

1 **June 5, 2015**

2
3 Honourable Steve Kent:

4 Good morning. Welcome. If I could have everybody's
5 attention. If you haven't yet found a place to sit,
6 I think we have combined a few tables. We'd like
7 everybody who's going to participate in the session
8 to find a place. And if you could that, that would
9 be great.

10
11 My name is Steve Kent. I am the Chair of our
12 All-Party Committee on Mental Health and Addictions.
13 We have a number of other committee members with us
14 today and there will be more joining us as the day
15 goes on. But we do have all parties represented. I
16 would like to introduce from the Liberal Party, the
17 official opposition, Mr. Andrew Parsons, who's down
18 in the middle, and Gerry Rogers from the NDP is down
19 at the back; getting coffee, I think. So, Tracey
20 Perry, Tracey Perry from the Progressive Conservative
21 Party will be joining us, as well, in a bit, and you
22 may see other members as the day goes on as well.

23
24 So I would want to welcome you on behalf of the

1 Committee to our third set of public consultations.
2 And we've had sessions in Corner Brook. We've had
3 other sessions here in St. John's. We're going to be
4 having more sessions here in St. John's and in other
5 places in the province. The Committee is off to
6 Labrador on Monday. We've heard lots of viewpoints
7 and perspectives and there's lots of interest so far.
8 And I want to thank all of you for your participation
9 and for your interest, because this is an important
10 topic. As I look around the room, I see lots of
11 familiar faces. I know we have many busy people in
12 the room, so I thank you for taking time out of your
13 schedule to be with us.

14
15 This Committee came about through a private
16 Member's motion in the House of Assembly that was
17 unanimously supported. And I can tell you that all
18 parties, all Members of the House of Assembly are
19 very much committed to this process. So we're doing
20 a series of dialogue sessions, like this one, where
21 we get a chance in an organized way to interact and
22 make sure everybody has their say. We're doing lots
23 of public presentations. So this afternoon there's
24 going to be 11 presenters who will speak to the

1 Committee, and we're going to do another day of that.
2 So if you want to present and you're not scheduled
3 today, you can sign up with the contact information
4 that's on the screen and still have a chance to give
5 a presentation as well.

6
7 We're going to be doing private meetings. If
8 anybody isn't comfortable with the public format and
9 wants to meet with the Committee privately or needs
10 more time, we're accepting submissions electronically
11 and in writing. We're hearing from experts around
12 the country and around the world. So, it's a pretty
13 extensive process and it's one that we're all pretty
14 passionate about and excited about.

15
16 So, I'm going to, in a moment, introduce our
17 facilitator for today but I will just finish by
18 saying we are all here with a common goal. We want
19 to see improvements in the province's mental health
20 an addictions system, and we want to make sure we're
21 providing the best care and the best services
22 possible. And already, there's some real themes
23 emerging in our consultation that I'm sure will help
24 us come up with some really good recommendations to

1 bring back to the House of Assembly this fall.

2
3 So, Andrew and Gerry and I are going to be
4 rotating from your tables this morning, and Tracey,
5 when she joins us, will probably do the same. So
6 you'll get a chance to get some time with at least
7 one of us during the course of your discussion this
8 morning.

9
10 I want to thank the folks that are here from
11 Health and Community Services and the Office of
12 Public Engagement and Eastern Health who are helping
13 facilitate the discussions and take notes.
14 Everything will be recorded and captured and all of
15 it is going to be put on the web and made public so
16 that there's full transparency on what we're hearing
17 and learning at these consultations.

18
19 So thank you so much for being here. I'm going to
20 go settle in at a table and I would like to introduce
21 Bruce Gilbert who's the Assistant Deputy Minister of
22 the Office of Public Engagement and he'll tell you a
23 little bit more about his role. He's going to be
24 facilitating the session for us this morning. So

1 thank you and enjoy the process. Really glad you can
2 participate with us.

3 Dr. Bruce Gilbert:

4 Thank you, Minister. Okay, I'm Bruce. My role is
5 pretty simple. It's to try and be a bit of a traffic
6 cop to get the session going and to stay out of your
7 hair. My role is pretty minimal actually. You do
8 all the work. Ninety-eight percent of the time is
9 dialogue at your tables. So, we've done this; this
10 is our third time. I think everybody would agree
11 that the first two variants of this were pretty
12 successful, for the reasons that I just described.

13

14 So just a couple of housekeeping things. I think
15 you can find the washrooms. They're out here
16 somewhere, if I'm not mistaken. Feel free to get up
17 whenever you want - down that way says Jay - feel
18 free to get up and grab yourself a coffee. There
19 won't be formal breaks per se. You can just go and
20 get it when you want.

21

22 On every table there 's a privacy notice. I just
23 want you to sort of, your facilitator can draw your
24 attention to that. Have a glance at that time but I

1 will just say a couple of things about it. There
2 will be somebody from the Government of Newfoundland
3 and Labrador, one of our people, taking photos. If
4 you do not want to accidentally end up in a photo, a
5 wide shot, a crowd shot, please identify yourself to
6 your facilitator and facilitators let Kip or Jay know
7 and we'll do our best not to take any photos. I mean
8 we're going to be taking photos all the time, but you
9 just may end up in a photo. That's one thing.

10
11 It is possible that media could roll through here.
12 Don't worry about that. They're not going to be
13 going around with audio or videotaping at your
14 discussion tables. They'll be doing wide shots and
15 stuff like that. So, just if you're concerned about
16 being captured on, your voice or something like that.

17
18 Yeah, use your discretion to the best of your
19 ability at your table when you're telling your story
20 or talking about issues. What I mean by that is
21 we're going to go capture all the data from each
22 table and we will make sure that if you accidentally
23 mention somebody's name, you mention the name of a
24 friend who had an experience, we're going to take

1 that name out of the summary of the table
2 discussions. We'll do our best but please help with
3 that. Just use discretion when telling, sharing your
4 insights and stories. We'll still be a second check
5 on that. We don't want personal information
6 inadvertently in either. So, that's that.

7
8 You have a recorder at every table and a
9 facilitator or what we're calling a host. Some of
10 you have an All-Party Committee Member as a host,
11 some of you have a staff person from Health and
12 Community Services. They will rotate somewhere
13 through the day so that you can mix that up a little
14 bit. The recorder's job is to try to capture the key
15 points in your words of what you're saying, without
16 your name attached. There'll be no comment with a
17 name. They don't know your names, although you do
18 have name tags, but just so you know that that's not
19 the intent. The intent is to grab the data and to
20 have it all available so the Committee Members can
21 look at all the things that were said here, compare
22 it to all the things that were said at the earlier
23 St. John's session and the next session, and the
24 Corner Brook session and the Happy Valley-Goose Bay

1 session and the Lab West session and so on and so
2 forth. That's the premise of that.

3
4 The discussion is largely wide open. We're not
5 boxing you in with highly focused tight questions.
6 They're all open ended. There's basically four
7 rounds or four cycles. Put it this way, I'm going to
8 interrupt you four times in your morning and to tell
9 you that I'd like you to move gently into the next
10 topic. So that's my role. And I think that's it.
11 So we can get going.

12
13 Oh, could the recorders just identify themselves?
14 Just stand up or wave your hands. There's the
15 recorders. And the hosts or the facilitators. We've
16 seen the All-Party Committee Members. But just so
17 you know who you're dealing with. There they are.
18 Okay. So we're good to go.

19
20 So, the first question that you are being asked to
21 consider and deliberate at your table around or on is
22 this. Well, it's actually not a question, it's an
23 instruction. Please share your perspectives or
24 experiences with the regional local provincial mental

1 health and addictions care system. Tell your
2 colleagues at the table a little bit about your
3 experiences. How are you intersecting with this
4 topic? Which another way of putting that is why are
5 you here? And if you haven't already introduced
6 yourself in terms of where you're from or your name,
7 you can do that the same time.

8

9 You've got about 30 minutes to do that and I will
10 check in when you're getting closer to the end.

11 Thank you. Take it away.

12 (Thirty-minute break for group discussion).

13 This is the report back from the end of the round table
14 discussions.

15 Honourable Steve Kent:

16 Hi, folks. It's really tough to do this in a couple
17 of minutes. And I think I get to go first to try and
18 set the pace and set the example for the others. So,
19 it's going to be at lightening speed and the idea is
20 that each of us is just going to capture some of
21 things we heard. Not all of it but just some of the
22 big things we heard that resonated.

23

24 So I was at two different tables. Talked a lot

1 about the need for more resources in a whole bunch of
2 places. More resources for methadone treatment, more
3 behavioral specialists, more psychiatrists, more
4 psychologists in order to reduce wait times.

5
6 We talked about housing a lot, supportive housing
7 and the need for wraparound supports to ensure that
8 people stay in housing.

9
10 We talked about post-abortion syndrome; talked
11 about the need for a 211 triage for your life
12 service. We talked about funding for different
13 programs like the U-Turn Centre in Conception Bay
14 North; the need for the replacement of the Waterford;
15 wait times.

16
17 Some interesting things that I heard at my second
18 table related to harm reduction in recovery. You
19 can't -- somebody battling addiction can't go have a
20 cigarette if they're at the Recovery Centre. And the
21 impact, the negative impact that that has from a harm
22 reduction perspective is a big deal. So, and it's
23 because of Regional Health authority policy. So,
24 that's something needs to be looked at.

1 You can't get into Humberwood if you're on
2 Ritalin. And I'm just throwing out a couple of
3 examples to show how there may be some policy changes
4 that are needed in order to solve some real problems
5 that really are big issues from a harm reduction
6 perspective and from a recovery perspective.

7
8 There is a need for an inpatient treatment
9 facility for eating disorders in the province. And
10 the transition when young people turn 18, they're
11 receiving services and then all of a sudden they end
12 up back on wait lists for other services. Like makes
13 no sense and needs to be changed.

14
15 Talked a lot about aftercare and the importance of
16 aftercare. Talked about the need for greater
17 emphasis in the system on lived experience; the need
18 for a radical shift in how services are delivered and
19 grounding them more in community; the importance of
20 the recovery approach and that that may need to be a
21 mandated system wide change, if it's going to really
22 happen. Heard a story of a young person being
23 transported from the Health Sciences Centre to the
24 Waterford just in the past week in a police car;

1 probably unnecessarily. Almost definitely
2 unnecessarily.

3
4 So, another issue that came up again today that
5 we've heard a lot about is what happens to parental
6 rights when a young person turns 18. So the people
7 that have been the biggest support, the biggest
8 advocates, the biggest champion for these young
9 people, because they turned 16 and then turn 18,
10 parental rights go out the window and that creates a
11 whole bunch other issues as well.

12
13 So, there is some really big issues that we talked
14 about that we need to tackle and some stuff that can
15 probably be fixed fairly easily, at least it seems on
16 the surface. So, that's the very, very quick summary
17 and I think that was about two minutes. Thanks.

18 Dr. Bruce Gilbert:

19 That really was two minutes. That was excellent.
20 Okay, Gerry Rogers, would you like to come up next?
21 The floor is yours.

22 Gerry Rogers:

23 Sorry about that. We were still so engrossed with
24 one another. I just want to say how fantastic it is

1 to be here and how wonderful to hear from everyone.
2 One of the issues that people talked about at our
3 table is the need for primary health care clinics
4 where there is a doctor, where there is a nurse
5 practitioner, where there is a social worker, where
6 there is a counselor. Not necessarily that you have
7 to have a full-time psychiatrist there but
8 counsellors so that you're not constantly trying to
9 navigate the system and trying to get into this
10 service or that service.

11
12 One quote that I think will be resounding, at
13 least for me, and I think we'll be able to keep
14 repeating is that "mental health and addictions don't
15 wait list well." And we talked a lot about that at
16 our table.

17
18 Some of the other issues we talked about is
19 accessibility and inclusion; that our services aren't
20 necessarily wheelchair accessible or accessible with
21 people with hearing impairments. And somebody said,
22 for instance during the blackout there was no GoBus
23 service. So people in wheelchairs couldn't even go
24 to warming stations, if they needed them.

1 The housing first model, how important that is but
2 it's not just about the roof over your head. It is
3 about the wraparound services, the support services.
4 And sometimes the support services are, for instance,
5 someone who will help you navigate the system. If
6 you need repairs done or if you have a history of
7 chronic depression then it's somebody who helps set
8 you goals because you may end up with your curtains
9 closed for a week at a time and not getting out of
10 bed. So this person will come and say okay, let's
11 set some goals. Tomorrow we're going to open the
12 curtains and you're going to go for a short walk or a
13 short roll. So those kind of services that the
14 support services can do. It is not like a big
15 psychiatric intervention and it is about hey, you
16 have an appointment Wednesday with such and such, so
17 and so, how are you going to get there? Do you have
18 what you need to get there? Do you need a wake-up
19 call, that kind of thing.

20
21 Francophone supports. Imagine if French is your
22 first language? Maybe you can get by in English.
23 You're in a crisis situation, you go to the hospital.
24 The translation services are available, for instance,

1 at Health Sciences but only during the regular
2 daytime hours. Then it's the doctor who decides
3 whether or not you get translation services, if
4 they'll call somebody in. And so you're having a
5 crisis. It's very, very frustrating trying to be
6 understood and heard in a language that's not your
7 first language. It escalates for you.

8
9 So there are no French signs in our medical
10 facilities, except there's a few in some places,
11 there's spelling mistakes in them, but predominantly
12 the French signage in our health care facilities are
13 simply ones that tell you, you can't smoke. So there
14 needs to be easier access and more support services
15 for our Francophone population.

16
17 Navigators. Navigators to help you go through the
18 system. People who are talking about their own
19 experience of trying to figure out, okay, who do I
20 see next. If you have a referral to the START clinic
21 and they're saying it's going to be a few months but
22 what do you do in the meantime? And then how do you
23 get, you haven't heard from the START clinic for a
24 month. Now what? Now what do you do? So how do you

1 get there?

2

3 And a navigator would be also the kind of person
4 that says hey, Suzie, you've got an appointment with
5 doctor so and so on Wednesday, May whatever. Do you
6 have a way of getting there? Do you need a wake-up
7 call, that kind of thing. So that people aren't
8 missing their appointments. And if you're really not
9 well it's so hard.

10

11 A warm place to be. There used to be a crisis
12 centre that accompanied the Crisis Line here at St.
13 Clare's and it was a place where you could go. You
14 don't need to go, for somebody who doesn't need to go
15 to the Waterford, who doesn't need to go to an ER but
16 needs a place to go. Where you can go, you have a
17 cup of coffee. You're experiencing extreme anxiety,
18 they can help talk yo down. Maybe you spend a night.
19 There are some beds there. So we needs those kinds
20 of barrier-free walk-in places that aren't high
21 medical interventions but a place where somebody can
22 help you get grounded because like, oh, you've had
23 nightmares for three nights in a row. You can't
24 sleep. Your only option is to go to the emergency

1 and that's really not what you need. We need
2 barrier-free clinics.

3
4 The Women's Centre, for instance, is starting a
5 walk-in, a free walk-in, barrier-free counseling
6 service two days a week. We need that kind of thing,
7 again, to help people cope with what aren't massive
8 crisis but it's like preventative medicine. If you
9 got diabetes, you don't wait until you're in kidney
10 failure before you get help. So it's kind of
11 informal supports but educated supports, because
12 nighttimes and weekends can be the worst. You don't
13 need emergency, you don't need the short term stay.
14 You need somebody to help you get grounded, help get
15 your breath so that you can get on.

16
17 Barrier-free shelters. We have no barrier-free
18 shelters and that means people who are using, if
19 they're using they can't go to a shelter. There is
20 no shelter in the province where they can go. And
21 dental services, really hard, hard. If you're on
22 income support, you have no money to be able to take
23 care of yourself. It's been increased a bit but it
24 is only \$300. So, if you're in prison or if you're

1 in the Waterford and a psychiatrist writes you a
2 prescription for more dental work you can get it, but
3 if you're not in those services you're kind of **shit**
4 out of luck. The emergency rooms get bogged down
5 with people who don't need to be there but who do
6 need help.

7
8 And my last, my last point, I know Bruce is
9 pushing me out of here, is there have been identified
10 problems with the Adult Central Intake in that I know
11 it is a new service but for some people it's causing
12 increased anxiety because you call the Adult Central
13 Intake, they ask you a whole bunch of questions which
14 they need to do in order to be able to direct you to
15 services, but then somebody else calls you and asks
16 you the same questions and then somebody else. That
17 in fact there's a real problem with it. Maybe
18 there's just some bugs that need to be worked out but
19 I think it's something that we need to listen to what
20 people are saying are some of the problems and see
21 are there some solutions to it, because I know that
22 some people were kind of really excited about it.
23 Maybe there is something to be done there. Thanks.

24

1 Dr. Bruce Gilbert:

2 Thank you very much, Gerry. I actually had something
3 in my throat. I wasn't actually I'm going to
4 invite Mr. Parsons up but I'm going to read a few of
5 these out. These are great. They're all going to be
6 typed up and put online:

7

- 8 1. Include people with experience with mental health
9 issues in consultations and planning.
- 10 2. The need for mental health services doesn't end at
11 4 p.m.
- 12 3. More resources for children and youth with autism
13 and behavioral issues.
- 14 4. Share the responsibility online collaborative
15 research document.
- 16 5. **Il serait important de s'assurer qu'il y ait des**
17 **services disponibles aussi en français ou**
18 **bilngues. Dans une situation de crise, le language**
19 **deviant très important. [Translation: It would be**
20 **important to ensure that there are services**
21 **offered in French or bilingually. In a crisis**
22 **situation language becomes very important.]**
- 23 6. Health is also a question of language.
- 24 7. Mental Health and Addictions need a case manager

1 to help them navigate the system. Someone to
2 follow them through the system start to finish.

3

4 Mr. Parsons?

5 Andrew Parsons:

6 Hi, everybody. I'll try my best to be quick. I just
7 want to say a big thank you. I had two tables, so I
8 will try my best not to miss anything. I did two
9 questions at one and two questions at another, but
10 both tables were excellent and really shared. It was
11 great.

12

13 We had lived experience, we had advocacy, we have
14 people within the system. So you really got the full
15 gamut there. Working well. People talked about just
16 the attention that's being paid and when you talk
17 about the Committee itself. And the commercials were
18 specifically brought up. People really like that.
19 So this is all going where we need it to, in terms of
20 trying to reduce stigma.

21

22 The crisis line was specifically brought up. It's
23 something that's working well and the mobile team is
24 working well. So it is great to hear that. There is

1 the interpretation system that is specifically
2 brought up, I believe. I may get that confused but
3 hopefully our note taker caught that.

4
5 People talked about the staff that they deal with
6 directly and the staff are really great. There is a
7 lot of people that go above and beyond. So we need
8 more of that. It was great to hear that.

9
10 In terms of the improvements, sometimes there's --
11 we got some concrete ones but some of them are so
12 much bigger. And the two things that really stood
13 out: Waterford and housing; Waterford and housing.
14 And so housing, it is hard to be sometimes concrete
15 but I think what I took out of it was that we
16 actually have to come up with a strategy, a policy,
17 what are we going to do because if you don't have
18 that place to lay your head at night, it is hard to
19 get well. And so, sometimes it is hard to really
20 break that down into those concrete things. There
21 are probably people smarter than me that are going to
22 do that, but that is so huge.

23
24 Community navigator. And again, Gerry and Steve

1 did a great job of bringing up a lot of the same
2 points, but the community navigator was brought up
3 and it is a great thing to look at.
4

5 Recovery homes, especially when we're talking
6 about addictions, we need those people. We can't
7 just take people when they come in and then put them
8 back out and may back into that cycle. So we really
9 need that recovery. And this is not something that's
10 business hours. This is 24/7. So, again, it is
11 great to see, especially with the Mobile Crisis Team,
12 it used to be five days but we need it seven days.
13 We needed 24 hours. We don't just need an eight to
14 five. We need a Saturday night, one in the morning
15 you need it, and that's why people brought up the
16 crisis line. You got to have someone to talk to.
17

18 We also saw, and I was lucky to sit with people
19 from RIAC, the Refugee and Immigration Advisory
20 Council. So that was another angle that I probably
21 wasn't aware of before, when people are coming here
22 and they need access to those community supports.
23

24 And I guess this is sort of a case of what else

1 would you share, what would you do. People
2 specifically brought up the community supports that
3 are out there doing a great job. We need to find a
4 way to expand their role and help them in what they
5 do. Whether it's CHANNAL, whether it's the Salvation
6 Arm whether it's, you name it, community groups.
7 Unanimously everywhere I've been, it's positive but
8 we need to increase and expand their role.

9
10 Maybe also within the health system, we need to
11 look at our approach when it comes to doctors and
12 helping other people, like nurses and nursing
13 practitioners and practice to the full extent. It is
14 not increasing the scope, it is practice to the full
15 scope; especially when it comes to primary health
16 care.

17
18 And a big one that we took out of it is we have to
19 get at, especially when it comes to children, we got
20 to get to the education system. We have to get in
21 earlier. We have to make mental health training a
22 priority for health professionals, educational
23 professionals, awareness, education. You can't
24 overstate the importance. So especially when we

1 have, once those kids go to school they're with their
2 teachers within the system. So, that's a big part of
3 their life. We need to make this a big part of that
4 as well. It needs to trickle down, not just from the
5 principals but right down to the teachers. So,
6 whether that's professional development, how we do
7 it. We need to get in between health, Department of
8 Health, Department of Education, get that together.

9
10 And there's a heck of a lot more here but I think
11 one thing I really took out of it is look, this what
12 we're doing now is great but we need to sustain it.
13 We need to keep it going so people like you folks
14 coming out and talking to us, you need, we all need
15 to keep this going because we can't just let it die
16 here at the tables and with the reports. So thank
17 you so much for letting me speak and I'll let Bruce
18 back up.

19 Dr. Bruce Gilbert:

20 Thank you very much. I'm going to invite Colleen
21 Simms up to report on this table and I'll read a few
22 more of these:

23

24

- 1 1. Mental health and addictions don't wait list well.
- 2 2. Go all in, including appropriate funding on
- 3 housing first for people requiring housing
- 4 solutions.
- 5 3. Need a transition house where daily living skills
- 6 are taught so persons can live independently
- 7 eventually.
- 8 4. Ground services in community.
- 9 5. Deconstruct the system.
- 10 6. Needed, inpatient eating disorder facility and so
- 11 on.

12
13 Colleen?

14 Colleen Simms:

15 Thank you, Bruce. First of all, I just want to thank
16 the table that I was sitting at. You are an awesome
17 table. People shared really well and very courageous
18 and got lots of really good concrete actions on how
19 we can improve things. So that's what I'm going to
20 focus on because luckily I'm going forth and so I'm
21 able to build on what everybody else has said
22 because, for the most part, what people have already
23 said was ditto for our table, particularly when it
24 cans to things about needing more recovery focus.

1 What are we going to do about not having a new, a
2 replacement for the Waterford Hospital. And a lot of
3 discussion around stigma and accessing services in
4 the child and youth system; particularly around
5 Janeway Emergency.

6
7 But some of the good things that we heard about
8 and what's working well were things like Western
9 Health's Acute Crisis Unit which at our table was
10 described as awesome because they actually create
11 their own recovery plan there. They do three days of
12 assessments. The environment is nice, warm and
13 welcoming. The unit was incredible and people are
14 focused on what the individual's recovery plan is and
15 everybody is working together there.

16
17 And some goods happening at Janeway, in terms of
18 once you actually access the service, the service is
19 excellent; but again, there were problems with
20 accessing the service. Also some issues with the
21 unit not being accessible for people with physical
22 disabilities.

23
24 Other things that were wonderful were the St.

1 Clare's Day Treatment Program. And looking at other
2 countries, like could we bring over something like
3 what New Zealand has, for example, where they're
4 actually legislating recovery-oriented systems there,
5 as well as a good program going on now at MUN
6 counseling centre called the Stepped Care Approach?
7 But some concrete actions to improve the system. We
8 really need to focus on the good staff that we have.
9 They're burning out. They need more education. They
10 need more support. There are programs out there like
11 the Better Days Program which is a peer support
12 program that really needs to be supported. We have a
13 system of bureaucracy that needs to be changed. We
14 need to -- government is creating mental health
15 problems because of the gaps that we have in social
16 services, because of the gaps we have in health
17 systems. We need to look at Workers Compensation
18 system and we need to look at actions to improve that
19 system. These systems are creating mental health
20 problems for people.

