1 **June 26, 2015** **St. John's**

2

3 Honourable Felix Collins:

4 My name is Felix Collins. I'm MHA for Placentia -

5 St. Mary's, and the Alternate Chair of this All-Party

6 Committee. I'd like at this time to ask my

7 colleagues to introduce themselves.

8 Christopher Mitchelmore:

9 Christopher Mitchelmore, I'm the MHA for The Straits

10 - White Bay North.

11 Gerry Rogers:

12 Hi, I'm Gerry Rogers and I'm the MHA for St. John's

13 Centre, which this is where we are. It's right smack

14 dab in the middle of it. I suggest people move

15 closer. Even those chairs are too far away, hey.

16 This is like if you want. Or during a break, I'm

17 going to move all the chairs closer with you in them

18 or without you in them. Michelle, you're first up,

19 hey?

20 Michelle Worthman:

21 You want me to go now?

22 Gerry Rogers:

23 Yeah, great.

24

1 Honourable Felix Collins:
2 Okay. Again, good morning and it's a pleasure to be
3 here today with the colleagues from the House of
4 Assembly and members of the Province's first
5 All-Party Committee on Mental Health and Addictions.
6 The members have just identified themselves. And the
7 establishment of this All-Party Committee is a unique
8 and innovative way to collaborate and help us achieve
9 our mandate, and that's to review the provincial
10 mental health and addictions system with a goal to
11 improving programs and services.
12
13 We've had a series of public consultations right
14 across the province, like the one that's happening
15 here today. Matter of fact, this is our third one, I
16 think, here in St. John's because there is a number
17 of people who wanted to present, and we have some
18 expert testimony on best practices, both nationally
19 and internationally, so we've had quite a lot of
20 input so far. We've travelled across the province,
21 met with residents and groups and committees and
22 health associations and mental health workers all
23 across the province to get their input. The
24 information that we're receiving will be invaluable

1 in helping us establish some directions and
2 recommendations when the process is complete. So
3 again, thank you all for your interest in this very
4 important area and for taking the time out to share
5 your views with us this morning.
6
7 In addition, incidentally, to the public
8 consultations like these, you can also give us
9 feedback online on BeHeardNL.ca. You can also email
10 BeHeardNL@gov.nl.ca or call 1 (844) 729-6310 toll
11 free and we've got information provided for you here
12 today, anybody wants to get it before you leave. And
13 on behalf again of the All-Party Committee, there are
14 a number of, by the way, there are other members of
15 the committee as well. I think the committee in
16 total has seven people, so we get a group of the
17 committee each time for the presentations.
18
19 At this point in time I'd like to introduce Bruce
20 Gilbert who will facilitate the discussion here
21 today.
22 Dr. Bruce Gilbert:
23 Thank you, MHA Collins. Welcome everybody. We have
24 15 presentations today. My job is to keep things

1 rolling because if each of the 15 take exactly the
2 amount of time they've been allotted, we will finish
3 exactly on time. There's no wiggle room. So I will
4 be sitting over here and I do have some cards. So if
5 you have 30 minutes to speak, I'm going to give you a
6 10-minute warning and a five-minute warning. Our
7 first presenter is Michelle Worthman. You have 15
8 minutes. I'll give you a five-minute warning. So
9 just keep your eye on me and that'll help you gage
10 your time. If you want to have some dialogue with
11 the Panel, I strongly recommend that you come in
12 under 15 minutes or 30 minutes, so if there's some
13 time for some questions and reaction.
14
15 For those in the room that are wondering about
16 privacy, I don't believe we have any media here but
17 if media show up we will let you know. Generally
18 speaking, when you make your presentation, it is
19 being audio recorded and we will transcribe it. This
20 is for the Committee to be able to use and refer to
21 later on. And it will be posted online, the
22 transcript of your presentation, unless you tell us
23 otherwise or have some issues with that. Without
24 further ado, I'll turn it over to Michelle and we'll

1 start your 15 minutes now.
2 Michelle Worthman:
3 I just wanted to start off with something called SIBS
4 .... I am someone with a mental health issue but I
5 am also someone who is wasting away because --
6 Gerry Rogers:
7 Michelle, I think it's a little bit hard for people
8 to hear if you don't use the mike. Great.
9 Michelle Worthman:
10 Okay. So, I'm in a situation that I feel that my
11 mental health and the stigma behind that and because
12 of ridicule that comes with mental health, I have
13 been placed in a situation where --
14 Honourable Felix Collins:
15 You got to stay close to the microphone. Stay close
16 to the mike. Here we go.
17 Michelle Worthman:
18 Okay. It seems more intimidating.
19 Gerry Rogers:
20 It does, yeah.
21 Michelle Worthman:
22 Okay. So basically, because of rumour mills and the
23 vulnerability that I have been placed to live under,
24 I have been placed in a situation where I am left

1 with no option to be able to go back to work because
2 there's a lack of understanding of what it is that
3 somebody with a mental health issue and somebody who
4 is full of anxiety can do. Instead of private
5 industry being able to take the time to give a few
6 months for to work out the bugs on what those
7 anxieties would be, I'm left in a situation where I
8 can't even get my foot in the door because starting a
9 new job means that I'm going to take a series of
10 panic attacks, whereas I strongly feel that if
11 government were to set up within the health care
12 system jobs where people such as myself would be able
13 to work within the health care system, for example,
14 in old age homes, where I have a mental health or
15 somebody is on Workers' Compensation, if we were to
16 become personal assistants to those within those
17 homes, we would be monitored by both the nurses and
18 we would be able to alleviate some of the work for
19 the nurses by making sure that we would be there for
20 their patients.
21
22 Now, how we would be able to do that is to start
23 with people that would be considered the least, by
24 somebody such as much that's on welfare that's living

1 in Newfoundland and Labrador Housing, if I were to
2 get paid in home equity, I would gain homeowner
3 rights, meaning I do not have to live in a situation
4 where people could place me in homelessness based
5 upon the fighting that's going on with that last
6 penny mentality where people feel that they're more
7 justified to be able to live inside of my home rather
8 than myself, and that's leaving people in very
9 vulnerable situations where they could be just placed
10 in -- you're just totally powerless.
11
12 Now, what I am suggesting is, if I were to get
13 paid in home equity, it wouldn't cost you, the
14 taxpayer, anything extra. I'm already living inside
15 of the home. The only thing that I would be gaining
16 out of it is homeowner rights for that particular
17 security. When I do get my OAS, which is not a
18 particular part of a pension plan, I would not have
19 to take any of that OAS cheque and put it into a
20 percentage of rent because then we can do a reversal
21 type mortgage, making sure whatever I receive on my
22 OAS will be all mine.
23
24 Now, in order for us to be able to start something

1 like this, if we were to sell something called SIBs,
2 which I have listed there, Social Improvement Bonds,
3 it would give us the opportunity to be able to bring
4 money into the system by bringing investors into a
5 situation where we can actually sell our problems,
6 meaning that if we were to start from a zero base,
7 looking at government from a cost-saving perspective,
8 we could transfer those cost-saving measures directly
9 to the investors. Meanwhile, to make sure that we do
10 get the investor money into government, we can
11 increase the amount of money that it is that they
12 will get because they'll be paid back over a longer
13 period of time.
14
15 So what I got here on the green piece of paper,
16 now I did print it backwards, by example, so, yes,
17 the commonsense part is actually on the back. It was
18 supposed to be the front, so I'm very sorry about
19 that. So that just explains what the SIBs are. An
20 example, if we were to sell 250 units at 1,000, what
21 we would be able to do is take that money and create
22 jobs. And what I mean by that, we can do home
23 renovations which does have a multiplier effect in
24 job creation. Not only that, the ones that do do a

1 lifetime contract for home ownership, that would mean
2 government in a situation where they would have so
3 many service hours that they would be able to provide
4 for our elderly, and again that would be a future
5 budgeting process that we can have some cost savings.
6
7 I also have listed different examples in which,
8 that we would be able to use these SIBs to ensure
9 that we do have enough homes for the people that are
10 on wait list. So that's that part.
11
12 Now, I also have here an example of how this would
13 work and how many hours that would be created. I'll
14 just pass that to you. I'm so sorry. So on the
15 front here, I have listed what I currently get on
16 welfare. On the bottom I have listed an example of a
17 home equity plan. Now, this home equity plan,
18 nothing has changed. This would be an example of my
19 monthly pay cheque. Nothing has changed, except for,
20 on the inside I do have listed the reality of 24-hour
21 care costs that is for our seniors, broken down by
22 different pay scales. As you can see, ten seniors
23 get sick in one year; you're looking at an average
24 cost of $3.5 million. This means that we have a huge

1 window, an opportunity to be able to create jobs for
2 people such as myself where it would actually reduce
3 these future costs.
4
5 On the bottom I have listed how many hours weekly
6 somebody would have to work in order to work off the
7 home equity plan, broken down by different pay
8 scales. The creativity behind it is that because I'm
9 already living inside of this home and because you
10 want to give true incentive for people to make sure
11 that they do work and do put in that commitment, we
12 can be creative with the pay scale, the job
13 structure. We can even pay people for healthy living
14 initiatives so that we would even further benefit or
15 further streamline our health care spending and
16 reduce future costs.
17
18 On the inside, on the other side, I also have
19 listed a 24-level training program with how many
20 hours it would take a life coach, which could be a
21 position of a psychiatric nurse or it could be an LPN
22 or it could be somebody that's already on government
23 dollar, how long it realistically would take them to
24 be able to do a proper skills assessment on people.

1 Those skills then can be matched with what it is they
2 can realistically do to be able to put hours into the
3 system.
4
5 On the back, I also have listed how many hours
6 that would be created, broken down by different pay
7 scales, and the amount that people would have to work
8 off based upon the home equity plan in the front, and
9 the timelines it would take people to be able to do
10 so.
11
12 Now, I don't have copies of this one. I'm not
13 that well-advanced, sorry. And right here is example
14 of how we would be able to use this particular
15 election to make sure that we could transfer your
16 political party funds to be able to do a proper case
17 study on what it is that could happen. For example,
18 what I do have listed for the coaches' salaries could
19 actually go into a promotion or something that all
20 three parties, seeing how we're all on the same page
21 now, would like to be able to transfer or use those
22 funds. So that would be your debate fund.
23
24 On the inside, I have listed Lesson A from Level 1

1 of the 24-level course. Basically it's just a start
2 on personal discovery. What it is that, the
3 questions that you have to ask, because when you are
4 somebody who has a mental health issue, you feel like
5 you're living in a black hole. You cannot see out of
6 it. You cannot do goal-setting. You cannot see --
7 you can't get past the hour sometimes, let alone be
8 able to plan out how you're going to get out of this
9 situation, and it becomes a downward spiral. I'm
10 wasting away and I do have skills and I'm not the
11 only person, so I do not understand why I cannot go
12 to you and say I want to be able to provide service
13 hours and not cost you any money being able to do so.
14 So those are some examples of some questions and how
15 we would be able to get started and what the end
16 result would be. I have a list there of what my
17 personal plan would be on the goal (phonetic) piece
18 of paper. So sorry if I'm moving fast.
19
20 Now, I'm going to move on to the main part of it.
21 In each lesson plan, as a Poverty Reduction Plan,
22 what we should do is actually pay people as an
23 incentive to get started, with food and products, and
24 what it is that they do actually need. This would

1 leave us in a situation where we can do major
2 contracts with distributors and grocery chains such
3 as Sobeys to do things such as buy one, get one free
4 specials, again, further streamlining the amount of
5 money that's currently being spent by making sure
6 that the products and services are actually going to
7 the individuals that they're promoting themselves to
8 be able to do the fundraising dollars.
9
10 So on there, I do start with a snowball recipe.
11 It's from an old book which has too much sugar in it,
12 but as we're going through the lesson plan we can
13 actually reduce the amount of sugar. We can actually
14 reduce the amount of sugar and start doing some
15 healthier lifestyle, healthier life choices. Again
16 on the inside I have personal discovery and what it
17 is that you need to look at to be able to start
18 changing your life and some negative questioning that
19 you can ask yourself, because when you get in that
20 dark hole, you got to question your thoughts that you
21 are telling yourself and be able to alter that, which
22 does take some time. The first snowball is a lot of
23 work but as we move along and people start practicing
24 this, it will become second nature to them, and the

1 more positivity that we can get into people's homes,
2 the further cost reduction that we would be to
3 government.
4
5 And I also have here a part of Lesson C, which is
6 a part of Level 1 of the 24-level training program,
7 and on the last part of the first one is really how
8 tomorrow is our future, and this is the way that we
9 got to start thinking, because it is, again, very
10 difficult and it's a concept that's foreign to many
11 people to be able to plan ahead.
12
13 So on the inside of here is how people can start
14 thinking about the home renovations that they would
15 like to have, to do a dream board. You start lifting
16 the chains of impossibilities and start planning
17 exactly what it is that they want inside their home,
18 giving them true incentive on what it is that
19 motivates them internally, what it is that they do
20 want in their lives.
21
22 This would also give us an opportunity where we
23 would be able to go to small contractors with
24 different SIB plans or to be able to go to Canadian

1 Tire for even further reduction on things that we
2 need for these homes. This would also reduce some
3 money that's being spent currently with inside
4 Newfoundland and Labrador Housing that's doing some
5 renovations, because the homes now would be better
6 serviced or provided for. And again, I do have
7 listed the snowball effect, and it's a theme that
8 would be throughout. But each lesson would be more
9 involved and then we would get into other things such
10 as more creative meal ideas, emergency plans for when
11 the power goes out, the products that they do need, a
12 hospital bag being ready, how we can get some local
13 businesses in onboard where we would be able to
14 promote them and give them small business contracts
15 over a longer period of time that would benefit them
16 as well as government, because people will be
17 prepared.
18
19 And again, if we start with the least, the ones
20 that are deemed a drain on the system, people such as
21 myself that are currently on welfare, that are
22 currently with inside Newfoundland and Labrador
23 Housing, it would not initially cost government any
24 extra money than money that is being spent but have a

1 huge amount of future cost being reduced. And again,
2 we could also go even further in the future and
3 purchase new homes so that we can extend this to
4 those that are on waiting lists, those that are
5 elderly and so forth.
6
7 So I guess my final -- I could tell you more but,
8 okay, I'm done, I guess.
9 Gerry Rogers:
10 Great.
11 Honourable Felix Collins:
12 Okay, thank you, Michelle. Any of the Panel have any
13 questions?
14 Gerry Rogers:
15 Yes. Michelle, I think that what you've hit on in
16 your presentation are some of the issues that have
17 come up again and again and again, everywhere that we
18 go in the province, and that's being able to have a
19 secure place to live.
20 Michelle Worthman:
21 And working is the best therapy.
22 Gerry Rogers:
23 And working. And we were in Labrador last week and
24 in Labrador there were people who talked about their

1 own experience and wanting to be able to work, but
2 also parents with adult children with persistent
3 mental health issues that they're dealing with and
4 how hard it is for their sons and daughters who
5 cannot get into the workforce for reasons like you
6 explained, like the high anxiety that you experience
7 when you start a new job. And so it's kind of
8 interesting because I think what we've done is we've
9 so deinstitutionalized over the years, in the '70s
10 and the '80s, which is a really, really good thing,
11 but, and then also, like, areas where there was
12 supporting work environments, but we haven't then
13 also built up enough opportunities for people to be
14 able to have the supports they need to work, and they
15 want to.
16 Michelle Worthman:
17 Actually, I disagree with one part. We may have
18 deinstitutionalized when it comes to a building but I
19 feel that we're more institution -- I can't say the
20 word.
21 Gerry Rogers:
22 Institutionalized. I think you're right.
23 Michelle Worthman:
24 Institutionalized to people with the mentality of

1 what it is that we have done. People are relying too
2 much on government because I feel there has been a
3 situation where people have been creating jobs for
4 themselves based upon the need and stigma of what are
5 considered at risk, and because of that I strongly
6 feel that these government workers are at an ideal
7 opportunity where we can sit down with them and to do
8 some real life plans on what it is that they really
9 want to do, because, you know what, there are some
10 people that are working, like an LPN that can get
11 paid to go jogging with some people for that healthy
12 living incentives. And I think we have to approach
13 it from, what is your time worth, what's valuable,
14 and what is needed. If you're jogging anyway, it's a
15 healthy lifestyle, perhaps maybe you should be paid
16 for those hours doing that.
17 Christopher Mitchelmore:
18 Michelle, supportive housing and supportive
19 employment has come up time and time again. I think
20 what you've presented is trying to get government to
21 look at a different way to be more creative with our
22 housing stock, and I sat as a director with the
23 Canadian Community Economic Development Network and
24 we've talked a lot about Social Impact Bonds. I'm

1 not as familiar with the Social Improvement, or maybe
2 it's a very similar type --
3 Michelle Worthman:
4 I researched this in the UK.
5 Christopher Mitchelmore:
6 Yes. And that's kind of where I was getting at.
7 This seems to be a very popular concept in the UK,
8 making quite headways with a lot of the social
9 concerns that are there.
10 Michelle Worthman:
11 When I first started, it was only one small place
12 that was doing it within a second-hand bookstore. I
13 have been approaching different governments in
14 different countries with what it is. I do have a
15 limited written communication problem but I am trying
16 to approach as many people as I possibly can with the
17 concept of what it is. This is like a blank cheque
18 for what it is that we do need. It's a matter of
19 political will to be able to get it done.
20 Christopher Mitchelmore:
21 I'm familiar with the bookstore and the concept and
22 the success that it's had.
23 Michelle Worthman:
24 Secondhand store.

1 Christopher Mitchelmore:
2 Yes. Thank you.
3 Dr. Bruce Gilbert:
4 Okay, thank you very much, Michelle.
5 Honourable Felix Collins:
6 Thank you, Michelle.
7 Dr. Bruce Gilbert:
8 Appreciate it greatly. Next up we have Karen Doyle.
9 And, Karen, you have 30 minutes. I think I'll sit at
10 this table so you can see my cards. I'll give you a
11 10-minute and five-minute. Take it away.
12 Honourable Felix Collins:
13 Welcome, Karen.
14 Karen Doyle:
15 I'm not used to sitting while talking to people at
16 microphones.
17 Gerry Rogers:
18 Do you want to stand?
19 Karen Doyle:
20 Sure. The Power Point is going to be where? On both
21 of them, okay. I can stand over here then. Hi
22 everyone. I used to be a circus performer so I think
23 my voice is probably loud enough. I probably don't
24 need a microphone.

1 Honourable Felix Collins:
2 Can you all hear Karen?
3 Karen Doyle:
4 Can everybody hear me? Okay. So right here I have a
5 picture of Gabor Maté, who is head doctor at Insite,
6 which is a leading harm reduction site in downtown
7 eastside Vancouver, and what it says there is there's
8 no war on drugs because you can't war on inanimate
9 objects, there's only a war on drug addicts, which
10 means we are warring on the most abused and
11 vulnerable segments of society.
12
13 So, from this I guess you guys can guess that my
14 presentation to the All-Party Committee today is
15 going to be on gaps and lack of service in addictions
16 and as well harm reduction within the Province of
17 Newfoundland.
18
19 So, do I have a clicker or? Is there a clicker?
20 Okay. Dominant discourse. So this is dominant
21 discourse on drug addicts. I think there's been --
22 am I not talking -- okay. Okay. I think there's
23 been a lot of challenging of the stigma around people
24 with mental health issues, which I think is fabulous,

1 and mental health has come a long way in this
2 province, and I know that we're getting peers who are
3 going into the hospitals, which is great, but I think
4 that addictions and use of peers in working in the
5 addictions field is yards behind. I mean, for
6 example, picture Gabor Maté, Vancouver has had a drug
7 abusers and ex-users consultancy and advocacy group,
8 VANDU, since 1998. We're now almost 2016 and we do
9 not have such a group here, and I think that just
10 speaks volumes about the amount of consultation and
11 that has been done with users when creating services,
12 when designing the services, implementing the
13 services and evaluating services. There's been no
14 feedback from the people who those services are
15 ostensibly designed to serve, right.
16
17 So anyway, here's the dominant discourse. I got
18 off topic. People who use drugs are dangerous and
19 unpredictable. People who use drugs are criminals
20 and should be incarcerated. These are really
21 shocking things but a lot of things that people in
22 society still believe about people who use drugs,
23 right. The person is to blame because he/she/we
24 chose to take the drug in the first place. Canadian

1 health care should not be responsible for the health
2 of drug addicts because they're doing it to
3 themselves. They deserve any diseases they catch and
4 also there's the belief out there that harm reduction
5 encourages people who use drugs to continue to use.
6
7 On to the next slide. So, I think it's important
8 to look at people who use drugs as another
9 marginalized population and also to recognize that
10 they are also citizens of our society and they
11 deserve the respect and the rights of normal
12 citizenship. Their population, because the
13 structural causes of drug use, I know that there's a
14 lot of individual differences within the population
15 but there's also high levels of commonalities, past
16 and present experiences that distinguish them as a
17 population.
18
19 For example, the background of people who use
20 drugs, there's higher levels of addiction in areas of
21 low hope, poverty, desperation and lack of
22 opportunities, and they often come from similar life
23 experiences of abuse, neglect, abandonment, trauma,
24 mental distress, mental illness and mental health

1 issues. A lot of people with mental health issues
2 when they find that they can't get help from
3 psychiatric medications often turn to use street
4 drugs. Like, that's something that happens all the
5 time. And they also have a common day-to-day
6 experience of living within the drug culture and
7 underground (inaudible) in illegal activities, the
8 desperation and addiction and the societal stigma and
9 marginalization that they face on a daily basis,
10 particularly from professionals. I would define this
11 population as marginalized because their human rights
12 and dignity are not respected, even by the people who
13 serve them. They're denied the rights of regular
14 citizenship and a really important example is health
15 care.
16
17 Okay, I'm not there yet, but anyway. In a recent
18 study, drug users identified negative attitudes,
19 judgement and perceived discrimination as primary
20 barriers to assessing health care. So people don't
21 even want to go to, like, the hospital because of the
22 way that they're treated when they go to hospitals as
23 drug users, and the stigma that exists there. I
24 mean, people with mental health issues have the same

1 barriers to accessing health care, but I would say
2 that because of the long way that mental health has
3 come, they have a lot less stigma coming from health
4 care providers than drug addicts. People who are
5 addicted to drugs, I should say.
6
7 And now recently mental illness, I mean drug
8 addiction has been included in the DSM V is mental
9 illness under substance-related disorders. So if you
10 believe that, then they are also members of another
11 marginalized population, people with mental health
12 issues, right. So personally, I don't really buy
13 into that. I believe the structural argument that
14 addiction and possibly mental health issues, we could
15 debate that, are caused by social injustices, and I
16 think that this needs to be seen as at least a
17 contributing factor in causing mental distress and
18 illness in people.
19
20 Also important to acknowledge the connection
21 between -- oh, I already said that, okay.
22 Regardless, drug-addicted persons and persons with
23 mental health issues, and all marginalized persons,
24 deserve equitable health care, and I don't think

1 anybody would argue with that.

