line at any point in time in the day and they'll speak with a registered nurse and they have the opportunity to talk about their symptoms or even if they just want some general health information they can call at any time and do that. The optional service with that is that if necessary and the client

wants to set it up we do have the ability to offer physician escalation where if the nurse is on the phone and if it is a situation the nurse can't imagine or if it something beyond her scope of practice, she can escalate it to a physician and put a physician on the phone with the patient.

Another service that we provide, workers compensation. I'm sure everybody is very familiar with the number of forms and the requirements and the documents that have to be filled whenever there is an injury. And also, too, the unknown as to how to manage the injury. So we have many employer groups who, if their employee is injured at the workplace they can call this number, our nurse will triage their symptoms. They will capture all the information that they need for the client's workers comp form and they'll direct the person to the best level of care for whatever is related to this injury.

We have an occupational exposure hotline which is another fantastic service. We work closely with Florida (phonetic) hospital systems to develop a specific protocol for managing exposures in the

workplace; specifically for health care workers, emergency response workers, police, fire, anybody who's potentially exposed to any sort of body fluid or a similar injury such as an inhalant or, like, a firefighter walking into a building and inhaling whatever unknown substance. So that hotline is fantastic in being able to give the people the answers they need right now when they're exposed and what do I do.

We have a wellness program as well also available. Typically, it is available as an individual or employer groups use that as part of their employee health packages.

Care transitions program. Really facilitating that need for when people first get discharged from hospital, that first 30 days when the recovery day is most important and people are not sure is this inspected. Should I be feeling more or less, or what do I need to do. So that's a program that's a short term program really designed to manage that.

And of course a disease management which is a new

program we've recently started in the last few years where we're doing more management of chronic diseases. And typically the biggest three that we see that are the highest cost to the health care system are diabetes, congestive heart failure and COPD. So those are three big ones that we have.

Once we started the development on those three, we also quickly realized behavioral health was such a big component of all of this, not just with disease management where we see a lot because there is a very high incidence of patients with chronic disease who do suffer with various depression, anxiety often related to their illness or their activities of daily living that are affected because of their illness. So in addition to that we look at this behavioral health program which is also one that we started just in the past couple of years and we've been doing a lot of work on the development with that one.

The last service that we have listed there is the biometric monitoring which is also a new service that's we've just been dabbling in it the last few years really where we're working with various clients

on remote devices and biometric devices. And we'll talk a little bit more about some of those.

Next slide. So in our behavioral health program, you can see that certainly it's a very detailed program. We engage, when we first undertook to develop the content for this when we engaged a mental health consultant in Newfoundland who helped with the research of published best practices and together we put the key indicators for the management of behavioral health and addictions issues and we put those into a computable format and were able to design a program based on that. Once we had that content all put together, we also looked at an advisory panel of professionals in the area so we were able to use a lot of local resources with the psychiatrists here, Dr. Hogan and Dr. Gary Tarrant, I believe. Physicians that are associated with MUN and certainly Eastern Health here.

We also engaged social workers, psychologists. We have physicians and psychologists as well from McMaster and University of Waterloo who also reviewed the content.

Our primary resource for the content was the enteri (phonetic) mental health guidelines and also we referenced, as well, the WHO guidelines on the management of mental health and behavioral health issues.

Next slide. The benefits of programs such as this, of course, access to care which we all here realize that's one of the biggest issues in how do we get people the care they need, when they need it. Certainly what we see here locally, especially if a new patient presents to one of the emergency rooms with some mental health or addictions type issue and they need a referral to a psychiatrist, oftentimes they're waiting 12 and 14 months before they're seen. There are other programs locally available, of course, to start clinic and other resources but what we see is that we can help fill the gap by providing another level of service in there with giving people access to nurses who are trained specifically in the management of mental health and addictions.

Benefits. Again, reduction of stigma, removal of the shame factor, coordinator of care and patient

acceptance, and certainly the cost savings by being able to provide a service remotely that is much more cost effective than having people available in clinics or emergency rooms, especially trained, and having those people available 24/7 is not an easy endeavor.

Next slide. So I just wanted to talk a little bit about some of our experience in some of the programs that we're offering. As we mentioned, the health line, we just recently started a new program that we're providing through the Health Line. We work closely with the Department of Health over the last, I'd say, probably 12 months or so in creating the protocols and the guidelines and the call flow for the management of this. So, essentially now, if anybody who calls the Health Line and if our nurses determine that this person has any possible need for a follow-up or perhaps if she triages the person and she uses one of the specific mental health protocols, when she gets to the end of the call she's going to ask the person would you like me to call tomorrow. Can we follow up and touch base and see how you're doing, see if there is anything else we can do to

help you. So if the person agrees to that, we do exactly that. We call them the next day and we do a follow-up. And we'll call them up to, I believe the protocol is up to six times over the next four or five days. And even if the person indicates that they want more callbacks and more support we will absolutely give them a call and continue with that. And essentially, the goal there is to be able to respond to the questions, give them the information they need, direct them to the level of care they need, and also help them identify what are the local resources? What's in my area that can help me, what are my specific needs and where can I go to find that.

Ginger.io is another group that we've been working with now for about six months now, I think. They're a great technology company based in the States who are doing various studies where they use patient smartphones to improve behavioral health in primary and specialty care. We're really excited to work with them because of the technology that they're bringing into the program and how they're applying it. Essentially, what happens with them is that they

capture this passive data through the smartphones and they have analytic applied to this and this mobile application identifies patterns in the patient's behavior and in their mental state that may impact their health and wellbeing. Providers can use the ginger.io platform to reach out when patients need support and deliver the right care at the right time, building a stronger connection between patients and providers.

So, I just, and sorry, the other two programs that we're also currently working with, I want to talk a little bit more about Ginger in a moment. Two other programs that we are working on right now with the Sober Living which I'm not sure if anybody is familiar. They are a group that's growing in the States and they have different locations where they're providing an in-home setting for support for people recovering or living with sober living. So they're a great resource. We provide support to them. Anybody who's in these residences has access to our nurse line. They can call 24/7 and our nurses will provide whatever support, listening and counseling that they need.