21
22 We need to take care of our veterans. We need to
23 develop an appreciation for what NGOs are doing but
24 at the same time non-profits have to be accountable

1 as well. They have mandates that need to be more
2 inclusive. And there is a bit of unfairness there.
3 We don't want NGOs to be competing for money. Is
4 there a better way that we can look at this and
5 streamline things so that when they are advocating
6 for us, they can have advocate with a freer voice?
7 There is a concern maybe that some groups don't speak
8 up because they're afraid of the funding that they
9 receive from government and it being affected.

10
11 And we don't want our programs to be diagnosis
12 specific and exclusionary. They need to be more
13 inclusionary. So we need to look at services that
14 are based on the needs of a specific targeted area.
15 We got the example of going by postal code. I said,
16 is this like a type of population approach? And it
17 is in a sense, looking at what a population needs and
18 going in there and being able to serve that
19 population.

20
21 More referrals are needed. The community services
22 were very fragmented because we have so many
23 community organizations. Again, that look at
24 streamlining. And I'm not going to talk too much

1 about housing because it's been brought up but it is
2 a huge issue. One thing that did come up at our
3 table was we need to look at the Tenancies Act so
4 that staff who work in the system can have more
5 accountability about going in to places where people
6 are living and helping them maintain some standards.
7 I think I'll stop right there. Thank you.

8 Dr. Bruce Gilbert:

9 Thank you very much, Colleen. Okay, I'm going to
10 give Cameron and Peggy a couple of seconds. Their
11 tables have already been reported on but I want them
12 to, if there is a couple of key points they want to
13 make about what their heard, sure.

14 Cameron:

15 All right. I will try to be really quick because
16 Minister Kent, I think, reported on the tables a
17 little bit. But a couple of the big themes that we
18 heard were around the navigation of services. So
19 understanding what services are out there, how you
20 can access them and how you can go to one place maybe
21 and get access to a bunch of different services that
22 you might need that are kind of intersectoral.

23

24 Both tables, we heard about supporting housing

1 options and housing options that need to meet the
2 needs of an individual that are not standardized or
3 targeted just at families, but that are both
4 supportive and meet the needs of individuals in their
5 own circumstances.

6
7 ... a lot about the continuity of care and this
8 idea that your continuity of care doesn't extend
9 between different services and also again the idea
10 that once you're 18 you're back at square one and
11 having to kind of start over.

12
13 We heard some positive comments around the stigma
14 around mental health starting to get a little bit
15 better and a little bit more awareness around that;
16 but that still personality disorders are kind of a
17 no-go area where there's still a lot of stigma and
18 there is still a lot of stigma around addictions. So
19 where mental health, people have started to embrace
20 that as an area of illness and health addictions is
21 still seen as a real taboo.

22
23 ... a lot about drugs and good drug compliance not
24 being the be all and end all. That supports need to

1 go beyond just pharmaceuticals. And that it's very
2 easy to get a long list of drugs that you need to
3 take but it is hard to find services that can help
4 you either reduce the amount of pharmaceutical drugs
5 you need to take or find other kind of behavioral
6 options.

7
8 And I think a core piece around all of this was
9 that solutions really need to be tailored to people.
10 They can't just be standardized. One of the quotes I
11 heard at the second table was that, I think it is
12 really great, is that there is a right recipe for
13 everyone and we just need to find out what that is
14 and be able to work with individuals to find that
15 right recipe that will help them succeed. Thanks.

16 Dr. Bruce Gilbert:

17 Okay. While Peggy is on her way up, I will read a
18 few of these. These are all really great by the way.
19 I encourage you to go to the website. We'll let you
20 know when they are up and read these.

- 21
22 1. Recovery from mental health and addiction is not
23 rocket science. Let's keep it simple.
24 2. Mental Health and Addictions need more people who

1 are experienced, been there, to be part of the
2 circle of care as paid employees.

3

4 Yeah. So Peggy, come on up.

5 Peggy:

6 Hi. When I came here today I didn't know I was going
7 to be standing up in front of a room full of people,
8 so. I'm just going to try to highlight a few things
9 that weren't already mentioned, because I know we're
10 getting short on time. One of the tables that I was
11 at talked about the human touch, the human element
12 and the gentle touch. That sometimes the first
13 response by first responders, paramedics or police is
14 often a more harsh approach and sometimes just the
15 human gentle touch would go a long way.

16

17 I heard about some really good things that are
18 happening and what does work. Stable housing works;
19 CHANNAL; peer support is important; the nurse
20 practitioner in mental health, in Eastern Health is
21 important; having good case management; outreach at
22 Eastern Health; the Hearing Voices network and
23 Choices for Youth were all mentioned.

24

1 Education was a real big theme at one of the
2 tables. Early education with children, parents,
3 educators in the school system, building it in to
4 their training. Collaboration at the departmental
5 government level. There was a recommendation that
6 there be a central agency similar to the Women's
7 Policy Office that would look at all new legislation
8 from a mental health perspective.

9
10 "Go beyond the overpass" was another comment. And
11 finally, the campaigns are good but, like we've
12 heard, there is still a lot of blaming that sometimes
13 happens and it is not your fault. Thanks.

14 Dr. Bruce Gilbert:

15 Thank you, Peggy. For someone totally unprepared and
16 surprised and caught off guard, I thought that was
17 particularly well done. I'm done. I'd like to
18 invite Minister Steve Kent up here to bring this
19 home. I will just say that you were a very easy
20 group to work with. I was correct, wasn't I? I had
21 very little to do, just let you go. You did it.
22 There is a lot of really interesting data captured
23 here. Jay Lawrence here is working with health to
24 make sure that all of the comments here will be up

1 online. And in fact if you go there now, I encourage
2 you to go and look at what people said in Corner
3 Brook and in the first St. John's session. It is all
4 there verbatim. No changes, no editorializing, no
5 summarizing. All comments are captured in your
6 words. And occasionally, if somebody swore at
7 somebody we kind of blocked that out but we did very
8 little touching of the data. It is all there and so
9 will all of your data be there. Thank you very much.

10 Honourable Steve Kent:

11 The only one anyone swore at was Bruce. So, or there
12 wasn't much of that. I would like to invite Andrew
13 and Gerry to join me up here, if they'd like. My
14 fellow Committee Members that are with us today. I
15 just want to quickly on behalf of my colleagues say
16 thank you for your participation. I want to
17 emphasize on behalf of the Committee that this is
18 just the start of the conversation. There is lots of
19 ways for you to have input. You're all welcome and
20 witness the presentations this afternoon. There is
21 going to be 10 or 11 people presenting to our
22 Committee this afternoon, starting at one o'clock,
23 right here. We're going to reconfigure a little bit
24 but it'll be happening in this room. So you're all

1 welcome for that.

2

3 There will be more consultation days here in St.
4 John's, like this one. There'll be more public
5 presentations like the ones that are going to happen
6 this afternoon. We're going to be meeting with
7 people outside the province to seek their input and
8 expertise. We're going to be doing consultations
9 around the province.

10

11 So, you can also write us, you can e-mail us, you
12 can call us. There may be people in the room who
13 really want a private meeting with us and that's okay
14 too. So all of that could be arranged. Just feel
15 free to get in touch with us. Contact any one of us
16 as well and we'd be happy to have your input. But
17 this is just the beginning of the conversation and we
18 hope we'll be hearing more from you.

19

20 The most disheartening thing I heard today,
21 although I wasn't surprised to hear it, and I
22 appreciated the honesty of those expressing it was,
23 "yeah, this is great but nothing is going to change."
24 Well, I can assure you that the folks standing before

1 you are very serious about, including me, are very
2 serious about changing the system. We wouldn't be
3 doing this, we wouldn't be gathering you all here, we
4 wouldn't be making this effort if we didn't believe
5 that we can change the system. And I really believe
6 we can. Some of it won't happen overnight. Some of
7 it is going to take time and it takes resources and
8 it takes money. Some of it takes a real change of
9 culture and behavior within the system but it can be
10 done. And there's stuff we've identified from our
11 travels already that can probably be done real quick
12 too.

13
14 So, I just ask you to give us the benefit of the
15 doubt. We're going to continue to work hard at this
16 into the summer. We're hoping to come up with a
17 report with some really clear recommendations to the
18 House of Assembly, and we wouldn't be doing that if
19 we didn't believe we can make the system better. And
20 we know we've come a long way in certain areas but we
21 also know there is a lot of work ahead of us to make
22 the system better and we all acknowledge that.

23
24 So, again, on behalf of the group, thank you so

1 much for being us. Enjoy your weekend and you're
2 welcome to join us at one o'clock, if you want to
3 witness the presentations. Is it 1:00 or 1:30? It's
4 one o'clock, I'm pretty sure. It's one o'clock,
5 yeah. Okay, thank you, folks. Have a great day.

6 **(Lunch Break)**

7 Honourable Steve Kent:

8 Sorry we're a few minutes behind but we'll make up
9 the time rather quickly. Thanks for joining us. I'd
10 like to begin by introducing those of us at the
11 front. My name is Steve Kent. I'm the Chair of the
12 All-Party Committee. We've a number of Committee
13 members with us today. There might be a couple of
14 others floating in and out, as well. With me at the
15 front is Gerry Rogers, another member of the
16 Committee; and Andrew Parsons, another member of the
17 Committee. So, on behalf of them and our other
18 colleagues who aren't with us at the moment, we want
19 to welcome you all here.

20

21 This is one of a number of days of public
22 presentations that the Committee will be receiving.
23 We embarked on this process several weeks ago. We've
24 been as far as Corner Brook. We have many other

1 stops to make, and Committee members are heading to
2 Labrador on Monday, so we're getting around, and
3 we're going to be back in St. John's again, as well.
4

5 We have 11 presentations to get through today,
6 which is a lot, probably too much, but we're going to
7 do our best to make sure everybody gets their time.
8 And we're going to have subsequent days. So if you
9 wanted to present and you're not on the schedule for
10 today, there will be other opportunities and there's
11 other ways to connect with us, as well. You can
12 e-mail us. You can call us. You can request a
13 private meeting with us. Many, many ways for you to
14 connect and get involved.
15

16 We also had a really good dialogue session this
17 morning here, and we're going to be doing more of
18 that, as well.
19

20 Anyway, I can tell you on behalf of the Committee
21 that we're very sincerely interested in hearing in
22 what you have to say. We're also very sincerely
23 interested in making changes to our Mental Health and
24 Addictions programs and services in this province.

1 We've come a long way but we still have a long, long
2 way to go. So that's why we're here. We're very
3 excited about the work and we're very committed to
4 it, and we're glad you can be with us for the
5 presentations, as well.

6
7 Bruce, who I'll introduce in a second, will run
8 you through some of the logistics. There's some food
9 and coffee and stuff at the back. Washrooms are in
10 the lobby. Make yourself comfortable. If you notice
11 that Committee members are on BlackBerries or taking
12 notes, some of us are taking notes on our
13 BlackBerries, so please don't take any offence.
14 That's the nature of, that's the nature of doing
15 business as an MHA. It serves as useful recording
16 device, as well.

17
18 So we're really interested in hearing from our 11
19 presenters, so I'm not going to say anything else at
20 this point. Thank you for being here. I'm going to
21 now introduce Dr. Bruce Gilbert. He's not one of
22 those medical doctors, though. He's like one of
23 those academic-type doctors. Just make sure that's
24 clear upfront. Bruce is the Assistant Deputy

1 Minister in the Office of Public Engagement, and he's
2 going to help facilitate this afternoon and be the
3 bad guy and keep us on track, so that we get all 11
4 presentations covered. So, Bruce, over to you.

5 Dr. Bruce Gilbert:

6 Thank you, Minister. Yeah, my job is to be the bad
7 guy in a really nice way, so that you like me at the
8 end of the day. Seriously, I'm going to be firm with
9 time, I'm going to be fair, I'm going to be polite,
10 and maybe I'll get lucky and even be funny. The goal
11 is to get people out of here at five because that's
12 what's scheduled, that's what we have the hall for.
13 And our panelists, some of them have other
14 commitments. So five o'clock it is. If we stick to
15 time strictly, we can do it. I think I've timed it.
16 We'll be out of here at five to five but there's two
17 things that have to happen here. The presenters have
18 to stick to their time, and the panelists have to be
19 aware of the presenters sticking to their time or
20 not, and adjust their dialogue with the presenters to
21 a degree that we don't chew up two or three
22 presentation slots with one presentation. So that's
23 what I'm talking about when I'm talking about being
24 fair. There are other opportunities.

1 If a presenter gets to a point where they're out
2 of time and they have closing remarks they never got
3 to make or whatever, not to worry. I'm going to ask
4 all presenters that if they get to that point to give
5 me anything that they felt they would have said at
6 the end and we will make sure that they are added,
7 those points are added to the transcript of their
8 presentation so that their presentation remains
9 whole, if you will. And I will personally commit to
10 hand those follow-up remarks to each of the panels as
11 soon as I can get them typed up. So that's how we're
12 going to deal with it.

13
14 So, what I'm going to do is I'm going to, for the
15 30-minute presenters - I believe Dr. Hubbard is 30
16 minutes - for the 30-minute presenters I'm going to
17 give them a ten-minute warning and a five-minute
18 warning and a one-minute warning. Then if I start to
19 wander over towards them, if a presenter starts to
20 see me shuffle across or shuffle towards you and I'm
21 standing beside you, that means you're out of time,
22 and that means when I tap you on the shoulder that
23 you need to sum up your last point. Now, I'm going
24 to be reasonable with this, but work with me, okay.

1 So, that's it.

2

3 A couple of things about privacy. All the
4 presentations are being audio recorded, and they're
5 going to be transcribed and put online. I think the
6 Corner Brook ones are up now. If they're not -- They
7 are up, aren't they? So, all that material is there.

8

9 There could be some journalists wander through the
10 hall. I think that we've had one presenter ask that
11 if the journalists are in the hall, that they don't
12 record their presentation. That's fine. If you're
13 one of them and want to add your name to that list,
14 see Colleen here in the front row.

15

16 Yeah, I think that's it. I think we're ready to
17 go. So I know Dr. Hubbard has put a package on each
18 of your, in front of each of you, to our All-Party
19 Committee members. And now, you need to leave some
20 time if you want to engage the Panel at the end.
21 Would you like that to be the ten-minute mark or a
22 five-minute mark?

23 Dr. Janine Hubbard:

24 Ten minutes would be great.

1 Dr. Bruce Gilbert:

2 Ten-minute mark, okay.

3 Dr. Janine Hubbard:

4 Yeah.

5 Dr. Bruce Gilbert:

6 okay, take it away. It's all yours. Thank you very
7 much.

8 Dr. Janine Hubbard:

9 All right. Well, thank you so much for the
10 opportunity to present and speak here this afternoon.
11 I'm here representing the psychologists in the
12 province and --

13 Gerry Rogers:

14 Can everybody hear?

15 Dr. Janine Hubbard:

16 Oh, sorry.

17 Gerry Rogers:

18 Can everybody hear?

19 Dr. Janine Hubbard:

20 Can you hear me okay?

21 Gerry Rogers:

22 No.

23 Dr. Janine Hubbard:

24 Okay. I can move this a little closer. I'm not

1 normally hard to hear. So, let's give this a try.
2 What I'd like to do this afternoon is to present to
3 you some ways that we think that psychologists in the
4 province can help to address and enhance some of the
5 difficulties within the mental health system. We
6 have some really practical hands-on suggestions that
7 can be implemented almost immediately, right up to
8 some much larger, much more systematic issues.

9
10 What I wanted to do first, though, is just very
11 briefly give you a tiny bit of background about who
12 are psychologists and what are we, because there's an
13 awful lot of misperception out there about us. For
14 your information, there's about 18,000 registered
15 psychologists in Canada. We have about 200 of them
16 in the province. So our numbers are very tiny.
17 However, nationally we actually make up the largest
18 regulated specialized mental health care providers in
19 the country. We outnumber psychiatrists four to one,
20 which means nationally we have some pretty good
21 influence.

22
23 Clinical psychologists are some of the most
24 extensively trained clinicians in the world. What

1 most people don't realize is where we're moving
2 nationally to a doctoral standard, Most psychologists
3 have at least seven to ten years of university
4 education, and then internships and residencies and
5 practical and additional experience on top of that.
6 So, we come really, really well trained at what we
7 do. So we'd like people to make use of us and make
8 really effective use of our skills.

9
10 We know that psychologists play a role in
11 diagnosis, treatment, consultation, health promotion
12 and research, program design, education and program
13 evaluation. We use this knowledge to help develop
14 assessments in treatments that can help people to
15 understand, explain and change their feelings,
16 thinking and behavior. We help people to recover
17 from and manage their problems and disorders using
18 evidence-based psychological treatments, which we
19 then develop and we evaluate. And one of the things
20 that we're really excited about is we know that our
21 interventions work. We have done some really
22 effective research. One of the things that's in your
23 handout package there is a research study that was
24 done a couple of years ago looking at the

1 effectiveness and efficacy of psychological
2 interventions. So, we know that they're proven
3 effective. We know that they are less expensive than
4 and at least as effective as medication for treating
5 a number of common mental health disorders such as
6 anxiety and depression. So we work and we're cheap.
7 This is good.

8
9 People with depression who are treated with
10 psychological therapy tend to relapse less
11 frequently, and they're not experiencing the negative
12 side effects that often lead to discontinuation of
13 treatment. The study's a few years old now, but back
14 when the Romanow Commission was doing their study,
15 they found that for every dollar spent on psychology
16 services, it yielded a five-dollar saving in medical
17 cost down the road. So, we wanted to talk about some
18 ways that perhaps psychologists could help. And as I
19 said, I'm starting with hopefully what is something
20 very practical and possibly immediate to much more
21 long-term solutions.

22
23 One of the first things that's important for
24 people to know is the Federal Government recently

1 increased the coverage for psychological services to
2 \$2,000 per year for federal employees. It was
3 previously \$1,000. They upped it to \$2,000 last
4 year. In contrast, provincial employees in
5 Newfoundland have the lowest levels of coverage in
6 the country; in particular, Eastern Health has one of
7 the absolute lowest anywhere that we could find.

8
9 What we know is that for many individuals early
10 and appropriate access to private psychology services
11 can significantly reduce cost and wait times within
12 the public system. We know that there are many
13 individuals who have very complex needs who require
14 the multidisciplinary care of a team within the
15 hospital. However, we also have quite a number of
16 people for whom if they could receive timely, early
17 intervention for, before things develop into a
18 chronic level. If we can get them 10, 12 sessions
19 early on when symptoms are first presenting or when
20 issues are first emerging, we can prevent them ever
21 needing to be seen within the health care system.
22 So, in terms of bang for your buck, this is possibly
23 one of the most effective ways to make use of our
24 psychologists who are here at the moment.

1 The other thing that we would ask, again looking
2 at reducing costs, decreasing or increasing access,
3 is removing the need for physician referral. At the
4 moment, if someone wants to access psychologists, in
5 order to have it covered through their insurance
6 plan, at least the provincial one, they require a
7 referral from a physician. That, of course, then
8 means you're having individuals having to block up
9 time with their GPs in order to go and talk about
10 something that they may or may not feel comfortable
11 disclosing to their GP. So, again, not an effective
12 use of the system. So, I'm looking. I have other
13 notes but I'll leave those be.

14
15 Okay, the second area, which again is something
16 that I think would be short term, quite manageable
17 and approachable, is increasing some of the health
18 psychology services that are available. Most people
19 when they think of psychologists you think about
20 mental health, but believe it or not psychologists
21 can also provide effective intervention for a whole
22 number of actual chronic and acute health conditions,
23 which again are going to lead to cost savings.

24

1 We currently have two health psychologists
2 employed by the health care system in this province.
3 I'm one of them. We have one in adult and one in
4 child, and what we know is we have some significant
5 gaps in the health care system, both in the adult
6 system and the child system. In particular, within
7 adult, we do not have a psychologist providing
8 services for individuals with cancer, with diabetes,
9 the pediatrics surgery program or general admissions
10 to the Health Sciences. Nationally, all of those
11 programs have psychologists attached to them, because
12 again we have really solid research that shows if you
13 can provide behavior psychological interventions to
14 assist with chronic disease management, you can
15 improve physical health and you can decrease costs.
16 Just as a for example, if you have an individual with
17 diabetes, assisting them through therapy on ways to
18 better manage their diabetic control, whether it's
19 helping with some of the lifestyle changes, whether
20 it's figuring out what's getting the way of their
21 adherence. That, in essence, is what health
22 psychologists do, is we really help to figure out how
23 we can get you to manage your chronic disease. And
24 like I say, we have some significant gaps.

1 Within pediatrics, we do not have anyone covering
2 cardiology, asthma, elimination disorders, GI and a
3 number of neurology conditions, including epilepsy,
4 and, for example - I just throw this out as an
5 example - epilepsy we know has a number of learning,
6 behavioral, emotional challenges that go along with
7 it for kids. We don't have anybody servicing them.
8 So, I'm just pointing out those ones out. Really and
9 truly, that would be a couple of positions that
10 could, again, really significantly impact the health
11 care system and decrease, decrease expenses for you.

12
13 Okay, and the other major gap in services that
14 we're seeing at the moment - and this is just
15 beginning to emerge - is the lack of services; not
16 just psychological services but services in general
17 for adolescences and adults with Autism Spectrum
18 Disorder. Currently, we know the rates of Autism are
19 about 1 in 66 live births, which means we have a huge
20 glut of kids who are becoming teenagers who are going
21 to be moving out into the adult world, and while
22 we've put a great deal of resources into childhood
23 interventions which have been fantastic, we are
24 significantly lacking in supports for individuals

1 with Autism Spectrum Disorder, particularly those who
2 are on the higher function end of the spectrum. And
3 we know that again this is an area in which
4 psychologists can really assist with their behavior
5 and emotional needs. We currently have one
6 psychologist within health care who sees adults with
7 Autism Spectrum Disorder, and that caseload is very
8 specific to individuals in general who have cognitive
9 limitations who may or may not then also then have
10 Autism. So, we know that especially within higher
11 functioning individuals this is a population of high
12 risk of anxiety disorders, social isolation and
13 underemployment. Appropriate psychological services
14 could assist in meeting these needs and helping this
15 emerging group of young adults become employed
16 successful happy individual members of the community.

17
18 How am I doing? All right. Oh, sorry. Thank
19 you. Sorry. Thank you. Apparently, I'm echoing. I
20 apologize.

21 Unidentified Female:

22 (Inaudible).

23 Dr. Janine Hubbard:

24 I'm echoing. One of the other things that we wanted

1 to talk to you about is the Doctorate in Psychology
2 Program at Memorial University. In 2009, MUN began
3 to offer the Doctorate of Psychology, otherwise known
4 as the Psy.D. Program. The only one of its kind in
5 Eastern Canada. The goal of this program is to offer
6 comprehensive, high level training in the practice of
7 clinical psychology that will help to address not
8 only the needs within our own province, but also the
9 reported need across Canada for well-trained doctoral
10 level clinical psychologists. As I mentioned
11 earlier, most jurisdictions across the country are
12 moving to doctoral level standards, and Eastern
13 Health has recently implemented doctoral level
14 training as the requirement for all of our
15 psychologists. So, in order to meet longstanding
16 issues with recruitment and retention of
17 psychologists in Newfoundland and Labrador, it's
18 essentially for us to be educating and training
19 locally. And so what we're asking for here is
20 ongoing funding and support for the Psy.D. Program at
21 Memorial University.

22
23 The last one here that I wanted to discuss is the
24 idea of really trying to meet national ratio

1 standards for educational psychologists within the
2 school system. The National Association of School
3 Psychologists recommends a school psychologist to
4 student ration of 1 to 1,000 in order to support
5 basic provision of psychological services to youth in
6 our schools. Based on the one study I was able to
7 find, in 2011 Newfoundland and Labrador had roughly
8 38 registered psychologists for every 100,000 people,
9 which obviously when we start looking at ratios we're
10 again significantly lacking, not just within health,
11 not just within education across the board, but this
12 is one that we wanted to highlight. What we want to
13 see are more educational psychologists to be employed
14 in our school system to ensure that the children and
15 youth who require psychological assessments and
16 treatments receive them. Lower numbers of
17 psychologists equal even longer wait times for
18 children to be appropriately assessed and diagnosed
19 for learning disabilities and other mental health or
20 developmental conditions. We know that the earlier
21 students are assessed the earlier they can receive
22 effective interventions to improve their learning
23 potential and wellbeing.