2

3 So I just want to talk a bit about harm reduction
4 because it's so important to the health of people who
5 use drugs. So harm reduction, you guys, I don't
6 know, you guys probably know all that stuff but I
7 wasn't sure if they did, so I just kind of put it up
8 there. Service reaction (phonetic) that attempts to
9 address the exclusion and stigma of drug users
10 through the provision of respectful access, the
11 health saving information, services and supplies. So
12 a great quote there is that harm reduction shifts the
13 culture from one where resources may be rationed on
14 the basis of deservedness to one which everyone is
15 seen of deserving care. So, harm reduction can
16 include things like condoms in schools to safe
17 injection sites, like they've got in Vancouver, or
18 programs like SWAP that we have here.

19

20 Okay. So, yeah, there's just some examples. Safe
21 using campaigns, counselling for controlled use,
22 because some people can use in a controlled way for
23 counsel but it's pretty rare, and I think detox
24 centres are also another example of harm reduction.

1 Sterilizing equipment for prisoners, (inaudible)
2 living houses. And as with any population, I think
3 there's subsections of marginalization that are,
4 like, compounded by different factors, for example,
5 like race. If you're an aboriginal, if you're
6 female, you're aboriginal, you're a sex trade worker
7 and an intravenous drug user, then you're probably
8 more marginal, or you're definitely more marginalized
9 than a person who is accidentally addicted to drugs
10 that their doctor prescribed them, for example,
11 right. So I think we need to break down a lot of the
12 stigma around people who are addicted to drugs
13 because I think it's mainly socially caused.
14
15 So, okay, the old Canadian drug strategy was
16 pretty decent. I mean, harm reduction was one of the
17 main four pillars, right. Harper came in and that's
18 gone, so now we have the new anti-drug strategy which
19 is horrible. I don't know if you guys have checked
20 all this stuff, but basically just to sum this up,
21 over 50 percent of the new anti-drug strategy is
22 enforcement. So this is a war against drug addicts,
23 like Gabor Maté was saying in the beginning, right.
24 And if you include drug treatment court in its proper

1 place, which is actually an enforcement, because they
2 have it put in a different place, let me see,
3 treatment action plan. No. Anyway, it actually
4 works out to about 60 percent of the entire funding
5 is going towards enforcement.
6
7 So, conflicts between -- okay. Anyway, that was
8 some people from the Drug Users Association in
9 Vancouver who are always consulted when any new
10 services are being put into place to serve them,
11 which makes sense but hasn't been done in
12 Newfoundland.
13
14 So, this is conflicts. Okay, so the conflicts
15 between the legislation and harm reduction, which is,
16 like I said earlier, really important to the health
17 of people who use drugs. So in one Health Canada
18 publication release I saw that, it talked about the
19 new Canadian Drug Strategy. Harper said, or it was
20 said that these actions demonstrate how the Harper
21 Government is acting to protect public health and
22 maintain health and safety in Canadian communities.
23 Whose health and safety? It's not acting to maintain
24 the health and safety of people who use drugs, that's

1 for sure. And like I said, I think that they need to
2 be included as members with regular rights of
3 citizenship, and they're not. If you think that they
4 are, then you're fooling yourself.
5
6 Removing harm reduction services from Canada's
7 Drug Strategy is in direct contradiction to Canadian
8 Health Care Policy. It hasn't worked anywhere else,
9 the prohibitionist policies that they've put in
10 place. It hasn't worked in the States. It's ended
11 up costing them more money. It won't decrease the
12 demand for illicit drugs as the Harper Government
13 claims, and will just drive them further underground
14 where it's more dangerous for people to use drugs.
15
16 It's in direct contradiction to Canadian Health
17 Care Policy, like I said. In Section 3, it says,
18 "The primary objective of Canadian Health Care Policy
19 is to protect, promote and restore the physical and
20 mental well-being of residents of Canada and to
21 facilitate," this is the important part, "reasonable
22 access to health services without financial or other
23 barriers." So cutting out harm reduction as the main
24 pillar is doing exactly the opposite of that.

1 Reasonable access to necessary health services for
2 injection drug users is virtually non-existent in
3 Canada and particularly in Newfoundland. So the
4 safety and health of people who use drugs is at
5 stake. There's an increase of life-threatening
6 diseases when harm reduction is not promoted: HIV,
7 Hep C, soft tissue infection that can lead to loss of
8 limbs or life, overdose, and more often than not
9 incarceration. I know that, I'm sure you're aware
10 that a lot of the people at large, a huge percentage
11 of people in the prison system are drug addicts.
12 Persons addicted to drugs is the proper term.
13
14 So, in conclusion, the new drug strategy focuses
15 on incarceration and punishment rather than
16 treatment, harm reduction and harm reduction for our
17 most marginalized citizens because usually people who
18 are addicted to drugs are also people with mental
19 health issues.
20
21 So limited accessibility, harm reduction in
22 Newfoundland. I don't know where that went. It
23 might come up later. Anyway, there's no peers in
24 harm reduction, working in harm reduction in

1 Newfoundland. And I'd like to -- and also there's no
2 peers working in the addiction field in Newfoundland,
3 which I think is a huge problem. On the mainland
4 there would be peers and there would be people who
5 are living in recovery and working in addictions
6 treatment, because they have innate understanding and
7 if you, if you agree with social work theory, like
8 expert, people who use drugs are the experts of their
9 own lives and they would have a greater understanding
10 than people who have learned from books about
11 addiction treatment and whatnot, right.
12
13 I'd like to also discredit the word "experiential"
14 here, because time and time again I've heard from
15 professionals that, oh, yes, there's lots of people
16 working in addictions in Newfoundland who are
17 experiential. And I'm like, oh, okay. Well, I
18 didn't know that. Can you name some people? They
19 tell me people and I'm like, okay, yeah, that
20 person's dad was an alcoholic. That person's uncle
21 was a drug addict. When they're talking about
22 experiential, they're talking about people who have
23 secondhand experience in addiction. They're not
24 talking about anyone who has firsthand experience in

1 addiction, knows what that feels like and knows what
2 that is like to live with every day, right.
3
4 So, basically I'm just going to quickly outline
5 the problems in services here, and these are things
6 that I think you guys pay particular attention to.
7 The wait list for counselling and treatment and
8 methadone maintenance treatment, any type of drug
9 treatment, there is a huge wait list. People can
10 overdose before they're ever going to get in to these
11 treatments. There's a lot of barriers put up such as
12 like having to wait to get in to see an addictions
13 counsellor, to even get your name on a list to get
14 into a rehabilitation centre. It's, like, you don't
15 need it, you don't need rehabilitation in six months
16 from now, you need it now.
17
18 Smoking in the detox, that's ridiculous. I heard
19 somebody else bring that up. We've got people here
20 who are trying to get help to get off hard drugs,
21 that they can potentially overdose or die from and
22 they can't have the comfort of a cigarette, so
23 they're choosing not to go in there. Like, they just
24 can't. They're like, I can't deal with not having my

1 cigarettes and not having my drug of choice. So the
2 result is that, the very real result, is the Recovery
3 Centre at maximum capacity years ago when there was
4 smoking, and you go there now and it's a ghost town.
5 So, obviously people are not accessing the services
6 that they need, right. It's commonsense.
7
8 There's also no medical detox, which is a huge
9 problem. I realize there's a slow transition going
10 on there but it's obviously a low priority, given on
11 the rate of speed that's happening here. Okay.
12
13 So barrier to harm reduction. Many health care
14 professionals choose not to take a role, despite the
15 fact that many experts and researchers agree that
16 increasing the availability of sterile syringes
17 through syringe exchange programs, making them
18 available at pharmacies and other outlets, reduces
19 unsafe injection practices such as needle sharing,
20 and reduces the spread of HIV infection, which like,
21 come on, that's going to cost, like, health care,
22 like, a ton of dollars, right. The hospital refuses
23 to provide harm reduction items to people. We have
24 SWAP. SWAP is great. It doesn't have enough funding

1 so it's not -- so it's got very limited hours of
2 operation, and where are you going to turn outside of
3 hours of operation? Addiction, like I've heard
4 people say about mental health, does not keep hours.
5 You're not an addict nine to five in the day, right.
6 So if you need supplies for safe use in the
7 nighttime, where are you going to go? You're going
8 to end up using contaminated equipment or you're
9 going to .... Despite -- okay.
10
11 Okay. The cost of treating soft tissue infections
12 in HIV- and Hep C-related conditions, for example,
13 would far outweigh the cost of providing a harm
14 reduction measure in hospitals and in pharmacies.
15 Right now, the current situation is that pharmacists
16 individually choose whether or not to take part in
17 harm reduction. So it totally depends on policies in
18 different pharmacies and pharmacists. So really
19 what's going on here is the pharmacists are choosing
20 or not choosing to make health care available to
21 certain populations, based on their own personal
22 judgement of that population. So this acts as a
23 serious barrier to people who use drugs for accessing
24 health care. And I mean, like I said, they are

1 citizens and I think that society is responsible for
2 the condition that they find themselves in because a
3 lot of it is through structural violence that these
4 people end up where they are.
5
6 Okay. Okay. So most addicts, nobody chooses to
7 be an addict, okay. Like, nobody wakes up in the
8 morning and is like, hey, I'm going to become a
9 junkie. That sounds like a great idea. The majority
10 of addicts don't choose to maintain their addictions
11 and they don't plan ahead for the next use, so when
12 sterile supplies aren't available, that becomes a
13 real problem. Many addicts see each time as the last
14 time, so they don't, like, stock up on supplies
15 either, which is what some people have suggested,
16 right. People don't want to live that life, so they
17 don't stock up and keep everything on hand, right.
18 Around-the-clock access is especially important for
19 IV cocaine users because of the frequency of use.
20
21 An important point is that there's been evidence
22 that drug workers' personal values, so people who
23 work with persons with addictions, may have a
24 significant impact upon client outcomes. This

1 highlights the need for attitudes of professionals to
2 change if harm reduction is to become in any way
3 comprehensive for drug-using populations. Yeah, so
4 in order to reduce barriers and provide equitable
5 access, as per Section 3 of the Canadian Health Care
6 Policy, professionals are ethically responsible to be
7 aware of the specific risks associated with various
8 drug use behaviours so that they can provide those
9 who use drugs with harm reduction options.
10
11 Okay, the joining of -- the recent marriage of
12 mental health and addictions services, all referrals
13 for both services, as you know, are now going through
14 Central Intake. In general, this means that the wait
15 list -- ten minutes left? Cool. The wait list for
16 addictions, to get in to see an addictions counsellor
17 has doubled. And until you get in to see an
18 addictions counsellor, you can't get even the basic
19 forms done to get on the wait list to go to rehab.
20 So it's like further and further down the road,
21 right.
22
23 So, I guess the reason that these two were joined
24 was because the DSM 5, now classifying addiction as a

1 mental health issue. Classifying addiction as a
2 mental health issue means that society can also wash
3 its hands of its role in fostering addiction, just
4 like it has with mental health issues. Addiction is
5 within the person, not our problem, and not caused by
6 structural injustices. Like, that's pretty much what
7 I'm reading into it.
8
9 The sad thing with people suffering from
10 addictions, and like I said earlier, a lot of them
11 are people who also have mental health issues, is
12 that, like I said, mental health is still stigmatized
13 to a large extent, but people living with addictions
14 are stigmatized, like, that much further, right. So
15 now my big concern is that now that the two of them
16 have been combined, it makes it a lot easier to
17 funnel money into the more acceptable personal
18 illness and away from addictions-related treatment
19 and harm reduction. Like I'm interested to see what
20 kind of fallout that has, right.
21
22 Okay. So problems with harm reduction treatment
23 in Newfoundland. No peer consultation or involvement
24 in development or delivery. That's something that's

1 happened in Vancouver and on the mainland for a long
2 time but has never happened here.
3
4 Wait lists for treatment. There's a lack of sober
5 living houses in the city. There's only one sober
6 living house and it houses four women. So, you've
7 got people going for treatment in Humberwood for
8 three weeks, which, by the way, if you read any of
9 the research on treatment programs, 90 days is the
10 recommended amount for it to be at all effective, and
11 we've got a three-week rehab, or what I like to call
12 a glorified detox program.
13
14 So we've got people coming back after three weeks
15 and where are they going? Back into the same squalor
16 that they've come from, like back into the boarding
17 houses, back into the living arrangements with the
18 other drug addicts that they're been living with for
19 their whole lives. So what do you think is going to
20 happen? If they last a month, that's pretty amazing,
21 right. They're going to go back at Humberwood again.
22 So we've got a revolving cycle here.
23
24 Sober houses are something that I would really

1 like the All-Party Committee to look into further
2 because they are low cost. Like, you could have the
3 sober houses run by people living in recovery, could
4 be the landlords, and if the government is already
5 paying social assistance to a lot of people getting
6 out of Humberwood or getting out of whatever rehab,
7 then they could pay that money to the rent in the
8 sober living houses, right. So, I mean, it's a
9 really low, it's low price, low economical price to
10 do a program like that and also very efficient,
11 because my personal belief is that there's nobody who
12 can help another drug addict like a person who has
13 been a drug addict, right. So that's a really low
14 cost, easy to put into place kind of program that
15 would be helpful, I mean, because you got people
16 coming out of rehab and they're not going to be going
17 back into the same situations. They're going to be
18 going into stable environments, right, with hopefully
19 reinforcement-based treatment going on, like
20 attending programs and whatnot. And a lot of the
21 sober living houses, like in the States, there's a
22 lot in the States, they have, like, 12-step meetings
23 going on at the house and stuff like that, right, and
24 then you'd attend your regular counselling and stuff,

1 and you're more likely to stay clean in that kind of
2 situation, right, and not be a revolving door with
3 the rehab centres.
4
5 Okay, I already said about that. There's no low
6 threshold MMTs, so people are constantly getting
7 kicked off the methadone program, which is another
8 problem and then they're having to wait to get on the
9 wait list to get back into it during which time they
10 could die. Yeah. Like, so we're talking about,
11 like, what? You use drugs? You're a drug addict and
12 you use drugs? We're going to kick you off this
13 program. Like, does that make any sense? It doesn't
14 make any sense at all. We need low threshold
15 methadone programs that understand that people are
16 coming from lifestyles of addiction and cycles of
17 addiction that are hard to break.
18
19 There's no peer naloxone programs here. I'm sure
20 that you guys have seen in the papers countless youth
21 who have overdosed in the past year. Front-page
22 news, oh it's very sensational. He's overdosed using
23 drugs. Like, oh, how shocking. Must have horrible
24 parents. But anyway, if there was peer naloxone

1 programs, so if drug addicts who generally hang out
2 with other drug addicts had access to Narcan, which
3 is kind of like an EpiPen kind of deal, it's a needle
4 you drive into somebody when they overdose, their
5 lives could be saved, right. And, I mean, a lot of
6 these young people could have very bright futures
7 ahead of them, right, if we can keep them, if we can
8 give them access to harm reduction in pharmacies,
9 hospitals, through programs like SWAP, if we can do
10 that for long enough, until they get to a point where
11 they're going to be able to get off drugs. Now, some
12 people might never get off drugs. Some people might
13 choose never to, but a lot of people, a lot of people
14 do have bright futures ahead of them and -- yeah.
15
16 So, increasing the availability -- I read this
17 already, right? So hospitals -- okay, I already
18 talked about that, subjective participation.
19
20 Okay. Recommendations: Elimination of Harper's
21 Canadian Anti-Drug Strategy. Right now, can you guys
22 do that? And reintroduction of harm reduction pillar
23 into Canadian Drug Strategy. So I'd like you guys to
24 get on that right now, after this presentation. So

1 that's going to take a little while obviously. We
2 got to get Harper out of government first.
3
4 Expansion of the needle exchange program. We have
5 it, like, in one specific location in the city. It
6 has an outreach van. They ship supplies out. But
7 I'm sure that Tree has already talked to you guys
8 about all the problems with this, because I think she
9 did a presentation, right?
10 Gerry Rogers:
11 She's doing it, you're doing it this morning, are
12 you?
13 Tree Walsh:
14 Yes.
15 Gerry Rogers:
16 Yes.
17 Karen Doyle:
18 Okay. I'll leave that to Tree. That's her area.
19 So, approval for opioid overdose prevention programs,
20 which is the naloxone thing I was talking about,
21 because that's a very easy training that you can do
22 with people. Intro of low threshold MMT. I didn't
23 mean high threshold.
24

1 Access to safe works in hospitals. This is done
2 in other countries and in pharmacies. This should be
3 something that pharmacists should be educated on,
4 that this is part of their responsibility to
5 providing health care to Canadians and drug addicts
6 are citizens. They cannot be refusing to provide
7 needles based on their personal judgements of people
8 who use drugs. That just seems like criminal to me,
9 like. They should be criminally charged. That may
10 be an exaggeration but maybe not.
11
12 The medical detox. No smoking at the detox needs
13 to be changed. I actually tried to put in a petition
14 in over there, that people would fill out and I'd
15 come and pick up the petition, and that idea was shot
16 down. But, also I think that we need to reinstate
17 the division of mental health services and addictions
18 because the wait list has just proved to me that
19 that's a horrible idea.
20
21 Introduction of a standard length rehab into the
22 province. We've got a three-week detox up in
23 Humberwood and I was really hopeful about this new
24 one that's going on in Harbour Grace, and I heard

1 only recently that the government has only approved
2 that to be a month long. That's one week longer.
3 Like, all of the research that I've read says 90 days
4 is, like, the minimum that you need to, like, start
5 to be able to make changes within a person, right.
6 So, instead of having like a one-month program and a
7 three-week program, both of which are going to be
8 mostly, for the most, for most people ineffective.
9 Like, why don't we combine the money that's being
10 spent on those two separate things and make it
11 actually a real decent rehab so that we don't have to
12 send people away to the mainland like we're doing
13 now. Like, it's costing the government loads of
14 money to send people away to the mainland. Why not
15 just have one really kick ass rehabilitation program
16 in the province? It doesn't make any sense to me.
17
18 So, yeah. Okay, toward human rights. I'm a
19 single parent of three. I have just completed a
20 degree at the university. I have no free time. I
21 have no me time. I've been spending a large majority
22 of my free time doing activist work with the users,
23 ex-users group. I've been one of two co-organizers
24 for this group. So we've had two meetings so far

1 that have gone very well, but honestly, as passionate
2 as I am about the subject and as much as I see the
3 need for there to be a users and ex-users support and
4 consultancy group, unless somebody is going to pay me
5 so, like, so I can support my children, to put all my
6 time and energy into this, like I can't, like,
7 ethically I can't put my time and energy there
8 anymore. I need to take care of my family. You know
9 what I mean? I wish that I could get paid to run
10 this group because I think that there should be a
11 group like this in town, because then you would hear
12 about all the problems that policies are causing,
13 like the no smoking in the detox, the lack of an
14 actual rehab in our province, the lack of access to
15 safe works and harm reduction services. Like, you
16 would hear these things, and people who are doing
17 research to develop programs would have the input of
18 people who the services are actually for. You would
19 never design a program for LGBT people, you would
20 never design a program for people living with HIV,
21 without consulting with these people first. This has
22 been done over and over again in Newfoundland. Users
23 and ex-users have never been consulted in any of the
24 services designed to serve them.