And of course the other one that you see there, the sexual violence and STD support line, this is a growing program as well and we're offering it to a lot of the universities in the States where they're providing access to their students 24/7 to have immediate access to a nurse if they're needing it. And if they're involved in any sort of situation they don't know what to do next, what's my next move here and what's the best situation to deal with.

So, if we can go to the next slide. With the Mood Matters, I just want to talk a little bit more about how that program is modelling and predicting the behaviors using the sensors and the data from the devices. And they've enrolled up to, I believe they're up to 1,000 individuals now. They initially started with 300. Their goal was to get a thousand and that was six months ago. And I think they're pretty close to that right now. So people are enrolled in this study for a six-month period and in order to enroll they do have inclusion and exclusion criteria. So the enrollment, you can see they have their specific criteria for enrollment. And on the next slide you'll just quickly see the exclusion

criteria. So they're looking to not work with somebody who's really acute because this is more of sort of a long term management program in looking at what are the issues that people are dealing with, anybody with a depression or anxiety disorder. So anybody who's excluded certainly doesn't go on into the actual program. And once they're in the program, essentially everybody will have this app on their smartphone and they will complete a two question little form every day. That is simply a screening tool basically to determine what is their level of their depression. Is it something that's affecting them today or not. So it's two question, like a pre-screener there. And as well everybody every two weeks completes a nine question screen.

So based on the analytics and the rules that this Ginger.io group has built into the application, anybody who does rank higher in their depressive state would send an alert out to our nurse here. So those people, when those alerts, are staff in St. Anthony pick up the alert responses to those and they'll put them in our electronic queue for the nurse to call and connect with the person. And of

course when they reach out to the person, they'll rule out any urgent need for assistance and they'll provide whatever support is needed at that time.

Next slides. So, overall our behavioral health program we offer personalized supportive counseling to individuals coping with mental illness, behavioral health issues and/or addiction. The program is designed to support individuals diagnosed with mental illness, including those transitioning back into their communities after being in hospital.

Our staff go through a fairly intense training. Our registered nurses are certainly experienced and they frequently speak with people in whatever crisis. So we provide the training that they need. For example, in Corner Brook the nurses out there have all done the Assist Program and they all found that absolutely fantastic and helpful for when they are on the phone dealing with patients who are in crisis.

Our staff offers support by providing the tools essentially that people need to help them cope and to make it through the day and identify where they need

to go for their resources.

Behavioral health counseling, of course, does not simply treat a condition but it really looks at the individual's environment, their emotions, their physical and their behavioral health. Essentially, what we look for with this program is that by providing the appropriate services in a cost effective manner will support the recovery and minimize the effects on people, their families and the community.

Next slide. So just to wrap up, I know it is a long day for everybody. What we look at, for active care management it's difficult because of the structure of our current health care system, specifically for solo practitioners, physicians out in rural communities where there's just one physician serving the whole community. Any small practices that just don't have the resources to offer immediate behavioral health support, we certainly think that technology and through various telehealth programs there's an opportunity there to fill that gap and to be able to give people the resources they need at

their fingertips. Technology solutions can certainly fill these gaps. And ultimately our goal in treating and providing people this support is that we're getting them also involved in their own health and the health of others is a great promise for addressing some of the gap by empowering people to do more in terms of recovery for themselves with the appropriate and timely professional support.

Honourable Steve Kent:

Thank you. Committee members any questions for Karen?

Gwen Mercer:

I'm baffled. My name is Gwen Mercer. I'm a psychiatric behavioral science nurse. What you're describing here, are you a private company or are you associated with health care?

Karen Todhunter:

We are a private company.

Gwen Mercer:

Okay. What got my attention first was when you described your phone system, where people could call in, and I suddenly wondered, government has hotlines where people can phone in when they don't want to appear in the emergency department because they don't

feel that they're that sick yet. I'm wondering does the government health care line include this model?

Honourable Steve Kent:

Yes, the Health Line that the province launched is actually provided by this company.

Gwen Mercer:

Okay. I wasn't sure because I didn't hear everything and I couldn't .... Okay. In some of the conversations that came up last evening with the panels, they talked about a warm phone, right. Warm line.

Honourable Steve Kent:

Warm line, yeah.

Gwen Mercer:

Yeah, right. Could it not be possible that government could adapt in this hotline, warm line, whatever you want to call it, that more activity is taken on and it be advertised a lot more so people could be using it for achieving this model, instead of ending up needlessly in waiting lines in a hospital? I mean I work every day at home, I have a private company as a nurse, and I help people get well naturally. And the stories that I'm hearing from these people, they would rather die in their bed

than to go and wait such a long waiting period in the outpatient department all around the province. And I'm wondering how we can have them more aware of the phone line so that they can prevent getting into the system when they don't have to be in the system yet, if they're caught fast enough.

Honourable Steve Kent:

Those are really good points, thank you. I just have a sneaking suspicion that our next presenter is going to talk about warm line because we have had some discussions.

Gwen Mercer:

And I'm done.

Honourable Steve Kent:

And in terms of raising awareness of those services, you'll be hearing more on that in the next number of weeks as well, so thanks for your comment. Andrew?

Andrew Parsons:

And I do have a question. I'm just wondering now what's the number for the Health Line?

Karen Todhunter:

The Health Line here in the province?

Andrew Parsons:

Yes.

Karen Todhunter:

It's 888-709-2929.

Andrew Parsons:

888-709-2929. I'm just wondering has there been any, because I like the idea of the Health Line, obviously, and you talked about last night, Steve, where you used it as a new parent and I used it as when my wife was pregnant. It is nice to know it's there. I'm just wondering, I think the AG might have mentioned in her review. Has there been any thought to simplifying the number, 611 or something along those lines? I don't know if there's a cost or.