24

1 Furthermore, the Mental Health Commission of
2 Canada states that up to 50% of adult mental and
3 behavior health problems begin before the age of 14.
4 So we know that these issues are present and not
5 being addressed. We know that early assessments and
6 intervention of many mental health disorders can make
7 a dramatic difference in young people's quality of
8 life and future productivity, and consequently can
9 increase cost savings to our communities. And
10 obviously, all of these points I'm making here apply
11 to both the school system and in general to our other
12 child psychologists, If we were to be looking, kind
13 of future planning, really beefing up the support for
14 child psychologists within the community.

15
16 And, so I mention we had some practical solutions
17 and then we had some longer term, much more
18 systematic issues. As many people are aware, *The*
19 *Globe and Mail* recently produced a fantastic series
20 looking at mental health needs and psychological
21 needs in the country. I've included one of the
22 articles in there for you. And one of, and CPA is
23 about to work on a campaign towards this, so expect
24 to hear more about this in the coming months. But

1 looking at the idea of including funding of
2 psychologists under MCP, it's been done in Britain.
3 It's been done in a number of places across the
4 world, and what they've found is including
5 psychologists, particularly in primary health care
6 teams working side-by-side with a family physician is
7 one of the most cost effective and effective ways to
8 assess and address mental health needs within the
9 community. And really, our key message that we've
10 been conveying through our public campaigns is let's
11 make access to a psychologist a right, not a
12 privilege. Thank you.

13 Honourable Steve Kent:

14 Well said.

15 Dr. Janine Hubbard:

16 I didn't get the hook.

17 Dr. Bruce Gilbert:

18 Wow, you are a model of presentation efficiency.

19 You're ahead of my 10-minute sign. We have 12, 14
20 minutes to carry on.

21 Dr. Janine Hubbard:

22 Excellent.

23 Honourable Steve Kent:

24 Go ahead. No, you go first.

1 Dr. Janine Hubbard:

2 Yeah.

3 Andrew Parsons:

4 Thank you so much. Can you guys hear me? Sorry.

5 Thank you so much for that. I have some specific
6 questions, just when you mention there's 200 here.

7 What is the wait list time?

8 Dr. Janine Hubbard:

9 It varies from service to service, of course, but at
10 the moment, for example Terrace Clinic within Eastern
11 Health, which provides the majority of outpatient
12 adult mental health services, is about 18 months to
13 two years.

14 Andrew Parsons:

15 What's the -- We have 200 here. What's the regional
16 breakdown? Do you know how many we have here in
17 Eastern, Lab, Western?

18 Dr. Janine Hubbard:

19 I can tell you we have one psychologist in Labrador.

20 I can, I can find out those numbers for you, if you'd
21 like.

22 Andrew Parsons:

23 Yeah, even if it is something that could be presented
24 to the Committee later.

1 Honourable Steve Kent:

2 Yeah.

3 Dr. Janine Hubbard:

4 Absolutely. No, I can, I can easily get that
5 information to you.

6 Andrew Parsons:

7 Now, I don't know if you'll know the answer to this
8 one. How many do we need?

9 Dr. Janine Hubbard:

10 Well, we have that lovely number of 1 per 1,000.

11 Andrew Parsons:

12 I'm not good at math.

13 Dr. Janine Hubbard:

14 No, I mean and that one they're looking specifically
15 at school children. I have heard bandied around the
16 ratio of 1 per 2,000, within the community. And
17 again, I know Quebec, I believe, is our, has the best
18 ratio in the country, and I can find out that number
19 for you, if you'd like.

20 Andrew Parsons:

21 And just one question on the, I think it's \$325 was
22 the coverage under --

23 Dr. Janine Hubbard:

24 Yeah.

1 Andrew Parsons:

2 What does that get you in terms of time?

3 Dr. Janine Hubbard:

4 That gets you two hours because we can fix mental
5 health issues in two hours, right?

6 Unidentified Female:

7 Two hours per year.

8 Dr. Janine Hubbard:

9 Two hours per year.

10 Andrew Parsons:

11 Okay. No, thank you so much for that and I don't
12 know if there's further questions.

13 Gerry Rogers:

14 Thanks so much for that presentation. And I think
15 that you know we all kind of knew this information,
16 but how great it is to hear it presented in a way
17 that gives us that whole picture. The doctorate
18 program at MUN, you say that we need to ensure that
19 there's ongoing funding. Is there any risk there
20 that it's not there?

21 Dr. Janine Hubbard:

22 Absolutely.

23 Gerry Rogers:

24 Can you tell us a little bit about that?

1 Dr. Janine Hubbard:

2 Absolutely. It has actually been in jeopardy twice
3 thus far, and we've had, we had to hold off one year
4 on accepting new students because the future was in
5 jeopardy. I believe at the moment it's been
6 guaranteed funding for the next two years, but in
7 terms of not just the long-term needs of training but
8 in terms of attracting a highly qualified faculty, in
9 terms of attracting the best and the brightest across
10 the country to come and train with us, we need people
11 to know that this program is here to stay. That it's
12 guaranteed. That it's not at risk of collapse.

13 Gerry Rogers:

14 Where are those decisions made? Are they made within
15 MUN? Are they made outside of MUN? Like where,
16 where is that locus of authority that can sort of
17 make a difference there?

18 Dr. Janine Hubbard:

19 I think a combination of government pressure and
20 administration at MUN need to be, need to be talking.

21 Gerry Rogers:

22 The other thing, when you talk about the need of one
23 psychologist per 1,000, that ration for students, but
24 that would, that works only if there are also

1 guidance counsellors in the schools as well, yes?

2 Dr. Janine Hubbard:

3 Yes.

4 Gerry Rogers:

5 So, that's not to take over from guidance

6 counsellors?

7 Dr. Janine Hubbard:

8 No.

9 Gerry Rogers:

10 That's if we also have a good compliment of guidance

11 counsellors.

12 Dr. Janine Hubbard:

13 Exactly. That's the experience on the mainland where

14 most of the schools have both educational

15 psychologists and guidance counsellors providing

16 services. And actually, a lot of schools also have

17 social workers in the schools.

18 Gerry Rogers:

19 And social workers, yeah. There used to be social

20 workers in the schools. So you're talking

21 psychologists, guidance counsellors and social

22 workers?

23 Dr. Janine Hubbard:

24 Yeah.

1

2 Gerry Rogers:

3 What happens to people - I know this might be a
4 self-evident questions - but when one waits and needs
5 to see a psychologist and they wait 18 months to two
6 years, what happens to that person during that time
7 of waiting?

8 Dr. Janine Hubbard:

9 I'm so glad you asked that question. No, I really am
10 because there are a number of things that happen.
11 What we know is that sometimes issues that may have
12 been short term and treatable become long term and
13 chronic. We know that by the time people are seen
14 perhaps they've been tried on a number of medications
15 that they perhaps have not found terribly successful.
16 A lot of times if they're waiting that long, it's
17 affecting their career. It's affecting their ability
18 to be employed. It's affecting their physical
19 health. I mean, we have people who wind up off on
20 disability. We have people who are, or we have
21 people who are trying their best to get to work but
22 are underperforming.

23

24 Again, when I was talking earlier about that idea

1 of the private insurance, because what we know is
2 that if people are trying their best to get through
3 their day but they're experiencing high levels of
4 anxiety, they're experiencing high levels of
5 depression, even if they're physically making it into
6 work, you're not, you're not getting a fully
7 performing employee.

8 Gerry Rogers:

9 I'll ask one more question, because I'm sure, Steve,
10 you might want to ask something. I think it's going
11 to be a quite a cultural jump for people to imagine
12 psychology services being covered by MCP, because oh,
13 well, it's talk stuff. But we do know that there is
14 a public funding of psychologists in other parts of
15 the world. How do you see us getting over that
16 barrier, because I think it's a huge barrier, and
17 again you can make that, that pitch for it being cost
18 effective but if you already -- we want our tax
19 dollars going for talk, talk, talk, talk and
20 somebody's going to be in there talk, talk, talking
21 for years. So, can you talk to us a little bit about
22 that?

23 Dr. Janine Hubbard:

24 Again, really good question. I think some of it is

1 people seeing things by example, seeing things as
2 just it's very normative.

3 Gerry Rogers:

4 And it works.

5 Dr. Janine Hubbard:

6 I'm just going to use a personal example because I'm
7 the pediatric psychologist at the Janeway, so I work
8 with kids who have chronic illnesses. I'm introduced
9 right off the bat that I'm just a member of the team,
10 and hey, you know what, you're having trouble coping
11 getting that needle today? I can do a one shot
12 intervention, spend half an hour with the kid, get
13 them more comfortable or get them taking their
14 medication and off they go. And they've had early
15 exposure to something where they went oh, wait, first
16 of all (a) she's not nuts or, well, she's maybe a
17 little nuts but I can hang out with her. She's not
18 judgmental and she has tools that work.

19 Gerry Rogers:

20 Tools that work, yeah, and then tell us a little bit
21 how you a psychologist working within a primary
22 health care team?

23 Dr. Janine Hubbard:

24 Absolutely. I mean there are a couple of different

1 models that this could fall under. In some cases it
2 could be very much part of a team, ideally where you
3 also had other allied health individuals, whether you
4 had access to a physio, whether you had access to a
5 licensed practical nurse, a team working together,
6 much like we already have within the hospital system,
7 but for individuals with less acute issues, but ones
8 that could be addressed.

9
10 Sorry, I lost my train of thought. In some cases,
11 it would be part of a primary team, but also much in
12 the way that we have some sole practice family
13 physicians out in the community, you could have sole
14 practice psychologists out in the community. You
15 could be looking at both models.

16 Gerry Rogers:

17 (Inaudible) models, yeah.

18 Dr. Janine Hubbard:

19 And we're still going to need psychologists within
20 the hospital, but it's just much in the same way if
21 you think about the way people access a physician.
22 Some of them have, perhaps, more specialty areas and
23 they're located within the hospital. Some are
24 community based. Some are sole practice. Each play

1 their role, because I think the important thing that
2 we were trying to communicate is making sure that the
3 right people are getting the right treatment at the
4 right time.

5 Gerry Rogers:

6 Oh, great. Thanks.

7 Honourable Steve Kent:

8 I have a lot of questions, but I'll try and only ask
9 a couple.

10 Dr. Janine Hubbard:

11 That's okay. We can chat again.

12 Honourable Steve Kent:

13 We need more. That's clear. So assuming we had the
14 funding to hire more today, the program at Memorial
15 is producing a small number. Any words of wisdom on
16 how we'd recruit, because I understand recruitment
17 has been a challenge anyway, even for the small
18 number we have? So what are your thoughts on how we
19 recruit? Is it simply a compensation issue because I
20 imagine it's bigger than that, even though that's
21 important?

22 Dr. Janine Hubbard:

23 It is bigger than that. Excellent question. Yes,
24 the program at MUN produces six graduates a year.

1 One of the things that has happened recently that
2 again is helping to address the long-standing
3 recruitment and retention issues, for which we are
4 very grateful, Eastern Health now offers a
5 Pre-doctoral Residency Program in Clinical
6 Psychology. Because as I mentioned, psychologists
7 when they're training for their doctorate, we have to
8 spend 12 months residency somewhere, and what we have
9 found is that where you do your residency often then
10 dictates where you apply for jobs, whether it's
11 specifically within the organization or even just
12 geographically moving somewhere within that area.
13 So, we have a few initiatives, and I know it doesn't
14 sound like a lot when we're talking what, that's
15 another four, but the nice thing is there are
16 psychologists across the country that if we can get
17 them here, part of it is salary, absolutely, and some
18 of it has also been finding ways to keep the current
19 psychologists stimulated and interested, and that's
20 one of the things that the Psy.D. Program has been
21 fantastic for because now we have students. We're
22 doing training. It's adding an additional level of
23 professional satisfaction, so it's not one that we --
24 There's a few, I think, that we could fill

1 immediately and then there's sort of the long-term
2 infrastructure that we'd be looking at.

3 Honourable Steve Kent:

4 So, I caught some of the numbers, but help us
5 understand the approximate breakdown of the 200.
6 Where are they? So, there's a limited number in the
7 system. There's a limited number in education.
8 There's some in the community, but can you paint the
9 picture of where the 200 are?

10 Dr. Janine Hubbard:

11 Certainly. And again --

12 Honourable Steve Kent:

13 And I know you'll get us the regional numbers, but
14 just in terms of where they're working.

15 Dr. Janine Hubbard:

16 Absolutely. And I can get you some specific numbers
17 on that. Certainly we have individuals in health
18 care across the country, or across the province. We
19 have individuals working in the school system. We
20 have some psychologists over at MUN, both teaching
21 general psychology courses, as well as at the
22 Counseling Center, and as part of the Psy.D. Program.
23 And then we have psychologists in private practice.

24

1 Now, that being said, we also have a fair number
2 of psychologists who are working part time in private
3 practice, in addition to either working for the
4 school system or MUN or the health care system.

5 Honourable Steve Kent:

6 So, how many would be roughly working in full-time
7 private practice, approximately?

8 Dr. Janine Hubbard:

9 I'm looking to my colleague to see if she has any
10 sense.

11 Unidentified Female:

12 (Inaudible) - not by microphone).

13 Dr. Janine Hubbard:

14 In the city here, I'd say. Yeah, probably about 10
15 full time.

16 Honourable Steve Kent:

17 Okay, so most are working in the public system
18 somewhere, whether it's in health or education.

19 Dr. Janine Hubbard:

20 Yeah, in somewhere. And then the vast majority of
21 the private psychology services that people are
22 accessing are those of us who also do a little bit of
23 part-time work.

24

1 Honourable Steve Kent:

2 Like in the evenings, on the weekends, whatever.

3 Dr. Janine Hubbard:

4 Yeah.

5 Honourable Steve Kent:

6 Okay, all right. Great, thank you. Thanks a lot.

7 Dr. Bruce Gilbert:

8 Thank you very much, Dr. Hubbard. I would like
9 welcome to the stage or to the table here now our
10 next presenter, Ms. Crista Brook Burnett. Crista
11 here? Here she comes.

12

13 You have 30 minutes and would you like a
14 ten-minute warning?

15 Crista Brook Burnett:

16 Yes.

17 Dr. Bruce Gilbert:

18 Okay, thank you. And I would also like to draw your
19 attention to our fourth All-Party Committee panelist
20 who's just joined us, MHA Felix Collins. So welcome.

21 Crista Brook Burnett:

22 Hi, my name is Crista Burnett, and first before I
23 jump into what exactly is 211, the context of why I'm
24 here, the context of why I'm standing in front of you

1 now, I am a mental health consumer speaking to the
2 need for psychologists. It took me and a year and
3 seven months to get in to see my psychologist.

4 Gerry Rogers:

5 Wow.

6 Crista Brook Burnett:

7 And in terms of speaking about the loss or getting
8 into crisis, the effects of not having access to a
9 psychologist, people are dying. I didn't. But I did
10 lose that much time of my life because by seeing a
11 psychologist who is a good fit, I was able to build a
12 better life. And I'm happier, my family is happier
13 and I'm on the way to being employed. And that's a
14 year and seven months of my life where I could have
15 been doing that.

16

17 Next, I do mental health advocacy, mostly because
18 I'm contrary and the idea that I need to hide a very
19 legitimate illness bothers me. So, I basically stand
20 up and say I'm not currently depressed but I've dealt
21 with it and that's okay, and I hope that more people
22 will because there is nothing to be ashamed of.

23

24 And on to the 211, I was here this morning for the

1 public dialogue sessions and many of you were. There
2 is a consensus, I believe, just a hunch, that people
3 are desperately navigating a very complex system.
4 And I'm not talking health, mental health addictions,
5 I'm talking everything. And quite frankly, there is
6 a better way and years ago I was a resource mom for
7 Healthy Baby Club and I would go and do a home visit
8 and speak to them for like an hour and essentially
9 they had a connection to see Child, Youth Family
10 Services, caseworkers, income support, everything.
11 They still weren't getting the exact help they needed
12 with everyday issues. For example, you can say, oh,
13 go to a food bank. Where's the food bank? Oh, I
14 don't know. Don't you know? No, I don't know.
15 Well, who knows? I don't know. Basically, I was
16 able to, through resource and making phone calls, and
17 I was explaining to someone when I have a problem
18 solve or something to track down I am like a dog with
19 a bone, I keep looking until I find it. So I would
20 find out, for example I was able to refer mom to a
21 food bank that delivers because she didn't have a
22 car, she wasn't near a food bank, and she didn't want
23 to go to the food bank locally because of stigma.
24 This is a place that delivered. So somebody pulls up

1 in their car, brings in groceries to a door, could be
2 anybody, could be a family member and it gives you
3 your hamper. How many people in the room know about
4 that service? Anybody?

5 Gerry Rogers:

6 That know what?

7 Crista Brook Burnett:

8 Know about the food bank in town that delivers?

9 Okay, I know you both know. How many people know
10 about someone, or themselves, or know of someone that
11 could be benefit from that? At the risk of being a
12 little, I kind of, I just settled a case for a 211
13 service but I will go in to explain what 211 is.

14 Honourable Steve Kent:

15 Crista, can you speak a little closer to the mike?

16 Crista Brook Burnett:

17 Yeah, I'm trying to move it closer so I don't have to
18 bend over. That's better.

19 Honourable Steve Kent:

20 It might be the way that the speakers are turned, I
21 don't know.

22 Crista Brook Burnett:

23 So 211 information referral is actually rather
24 complex. A lot of things today people were talking,

1 the answers are so simple. Well, the answers are
2 simple but actually implementing those answers gets
3 tough then. That's when people start leaving the
4 table. Essential knowledge base for 211, for any
5 discussion about bringing 211 to Newfoundland and
6 Labrador. N11 numbers, what is information referral,
7 I&R standards.

8
9 I'm going to refer to information referral from
10 here on in as I&R, and the role of community resource
11 and I&R specialist with 211 and information referral.
12 N11 numbers are property of, essentially, the
13 Canadian Radio Television and Telecommunications
14 Commission. I won't be saying that one again.

15
16 In 2000, the United Way of Canada informed Canada
17 and United Way of Greater Toronto requested the
18 assignment of an N11 code for access to information
19 and referrals for community, social, health and
20 government services. They got it. These are N11
21 codes. You got your 211, but we don't. You got your
22 411, 911, 311 and 811. 311 is City of St. John's,
23 nonemergency municipal government services: tickets,
24 animal control. 811 is nonurgent health tele triage.

1 So like our health line but with three numbers. 911,
2 everybody knows. 211 is the information and referral
3 health line to community, social, government and
4 health services.

5 Now information referral is a sector. It is a big
6 thing. And I&R is the art, science and practice of
7 bringing people and services together. So basically,
8 a lot of people in this room, that's their job. This
9 helps. This is a tool you can use for that. When
10 individuals, families and communities don't know
11 where to turn I&R is there for them, and that's from
12 the ABCs of I&R, which is 566 pages. I'm almost
13 through it. There it is. No, sorry, that's the
14 standards.

15
16 The Inform Canada is the professional association
17 for information referral specialists and for the
18 sector. You've got Inform Canada and in the states
19 you've got AIRS. These are the standards for
20 information referral. I'll give everyone a moment to
21 read that and I'm going to take a break.

22
23 So the I&R standards, they are really good in my
24 volunteer work advocating. I have individuals

1 actually approach me and ask for help. I actually
2 use the I&R standards to do that for them, to hold
3 myself to a professional standard and for practice
4 for some day. And they're proven, they are there,
5 and they're an asset that we should be using.

6
7 Information referral specialist: They are the
8 people who, with the 211 service, answer the phone;
9 or, are the people who have the directors of
10 services. Many of you are information referral
11 specialists.

12
13 The resource specialists are the I&R professionals
14 who work with the database to index, edit and
15 maintain it. Now this is the really exciting thing
16 that I find because I'm a bit of a geek. The
17 database of 211 is basically a collection of all the
18 services and it's organized by service, because right
19 now if you're looking for a psychologist, where do
20 you look? You go to your doctor. I'm here to tell
21 you that most times your doctor doesn't know. And
22 it's organized by service, not agency, which makes a
23 huge difference. Resource specialists are
24 responsible for indexing the database, using what's

1 called the taxonomy of human services. And I won't
2 get into that because it's really, really nit picky.
3 However, how many people have been in a library in
4 the past year? An actual library, not online.

5 Honourable Steve Kent:

6 I have in the last year.

7 Crista Brook Burnett:

8 Okay, more than I expected. Nice. You go into a
9 library, you need a book. You need a book for the
10 next day. You got to finish a paper and you've got
11 to have this book. You go in, you say, okay, I don't
12 have time, the library is closing in 20 minutes. Go
13 to the librarian. I'm going to need this book.
14 Where is it? The librarian says, oh, okay, here's
15 the index card, go to the third floor, it's on the
16 second shelf. Wicked. You go there and on the way
17 you bump into someone and say I'm just on my way up
18 to get such and such a book, and the librarian that
19 you just bumped into said that's not here. Silly.
20 That's over on the first floor. And it's in the
21 reference section. You go there and you go there and
22 you can't find it. So you go back to the desk and
23 say, well, where is this? They say, oh, crap, I
24 think we cataloged that under a different system. I

1 don't even think we have that. That's what it's like
2 trying to find help right now. It's a nightmare and
3 there is more at stake than finding a book for a
4 paper.

5
6 What 211 information referral does is gives you a
7 way to collect it all using one language, one system
8 and it's very powerful. There's more about the
9 taxonomy. I won't get into it, it's kind of boring.
10 211 is available to 60% of Canadians in seven
11 provinces. The white ones, that's where 211 is.
12 Ninety-five percent of the U.S. citizens have access
13 to 211. It started in the States back in '97.
14 Currently, PEI is developing theirs. Nova Scotia got
15 theirs in 2013. Their most recent Annual General
16 Report is just released. We don't have it. And
17 talks are happening. Talks are happening here.
18 They're happening in silos. My job has been getting
19 all of those people to talk to one another,
20 hopefully.

21
22 211 is for everyone. If you need a food bank,
23 you're looking for information on federal benefits,
24 everyone. And my own personal experience, I had to

1 call 211 for my brother in Ontario. So I called the
2 1-888 number for people who aren't in the region. It
3 was a great experience. He also called. I called
4 him up after I spoke with him and I got a number of
5 referrals, and do you know they followed up with me
6 two weeks later? The same person I spoke to in
7 Ontario called me at home, because I had asked them
8 to, she asked would you like us to follow up? I said
9 yes. And she called me back and it was the same
10 person, and she said how did those referrals work
11 out? And I could tell her. And my brother, who I
12 convinced to call on the condition that he call me
13 back and tell me how it went, had a really good
14 experience. He was amazed.

15
16 How does this work? I'm supposed to click on this
17 and it brings me to a link. Doesn't work, does it?
18 Oh, Rick, if you can click on that it should bring
19 you to a video. I can skip the video. Scroll down.
20 You can play that one. It's not as good but you can
21 play it.

22 **(Video of Ontario 211 website is played)**

23 Crista Brook Burnett:

24 I found his voice a little smarmy. That explains it

1 basically. So, that's 211 website, for Ontario
2 anyway. There we go. No. Okay. So how does 211
3 improve mental health and addictions programs and
4 services in our province? This is for the audience.
5 Anybody want to stand up and throw a guess out there?
6 Go on. Ed?

7 Ed:

8 (Inaudible - not at microphone).

9 Crista Brook Burnett:

10 Anybody else? Purple shirt?

11 Unidentified Female:

12 (Inaudible - not at microphone).

13 Crista Brook Burnett:

14 Yeah, the youth directory of services.

15 Unidentified Female:

16 The youth directory of services, this is like a small
17 part of your job in the (inaudible). But this could
18 be a full-time position that (inaudible). It would
19 be current and on top of things all the time. (Not
20 at microphone).

21 Crista Brook Burnett:

22 The standards include having to update your database
23 once a year and that's a full verification and the
24 standards cover how to verify data, who -- it's

1 really, I can give you the standards and it lays out
2 everything. Catherine?

3 Catherine:

4 (Not at microphone). (Inaudible). 211 and this word
5 has not been used yet today in this discussion,
6 empowers the person (inaudible).

7 Crista Brook Burnett:

8 I was getting to it.

9 Catherine:

10 So (inaudible) it's our having to go to find
11 (inaudible) to help us (inaudible). I am empowered
12 as a mental health consumer to be able to (inaudible)
13 211. And that's very, very important.