1 So there's also a research exchange group
2 involving policymakers, researchers and users and
3 ex-users in the works for beginning in the city, so,
4 yeah. I'd love to see the, I think the users and
5 ex-users group could be like a very powerful tool for
6 consultancy for the government and for policymakers
7 in implementing new services. So hopefully that's
8 something, I don't know, that the government could
9 look into possibly funding. I know it's done in some
10 other places. That's it for me. Thanks for
11 listening.
12 Dr. Bruce Gilbert:
13 Okay, put it over to the Panel.
14 Honourable Felix Collins:
15 Thank you. Bruce, do we have a few minutes for
16 questions? Okay. Any questions from the Panel?
17 Gerry Rogers:
18 Yes. Karen, thanks. That was great. That was nice
19 and thorough. And we haven't heard up to this point
20 a whole lot around the issue of addiction services
21 and needs, except from some doctors in different
22 parts of the province who are really trying to work
23 closely with users and ex-users, particularly doctors
24 who are trying to look at harm reduction in their

1 communities and talking about how difficult that is.
2 But we've also heard again, some from mental health
3 users as well and the real need for harm reduction
4 programs and policies in the different regions. So
5 it's so good to hear your presentation and kind of
6 doing an overview and putting it together and looking
7 at ....
8
9 One thing that I'm kind of interested in, when you
10 said that now when we have the recent marriage of
11 mental health and addiction services. So for
12 addiction services everyone needs to go through Adult
13 Central Intake now and the wait. Can you talk a
14 little bit about what you've heard and what you know
15 about what's happening with the wait list there
16 because of that?
17 Karen Doyle:
18 What I heard from addictions counsellors is that the
19 wait list has gone from, it was, like, up to three
20 months and now it's gone, like, up to six months to
21 get in to see an addictions counsellor.
22 Gerry Rogers:
23 And so where is the bottom at? Do you know what's
24 happening, why the wait list has grown?

1 Karen Doyle:
2 I don't know. Like, maybe just less workers at the
3 Central Intake as opposed to if they had, like,
4 addictions and mental health separated. When they
5 got them both together, they've got a bigger
6 caseload. That's my only guess at that, Gerry.
7 Gerry Rogers:
8 Okay.
9 Karen Doyle:
10 Yeah.
11 Christopher Mitchelmore:
12 I want to thank you, Karen, for the presentation,
13 specifically focused around harm reduction. I've had
14 constituents myself who chose to get incarcerated
15 basically to get drug help they need because the
16 services, they couldn't get it in a quick manner any
17 other way, and that's quite sad and a significant
18 cost to the system.
19 Karen Doyle:
20 I have friends who've done the same as well.
21 Christopher Mitchelmore:
22 And I know you talked about people who are addicted
23 to narcotics. I've known people who have been,
24 who've lost their job, they've became clean and then

1 they became counsellors helping others on the west
2 coast. So I think we need more advocates. We need
3 more of those supports. But my question, I guess,
4 towards you would be around the sober houses. The
5 concept seems to be something that hasn't been
6 brought up a whole lot at our consultations
7 previously. Would Newfoundland and Labrador Housing
8 units be an acceptable type of space that could be
9 used?
10 Karen Doyle:
11 I think it would have to be communal living, like,
12 kind of like a boarding kind of house, but I don't
13 know, maybe that would work too. We've actually
14 back-stepped in, like, a lot of these ways from,
15 like, say, I don't know, seven years ago or whatever.
16 Like, there was a program called RAFT that was run by
17 Brock Ballard and that had a sober living house in
18 it. I mean, how many beds do they have there? I'm
19 not sure. Like, maybe --
20 Unidentified Female:
21 I think about four or five.
22 Karen Doyle:
23 Yeah, four or five. But that was run by a
24 recovering, a person living in recovery, right. So,

1 like, that was there, but now it's not.
2 Christopher Mitchelmore:
3 A number of Newfoundland and Labrador Housing units
4 would be kind of in a similar row. There would be
5 maybe three bedrooms in most of the units. A lot of
6 the applicants now, there's just one person applying.
7 So, like, you may be able to fill, bridge a housing
8 gap that exists for people that need that need,
9 especially if they're on income support as well.
10 Karen Doyle:
11 Yeah.
12 Christopher Mitchelmore:
13 So I'm just wondering if there could be a retooling
14 of some of the programming there with community
15 supports as a means to meet that gap, because I'm
16 sure there are community supports out there as well
17 as with departmental supports to kind of help that
18 sober living. And I think you're absolutely right,
19 there needs to be a good, smooth transition once you
20 leave a detox facility.
21 Karen Doyle:
22 There really needs to be a continuity of care because
23 it's been shown through, like recent research just
24 consistently shows that addiction is a chronic

1 lifelong condition, and relapse is also a part of
2 recovery, which is a new way of looking at things
3 because it used to be that relapse was looked at as
4 failure but now relapse is looked at as a part of
5 recovery. You are going to, most likely, most often
6 most people are going to relapse at some point along
7 the way. Like, maybe it'll be 20 years down the
8 road, maybe it'll be a year down the road, but
9 relapse is a part of recovery. That's what they're
10 saying with the most recent research. So you have to
11 kind of look at that continuum of care. So how do
12 you get people back into recovery quickly when
13 relapse does happen.
14 Honourable Felix Collins:
15 Karen, continuity of care is a theme that comes
16 through in all the presentations and adequate
17 housing, and sober houses is a new term that's been
18 introduced here today but certainly quite an
19 interesting one. I want to thank you for your
20 presentation. As Gerry pointed out, and Chris, most
21 of the presentations and focus we've been receiving
22 have been on mental health issues and it's good to
23 get such a detailed presentation on addictions, and
24 you certainly have given a very informative and

1 interesting presentation today and thank you very
2 much for it.
3 Karen Doyle:
4 That's why I wanted to do that, because even in the
5 roundtable discussions I kind of, like, felt like
6 everybody was talking about mental health and I'd be,
7 like, addictions. Addictions. And I felt kind of
8 bad, like, because I was changing the subject but,
9 like, it's kind of like just a little attack on their
10 mental health and addictions. But I think it's also
11 because people don't want to talk about addiction
12 because it's still very stigmatized.
13 Honourable Felix Collins:
14 Well, the purpose of this Committee is mental health
15 and addictions. So, but mostly what I've been
16 getting is mental health. So thank you again very
17 much.
18 Karen Doyle:
19 Thank you. If you guys would like more -- I did a
20 lot of research on sober living houses and I could
21 send you my research and evaluation that I've done on
22 that.
23 Honourable Felix Collins:
24 It would fantastic. Absolutely.

1 Gerry Rogers:
2 And can you give us your slides as well?
3 Karen Doyle:
4 Yeah.
5 Gerry Rogers:
6 Great.
7 Dr. Bruce Gilbert:
8 Thank you, Karen.
9 Honourable Felix Collins:
10 Thank you, Karen.
11 **(Off the Record)**
1 Honourable Felix Collins:
2 Thank you very much. At this time, we'll
3 take a small break. We're scheduled for a 15-minute
4 break but I'm going to ask you to cut it back a
5 little bit, a five-minute break so we can get back on
6 schedule.
7 **(Off the Record)**
24

1 Dr. Bruce Gilbert:
2 We'll get our Panel back and also get our next
3 presenter set up, and that's Tree Walsh, who has 30
4 minutes, and I'll give you the 10 and five little
5 card for you to keep you on track, but you won't need
6 that.
7 Tree Walsh:
8 Oh, I've been known to ramble.
9 Dr. Bruce Gilbert:
10 Welcome to the club. Okay, MHAs Mitchelmore and
11 Rogers.
12 Honourable Felix Collins:
13 Let's go, folks. Welcome, Tree.
14 Tree Walsh:
15 Thank you.
16 Dr. Bruce Gilbert:
17 Take it away.
18 Honourable Felix Collins:
19 The floor is yours.
20 Tree Walsh:
21 Okay, thank you for the opportunity to speak to you
22 today. I'm representing the Safe Works Access
23 Program, affectionately known as SWAP, and that was
24 the first harm reduction needle exchange program

1 established in the Province of Newfoundland and
2 Labrador. SWAP was born out of the OxyContin Task
3 Force and received their first funding in 2005. We
4 operate out of the Aids Committee of Newfoundland and
5 Labrador offices, currently at the Tommy Sexton
6 Centre. That's where SWAP is headquartered. Once we
7 established operations in St. John's with the main
8 office, we set up satellite sites at Choices for
9 Youth, Thrive, Street Reach Program, the Naomi Centre
10 and the Tommy Sexton Shelter.
11
12 So those organizations came on board very early on
13 to collaborate, to get safer using equipment and
14 information to people who are at the highest risk for
15 contracting HIV, Hepatitis C, and a really unholy
16 host of other blood borne infections and other harms
17 to themselves and indeed to the community.
18
19 Harm reduction is built on a philosophy of any
20 improvement is harm reduction. So working from the
21 position of initially Nothing About Us Without Us,
22 which came from the HIV movement, when HIV was
23 killing people holus-bolus across the country.
24 People living with the virus said you know, we are

1 the experts here and we need to inform the process of
2 establishing what services we need. Anyway, harm
3 reduction works from that very premises well. That
4 the people who use the drugs are the experts in their
5 lives, and building on their experience we can
6 provide the services needed to prevent major illness,
7 disease and death among people who end up using drugs
8 that put them at a very high risk.
9
10 In 2010, the government gave us funding to expand
11 to Corner Brook. At that time, we were aware that
12 there was a major need for needles in the Corner
13 Brook area and it was being demonstrated to us
14 through the numbers of people coming to the methadone
15 clinic in St. John's. So we know people who are on
16 methadone have injected drugs and the numbers are
17 really, really difficult to nail down because it is
18 behaviour that is stigmatized, not only in the
19 general community but even among the drug users. If
20 you're sticking needles in your arm, you're the
21 lowest of the low. So when we opened in Corner
22 Brook, we expanded a little bit so we could reach the
23 people on the west coast.
24

1 The funding levels are always challenging and we
2 do the best we can to work with volunteers,
3 community, partners, etc., to reduce the costs of
4 delivery, but the equipment that we distribute to
5 people is very expensive. We distribute needles and
6 syringes for drug users and steroid users. You don't
7 hear so much about the steroid users but they are at
8 as much risk for infection and disease if they share
9 or reuse their injecting equipment.
10
11 We provide cookers, that are little sterile
12 spoons, for lack of a better way to describe it,
13 cotton filters so that when they prepare their drug
14 in the cooker they want to filter out anything that's
15 in there that maybe, if it's a crushed pill,
16 uncrushed (inaudible), if it's a street drug, it
17 could be any kind of old --. So they put the
18 little filter in the cooker and draw through that so
19 it doesn't go in their needle.
20
21 We provide sterile water. Anecdotally I'm told --
22 I have these signs, posters, all over my office to
23 get people to ask questions about it. So I have my
24 water poster and it goes from sterile water, boiled

1 water, right on down to puddle water, and people will
2 say, oh my God, they don't use puddle water, but the
3 only thing missing is urine. People will inject
4 their own urine to get a hit if they don't have
5 water. There's nothing people who are desperate for
6 a drug, there's nothing they won't do.
7
8 When we're talking about drug use and we're
9 talking about needle use, we're talking about drugs
10 like heroin, which is not real popular around here,
11 and anecdotally I can tell you why, because back in
12 the day when we first started with SWAP, OxyContin of
13 course was the flavour of the month and we had
14 unfortunate deaths because of it and we had some
15 great results because of it. We've improved how we
16 address the issues.
17
18 But Hells Angels showed up in town trying to sell
19 heroin and they couldn't give it away, because
20 everybody was on Oxy. It's pharmaceutical grade.
21 You don't have to worry about adulteration, etc.,
22 etc. Newfoundland drug users were quite savvy. But
23 when you're talking about those drugs - morphine,
24 oxycodone, methadone, hydrocodone, codeine,

1 hydromorphone, buprenorphine - and lately we're
2 hearing a lot about fentanyl. Fentanyl is extremely
3 strong in the opioid class. These are opioid drugs.
4
5 Fentanyl is a hundred times stronger than
6 morphine. What we're seeing in this country at
7 present are drug dealers who are extracting fentanyl
8 from patches and putting them into pills and making
9 those pills look exactly like oxy 80 pills that were
10 so popular years ago. So people who think, oh yeah,
11 oxys, I'm used to those, are overdosing immediately
12 because the fentanyl is so much stronger than what
13 they think they're taking.
14
15 Anyway, before I digress I'll go back to what we
16 give out. Alcohol swabs to clean the site,
17 tourniquets to tie off, acidifiers. Certain drugs
18 that people want to inject need to be returned to an
19 injectable form. Like, they'll crush pills, etc.
20 Some pills and brown heroin, some street drugs, need
21 to be broken down, and another example is crack
22 cocaine. They've taken cocaine, cooked it up with
23 bicarbonate soda and made it rock cocaine, so they
24 get a little intense high out of it. But some people

1 want to inject that so they'll take their pill or
2 their rock of cocaine and put it in their cooker and
3 then they'll mix an acid with it. Normally it's
4 vinegar or lemon juice, and that will help break down
5 the pill so they can inject it. Then they will
6 inject the lemon juice or the vinegar and it does
7 insurmountable damage to their veins. So we provide
8 them with Vitamin C powder which is ascorbic acid,
9 which is still not pleasant to be injecting in your
10 veins but it's so much less harmful than vinegar or
11 lemon juice. So we're not about eliminating the
12 risk. What we're doing is meeting people where they
13 are in their drug use and saying do you know the risk
14 you're at, do you know how much damage that vinegar
15 is causing inside of your veins.
16
17 The other avenue of disease prevention that's
18 really involved in this endeavour to reduce disease
19 is smoking of crack. People who smoke crack cocaine
20 are at very high risk for Hepatitis C in particular.
21 Apparently when you smoke crack cocaine your pipe
22 gets really hot. So we provide a Pyrex glass stem
23 that serves as a pipe. We provide brass screens to
24 put in there so that when the crack is being smoked

1 none of the garbage goes down their throats.

2

3 In the absence of those lovely little brass
4 screens, people will use steel wool, and they put the
5 steel wool in the pipe and as they're burning it with
6 coke, the steel is melting and going down their
7 throats and burning their throats and lungs. So I
8 really, really, really try to get them to use the
9 brass screens. It's really difficult but over time
10 they understand and I talk to them about what they're
11 spitting out after, and that's your lungs, man. You
12 know, try to save your lungs. You only got two,
13 right. So with the crack pipes, we give them a
14 little mouthpiece that goes on the end so that if the
15 pipe gets hot your mouth still won't get burned.
16 It's vinyl tubing used for water or whatever. We cut
17 it up and make little crack pipes out of it.

18

19 So then the mouthpieces and the push sticks to put
20 the screens into place. We provide condoms and lube,
21 Sharps containers in small, medium, large, and little
22 minis for people who want to carry it on their
23 person. It'll hold 25 used needles.

24

1 And one thing that we get a lot of requests for,
2 and I don't know how people across the province found
3 out, we have one case of Ensure donated a month.
4 That's the food supplement, the meal supplement, and
5 we've gotten requests from far away as Grand Falls
6 for Ensure because people are hungry. They're using
7 their money for whatever they're using it for but
8 they're asking for the food supplement.
9
10 To do this work we -- oh, yeah, in 2014 we had a
11 new satellite come on in St. John's and that's a Safe
12 Works, the Safe Harbour Outreach Program, SHOP, which
13 is the program that works with sex workers in the
14 city. So we've made a really good connection there.
15 We mail out orders to anybody outside of St. John's
16 or Corner Brook and area. In the areas, we normally
17 have a van. What people do is they'll phone into our
18 office and place an order and normally they will --
19 people are scared. They don't trust us. For the
20 first number of years, our needle distribution
21 numbers were really, really low, but over the years
22 they've come to trust us. In the beginning they were
23 saying are the police watching this van or they would
24 meet us way far away from their house. Over the

1 years we've come to their house.

2

3 And we don't only serve the people who use the

4 drugs. We work with natural helpers. A natural

5 helper is somebody in the community who cares whether

6 people who are using drugs get sick, live or die.

7 Some of them are former drug users. Some of them are

8 family members of people who are using drugs. And in

9 fact one of our most, I guess our busiest natural

10 helper in the city passed away not too long ago, but

11 she supplied, I think, the entire southwest coast of

12 the island with supplies. We brought so much stuff

13 to her house, and I found out after she died why she

14 was doing it. She'd been infected with Hepatitis C

15 through the blood system back in the day and living

16 with Hep C was so horrible. She saw her sons who

17 were involved in injecting drugs and she made sure

18 she had everything for them to stay safe, and then

19 their friends would come and their friends would

20 come. And she distributed thousands and thousands of

21 needles every month from her home, along with all the

22 other using equipment, to people and they would bring

23 in their used needles to her and we would go to her

24 house and pick it up. So we'd go and drop off a van

1 load of supplies and pick up a van load of needles.
2 We have people like that across the province.
3 There's a woman in Gander who's doing it out of her
4 house. There are lots of users who are natural
5 helpers who will order 3,000 needles when they need
6 500, to give to their friends, because they can't
7 access needles in small town Newfoundland and
8 Labrador. They can't access them in St. John's now
9 with pharmacists who are refusing to sell needles to
10 people who need them. They're demanding
11 prescriptions for needles, which are not needed in
12 this province. There's no law requiring a
13 prescription for needles. They're refusing to sell
14 needles by the bag. There's 10 needles in a bag.
15 There's 10 bags in a box. So they can buy a bag and
16 get through a few hits, but buying a box is up
17 towards 35, 40 bucks. They don't have that money.
18 So instead they will reuse or share already used
19 equipment, and that guarantees illness.
20
21 As I said, we mail out to areas we can't drive to.
22 Currently in St. John's we're in a crisis. We do not
23 have a van. Our van that we've been using for a
24 number of years finally got to the place where the

1 repair bill was higher than the value of the vehicle,
2 so we had to let her go. So since April we have not
3 been able to deliver thousands of needles to the
4 people in this area. I am at a loss as to where
5 they're getting their needles. I've been asking some
6 drugstores who do sell it, they're seeing some
7 increase, and I'm getting a lot of calls about
8 needles left all over mostly Housing and
9 neighbourhoods, where people who have been provided
10 with safe disposal material, for whatever reason -
11 ignorance - are putting it anywhere outside of their
12 apartment to get rid of it. Even the City of St.
13 John's tells them if it's in a sealed container it
14 can go to the landfill. We disagree with it. We
15 collect all the used needles we can and have them
16 sent away to be destroyed.
17
18 So we're trying to get a needle van for St.
19 John's. We've tried everything. Our budget is
20 strapped. We started out this fiscal year with a
21 $50,000 debt, so we already know we're $50,000 in the
22 hole, and we have no money for a van. So we've been
23 trying to seek out donations. The City of St. John's
24 has stepped up and donated a little Suzuki car that's

1 coming out of service. It will not allow us to put
2 the needle exchange on the road but it will allow us
3 to do home deliveries again, which we are ever so
4 anxious to get ready to do, because I distributed to
5 you earlier our statistics for this year, just in St.
6 John's, I didn't include Corner Brook, and we've
7 distributed half a million needles in the St. John's
8 area alone in the last year. I gave you the stats
9 and the highlighted in yellow is what we did in the
10 van, so that work has not been done at all for a
11 couple of months now. That's a lot of needles, in
12 and out.
13
14 But the needles and the equipment are bait.
15 That's not what we exist for. That's the bait we use
16 to get them in the door to talk to them about their
17 health. When it comes down to it, people who come to
18 a needle exchange, that's probably the first thing
19 they've done about their health in a very long time.
20 They've come and they said, you know what, I'm doing
21 something that's very unhealthy and I need help. So
22 we'll give them all the supplies they need in the
23 numbers they want. We don't limit it.
24

1 A person who injects crack or cocaine will inject
2 every 15 minutes, every 20 minutes, because the high
3 is so quick, right. An opioid user might inject two
4 hours, three hours, depending on the amount they're
5 using, their tolerance, etc., etc. So cocaine users
6 use a lot more needles than opioid users and opioid
7 users use a lot of needles.
8
9 Once the needle goes through the skin once, it
10 starts to curl. When it goes in twice, it's a bigger
11 curl. By the time six times, it's like a hook. So
12 when people come in, the first thing I say is do you
13 have any needles you want to dispose of, and all too
14 often a young fellow will say, well, I got this one.
15 Okay, throw it in the Sharp's container. How many
16 times did you use that? He'll say, well, all the
17 numbers are gone off the outside. Well, how did you
18 get it in your arm? It must be like a fence post.
19 Oh, well, you can haul the hook off that, he said.
20 In prison we rubs them on the bars until the hooks
21 are gone, but if you can get it on a piece of an end
22 of concrete or a matchbox or something like that, to
23 sharpen the needle so they can get it in their arm.
24