Honourable Steve Kent:

You're stealing my thunder.

Andrew Parsons:

I don't know if there's a cost associated with it but sometimes part of the awareness is the dummying it down for people like me.

Honourable Steve Kent:

I'll let you in on a little secret. We're about to make an announcement in that regard and there is going to be a three-digit number that everybody in the province is going to be able to call to access Health Line.

Andrew Parsons:

I just got more out of you here now than I've ever got in Question Period.

Honourable Steve Kent:

You just got to ask the right questions. So the technology is in place, the infrastructure is in place and the announcement is coming. So we've been working with Fonemed with that as well, so. Well, Karen thank you again.

Karen Todhunter:

Thank you.

Honourable Steve Kent:

Our next presenter is Ms. Paula Corcoran-Jacobs who is the provincial executive director of the Consumers Health Awareness Network Newfoundland and Labrador which many of us know as CHANNAL. And Ms. Corcoran-Jacobs is also a member of my provincial Mental Health and Addictions Advisory Council. So, Paula, welcome and the floor is yours.

Paula Corcoran-Jacobs:

Thank you and thank you for having me today. I guess I'll wait for the presentation. I do have some handouts. Gerry, if I can just start with you and we will pass some up along the way. I was instructed to

bring enough for the council but I did bring some extra. So at the end when everything is left over, if you want to hand them out, that's absolutely fine.

So I will guess, I'll usually start with a bit of an introduction on myself which Minister Kent did lovely for me. I am the Executive Director of our provincial organization CHANNAL. And if we can start the slide presentation, that would be great.

I always take an opportunity to educate people. As we heard our last speaker, how do we let people know this information is out there. I jokingly share, we're only 25 years old so that's probably why you haven't heard about us yet. But we've been around since about '89 where our program was Canadian Mental Health Association and began our own organization about eight years ago, in 2006. We are a provincial organization so we exist here in St. John's, as well as Grand Falls-Windsor and in Stephenville. And we have about 400 members province wide who are individuals who choose to sign up as a member, cost free, who just want to be a part of the organization. We have about seven staff members

currently that cover the entire province and we do take Board of Director volunteers, and we actively look for them throughout the year. And of course volunteers.

Maybe if I had a clicker. Who we are. One of the key points about our organization which makes us extremely unique is we're the only provincial organization in the entire province that's run for and by people with mental health issues. Essentially, what that means is one of the job requirements to have employment with our organization is that you have a mental illness and that you're willing to share that publicly. Most of us are probably aware that while stigma is alive and well in our province, that's usually a barrier for employment. And so our organization requires people to have a mental health issue. So, of course, that means I live with a mental health issue.

I was diagnosed personally about 12 years ago with several mental health issues. And, so, it really brings a professional piece for me but certainly a personal piece when I give such presentations.

Some of the focus of our organization is peer support policy consultation and public education. Peer support, I'll certainly speak about a little bit more in detail in a few moments, but policy consultation, as the minister alluded to, I sit on a provincial advisory council but also throughout the organization between the seven of us we sit on about 30, 35 committees and boards and the like. And we really just ensure the voice of lived experience is present, so that sometimes when decisions are being made about programs and policies we're standing up, saying wait a minute, did you talk to the person who's actually going to use the service. Did we ask the person. So we're usually there and very delighted to be a part of that for the most part.

We advocate for and bring awareness to issues that need public attention on a systemic level. We advocate to eliminate stigma, of course, and, as I mentioned, consult with the government on a regular basis.

Next. A really quick overview. As I said, there is a couple of handouts if anyone is interested. I

really always loved the opportunity to share this information. Some of the services that we offer. Peer support. We do in-person peer support groups. We have in-person peer support. We get the opportunity to sit down and talk to somebody about a mental illness who can truly understand some of the challenges that you're going through. E-peer support to follow up on the last presentation, that notion of using technology to our advantage. So delivering services through online group chats, through Skype, through texting, through e-mail, through telephone service. So, again, offering that opportunity across the province as much as we can.

We have opportunities for wellness workshops, for critical incidents, stress debriefing and supporting groups or communities in establishing their own groups. So, again, it's not about how CHANNAL can start groups, it's about how we can support you to start a group. And if we can provide peer support across the entire province, that would be our dream.

Public education. We do ongoing presentations, like the one I'm giving today. We also deliver

professional trainings. So, as I spoke earlier, we teach Mental Health First Aid which is a course that's similar to Assist, which is similar to a regular First Aid course but really addresses many, many more crisis situations from a mental health perspective. We teach the course regularly. Actually, last count, I have taught the course 14 times this year with a class of about 20 people each time. So we're really, really moving forward with that. And the recovery approach I'm going to speak about a little bit more in a moment.

How to access our services. I was asked this from a clinical perspective several months ago and someone had asked how do I access your services, wait times, criteria, all those questions and my answer was you want to come, come. That's our criteria. Any individual who self-identifies with living with a mental health issue can access our peer support services. We don't require diagnosis. We don't require any length of time. If you woke up this morning and you're having a rotten day then you're having a mental health issue today and so we encourage people to avail of our services. Any

individual organizations who are seeking to improve their mental health literacy or provide additional wellness support within their organization can access our public service. Or sorry, public education services. So we've facilitated from every group from closed groups of individuals to the board of education, health authorities. So it is a huge range of individuals and groups. And you simply contact us. Give us a call on our provincial line or contact us on our website and we'll have the contact information at the end of the slide.

And the bulk of why we're here, how do we move forward. So as I talked about, I live with a mental health issue so I'm certainly not coming from just a professional perspective. I was diagnosed at the age of 25 with a major depressive disorder, among some other things. But recognized that I potentially lived with a mental health issue from about age 15. Why I went ten years without a diagnosis was potentially related to stigma and lack of services. I felt and had no knowledge to contradict that how I felt and how I lived and the things I lived through were parts of everybody's life and it wasn't until

the age of 25, being lucky to find the right services and the right providers within the system, that I was able to move forward in my recovery.