14 Crista Brook Burnett:

15 I have my ten-minute warning. Okay. Does anyone
16 else want to say how could 211 help? Megan?

17 Megan:

18 (Not at microphone). I was going to say, what's
19 interesting about 211 is if you're calling about
20 mental health issues as well as issues like with
21 budgeting or housing or anything else, 211 is
22 designed to help you with all of those things.
23 (Inaudible) in turn can help you with your mental
24 health as well because you can't get better if you

1 don't have a roof over your head. (Inaudible).

2 Unidentified Female:

3 (Not at microphone). I had no idea about this. My
4 sister lives in Ontario. (Inaudible) my family
5 doctor and he said there was a 14-month wait list.
6 So I said what am I going to do now? I ended up in
7 hospital for three weeks, the Health Science, and
8 I've only been complaining now, after 17 years of
9 living in silence with depression. So, thank you
10 very much.

11 Crista Brook Burnett:

12 Okay, thank you. Thank you. Thank you for being
13 here today and standing up.

14 Unidentified Female:

15 Thank you very being here.

16 Crista Brook Burnett:

17 Okay. So, why people call 211 in 2013 in Ontario,
18 27,073 calls. That's Ontario's bigger population.
19 Also, for health, income, financial assistance,
20 community services, housing, legal, public safety,
21 provincial government, individual family services,
22 da-dit da-do. Yeah, it's useful.

23

24 The Saskatchewan 10 Year Mental Health and

1 Addictions Action Plan, this is from 2014. Mental
2 health is the most commonly searched services. 211
3 has emerged as a useful tool to help people find
4 services that are important for their wellbeing. The
5 Deloitte Study, there is research on 211; lots of it.
6 This is one of them I'm going to be providing to the
7 Committee.

8
9 211, the software used, and because you're
10 collecting data you ask for a postal code and if
11 you're talking to an I&R specialist and they suggest
12 a referral to you and you say, oh, crap, well, is
13 that accessible? I can't. And they say, no, it
14 isn't. They actually put that in as a barrier to
15 service. That's collected data.

16
17 211 service data in Toronto, they did an analysis
18 of the data collected through delivery of a 211 I&R
19 service, and they noticed all these little green
20 dots. I don't know if you can see the green dots?
21 Vaguely, yeah. Green dots were the services for
22 Asian (phonetic) population. What do you think all
23 those red blotches are? Where they live. So all
24 these little green dots are where you need to go for

1 help and the people who are actually needing that
2 help lived way the hell in those red big blotches.
3 And when they looked at these results from a data
4 analysis from 211 date that's collected, via
5 delivering a very good service, they kind of all sat
6 there and went what? How did we miss that? And so,
7 they started to move the services to the people.
8 That's the end. Any questions? How many? I got
9 five minutes?

10 Gerry Rogers:

11 So, a service in and of itself. So if someone calls
12 in a mental health crisis they do not refer you to a
13 doctor but they would refer you then, for instance,
14 to the mental health crisis line, is that it?

15 Crista Brook Burnett:

16 I&R specialists are trained and they are standards to
17 following for crisis. So if I were to call a 211 in
18 crisis and actually indicate that maybe I was
19 suicidal, they have a standard to follow to -- well,
20 it's complicated. I don't know the standard offhand.
21 But, they can actually transfer you to the crisis
22 line.

23 Gerry Rogers:

24 So they would like dispatch your call?

1 Crista Brook Burnett:

2 They can actually dispatch the police as well if it's
3 an immediate threat. And stay on the phone with you
4 and tell you that the police are coming.

5 Gerry Rogers:

6 And how is 211 paid for?

7 Crista Brook Burnett:

8 Money. It varies. In Nova Scotia, the provincial
9 government is footing most of the bill.
10 Approximately 10% municipalities in some provinces,
11 80 to 90% from the province and there is also federal
12 funding. Startup money is often funded by private
13 corporations. The call centre in Nova Scotia was
14 actually paid for, essentially, by Bell Aliant, who
15 FYI are interested in funding something here. Not a
16 call centre. The 211 Nova Scotia call centre was
17 built keeping in mind that the other Atlantic
18 provinces would be coming into 211.

19 Honourable Steve Kent:

20 You can go first, if you want.

21 Undeidentified Male:

22 (Inaudible).

23 Honourable Steve Kent:

24 Sort of. Okay, I'll go first. See how well we all

1 get along? Wait till Question Period 1:30 Monday,
2 it's a little different then. (Laughter). Thank
3 you, Crista and thanks for your leadership on this.
4 You've been a tremendous advocate over the last
5 number of months for this and many other topics. So,
6 keep up the great work.

7
8 A couple of questions for you. First of all, a
9 little bit of news which you already know but the
10 folks, the folks here don't know. This is something
11 we're actively working on. But Crista is right. We
12 need to get everybody talking to each other. So,
13 it's great that government departments are talking to
14 each other, which is hard enough, believe it or not,
15 but we also need, we also need to engage the right
16 partners in the community. So one of the questions I
17 had for you, Crista, as we (recording issues) with
18 your help, some of the people we logically need to
19 get involved in the conversation are obvious. Like
20 we need to engage Thrive who is already doing some
21 referral work. We need to engage groups like United
22 Way who have some experience in this; potentially
23 Community Sector Council; potentially Seniors
24 Resource Centre. Are there any other people that

1 logically should be part of the discussion right now?

2 Crista Brook Burnett:

3 Just off the top of my head?

4 Honourable Steve Kent:

5 Yeah. Just like any big ones that are obvious to you
6 that we need to make sure are at the table from the
7 start?

8 Crista Brook Burnett:

9 I have a list from a year ago that I'm working my way
10 through.

11 Honourable Steve Kent:

12 Cool. Well, if you could share it with us that would
13 be really helpful.

14 Crista Brook Burnett:

15 Okay. Well, United Way, obviously. They're usually
16 the champions for 211 in each province.

17 Honourable Steve Kent:

18 Yes.

19 Crista Brook Burnett:

20 You definitely have to be contacting 211 National.

21 Honourable Steve Kent:

22 Yes.

23 Crista Brook Burnett:

24 The national director of 211 who is responsible for

1 the mandate of spreading 211 across Canada.
2 Definitely get in contact with Nova Scotia 211
3 because they've recently tread the path.

4 Honourable Steve Kent:

5 So that's helpful. And that list you're working
6 through, if you could share that with us that would
7 be really helpful for sure.

8 Crista Brook Burnett:

9 Yeah. Lisa Zigler.

10 Honourable Steve Kent:

11 And my second -- Lisa Zigler?

12 Crista Brook Burnett:

13 Yeah, there is a whole list of people.

14 Honourable Steve Kent:

15 Cool. All right, excellent. Share that with us.
16 And my second question, and I will let the others ask
17 questions, if they have any. Of all the services in
18 the country, my little bit of like internet research
19 tells me that Ontario is really impressive, but
20 you've done more research than I have. So who do
21 you, of the provinces that are already in this, who
22 do you think is the best model or is there one?

23 Crista Brook Burnett:

24 There's no best model because every 211 is according

1 to the standards developed by AIRS, the Alliance of
2 Information Referral Systems, as well as Inform
3 Canada. And those standards are developed and proven
4 and worked on constantly.

5 Honourable Steve Kent:

6 So you'd say the services are pretty comparable from
7 province to province?

8 Crista Brook Burnett:

9 Very much so.

10 Honourable Steve Kent:

11 Okay.

12 Crista Brook Burnett:

13 One of the fundamental questions is how was it
14 developed? There is no one answer because it was
15 developed individually by province and by region in
16 within provinces.

17 Honourable Steve Kent:

18 But they look and feel the same pretty much today?

19 Crista Brook Burnett:

20 Yes. In Nova Scotia, if you call 211 in Nova Scotia,
21 if in 30 seconds your answer isn't called -- your
22 call isn't answered by an I&R specialist in Nova
23 Scotia, it gets bumped to Findhelp in Toronto. And
24 also between 7 p.m. and 7 a.m. your calls are

1 transferred to Findhelp in Toronto. That's an
2 agreement between Nova Scotia 211 and Ontario 211 and
3 Findhelp Information and Referral Services. Leading
4 up to that partnership, they did a lot of work on
5 making sure if someone in Nova Scotia calls and gets
6 transferred over to Toronto they can't tell the
7 difference. So they did work with the staff.
8 Basically, if I were to call 211 in Newfoundland and
9 talk to somebody here, great. If I talked to someone
10 in Toronto and they say, oh, just hop on the bus and
11 it's January, not so helpful. So, basically, those
12 regional differences are addressed.

13 Honourable Steve Kent:

14 Cool. All right, thank you.

15 Crista Brook Burnett:

16 Any other questions? No.

17 Andrew Parsons:

18 If I could toss one quick one out and let me preface
19 it by saying this is to sound brilliant, I mean this
20 sounds so --

21 Crista Brook Burnett:

22 It seems so obvious, doesn't it?

23 Andrew Parsons:

24 Yes, completely. What's the ballpark cost that

1 you've been seeing in different provinces to make
2 sure that this is run? And maybe Steve knows that.

3 Crista Brook Burnett:

4 Five thousand dollars off the bat for icarol
5 software.

6 Honourable Steve Kent:

7 Yeah, it's varied from jurisdiction to jurisdiction.

8 Crista Brook Burnett:

9 It's very variable.

10 Honourable Steve Kent:

11 The ongoing operating cost, depends on how you set it
12 up but that's something we need to get our heads
13 around. Who's going to take the calls.

14 Crista Brook Burnett:

15 And also who carries the cost? Is it Nova Scotia
16 211? Is it based in Newfoundland? Do you have
17 people answering calls from their homes, which
18 they're working on?

19 Honourable Steve Kent:

20 That's probably the biggest stumbling block.

21 Crista Brook Burnett:

22 There's a lot of details.

23 Gerry Rogers:

24 I just have one quick question. I'm sitting here

1 thinking particularly after Janine's last
2 presentation. So, I call 211. I say I really need
3 to see a psychologist. I don't have a lot of money.
4 I don't have a private insurance plan. And then they
5 tell me well, there is a psychologist that is paid
6 for by MCP that you can see at Terrace in the Square.
7 However, it's an 18-month waiting list. I'm sorry,
8 that's playing in my head.

9 Crista Brook Burnett:

10 When you call the crisis line or, sorry, not the
11 crisis line, the Adult Central Intake and you're told
12 what the wait list is and things like this, and you
13 say well, what do I say in the meantime? They don't
14 really have an answer unless the person you're
15 talking to, who happened to be working, knows about
16 other services personally. And they don't know any
17 details. A 211 information referral specialist can
18 actually say, did you know about LeMarchant House?
19 Here's their hours of operation. Well, am I
20 eligible? And they know the eligibility criteria.
21 That's a field within the database, as well as the
22 wait list, if that's one of the things you include in
23 the 211 inclusion and exclusion policy for the
24 database.

1 And I'm free to present to anybody else who wants
2 more information. Just call me or call Bill Morris,
3 he'd be very happy to hear from you. He's sick of
4 hearing from me. (Laughs).

5 Dr. Bruce Gilbert:

6 Thank you very much, Crista. That was excellent and
7 I commend you for not breaking into a sweat when they
8 went and found that video, because that was amazing.
9 I wouldn't have been able to do that and I shout out
10 to those guys (recording ends). Now, Angela has
11 15 minutes. And would you like a five-minute
12 warning?

13 Angela Crockwell:

14 Sure.

15 Dr. Bruce Gilbert:

16 Okay. Thank you very much.

17 Angela Crockwell:

18 Let me know if you can hear me. Every time I present
19 I always start out with saying me and technology are
20 not friends. So do I just hit the green button?

21 Honourable Steve Kent:

22 Yeah, green button will change your slides.

23 Angela Crockwell:

24 Okay, perfect. See, we're not friends. There we go.

1 So I'm just here representing Thrive which is the
2 community youth network for St. John's. And I just
3 want to start out by saying thanks for the
4 opportunity to be able to speak today.

5
6 I'm going to kind of just very quickly go through
7 the first couple of slides because the heart of what
8 I want to say is actually at the back end. So for
9 those who don't know who Thrive is, we provide
10 programs and services to vulnerable youth and young
11 adults, and we do community collaboration and
12 information sharing and, really, also work to
13 identify gaps in services.

14
15 I also wanted to take a moment to recognize, there
16 are some good things happening and recognize some of
17 the improvements, and some of the ones that we've
18 particularly noticed is the expansion of the Mobile
19 Crisis team hours of operation. We do have two new
20 treatment centres for young people in Paradise and
21 Grand Falls, a new treatment facility is coming in
22 Harbor Grace, and, obviously, this All-Party
23 Committee on Mental Health and Addictions is, for us,
24 seen as a very positive thing as well. So, there are

1 good things happening.

2

3 A lot of information on this slide and maybe
4 difficult to read. I just wanted to give some
5 context in terms of the data that Thrive is seeing.
6 So outside of our programs and services that young
7 people show up and attend, whether it's school or our
8 adventure program, we also have a series of
9 individual support outreach and case management
10 services, and see that as really critical to be being
11 able to support people. If they come in for
12 education, there is lots of other things happening
13 for them.

14

15 So, during 2014-2015 fiscal year, we supported 236
16 individuals through that outreach individual work
17 that we do. And of those 236 individuals, we
18 provided just over 7700 services to them. So an
19 intense amount of work is needed and required. Of
20 those, of the people that we served, mental health
21 and addictions are primary issues that they're faced
22 with. And so, over 50% identified mental health as
23 their primary issue that they needed support and 50
24 individuals identified addictions as their primary

1 issue.

2

3 It is also important to recognize that for many
4 people it's not just one single issue. And there is
5 a lot of things happening for people. So it's not
6 just a mental health issue. It's not just an
7 addictions issue. So I have highlighted there some
8 of the other things that compounds the issues. So, a
9 large majority of our participants also struggle with
10 issues relating to family and connection to family.
11 Fifty-three percent don't have an adequate education.
12 Forty-one percent of those people aren't adequately
13 housed, and many aren't housed at all. And the list
14 goes on. So I think it's important when we think
15 about service delivery and interventions and supports
16 is to recognize that wholistic need to support,
17 because, again, if we're only going to focus on an
18 addiction and not think about housing or family
19 context or physical health is actually a significant
20 issue that we also find when people aren't doing
21 well. Their physical health is actually a
22 predominant need that they need addressed as well.

23

24 So, I basically have four areas that I think I'd

1 like to speak to in terms of opportunities for
2 improvements or enhancements. So the first is really
3 to look at opportunities to increase outreach
4 collaboration and harm reduction in our systems and
5 in our services. So, while it is really great to
6 find opportunities for more funding and more
7 services, we would absolutely support that there is
8 lots of need for that.

9
10 I also think there is an opportunity to seek
11 opportunities to consolidate efforts to reach and
12 serve the maximum number of people. So we have
13 addictions service workers and mental health workers
14 embedded in formal structures, and we also have a lot
15 of people who do not connect well with formal
16 structures. So I really do believe there is an
17 opportunity to imbed people in community where people
18 already have the relationship, have the trust.
19 People are accessing services. So I had said this
20 morning, one of the examples is if we look at how
21 Public Health nurses have been imbedded into
22 community centres and what positive outcomes have
23 come from that. I think there's such an opportunity
24 to embed Mental Health and Addictions practitioners

1 in community and it would enhance the service because
2 community can do things to go along with the work of
3 the Mental Health or Addictions staff.

4
5 And I have talked about the need to increase
6 outreach efforts as opposed to in-reach. So we have
7 a lot of systems where we're waiting for people to
8 show up to us, and we need to find creative efforts
9 of how are we going to find people and reach out to
10 them. Because for many people who have significant
11 struggles, outreach is really a critical component.

12
13 And the last is I really do believe we need to
14 find opportunities to utilize a harm reduction
15 approach and recognize the importance and the value
16 of harm reduction in terms of working with people.
17 And this is often, for us the stuff that we see is
18 that harm reduction approach is often the first
19 critical step for building relationships and for
20 long-term change for people.

21
22 So, in my next kind of series of slides I'm going
23 to have HR next to what I think is a very clear
24 example of how we could be doing very better harm

1 reduction. And I know Tree Walsh is in the room. So
2 one is just at our detox facilities. I think we need
3 to find ways to reduce and eliminate waiting times
4 and not have people again show up to Thrive every
5 day, to make a call down to the detox centre and say
6 no, no beds today. Try again tomorrow. Call again
7 tomorrow. No, no beds. Show up again. So I think
8 those, there's a need for finding a way to eliminate
9 that, because what we find is often people wait till
10 they're really desperate and in really hard shape
11 before they finally say, okay, I will go to detox and
12 then when they pick up the phone and there's no bed
13 available, sometimes they will come back the next
14 week but we mightn't see them for another week or two
15 before they show up.

16
17 I also think there is a specific barrier at detox
18 for females, and so we've recently had the experience
19 again where we were working with a young woman who
20 finally came to the decision that she would go to
21 detox, but when she called there was a man in the
22 observation room, because I guess they have to hold
23 people for observation for a certain amount of time.
24 So, and they won't put a woman in there, as well,

1 with a man. So she couldn't, even though there was
2 space available, because she was a female she
3 couldn't access the service at that time.
4

5 And the third is I think we need to address the No
6 Smoking policy and again harm reduction. So, we see
7 a lot of people who will not or cannot access detox
8 services because they want to be able to smoke while
9 they're there. So that is a real barrier. That
10 makes no sense in terms of denying people access to
11 detox facilities. So again, pretty basic, pretty
12 clear, pretty easy to fix, I think.
13

14 One of the things that I haven't heard today is
15 around education in terms of like the education
16 system. And so, at Thrive most people would know we
17 are pretty passionate about education and making sure
18 people are educated and get high school or GED or
19 their ABE. So, we serve about a hundred people a
20 year through our education services. The average
21 learner is leaving school at grade seven and we've
22 seen people leave as young as grade three. And
23 mental health is a predominant factor that causes
24 people to leave. So we see real inconsistencies.

1 And I know the psychology presentation spoke about
2 the lack of psychology services in the school system.
3 We see an inconsistent continuum of supports as
4 people had in the high schools. So if I've had a
5 mental health issue and I had some supports available
6 to me, that generally drops by the time people get
7 into high school.

8
9 You have to have an assessment as a prerequisite
10 for service, and this actually disqualifies many
11 young people from being able to access services
12 because you actually have to be in school to get the
13 assessments, and, unfortunately, way too many of our
14 young people are not in school. We recently seen the
15 Rowan Centre school closed and district school, which
16 is a wonderful, wonderful school is part time. So if
17 I have a pervasive mental health issue and I want to
18 go to school full time, I can't. So, that's just,
19 for us, kind of not good enough.

20
21 And in terms of programming barriers, we are
22 dropping people who miss three or more appointments.
23 And so, again, if I have a significant addiction I'm
24 probably not going to do well with making and keeping

1 appointments, and, so, to drop people is not the
2 answer. The answer is how do we create a service
3 where we're able to connect and reach out to people
4 and serve them in a way that's going to work for
5 them, as opposed to how you're going to connect with
6 service doesn't work with us, so you're going to have
7 to go.

8
9 We also see Humberwood not accepting people
10 because of existing medications that they take. We
11 recently have had some somebody turned down at
12 Humberwood with a significant addiction, heavy IV
13 drug use, but she's also on Ritalin. That is part of
14 her mental health treatment, and she can't, she
15 wasn't accepted.

16
17 Lack of funding for SWAP and, so, I think SWAP
18 which is the, I'll call it, the needle exchange
19 service is a really critical part of the service
20 delivery here in St. John's and across the province,
21 and we really would like to see an increased funding
22 for SWSD because the service they are providing is
23 really critical for people.

24

1 Honourable Steve Kent:

2 Does that funding come through Eastern Health or?

3 Unidentified Female:

4 Department of Health.

5 Honourable Steve Kent:

6 Yeah, directly from the department, not through the
7 Health Authority?

8 Unidentified Female:

9 SWSC.

10 Honourable Steve Kent:

11 Oh, SWSC, okay.

12 Gerry Rogers:

13 What's that?

14 Honourable Steve Kent:

15 Seniors Wellness Social Development.

16 Unidentified Female:

17 (Inaudible - no microphone).

18 Honourable Steve Kent:

19 Okay, all right.

20 Angela Crockwell:

21 And I know that counseling is a part of the methadone
22 program, the Opioid Treatment Centre but I will say
23 our participants say that they have very limited
24 access to counseling services as part of that. We do

1 not have long-term treatment options in this
2 province, and Humberwood is three weeks. It's okay
3 but for people, again, with significant it's just
4 scratching the surface. And again, Thrive believes
5 that anybody who's doing any work in the field of
6 addictions or mental health, their services really
7 need to be trauma informed because what we're
8 identifying is trauma is actually often the
9 foundation for a lot of the mental health and
10 addictions. So if we're not, we're not trauma
11 informed and we're not getting at the trauma then
12 we'll really not getting at the core of the issue.
13 Thank you. That's it.

14 Honourable Steve Kent:

15 That's excellent.

16 Dr. Bruce Gilbert:

17 So we have a couple of minutes.

18 Gerry Rogers:

19 Is there a question from the floor? Can you take a
20 question from the floor?

21 Unidentified Female:

22 (Inaudible - not by microphone).

23 Angela Crockwell:

24 So, my understanding, and there's probably people

1 here but, there are counselors attached to that
2 program and so people should be getting counseling as
3 part of that. What we're hearing from people is that
4 it is actually not happening for a lot of people.

5 Yeah.

6 Unidentified Female:

7 (Inaudible - not by microphone).

8 Dr. Bruce Gilbert:

9 Okay, we have a couple of minutes.

10 Honourable Steve Kent:

11 You guys go first.

12 Gerry Rogers:

13 Okay. I'm curious. I want to thank you very much
14 and I know the incredible work that Thrive is doing;
15 often lifesaving work and I want to thank you for
16 that. I know that some of your challenges are not
17 knowing what your funding is going to be from year to
18 year; not knowing soon enough what your funding is
19 going to be. I don't know how you can keep the
20 fabulous dedicated staff that you have. Are you ever
21 at the point where you, because of lack of funding,
22 that you're not able to deliver the services that you
23 need to deliver?

24

1 Angela Crockwell:

2 Absolutely. And I would think that we're probably
3 not unlike most non-profits and charities in the
4 province. But funding is an ongoing issue and we've
5 been really successful at engaging the corporate. So
6 I can tell you one of the things that where we will
7 lose is corporate funding, because our contract is
8 up, to be able to do the work around the education
9 piece with young people. And that I really strongly
10 believe the education system needs to rethink
11 alternative education and the importance of that and
12 how well it can serve people. And alternative
13 education is not about creating kind of separate
14 entities but it is part of a continuum of care and it
15 is a critical component, and we've seen such
16 improvements in young people's lives and, really, the
17 trajectory of their life because of education.

18 Gerry Rogers:

19 And one more quick question. I know that I'm hearing
20 from other groups that depend very much on corporate
21 funding, because of the particular economic situation
22 that we find ourselves in. That there are a number
23 of groups who are saying that they're not getting the
24 oil money right now. And is that going to be a

1 problem for you? And if so, what will be the
2 ramifications of that?

3 Angela Crockwell:

4 I mean, again, lack of funding, and I know obviously
5 that funding is critical to ensure the service
6 delivery of people, and you're right, there are
7 organizations and Thrive is one of them that really
8 is doing lifesaving work, and when people aren't
9 connected, because we have done a really successful
10 job of supporting people who really live on margins
11 and so when we're not able to do that it's not a
12 matter of people don't get some minimal amount of
13 support. It really is a critical piece and so we do
14 need to be appropriately funded, for sure.

15 Gerry Rogers:

16 I do have one more question.

17 Honourable Steve Kent:

18 Go for it.

19 Gerry Rogers:

20 Can you talk a little bit about the specifics of
21 young women? I know we heard the barrier in terms of
22 the detox if there's a guy in the observation room.
23 But are there other issues specific to young women
24 that you see or deal with?

1 Angela Crockwell:

2 Yeah, I mean I think Thrive tries to ensure we're
3 always using the gender lens in the work that we do,
4 and so most people who know the work we do will also
5 know we're very passionate around the issue of sexual
6 exploitation and human trafficking and that. While
7 that happens to young men in our province, when there
8 is a definite clear link between housing addiction
9 and sexual exploitation and so that's one that we see
10 happening more for our young women than our young
11 men.