1 So we want to teach them about how bad those ideas
2 are and how you use your equipment once and then
3 dispose of it safely. We'll give you the container
4 to use it in so that nobody else is at risk. And
5 even if they're reusing their own needles, they
6 think, okay, I don't have HIV, I don't have Hepatitis
7 C, I don't need to worry, but you're using equipment
8 that has been used, your needle is no longer sharp,
9 your cotton, your filter, has been warm and wet. Now
10 where does bacteria like to grow, you know?
11
12 I had a young fellow come in one day and he said,
13 oh, I got a cotton, a cotton. He took out his spoon
14 and the spoon was black, it's been used so often, and
15 there was this dark grey thing stuck to it, and he
16 said you just adds a bit of water to that and poke it
17 with your needle, you can fluff it right up. I was
18 like, no, it's disease waiting to happen.
19
20 So the education is the piece we want to get to.
21 Eventually they get sick and tired of being sick and
22 tired and that's when we can help connect them to the
23 next natural place, most often is methadone because
24 if they're hooked on opioids they're going to be very

1 sick for a very long time until they get that out of
2 their system. So we talk to them about safer
3 injecting, safer smoking, safer sex. A drug
4 infection can be passed on sexually. A sexually
5 transmitted disease can be passed on through your
6 blood. So it's all interrelated and most people have
7 no idea what they're involved in.
8
9 The biggest problem, one of the biggest problems
10 we have in the province right now is overdose. I
11 suspect the adulterated oxys are on the street. The
12 people who come in and tell me, well, it looked like
13 an oxy and I started to cook it and it turned black,
14 so I threw it away, I was scared of it. Not
15 everybody is scared of it. They're so desperate they
16 just want to get it in their body so they're not sick
17 anymore.
18
19 Naloxone is a drug that treats overdose. Naloxone
20 can be administered either with a shot or there's a
21 nasal spray, and it works pretty fast, so if someone
22 is in overdose and naloxone is administered, they
23 come out of their high immediately.
24

1 I have heard stories from, you see outside of
2 Newfoundland needle exchanges carry naloxone. People
3 who use drugs a lot in some places carry their own
4 naloxone in case they overdose. Not every ambulance
5 in St. John's carries naloxone, and we're the capital
6 city. And if there is naloxone available on the
7 vehicle, the person aboard has to be trained
8 adequately to administer it. These are barriers.
9 Naloxone has and is currently being used by drug
10 users, self-administered when they're overdosing.
11 I'm not saying we go there but I'm saying every
12 emergency department, every ambulance, should have
13 naloxone on board because of the numbers of people
14 who are injecting.
15
16 You have no idea. I had no idea. It's not the
17 typical person you think of. It's mom; it's dad;
18 it's pop for some kids. And every time I get new
19 volunteers and I take them out on the street and
20 they're always anxious. Is it scary? Is it
21 dangerous? Have you ever had to call the police?
22 No. We're here to help folks. They appreciate the
23 help because they are treated like -- wherever they
24 go.

1 If they go to emerg, they're accused of drug
2 seeking even when they're not drug seeking. They'll
3 tell you themselves, yes, I've been up here looking
4 for drugs but tonight I'm sick. And how does a
5 worker know the difference? The worker doesn't know
6 the difference.
7
8 So while we are doing our best, harm reduction
9 needs to be integrated right across the system just
10 like the recovery model works now through mental
11 health and addiction. When you see something works,
12 use it, and naloxone is a really, really needed -- I
13 think it could be implemented rather soon because so
14 many lives are dependent on it.
15
16 The thing with the needle use now, and we
17 predicted it a number of years ago, that with the oil
18 things are going to change. With the oil, people are
19 being tested for their drug use. Marijuana stays in
20 your fat cells, and some of us got lots of them, but
21 even when you don't they're there. Even if you're
22 the skinniest thing on the face of the earth, you got
23 fat cells and that's where the marijuana is going to
24 live in your body and you'll test positive for a

1 number of days, weeks. Gods knows if you're into it
2 enough, it'll be months. But if you're doing
3 cocaine, it'll clear your body pretty quickly. So
4 what's happening is people in the oil fields are
5 being tested so they can't smoke dope anymore. They
6 have to use a drug that will clear their body as fast
7 as possible, hence the, I guess, the attraction of
8 the needle.
9
10 I'm hearing stories of people bringing the drugs
11 back and now people here are on it, so it's grown.
12 People selling crack pipes for $20 each because they
13 know they're so hard to get in Newfoundland. Twenty
14 dollars for a crack pipe. We give them away for free
15 but we don't have access to everywhere.
16
17 I gave you a Power Point, which is just a brief
18 overview of an evaluation we did of SWAP a couple of
19 years ago. (Inaudible) did the research and the
20 researcher went right across the province and spoke
21 to mayors in towns and every mayor, without fail, has
22 a needle problem in their community. Nobody wants to
23 say it out loud but it's there and we need to address
24 it. We don't need to reinvent any wheels. We're 20

1 years behind the rest of the country.

2

3 While Harper's anti-drug strategy has been a

4 disaster for Canada, thank God we're in Newfoundland

5 and Labrador. At least we haven't experienced the

6 full brunt of what that would have been if our

7 provincial government strictly adhered to the

8 National Anti-Drug Strategy, which does not include

9 alcohol, by the way, the most damaging drug, the drug

10 that costs the most and it's not even covered because

11 it's all about a moral judgement. It's the anti-drug

12 strategy.

13

14 It's very scary but thank heavens we have some

15 clearer thinking people in power who are willing to

16 listen to the voice of the people and those of us on

17 the front lines, and I hope you do take into

18 consideration the lifesaving qualities of harm

19 reduction and how it really needs to be implemented

20 right across the board, because, like Karen said

21 earlier, nobody woke up and said I want to be a drug

22 addict. It happens to people and the circumstances

23 are different for everybody but the result is the

24 same. You're living with a life-altering disorder

1 and you need help to be able to change, and if we can
2 get them in school before they even try, the better.
3
4 There's an alcohol and drug awareness week that
5 happens every year in this province. A number of
6 years ago I tried to get harm reduction into the fair
7 that's held at the police headquarters. It has been
8 held there. It's been held other places. But it's
9 an information fair around all the aspects of
10 addiction, and we were told that harm reduction
11 wasn't appropriate to bring into that venue because
12 it was for grade eights and grade eights are too
13 young.
14
15 Well, at one point while I was having that
16 argument, there was a young grade eight girl who was
17 screaming because she was addicted to OxyContin. Her
18 mother was a 911 dispatcher who went public about it,
19 the very same week as I was told by the system that
20 grade eights are not ready for injection drug
21 information. They're injecting in grade four, folks.
22 Let's start getting the information into the schools.
23 If I go in and show a film about people injecting
24 drugs, I don't show it as, oh, look how much fun this

1 is. It's shown as this is what actually happens when
2 you use drugs.
3
4 How are children or young adults ever to make an
5 informed consent to using the drugs if they're not
6 allowed to learn what the harms are? The first
7 thing, if you put a needle in your arm you will die.
8 That's the first thing. You could die. And there's
9 no sugar coating it, but they need to know the facts.
10
11 A couple of years ago there was a report that RCMP
12 in Happy Valley-Goose Bay had confiscated some
13 marijuana that was laced with crystal meth, and I
14 phoned the local detachment and I said have you
15 actually made a bust of crystal meth laced with
16 marijuana, and he said I'm not aware of it. I said,
17 well, Goose Bay is saying you got it. Here's the
18 deal. If that's a lie, the kids are saying, oh, I
19 smoked it, it's not so bad, right. If that's what
20 it's like when it's laced with crystal meth, well,
21 it's not so bad, so maybe you'll show me someone who
22 says, oh, here's some meth, try that. It's not so
23 bad. But it's a lie. There was no meth in the
24 marijuana. Tell people the truth. What else can I

1 say?

2

3 Thank you for your time and your attention.

4 People's lives are really important. They up;

5 they make mistakes. Excuse the language but that's

6 the language of the people I work with and they need

7 help. Thank you.

8 Honourable Felix Collins:

9 Tree, you had a comment in there somewhere, most

10 people have no idea and it's such a fascinating, a

11 fascinating presentation and thank you so much for

12 it.

13 Tree Walsh:

14 You're very welcome.

15 Honourable Felix Collins:

16 We're going to take some time for some questions.

17 Christopher Mitchelmore:

18 I just want to say that I think you're right, that a

19 lot of people really have no awareness of how much

20 this issue has become and how big it really is. And

21 in Grand Falls-Windsor I was sitting at a table and

22 the youth at the table were telling me about how

23 young people were smoking marijuana as young as 10,

24 shooting up at 12 years old. Like, these are not

1 things that I was aware of. And being confronted
2 with that as a politician, as somebody who deals with
3 legislation, and things like that, it really presents
4 this opportunity for you and the Committee to hear
5 these concerns from citizens and others, really
6 validates what's going on around.
7
8 Do you have any indication of the number of
9 people, because I'm just seeing here, like, how much
10 the statistics have grown in your presentation, but
11 how many people would be coming through your doors or
12 that you would be dealing with?
13 Tree Walsh:
14 It's really hard to say because a lot of people are
15 natural helpers. So they'll come and they'll pick up
16 gear for five people, right. So it's s really
17 difficult number to nail down.
18 Christopher Mitchelmore:
19 I'm just wondering how as, like, a government you'd
20 have any indication as to how many people are
21 actually using needles to be able to better deal with
22 the particular issue?
23 Tree Walsh:
24 Well, all we can do is look at things like we gave

1 out 200,000 needles, more this year, 14-15, than we
2 did in 13-14. So 200,000 extra. How many people is
3 that? See, there's no way to know. And the numbers
4 is huge, huge, and it's so easy to overdose, even if
5 it's not street crack, because especially new users.
6 They really don't know. They don't know how to
7 inject. They're injecting down. They don't even
8 hear the term "shoot up." They're shooting in the
9 wrong direction. They are going straight in.
10 Christopher Mitchelmore:
11 Tree, I think though the point that you made around
12 education, like getting into the school system,
13 having that ability and, like, around this harm
14 reduction for the week, I think that you make a
15 really good point based on what's going on there.
16 Tree Walsh:
17 We have to tell them the facts because ignorance was
18 never bliss.
19 Gerry Rogers:
20 Tree, where does most of the funding come from for
21 the SWAP program?
22 Tree Walsh:
23 The province, all of it. The federal government will
24 not fund harm reduction operations anymore on a

1 purely moralistic ground, in my humble opinion.
2 Gerry Rogers:
3 Yeah, not evidence based.
4 Tree Walsh:
5 Where a person's health and a person's life is at
6 risk, that's a health issue to me.
7 Gerry Rogers:
8 And you said that this year you started with a
9 $50,000 deficit. Was there a reduction in funding or
10 is it because the increase in demand?
11 Tree Walsh:
12 No. The increase in demand. We just can't keep up
13 with it. Like, I mail so much stuff to Central
14 Newfoundland, it's unreal, yet the research showed
15 CBN is a hot spot, and it certainly is, and Labrador.
16 But Central Newfoundland is just busy, so. It's
17 growing exponentially.
18 Gerry Rogers:
19 And I know that you don't have the empirical studies
20 or anything, but I guess even anecdotally, so the
21 people that you're interacting with, what are they
22 asking for besides the gear, besides the works?
23 Tree Walsh:
24 Methadone. How do I get off this? How can I get on

1 methadone and stop getting kicked off it. So we do
2 need --
3 Gerry Rogers:
4 Do you want to talk a little bit about that?
5 Tree Walsh:
6 Well, when a person receives methadone, they're
7 monitored quite closely to make sure they receive the
8 right dose, etc., etc., and when they do well they
9 get what's called carries. So instead of having to
10 go to the doctor, the pharmacist every day to get
11 their methadone, they'll get a number of carries to
12 take home. So that'd be a number of doses they can
13 take at home without having to go see the doctor.
14
15 Some people get kicked off methadone because of
16 things like other health issues. I'll give you a
17 prime example. A young man phoned me one day and
18 he's on methadone. He had six carries, so that means
19 he's doing really well. He only has to go once a
20 week to see the doc, and he had an anxiety attack and
21 ended up in the hospital and they treated him with
22 Ativan and sent him home. And a couple of days later
23 he thought he had a heart attack and he went back to
24 the hospital again and he talked to the doctor, saw a

1 cardiologist, and said, no, it's not a heart attack,
2 indeed it is anxiety and he's treated with Ativan.
3 So, he goes back with his carries and he's drug
4 tested. Ativan is one of the banned drugs, so he
5 loses his carries. So, he'll get deathly ill if he
6 doesn't have his methadone every day. So, now he's
7 got to go in everyday again because he's anxious.
8 What do you think it does to his anxiety? And if he
9 can't get his methadone, he's back on the needle,
10 because he's not going to stay that sick. And it's a
11 Catch 22.
12 Gerry Rogers:
13 I'd be interested too in hearing a little bit more
14 about when you're saying people say that they want
15 methadone or how to get off the drug, the drugs. So,
16 are the services there for people who are saying how
17 do I get off this stuff? And talk to us a little bit
18 more about who's using.
19 Tree Walsh:
20 Who's using? It's anybody and everybody.
21 Gerry Rogers:
22 Because we have such sense of --
23 Tree Walsh:
24 There is a stereotypical image that is so wrong, so

1 wrong. The first person who came to swap when we got
2 the funding, way back in the day, was a paramedic,
3 working full time in the field, addicted to opioids
4 because of a former car accident injury. Injecting
5 it because it wasn't working any other way. So,
6 working in the field as an injection drug user, being
7 supervised by her physician because there was no
8 methadone program at the time. So, the doctor was
9 managing, help her managing her addiction and that's
10 illegal. But he saw her and saw that she could
11 function, if she could have got off it. So when
12 methadone came about she did eventually go in and she
13 did get clean but that took a couple of years. And
14 even though we have the methadone program now, maybe
15 it's taking a bit too long and maybe the barriers are
16 just too insurmountable for some folks. So we need a
17 low threshold program for sure.
18 Honourable Felix Collins:
19 Tree, we could carry on this discussion for some
20 time.
21 Tree Walsh:
22 Just give me a call. I'm around.
23 Honourable Felix Collins:
24 And thank you so much for your presentation.

1 Tree Walsh:

2 Thank you.

1 Dr. Bruce Gilbert:

2 Thank you. John Abbott. John has 30 minutes.
3 We're 30 minutes behind. We're going to move into
4 the lunch break, if you will. Take it away, John.

5 Honorable Felix Collins:

6 Thank you for coming, John.

1 John Abbott:
2 Thank you on behalf of Canadian Mental Health
3 division here in the province. I'm currently, as of
4 last night, the President of the Association.
5 Gerry Rogers:
6 Congratulations.
7 Honorable Felix Collins:
8 Congratulations.
9 John Abbott:
10 So my first official duty is to present here today.
11 And secondly, I'm also for the treasurer for the
12 National Association, so I have some perspective on
13 what's happening across the country in terms of our
14 organization and the issues that we're dealing with.
15 And knowing you're behind, I will move and then I
16 will leave some time, hopefully, for a few questions.
17
18 A little bit about the CMHA Newfoundland. We've
19 been here in the province now for over 50 years, so
20 we have a wealth of knowledge and experience, I
21 guess, to bring to this discussion today, and again,
22 as part of a national organization and we really have
23 been able to work with other divisions across the
24 country, learn from them, bring their best practices

1 and experiences to Newfoundland and vice versa. But
2 I think the critical thing, and just spilling on
3 previous presentations, is we're volunteers, we're in
4 the community, and our job is really to listen and to
5 work within the community. And we, too, want to be
6 listened and heard and we think we obviously have
7 something to bring to any discussion, any policy, any
8 legislation, any services and programs impacting the
9 delivery of mental health services and for mental
10 health and addictions across the province.
11
12 Currently we have three offices and supported by
13 the Provincial Government here in St. John's and
14 recently in regional offices in Grand Falls-Windsor
15 and out in Stephenville. Obviously, we'd like to
16 expand into Labrador in the near future, subject to,
17 obviously, availability of funds.
18
19 Basically, what we see ourselves and what we
20 strive to do is to be a champion for mental health
21 across the province and, again, across the country
22 and really our tag line Mental Health For All is
23 really what we're trying to focus on and we live
24 through our mission. And we do a number of things.

1 We try to facilitate access to resources that people
2 need and are looking for and I receive numerous calls
3 on that on a daily basis but we look at the whole
4 area in terms of recovery model, how do we improve
5 mental health for the individual, for the community
6 and that takes, obviously, a number of actors and
7 players and services and dollars and recourses and
8 individuals to make that happen. So, really, what we
9 are trying to do with others in the community is
10 really to integrate, support each other and to move
11 the agenda forward.
12
13 Again, in terms of the things that we focus on in
14 terms of building capacity, so in trying to build
15 capacity for the individual, for the community and
16 for the public and private agencies and organizations
17 that are dealing with mental health and addictions
18 issues across the province. Influencing
19 policy/advocacy is certainly an area that we have
20 been working consistently over the 50 years that
21 we've been in operation and, obviously, that requires
22 us to do a fair bit of research, understand what the
23 issues are at play but, more importantly, working
24 closely with government and its agencies in terms of

1 the design and delivery of programs and services
2 across the province.
3
4 Providing services, again we've listed a number of
5 areas that we currently are delivering services and
6 I'll speak to those as examples later on, but we
7 certainly focus on education, awareness and training
8 across all sectors in the province. We're working
9 with the Department of Justice, through the
10 Corrections Division, in case management with
11 individuals inside the penitentiary who have mental
12 health issues and illnesses to help them transition
13 back into the community. And that's been a very
14 successful program. We're currently working with 25
15 individuals right now and there's a wait list for
16 that service.
17
18 Obviously, we have our mental health week in terms
19 of raising awareness. A very creative program that
20 we involve ourselves in is the mind scape art exhibit
21 in the fall. So at this time of year we will call
22 for expressions of interest for those with lived
23 experience who use art as a means of therapy to
24 actually develop their art, mostly visual art, and

1 present that to us. We have a jury that selects the
2 art and we exhibit that in the fall and then we
3 auction it off and share the proceeds with our
4 organization and the artist, and that's been quite
5 successful. And obviously, fundraising to allow us
6 to deliver many of the services that we're looking to
7 provide. And that's an area that we need to focus
8 more on as an organization and work with others in
9 raising funds.
10
11 So, we submitted a detailed paper to you, and our
12 perspective and experiences we feel really draw on
13 what we hear, and I think you are hearing many of the
14 same things over your hearings across the province,
15 is what people in the community are saying and from
16 our own program delivery experiences.
17
18 So the four areas we want to just touch on now is
19 talk about the adequacy and responsiveness of the
20 mental health services in the province. We heard two
21 examples just in the past hour or so. We want to
22 talk about stigma and that's a real issue right
23 across the province, their service delivery system,
24 the social determinants of mental health such as

1 housing and corrections, absolutely housing and
2 education, and then we want to talk about the need to
3 continue to fund community agencies like ours who are
4 active in the field.
5
6 So when we talk about adequacy and responsive
7 services, it can mean many things. We've identified
8 a few examples. So the adequacy of the Waterford
9 Hospital. I think it goes without saying that it's
10 lived its useful life and we certainly want to see
11 the Waterford replacement accelerated with no further
12 delays. We appreciate the financial bind that the
13 government is in and we know there is choices that
14 obviously have to be made. We think the wrong choice
15 has been made to stop the development. So, you, I
16 think, can hear us pretty clearly on that.
17
18 In terms of Her Majesty's Penitentiary here in the
19 City, again we are competing with the two oldest
20 facilities not only in the province but in the
21 country. And this is a classic case of we're really
22 at the end of the line here. And so, we want to
23 focus certainly in the short term in the capacity of
24 the penitentiary and the correction system to respond

1 to the mental health needs of inmates. I know you've
2 had other presentations on that. Colleen Hanrahan,
3 who I know quite well, who's presented on that, and
4 we feel that certainly needs to be addressed. And
5 our insider knowledge on that is certainly developed
6 through our justice program, working with the inmates
7 and clients there. But not only are we working with
8 the inmates, the corrections officers and captains
9 and others in management have called on us to help
10 them in their training. So, definitely a recognized
11 need for education and training and certainly
12 continued intensive case management for the areas
13 that we deliver but also mental health services
14 overall.
15
16 The adequacy of the Adult Central Intake line,
17 again I think this is a case where the system has
18 said, look, we think we can improve by putting in
19 this intake line. The challenge now is to make it
20 work effectively. And what we hear, what we see, it
21 isn't responding adequately in a timely manner and
22 referrals are not happening the way people were led
23 to believe. So that needs to be addressed
24 immediately and on a go-forward basis.