I really am concerned when a part of my recovery journey is that I was very lucky. I was lucky to find the services at the right time. I was lucky to find the right people in the system. When we talk about health care systems, I don't think we should be talking about luck. I shouldn't have to be lucky to get services.

And so we move into the recovery approach. The recovery approach, while it is certainly I'm not going to take the opportunity right now to educate people on it but it's a program that CHANNAL has been involved with for about three years with the Department of Health and Community Services. Certainly, as an organization representing about 400 people who have mental health issues across the province, we feel that the recovery approach, the continued support and advancement of the recovery approach is certainly how we move forward in this

province. It's taken a system that's about 200 years old and moving forward into the future, lining up with what's happening, not only in Canada but across the world and, again, speaking to the people, asking the individuals, hearing what people need, what people want and providing the opportunity for people to lead that recovery approach. So, certainly supporting and continuing to support the recovery approach.

The voice of lived experience. Again, ensuring the voice is heard. That people are not simply becoming tokens. That we are saying okay we have, we can tick the box. We have Paula sitting at the table so we can tick the box. Let's really move forward on how do we really truly have the voice of lived experience at the table? How do we ensure individuals who use the services who live with mental health issues, their voice is being heard and their approaches are incorporated into our services. And I actually provide a video at the end of the slide that will hopefully reiterate the importance of lived experience.

Peer support, a huge, huge concept. Again, anyone who knows me knows I can speak for maybe ten hours on this topic, so I will try to keep it short. But again, in moving forward and in specific to the conversation today, it's really about how do we make it more accessible. We currently provide a huge range of peer support services but in the St. John's region we're actually one person who delivers services for the entire eastern region. So this, obviously the services are very, very, very limited. We provide service in the hospital, in our provincial hospital, the current Waterford Hospital. Unfortunately, we provide service for two hours a week. Again, the need is huge. We service and support about 10 to 12 people in that two-hour period with a large portion of that being family members who are very scared, very confused, very unsure, very afraid just to be inside the building. And so to have somebody who has been a part of the system and has experience being through the system of the Waterford Hospital in particular that support to families is huge, huge, huge impact not only on the families but on the impact, the mental health of the individuals.

So, again, increased peer support for the hospital in particular but certainly for an overall program across the province.

I'm going to skip Warm Line and come back to it because it is one of my favorite things to talk about, and of course it was addressed earlier. Quickly mentioning specific gaps, we've talked in general about some of the programs that we really see need support. Specific gaps, we recognized in our organization speaking with individuals, providing different services a huge gap in service for families as well as in a specific region in Labrador. We, as an organization, do not provide service in Labrador simply because of lack of resources. As we know, Labrador has repeatedly provided information that lack of resources is a huge issue across the board in health care; in particular mental health needs. So again, how do we address that need? How do we provide the services there?

And from a family perspective, we've just recently changed our mandate to -- does that mean I'm out of time? My slides disappeared, I thought that was a

polite way to say stop talking now.

In terms of family resources, so we've actually just recently changed our mandate simply because the majority or at least a third of the calls we receive are from family members saying I don't have a mental health issue but I need someone to help me. I need support and there is no nowhere to call. There's nobody to talk to. And so, we would provide the service. And so just to be true to our mandate, we've actually recently changed our mandate so we can provide that services.

Families, and I always argue the issue when we say I don't have a mental health issue, it's my family member and I'd like to speak to a family member who is -- who has a loved one living with a mental health issue where their own mental health is not compromised. Being a family member supporting someone with mental health issue, it compromises your own mental health. It does. Period. And so we need to provide those extra supports.

To jump back, I'm just recognizing I got plenty of

time, I'm doing wonderful. We do have a video to show towards the end. It's about three minutes. A provincial Warm Line. So it's been alluded to last night during some of the presentations. We had an audience who spoke of it this morning. Back in October of 2014, I submitted, our organization submitted a 30-page proposal to our current government suggesting that and providing and all of the research over the last ten years of how and why a warm line would not only support people and provide better outcomes, but certainly be a financial and fiscal opportunity. A warm line, for anyone who's not sure of the term, it's a little bit like a hotline but not quite. It's a warm line. So it's not an opportunity for people who are not yet in crisis to contact someone, to talk to someone and hopefully with the goal to avert crisis, to have the conversation before the crisis happens.

The feedback, while we do have a provincial crisis line that is 24 hours and it is available and effective, the issue is that when people call who are not in crisis the service isn't necessarily available. And so then what happens is individuals

who have completely, completely built up the courage to call after time and time again of being not well, they're told that unfortunately unless you are in crisis this isn't the line for you to call. And so those individuals are then left with no opportunity. If the crisis line cannot help me, then where do I turn?

As an organization we submitted the information in October that we would take about 30 calls per month. Last night, I did a statistical analysis just to be sure of the data presented today. We take now about 120 a month. Since October that's - what's the math - quadrupled just since October. What that means is our staff are on the phone for about an hour, an hour and a half consistently just supporting someone to ensure that they have a voice. They are feeling heard and they have support. I just recently had the opportunity to present to a group of individuals. It was constituency assistants as well as executive assistants with several departments and their feedback to me was once I defined a warm line call or warm call their feedback was that they provide service regularly as well. So, again, the need is

there and certainly in my 30-page proposal it was highlighted that that need is there and providing the service for people will provide the opportunity for us to stay out of the emergency rooms, to stay out of the clinician's office, to have a conversation with somebody who can truly say I know how you feel. I've been there. I might be there again tomorrow but I'm not there today and so how do we move forward together.

So, certainly providing support for a warm line and not to steal from the last presentation but certainly a lot of the information in the last presentation around the advantages of using technology, having it in a remote location versus having to come out to the hospitals and all the costs associated with that.

I think I'll stop there. I would actually prefer to show the video before we entertain questions, if that's okay.

Honourable Steve Kent:

Yeah, no problem.