12 Honourable Steve Kent:

13 Is there time for another one?

14 Dr. Bruce Gilbert:

15 Yeah.

16 Honourable Steve Kent:

17 Thanks.

18 Dr. Bruce Gilbert:

19 A short one.

20 Honourable Steve Kent:

21 Great presentation. You've made some very practical
22 suggestions on things we can do pretty quickly. And
23 you've also identified some things that are a bit
24 more complex that will probably take us some time.

1 You mentioned housing. I know you didn't get a
2 lot of time to talk about it but I do want to ask you
3 a question because I know you got a good knowledge of
4 who's going on in this region. We've heard in every
5 session we've done so far that access to supportive
6 housing is a huge challenge. So, based on your
7 knowledge of who's doing what in this region, it's a
8 problem across the province, but a bulk of the
9 population, 60% of the populations near here. So if
10 there was some funding available to tackle that, any
11 thoughts on next steps to expense supportive housing?
12 Do you have any thoughts on what a model would look
13 like? We've got a big need and I'm just curious how
14 you'd go about tackling that challenge, because I
15 know housing is a lot of, a big issue for a lot of
16 the young people you deal with.

17 Angela Crockwell:

18 Yeah. And supportive housing is critical. Safe
19 housing is critical.

20 Honourable Steve Kent:

21 Yes.

22 Angela Crockwell:

23 One of the other pieces that we identify is
24 barrier-free housing is also really critical.

1 Honourable Steve Kent.

2 Right, right.

3 Angela Crockwell:

4 So for people who are really struggling and have an
5 active addiction, we see people who are barred from
6 shelters on a consistent basis and they are not able
7 to access any housing. So, I'll give you an example.
8 We had a young woman in our facility maybe a couple
9 of weeks ago and she's been barred from every shelter
10 in the city, and then talked about where am I going
11 do crash tonight and what am I going to do, and if I
12 crash at a friend's house I'm going to be expected to
13 pay for him, so I might have to go over to one of the
14 massage parlours and see if I can hoof enough money
15 to be able to have a place to sleep. So I think
16 while there is a significant need for safe and
17 affordable housing, there is a significant need for
18 supportive housing because people need that to be
19 able to take care of their needs.

20

21 There is also a need for that barrier-free piece
22 as well, where we aren't kicking people out of
23 housing and out of shelters because of complex mental
24 health and addictions needs and putting them on the

1 street.

2 Honourable Steve Kent:

3 Right. Good point. Thank you.

4 Angela Crockwell:

5 Thanks.

6 Dr. Bruce Gilbert:

7 Okay. Thank you very much. Okay, next up we have

8 Mr. Dave Banko, Executive Director of the

9 Schizophrenia Society of Newfoundland and Labrador.

10 You can use the podium.

11 Dave Banko:

12 I'm a little old school because I tend to have

13 technical difficulties, so you're stuck looking at

14 me. Essentially, these are a number of issues that

15 were brought forward after consultation with some of

16 our membership. The first one will be brief. It's

17 essentially the Waterford hospital needs to be

18 replaced. (Clapping).

19

20 The next issue is family and caregiver supports.

21 Often times we see ... hold on a second here.

22 Oftentimes we see family members or I'll get phone

23 calls from family members where their loved one is

24 being released from hospital or discharged and they

1 have no, they have no supports in place because they
2 are going home. Or, because they're an adult and
3 they are going home with a loved one, the family
4 members or the primary caregiver isn't given any
5 information with regards to medications, side
6 effects, signs and symptoms of relapse. They are not
7 aware of any community organizations that provide
8 services. And as an example, I mean we have members
9 who have found us by virtue of the newspaper or
10 bulletins, wherever we place them. But essentially,
11 it's the same thing with CHANNAL, where they offer a
12 service within the Waterford, our office is in the
13 Waterford and the staff aren't, I mean they're not
14 aware of the services that are being offered in the
15 community, so they are not even directed to us and
16 we're just down the hall. Or in CHANNAL's case they
17 actually have peer support workers sitting in the
18 hospital that aren't being utilized.

19
20 And one of the big sticklers for a lot of family
21 members is they don't have a voice in the system.
22 Oftentimes, again, they have grievances they need to
23 air, they need to communicate with someone. And they
24 often feel like they're essentially get lip service

1 until they're forced to contact the media or harass
2 the Minister.

3
4 Mobile Crisis Response Team, I mean we're very
5 happy, a lot of our members are very happy that it's
6 now seven-day service. It would be great if it was
7 24 hours. (Clapping). And it would be even better
8 if the boundaries were expanded and if a similar
9 service was available in other larger demographic
10 areas. Oftentimes we'll get phone calls from our
11 family members in Corner Brook and they say, oh,
12 that's great, but what do we do here?

13
14 Mental health and the school system. We would
15 love to see something put in the curriculum on mental
16 health. (Clapping and cheering). We did a
17 presentation two months ago at the provincial
18 conference for the School Administrators' Council.
19 Last year we did the presentation at the Federation
20 of Student Councils. Less than about 6% of them,
21 maybe even 5%, had any kind of mental health first
22 aid or assist training. So what we would like to see
23 is staff, educators, whoever, have the opportunity to
24 take mental health first aid training within the

1 school system, and that includes assist training as
2 well.

3

4 How am I doing for time? One of the things that,
5 I mean some of you already heard me ramble about this
6 in the past, but what the students at Holy Heart did
7 and Gonzaga was phenomenal. (Clapping).

8 Gerry Rogers:

9 Yeah. There they are.

10 Dave Banko:

11 However, as awesome and empowering as it was, it's
12 also a sad reflection on us and where the education
13 system is the government and community organizations
14 are and how we've actually dropped the ball.

15

16 Wait times are another issue across the province.
17 I know I've said it, Janine, who's gone, she said it,
18 and I think Angela said it as well. One of the
19 issues or concerns that we have is yes, all the
20 stigma awareness stuff is working. So what happens
21 now with it being successful and more people coming
22 forward and accessing services? What happens to
23 those wait times?

24

1 Labrador and rural Newfoundland, I regularly get
2 phone calls and e-mails from families in Labrador and
3 rural Newfoundland, and sometimes the question is,
4 well, what about mental health first aid? Mental
5 health first aid is great if you actually have access
6 to services because it's like regular first aid.
7 You're there to just put a band aid on the situation
8 for that brief time period, but you need to follow up
9 with actual services. And if you live out in St.
10 Anthony, you're crap out of luck.

11
12 Something that we've discussed, well, with my
13 Board members and I mean some other community
14 partners is that we're actually encouraged by the
15 government's interest in looking at public/private
16 partnerships and privatizing some services. My
17 experience, coming from Hamilton, there are programs
18 that are offered more efficiently and better through
19 non-profits and community-based organizations than
20 through regional health authorities or the
21 government.

22
23 And last but not least, housing. More so a
24 proactive issue for us to solve. We have an aging

1 population. It's something that I get a phone call
2 at least once a week are family members who are in
3 their sixties, or older, and they're saying what do I
4 do, I know I'm not going to live forever, but how do
5 I ensure that my loved one has a place to stay or has
6 access to funds without blowing its all on VLTs? One
7 of the examples that I'm dealing with right now is a
8 family member who inherited his home -- actually, I
9 might be dealing with one other person who's in a
10 similar situation. But they essentially inherited
11 their home and they're at risk of losing over
12 two-thirds of their social assistance. So,
13 essentially that puts them in this cycle where they
14 have to sell their home, live off of those funds
15 until it runs out. Once they lose all that money and
16 use it up on living, rent, not on their home, feeding
17 themselves paying for whatever because they're all
18 going to also going to lose their drug subsidy, then
19 they can apply for Newfoundland Housing afterwards,
20 which is backwards. (Clapping). Look at that, that
21 was my last one. Questions?

22 Honourable Steve Kent:

23 Lots. You want to go first?

24

1 Gerry Rogers:

2 Thank you so much, Dave, for this. When we were in
3 Corner Brook, there were a number of people who came
4 to the round table discussions from the Schizophrenia
5 Society and they were predominantly parents of adult
6 sons and daughters with schizophrenia, and they were
7 all, without exception, talking about what happens
8 when I'm too old to help my kids? The other issue
9 that they talked about was similar to what you
10 brought up in that their adult son or daughter may
11 see a psychiatrist or may be resistant to seeing a
12 psychiatrist, but their concerns were they wanted to
13 be able to hear from the doctor about what was going
14 on with their son or their daughter so that they
15 could better understand, whether it's medication
16 regimes or what they can do to help. Can you talk
17 about those two issues?

18 Dave Banko:

19 Sure. That's something that we're always dealing
20 with, without violating patient confidentiality. But
21 we always encourage family members to give
22 information to the health care team, whether it is a
23 journal of things that are always happening. But I
24 don't see why health care professionals can't still

1 do the human thing and still offer reassurances, as
2 opposed to just completely shutting out family
3 members entirely.

4 Gerry Rogers:

5 And the whole issue again of the adult son or
6 daughter with a parent worried that the parent is
7 going to be too old to take care or what happens with
8 their son or daughter when they pass on. I guess,
9 what they really are concerned about is some form of
10 supportive housing, supportive care for their sons or
11 daughters. I don't know, I'm just wondering if that
12 was an issue that has been brought up to you.

13 Dave Banko:

14 Yeah. Well, housing is always being brought up,
15 especially with older family members, because they
16 don't know what to do. And as of last fall I've been
17 directing them to call, to contact their personal
18 bankers and say listen, put me in touch with an
19 estate planner, regardless of how small their estate
20 is, and then work with them. Right? Because as it
21 stands, anybody who inherits a significant sum of
22 money they're going to lose whatever social
23 assistance they have, which is great for a year or
24 two, but then they look, then they face having no

1 extra money and, again, applying for Newfoundland
2 Housing and, basically, starting from scratch.

3 Gerry Rogers:

4 Okay, sorry, just one more question. We heard you
5 loud and clearly about the Waterford, the Waterford,
6 the Waterford. Realistically speaking, it's going to
7 be years before the doors are going to be opened on a
8 new Waterford and one of the questions I've been
9 asking, so what about the interim? What do we do in
10 the meantime, because we know you can't just, it's
11 going to be years? Do you have any suggestions or
12 insights into that. What can be done to alleviate
13 the crisis that that facility is in right now in
14 terms of the services that have to be provided to
15 people?

16 Dave Banko:

17 A lot of those services can be provided in a
18 community. Does it mean more money? Yeah, it does
19 mean more money. But I mean if we can find a million
20 dollars a season for Republic of Doyle. (Clapping
21 and cheering).

22 Honourable Felix Collins:

23 A quick question, Dave. Has there been any
24 discussion or any with the educational officials or

1 the Department of Education with regard to mental
2 health unit in high school curriculum? Has that ever
3 been approached?

4 Dave Banko:

5 We actually met with someone two years ago, I think
6 it was two years ago. It was prior to the
7 announcement of the school districts amalgamating,
8 and we were told the only way we could actually do it
9 is if we partnered with someone who is doing graduate
10 level research at MUN. That's the only way they
11 would consider it.

12 Andrew Parsons:

13 Dave, mine is just a very simple question. The
14 Mobile Crisis Team, which, again, I would love to see
15 everyone, I'm from the West Coast myself. What is
16 the boundary here in the area where it actually goes?
17 I have no idea.

18 Dave Banko:

19 Essentially, it's forty minutes outside of, up to
20 forty minutes outside of St. John's.

21 Andrew Parsons:

22 Up to forty minutes.

23 Dave Banko:

24 So, like Holyrood is essentially the boundary, going

1 in that direction, and I think Bay Roberts going
2 south. Am I wrong? Someone else might know. Bay
3 Bulls, sorry. I'm a mainlander. There you go.

4 Honourable Steve Kent:

5 Thank you.

6 Honourable Felix Collins:

7 If I could come back to the mental health units and
8 high school curriculum again. Given the great work
9 that's been done in Holy Heart and Gonzaga in recent
10 times, the impetus for spurring discussion on that
11 issue might have been increased, and I'm wondering if
12 you shouldn't open that discussion again.

13 Dave Banko:

14 I didn't actually hear the whole thing. Could you
15 repeat it?

16 Honourable Felix Collins:

17 Given your approach to the educational officials
18 initially to establish a mental health unit in the
19 curriculum, and you gave me the answer, that you had
20 to partner up with some graduate student, research,
21 however. How long -- it was a couple of years ago
22 you said?

23 Dave Banko:

24 Yeah, that was about two years ago.

1 Honourable Felix Collins:

2 Yes. And given the great work that's gone on
3 recently in Holy Heart, for example, and Gonzaga, I'm
4 wondering if that wouldn't help enhance your position
5 now in going back and looking for some mental health
6 units in curriculum?

7 Dave Banko:

8 We certainly hope so. I mean that is something that
9 we have discussed and we are also pursuing our
10 options in trying to develop a partnership directly
11 with the Faculty of Education.

12 Dr. Bruce Gilbert:

13 Thank you very much. That was excellent.

1 I'd like to invite (inaudible) to the
2 stage ... Take it away, thank you.

3 Bruce Pearce:

4 Well, we'd really take to thank the All-Party
5 Committee for the opportunity to present here. Can
6 you hear? Sorry. We really want to thank you for
7 inviting us to participate and inviting the world in

1 for this needed conversation in our community. It
2 doesn't happen easily so we know it took some
3 negotiation and partnerships to make that happen.
4 Very much akin to what we're going to be talking to
5 you about, a barn raising in our community to end
6 homelessness. All hands on deck. We've got some
7 ideas and some resources to bring with that, but
8 first let me introduce myself and my colleague will
9 introduce himself as well. I'm Bruce Pearce, the
10 community development worker for End Homelessness St.
11 John's.

12 Shawn Skinner:

13 And I'm Shawn Skinner and I chair the Board of End
14 Homelessness St. John's. And in our presentation
15 we'll tell you a little bit more about our group and
16 the work that we do.

17 Bruce Pearce:

18 And this is our clicker. Hopefully folks can see
19 that. Well, hopefully the name is obvious, who we
20 are and why we're here. But our name says it, we're
21 here to end homelessness in St. John's and we mean
22 it, and in order to do that we must do it together
23 with the community and that means everyone in this
24 room and everyone outside it. And all of you on the

1 All-Party Committee.

2
3 So all too often homelessness results when people
4 in our community are challenged by mental health and
5 addictions - I know you've heard a lot about that -
6 and not having the right supports and the right
7 housing at the right time. Finding that sweet spot
8 that works for everybody based on their need. So
9 since 2000, our successive community plans have
10 mobilized partnerships and resources to provide
11 supportive housing in our community. And these are
12 some photos of some of the examples, not all of them,
13 in our community. But during our first decade, since
14 2000, we focused largely on capital projects and that
15 means helping our community create new supportive and
16 transitional housing and emergency shelter capacity
17 such as the ones you see here. Catherine mentioned
18 Stella's Circle as an example and Choices. That's
19 about over 300 units city wide and we've invested
20 about 18 million in federal homelessness resources
21 towards that. So this has made life-changing
22 difference for people who had no place to call home
23 before; including many who struggle with mental
24 health and addictions. It provided a home base for

1 recovery and wellbeing and a safe, supportive
2 community offering dignity, respect and inclusion.
3 And it reduced hospital and prison stays and
4 associated costs. But as we know, we haven't been
5 able to fully meet the need. So last year, building
6 on what we'd learned along the way, we held extensive
7 community consultations culminating in the forum you
8 see here at City Hall last year to develop an
9 ambitious new plan to prevent and finally end
10 homelessness St. John's, based on a Housing First
11 philosophy. And you may have heard a lot about the
12 Housing First philosophy here but what it means to us
13 is immediate access to housing as a right without
14 preconditions, without expectations of compliance,
15 tied to client-directed supports of client choice.

16
17 So, in order to walk that talk, our new community
18 plan which you see here before you sets the following
19 directions: to end chronic and episodic
20 homelessness; to rehouse and support homeless persons
21 and prevent homelessness for those at risk; to reduce
22 the average length of stay in our emergency shelters;
23 to develop a coordinated homeless serving system.
24 And obviously, in doing so, these last three points

1 mean integration and alignment of funding resources,
2 public systems to be able to get us where we need to
3 go. We brought copies of our plan for you and for
4 anybody in the room who'd be interested in seeing it.

5
6 So, while we were busy developing the plan, we
7 realized we needed a new vehicle to drive it forward
8 or to renew the vehicle to drive it forward. So the
9 community also redesigned our leadership team, which
10 you can see here presented before you, to pursue the
11 plan's priority. So, shown here is the community
12 entity in light blue. The City of St. John's holds
13 the funds that we marshal from all the partners and
14 they don't charge us any admin for that. So we put
15 it all into the community directly. It is part of
16 the City's contribution to our work. And it's all
17 overseen by our multi-stakeholder board.

18
19 We've also got teams that underpin the community
20 plan from the broader community which you see here
21 around our four priorities: system coordination;
22 information and research; housing and supports; and a
23 big one that we're embarking on this year is
24 leadership resources and coordination.

1 We also have a frontline table that you don't see
2 here which is anybody who wants to come and meet with
3 us bimonthly. And it's a lot of the frontline groups
4 you see here and consumers who are our ground
5 (inaudible) for the work that we do so we can adjust
6 as we go.

7
8 We're blessed to have a talented and passionate
9 leadership team from all sectors committed to ending
10 homelessness. I'm sorry, I'm dwelling a little bit
11 on who we are and how we pulled it together, but it's
12 been part of our reformation in the last little
13 while. And the team includes the wonderful Colleen
14 Simms from Health and Community Services who's here
15 today and many more from all sectors.

16
17 So, just briefly what we'll do along the way, this
18 is laid out in our years of our community plan, 2014
19 up to 2019. We just finished the first year
20 establishing the foundation I told you about. 2015,
21 which we're partway into, is now putting some
22 programs on the street. And that's starting with
23 programs that will end chronic and episodic
24 homelessness starting this year, permanent supportive

1 housing and intensive case management, and next year
2 moving upstream to prevent homelessness, close the
3 front door to homelessness and provide rapid
4 rehousing for folks the minute they appear as
5 homeless and divert them from shelters into stable
6 housing. Then from there, we maintain focus in 2017,
7 start thinking about where we go after 2018 and
8 beyond, so we don't drop the ball.

9
10 A quick look at homelessness in St. John's. Why
11 people use shelters. It won't be surprising to you
12 but this is verified by data that was collected for
13 us from the six emergency shelters in St. John's by
14 the Newfoundland Statistics Agency, and it clearly
15 points to the need to address the underlying issues
16 which cause homelessness; i.e., not to build more
17 shelters is the response, but to get to the root of
18 the problem. And addressing mental health issues and
19 substance use in housing, framework in which people
20 can recover and flourish. People who have
21 experienced homelessness tell us that housing, plus
22 tailored supports based on choices are the key to
23 ending the cycle of homelessness. And all the
24 evidence nationally and internationally supports this

1 to be true.

2
3 So, based on our community shelter data and
4 factoring in people who are homeless but don't appear
5 in our shelters, we estimate St. John's homeless
6 population at approximately 800. That's not an any
7 given night. That's the over the course of a year.
8 And each person is unique. They're a human being, a
9 member of our community, not a number, and each has
10 unique strengths and needs. So, our community plan
11 sets out to help them regain control of their lives,
12 getting their housing in place first with the right
13 supports and we're starting now by ending
14 homelessness for those who've experienced chronic and
15 episodic homelessness which is about 15 to 25%, as
16 you see at the bottom of the graphic here, about 120
17 to 150 individuals. This means they've been homeless
18 for more than half a year, if you can imagine, or
19 have been homeless at least three times during the
20 year. And that's corroborated by the information we
21 already have. Then we'll move next year, we're not
22 waiting long, to introduce housing solutions and
23 supports for the majority of the population, the
24 other 80% who are transitionally homeless or who may

1 be at imminent risk of homelessness.

2
3 So, our interventions just take a quick closer
4 look at it. We've developed a plan based on needs
5 and based on experience of other communities with
6 plans to end homelessness. Our sister community of
7 Medicine Hat, Alberta is poised to become the first
8 Canadian community to end chronic homelessness this
9 year, and we partnered with them to design some of
10 our programs, as well as Calgary, who are also moving
11 forward too, despite the major floor they had a few
12 years ago.

13
14 So, for individuals with lower acuity or lesser
15 needs, so to speak, we'll be tailoring rapid
16 rehousing and affordable housing and prevention
17 services for them with them. And also, for persons
18 with moderate acuity, we're launching an intensive
19 case management program with housing supports. Very
20 much like what Catherine just mentioned, more housing
21 support workers in the community, more case managers,
22 and not just staff but money to actually, if you find
23 that apartment Friday night at two in the morning and
24 you don't want to wait for the provincial system to

1 kick in, we understand things takes time, we'll use
2 some of our federal homelessness money in an
3 emergency way to make that bridge happen. To get the
4 furnishings, to fix the hole in the wall, if there's
5 damage. There's lots of creative things we can do.

6
7 For permanent supportive housing for individuals
8 who have had the longest experience of homelessness,
9 we've just done three contracts with community-based
10 groups to house chronically homeless persons, along
11 with the supportive housing they are already
12 developing.

13
14 So here's the three programs in pink in the middle
15 that we'll be rolling out. Intensive case management
16 and housing supports this fall and then meanwhile
17 we'll start redesigning our homelessness prevention
18 and rapid rehousing program this year. We'd love
19 people's advice on that, so it will be ready to
20 launch next spring.

21
22 And I'm going to finish with that and ask Shawn to
23 conclude our presentation with a few words about our
24 investments and partnerships for ending homelessness.

1 Shawn Skinner:

2 Okay, thank you very much. And as Bruce said, we're
3 thankful for the opportunity to come here today and
4 it's good for me to walk into a room and see so many
5 other people here as well and to know that this is of
6 interest and concern and importance to a lot of
7 people in our community.

8

9 Up here, we've got on the light blue \$3.4 million,
10 give or take, that we've been able to access from the
11 Federal Government through the homeless partnering
12 strategy which we can use to implement our five-year
13 plan and to action the five-year plan that we've
14 developed. We need, in this sort of gray area in the
15 middle there, matching sources. That's money we
16 don't have that we're out looking for. While we're
17 doing all the work that Bruce talked about very
18 quickly, we're also trying to come up with this money
19 to do the things we need. I'm happy to say that some
20 of that money has already been committed. As an
21 example, the second line, permanent supportive
22 housing, \$802,000 needed. Newfoundland and Labrador
23 Housing has come on board and committed that money
24 for us. (Clapping).

1 We've had great support from the City of St.
2 John's, as Bruce has already mentioned. The
3 province, through a number of departments within
4 government, has been very supportive. And as I've
5 said, the Federal Government has come forward with
6 this money as well.

7

8 Gerry Rogers:

9 Yeah, Dave.

10 Shawn Skinner:

11 It was Dave, yeah. They talked about needing support
12 in the community. This is what we're trying to do.
13 For the past ten years our group of volunteers has
14 been working on capital and infrastructure. And
15 there was some slides up there showing places where
16 people, where we've built beds, I guess, is the way
17 I'd put it to you. Now what we're trying to do is
18 make sure that we are able to finance the supports,
19 finance the ability of people to get into the
20 community to do. And so that's what our plan is about now.

21

4 And one of the messages I want to leave with you
5 is that we understand that's important. A lot of
6 people that we work with understand that's important,
7 that we have great support from the community.
8 Organizations that have been mentioned here today,

9 like Choices for Youth, Stella's Circle, some of the
10 Provincial Government departments, all of those
11 groups are working with us. But to do the capital
12 work that we need I wanted to make a point, and I
13 hope there's some media in the room listening to
14 this, we need support from other people. We need
15 support from our business community. We need support
16 from our corporate community. And that money is out
17 there and we're going to go after it and we think we
18 can access a lot of that to help us with the work
19 that we do. But this money is being used, 100% of
20 what we raise is being used directly in the community
21 to provide the level of supports that are needed.
22 And some of the things that we've already done in the
23 last year and a half, are already in action, will be
24 to do things like intensive case management, to be

1 able to do supportive housing. We've got a permanent
2 supportive housing program that we have where we have
3 two dedicated people in our program who will do the
4 kind of work that Catherine talked about. So these
5 are people who are nimble, mobile, well qualified,
6 well experienced and able to help the people, able to
7 assist the people that need the help and assistance.
8 And that's the kind of work that we, at End
9 Homelessness St. John's, are doing.