1 The Mobile Crisis Response Unit, again, a very
2 good concept but it's limited to sort of the
3 northeast Avalon. We need to see that really
4 developed right across the province. And that's not
5 true for only that service but for many others.
6
7 And the psychiatric assessment unit here at
8 Eastern Health, again this speaks to the stigma issue
9 I think that really needs to change and staff
10 attitudes needs to be more welcoming. And we're
11 seeing that in many of the mental health and
12 psychiatric and related psychiatric and addictions is
13 there is either a physical barrier or there's a human
14 barrier in attitudes and approach in welcoming and
15 dealing with clients and patients.
16
20 We have a program that addresses that very issue
21 and we are out across the province promoting our
22 Changing Minds. And that's what it is, it is
23 changing the minds of those who are in the service
24 who are there to help. They are to welcome, not to

1 act as yet another barrier to accessing the services.
2 And that needs to be continued.
3
4 So, in terms of stigma, again I note an issue that
5 most people have heard about and don't appreciate it
6 until you face it. We know there is progress being
7 made. I know the government and others have been,
8 with the different ad campaigns, to bring this
9 attention to the public but we did, even to this day,
10 we see that people with mild to moderate symptoms are
11 not reporting, not going for assistance or help, I've
12 seen that in the workplace and others, because of the
13 stigma issue and consequently resulting in treatment
14 caps and the result being those people are getting
15 worse over time.
16
17 We have our Think Twice. So in terms of being
18 proactive on this, in this area, we have our Think
19 Twice program which is effective means to reach,
20 basically, high school students throughout the
21 province. So, again, it's bringing our training
22 modules to the schools to alert and inform and
23 communicate with the high school students around the
24 whole issues around mental health, what it is, what

1 may be happening in your community, within your
2 school, amongst your peers has been very effective.
3 We've reached over 30,000 students so far over the
4 past number of years and we, through the support of
5 the Provincial Government, the money has been
6 reinstated for this year in which we'll be doing an
7 evaluation to make sure that we can make that program
8 even more effective.
9
10 While we're in the schools but what's interesting
11 is happening is that the teachers and principals are
12 also saying we need support because of the multitude
13 of issues happening in the high schools of bullying
14 as an example where we are also now going in and
15 talking about how to address bullying in the schools,
16 both with students and, obviously, with the students
17 and counsellors and the like. So, again, by being
18 out there in the field we've been able to focus our
19 efforts in bringing those issues to the fore and
20 there 's a lot more, as you can appreciate, needs to
21 be done and it has to be ongoing.
22
23 And addictions, of course Tree talked quite
24 eloquently about her organization's approach to the

1 issue. And agreed it is not a well understood issue,
2 it is not always seen even as a mental health issue,
3 and at the same time those with mental health issues
4 also have addictions issues and the issue then of
5 sort of comorbidities and then you're trying to treat
6 one part of the issue and not the whole person. And
7 an example, not necessarily one that is, so somebody
8 with a mental health issue may be addicted to
9 smoking. But a No Smoking policy at our public
10 facilities, I mean understood for one reason, it
11 works against the interest of that individual at that
12 time. Again, it is looking at this in a holistic
13 approach as care plans are developed certainly for
14 patients who are going through in our public health
15 system.
16
17 The other thing that we've been trying to focus on
18 is around the whole, and alluded to a few minutes
19 ago, is around the whole issue of professional stigma
20 of our providers. And it isn't obviously pervasive,
21 it isn't all professions but we do hear, again (inaudible)
22 spoke a few minutes ago, about how our frontline
23 providers due to, in our view, lack of training and
24 awareness around the complexities of the issues

1 facing the people, patients who present to them are
2 really further stigmatizing the individual. And so
3 you have to ask yourself, and I will ask people to
4 think about this the next time they go to one of our
5 public health organizations, to ask why are there
6 screens and barriers in place? Why are people who
7 are presenting with mental health issues treated
8 quite differently? Again, the locks, the bars, the
9 whole attitude. Why is the Waterford the place to
10 put people who are at the Health Sciences. Yes, we
11 had a structural problem at the Health Sciences
12 recently, but why would people think it was
13 appropriate then to move those patients over to the
14 Waterford?
15
16 Again, when we go to our cancer agency, as bad as
17 that experience is for families, you are treated with
18 respect and welcoming. That people do not say that
19 when they're going to the Waterford or going to some
20 of our other facilities. And that is the same people
21 running those systems, but we are challenged in our
22 mindsets to treat one the same as the other. Again,
23 that's something we can work on; something we do, as
24 an organization, have developed programs and services

1 to support people who want to make the change.
2
3 Actually, one of the organizations that has used
4 our program quite extensively are the Royal
5 Newfoundland Constabulary because they see the need
6 to make a change in how they approach people who
7 present with mental health issues on the frontline.
8
9 The next area I wanted to speak about quickly is
10 around addressing the social determinants. People
11 with mental health don't live only with a mental
12 health issue. They have housing issues, they need
13 access to education, training and employment, and
14 they need income and they need support.
15
16 We certainly need more options when it comes to
17 housing, obviously, and that can't standalone, they
18 have to be integrated with other services. And we're
19 some of the leaders in the country around social
20 housing initiatives and, certainly, Stella Burry is a
21 classic case. So, we need to be working closely with
22 those agencies and finding the best practices and
23 putting those into place. Because we offer safe and
24 affordable housing, its difficult to address other

1 issues and there are different communities across the
2 country that are looking at this issue from a housing
3 first policy. That when an individual is safe and
4 has comfort, then he and she and we, collectively, as
5 a community, can help support them with their other
6 issues. It will need an infusion of dollars,
7 obviously, up front, but, again, we have instruments
8 in place. We have Newfoundland and Labrador Housing
9 agency and others, community housing programs that we
10 can build on. And some of the work that we're doing
11 now through the Justice program is just that. We are
12 finding apartments, not shelters, not bed sitters,
13 we're finding apartments but we need support to
14 continue that. So rental subsidies, they are limited
15 and we are in a wait list for those and we would
16 argue that doesn't make any sense and we need to look
17 at that.
18
19 So, we need to have the Housing Corporation and
20 Justice and Health and others say, yeah, we are going
21 to come at this from a housing first policy and then
22 build the supports around that.
23
24 Obviously, around education and training and

1 employment, more services needed. There are some
2 services in place, obviously not sufficient. And I
3 cited an example recently where the government,
4 through one lens, in terms of the ABE program,
5 streamlining and privatizing it, its work has been
6 counterproductive to the approach that the College of
7 the North Atlantic had in delivering the program on
8 the Waterford Bridge Road campus because there it was
9 not only an ABE program, it was a fully integrated
10 program. And I think you've heard Mark Grouchy and
11 others speak about that, where that not only was
12 education was important but it was the supports
13 around that. So, you can't do these things in
14 isolation. You have to look at it from a
15 client-centered perspective. And I don't think this
16 was a dollars issue, I think it was just a one
17 philosophy collided with another and I think the
18 wrong one won out in this case.
19
20 Again, the Justice program, where it's an
21 integrated approach for currently 25 clients. There
22 is a wait list. We're seeing success. There are
23 many individuals coming through that program. This
24 is the longest time they have been outside

1 incarceration. We're talking months now, if not
2 years, and we're seeing people moving on to education
3 and training that otherwise would not have done. And
4 if you look at the cost per client on this, it is
5 minimal, relative to the cost of incarceration for,
6 in many cases, almost a lifetime and we need to
7 expand this approach across the province. We're
8 starting to reach out but, obviously, we need to deal
9 with the women's facilities and the other facilities
10 across the province and we're prepared to gear up for
11 that, if the resources are there.
12
13 And one other thing we just wanted to highlight,
14 it's not on the slide but again, mental health issues
15 in this province have grown by a large factor over
16 the past ten, 15 years. Oil development has taken
17 place, the fishery has collapsed in certain parts of
18 the province. All of these factors have, obviously,
19 compounded and come together to present a huge
20 problem to us. So, we think it's useful and we've
21 been trying to do this and I think government and
22 other leaders in society need to bring the private
23 sector more into solutions and providing resources to
24 help us as a community address that. And this is

1 more than just knocking on the door for funds, for
2 fundraising, this is looking at, again, from a more
3 holistic perspective, that this is a large societal
4 issue. It's caused by multiple factors, many of
5 which we don't even really understand or have good
6 data on. But we know what leads to addictions, we
7 know why there's a prevalence of drugs in society.
8 That means there's resources going to that. Where is
9 some of that coming from? And our oil, I'll call it
10 the oil sector, but our larger employers in this
11 province really need to also step up to the plate and
12 help government and the community agencies, in
13 particular, to help address these issues.
14
15 And this is more, I will call it, probably more
16 self-interested, sort of part of the presentation, is
17 around the funding of community agencies. We are the
18 closest, outside families, we are the closest to the
19 persons with lived experience. So, we feel we have a
20 very close handle on the issues. Again, as I said
21 earlier, we want and need to be listened to in terms
22 of when governments and the health agencies and
23 others are designing programs and services and
24 policies. We advocate but we are also in the service

1 delivery, so we know what it's like to have to
2 deliver and balance a budget and resource that. We
3 want to be recognized as full partners and we feel we
4 should have an integrated and equitable role in
5 service planning and program delivery.
6
7 Again, and this is I think in this province and my
8 experience certainly working within government in the
9 past is that we can get the right people in a room
10 pretty quickly but it shouldn't be ad hoc. It needs
11 to be consistent and that we really have an
12 integrated approach. So when a proposal gets to the
13 provincial cabinet, for instance, the ministers need
14 to ask, "And have all the players been at the same
15 table? Where are the differences? Where is the
16 mutual support and where is it we really need to
17 go?", and then I think because when a policy and
18 program then rolls out from that I think then you get
19 much better buy-in and movement much faster. And
20 where we have worked with the departments, whether
21 it's Health or Justice, on solutions, we find that
22 those get acted on pretty quickly, on both parts but
23 it needs to be, certainly, an open relationship and
24 ongoing and that's not only for us but we have the

1 Community Coalition now in place and others, because
2 there's definitely a recognition that, for whatever
3 reason, over time, government has drifted off in one
4 direction and the community has drifted off in
5 another and the only ones losing when that happens
6 are the clients and the public that we're trying to
7 serve.
8
9 Again, most of us, and certainly our organization
10 is highly dependent on government funding, despite
11 our efforts at fundraising. So any arbitrary
12 cutbacks does hurt our ability to delivery on our
13 mandate. And past funding decisions, again, were
14 arbitrary. We understand the plight of government
15 but there is a better way of doing this and we're
16 still living with the results of those cutbacks.
17 Even though there was no cutback this year, we're
18 living from the cutbacks, the base has been reduced
19 and we're having to deliver our services with reduced
20 funds. And, again, with a new approach to funding, I
21 think we can help stabilize finances and build
22 capacity right across the country, excuse me, across
23 the province in all our services. That's not to say
24 that evaluations don't need to be done, that certain

1 services may no longer be required, new ones
2 certainly need to have to come to the fore and we're
3 open to any of those discussions that make sure we
4 expand and improve the system and not just stabilize
5 the status quo.
6
7 So, I guess, finally, for us, we're committed to
8 moving forward to make this province a more
9 supportive place for achieving and maintaining good
10 mental health and governmental health in this for all
11 and we're willing to work with government through
12 this committee and all stakeholders to achieve this
13 goal.
14
15 There's one final thing I just wanted to add. As
16 you are deliberating and finalizing, and doing a
17 report, and I appreciate given the electoral
18 situation we're facing, your Committee will finish
19 and will table a report and who is going to be there
20 post-November 30th, we don't know. One of the things
21 that, this is less an official position of our
22 organization but many of us have been chatting, what
23 happens to the Committee and its work after you do
24 table your report. We'd ask you to give serious

1 consideration, given the pervasiveness of this issue,
2 to our society, to our economy, to the politics of
3 this province, should we not move to a standing
4 Committee to the point where we can, at some future
5 date, yes, we've addressed all these issues as a
6 society, but until then we, the elected members, are
7 prepared to listen and understand and to engage the
8 community at large while we're addressing this.
9
10 One other factor we'd like to ask you to think
11 about, and was alluded to at different points, is we
12 need to really do some further analysis study on the
13 quality and effectiveness of the programs and
14 services we deliver here. So, we need sort of a
15 baseline and really compare ourselves to what other
16 provinces are doing and where they haven't addressed
17 the problems satisfactorily, what other countries are
18 doing, whether it's in Scandinavia, in Britain and
19 what have you. I mean, that's what we do, as the
20 example before, as (inaudible) mentioned before, that's
21 what we do in other sectors, we need to do them here.
22 We have the skills and resources and willingness to
23 deliver services, I think we're well served but we're
24 not always abiding by the best practices and we're

1 losing and we're spending money on quality or, I
2 should say, less than the quality that we deserve and
3 that has to be a frustration for government and
4 Eastern Health and anybody else that has limited
5 resources, and a lot of these solutions are within
6 the community and they are not expensive, but they
7 need a change in attitude and redirection of
8 resources. So, I'll leave it there, thank you.
9 Honourable Felix Collins:
10 Thank you, John, and congratulations, again, on being
11 elected President. It's a very important
12 organization in our province and I wish you luck,
13 best wishes, and I know you'll do a good job.
14 There are so many issues you mentioned here and so
15 many issues you touched and so many responsibilities
16 and so many cross-sections of society that your
17 organization touches and it's difficult to have
18 enough time to address each of them. So, I'm going
19 to give the members of the Panel a few minutes to
20 make any comments or questions that they have.
21 Christopher Michelmore:
22 I'll just make a quick comment, John. We've had the
23 opportunity, I guess, to listen to your counterparts
24 in Grand Falls-Windsor and on the West Coast at the

1 sessions, and I appreciate your final comment around
2 the point, politicians may come and go and change but
3 the work of the Committee or a standing committee on
4 this particular issue doesn't have to. The work can
5 continue and advance, depending on who is the
6 representative.
7
8 And you've raised a lot of the issues that have
9 come up previously. But without a rent supplement,
10 where do the people who deal with the Justice aspect,
11 where do they go? What do they do? I mean, they
12 have to be housed somewhere?
13 John Abbott:
14 Well, then they would, they would be stuck in a bed
15 sit or something like that.
16 Christopher Mitchelmore:
17 Okay, it's just the quality of the type of housing?
18 John Abbott:
19 Yes, it's the quality. Yeah, so, it's, again, from a
20 housing first perspective, as you and I would expect
21 to, that's really what we're saying here. When I
22 used the word "stigma" earlier, this would be an
23 example. We would not and should not expect anybody
24 to live in substandard housing, no matter where, but

1 we are saying, well, that's “acceptable”, and we need
2 to change that.
3 Christopher Mitchelmore:
4 So, John, from a Justice perspective then, how much
5 would need to be provided? Do you have numbers in
6 terms of providing adequate rent supplements for that
7 specific group? Or it's a broad range. I mean,
8 there probably could be an endless supply of rent
9 supps that would be needed.
10 John Abbott:
11 Again, we're only, because our program is simply down
12 to 25 clients, where right now I think we just have
13 one or two who are, sort of, in that position. So
14 it's not, as I said, so the dollars are relatively
15 small on that and that's not to deny anybody else in
16 the system. And I think if you look at anybody that
17 dealing with housing issues, they would say, yeah, we
18 need more social housing units and/or subsidies to
19 help people. So, this is one, obviously, very
20 specific group but without that in place, it becomes
21 more difficult to do the larger case management
22 supports that we're trying to build around, because
23 we're trying to normalize life for an individual
24 that's been in an institution and going from an

1 institution to a bedsitter is not much of a life.
2 Gerry Rogers:
3 Yeah, and the Justice program is great but I know
4 that what has happened, I've had constituents call me
5 and then I intervene with them with and Newfoundland
6 and Labrador Housing and say, well, the Mental Health
7 Association has rent supps through the Justice
8 Program, but you're full.
9 John Abbott:
10 Right.
11 Gerry Rogers:
12 You're full. I have a few questions. A) I'm
13 interested in hearing what you were meaning by the
14 new approach to funding required to stabilize
15 financing and build capacity. So, I'd be interested
16 in that.
17
18 The other thing is, I have a question about the
19 Waterford. Have you seen the new plan? What is your
20 sense of that new master plan? And also, it's going
21 to be a number of years before, whether, even if
22 someone makes a decision soon that it's going to
23 happen, it's years before we see that door open.
24 What do we do in the interim? Do you folks have some

1 ideas on that and the same thing with HMP. Is there
2 something we can do in the interim? So, those three
3 questions.
4 John Abbott:
5 Well, on the Wateford, so, yes, we've been consulted.
6 Again, I think the consultation could have been more
7 effective, but, and we have seen the plan. I don't
8 think we've taken a position one way or the other on
9 it. I think we're generally satisfied that there's
10 movement and movement, definitely, in the right
11 direction. But in the interim, we know money has to
12 be spent on the existing facility to keep the doors
13 open, to keep the paint on, what have you. That is
14 money now that could be used for moving forward with
15 the new facility, and so that's just the practical
16 side here.
17
18 If the Waterford is going to stay in place, then
19 huge dollars is going to have to be put in to keep
20 that just functional. Those dollars, now, could be
21 used to further the planning and to accelerate, but
22 that's a choice issue at the end of the day. And the
23 same would be true for the penitentiary in that
24 regard. So we focus one on the service side, to make

1 sure we can deal with that while planning for the
2 penitentiary proceeds. Again, a lot of work has been
3 done, but, again, the government has got to make a
4 choice, really, to move that whole thing forward and
5 we recognize there are big issues here. So, we're
6 just going to advocate for the change. There's a
7 vigil on Monday night at Bowring Park to bring
8 attention to this whole issue.
9
10 Around the funding of agencies, again, I think
11 it's looking at sort of going .... So, the
12 Department, for instance, on behalf of the government
13 has a strategic plan in terms of what it wants to do.
14 It wants to move forward, obviously, with a new
15 mental health strategy. That strategy needs to
16 address the need for community agencies and to
17 support them and within that is, all right, how do we
18 fund that? How do we fund that? So, if they are
19 providing services that are in the public interest,
20 such as the Justice program then those dollars need
21 to flow and they may need to flow consistent with if
22 the service was provided within the Justice
23 Department. So, for instance, our social workers
24 aren't necessarily funded at the same rate as social

1 workers in the system.
2 Gerry Rogers:
3 In the public sector.
4 John Abbott:
5 But we have to pay at that rate to be competitive and
6 get the best qualified. So, those kinds of issues
7 need to be considered and we need to look at multiple
8 yearlong-term funding and there needs to be,
9 obviously built in, evaluation accountability
10 agreements.
11
12 So, if the Justice program, for instance, is
13 important, and you want us to deliver it then fine,
14 we need to be supported. I think there's
15 recognition, at least in the past, and I think this
16 is hopefully true going forward, that governments
17 recognize that agencies like ours, and of the
18 community will also have an advocacy role and they're
19 going to say things that the government doesn't want
20 to hear from time to time, but they need to hear
21 them. And we are all mature adults, shall we say,
22 living in a modern, democratic society and so that's
23 to be expected.
24

1 So, organizations such as ours should not feel,
2 quote unquote, that their funding would be threatened
3 because they said something that the minister of the
4 day didn't particularly want to hear. It was said to
5 be constructive and well-intentioned. If it's not,
6 then, obviously, other conversations have to take
7 place. But some of the conversations we would have
8 around our table would be “Can we say that? Should
9 we say that? Is this the right timing”, because
10 we're having budget discussions with the Department
11 of Health or the Department of Justice. And
12 obviously, you want to remove that barrier and that's
13 where multiyear funding certainly would come into
14 play. And that there is recognition that if there
15 have to be cuts because of the larger fiscal
16 situation, then the organizations are engaged in a
17 meaningful discussion. And I think that would help
18 everybody to move forward and to support everybody's
19 agenda to improve mental health right across the
20 province.
21 Honourable Felix Collins:
22 Thank you very much, John, for the very informative
23 presentation, and I'm sure that the directions and
24 recommendations coming out of this Committee

1 certainly will give your presentation and the role of
2 the Canadian Mental Health Association will be front
3 and centre in the information you give.
4
5 We are supposed to have an hour for lunch but we
6 are already 20 minutes to one, so we're going to
7 reconvene as close to one as we can because there are
8 people who are ready to make presentations at one.
9 So in fairness to them, we should begin at one
10 o'clock. So, we will have a short lunch period and
11 for those of you who are with us this morning and
12 listened to the presentations and want to stay for
13 the afternoon session, by all means, feel free to do
14 so.
15
16 So, we'll reconvene at one or as close thereto as
17 possible. Again, John, thanks very much for coming.
18 **(Off the Record)**
19 Dr. Bruce Gilbert:
20 We are going to start our afternoon session. So, our
21 first presenter this afternoon presenting as a
22 citizen and it's Darlene Brown. Is Darlene here?
23 Darlene Brown:
24 I'm here.