Paula Corcoran-Jacobs:

So, Understanding Changes Everything. As most know, it is actually a program, stigma awareness campaign done by our provincial government that I was very, very fortunate to be a partner with. And I use this as I teach Mental Health First Aid regularly because it is great opportunity to actually hear the voice of lived experience. Okay. Any got any good jokes? Do we want to open it for questions while we ....

Honourable Steve Kent:

While we get the technical details worked out, let's take some questions from the Committee members, if they have any.

Gerry Rogers:

Yeah, Paula when you're talking about family support and family services, what kinds of supports and services do you think families are looking for and need?

Paula Corcoran-Jacobs:

That's a really great question, Gerry, thank you. Oh, do you want to play or will we wait? No worries.

(Video played)

Paula Corcoran-Jacobs:

So I will answer your question, Gerry. The question

was around services for family. Certainly, from our perspective, organizational perspective, peer support would be some of the huge, huge gap and certainly we hear that from a lot of other organizations. And when I talk about peer support we talk about the opportunity for one on one. So, sit down with a family member, an individual who's also a family member of someone who has mental health issues and be able to share those experiences together and relate from that level to share hope and optimism that change is possible. That recovery is possible. From our perspective as an organization we provide that service. We provide it through telephone as well as appointment based. We have not moved into group supports at this point for families. However, it is something we hope to do in the near future. That we provide an opportunity for family members and, again, family of choice. So whoever people feel are their family, their circle of care, our circle of family to come together as a group to share those experiences. Did that answer your question?

Gerry Rogers:

Yeah. But aside that kind of support are there specific things that family members are asking for in

terms of that would help them and the person that they're trying to support? And the other thing is since you speak with and hear from so many people with lived experience, what are some of the recurring themes that you hear from people in terms some of the real challenges that they're facing; like, whether it be housing or poverty or wait lists or whatever that might be?

Paula Corcoran-Jacobs:

It's certainly potentially a reflection of the organization that we work with, majority of the frustrations and the barriers we hear are with the current system in particular. We hear some conversations around barriers to housing but certainly majority of the feedback that we get in our organization is around the care. So wait times to see a professional, certainly from a psychiatrist or a psychologist is about 18 months. And the feedback often is if I need care right now, I may not be alive in 18 months. So 18 months isn't really sufficient.

From a short term perspective, waiting eight hours in an emergency room, only to be told that you have to get a taxi to a different hospital, is not

sufficient. Being in an emergency room where the care you receive depends on what type of service support you have. So, for example, if there is a CHANNAL support with you, the service is quite more adequate than if you come alone. That's not sufficient. So, certainly challenges in the system in terms of that.

Broader being access in rural areas. So we certainly have some challenges here in the St. John's region where wait times are very long. There is regions in our province in Newfoundland and Labrador where services simply don't exist. We had a conversation recently, actually, around access to services, if services are available. Certainly services are available and whether or not they are accessible are two different conversations. And as I alluded to a couple of years ago in a presentation with Eastern Health, if you have 28 programs, that's great, and I think the 28 programs that Eastern Health runs are fabulous programs but if my first experience with your health care, with your hospital, I was faced with stigma, discrimination, judgment, I will not access any of your other 28 programs. Okay.

So, again, it's that barrier of how do we get past the stigma. How do we move forward in accessing services, if the individual I'm meeting front and centre is not recognizing me as a human and recognizing my rights to dignity?

Unidentified Female:

Has that changed, do you think?

Paula Corcoran-Jacobs:

The question is: Has that changed a bit. Certainly, I've been working with the recovery model for about three years now and antidotally we have had people come back to the organization and say I'm not really sure how but things feels different. We're not really able to put our finger on it to say this one thing has changed, but it feels different. And for me that's evidence for me to have somebody walk out of a psychiatric unit or hospital and say that felt better than the last time. Then that's solid evidence for me.

Honourable Steve Kent:

Paula, thank you.

Paula Corcoran-Jacobs:

Thanks for having me.

Honourable Steve Kent:

I'm sure. Thank you. Our next presenter is Trudy Bradbury who is a citizen of eastern region.

Trudy Bradbury:

Mount Pearl. Born in St. John's. My name is, as you know, Trudy Seymour Bradbury and I am a retired nurse. And I am an advocate for mental health. As we all know, one in five people suffer from some type of mental illness. Almost five percent suffer from depression and there may, it may be even a higher number of people suffering from mental illness because a lot of people suffer in silence. I myself suffer from unipolar depression which is simply depression. Okay? I want everybody in this room to know to be assured that there is research being done to alleviate the suffering caused by mental illness and there is a lot of suffering out there. If we

ourselves are not suffering, then someone we love is suffering.

We're now going to show you a four-minute interview given by Dr. Jonathan Downar, a neuroscientist and psychiatrist at the Toronto Western Hospital. Dr. Downer gave this interview to the Globe and Mail in 2014. He highlights a groundbreaking procedure. It's called rTMS or repetitive transcranial magnetic stimulation. That is currently being researched as a tool to combat depression and as research continues other conditions linked with depression such as anxiety panic disorder. Anyway, I guess we'll pass the floor to who should put on the video.

Honourable Steve Kent:

Yeah, just one moment.

(Video playing)

Trudy Bradbury:

I'm just wondering was that clear? Could you hear what he was saying?

Honourable Steve Kent:

We'll get the link so that we can watch it again as a Committee.

Trudy Bradbury:

Yeah. Are there any questions that I can answer for you to the best of my ability concerning this procedure?

Unidentified Female:

How did you get hooked up with this? How did you find out about it?

Trudy Bradbury:

Well, okay, as a nurse I've seen a lot of depression in my practice. I did not work in psychiatry as such but I certainly saw a lot of depression. And not only that, I myself had an experience with depression, unipolar depression. And so I have felt depression is what I would call bitter bite. I started to research what was, during a depressive episode, I started to research myself what was available or what was becoming available in the world and I, with some help of a medical psychiatrist, I managed to get the name of one of the key psychiatrists in Canada who then gave me Dr. Downar's address and he so kindly e-mailed me back and has kept in touch with me ever since.