10 Gerry Rogers:

11 Great.

12 Shawn Skinner:

13 And I thank you for the time.

14 Dr. Bruce Gilbert:

15 So we have a couple of minutes if the Panel has any
16 reaction, quick reactions or short questions.

17 Gerry Rogers:

18 My initial reaction is oh my God, is this doable?
19 And it just makes so much sense and tell us it's
20 doable.

21 Shawn Skinner:

22 It's definitely doable, Gerry, and we wouldn't be
23 sitting here today if we didn't think it's doable.
24 And it's doable because we've had challenges like

1 this in the last 10 to 12 years where we've done
2 things. Stella's Circle has all kinds of housing,
3 Carew Lodge, the Wiseman Centre, the Native
4 Friendship Centre. All of those agencies and
5 organizations are things that the community has put
6 their focus on and been able to accomplish what
7 needed to be accomplished. This is just another
8 focus and we will accomplish. I have no doubt that
9 we will be able to implement it.

10 Bruce Pearce:

11 I wouldn't mind building on that, just quickly.
12 Other communities have gone before us and in fact
13 we've got our own best practices here. We just need
14 to scale them up. And so, this is the first time
15 we've ever done a plan in St. John's, and even in
16 this province, where we've sized the plan to the
17 scale of the need, as opposed to managing our way
18 along from year to year and feeling good that you've
19 done 20 units, 40 units, helped a few people. This
20 is about, we know the universe of our shelter
21 population and our homeless population and that's
22 where we're going to stick to our knitting. We're
23 not going to be doing all the affordable housing in
24 the province or the city. We'll plug and play into

1 the mayor's housing committee and NL Housing for
2 that. But we're going to be focusing on lifting
3 people out of homelessness together with them and
4 preventing them if they're at immediate risk. And
5 that's a doable job. But we need to think, Shawn had
6 mentioned, we need some friends to help us, but it's
7 not a bad deal. We've got half the money from the
8 Feds. Wouldn't it be great if we could --

9 Gerry Rogers:

10 I have another question.

11 Bruce Pearce:

12 Yeah.

13 Dr. Bruce Gilbert:

14 Steve Kent?

15 Gerry Rogers:

16 Sorry.

17 Honourable Steve Kent:

18 You can go ahead.

19 Gerry Rogers:

20 Okay. My other question is, we see this really
21 growing proportional shift of seniors. Are they in
22 your vision? What does that mean, because we see so
23 many seniors over-housed or what's going to happen to
24 them?

1 Shawn Skinner:

2 So there are two groups, I guess, that I would say we
3 think are going to be large in terms of numbers. One
4 is seniors as you've identified; the other is youth.
5 There is a growing population of youth that need
6 service and help as well. And the short answer is
7 yes, our plan does take that into consideration and
8 our plan does understand that we need to tackle that,
9 but we'll do that in consultation with other groups,
10 as Bruce has mentioned. There are people out there
11 doing great work now. They just need us to help them
12 a little bit or we need a little bit of help from
13 them. We don't need to do it all ourselves and we're
14 building on what's already happening in our
15 community. And the beauty of our community is that
16 the people who come to the table - Bruce had the long
17 list of all of our people up there from the different
18 agencies - they leave their hats at the door. They
19 come in and they get at the problem. And they don't
20 come in looking for themselves, they come in for
21 looking for everybody, to help the greater good. And
22 so we've been fortunate that we've got those kind of
23 people at the table. So yes, to answer your
24 question, we recognize that population and we will

1 have opportunities to service them in and assist them
2 in our plan.

3 Honourable Steve Kent:

4 I just want to echo the sentiments that have already
5 been expressed. Wow. I knew you had done good work.
6 I knew a little bit about the work you had done. I
7 had no idea that it was as far along as it is. So, I
8 mean this is awesome. Just on behalf of the
9 Committee, I would like to invite you to have a
10 follow-up session with us, because supportive housing
11 is a big, big issue, as I've said already today. You
12 can probably help us get our heads around some of the
13 issues that we're already struggling with. So I
14 would like to invite you to do that because we need
15 to have, I think, a longer discussion. But this is
16 excellent work. So thank you for that.

17 Bruce Pearce:

18 Thank you.

19 Shawn Skinner:

20 Thank you.

21 Dr. Bruce Gilbert:

22 Thank you very much. Yet again, another awesome
23 presentation. Next up we have Mr. Ron Fitzpatrick.
24 And he's a member of Minister Kent's Provincial

1 Mental Health and Addictions Advisory Council. So,
2 Ron, you have 30 minutes. You can walk slowly up
3 here because some people were looking to have a quick
4 little break. So, you can go as slow as you want to
5 get up here. Ron, since you've got 30 minutes, are
6 you going to be at the table or do you want to stay
7 at the podium?

8 Ron Fitzpatrick:

9 I'd sooner stand up in case somebody wants to throw a
10 bottle or something at me.

11 Dr. Bruce Gilbert:

12 Okay, he wants to stay up here in case somebody wants
13 to throw a bottle at him, he said. And I'm going to
14 give you a ten-minute and a five-minute warning. How
15 about that?

16 Ron Fitzpatrick:

17 Sure, yeah.

18 Dr. Bruce Gilbert:

19 There you go.

20 Ron Fitzpatrick:

21 Thank you, Bruce. I hope you can hear me because
22 we're sitting over there and I can't hear too much.
23 So, when you get my age you think it's your hearing
24 is going but, can you hear? Did you hear the one

1 about the -- now, okay.

2
3 It's an honor to be here because it gives me a
4 great opportunity to speak to some things. I'm on
5 the Minister's Advisory Council for Mental Health and
6 Addictions, and this month it will be five years that
7 I'm on it with other people. And we've discussed
8 many, many, many issues in that five years
9 surrounding mental health and addictions. And the
10 few things that we see in our work, I work at
11 Turnings with Dan McGettigan and Kevin Foley and
12 numerous volunteers that we wouldn't be able to do
13 anything without, the backbone of Turnings. But we
14 work with offenders and 60% of the people we work
15 with have one or more forms of mental illness and
16 addictions issues. And we're in and out of prisons,
17 federal and provincial, and we do things like that,
18 and we're in courts regularly with them. And some of
19 the things that get on my nerves, I'm going to pass
20 out to you today because I say this as a human being,
21 and sometimes as a Newfoundlander it makes me sick
22 when I have to see some of the things I see when
23 you're in some of the prisons. And this day and age,
24 anyway it's not, I can't accept it, so I want to pass

1 it on here today. Hopefully it will open your minds
2 and you can speak to it, to the people you're in
3 contact with because we're all networking together
4 and we're all, we're all going the one way, to
5 better, safer communities and a better life for each
6 and every one of us.

7
8 Now, all of our prisons should be safe and lawful
9 and humane but because of various things that go on,
10 there's breakdowns and flaws in every prison. No
11 matter where they are, breakdown in the systems.
12 Now, it's been documented that about 60% of all
13 prisons, 60% of inmates in most of our prisons have
14 one or more forms of mental illness and that's 60%,
15 and that's enough to get on, like to cause concern
16 for anybody. But one of the other factors, which is
17 really outstanding, is the fact that 4% of all
18 inmates, 4% of the inmates in all of our prisons have
19 a severe - severe with a big capital S - mental
20 illness. Now unless I'm the only one here that's
21 totally out to lunch, somebody with a severe mental
22 illness does not belong in prison. If they get
23 there, there's a breakdown in the system somewhere.
24 And I mean I don't care if everybody in this room

1 said, Ron, they're not, you're not well. Well I
2 don't care. I don't want to be in the group that
3 says I'm out to lunch. When 4% of people with severe
4 mental illness are in prison, I wants to be, I don't
5 want to be part of the group that says they belong
6 there. I can't handle it.

7
8 And prisoners we run into with full-blown
9 schizophrenia, major depression issues, bipolar. It
10 goes ADHD, all these kinds of things. And a lot of
11 times when they go to prison they've been in the
12 community, they'd been seeing a psychiatrist
13 regularly, a psychologist regularly, family doctors,
14 addictions counselors, support groups. Then they get
15 into prisons and most of that is taken away from
16 them. They could be on, say, five types of
17 medications then they're down to one or two and they
18 cause problems and then they end up in segregation.
19 And this is a fact.

20
21 Now any of you people out here, have you heard
22 tell of a guy named Howard Sapers? He's the
23 ombudsman for the Federal Government. I think most
24 of us here know him. Anyway, Howard has done a lot

1 of work, and thanks to Howard we've all come -- this
2 is a fact that I'm going to give you now.

3 Correctional Services of Canada is now, without a
4 doubt, the biggest provider of mental health care in
5 our country.

6 Gerry Rogers:

7 Wow.

8 Ron Fitzpatrick:

9 Now that's another thing that really boils my blood.
10 I'm not kidding you. Like drives me nuts to think of
11 that. Now we got prisoners, you know, and prisoners
12 with the most acute mental illness, a lot of them are
13 being locked up and put into isolation because, like
14 I said, when they came out of the community, they're
15 brought into prisons and then when especially when
16 they're taken off their medications naturally they
17 act up because they're getting depressed or anxiety.
18 They have all kinds of stuff on the go and they act
19 out with staff or they act out with other inmates.
20 You know what? Howard Sapers said that prolonged
21 segregation of people with mental illnesses causes so
22 much stress on them that they're more likely than
23 anybody else in the prison to harm themselves, harm
24 staff or other inmates or commit suicide.

1 So inmates with severe mental illness in many of
2 our prisons, we've been up on some of them on the
3 mainlands with guys. We go up to have a talk to the
4 Newfie. Well, some people don't like that so I'll
5 say Newfoundland inmates that will be coming home
6 soon. Let them know that we're here and willing to
7 help them and everything. Several, we go up several
8 times. You meet people that we've worked with for
9 years. Dan and I were recently there, just one day
10 last year and we were up in Westmoreland. I won't
11 say anything about who met with or anything but. A
12 couple of guys we worked with, they were so sedated.
13 They were in a group with about another 30 or 40 and
14 they were all there like ra ra. They didn't know who
15 they were, where they were. Didn't know who we were
16 and we working with them for eight or ten years. So
17 when they're getting ready, they're going to be
18 released, say, in a couple of months, so when they're
19 being, just before they get released, of course now
20 they'd be tapered back till they're off of stuff, and
21 they're coming out, they're so stressed out and wound
22 up like springs. Like they're just an accident
23 waiting to happen. And like everybody here talking
24 about housing, from here to Vancouver everybody who

1 works with offenders or ex-offenders can tell you
2 that no matter what's going on, mental health issues,
3 addictions issues, anything, whatever it is, if you
4 want to get back on your feet, before any doctor can
5 help you so like except for the Lord himself, you got
6 to have safe and affordable housing. You cannot get
7 in schools. You know what I mean? You cannot try to
8 improve yourself, if you're going back out in that
9 community out there with, like there's five or six
10 beds in a house and everybody shares the kitchen and
11 the bathroom, and that guy in there is shooting up.
12 There's a prostitute in there doing something else.
13 Somebody else there is getting loaded. And I mean
14 you're trying to up your education or whatever like
15 that and it's just so dysfunctional. No matter what
16 else you do is not going to work. Safe and
17 affordable housing, everybody here knows it, we've
18 heard it all so far the afternoon, it is priority
19 one.

20
21 Shawn, wicked, my son, what you're up to. I'm
22 telling you, it's priority one. Nothing else going
23 to fall in place. We all know, we were all told
24 growing up that without a solid foundation nothing

1 else happens. Right or wrong. Solid foundation and
2 then you get on with the rest of it.

3
4 Then United Nations even talks about when we got
5 people in prison, like I was just saying, and it's
6 got nothing to do with the staff in prisons. I mean
7 people are putting these people in prisons.
8 Management and staff in these prisons have to deal
9 with them. They have to make the best of the
10 situations because the people are given to them.
11 Somebody said he or she is fit to stand trial, fit to
12 be judged. The judge has to pass sentence because
13 somebody said they're there.

14
15 Now a lot of people don't want to hear what I'm
16 going to say now and all I can say is that's tough.
17 You can put it in a pipe and smoke it. You're going
18 to hear it. People out there who say that a lot of
19 these people are fit to stand trial, fit to go to
20 prison and even when they're coming out, being
21 released from prisons, they are going in the
22 community, they are better off. Well, if I come up
23 here and I say you know what, I'm working with Johnny
24 Jones for the ten years and I can tell you he's been

1 documented, he's got papers signed saying that he's
2 50 years old, he got the mind of a 10-year-old. He's
3 full blown, he got five -- he's severely mentally
4 ill. And I'm saying every time he gets out of
5 prison, he can't function with the rest of the stuff
6 because like he gets in trouble, he stays, he don't
7 take his medications properly, he's hanging around
8 with the wrong crowd. People are stealing his
9 medications in the community. He's selling them for
10 stuff, to get coffee and doughnuts and all this kind
11 of stuff. And anyway, then when he gets off track he
12 gets in trouble and because of his past records he's
13 back in jail. And everyone is saying, these guys,
14 like what's their problem. They are in and out, in
15 and out. Half of it is not their problem. I don't
16 care if you're six-foot-six, 300 pounds, if you're
17 certified having the mind of a 10-year-old, you're a
18 10-year-old. And I mean with issues. And this is
19 what we're dealing with in our prisons. It's not the
20 staff in the prisons. They are being put in there.
21 And I says I disagree and someone will say, well,
22 your Ron Fitzpatrick. How many medical degrees you
23 got? None. Are you a psychologist? No. What are
24 you? I'm just an ordinary Newf with an ordinary job

1 trying to help people. But four other people,
2 because they're PhDs or whatever the degrees
3 are, they're going to listen to them because they got
4 25 years of service.

5
6 Now I'll simplify, like I tells people here and
7 they say, like you're all going to say, what's he on?
8 Maybe he's rolling them too tight. I'm not. But I
9 can tell you this, how many times have you got to
10 look at a dog, for instance, to say, yeah, that's
11 definitely a police dog. And that little one there,
12 yeah, that's guaranteed that's a little poodle. Do
13 you have to be a vet to know that? If you took a
14 normal 10-year-old child around with myself and Dan
15 and Kevin in the work we do, in our offices meeting
16 people, you know what, after a while that child would
17 say why is this person in prison? This person is
18 sick. This person needs help. I'm not making it up.
19 They would say it. This is true. You know, it's
20 unreal. I'm not saying that everybody out there in
21 the medical profession and everything else is out to
22 lunch. But you know what, I just put it this way, if
23 Hickman Motors got a hundred mechanics in there and
24 Terra Nova Motors got a hundred, are they all

1 fabulous fantastic mechanics? I had my car in last
2 week to get the snow tires off and they told me it
3 was out of line. I never had a hitch with it when I
4 put it in. Now I'm busy this last few days, I can't
5 get back. The thing is pulling. You puts
6 on the brakes she's going everywhere. Now what
7 genius did that? You know what I'm saying? So all
8 I'm saying is everybody out there, when we got people
9 in our communities like that are in this room and
10 five or six of us get together and say that Johnny or
11 Suzie should not be in prison like that, somebody
12 should listen to us. Seriously. Should listen to
13 us. (Clapping). We're all the same.

14
15 And the continuity of care is the big thing I've
16 been talking about. I'm almost wore out talking
17 about it. Continuity of care. We got, like I just
18 said a minute ago, we got these individuals. They're
19 mentally ill. They got severe addictions issues.
20 And out in the community they're seeing like five or
21 six professional people. They go to prison, bango.
22 That's just like a balloon on a string. Bang, that's
23 gone while he's in prison. Everybody that goes to
24 prison should come out of that prison in better shape

1 than they were when they went in. If they don't,
2 we've lost the battle already. Nothing is ever going
3 to happen. So what we need is a continuity of care.
4 Whoever these people are seeing in the community,
5 they need to be in touch with the prison so that they
6 get the care they needs. People are sharing
7 information. And when somebody goes into the prison,
8 right off the bat they have, soon as they walk in
9 through the door they have to be set up and sat down
10 and a more in-depth analysis of who they are, what
11 they are, what doctor they're seeing, what
12 psychologist they're seeing, what addictions
13 counselor, what drugs are they on, how old are they,
14 how long have they been doing these things. And then
15 what we needed, I know we're talking about the
16 Waterford here and the prison was turned down. Now
17 these are ideas we came up with on the Minister's,
18 people on it like Colleen. I mean she 's a genius.
19 She's after forgetting more than most of us knows,
20 I'm telling you. And she knows what she's talking
21 about. These are things we're putting together. Now
22 the prison is the same way.

23
24 And you know what? I got a call the other day

1 from CBC asking me I guess you're really PO'd about
2 the prison. I said, listen, I got no comment. The
3 government doesn't have any money. Times are hard.
4 We got to best of it. We got to use our money. So
5 the prison ain't going up. The money is not there
6 right now. Whether it takes four years, five years,
7 but there's so many things we can do in our
8 provincial prisons. Like half the people in prison
9 are on remand and, probably a third of them are
10 probably innocent. And then we got weekenders. I
11 mean there is things we can do to cut back the counts
12 and everything, and there's things we can do with
13 weekenders and more people on house arrest. I mean
14 there's all kinds of things we can do to save a buck
15 and to be accountable and everything else and to make
16 things better for management and staff in our
17 prisons, cut down on violence and allow more
18 programming so the people can come out in a better
19 frame of mind. Dan, for instance, Dan McGettigan
20 runs a prerelease program down there, where we build
21 relationships with the guys. And when we get them
22 out, before they get out we know that they need to
23 see this lawyer or that doctor or they need to try to
24 get to get back with their family. And we're working

1 on, we meet with everybody to try to restore their
2 confidence and get them going again. And it's a real
3 stigma. We work with high profile rapists
4 and pedophiles and murderers and everything else, and
5 people are going, I often had fellows that would be
6 out at parties ready to take me on. I must be just
7 as bad as them working with them. But somebody got
8 to work with them. We're not offender huggers. We
9 don't want to see anymore victims. And I mean unless
10 a person gets the attention they need in prison that
11 you would get in the community, they're not going to,
12 if they don't come out in better shape than they were
13 when they went in, well that was a waste of
14 government taxpayers' dollars. I mean even if you
15 don't care about who's in prison, they're wasting
16 your taxpayers' dollars if they don't make these
17 people come out in better shape. It's a waste of
18 money. We're just being pennywise and pound foolish.
19 And I mean there's lots of things can be done. We
20 got volunteers. When they come out we put circles of
21 support and accountability around them. We got seven
22 going here now with violent rapists and pedophiles
23 and we got one in Labrador going because we set up
24 there, thanks to the Government, thanks to the

1 Justice Department, the Health Department. And we
2 got one, a guy just got out of prison say a month ago
3 and he's really violent and everything, and we got
4 him all set up there now with a group that's looking
5 after him. We set up like prevention, pre-released
6 programs, doctors, everything they need and if they
7 step out of line of that we'll report them to the
8 police, whatever it takes to make it happen because
9 we don't want anymore victims and we don't want the
10 safety of the community to go out the window.

11
12 And we have to work with the government, and like
13 I heard it said here today, the business community
14 has to come on more. The worst part, we got guys who
15 were extremely violent rapists and pedophiles and
16 everything and they got jobs. We helped them get
17 jobs. But you know what, anybody who steals, nobody
18 wants them in the building. The guy who steals or
19 the girl who steals is the worst. So they got a lot
20 of stigma to breakthrough.

21
22 And Kevin runs an ACoA program. That's the
23 acronym for Adulthood Children of Alcoholic Parents.
24 These are parents who grew up in extremely

1 dysfunctional homes, and all they saw was their
2 parents like getting loaded all the day long, stoned
3 all day long, live sex on the chesterfield, fist
4 fights, the old man beating up the mudder, beating up
5 sons and daughters. And even if they don't drink,
6 they got that attitude. It's imbedded in them from
7 the time they're little babies. And then they're in
8 prison and they're coming out and unless they get the
9 help they need, and it's going to take a long while.
10 And if once they start drinking themselves or doing
11 drugs, like they become what they saw all their life.

12
13 Listen, I could go on till the cows come home but
14 all I'm saying is things are being done to help the
15 people we are working with now. And like Shawn and
16 his group and everything else they're doing, that's
17 what we need. Like we need the better foundation.
18 Our government right now is stepping in. Like this
19 party formed and our government is like putting
20 committees together, we're doing what we can and it's
21 great to see all parties. Everybody wants our
22 communities to be safer and more enjoyable for all of
23 us.

24

1 So just in case you got any questions, I'll finish
2 up now. I didn't even touch what I was going on
3 there because I gets that wound up about it I can't.
4 (Laughter). Listen, you go in a prison, I'll give
5 you an example, you go in a prison and when you sees
6 somebody there and you meet them. They're trying to
7 get a relationship. And you go, Johnny, how are you
8 doing, Johnny? Where do you live? Ah, ah, ah, I
9 think it's Patrick Street, I think. You got any
10 brothers? Ah, I don't know. Got any sisters? I
11 don't know. I mean, give me a break. Somebody like
12 that should be in a hospital, a system where they're
13 getting better treated, not out in the community
14 where people are stealing stuff on them and
15 compromising their attitudes. So listen, you can
16 talk about it forever and you'd be sick of listening
17 to me, but I don't want to spoil your weekend. So
18 anybody got any questions you'd like to ask?

19 Gerry Rogers:

20 I want to thank you so much very for the work that
21 you do and for the work that you do through Turnings.
22 And I've been down to your shop a few times and I
23 tell you I'm sure impressed with what you do with so
24 little. And I've never heard anyone say it quite

1 that way, so I'm getting a crook in my neck from
2 twisting, but that it's a waste of taxpayers dollars
3 if people don't come out of prison better than when
4 they go in.

5
6 And so I'm just wondering, Ron, if you have any
7 sort of concrete -- the other thing Howard Sapers, he
8 also said, I believe, that our prisons have become
9 our biggest asylums in Canada and in the U.S. And I
10 believe that that is evidence of our failure to
11 develop good, thorough, comprehensive mental health
12 services in our communities.

13
14 But do you have any concrete ideas, what can
15 happen in prison so that people who end up
16 incarcerated, whether they really should be there or
17 not, but the reality is, is that they are there, what
18 can happen in prison, do you believe, that could help
19 make people come out having had help, coming out in
20 better shape than when they went in?

21 Ron Fitzpatrick:

22 Oh, give them all a million dollars cash. No, I'm
23 only kidding. But I tell you what, this is the one
24 thing that can really happen, and you don't need the

1 new prison, for instance, in Newfoundland, right here
2 in St. John's now to make it happen. Set up a
3 state-of-the-art, and it can be done, if you set up a
4 state-of-the-art mental health unit within our prison
5 right now so that when people come in, get people out
6 in the community, the professionals out there, maybe
7 even our medical students in their last year of
8 university or psychiatric nurses, whatever, whoever,
9 get them involved, get the people in the community
10 the professionals coming in and out and assign a
11 special staff. Have that staff fully trained to
12 operate and deal with people with mental health and
13 addictions issues, and have training ongoing for
14 them. And then at the same time set up a dry unit so
15 that anybody that really wants to get off drugs and
16 booze and whatever, there's a dry unit, so they're
17 all on the one page. Because it's not just talking
18 about it. Like in prison there's a prison mentality.
19 It is like planet X. It's not, and somebody is out,
20 you gets out, if you want to talk to me, the rest of
21 them thinks I'm ratting somebody out. And if I'm
22 down to you talking to you about getting clean and
23 everything else and then if the rest of them don't
24 want to get clean, you're not one of them. It's like

1 you're looking down on them. So there should be a
2 clean unit.

3
4 And then we need more programming. If we got some
5 of the people off remand, the weekenders, change that
6 around, get more people home and cut down the number
7 of people filling up the prison down there, then we
8 could do more programs. More people who could take
9 advantage of it.

10
11 People with mental health and addictions issues
12 don't get in a lot of programs because a lot of
13 programs are upstairs and out of the way. And if
14 these people are off their medication and they're
15 freaking out and they're seeing people and hearing
16 voices and doing everything else, they're not going
17 to be allowed to go because they're going to be
18 considered dangerous. So a lot of times the people
19 who most need the help don't get it because they're
20 considered dangerous and stuff like that.

21
22 But that's what we need to do. We need people in
23 the community come in. Somebody come in and teach
24 them how to be a plumber, teach them a bit of

1 electricity. Tell them how, come in and teach them
2 how to do some carpentry work. But you could do that
3 if you set up the space. Right now, there is not
4 enough room down there to drop a screw bag, let alone
5 teach anything. You know what I'm saying? So, there
6 is things we can do. You don't have to wait till we
7 gets that much money we can build it all.