1 Dr. Bruce Gilbert:
2 Okay, and, Darlene, you have 15 minutes and if you're
3 comfortable taking a chair over there at the
4 microphone and I'm going to sit here, and I'm going
5 to give you a five-minute warning, so you'll know
6 where you are in terms of your timing, okay?
7 Darlene Brown:
8 Okay.
9 Dr. Bruce Gilbert:
10 So, feel free to take it away.
11 Honourable Felix Collins:
12 Thanks for coming, Darlene. You can begin.
13 Darlene Brown:
14 Thank you. Felix Collins, okay. Hello, Mr. Collins.
15 My name is Darlene Brown. I'm here today on behalf
16 of my own personal issues dealing with autism. My
17 son is six, he was diagnosed at five as being ASD on
18 the higher end and when I first started my journey
19 with my son I found out that he had a
20 two-and-a-half-year waiting list for services for OT
21 and speech pathology. Even to see a specialist at
22 the Janeway, I think, was a year and a half. So I
23 went to a different doctor and got a diagnosis and
24 through talking to some people, I started to realize

1 that there was private care for my son, which I am
2 now paying for monthly, which is very costly.
3
4 So, the first thing that came into my mind, well,
5 Newfoundland already has a two-tiered health care
6 system, considering that I'm paying for services that
7 should be provided by the government. Since that
8 time, I have met with the government officials
9 numerous occasions, MHAs. We've had rallies at the
10 Confederation Building. I've been practically been
11 pleading for changes to the autism services that are
12 here in this province, which are very, very lacking
13 to the rest of the provinces in Canada.
14
15 Most provinces in Canada deal with a pivotal
16 response therapy for children. We deal with an ABA
17 system, which is kind of old. Works for some
18 children, don't work for all and it is costly, and
19 the training for a person to take care of your child
20 is a three-day course which, to me, is not enough
21 time to train anybody to take care of an autistic
22 child. A pivotal response training is taught to the
23 parents, they bring it back and just do it with their
24 children. You don't need any therapists in your home

1 to do it with.

2

3 I know a place in Nova Scotia tried to come to
4 Newfoundland last year and talk about this and they
5 were stopped. I don't know why. We need to help
6 these children. Early intervention is the key. We
7 hear it every day. There's no such thing as early
8 intervention in Newfoundland. Two-and-a-half-year
9 wait list to me is not early intervention, it's far
10 beyond. And some children, I'm lucky in the way that
11 I can afford to pay for private services and my child
12 is high functioning. The parents of children that
13 aren't high functioning, I don't know how they're
14 surviving. I don't know how they're going to get
15 their children through two and a half years and can't
16 afford private care.

17

18 All I hear is we don't have enough OTs, we don't
19 have enough this, we don't have enough that. Well,
20 you know what, if you don't have enough there are
21 lots of people out there, private care, I think the
22 government should take on a role and contract out
23 some work so at least some families could start
24 getting some help how to deal with their children

1 now, not two years later.

2

3 In a meeting the other day with Steve Kent's
4 office, we had a meeting and I brought up the same
5 issues that I keep bringing up, which is what I'm
6 bringing up here now, time limits, wait lists,
7 departments having no connection. Like, you've got
8 the Department of Education don't know what the
9 Department of Health is doing and when you got a
10 child in the education system and they're sent home
11 every other day because they're making odd noises or
12 they're kicking up a fuss because they're having a
13 meltdown because nobody knows how to deal with it,
14 they got to realize that this is affecting health too
15 because this child is having mental health issues
16 over it. You got to deal with that.

17

18 My suggestion was we have focus groups for
19 families to be able to go in and talk to the powers
20 to be. The people that know these children are the
21 parents. They live with it day in, day out. From
22 the time you put your feet to the floor, to the time
23 you close your eyes. We're the ones that know the
24 triggers. We can help. You're not allowed, I mean,

1 OTs are not even allowed in the schools anymore.
2 They took them out of the schools to reduce the wait
3 times at the Janeway. The wait times at the Janeway
4 have not been reduced, they're still two and a half
5 years. Unless somebody can find out that's
6 different, that's the last I heard. That's what we
7 were told. They were taken out of schools, so
8 children in schools now don't have access to OTs.
9
10 There's not enough training for the staff in the
11 schools either, as far as I'm concerned, for children
12 to be sent home or barred in closets, or whatever the
13 cases may be for certain personal stories. I haven't
14 been there yet. My son is starting kindergarten in
15 September and I will be the parent that's going to be
16 guiding that along because I'm the one that knows him
17 best. Whether or not I'll be allowed to do that, it
18 will only be a help. I don't want my son having a
19 bad experience in school and being sent home. He's
20 high functioning. He could be anything he wants to
21 be, with help.
22
23 I don't even think there's one-on-ones anymore. I
24 think there's one-on-three. There's no such thing as

1 one-on-one anymore. My son is a runner and I have
2 expressed that. If he gets anxiety, he's going to
3 bolt.
4
5 In speaking with the principal of the school, my
6 understanding was that my child would have a worker
7 who is going to be one-on-three. Now, if she has
8 three children that are runners, I don't know how
9 it's possible.
10
11 What else was I going to talk about today? The
12 ABA. It starts when your child is diagnosed but it
13 ends at grade three. Autism doesn't magically go
14 away when a child is in grade three. They have this
15 for the rest of their life. It is a mental health
16 issue.
17
18 What else was I going to talk about today? I
19 talked about the wait times, the OT. Education is
20 something in itself. The departments that have no
21 connect.
22
23 Oh, yes. The Special Child Welfare Allowance
24 Program that allows certain things for families to

1 help them with their children. This process is so
2 intrusive. You have to walk over glass, go through
3 fire hoops, you have to do everything. I am at it
4 since last July.
5 Gerry Rogers:
6 Darlene, what's it called again? The what?
7 Darlene Brown:
8 It's Special Child Welfare Allowance.
9 Gerry Rogers:
10 Okay, thank you. Yes.
11 Darlene Rogers:
12 A very, very grueling process. The application
13 alone, I'm sure some families would not even be able
14 to complete. I completed it. They have more
15 information on me than the federal government. I am
16 not joking. They have my mortgage papers and they
17 have every single thing that I own dear, all my
18 privacy, everything, they have. Still not enough.
19 They want to know everything about you. Everything.
20
21 I think it could be simplified. The application
22 is way too complicated. It could be simplified and I
23 think a T4 should suffice to show your income. I
24 don't think you should have to give everything under

1 the sun that you own to somebody. Actually, I think
2 if I brought it to a lawyer I would say that it's a
3 privacy breach, or an invasion of privacy what you
4 have to give.
5
6 In saying that, I was approved for services after
7 going to the media, after having rallies, after
8 meeting with Minister Kent's office, I finally got my
9 child tested. It wasn't the IQ test that they
10 normally do, which is another issue. The IQ 70. IQ
11 and autism have nothing to do with one another and I
12 don't understand why anybody can't get that.
13
14 I finally got my testing, got services. Nothing
15 has ever been paid for, so now I'm in the process of,
16 actually, what I did do is tell them to forget it,
17 I'll pay for what I wants to pay for myself. I've
18 actually told them just, I'm wore out dealing with
19 them, let alone dealing with an autistic child.
20 That's an all day, every day job and have to deal
21 with this department that are there to help, I think
22 it's just nice talk, nice words, we're there to help.
23 No, you're there to crucify because that's what I
24 felt like I've been through, crucified.

1 I have had to give them everything and every time
2 I phone it's something different and we always have a
3 few more questions. It's on my T4 what I make. What
4 do they think I'm doing with the amount of money that
5 I get is, I don't know. It's actually funny and like
6 I said to them, sometimes commonsense goes a long way
7 and we have lost commonsense along a route somewhere.
8 If it's not written A, B, C and D, that's it's. You
9 can't think for yourself to make a judgement call or
10 to speak to somebody. And these people are just so
11 intrusive and I'm still here today, a year later and
12 still nowhere ahead. I'm still paying for my own
13 services and like, I mean, I'm leaving out things to
14 pay for these services. There's other things I can't
15 have or my other son can't have because my other son
16 needs it and that is there to help and when they did
17 their calculations, I still had to pay them $88 a
18 month. And when I did my charts up, $88 a month
19 would have covered what my child was going to get in
20 a six-month period anyway and he was only qualified
21 for six months.
22
23 So, I mean, so I did all this work, got every
24 paper that they needed, had to request things, it

1 took weeks, I had to drive around and get what they
2 needed and I ended up in a boat where, nothing. No
3 help whatsoever which, as far as I'm concerned, the
4 help that I'm trying to get should be readily
5 available for children like my son. I shouldn't have
6 to go begging for it. I shouldn't have to go through
7 this process, it should be here. If other provinces
8 can do it, what's the problem with Newfoundland? And
9 we're talking about bringing other people into the
10 country, I think you've got to look after what's here
11 first.
12
13 I can't get my child looked after and we're
14 talking about bringing other people in? It don't
15 make sense. I'd like to see the papers and the
16 figures on this. If you can't help my child, how are
17 you supposed to support and help other families? I'd
18 really like an answer on it. And same way in the
19 schools. We got all this French Immersion, we got
20 this and that, and full day kindergarten, you can't
21 meet the basic needs of my child, but you'll do all
22 this. Put in full day kindergarten when my basic
23 needs of my son, who's entitled to an education,
24 can't be met and I feel very strongly about that.

1 I feel very strongly about everything I spoke of
2 today. I've been very vocal, I've been in the
3 newspaper, I have requested meetings one-on-one
4 trying to get people just to understand that our
5 children are the future, our children are important
6 and our children need services. With services our
7 children can flourish and be anything they want but
8 they're not getting it. And like I said, I'm one of
9 the lucky parents, who I can afford to give my child
10 some help. What about the parents out there who
11 can't. Some parents can't even get respite. I don't
12 get respite. I spend 24/7 with my child. Some
13 parents have two children and can't get it. I can go
14 on and on about stories that I know.
15
16 I mean, I know one mom requested help. Social
17 Services was on her doorstep questioning her. So,
18 we're not going to help you but we will send somebody
19 in to see what you're doing. But I think it's time
20 that all autism moms get together, we stand in one
21 big circle and we stand together because it seems
22 we're the only ones that are supporting each other
23 and that's it. That's about all I have to say.
24

1 I think I've touched on everything that I -- to
2 me, yeah, bottom dollar is this government's goal,
3 it's not people, and without the people of this
4 province you have nothing. That's just how I feel.
5 You've got to invest in the people. I know
6 everything is Muskrat Falls and mining and it's all,
7 that's all you see, that's all you see. Come in my
8 home and look at my child, that's what's important.
9 It's the people of this province. It's not the
10 mining you're spending billions of dollars on and the
11 gas. Yes, we need it. We also need help for our
12 families. That's how I feel. That's my speech for
13 the day.
14 Honourable Felix Collins:
15 Well, thank you very much.
16 Darlene Brown:
17 Thank you.
18 Honourable Felix Collins:
19 Could you stay for a second?
20 Darlene Brown:
21 Sure.
22 Honourable Felix Collins:
23 I'm sure the Panel will want to interact with you.
24 Before you go, you mentioned autism parents to stand

1 together. Is there a support group existing of
2 autism parents? Is there a support group, as such?
3 Darlene Brown:
4 There is a support group, which I'm a part of. I'm
5 here today solely on my own. Yes, we have a support
6 group and there's somebody speaking Monday on behalf
7 of that group. I'm not speaking on behalf of that
8 group today, I'm speaking from my own personal
9 experience, but yes, I find out, that's how I found
10 my private services was through that group.
11 Christopher Mitchelmore:
12 Darlene, it's so important, I guess, that you speak
13 out as a parent and share your experiences and we
14 need more advocates like yourself to raise the issues
15 and the experiences that you're having because
16 there's so many people who can't speak up for
17 themselves or know the process in such a way. And I
18 hear it, time and time again, the red tape, the red
19 tape, accessing service, the barriers that are put
20 up. And we've heard it across multiple presentations
21 where the Committee has gone around. Once you can
22 get access to a service, generally the experience is
23 pretty good but getting to that level can be very,
24 very difficult, and sometimes the service just

1 doesn't exist, compared to other provinces but red
2 tape is certainly something that needs to be worked
3 on.
4 Darlene Brown:
5 Well, see there was a red tape reduction there a few
6 years back, wasn't it? What happened to that,
7 because I find more red tape since we did that red
8 tape reduction. And another thing I found,
9 consultations. We're going to do a consultation. We
10 have to hire somebody, we have to hire somebody.
11 What happened to the other consultations? Unless you
12 get a consultation and somebody can actually sit down
13 and read that and get that rolling and put that in
14 place, that's going to sit on a shelf until the next
15 consultation comes around, when this money can be
16 better put somewhere else.
17 Christopher Mitchelmore:
18 Darlene, I think it's been really clearly made by you
19 and others around the need for measurables when
20 you're talking about outcomes, whether it be with
21 wait times or the services that are there. You've
22 raised a lot of issues around autism and one of the
23 points I think around the focus groups where there's
24 an engagement piece directly with government, around,

1 whether it be autism moms, autism dads or those that
2 are experiencing it every day as to how services can
3 be better is a good approach and a great suggestion.
4 Darlene Brown:
5 I think it would be a fabulous approach. I think,
6 like I said, when we were in our meeting last week
7 with Minister Kent's office, there was a lady there
8 who was doing an autism review of what's going on
9 now, because, as I said, whatever they're doing now
10 is not working. And unless she speaks to families,
11 she can't do her job in my opinion. She can't do her
12 job. She needs information from the families to find
13 out, to get to the root of the problem, that's how I
14 feel. If I was hired to the job, my first goal would
15 be, I'm going to speak to families. I want to hear
16 what's going on. I want to hear what these kids
17 need. I don't know if that's even on their agenda.
18 She never did, when I asked, she never did say
19 anything about it, other than they're going to
20 contact other provinces.
21 Gerry Rogers:
22 Thank you very much for your presentation, and we're
23 hearing loud and clear about the issue of the IQ 70
24 issue.

1 Darlene Brown:
2 Oh, yes.
3 Gerry Rogers:
4 And we have no idea how many kids with autism are no
5 longer in school. We have no idea what those numbers
6 are. And I think they're growing.
7 Darlene Brown:
8 I'd say up around 500, from what I heard.
9 Gerry Rogers:
10 Yes, and it's a problem that's growing. And if you
11 were queen of the world, what would be the next steps
12 that you would take? How would you start making the
13 system more responsive to the needs that your son,
14 that you're experiencing, and I know I went to that
15 meeting. It's Team it's called, isn't it?
16 Darlene Brown:
17 Feet.
18 Gerry Rogers:
19 Feet, right.
20 Darlene Brown:
21 (Inaudible) feet.
22 Gerry Rogers:
23 Fabulous group and a fabulous meeting. What would
24 you like to see happen? What are the steps we can

1 take?
2 Darlene Brown:
3 Oh my God, the first thing I would do is like, I
4 mean, the waiting lists, the education system,
5 everything has to be looked at now, it can't wait two
6 years. Children are suffering. Two years is too
7 long. I would actually start focus groups. I would
8 listen to the people. I would sit down with
9 families, specialists, private people who deal with
10 this every day, who are parents themselves of
11 autistic children and figure this problem out and
12 start writing stuff on boards. Start just
13 brainstorming on issues that are giving us problems
14 and start in baby steps. I know this is a very,
15 very, very big challenge and it's a very broad
16 challenge. It's huge and there's more kids coming
17 into the system every day. Really.
18
19 And I mean, that's what I would do. I would start
20 brainstorming, talking to parents and try to figure
21 this situation out as soon as possible. Never mind
22 another consultation from a person who haven't got a
23 clue what autism is but he's going to learn about it
24 in a book. That's not what it is. You have to speak

1 to the parents to help these children. These
2 children are unique. Every one of them is different.
3 Every one of them has different needs. And if we can
4 get down to the brass tacks of this and start talking
5 to families and figuring stuff out, start putting
6 some services in place. And as I said, if you
7 haven't got enough OTs and you haven't got enough
8 therapists, there's private people out there. I'm
9 paying for it. The government should be offering
10 some kind of contracts with these people to help
11 these parents while they're on the wait list. And
12 once a spot comes up, then you can take that person
13 off and let them avail of government services. But
14 then the government services, a person gets into
15 speech, they only get so many blocks. After a
16 two-and-a-half-year waiting list they get so many
17 blocks and then they're put back on the waiting list
18 again. So by the time your name comes up again, your
19 child has regressed to what he started with. So
20 we're basically just a hamster in a circle. Just
21 running around in a cage.
22 Honourable Felix Collins:
23 Darlene, from the perspective of this Committee, the
24 whole business of the mental health and addictions

1 that we're exploring, a lot of the recommendations
2 and a lot of the solutions are long-range and will
3 take place over a period of time, but a lot of
4 things, I think, as a result of this Committee what
5 we're hearing, we should be able to implement rather
6 expeditiously.
7 Darlene Brown:
8 Yes.
9 Honourable Felix Collins:
10 Some of the things that you mentioned today is
11 something that this Committee can focus on is to do
12 in the short term.
13 Darlene Brown:
14 Yes.
15 Honourable Felix Collins:
16 Red tape is certainly one.
17 Darlene Brown:
18 Is definitely one.
19 Honourable Felix Collins:
20 There's no excuse for that sort of system. These are
21 the sort of things that we can effect in short order.
22 A lot of the stuff that we get, obviously, is going
23 to take a lot of time. We thank you very much for
24 coming today and expressing your opinion, it's very

1 valuable and we want people to tell it like it is.
2 The only way that this Committee is going to be able
3 to be effective is to hear the open and frank
4 comments from people like yourself. So thanks very
5 much. Thanks very much for coming today.
6 Darlene Brown:
7 Yes, perfect. Thank you very much. Thank you.
8 Dr. Bruce Gilbert:
9 Okay, our next presenter, presenting also as a
10 citizen is Wanda Martin. If you'd like to take your
11 chair over there and you have 15 minutes, and if I
12 need to I'll show you the five-minute card to keep
13 you on track.
14 Honourable Felix Collins:
15 Thank you for coming, Wanda.
16 Wanda Martin:
17 Let me just start by saying I'm not as good at
18 speaking as Darlene, so I'm going to take a different
19 approach to this.
20 Honourable Felix Collins:
21 You're here for a reason. That will give you
22 motivation enough to speak, I'm sure.
23 Wanda Martin:
24 I, also, am a mom of a little boy with autism. He is

1 ten years old. He is the love of my life. I am an
2 older mom. I had my first child, and he's my only
3 child, at 42. It's not an easy thing being a parent
4 of a child with autism. So, I come here today in
5 hopes of better services, mental health, OT, speech
6 and language; hope for less wait times, hope for
7 better services in education, more one-on-one
8 training, but I also hope people that can make the
9 change listen to our voices. Please, please listen.
10
11 Autism now, statistics say, is one in 68. It's
12 epidemic. There's no if, ands and buts about this.
13 Look around to all the other things on the rise,
14 whatever it be what other specials needs are going
15 on, autism is epidemic. They say by the year 2025,
16 they're predicting that one in 50 children will be
17 born with autism. So, I have some questions. Where
18 is it coming from? What's causing this? Where are
19 we going to be in 40 years? Who's going to run this
20 government? I'm worried about my child's future and
21 I'm worried about everyone else's future because one
22 in 68, one in 50, they're high numbers.
23
24 I would just like to take a minute and read to you

1 a poem I have written. Sometimes when I'm having
2 really hectic days and I can't vocal or I don't know
3 who to call or who's going to listen to me, I write.
4 It's the only way that helps me cope, but I wanted to
5 say before I go on with this, is Darlene is a lucky
6 mom because she has the ability to provide services
7 for her child that she can. I'm not one of those
8 parents. I'm a single mom so I rely completely on
9 the government to help me and the wait times, the
10 help we're asking for, it's devastating what we go
11 through just trying to be heard.
12
13 On that note now, I'm going to read you this poem,
14 it's called, "A Day in Our Life, Autism." I believe
15 you have a copy of it on your desk.
16
17 Another year has come and gone, so many new
18 parents knowing something's wrong. You feel all
19 alone, what will you do, your worst fear has just
20 come true. You knew something was different almost
21 from the start, but to hear the words really broke
22 your heart. Your child has autism, is what they'll
23 say, you'll fall to your knees and you'll search for
24 a way. A way to fix something that isn't broke,

1 but as I watch you struggle, on silent tears I choke.
2 He does not look autistic, is what someone said, my
3 heart filled with pride but then I shook my head.
4 Things are not what they seem, as so many of us know,
5 spend a day with my child, let the story be told.
6 His day starts out with fear, a meltdown or two.
7 With a little love and understanding, a smile will
8 come through. A little later today as you travel
9 down our road you will notice things now, it's called
10 sensory overload. Flapping and squealing, covering
11 his ears, the noise, the lights, sometimes a touch,
12 is too much for him to bear. Then comes bed time,
13 he cries himself to sleep, his mom whispers words of
14 comfort as she too silently weeps. Now it's
15 tomorrow, who do I beg today? Wait times and lack of
16 resources never goes away. Yet again, another year
17 has come and gone, so many new parents knowing
18 something is wrong. Please help. That's all I have
19 to say.
20 Honourable Felix Collins:
21 Thank you very much.
22 Gerry Rogers:
23 Wanda, there was another mom who wrote a poem and
24 read it for us in Labrador, and she was the mom of an