Dr. Downar has, well, I should say CBC, I have

asked Chris O'Neil Yates to do an interview with Dr. Downar who he has accepted and hopefully we will get this interview down the road and on CBC. I hope.

The thing about this is that I'm not an expert, okay, but I'm giving you what I know. Okay. Two-thirds of the people respond to treatment for depression. One-third have difficulty, a lot of difficulty. And this procedure is aimed at the one-third that are what they call treatment resistant, okay. And there has been some research done on RTMS for a while now but they are coming up with better and better ways of researching this. And the machine itself now they have had found with the developments, the technological changes, that if they give 28, approximately 26 to 28 sessions once a day this will, after 28 sessions, 50 percent of the people remit, up to 50%. And as a matter of fact, 30 to 35% of the patients fully remit. At the same time, this does not mean you're cured. And I say that when I think that often medications are certainly effective for many people but not for everybody and sometimes they start to lose their effect over time. So, according to Dr. Downar this,

what you would require is a booster shot every eight or so months. But instead of the body saying hmm, I found out how to deal with you, machine, so I'm going to get harder on you. Actually, the depression times, the intervals of depression actually lengthen out and you required less, according to what Dr. Downar has told me and in his e-mails.

I, myself, have been, I guess once I retired I felt I had to do something to try to help people suffering in this area. I no longer have to worry about my family and my children. They're all raised and hubby is doing his own thing and so now is the time to reach out and try to help. And I think together we can help each other as we educate each other because education is paramount.

This treatment is expensive and Dr. Downar last informed me that they're trying to bring down the cost so that it can be readily available in all hospitals in Canada.

I guess that's about all I can tell you for now. Yes, but what else can I help you.

Gerry Rogers(?):

I couldn't quite get from the interview there but is the treatment being used in any hospitals in Ontario?

Trudy Bradbury:

This treatment is being used, to my knowledge, at the west, I'll just check here, one of the hospitals where he does his research. And I understand, now this is my understanding, that there was a large, large sum of money given by somebody, donated by somebody who had a child suffering from a psychiatric condition. So they built a state-of-the-art facility. And I think up to the time Dr. Downar, one of the last few times I was talking to him, he mentioned that I think 300 people had gone through this facility and received rTMS. And these are the people that who are the worst. If I say the worst cases, I mean the most troubled with depression. The people that are not responding to medication and psychotherapy. So, and they are having excellent results.

It just seems that I think it's time that we looked at this. It's going to be, like I say, he is trying, they are, the researchers are trying to get

the cost down and it would involve training a psychiatrist and, I guess, support staff. But the treatment is out there and it's in the UK, I know in London. And I understand, and I stand to be corrected, that there are 500 transcranial magnetic stimulators in the United States. Now, I'm not sure what the levels or how refined these rTMS machines are but they're being improved on every day and Dr. Downar enlightened, well, I think he made a great analogy when he said, for instance, depression is actually an arrhythmia or irregular pulsations, just like the heart. And until we start to see it as a physiological condition, in my opinion, which it is, and it causes all kinds of emotional distress, then we're going to fall behind. We have to keep up from the research and supporting each other and letting each other know what's available.

Honourable Steve Kent:

Well, Trudy, thank you so much for sharing that with us.

Trudy Bradbury:

You're very welcome.

Honourable Steve Kent:

Really appreciate it.

Trudy Bradbury:

Thank you.

Honourable Steve Kent:

Our next presenter is Bob Ryan. Mr. Ryan? And folks, thank for your patience. I know we're overtime. We had a couple of late additions. So, Mr. Ryan, welcome. I'd ask that you keep it to about 15 minutes.

Bob Ryan:

Yeah, that'll do me in. Thank you. I'm going to start off with a couple of references that Roy Bleakley (phonetic) touched upon earlier. Alexander Solzhenitsyn, he wrote a book called The Gulag Archipelago. He got the Nobel Prize for literature for writing it. It was about his time spent --

Unidentified Female:

Bob, can you pull that mike a little closer to you, sir?

Bob Ryan:

I'm talking about Alexander Solzhenitsyn who wrote

The Gulag Archipelago. He wrote a book about the time that he'd spent in the soviet prisons in the far north. A place that was only accessible about six months of the year, otherwise you had to fly in and fly out, and it was there that the soviet regime mixed the most dangerous criminals, mass murderers, rapists, mixed them with political dissenters and people with mental disabilities. And in writing the book, Solzhenitsyn stated that the reason that the soviet regime put these people there was so that nobody could hear the screams. This comment resonates with me. It says if today nobody can hear the screams, earlier somebody made a reference to Nazis and marching people off on the train. The first 300,000 of the 11 million that Hitler executed were children with mental disabilities. In (inaudible), Hitler wrote about his admiration for American psychiatrists who had called for the sterilization of people with mental disabilities. This went on in the U.S. in the '20s and resulted in a major U.S. Supreme Court decision called *Buck V. Bell* where the U.S. Supreme Court approved mass sterilization of persons with mental disabilities.

So this is sort of some of the early background. We can't just point at Nazis and the soviet regime. It was people from North America who preceded them. So, we all have the ability to miss the boat and to listen to so-called experts who will lead us astray.

My aunt had two lobotomies performed on her at the Waterford Hospital. Not one but two. It destroyed her life.

Does anybody here know what sanism is? Sanism, s-a-n-i-s-m, sanism. Sanism is a behavior like sexism and racism. It's the way in which society treats persons with mental disabilities. It's been written about by Michael L. Perlin, a law professor at New York University whose written over 200 articles on sanism, and these are peer reviewed articles.

Sanism, basically, is about negative stereotyping pretext, pretextuality, victimization and re-victimization, negative bias and fear mongering. And sanism is what leads to stigma and that stigma can be either internal or external and often is both.