8
9 Listen, if you can think it, you can make it
10 happen, seriously. And there's a lot of things we
11 can do. And especially when we got people like sat
12 at the table here right now. These are four people
13 knowing what's going on and you guys could make it
14 happen. There's no doubt about it, with people in
15 this room.

16 Honourable Felix Collins:

17 Ron, just a quick comment. You don't have your PhD.,
18 you don't have your MA, you're not a psychiatrist,
19 not a psychologist but you got something that's
20 special and that's dedication, commitment and a hell
21 of a passion. And this society owes a hell of a deal
22 of gratitude to people like yourself and Dan
23 McGettigan and Turnings.

24

1 Ron Fitzpatrick:

2 Well, listen, I got to say this, and when I say this
3 I thank you very much, Mr. Collins. And by the way,
4 how is your wife? The last time I met you your wife
5 with you; a lovely woman, a friendly woman. I just
6 want to say that Dan and Kevin and myself don't take
7 credit for anything we do. We only do what the good
8 Lord let's us do. That's it.

9 Dr. Bruce Gilbert:

10 Thank you very much. Thank you, Ron. Okay.
11 (Recording not turned on) ... Program and Education
12 Coordinator with the Alliance for the Control of
13 Tobacco. And there's two of you. So I'm thinking
14 maybe you want to be here, or?

15 Melissa Moore:

16 (Inaudible - no microphone).

17 Dr. Bruce Gilbert:

18 Okay, no problem. And you have 30 minutes. So I'm
19 going to give you 10- and a five-minute warning, if
20 that's okay. Great, take it away.

21 Melissa Moore:

22 Good afternoon, everyone. My name is Melissa Moore
23 and I am the Program and Education Coordinator for
24 the Newfoundland and Labrador Alliance for the

1 Control of Tobacco. I apologize in advance. I am
2 not half as exciting as the previous presenter. I'm
3 also dying with the flu, so give me a little leeway
4 here.

5 Gerry Rogers:

6 Oh, your poor darling. Thank you for telling us.

7 Melissa Moore:

8 Thank you. Yeah, it's okay. Okay, so we're here to
9 talk to you today about something that's sometimes
10 forgotten when it comes to mental health and
11 addictions, which is the addiction to nicotine and
12 tobacco. We have a recommendation, the two
13 organizations, that tobacco addiction be included
14 within the mandate of mental health and addictions.
15 Based on research and evidence, this presentation
16 will show the statistics around high smoking
17 prevalence among individuals with mental illness and
18 addictions, and how this population is
19 disproportionately affected by the devastating health
20 effects of tobacco use. I'm really sorry. My voice
21 is going.

22

23 Okay. When someone goes in to addictions
24 counseling, is it fair that tobacco addiction is

1 sometimes forgotten? It is one of the situations
2 when a counselor is providing treatment for addiction
3 to various drugs, is it right to ignore the tobacco
4 addiction and leave it up to the individual to find a
5 method to overcome that on their own? The
6 presentation that we're going to do today will review
7 the key evidence and research that prove it is
8 possible for these individuals to quit smoking, and
9 it will clearly demonstrate that quitting smoking
10 positively impacts their recovery, as well as
11 improving their overall health.

12
13 Finally, we will give some specific
14 recommendations regarding approaches and methods to
15 integrate treatment for tobacco addiction within
16 mental health and addictions programs.

17
18 Okay. So just to give a bit of context about the
19 organization that I represent. The Newfoundland and
20 Labrador Alliance for the Control of Tobacco has been
21 in existence since 1999. We are responsible for the
22 development and implementation of a tobacco reduction
23 strategy that covers the entire province. Our vision
24 is to significantly improve the health of

1 Newfoundlanders and Labradorians by reducing the harm
2 caused by tobacco use, especially among priority
3 populations. And we have identified priority
4 populations as youth and young adults, aboriginal
5 peoples, pregnant women, people living with chronic
6 disease, people living with low income and, finally,
7 people living with mental illness. I think sometimes
8 it's an easy sort of thing to forget that tobacco is
9 still a problem. And while our smoking rates are
10 decreasing among the general population, when you
11 look at these priority populations the smoking rate
12 is actually increasing or remaining the same. So, we
13 have a problem when it comes to these particular
14 groups.

15
16 Our tobacco reduction strategy has four goals:
17 prevention, which is preventing children, youth and
18 young adults from starting to use tobacco;
19 protection, protecting Newfoundlanders and
20 Labradorians from secondhand smoke; cessation which
21 is why we're here today, to encourage and support
22 Newfoundlanders and Labradorians to successfully quit
23 using tobacco, and something called demoralization
24 which is having Newfoundlanders and Labradorians

1 change their attitudes about tobacco use, basically
2 making it so that being tobacco free, being smoke
3 free is actually the norm.
4

5 So, when we talk about tobacco, we are still
6 talking about the number one cause of death,
7 preventable death, in Newfoundland and Labrador. It
8 kills about 37,000 Canadians every year. Worldwide
9 that number is in the 10 to 20 billion number.
10 Smoking causes a thousand deaths every year; 20% of
11 all deaths and 90% of all preventable deaths in the
12 province. Half of all smokers are going to die from
13 their addiction, loosing on average 15 to 20 years of
14 life.
15

16 The average age for Canadian youth to start
17 smoking is actually 12. This number has always been
18 12. Sometimes you have young adults starting to
19 smoke at age 17, 18, 19 when they hit university, but
20 in general if you talk to somebody that started to
21 smoke or is smoking right now, I can almost guarantee
22 you that they're saying that they starting smoking
23 when they were 12, 13, 14. It really is a childhood
24 epidemic in a lot of ways. Eighty-five percent of

1 smokers start before they are age 16.

2
3 In Newfoundland and Labrador our smoking rate is
4 higher than the rest of Canada. We have 15% of
5 Canadians, 20% of Newfoundlanders and Labradorians.
6 The age groups break down like this: 10 to 14 years
7 old, about 2.4% are smoking. I speak to people
8 sometimes as a counselor in the Smokers' Helpline,
9 and people are telling me they started smoking when
10 they were eight and nine and 10 years old. That's
11 when they picked up their first cigarette. Fifteen
12 to 19 is about 12%. We have a real issue with 20 to
13 24-year-olds who are smoking at a rate of about 28%,
14 and 25 to 44, 24%. Forty-five plus is 17%. A lot of
15 people try to quit smoking after they're 45.

16
17 So, addiction. Nicotine dependence is actually
18 the most common form of chemical addiction and
19 chemical dependence. It is classified as a mental
20 condition in the Diagnostic and Statistical Manual of
21 Mental Disorders, and research suggests that nicotine
22 is as addictive as heroin, cocaine or alcohol. When
23 a young smoker picks up a cigarette for the first
24 time, generally it takes about two cigarettes and

1 they are addicted for life, so it works fast and it
2 works hard. Drug levels peak within 10 seconds of
3 inhalation when it comes to nicotine, but the effects
4 dissipate quickly. They go away quickly, so that
5 causes the smoker to continue dosing to maintain the
6 drug's pleasurable effects and prevent withdrawal.

7
8 Most smokers in Newfoundland and Labrador right
9 now are smoking around 12 to 15 cigarettes a day. We
10 have some people that are only smoking two or three.
11 We do speak to people sometimes that are smoking
12 three packs a day, which is about 60 cigarettes a
13 day.

14
15 Examples of nicotine withdrawal are irritability,
16 anxiety, difficulty concentrating, insomnia,
17 restlessness and increased appetite, and quitting
18 tobacco use is difficult and may require multiple
19 attempts. It takes the average smoker about seven
20 good attempts before they actually are successful,
21 and only three to five percent of individuals who try
22 to quit without support are successful in quitting.
23 So that's people who try to quit cold turkey or
24 people who try to sort of do it on their own without

1 any support, be that through nicotine replacement
2 therapy or counseling through the Smokers' Helpline
3 or any other form of counseling.
4

5 Just give me one second there. Okay, smoking
6 rates are two to four times higher among people with
7 mental illness than in the general population.
8 That's a really disturbing number. Fifty to 90% of
9 individuals with mental illness or addiction are
10 tobacco dependent. People with Bipolar Disorder
11 smoke between 51 to 70%; depression up to 80%;
12 anxiety disorders, 60%. Schizophrenia is very high,
13 62 to 90, and other substance abuse, be that alcohol
14 or any other drugs, at about 50%. They also tend to
15 smoke more heavily, so they smoke more cigarettes
16 than in the general population. Research from the
17 United States actually indicates that nearly half of
18 the cigarettes smoked in that country are used by
19 people with co-occurring psychiatric or addictive
20 disorders. So it's a problem and the facts, of
21 course, are pretty clear. Research clearly shows
22 that the high rate of smoking among this population
23 lead to this shocking result. Individuals with
24 mental illness and addictions are disproportionately

1 affected by smoking-related death and disabilities.
2 This means that compared to the general population,
3 individuals with mental illness are much more likely
4 to die from smoking-related illness or become
5 severely disabled due to smoking-related diseases,
6 such as lung cancer, chronic obstructive pulmonary
7 disease or COPD, cancers of the mouth and throat, as
8 well as cardiovascular diseases and diabetes.
9 Numerous studies have investigated this issue through
10 looking at mortality data for populations of
11 individuals served through public mental health
12 departments, both inpatient and outpatient. And the
13 World Health Organization points out that 10- to
14 25-year life expectancy reduction in patients with
15 severe mental health disorders. So they may die up
16 to 25 years earlier than individuals in the general
17 population.

18
19 As well, smoking is expensive. It's kind of easy
20 to say well, I smoke two packs a day or one pack a
21 day or half a pack a day or whatever, but at \$10 a
22 pack, if you're smoking three packs a day that's \$30
23 a day, even if you're getting the cheapest ones you
24 can find. Even if you're rolling your own, you're

1 still talking about \$20 to \$25 every single day,
2 which is an incredible amount of money in a
3 population that in many cases is already suffering
4 from low income. So, usually if you are smoking a
5 pack a day, obviously that's about \$300 a month on
6 cigarettes, and it's a significant portion of their
7 monthly income and impacts how much they're able to
8 spend on healthy food, on other necessities of their
9 life, on recreation, on social activities and
10 actually in getting any sort of other help that they
11 have.

12
13 So, when you look at tobacco across that continuum
14 it really is something that we can't forget about.
15 And again, tobacco is one of those issues that
16 sometimes it's easy to just sort of push off to the
17 side and say oh, well, it's not as bad as or we need
18 to deal with the alcohol first. We need to deal with
19 the Oxycodone first. We need to do all of these
20 other things first. But in fact the tobacco
21 addiction is probably one of the most, one of the
22 most difficult addictions that they will actually
23 have to deal with in their lifetime. And I'm going
24 to pass it over to Mary Lynn. Thank God, because my

1 voice is just gone.

2 Mary Lynn Pender:

3 Okay, so moving on to look at the challenges this
4 population has to quit and why they need extra
5 support. First of all, I guess, we know it's hard
6 enough to quit for anyone, but for this population
7 there's other issues going on. There's a
8 neurobiological, the physical side of it. So there
9 may be a genetic predisposition, changes in the
10 receptor, your receptor abnormalities in your brain
11 that make it difficult to quit. So nicotine might
12 normalize some aspects of the individual's mental
13 illness, such as their mood, their cognition, their
14 sensory processing and so on. Similarly, individuals
15 may be smoking to manage some of the side effects of
16 the medications that they're taking, so they use
17 smoking as a coping mechanism. And however, of
18 course, the risk of smoking far outweigh any possible
19 benefits.

20

21 Smoking affects the same neural pathways in the
22 brain as alcohol, opiates, cocaine and marijuana, so
23 that's another physical aspect that's certainly
24 complicating things for people that have co-occurring

1 addictions.

2
3 In addition to the physical aspect, there's, of
4 course, other things going on in the person's life.
5 So challenges in their daily life and stressors may
6 make it difficult to focus on quitting. There's a
7 psychological side of it where feelings are triggers
8 to smoke, and boredom and sadness and even happiness
9 sometimes are all linked to smoking, as well social
10 environment may be tied to their smoking. So
11 researchers point out that people may be smoking to
12 feel part of the group in the mental health and
13 addictions setting, and smoking is often associated
14 with social activities. So, individuals may not be
15 offered the support they need. It's been well
16 established that accessing support boosts quit rates,
17 and for this population there may be a lack of
18 support to help them with quitting and also barriers
19 to access the supports that are there. They may know
20 about different options, or they may not know about
21 the different options that are out there, as well
22 health care providers may not be addressing it or
23 they may be ignoring it completely.

24

1 So, researchers point out that traditionally
2 medical clinicians do not view tobacco cessation as a
3 part of their scope of practice, or it's too time
4 consuming, or it's not a treatment priority, and/or
5 the clinician doesn't address it because they think
6 it may negatively affect their recovery or their
7 treatment. Tobacco is viewed as a less harmful
8 alternative to alcohol or other drug use.

9
10 So, we know they need comprehensive supports, of
11 course, but just to note regarding that reluctance of
12 health care providers to address the tobacco use, the
13 evidence clearly supports that it is extremely
14 important, of course, and to offer the smoking
15 cessation support in every case. There is no safe
16 level of smoking. Smoking even just one to four
17 cigarettes a day nearly triples the risk of death
18 from heart disease. Individuals, this is interesting
19 individuals in treatment for alcohol dependence are
20 more likely to die from smoking-related illness than
21 from their tobacco, or than from their alcohol.
22 Individuals with drug problems who smoke are four
23 times more likely to die prematurely relative to
24 individuals with drug problems who don't smoke. So

1 there's the facts right there. They're basically
2 saying they're going to die from smoking rather than
3 from the drugs or alcohol that you're treating. Oh,
4 and in addition although it's not well known, smoking
5 is one of the strongest predictors of suicide.

6
7 So, now for the good news. Just to address some
8 common misconceptions that are out there. For a long
9 time it's been viewed that this population is not
10 interested in quitting anyway. They're too heavily
11 addicted. They've been smoking for too long and
12 they're not likely to be able to quit at this point.
13 However, studies have shown that mentally ill clients
14 are interested in quitting at about the same rate as
15 people in the general population, so we know stats
16 say about 70% of smokers are interested in quitting
17 and that's the same case with this population. So,
18 this is an opportunity, of course, to offer support,
19 and they're able to quit with good success rates.
20 So, while some studies have found that quit rates are
21 a little bit lower in this population, they're still
22 substantial, so it's certainly worth addressing.

23
24 Another misconception is that quitting is, like I

1 said, going to negatively impact the individual's
2 recovery or treatment, but many studies have
3 concluded that quitting smoking does not worsen
4 symptoms or negatively impact mental illness recovery
5 or addiction treatment. In fact, quitting has been
6 linked to very positive outcomes. And in a study of
7 metaanalysis of 19 different studies it was revealed
8 that smoking cessation interventions for individuals
9 with substance abuse problems were associated with a
10 25% increase in long-term absence rates from their
11 alcohol and other drugs. Continuing to smoke is
12 actually associated with worse outcomes. Individuals
13 with mental illness who smoke experience more
14 psychiatric symptoms, have more frequent
15 hospitalizations and require higher doses of
16 medications and they just, and generally just do not
17 do as well in treatment.

18
19 So, I just want to talk a little bit about our
20 partnerships and where we can go from here. The
21 Helpline has been doing work in smoking cessation
22 for, oh, my goodness, 15 years now. And so the
23 Helpline was established back in 2000 as a central
24 line that anybody can call to get support in

1 quitting. It's operated by the Lung Association and
2 funded through the Federal and Provincial
3 Governments. We get about 1,300 calls each year from
4 smokers looking for help with quitting and we provide
5 service and support them through that. And
6 additionally, 300 to 400 calls are from family
7 members and friends and nonsmokers, people with
8 general inquiries around smoking cessation.

9
10 So, when someone calls we offer them the different
11 services that are available. There's over the phone
12 support. There's a self-help information package,
13 web-based supports and group programs, and we link to
14 group programs all across the province. So it really
15 is a central resource that has many different
16 highlights there that are listed, but I mean it's
17 effective. The studies, the valuations show that it
18 does boost quit rates, so it's really good support.
19 And just about the way it works, I guess, when a
20 person signs up for our service it's not usually just
21 one time call, but when clients enroll they can get
22 up to six to 12 proactive counseling calls where the
23 counselor calls that individual back at an
24 agreed-upon time, once a week or once every second

1 week to help them through the process of quitting and
2 talk about quit tips and withdrawal symptoms and all
3 that.

4
5 So, we do have a referral program in place. It's
6 been a great success. Launched in 2004 and has
7 certainly expanded over the years. It's been a great
8 success, received a lot of attention nationally and
9 internationally for its success in bringing together
10 partners on the issue of helping people quit, and as
11 well as being an effective way to promote the quit
12 line. Fifty percent of our callers come from care,
13 so it's huge. So this is reflective of all the great
14 work that's getting done across the province by other
15 health care providers who are referring to us. So,
16 yeah, it's a simple form. It's an easy tool. The
17 health care provider simply asks if the person smoke
18 and if they do they advise them to quit, ask if they
19 like to be referred to the Help Line, complete the
20 fax form and fax it to us. And, of course, we hope
21 to move to an online referral system soon to make it
22 easier to make those referrals. And of course the
23 great thing about this is it's a great tool for
24 everybody including in mental health and addictions.

1 Incorporating this systematic referral would be a
2 great way to build on the interventions that are
3 offered there and ensure individuals have access to
4 the support that they need.

5
6 So, just in summary, why we feel tobacco should be
7 included, here's the evidence. We know smoking rates
8 are high. We know it's a drug. We know people are
9 severely negatively impacted by their smoking.

10 People can quit. There's guidelines, CAN-ADAPTT
11 guidelines, that bring altogether all the evidence
12 and recommendations and best practices to say what
13 systems should be doing to support smokers and that
14 recommends that every person that comes into a health
15 care system should be asked about their smoking and
16 linked with support to quit. And as I said, we know
17 we do have the good supports in place to help
18 individuals quit through the Help Line, and we
19 encourage Government to explore all the options. We
20 don't have to have all the answers here today, but we
21 certainly put forward a few recommendations for you
22 to consider. We know that mental health and
23 addictions staff already have lots of skills and
24 knowledge around addictions, and many of this would

1 be applicable to tobacco addiction as well. So in
2 moving forward with this recommendation that we're
3 making, this would mean that tobacco would be
4 addressed the same as other drugs, so drug
5 prevention, drug cessation, tobacco messages would
6 all be in there, as well. It would mean that all
7 patients and clients coming into the system would be
8 assessed for tobacco use and offered follow-up
9 support to help them quit. There'd be programs in
10 place to eliminate any financial barriers to help
11 them get ongoing access to the smoking cessation
12 medications that they need, and follow-up, follow-up
13 support. Did I note that? Follow-up support would
14 be offered, whether it be brief counseling or more
15 moderate counseling offered through programs at
16 mental health and addictions, or whether, of course,
17 integrate the care referral in there for more ongoing
18 community support.

19
20 And just to clue up, the problem I think can be
21 summarized. I saw this statement from leading
22 experts in the field. It said regarding tobacco, the
23 tobacco problem, it's a hidden epidemic with serious
24 consequences for the physical, psychological and

1 financial health of this already vulnerable
2 population, and I just want to say tobacco use is
3 impacting lives here in our province. People are
4 getting sick and dying from tobacco-related illness,
5 and we may look at it, it's common. Smoking is all
6 around us, right, but look at it as well in that the
7 devastating illness is all around us, too, that is
8 linked to smoking; the cancer, the cardiovascular
9 disease and respiratory disease. So, something has
10 to be done about it, and we just encourage Government
11 to incorporate tobacco treatment policies, ensure
12 that they're followed and consistently offered in
13 health care settings. All health care settings
14 should be offering tobacco treatment regularly, every
15 time, but particularly in the setting of mental
16 health and addictions. Thank you.

17 Dr. Bruce Gilbert:

18 We have five minutes. We have five minutes if you
19 want to make a comment or ask either of these two
20 presenters.

21 Honourable Steve Kent:

22 I'll go first this time. Thank you for your
23 presentation, and I understand you got a written
24 submission that you'll send to us which is great.

1 Mary Lynn Pender:

2 Yeah.

3 Honourable Steve Kent:

4 So, was there a time when tobacco addiction was under
5 the Mental Health and Addictions, are you aware?

6 Because since I've been in this role it hasn't been,
7 which is a very short time, so I'm just curious. Was
8 there a time when that was the case or no? No.

9 Colleen is saying no.

10 Mary Lynn Pender:

11 Someone may be better equipped to answer that
12 question, but my understanding, no.

13 Honourable Steve Kent:

14 Colleen says no. Okay, because what you're saying
15 makes lots of sense. I got one more question for you
16 and then I'll let the others go. There was what I
17 thought was a really good idea presented earlier
18 today that I'd like your reaction to. I'll just put
19 you on the spot, maybe unfairly, but given your
20 passionate expertise, I'd like your opinion. When
21 people are in detox programs, for instance, and they
22 are smokers, they're not able to go outside and have
23 a cigarette and while I certainly don't want to sound
24 like I'm promoting the use of cigarettes, there's a

1 really compelling argument to be made that while
2 somebody is going through that process that cigarette
3 at that point in their journey is pretty important to
4 them, even though ultimately it would be great if
5 they weren't smoking too, so I'm just curious. There
6 seems to be a policy thing that could be easily
7 fixed, and I'm just wondering what your thoughts are.
8 I don't know if you were here when we had that
9 discussion earlier or not.

10 Mary Lynn Pender:

11 No, but I would say that's the prime opportunity. If
12 the supports are there, the health care providers are
13 there to address the smoking as well and just
14 encourage or ensure that their symptoms are looked
15 after with regards to withdrawal from the nicotine,
16 because there are aids available. There's five
17 different nicotine replacement products and two
18 prescription medications that can be used to help
19 them manage their symptoms. But I would look at that
20 as an opportunity to education them on why it is
21 important to quit all of the addictions at once and
22 to use this time here in detox to kind of detox from
23 quitting smoking completely. Yeah, the properties
24 are smoke free, right.

1 Honourable Steve Kent:

2 But that's the challenge for some people.

3 Mary Lynn Pender:

4 Yeah, but they're going outside, right, across the
5 road or whatever.

6 Honourable Steve Kent:

7 They're not even allowed on the property, so it's
8 tangly and it might be preventing some people from
9 actually going through the detox program, so.

10 Mary Lynn Pender:

11 Yeah, okay, it's a complicated question, for sure.

12 Honourable Steve Kent:

13 It is. It is. So I was just curious what your
14 reaction was first.

15 Mary Lynn Pender:

16 Yeah, I would look at it as education around it and
17 supporting their withdrawal symptoms.

18 Honourable Steve Kent:

19 Okay, thank you.

20 Mary Lynn Pender:

21 Managing that, right.

22 Gerry Rogers:

23 I guess just to just to follow up on that, there's
24 also the whole issue of harm reduction.

1 Honourable Steve Kent:

2 Yeah.

3 Gerry Rogers:

4 And so it's a complicated one, hey.

5 Honourable Steve Kent:

6 Yes.

7 Gerry Rogers:

8 I think one of the toughest things I've ever done in
9 my life was quit smoking, three times I believe, but
10 maybe it was twice. But anyways, it's been a long
11 time now, so. But I think the discussion was do we
12 have times to take account the harm reduction model,
13 because the concern is that sometimes people will not
14 even avail of detox when -- And, you know, everybody
15 waits that ideal sweet moment when you have it in
16 your head, I'm ready now. I want help and then,
17 I'm not going to do it if I can't even have a
18 cigarette. Like, so, if one applies the harm
19 reduction model, is it that you say okay, come, we'll
20 help you with your opiate addiction or whatever, and
21 then let's tackle that tobacco monster after? I
22 mean, I don't know, that's a complicated question.

23 Mary Lynn Pender:

24 Yeah, I think there's some experts here in the room

1 who might want to speak to it.

2 Unidentified Female:

3 (Inaudible - no microphone). Now the smoking is a
4 real barrier. Now I absolutely agree that we should
5 be finding ways to support them to quit if that's
6 (inaudible).