1 adult child with a very persistent mental health
2 issue and her poem, too, was so incredibly moving and
3 it's a very powerful way for us to really understand
4 a little bit what it's like. And I thank you.
5 Honourable Felix Collins:
6 Wanda, when you came up you said you weren't a good
7 speaker, I don't know how much more powerfully you
8 could have expressed yourself. And people say when
9 you can't say something verbally put it in writing or
10 put it poetry and you've certainly done that. Thank
11 you very much.
12 Dr. Bruce Gilbert:
13 Okay, thank you very much. Our next presenter is
14 Ryan Young. Okay, Ryan has 15 minutes and, Ryan, as
15 a courtesy I'll just show you a five-minute card when
16 you've five minutes left, so you know where you are.
17 Ryan Young:
18 Okay, thank you.
19 Honourable Felix Collins:
20 Thanks for coming, Ryan.
21 Ryan Young:
22 Well, thank you Minister Collins, Mr. Mitchelmore and
23 Ms. Rogers for hosting these events for us and for
24 allowing me to present, and to Rick for all the hard

1 work and for working hard to get the rest of us in
2 here today as we've all been waiting to be heard.
3 I'm here today to talk a little bit about
4 transitional and supportive housing in Newfoundland
5 and Labrador. Right now, in Newfoundland and
6 Labrador there's currently a huge need for
7 transitional housing services and I'll start there
8 with the transitional housing.
9
10 There are, currently, 12 transition houses in the
11 province and those transition houses for women and
12 children affected by violence. So we definitely do
13 need those transition shelters and they do great
14 work, of course; but there's also a strong need for
15 transitional housing for families and vulnerable
16 persons. In particular, there is no transitional
17 housing in the province for single fathers. I found
18 this out on my own last year when I became a single
19 father. Some of you may have heard my story over the
20 last little while. I actually had to give up my job
21 working with the City of St. John's because of child
22 care costs. Go home, right now, I'm living in
23 Newfoundland and Labrador Housing and receiving
24 income support benefits. I certainly don't believe

1 that that's where I should be. That's where I ended
2 up. And through my process of getting there, I ended
3 up homeless last summer for about five weeks.
4 I had to leave my home because I couldn't afford to
5 pay the rent. I had lost my job, had lost my EI
6 benefits, really got in a hard spot, falling through
7 the cracks and there was nowhere for me to go. I
8 could have given up my kids into foster care and went
9 into a man's shelter at the Wiseman Centre, I guess,
10 or let my kids stay with family members and that's
11 what I ended up doing. They went with my mother and
12 my grandmother for that period of four or five weeks
13 last summer while I lived in a tent trying to figure
14 things out.
15
16 And I know a few weeks ago in the House a question
17 was raised about income support payments for people
18 that are homeless, and I can tell you, I found that
19 out firsthand, as well, that you cannot receive any
20 income support payments unless you have an address.
21 I was lucky that I had my grandmother that was
22 willing to let me use her address and after a few
23 weeks I was able to get some benefits and try to get
24 my life back on track to a little bit of a semblance

1 story. I'm not following my slide show here, I'm
2 reading off my thing, so I apologize for that. So
3 that's where we are now.
4
5 So, I can see that as a big, big issue. If you
6 look at the stats in Canada right now, the stats are
7 really changing and about 20 years ago it was almost
8 unheard of to hear of single father families. I
9 mean, there were a few but there weren't very many.
10 Nowadays, about 20 percent of single parent families
11 in Canada are headed by single fathers. So, after
12 going through my situation it kind of seemed like
13 there's probably a lot more single fathers that are
14 dealing with this and I think that we really need to
15 look at an option for transitional housing for single
16 fathers.
17
18 As I mentioned, in order to receive income support
19 benefits an applicant needs to supply an address and
20 housing is one of the leading causes of stress for
21 vulnerable individuals and families. So, I can
22 certainly tell you that that was my big issue last
23 year. Brought me down a mental health spiral,
24 dealing with depression, trying to look for the

1 positives in everything and try to stay on top for my
2 children and it was hard. And, eventually, I got to
3 where I wanted to be but not without a lot of phone
4 calls, a lot of gesturing and a lot of help from the
5 media and some other people. So I finally got into
6 housing and on income support, but just getting there
7 was a really hard battle. So, I really think that
8 transitional housing really needs to be addressed.
9
10 In addition to transitional housing, I'd also like
11 talk a little bit about supportive housing in
12 Newfoundland and Labrador. Addiction and
13 homelessness are both on the rise in Newfoundland and
14 Labrador. We all know that. You guys have heard all
15 that. I won't get deep into the stats because I've
16 read all the things that you guys have been posting
17 online, so I know what you guys have been hearing.
18
19 There are very few supportive housing options
20 available to those who need them in St. John's,
21 especially, and throughout the island. Hard to house
22 individuals are often bounced around. Here I am
23 looking at my thing again, I'm sorry.
24

1 Gerry Rogers:
2 You can see it there, too, Ryan, look.
3 Ryan Young:
4 Oh, yes, so I can. Thank you Gerry. Hard to house
5 individuals are often bounced around in different
6 group homes and have difficulty finding practical
7 housing solutions. I mean, we know that. Many of
8 these end up in prison and I don't have there, but
9 many of them also commit suicide. We do have a high
10 suicide rate in Newfoundland and Labrador and many of
11 the people that are committing suicide are hard to
12 house, vulnerable citizens.
13
14 Nobody in government is really talking about the
15 steady rise in drug-related crime, both in St. John's
16 and other areas of the province, and many people do
17 not understand that the truth about addictions that
18 lead so many people into that criminal lifestyle.
19
20 In the 1990s, Vancouver was dealing with many of
21 the same problems that St. John's is dealing with
22 right now. I understand Vancouver is a much larger
23 city than we are, but they are still dealing with the
24 same problems. The Downtown East Side Residents'

1 Association founded the Portland Hotel Society to
2 address the housing needs of their neighbourhood.
3 The program is co-funded by the BC Housing Authority
4 and the Vancouver Coastal Health Authority. Initial
5 funding came from Federal, Provincial and Municipal
6 funding and in addition to that, there was
7 fundraising from several foundations. So I think it
8 was around seven or eight million dollars that they
9 raised through government and private donations and
10 through that, they were able to open up this
11 beautiful place, the Portland Hotel.
12
13 It is named the Portland Hotel because the city of
14 Portland is well-known for its stance on
15 homelessness. Really, really supportive to their
16 vulnerable citizens, so they named this the Portland
17 Hotel. And it was open in 1999. Accommodations for
18 86 adults with mental health, addictions and other
19 problems and the facility included professional
20 supports to assist residents with their needs. So,
21 they had eight mental health workers providing
22 24-hour support to their residents. They had doctors
23 that would come in four half days a week and meet
24 with residents. They also opened Canada's first

1 safe-injection site, Insite.
2
3 For most residents the rent is based on a
4 percentage of their income support or pension
5 benefits. Working residents pay less than $500 a
6 month for rent and the average is around $350 to $450
7 a month for their rent. Forty percent of residents
8 stay for over ten years and the average stay is six
9 to eight years. Residents have a home where they
10 feel accepted and respected and that's a big one,
11 especially for, what we call hard to house,
12 vulnerable people. Feeling accepted is really,
13 really hard for these people and especially feeling
14 that they're being respected. So, it was really nice
15 for these people to have a place where they can feel
16 accepted and respected.
17
18 The program has been a great success and has
19 drastically improved the lives of thousands of
20 people. It has kept many people off the streets, out
21 of hospitals and jails. They've actually got a
22 no-eviction policy in the Portland Hotel. So,
23 there's some pretty tough situations that they've had
24 to deal with over the years but, surprisingly, very

1 few that actually ended in violence because of the
2 trained mental health workers that are onsite, that
3 are able to deal with nonviolent crisis management.
4
5 So, what we need in Newfoundland is an East
6 Portland Hotel. In BC they realize that this program
7 is cheaper and it produces better outcomes than
8 people living on the streets and being constantly in
9 and out of hospitals and the justice system. I think
10 together we can start the shift towards a better
11 future for all Newfoundlanders and Labradorians.
12
13 I kind of started looking at this, it was funny.
14 I was reading a book a few weeks ago, or a couple
15 months ago, right around the time you guys started up
16 and this was mentioned in there, the Portland Hotel
17 Society and I really got to thinking what a fantastic
18 idea and they've done such good work for people in
19 British Columbia. I live in Housing so I walk around
20 my neighbourhood and I talk to people. I talk to a
21 lot of people that are dealing with these problems,
22 are dealing with mental health issues, that are
23 dealing with addiction problems. It's great, they
24 love the fact that Newfoundland and Labrador Housing

1 gives them a house over their head but they feel that
2 beyond that they really don't have much support
3 available to them. So, if we had some sort of a
4 facility like this, where we could put people in,
5 we've got the workers there to talk with them, to
6 help them through their hard times, give them the
7 support that they need, make them feel they're
8 accepted in the community, make them feel that
9 they're respected and bring our vulnerable people
10 back to a place where they can feel good about
11 themselves, and I think that's the most important
12 thing that we need to remember. So, that's pretty
13 much it, thank you very much.
14 Honourable Felix Collins:
15 Thank you very much. I have a quick question for you
16 before you go and the panelists might have some
17 questions for you as well. In the British Columbia
18 Hotel, Portland Hotel, has a capacity of 86 people,
19 you said?
20 Ryan Young:
21 Yes.
22 Honourable Felix Collins:
23 Some of them stay for as long as ten years?
24

1 Ryan Young:
2 Yes.
3 Honourable Felix Collins:
4 So, I'm just wondering, and majority is six to eight
5 years. So in terms of transition then, the people
6 who seem to be there stay there for a long period of
7 time, so I'm wondering how that works in terms of
8 getting new clients, when it comes to transition, new
9 clients are coming in.
10 Ryan Young:
11 Sure. And through my research, and I've been looking
12 at different things, what they actually did in the
13 hotel too, is they make long-term and short-term
14 facilities available. So, some rooms have shower,
15 bathroom facilities, kitchens, full apartments
16 basically, while other places are kind of just like
17 bedsitting rooms and they've got common kitchen areas
18 and common living areas that they can go and hang
19 out. So, basically, I guess, the short-term members,
20 they basically stay in the transitional part of the
21 hotel; whereas, the long-term members have a bit more
22 of a permanent residence.
23
24 As for your question about the transition, I guess

1 I really don't have a solid answer for that but I
2 would imagine that as people are being able to
3 progress and come along in their mental illness,
4 they're able to get out of the hotel and move in,
5 whether it's with family members or other members
6 that have perhaps lived in the hotel before that they
7 have made friendships with and they've been able to
8 get out and actually live somewhat productive lives
9 which they were unable to do before the Portland
10 Hotel Society came along.
11 Christopher Mitchelmore:
12 It certainly seems like a great model that you've
13 presented in terms of what's happening there and in
14 BC. And it's been coming up more often about the
15 lack of services that exist for men or men with
16 children. This Portland Hotel, though, it's for
17 everyone. Is it inclusive? Or is it for men and --
18 Ryan Young:
19 No, it's inclusive. It's for everyone, yeah.
20 Christopher Mitchelmore:
21 Okay, it's for everyone.
22 Ryan Young:
23 I don't think they take families with children but
24 adults with mental health and addiction issues.

1 Christopher Mitchelmore:
2 So, it would be both men and women that would be
3 staying here at this hotel?
4 Ryan Young:
5 And the fact that they've got 24-hour support onsite,
6 I guess that makes that a little easier for them.
7 Christopher Mitchelmore:
8 Yeah, we've had a number of presentations, things
9 like co-location of different services and whatnot
10 seemed to make a whole lot of sense. So having like
11 a safe site there for the in-site that was presented,
12 seemed like it would be a fit as well.
13 Ryan Young:
14 Absolutely. And I live in the Rabbittown
15 neighbourhood and I mean we had a big issue this year
16 and I had to sit down with my seven-year-old and say
17 this is a needle. If you see it, don't touch it.
18 And not to say that an in-site centre would take all
19 of that away but it would certainly alleviate some of
20 the problems for sure.
21 Gerry Rogers:
22 Ryan, thanks so much. And we've been hearing
23 everywhere we go the issue, the housing crisis and
24 the call for housing first as a model in terms of how

1 we're looking at housing. And we know that Stella's
2 Circle does supportive housing as does Choices, but
3 there's also a new housing project, supportive
4 housing project up in Goose Bay and it's being
5 administered by the Nunatsiavut government and their
6 mental health services program and it's doing really
7 well.
8
9 What's happened is that a number of men who were
10 frequently incarcerated are now in this supportive
11 housing environment, living, some of them are living
12 in separate units, some of them are living in
13 communal units and the recidivism rate has dropped
14 dramatically. That they're not going back to jail
15 and they're not violent. So, it makes so much sense.
16 Ryan Young:
17 It gives people something to believe in.
18 Gerry Rogers:
19 Yes.
20 Ryan Young:
21 Something to give them a roof over their head. I
22 mean, that means so much to people just to have that.
23 Gerry Rogers:
24 So, we're seeing it. What's interesting is that they

1 use some Newfoundland and Labrador Housing units. So
2 we need to look at what kinds of housing stock, what
3 kinds of resources do we have, and how can we start
4 using them better.
5 Ryan Young:
6 Sure. Just before I finish, I would like to say that
7 I'm presenting today as a private citizen but I'm in
8 the process of meeting with different individuals and
9 talking to different people as much as I can to try
10 and come up with a committee or a foundation or
11 something that we can get together and look at
12 something like this and then come to you guys in the
13 government with a proposal to say this is something
14 that we think we could work. So, certainly, if you
15 have anybody in mind that you think that would be
16 interested in that put them in touch with me by all
17 means, and I think over the next year we've got a lot
18 of work to do to even try to think about planning
19 something like that but with enough good people and
20 the dedicated people that we have in this province I
21 think we could get a team to really tackle this
22 issue.
23 Gerry Rogers:
24 Yes. Well, there's the Housing and Homelessness

1 Network. I don't know if you're aware of that
2 organization?
3 Ryan Young:
4 I am, yes.
5 Gerry Rogers:
6 And then the OrgCode report has come out. We haven't
7 seen, yet, government's response to that but that
8 should be kind of interesting.
9 Ryan Young:
10 I think that's the next step for me, is to start
11 reaching out to different groups now and see if we
12 can get some people on board.
13 Honourable Felix Collins:
14 Ryan, let me say this to you as well, that if you
15 have other ideas or other suggestions or information
16 that you want to share with us, we have web sites and
17 email address and whatnot, by all means, take
18 advantage of it.
19 Ryan Young:
20 Absolutely.
21 Dr. Bruce Gilbert:
22 And thanks very much for coming out today.
23 Ryan Young:
24 Thank you very much, have a great day.

1 Dr. Bruce Gilbert:
2 Thank you very much, Ryan. Okay, Darren Fancey. Is
3 Darren here?
4 Darren Fancey:
5 Yes.
6 Dr. Bruce Gilbert:
7 Okay, Darren. Darren's got 15 minutes and as per the
8 others, I'll show you a five-minute card if and when
9 required.
10 Honourable Felix Collins:
11 Thank you very much for coming, Darren.
12 Darren Fancy:
13 Thanks very much.
14 Honourable Felix Collins:
15 The floor is all yours.
16 Darren Fancey:
17 Thanks very much for the opportunity. I'd just like
18 to say, first off, that I really appreciate what you
19 guys are doing here, and I know it's going to mean a
20 lot to a lot of people and I think that Newfoundland
21 is really now poised to come out and set an example
22 for Canada, I think, and what it's doing for mental
23 health. So, I appreciate this.
24

1 I'm here on behalf of the Better Days Support
2 Society and just to give you some background on that
3 to start, we're a group that's been meeting at
4 Dominion on Blackmarsh Road for about five years and
5 we're just a group of peers, no professionals, but we
6 do have some professional backing from groups like
7 ASIST, which are suicide interventionists and as well
8 as, I guess, professional counsellors and stuff like
9 that. Just kind of friends of the group kind of
10 thing, so that's who we are.
11
12 I say we've been meeting for about five years and
13 I'd say in that amount of time we've seen hundreds of
14 people go through there and a typical meeting there's
15 maybe 15 or 20 and it's been up as high as over 30
16 where it's kind of standing room only. So,
17 generally, a good group of people and always new
18 faces, so that's why I say for sure there's hundreds
19 of people that have gone through Better Days.
20
21 I like to just kind of, I've just got a few
22 minutes so I'll briefly kind of touch on three
23 things, I guess. I wanted to start with the
24 experience of what it is to deal with mental illness

1 because I'm not sure that that's always fully
2 understood. And we've done some talk in classrooms
3 and stuff like that, to high school kids, and I think
4 it's good to kind of illustrate what anxiety is and
5 what these kinds of things are and with a goal to,
6 once you identify it then better the devil you know,
7 so then you know how to deal with it. So I think
8 it's good to kind of start off with that.
9
10 I just kind of wanted to say something that we do
11 in class. Something so that the kids will remember.
12 When we're in a classroom I kind of start off with
13 this and I take this foghorn and I put it together.
14 At least this is a marine foghorn. It's really, it's
15 hellishly loud. It's very, very loud. So if I were
16 to stand up, everybody's heart kind of picked up a
17 little bit then, they thought I was going to blow the
18 horn, right. That's kind of an initial response.
19 That's stress, that's anxiety. It's natural and it's
20 perfectly healthy. It's a message to us that
21 something's going to happen and that we have to
22 prepare for it. That's kind of anxiety at its kind
23 of base level.
24

1 What happens if somebody told you they were going
2 to follow you around with this all the time and
3 randomly they're going to blast it in your ear,
4 right. So, pretty soon you would have trouble
5 concentrating and thinking. All you'd be
6 concentrating on is that sometime this guy's going to
7 blast this thing in your ear. So, you'd be
8 preoccupied. So having anxiety, which is the base of
9 a lot of types of, I guess, emotional and mental
10 illnesses is, it really comes down to that kind of
11 core of impending doom. So, you could no more teach
12 anybody that there's no impending doom, that
13 everything is fine, than you can teach someone to
14 unlearn how to type or unlearn how to play guitar.
15 So, that's the kind of challenge, I guess, of dealing
16 with anxiety.
17
18 I kind of want to talk a little bit about -- at
19 one point in the group one of our facilitators
20 mentioned that anxiety, because I've had anxiety and
21 depression and a lot of people can deal with anxiety
22 and depression as kind of two parts of the same coin
23 and somebody mentioned that anxiety is like looking
24 to the future and worrying about the future and

1 depression is like dragging stuff in the past. So,
2 this is an illustration that's been used to kind of
3 illustrate that, so this would be somebody who's kind
4 of in crisis. On the one hand they're trying to hold
5 off this big ball of anxiety that's going to roll
6 them over if they let it go. On the other hand,
7 they're being dragged behind by depression. So this
8 is an example, this explains a lot in terms of,
9 people say that they're tired all the time when
10 they're dealing with mental illness and stuff like
11 that. This is kind of the battle that's happening in
12 your mind. So I thought that was a good
13 illustration. This can also illustrate the kind of
14 bipolar effect and that kind of thing.
15
16 From there, I thought this was a good slide to add
17 because this is not always well understood. I call
18 this the uneasy balance, and I put that there because
19 a lot of times this position is not well understood
20 and somebody will go and look for help and the key to
21 getting help, and this is not just in Newfoundland,
22 this is kind of globally, I think, but the key to
23 getting help is to say that you're in danger of
24 harming yourself or someone else and that's kind of a

1 line that happens.

2

3 So, the person may very well be in this position,
4 quite often they are, that they manage to find some
5 balance, find some time to seek help. So, in answer
6 to that question, realistically, no, at that point in
7 time, they're not going to harm themselves, they're
8 not going to harm anybody else but they've got a
9 precarious balance here in terms of their own
10 balance.

11

12 People cycle very quickly between the seesaw and
13 the hill, that's the problem. So, it's not always
14 dismissive to say, okay, I'm not going to hurt myself
15 or anybody else, at this point and time, so you're
16 good to go. You're not necessarily good to go.