So a person feels bad about themselves because the way other people are mistreating them, and the fact that other people are mistreating them, it's the circle.

What can we do about this stuff? What we've said that the education system is based upon the three RRRs, reading, writing and arithmetic, and we wonder why today we see children behave the way they do, then young adults the way they do and significant numbers of adults behaving the way they do and it is not acceptable behavior in a modern society. Well, for a lot of families to pay the rent, if you're working at a minimum age requires both people be working at the minimum wage. If you own a house, both parents, in most cases, have to be working. So children, to a large degree, and, of course, women, as has been the history, end up performing nine or ten different jobs simultaneously. Children under those circumstances are going to be lost, unless we change the education system. If we don't introduce into the education system what, in my view, is the most important R, that R being respect. If we don't start teaching children about respect at kindergarten

and every grade after kindergarten till they finish high school, and every time somebody wants to get an undergraduate degree they have to have taken courses that deal with respect. Memorial University, our university, our place of higher learning, it doesn't have a single course that's offered every semester in human rights. Few, if any courses are offered in constitutional law.

What about respect? The people to my left here have all sworn on a Bible to uphold the constitution of this country, the highest law in the country. And that constitution is based upon what's known as democratic and constitutional values and we've heard people talk about how those values have been systemically ignored here today. And I don't think people consciously ignore them. But when you take away somebody's dignity, that's a constitutional value you've wiped out of them. When you take away their autonomy, whether it's personal or medical autonomy, their right to decide who's going to treat them, when they're going to be treated; when their employer tells them that in order to remain employed they must subject themselves to blood testing to make

sure they were taking their medications. Now I dealt with a case involving that, where the man shrink got on the witness stand and testified that there was no evidence this man has ever failed to take his medication. All the blood tests that the guy had carried out when his doctor asked him indicated that he was in the normal therapeutic range for his medications, but he still got ill. And this is one of the problems, one of the problems and it's a part of sanism is this negative stereotyping. It's the assumption that people who are labelled with mental disabilities, and whether we're talking about depression or bipolar disorder, schizophrenic, schizophrenia or a host of others, they're going to get sick even when they're taking their medication. And in fact it's the medication in some cases, long term use that can make them ill.

Women who are diagnosed with schizophrenia are frequently prescribed Olanzapine, a so-called atypical neuroleptic, otherwise known as Zyprexa, same drug. Average weight gain for women taking this drug, 60 pounds. That's average. Wow. We have all kinds of problems. We have problems of people, their

dignity is not respected. Their privacy is not respected. Their autonomy is not respected. Their reputation is not respected. Their psychological integrity is frequently lost as a result as a result of these other values.

What about the drugs, the miracle drugs that are produced by the pharmaceutical companies which medicine today seems to be pushing and pushing and pushing? What about these drugs? Well, I spent a lot of time looking at this. And I would urge anybody who's really interested to study in this stuff to read Richard Whittaker's Mad to America or Michael Perlin's Mental Disability on Trial, two wonderful books. There are lots more out there.

The drugs that people are prescribed to have bipolar disorder and who are diagnosed with schizophrenia frequently are these atypical neuroleptics. Very rarely is the dosage reduced or are people titrated down to get off them. Very rarely. People are on them for life. And what do these drugs do? Why they do the same thing that used to happen when they used to stick a spike between

your eyes and split your brain open. Well, your problem is no longer a mental disability that they can label. Now you're in a vegetative state. We have extrapyramidal effects that occur as a result of it. And if you want to see some of those people with trembling hands, their ability to walk, their gait is altered. They can't swing their arms. They've forgotten how to walk. Their brain has slowed down so much they can't do these things.

Now, there's got to be better ways to deal with people. The medical approach hasn't worked for the last 50 or 60 years. I would urge people to have a look at this. I would urge people who are really interested in the care of their loved ones to have a look at what goes on inside our own health care system and the role played by pharmaceutical companies. We are creating for the short term maybe some savings, people aren't hospitalized. For the long term, we have people whose lives and brains are being destroyed. And in 15, 20, 25, 30, 35 years who's going to look after those people? So, I would urge us to look at seriously changing our education system all the way through academia, whether it's

trades school or whatever, if you want to get something that says you have this degree, then you should be studying something that year with regards to respect, ethics and these values that I've talked about. That will change the way society thinks, it will change the way society acts and it will improve society in my view.

What about the hospital? What happens at the Waterford Hospital? I mean people don't go into the Waterford Hospital for a vacation. It's not a spa. They land there because they are in a mental health crisis and some doctor puts in front of these patients a form where they're supposed to sign this form and give their informed consent for this doctor to do whatever they want. So I'm going to ask my esteemed friends on my left here if they have any idea what actually goes on at the Waterford? How often they've ever made a surprise visit to the Waterford? Do you know how many people are treated with ECT on a daily basis? A weekly basis? A monthly basis? I know there are people in the room here who think that ECT, electroconvulsive therapy, shock treatment is good for the patient. Well,

certainly after they've lost their memory, they don't remember being depressed. I had somebody who'd recently, and I don't mean recently like last week, but at the time a person phoned me up and asked me to meet them on Signal Hill. This person was a journeyman tradesperson and he had a suicide kit on him. He had a mickey of vodka and enough neuroleptics to kill an elephant. He had a plastic, a rubber hose to hook up to his exhaust pipe that he was going to run back inside his pickup and he was going to kill himself. He couldn't remember what he was diagnosed with. He knew he had been given shock therapy. He couldn't remember what trade he had. What we're calling this medicine. Now I guarantee you there is nobody here in this room can tell me how often last week, last month, last year, the last three years or the last five years that process was carried out, but, of course, we have great proponents of that. Recently in the last ten days, there was a report out of the University of Auckland. I believe it is by Dr. John Reid. And Dr. Reid is in the Psychology Department of the University of Auckland. He did a meta-analysis of all the studies in the world that had been produced about ECT. His

conclusion, the various types of amnesia caused by ECT made ECT unacceptable in terms of risk analysis. It's so discouraging. The idea that people, and you hear it all the time, check your meds. Oh, that guy must be off his meds. She's not on her meds. She must be, she's acting strangely. Well that's a negative stereotype. People can be ill for a whole pile of reasons: diet, hunger, not enough sleep because they're stressed out about their family, reaction to the drugs, the very drugs that they're taking.