7 Mary Lynn Pender:

8 That's what I'm saying. At the end of the day,
9 that's sort of what we're saying. We're saying if
10 somebody wants to go into rehab and says I'm smoking,
11 I'm drinking, I'm taking heroin and I don't want to
12 do anything anymore, then the addictions counselor
13 should have the skills and abilities to deal with
14 every single one of those addictions, including
15 tobacco. That's all we are saying. We're not saying
16 that they have to go in and they have to quit smoking
17 and if they shouldn't be there and if they're
18 smoking. We're saying addictions counselors,
19 addictions services should have the ability and the
20 skills to deal with every single addiction that comes
21 in through their doors. And unfortunately, what's
22 been happening is that the tobacco has been
23 completely forgotten. So while they are helping them
24 with their alcohol, while they are helping them with

1 their heroin, they're still smoking. Research is
2 showing that that's going to negatively affect their
3 success rate with their other addictions. So, that's
4 all we're saying.

5 Honourable Felix Collins:

6 When I saw the topic on the list here, smokers,
7 smoking topic, I questioned why are we going to be
8 talking about smoking in this mental health and
9 addictions context, but it's the first time I've
10 heard the discussion in that context and it's an
11 extremely interesting presentation. I never made the
12 connection before like you made here. It's a great
13 presentation.

14 Mary Lynn Pender:

15 Thank you.

16 Dr. Bruce Gilbert:

17 This guy is eager. ... of Minister Kent's Provincial
18 Mental Health and Addictions Advisory Council.

19 You've got 30 minutes. I'll give you a 10-minute and
20 a five-minute warning, if that's all right with you.

21 Take it away.

22 Sheldon Pollett:

23 Thank you, Bruce. Hi, all. For some of you this is
24 going to be a bit of a rehash. Some may know that on

1 Monday we launched first ever, I guess, call for a
2 provincial plan to end youth homelessness in our
3 province. And just to be clear what that means
4 because most people would say what problem with youth
5 homelessness do we have. When we refer to that what
6 we talk about is young people, certainly more young
7 people than you think, sleeping and showing up in
8 homeless shelters than most people are aware of. But
9 also young people who are imminent risk. They are
10 either couch surfing in many cases or in and out of
11 shelters, in and out of home, in and out of different
12 arrangements, just to keep a roof over their head.
13 Choices for Youth alone served over 1,000 young
14 people last year which is a growing number year over
15 year. But what we are clear on, as well, in this
16 report is we actually don't good statistics from the
17 rest of the province. But that shouldn't deter us
18 from creating a plan around youth homelessness
19 because one thing I do know, with better information,
20 more information from other parts of the province I'm
21 pretty sure the number is not going to go down. So
22 what this plan is really talking about is getting on,
23 all the resources, all the various stakeholders on
24 the same page when it comes to addressing the wide

1 ranging issues that are leading young people to fall
2 through the cracks, fall into these scenarios in the
3 first place. Addictions and mental health are the
4 two issues at the very top of the list. And if
5 nothing else, one thing to think about is while it's
6 true not everyone who has a mental health issue is
7 homeless, I can pretty much guarantee you if you are
8 a homeless young person or at risk of becoming
9 homeless, your mental health is compromised to some
10 degree. So put it in that context it is very
11 relevant that I'm here today talking about this.

12

13 So, there's an overarching, I guess, message
14 around creating such a plan. One of the things I
15 guess that's important for people to realize is that
16 this is actually a growing movement across the
17 country. That there are actively plans being created
18 in, I think, six going on seven communities across
19 the country. There is actually one provincial plan
20 already put in place in Alberta as of February of
21 2015. So one of the things that we're really clear
22 on, this is not about, hmm, is this possible to do?
23 It is a pretty complex thing to try and figure out.
24 Clearly, if all the communities in this country have

1 done it, it is not about is it possible, it is about
2 whether or not we make the decision to do what's
3 right in my view for the most vulnerable young people
4 in our community in this province. And I think we're
5 more than capable and live in the kind of province I
6 think that I'm pleased to say that we can do that.

7
8 So, I guess I want to drill down a little bit in
9 terms of the mental health and addictions piece. We
10 do know, as I said, that any given night of the young
11 men at our emergency shelter, for example, the vast
12 majority of them have some degree of mental health
13 and addictions issue. There's also things like FASD,
14 Autism Spectrum Disorder, there's a number of issues
15 creating the vulnerability that leads young people
16 into this situation.

17
18 So, I also have to apologize because one of the
19 people that was supposed to be here with me here
20 today is Sarah Brown who is the director of our Youth
21 Leadership Council. And again, I promise you this,
22 is that if she was here she would be the star of the
23 show, as it should be, because she is well able to
24 articulate, not only based on her own experiences but

1 the many young people that she herself comes into
2 contact with, what this translates into day in day
3 out for vulnerable young people.
4

5 So I've got some examples. So bear with me in
6 terms of I'm going to try to do my best to translate
7 a lived experience set of examples to you guys. So
8 one of the things that came up was an example where
9 young people repeatedly are being refused access to
10 assessment services because they haven't been able
11 clean for a long enough period. Well, one of the
12 realities we know, certainly in the most vulnerable
13 young people we're dealing with, many of them have
14 co-occurring disorders. That they do have some
15 degree of addiction or certainly drug use issue. So
16 the notion that a young person is going to have to be
17 clean for a certain period of time before they can
18 access the most basic services, I think there's a
19 huge gap there for young people, and one of the
20 things, I guess, this overarching message from me
21 today and always is access. But access in terms of
22 like this overarching. And when I talk, what I mean
23 by that is if we design systems that we inherently
24 know, in particular the most vulnerable young people

1 in our province can't or don't want to or, for
2 whatever reason, don't access, then we got to stop
3 putting the responsibility on them because the common
4 phrase then is they're not ready. But I guess the
5 challenge to me is the community-based agency or even
6 the government services, but if I know that going in
7 and I design the system that way anyway, who's
8 responsibility is that?

9
10 The example I can give you. I ran employment
11 programs at the Murphy Centre for many, many years,
12 and at the time 50% of the young people coming
13 through our doors were being turned away because they
14 were too at risk. Their mental health was too
15 compromised, their literacy was too low, their drug
16 addiction was too current; that sort of thing. And
17 that was the response all the time. Well, they're
18 not ready, they're not ready, they're not ready.
19 Fifty percent. So then I go to work at Choices for
20 Youth on a Monday morning and that 50% is now 100% of
21 the clients that we're working with every single day.
22 But the response all the time from an employment
23 perspective, for example, is, well, they're not
24 ready. Again, that's where, I guess, it popped into

1 our head around, well, if we know that going in and
2 we design it that way anyway, then whose
3 responsibility is it?
4

5 So, part of it for me would like to a system, I
6 guess, reorientation from the eyes of the people
7 needing to use the system. That it needs to be
8 designed to meet their needs first and less focus on
9 the system needs that we have, I think, right now.
10

11 We also have an example where a young person did
12 not want multiple residents in the room when they
13 were going in to seek services. And the response was
14 this is a teaching facility, therefore this is the
15 way it has to be. So all of a sudden the priority on
16 a teaching facility became more important than the
17 needs of the young person there seeking service. And
18 I get the critical importance of a teaching facility
19 but we end up with things a little backwards in terms
20 of where that gets prioritized over the needs of the
21 young person.
22

23 I think it's widely acknowledged the ACT Team here
24 in the city, for example, needs, in my view, and I

1 keep hearing it over and over again, needs, I guess,
2 a bit of a reorientation around better alignment with
3 community-based practices and approaches.

4
5 We actually had a young man, for example, had a
6 job as a dishwasher, and I get how systems work and
7 schedules work and all of that stuff, but what it
8 boiled down to this, we had been supporting him for a
9 number of years around his mental health and housing
10 needs. He had a job as a dishwasher, fantastic. We
11 couldn't figure out how to get his meds delivered
12 after hours to meet his needs. He ended up losing
13 his job. So simple things that you think about how
14 the system is oriented make a huge difference in the
15 lives of people who need those services.

16
17 The other things that we've heard about is wait
18 times for methadone addiction services. There is an
19 acknowledgment that wait times are improving but I
20 think broadly is that there is a ways to go yet in
21 terms of being able to access those services in a
22 timely way.

23
24 The Central Intake System, I think people are

1 generally very happy with in lots of ways; however,
2 we do have examples, tragic examples, where young
3 people, while they were waiting, we had one young man
4 passed away due to an overdue. He waited 45 days for
5 a response. We had another young man who committed
6 suicide. He waited 30 days for a response. Now do I
7 think people in those systems don't care or turn a
8 blind eye? Absolutely not. But I think we need a
9 better way of perhaps triaging those urgent cases.

10
11 We actually had another young man who had been
12 referred through Central Intake, was waiting,
13 attempted suicide, went back and was told, well, your
14 circumstances have changed now so you have to start
15 the process all over again. Now whether or not
16 that's how it's supposed to work in Central Intake, I
17 don't know. But these are actual examples affecting
18 the lives of young people each and every day.

19
20 Generally speaking, access to counseling services
21 continues to be a serious challenge for our young
22 people. That the wait lists are way too long. I
23 think, again, efforts are being made around those
24 things. Choices for Youth, willing to do our part.

1 We actually set up our own in-house counseling
2 program. Very limited, on the corner of a couple
3 staffs' desk to try to meet the immediate need.
4

5 One of the other issues that we repeatedly hear,
6 and we've certainly made attempts over the years to
7 create relationships that mitigate this issue, but we
8 do find that, for example, taking young people to the
9 Psychiatric Assessment Unit, often it ends up feeling
10 like a bit of a revolving door. That we're sitting
11 with a young person each and every day in our
12 outreach drop-in, feeding them meals, listening to
13 them struggle with their mental health, take them to
14 the unit and in and out in five minutes. That
15 they're not taken seriously; that they're drug
16 seeking; they're attention seeking, so on and so
17 forth. So I also know that the system itself is
18 pretty much overwhelmed on any given day. Again, I
19 don't think it's because those people don't care, I
20 think it's a systemic issue that we to deal with.
21

22 One of the big items, I think, affecting young
23 people, and this is a big theme for us why the plan
24 is so critical, that there are so many systems and

1 policy decisions that are affecting the mental health
2 and addictions needs of young people that this
3 division is not responsible for. Things about
4 poverty and access to housing. The big item for
5 young people is what happens to them when they turn
6 18. So we have an increasing number of young people
7 18 years old who have huge needs around mental health
8 and addictions being exited to the adult system. And
9 once there, then it's pretty much a coin toss in
10 terms of what kind of supports and services they get.

11

12 What I would like to see through this plan is
13 reorienting this system. Say I don't actually care
14 who is paying you income support. I don't really
15 care who's paying the rent. That's the technicality
16 around financial support. And by the way, just in
17 case no one realizes it, it all comes from one
18 treasury department anyway. But what I care about is
19 16 to 24 years old, based on your needs, that is what
20 determines the level of support and service you're
21 getting. What we have, and I can give you examples
22 where, and this is an issue for Child, Youth and
23 Family Services, young people at 18, they have to
24 meet certain criteria, even if they're eligible to

1 21. Those criteria are in school or working. Pretty
2 sure we can all guess who is least likely to meet
3 that criteria. So that is the young person who's
4 most likely to get a reduction in services and exited
5 to the adult system. We've had situations where
6 young people are in the Waterford Hospital for their
7 mental health needs who are exited to the adult
8 system while in the Waterford Hospital. This has got
9 to stop. We can figure out the financial supports of
10 these young people. What we have to do is figure out
11 how to save 16 to 24 - under 16 is Child Welfare - 16
12 to 24, based on your needs, if you're in this
13 province and you pop up on the system somewhere as
14 being at risk or vulnerable, the response should be
15 consistent across the board.

16
17 And Moving Forward, evaluation. One of the
18 things, I guess, I can draw attention. The Moving
19 Forward Program is a complex needs program for youth
20 here in the city based on the successful model run by
21 Stella's Circle, the community support program. It
22 was created because they recognized that as great as
23 that program was we needed a youth specific model.
24 It currently works with ten youth at any given time,

1 16 to 24 years, with significant mental health
2 diagnosis.

3
4 Of the last five exits, because young people
5 turned 18, within four months four of them were
6 charged or incarcerated versus while in the program
7 those same population of young people were able to
8 maintain stable housing for ten months or more. So,
9 we have clear examples day and night what it looks
10 like with support and what it looks like without
11 support. I absolutely applaud the investment in the
12 formal system around youth mental health and youth
13 addictions in this province; however, the other piece
14 of it is young can't and shouldn't live in treatment
15 forever. So then what? There's tons of evidence to
16 say do you simply provide that intensive support, get
17 people to a good place and they go back to the same
18 dangerous, unhealthy environment they came from? It
19 is a matter of weeks before they're right back to
20 where they were. So, certainly continuing to vest
21 with on the ground intensive models of support on a
22 range to meet the needs of vulnerable young people in
23 our province. And that's a model that, take youth
24 out of it, works from any age to any age.

1 So, I guess the piece for me as well is around
2 primary health care and it's such a huge piece and
3 this is the intercept for me. So we've been
4 approached countless, countless, countless times
5 around health care professionals coming into our
6 centre. This is where the vulnerable population is,
7 so let's go there. I know there is a number of
8 agencies - Stella's Circle, Salvation Army, Native
9 Friendship, Association for New Canadians - all
10 operating in the downtown, all wanting some component
11 of primary health care. Let's just get everyone in
12 the one room and figure out because I know resources
13 are limited, I'm not practical around these things,
14 can we get everyone in the one room and say how do we
15 have a central place in the downtown within satellite
16 services that work around that? I think that can
17 serve as a model for other parts of the province as
18 well. It's time we actually, and we've known this
19 for years, it's time we actually put that into
20 practice. And then the connect to physical health
21 and mental health and addictions is pretty obvious.

22
23 I had some other notes on the back of this. All
24 right, no, I think I might have pretty much covered

1 it off. So, if I'm early, great. If I have
2 questions, great.

3 Gerry Rogers:

4 Great, great, great. I always get to go first, I
5 don't know why that is. Sheldon thank you so very
6 much for your presentation. And the work that you do
7 through Choices is so incredible and often
8 lifesaving. We heard from Janine with the
9 Newfoundland and Labrador Psychologists Association
10 and she talked about the need, the role that
11 psychologists can play in counseling sometimes making
12 it possible for people to avoid meds, if that's their
13 desire. And so, I'm wondering, do you have any
14 psychologists actually based in Choices for Youth?

15 Sheldon Pollett:

16 No.

17 Gerry Rogers:

18 And if not, would you like to have a psychologist
19 based in Choices?

20 Sheldon Pollett:

21 The more people I could cram into Choices helping row
22 the boat, the better. No, we do not. We do have
23 relationships beyond Choices around accessing
24 services, but they tend to be very opportunistic and

1 I think those are great but it's not the same as
2 having a consistent access and partnership around
3 these things. They are models of outreach and
4 drop-in services across the country to talk about if
5 you can find a place that is a natural magnet and
6 centre place where these are where people are
7 gravitating towards, then you pile in as many
8 different access points. I mean there are models in
9 the country, for example, around you should be
10 providing dental services that way, you should be
11 providing physical health. Like, it's known that we
12 can actually do a whole lot more when we do that.

13

14 One of the stories I often think about in my
15 career in working with youth is I remember being at
16 the Murphy Centre a long time ago, and I don't know
17 if people know where the Murphy Centre used to be,
18 across the street is a War Memorial. And we were
19 having a conversation - my life is full of these
20 light bulb moments - about, well, it's hard to find
21 at risk youth, hard to engage, hard to engage, and I
22 looked out the window and there is about 40 of them
23 on the War Memorial. We're thinking about this
24 completely the wrong way. Right?

1 When is a young person most at risk? They are not
2 at risk when they are sitting in my office for an
3 addictions treatment program appointment. They are
4 most at risk the other 23 hours a day when they're
5 out there exposed to all the various factors that are
6 happening in their lives. I think a lot more of our
7 focus should be ongoing to where the individuals are
8 most at risk. And I know when it comes to mental
9 health and addictions, there is a broad spectrum of
10 needs in the general public. It's not just the most
11 vulnerable we're talking about. But I use very
12 simple logic in terms of if we do a really good job
13 meeting the needs of most vulnerable in our society,
14 it stands to reason that other people are going to
15 have their needs met. But we do need to focus more
16 on being realistic. It's what it's going to take to
17 change the lives and support those individuals we are
18 most worried about.

19
20 I think historically, I don't know if the number
21 is even accurate anymore, in fairness to my health
22 colleagues. I have a few years about this 30% no
23 show rated in addictions. So we have two choices.
24 We accept that that's just a cost of doing business,

1 thirty percent of the time they're not going to show
2 up next. Or maybe we should think about who's least
3 likely to show up for that standard traditional
4 approach to addictions. The person we're most
5 worried about it. So maybe 30% of the time we need
6 to figure out something else to be doing.

7 Gerry Rogers:

8 It's been interesting, when I attended your event
9 last week, where the young people Sarah and, is it,
10 Jessica?

11 Sheldon Pollett:

12 Sarah, Jess and Kayla.

13 Gerry Rogers:

14 Yeah, and they talked about the need for one stop
15 shopping and, really, it's about primary health care.
16 And then to hear, in the sessions we had this morning
17 in the round table sessions, we heard similar things
18 where people want one stop shopping, but, again, that
19 sense of that primary health care where mental health
20 and physical health are not separate entities. And
21 that if you see a doctor and that you need some help
22 with depression, that right there within that centre
23 you're hooked up someone, so there's not this
24 18-month waiting list to get some kind of help for

1 depression or whatever. And I think we're hearing
2 that, as well, from community groups, the need to
3 have those complimentary services.

4 Sheldon Pollett:

5 So my response to the one stop shop, I think great.
6 I don't think you can put one stop shop everywhere.
7 So, another way to look at one stop shop is no wrong
8 door, and Bruce knows this from some of our
9 colleagues out in Alberta, is that notion of you
10 take, the idea behind the one stop shop is you go
11 there, it's all in one place, you're going to get a
12 consistent from all the people in that building. The
13 other option, in addition to that, is to actually
14 orient the system around, it doesn't matter where you
15 pop up, mental health, addictions housing, ta-dit,
16 ta-dit, ta-da, based on your needs you're getting a
17 consistent rapid response around your needs. I think
18 we can have both. They are both designed
19 fundamentally to do the same thing; meet your needs
20 in the most efficiently timely effective way possible
21 that you actually then are motivated to engage in.
22 Because we don't actually have a system that helps
23 people feel really motivated to engage in it. Go
24 ahead.

1 Honourable Felix Collins:

2 Just want to say, first of all, again, thank you for
3 coming here and certainly we all appreciate the great
4 work that you're doing. Now, your core funding does
5 come from government, I believe. One thing I just
6 want to ask you this, your opinion on, because I have
7 heard at the other sessions we've done, sometimes the
8 groups year by year is a struggle because you wonder
9 what the funding is going to be like and we know
10 there is always a stretch there. Would you be able
11 to do a better job if there was multiyear funding or
12 different approaches to that so you could better plan
13 agendas?

14 Sheldon Pollett:

15 I'm laughing at Morley over there. He's laughing at
16 me. Sorry, go ahead.

17 Gerry Rogers:

18 And to hold on to staff.

19 Honourable Felix Collins:

20 Yeah. Well, I've heard it before and it is not a
21 case it is more money, it is just, well, you know
22 what you got for a longer period of time which allows
23 to better plan long term.

24

1 Sheldon Pollett:

2 This is long term work, right. And I think one of
3 the issues is we've done a rabbit hole where
4 everything is year to year to year to year. It is
5 sort of like I'm going to invest in but at the same
6 time I made this investment, I got one foot out the
7 door. This is long term work and I have no issue
8 whatsoever around accountability, delivering on good
9 service, are you meeting the need in the right way
10 and, like, no issue. But stabilizing the core
11 funding that is being provided is critical and key.
12 I think from a government perspective in terms of
13 where we're at now in terms of the provincial
14 economy, you also have to look at, well, the cost to
15 government to running a business that way. I don't
16 know if that really ever gets looked at is that,
17 okay, well, the extra administrative cost to
18 government, separate from how that works from
19 community agencies, are we sure that micromanaging
20 year over year over year over year is particularly a
21 good resource way to spend administrative dollars,
22 even within government? I don't know if people think
23 about that a lot.

24

1 But certainly, when you're looking at long term,
2 and there is room for project-based efforts as well,
3 but when you're talking about long time work,
4 specifically for me it when it comes to the most
5 vulnerable folks in our community, we have to have a
6 better way of stably funding them with measures and
7 accountability and all that stuff which is part of a
8 plan, then we'll make a lot more

9 Honourable Felix Collins:

10 Thank you.

11 Honourable Steve Kent:

12 Sheldon, that was a great presentation. Thank you.
13 Just, my question is really more of a request. You
14 made a whole bunch of comments that struck me but two
15 relate to specifically how the system is operating
16 today, where it feels like we should be able to make
17 some impact quickly by making some changes.

18

19 One was you mentioned how the ACT Team needs to be
20 better aligned with community-based practices and
21 approaches. So, that's really important. I was also
22 really concerned about your comment around the
23 revolving door at the PAU and how young people are
24 being treated. I'd like for you to sit down with

1 some folks from Eastern Health to try and tackle that
2 quickly.

3 Sheldon Pollett:

4 My staff will be more than happy to do that.

5 Honourable Steve Kent:

6 Because that's concerning and there may be some
7 things we can do quickly to impact that. And I'm
8 sure you have ideas on what exactly needs to be done.
9 So let's connect the right people and make that
10 happen.

11 Sheldon Pollett:

12 Fantastic.

13 Honourable Steve Kent:

14 Secondly, excited to hear you talk about primary
15 health care. I think doing some kind of project
16 downtown to create that one stop shop that we've
17 heard about repeatedly, as Gerry alluded to, is a
18 great idea. And we've got some funding in this
19 year's budget to start to advance primary health
20 care. So I would like to also connect you with some
21 of our primary health care folks to see if we can get
22 those right people in the room from the agencies you
23 mentioned and from within the system to try and
24 figure out what's possible; because, like you say,

1 there are multiple organizations working in the same
2 space who have similar needs. So, surely if we get
3 the right people in the room we can make something
4 happen, so.

5 Sheldon Pollett:

6 It's one of those things we're I think we're already
7 on the same page, we're just not in the same room
8 yet.

9 Honourable Steve Kent:

10 Right, yeah. And I think there has been a number of
11 topics today where we're on the same page but not
12 everybody is in the right rooms together. So we
13 should be able to figure that out. So, anyway, thank
14 you. That was a great job, once again.

15 Sheldon Pollett:

16 Not a problem.

17 Dr. Bruce Gilbert:

18 Thank you very much, Sheldon. Okay. Well, as Chair
19 of the All-Party Committee, Minister Kent, would you
20 like to wrap this up? I don't know, there's a few
21 minutes. You can do it in any way you like. My job
22 is done. Thank you very much. And you're under
23 time.

24

1 Honourable Steve Kent:

2 Well, Bruce, thank so much for keeping us on track.
3 I think you did a very effective job of that and you
4 still managed to allow everybody to have their say
5 and we got to ask questions each time. So, well
6 done. I want to thank all of you. I want to thank
7 the brave souls who stuck around till the end. So,
8 congratulations to those of you who made it through
9 the entire afternoon.

10 Gerry Rogers:

11 And morning.

12 Honourable Steve Kent:

13 And morning. About half the room were here with us
14 for this morning, so. So we really appreciate that.
15 On behalf of Felix and Andrew and Gerry and the other
16 members of the Committee, I want to say a big thank
17 you to all of you. There are more opportunities for
18 you to have input. Some of you are going to get
19 tired of hearing me say that, but we do want to hear
20 more from you. If you have more input that you want
21 to share with the Committee, if you've had ideas as a
22 result of today, if next week something jumps to mind
23 that you want to talk about, then we'll meet with
24 you, we'll take phone calls, we'll take written

1 submissions. Whatever works for you, we want to hear
2 it.

3
4 I think a lot of what we heard today was
5 incredibly insightful and informative, and I think
6 it's going to be really helpful to us as we formulate
7 recommendations. We will have more sessions like
8 this in St. John's. They'll be announced soon. In
9 the meantime, check out our website for continued
10 updates. And the transcript from today and the notes
11 from this morning are all going to be published on
12 the website real soon, so you'll have be able to see
13 the raw feedback and the raw information and the raw
14 data that's been gathered. So please check that out
15 as well.

16
17 Anyway, I want to thank you again on behalf of the
18 Committee. I hope you have a great weekend and look
19 forward to seeing you as this process continues.
20 Thank you.

21
22
23
24