I've probably run over my 15-minute mark. I could go on for hours here but you people just would not put up with me. Thank you.

Honourable Steve Kent:

Thank you, Mr. Ryan. You've raised some very interesting points for sure. Committee members, questions?

Gerry Rogers:

I'll ask a quick question. I read Mad in America and it kind of blew my mind. So, Bob, I hear your critique of ECT and some pharma stuff. What are some alternatives?

Bob Ryan:

Good question, yeah.

Gerry Rogers:

For people, particularly for people with real deep suffering, what can we do?

Bob Ryan:

Well, there are other changes that need to take place. The single biggest prescription that people with mental disabilities need is love. Next to that, they need a job that pays a decent amount of money. They need to feel like they're included in society. That they're contributing, that we're contributing. I don't say they. It is not us and them, it's us, right. That we're all contributing members of society.

The medical model has not worked. It doesn't take an Einstein to owe that continuing to repeat the same things that doesn't work isn't going to change a lot. So we do need to move off the medical model.

In the Waterford Hospital, I visited a patient there one time when he was one of seven people sleeping in the same room. I don't know how many

people sitting here have read the Luther report and the recommendations that were made in that very expensive judicial inquiry. I would suggest people read it. The reference to A-C-T Teams, ACT Teams, Assertive Community Treatment Teams. Does anybody here know in any area of Newfoundland, particularly like say St. John's, how many people are on ACT Teams and how many clients they have? Because that's what people are called, they're clients. I'm not crazy about the word but it took me ten years to get somebody even to be able to participate in the ACT Team, and after that I just went, did I really do that?

We have a system here that is so flawed it's scary. We have lawyers who are experts in constitutional law. They know how to apply the Charter of Rights and Freedoms to people who are charged with criminal activities. When it comes to civil law, which impacts a thousand times more people than the criminal law, he spent three years in law school and what do you get? Do you get a couple of months studying mental disability law? So if you really want to understand how the law affects your

average every day citizen, you need to understand mental disability law. What the heck is that says somebody? Why, that's something that's only taught in three of 19 law schools in Canada and there it's not a mandatory course, it's only a course for people who are taking postgraduate studies and want to get a diploma in health law so they can make money from insurance companies. And under that, taking a course in mental disability law at Dalhousie or the University of Toronto, I believe it is, and the University of Alberta, they are strictly optional. Yet, we have lawyers who are representing people at the Human Rights Commission, who are citing cases from the early '80s, when there's law, modern law from the Supreme Court of Canada. These people, look, sorry, I really like lawyers. I don't mean to be too cynical about this, it's the system. The system is broken and everybody has turned a blind eye to it and I know you asked me a question, Minister Kent, and I'm sorry but I went off on a tangent. Sorry.

Honourable Steve Kent:

Bob, thank you very much. I appreciate it.

Unidentified Female:

(Inaudible).

Honourable Steve Kent:

Very quickly because we're about to conclude.

Unidentified Female:

Okay. So, do you think that if we were to actually bring it back to actual (inaudible) that we come from the same page that we would be able to take (inaudible) and all things that have been in place and just start doing it right away, do you think that that is possible? Because instead of having all this particular committee (inaudible), don't you think it makes more sense if we start with people that are on welfare in Newfoundland and Labrador (inaudible) with a mental health issue, we create a mental health program where you can (inaudible), it wouldn't cost them any extra money, but we would be able to streamline things right back to the kitchen table because there is a lot more (inaudible) pharmaceutical supplies. And I'm wondering whether or not (inaudible) addicted to it, if we should not try to reduce that particular (inaudible) a program through Addictions and Health and Community Services. Do you think something like that could start by

(inaudible) commonsense?

Bob Ryan:

No, I don't but I think there is room for all kinds of input, and the reason I say no to you is I want to make sure nobody here leaves with the idea of going out of here and saying to somebody, stop taking your meds. Or people will get immediately very, very, very ill. In order for somebody to come off these psychotropics, it takes a long period of time to titrate yourself down or you'll get very, very ill.

In terms of what you're suggesting there, there are all kinds of options, not excluding the one that you're presenting. Right. But there needs to be much more input in terms of how people are going to be treated in the community. And I've been involved before in hiring processes. I once went out and when General Motors said well, we don't have any women working here. I said to him, we don't have any women working here. We made him hire two women for every man. Then they said well, women aren't applying here. I said why would they apply when you don't hire them? Well, what do you propose to do to change it? I said, well, give me 30 applications and I will

go out and I'll make sure they get taken care of. And I went out and I made sure that 30 women who were single parents on welfare got those applications and a whole bunch of them got jobs at GM. There is all kinds of ways of doing things.

Unidentified Female:

But if you (inaudible).

Bob Ryan:

Of course you can.

Unidentified Female:

(Inaudible) mental health.

Bob Ryan:

Of course you can.

Unidentified Female:

(Inaudible).

Honourable Steve Kent:

So, folks, I want to thank you very much for your participation today and for listening. This has been extremely valuable, extremely informative. I know my colleagues agree. And this is only the beginning. We're going to have another session like this on June 5th. If anybody would like to come either to schedule to present or to just come and listen, we'd love to have you back. And there's going to be

another public dialogue session as well that we'd invite you to participate in. You can get in touch with us by e-mail, by phone. We have a website with lots of information which will include presentations we received as well. So, again, thanks so much for being here this afternoon.

We also have food at the back and I believe there are some containers if anybody would like to take anything with them, they can feel free to do so, so it doesn't go to waste. Folks, thank you very much and enjoy your weekend. Thank you.

(Hearings conclude for the day)