17

18 Just in terms of, I guess, people that's gone
19 through Better Days, I want to put down some examples
20 of positive change people that have gone through
21 Better Days and really had some good, positive, and
22 not only Better Days but like, I guess, seeking
23 mental health in general, but these are specific
24 people I'm thinking of. A parent in looking for care

1 for a child realize they are, themselves, not looking
2 after their own mental health and they came there to
3 seek help for their daughter and they come to group
4 now as somebody who has a realization of their own
5 anxiety. They're both actually doing really well,
6 now.
7
8 Another parent supporting their child, the child
9 was for a long time, perhaps a year or two, the
10 parents would come supporting their child. The child
11 was a little, so this is an adult child, actually,
12 but they were kind of slightly misdiagnosed and they
13 were in a crisis. What happened was they were able
14 to get a redefined diagnosis, a better diagnosis and,
15 therefore, the treatment was adjusted and they're all
16 doing much better.
17
18 A person with lived experienced, they first opened
19 up to the group. The only people that knew in the
20 world that was anything wrong was our group and now
21 they're an advocate for mental health.
22
23 A man who has compulsive behaviours who they came
24 to the group and when they were kind of talking about

1 where the compulsive behaviours come from, that was
2 flawed and unhealthy and their compulsions were
3 diminished and then removed.
4
5 Another person with OCD connected with a
6 psychologist who themselves had OCD and that made the
7 mark for him. And the last one, which I think is
8 very important to the collaborative approach to
9 mental health is that other members have been
10 networked to somebody else, to Survivors of Suicide,
11 to Alcoholics Anonymous, Marguerite's Place, Emmanuel
12 House, Wiseman Centre, all these place and they might
13 come to us and they might end up with somebody else,
14 they might come back and forth, but I'm glad that
15 this kind of coalition, this All-Party Committee has
16 come together because it's really allowed all the
17 pieces of the puzzle to talk, all the people to talk
18 to each other.
19
20 I've got a bunch of those here, but I don't know
21 how I'm doing for time, so I won't go through them.
22 Dr. Bruce Gilbert:
23 Well, you have seven minutes.
24

1 Darren Fancey:
2 Oh, okay, very good. That's with questioning time?
3 That's total?
4 Dr. Bruce Gilbert:
5 Five minutes.
6 Darren Fancey:
7 Okay. Another example, I'll give you a couple more
8 examples then, because this is kind of important,
9 too. When somebody is suffering from mental illness
10 or when their children are suffering or they're
11 supporting someone suffering, they'll do whatever it
12 takes. So, there are cases where people have paid to
13 send their children or their adult loved one off to
14 facilities on the mainland and these things might be
15 at a cost of like $15-$20,000 a month and I've seen
16 that. People do that.
17
18 So, with respect to what people are willing to do,
19 I mean, people are willing to do anything. I've seen
20 some really extreme examples of what people are
21 willing to do. And on one end there's suicide, on
22 the other end is paying $20,000 for recovery. People
23 will do whatever in the extreme.
24

1 So, lastly, I'd just like to kind of talk about, I
2 guess, things that have kind of been shown to work
3 and I call this the recipe because everybody's is a
4 little different but they're all very similar, too.
5 You need a comprehensive approach to your mental
6 health and wellness and these are just kind of a
7 couple things that came to mind yesterday when I was
8 putting this together very quickly. You need
9 support. That could be medical support, peer
10 support, family support, loved ones. You need to
11 take care of your physical self, your diet, physical
12 activity, your sleep regime. You need professional
13 help. That might be prescriptions, it might be a
14 psychiatrist, psychologist, professional counselling,
15 and there's also a personal journey that someone has
16 to go through and that's been grounded and mindful,
17 thought exercises. A big thing is people kind of
18 talk to themselves negatively. You have to learn how
19 to talk positively. So, this is the kind of things
20 that kind of all have to come together for somebody
21 to kind of succeed in their wellness.
22
23 I've made a separate slide for peer support
24 because that's kind of what we do. In peer support

1 we try to recognize behaviours and language in people
2 that we recognize as being problematic to their
3 mental health. You hear things like people discuss
4 how they blame someone, how they wish stuff was
5 different or a big one that I always hear a lot of is
6 this absolutism. Like, if you say, what's wrong,
7 they say everything is wrong. You say, who do you
8 have a problem with? Who are you angry with?
9 Everybody. Because the problem is so large and it's
10 so overwhelming that to get down to define really
11 what's wrong is what you're trying to do in your peer
12 support, because at the moment you're talking to them
13 in this kind of crisis situation, they're being
14 overwhelmed and, I mean, you can't think clearly when
15 you think everything is wrong. So, it's really about
16 listening and attempting to understand with an
17 experienced ear and allowing a free and open and
18 confidential dialogue.
19
20 So, those couple of things, I made this slide
21 separately. I want to mention that, like these
22 couple of things have led to positive change. These
23 are true examples. These are examples that I've seen
24 and it's important to know that these don't require

1 extensive resources on the health care dollar but
2 they can be realized in building an army of
3 understanding. The more people that understand the
4 more people they help, the easier it is. And this is
5 building on training of frontline staff and utilizing
6 peer support as people with lived experience. And in
7 doing that we will, hopefully, take the "I" out of
8 mental illness and put in the "we" and have it become
9 mental wellness and that's our meeting dates. That's
10 it. Thanks very much.
11 Honourable Felix Collins:
12 Thank you very much, Darren. And you've brought out
13 what we've been hearing on so many different
14 occasions, the necessity and the importance of peer
15 support. And, in fact, support groups are just as
16 important and probably more important sometimes than
17 professional services and that peer support really
18 opens up gateways to different avenues. I don't know
19 if anybody wants to have any comments, on the Panel.
20 Christopher Mitchelmore:
21 I think what you stated, I mean Better Days has
22 certainly helped significantly so many people and
23 your last commentary about having an army of
24 understanding is really important. Is there a way, I

1 guess, to have Better Days expanded to other regions
2 and areas so that it's ....
3 Darren Fancy:
4 I think that's always kind of been a goal but I mean,
5 we don't have money or resources or anything. So,
6 like, we always kind of had in the back of our mind
7 that we would go and like, as a group, a small group,
8 like a kind of a seed group and start a group
9 somewhere else. And we spoke to people in Placentia
10 about that and Central and everything, but I think
11 they are kind of, there are Better Days like groups
12 being sparked in other areas. I think it's maybe
13 just a matter of getting people together and kind of
14 sharing resources.
15 Christopher Mitchelmore:
16 Great, thank you.
17 Gerry Rogers:
18 I am so thankful for Better Days, Darren. I don't
19 know how many people, it's just been so wonderful to
20 be able to say, "Hey do you know about Better Days, I
21 think you should check this crowd out. They're doing
22 great work." One of the things we're doing is trying
23 to find ways of improving our mental health services
24 and our system. So from the scads of people that you

1 folks have met with and worked with together, is
2 there anything particular that stands out in your
3 mind in terms of key areas that we need to look at in
4 terms of improving the system? And before I forget,
5 I do believe the Office of Public Engagement has
6 money to help citizens help citizens to do work in
7 their communities. Is that right? Like, maybe there
8 is some kind of pot of money where Better Days can
9 get a little bit of pot of money to go do some
10 workshops in Placentia, or wherever.
11 Dr. Bruce Gilbert(?):
12 There's money for groups. There's an application
13 process for groups to apply to improve their
14 collaborative work with others.
15 Gerry Rogers:
16 Perfect. Keep that in mind. You should speak to
17 Bruce.
18 Darren Fancey:
19 Appreciate that.
20 Gerry Rogers:
21 Yeah, so my question is, where are some of the keys
22 areas where we can be making some improvements, or
23 what people need? Or, is there something that people
24 have identified that really works and is great or we

1 need more of?
2 Darren Fancey:
3 I guess I kind of closed it off with the recipe to
4 mental health because it's really complex and it kind
5 of depends on the person. And when we had, like,
6 round tables before, I mentioned early and accurate
7 diagnosis and I mentioned that, and I was actually at
8 Minister Kent's table when we spoke about that and he
9 said, like, how do we fulfill that? I guess
10 immediately you're kind of thinking, okay, more
11 psychiatrists and stuff like that but I had a little
12 bit of time to think about it after and I was
13 thinking it's not necessarily about having more
14 psychiatrists. A diagnosis is really a gift to the
15 person. It's something to help them realize that
16 something in their behaviour may not be quite right.
17 Something in their way of thinking may not be quite
18 right. It's a way for them to kind of evaluate how
19 they think and how they behave. And as a starting
20 point and say okay, because if you have, from
21 experience, if you have anxiety, depression, you have
22 panic attacks and you don't know what it is, you just
23 kind of think you're crazy. So, a diagnosis, at
24 least, says, okay, you're not crazy. These are the

1 specific things happening to you. And I mean people
2 can do their own research as to what to do about it
3 and that will end up being, I guess, their own
4 personal recipe, right.
5
6 So, I wish there was kind of a quick fix but I do
7 say that connection early with a
8 psychiatrist/psychologist, I think is essential.
9 Gerry Rogers:
10 Okay.
11 Christopher Mitchelmore:
12 Thank you.
13 Darren Fancey:
14 Thank you very much.
15 Gerry Rogers:
16 Thank you so much.
17 Honourable Felix Collins:
18 Thanks, Darren.
19 Dr. Bruce Gilbert:
20 Okay, I believe you're representing U-Turn and Jeff
21 has 15 minutes, so you can grab a spot. If there's
22 two of you, you can both go up there.
23 Jeff Bourne:
24 I'm nervous now.

1 Christopher Mitchelmore:
2 Don't be.
3 Jeff Bourne:
4 Don't matter how often I speaks in front of a group
5 of people, I'll always be nervous but I guess that's
6 what keeps me hopeful, I suppose.
7
8 Good afternoon, friends. I use the word "friends"
9 when I speak in places because I feel we're not
10 strangers we're just friends that we haven't met yet
11 and where we all got a passion for mental health and
12 addictions I'm sure that if we all got together that
13 we can all become really close friends.
14
15 First of all, my name is Jeff. I'm also a
16 recovering alcoholic and drug addict and I also
17 suffer with depression. So, through lived
18 experience, I now have a passion for mental health
19 and addictions. My wife Tammy and I are both
20 non-paid volunteer coordinators at the U-Turn drop-in
21 centre located in Carbonear, Newfoundland. After
22 sitting at the round table discussion at the
23 All-Party Mental Health and Addiction Committee
24 meeting a couple of weeks back, Tammy and I have

1 requested to attend the public presentation session
2 to educate you about the services and discuss
3 U-Turn's future.
4
5 As we talk about U-Turn, its services, what it has
6 to offer, what an asset in the community it is, and
7 how it saves the government money, you will be
8 shocked to learn that today U-Turn has been under the
9 operation of two volunteer coordinators, that's
10 non-paid volunteers. I got to clarify that because
11 sometimes you say volunteer coordinators, they thinks
12 I'm a coordinator for volunteers. We're non-paid.
13
14 The centre has come to a point that it's essential
15 that a full-time paid coordinator is needed in order
16 for U-Turn to meet its demands and meet the needs of
17 the clients we serve. We are looking forward to your
18 support in making this possible.
19
20 First of all, a little bit about U-Turn. U-Turn
21 is a non-profit organization committed to helping
22 individuals through the process of addiction,
23 recovery and supporting family members who are
24 affected by addiction. U-Turn had its grand opening

1 back in July the 17th, 2011.
2
3 At U-Turn our motto is, “No matter how far down
4 the road your addiction has taken you, you can always
5 make a U-Turn and come back out.” Our vision is
6 helping people live beyond addictions. Our mission
7 is to bring experience, strength and hope to people
8 who seek recovery from addictions. Our values are
9 respect, compassion and integrity.
10
11 U-Turn provides a supportive, safe environment for
12 all visitors to our drop-in centre to make referrals
13 to professional services, support individuals and
14 families in need due to addiction issues, provide
15 information and educational resources and to provide
16 the opportunity for fun, safe and clean activities
17 that support an addiction-free lifestyle.
18
19 In the last 12 months, our centre had 4,105
20 drop-ins with an average of 15 to 20 new people per
21 month.
22 Gerry Rogers:
23 Wow.
24

1 Jeff Bourne:
2 These drop-ins include addictions, support,
3 volunteers, 12-step recovery meetings and extra
4 activities. The numbers here are strictly our
5 addition daytime operation that we're open is 899 for
6 addictions. Visitors, we had 302 visitors.
7 Sometimes these visitors comes in for a short while
8 and then they comes to the conclusion and they opens
9 up a little bit to be honest about their addiction.
10 Support of 71 people. Support, that kind of entwines
11 family members that's coming in looking for support
12 because they got a family member that's in the grip
13 of addiction. Recovery meetings, we had 2,157. At
14 our special events, we had 610. That brings up to
15 the total of 4,105 people.
16
17 U-Turn is open five days a week for people to drop
18 by and spend time in the clean and safe environment.
19 They meet with other addicts, others with addictions
20 that make their life changing and they can talk with
21 Tammy or me. Tammy and myself are pretty much
22 available 24/7 to the recovering addict. I'll
23 explain this a little bit. We both have cellphones.
24 Our phones are on at all times. There could be a

1 call probably one o'clock in the morning and end up
2 going out to emergency or meeting somebody where
3 they're to. And that's why we're, like I said, on
4 call 24/7.
5
6 At the U-Turn centre we have five 12-step recovery
7 meetings. We have recovery workshops and
8 presentations, clean and safe, sober outings, support
9 people in finding affordable housing. We also have
10 gathered furniture, clothes and other items to help
11 people in need to get a fresh start.
12
13 When requested, we support people in recovery as
14 they make their way through the court system. Matter
15 of fact, we got to take off right after because we
16 got a friend in here that's going to see a Legal Aid
17 lawyer, so we got to kind of hit two birds with one
18 stone this evening, I guess.
19
20 We offer transportation for people to the recovery
21 centre or the methadone doctor's appointments in St.
22 John's when needed. We also meet people outside of
23 U-Turn, probably in a coffee shop or at their home
24 just to get them to know us a little bit before they

1 actually come into the U-Turn centre. Like, living
2 out in a rural community, the stigma to addictions is
3 really huge, so we almost got to meet people where
4 they are to get them to come to the centre after they
5 get to know us a little bit.
6
7 So, that's my spiel. Now, Tammy's going to talk a
8 little bit about what we're kind of here advocating
9 for today.
10 Gerry Rogers:
11 You can pull that closer to you Tammy, so you don't
12 have to reach so much for it. There you go.
13 Tammy Bourne:
14 Okay. You may be asking yourself, is addiction an
15 issue in our community? The answer is certainly yes.
16 Eastern Health research scientists have demonstrated
17 that drug use in Conception Bay North, like most
18 areas in our province, is a major issue. The disease
19 of addiction can affect all types of people from all
20 types of backgrounds.
21
22 Someone struggling with an addiction may be a
23 family member, a neighbour, a professional or the
24 person serving you at the store. What we have

1 observed is that most people we talk to with a drug
2 addiction, and they're under the age of 25, have used
3 drugs intravenously. We have come across cases where
4 people are homeless, living in cars, living in small
5 mobile campers with no electricity or propane, not
6 having personal care items or proper facilities to
7 get a bath, no access to laundry facilities and not
8 having food to eat.
9
10 Yes, my friends, this is happening here in our
11 small towns and is not just limited to people in
12 their 20s. People from all walks of life and
13 socioeconomic status has come through our doors.
14 From the addict benefitting from the big money of
15 Alberta and the seniors addicted to prescription
16 drugs, we have seen it all. Let's face it, ignoring
17 addiction and turning a blind eye to the problems
18 associated with it, won't make it go away. People
19 have said that at U-Turn lives have been changed and
20 some have gone as far to say that lives have been
21 saved.
22
23 At U-Turn we've been asked, clients have asked us
24 to do many different things or come alongside of them

1 and there isn't anything that we've said no to. We
2 always try to accommodate them in any way that we
3 can, from a client of ours who's been at the centre
4 for two years, was diagnosed with cancer and she
5 wished to have her funeral arrangements done and we
6 sat with her and done that and made sure that her
7 funeral went according as the way she wanted it and
8 it went well.
9
10 Also, I had a client that she's going to have a
11 baby and she was clean and sober for a couple of
12 years but people still continues to come to the
13 centre so they can stay clean and sober. And she
14 wanted my company in the delivery room and I went
15 there too. So, there's not much that we don't have
16 our hands into, that's for sure, and I'm more than
17 glad to do these things for people because we
18 absolutely love them.
19
20 Here are some of the things happening at U-Turn
21 Centre that we suggest can save the government and
22 local businesses and taxpayers money. Clients using
23 the centre no longer require hospitalization due to
24 their mental health and addictions issues. There is

1 a gentleman that we had, he said before U-Turn opened
2 that he was hospitalized five or six times a year,
3 for many years now because of his depression and he
4 isolated himself from the world, and since he's been
5 coming to U-Turn he has not been hospitalized since.
6 And when he came out into the world, he said even the
7 top of a Tim Horton's cup, how you fold that back,
8 he's never even seen that before. He said he felt
9 like he was in some kind of a time capsule or
10 something but we helped him adjust. We came
11 alongside of him.
12
13 Clients have regained custody of their children
14 from Child, Youth and Family Services. Clients who
15 get their addiction under control no longer turn to
16 crime to feed an out-of-control addition; for
17 example, shoplifting, drug trafficking, driving with
18 suspended licence, and etc.
19
20 Clients have gone back to school. Some who have
21 completed trades and are now in the workforce.
22 Reduction of injection drug use which protects the
23 person in recovery from developing health issues and
24 reducing a number of used needles being discarded

1 around the community which, in return, protects
2 everyone. As a result of the U-Turn Centre 12-step
3 meetings, which we do be open in the evenings as
4 well. There are four nights that we have 12-step
5 meetings. A number of members have decided not to
6 take part in the methadone program. This, in itself,
7 is a major cost-saver. This alone has saved the
8 government hundreds of thousands of dollars per year.
9
10 We've done some research and the numbers per
11 methadone patients -- my time's up? Okay. I've got
12 five minutes?
13 Honourable Felix Collins:
14 No, you've got five minutes. Carry on.
15 Tammy Bourne:
16 Okay. Between 50 and $60,000 per patient out in the
17 rural area because there has to be accommodations.
18 There's no public transportation. There has to be
19 taxis. And with the 15 people alone who have come
20 alongside and said you can do it without the
21 methadone program, 15 people comes to about $900,000
22 in that one year and it's working. It really is.
23
24 When people came to the end of the road of their

1 addictions, and want to change, U-Turn has been a
2 place to go and make that first step towards
3 recovery.
4
5 If you have any questions on the need of U-Turn
6 Drop-In Centre being an assist in our surrounding
7 communities and is in the position to hire a
8 full-time coordinator. On behalf of myself and Jeff,
9 the Board of Directors, those who use the centre and
10 the still-suffering addict, I would like to thank you
11 for your time and for listening and hopefully we can
12 get somebody hired there. It's definitely a
13 full-time position there that's needed and I just
14 feel so grateful to be a part of that. Thank you.
15 Honourable Felix Collins:
16 Thank you very much. One of the things we're finding
17 as we are having these consultations is that there
18 are an awful lot of great groups out there doing
19 great work and, obviously, you're one of them and we
20 thank you very much today for coming and making your
21 presentation. I don't know if Gerry or Chris has any
22 comments or questions.
23 Gerry Rogers:
24 And congratulations and thank you for the incredible

1 service you're doing. And we're hearing loudly and
2 clearly the important role of peer support and people
3 working together. I would like to see you funded and
4 we've seen a problem with funding with our community
5 groups and organizations that are doing such great
6 work. That funding has either been cut back over the
7 years, a few years ago we saw a 12 percent cut in
8 funding community groups that were doing such
9 important work but then when there's not even an
10 actual cut, that funding almost maintains and so that
11 is a cutback because there's nothing for cost of
12 living and inflation. But I'm not quite sure how the
13 funding works for groups, like the work that you're
14 doing but I'm thinking maybe it might be interesting
15 to speak to Colleen Simms over there in the back of
16 the room. Colleen is the Director of Mental Health
17 and Addictions for the whole province and she would
18 know, exactly how that kind of funding works. And
19 she's shaking her head there.
20 Jeff Bourne:
21 Yeah, I know Colleen and I knew Colleen for a number
22 of years. I'm also involved volunteering with the
23 Newfoundland and Labrador, is it, All Addictions
24 Committee or something?

1 Gerry Rogers:
2 Oh, the advisory committee?
3 Jeff Bourne:
4 The Newfoundland and Labrador Recovery Network is
5 also the advisory committee for the treatment centre
6 which is going in Harbour Grace.
7 Gerry Rogers:
8 Great.
9 Jeff Bourne:
10 So, we say this is some of the things. And like,
11 they're talking about lived experience, this is
12 something that came from the workshop last year with
13 this Newfoundland Recovery Network.
14 Gerry Rogers:
15 That's right, yeah.
16 Jeff Bourne:
17 Here it is, you've got a place that's open that
18 people that's running with lived experience, but it
19 seems like the government wants lived experience, and
20 they're starting to see it as an asset, but they
21 don't start giving paid positions to people with
22 lived experience.
23 Gerry Rogers:
24 Yeah.

1 Tammy Bourne:
2 I just want to throw out there before we're all done,
3 because I know we're running out of time. U-Turn
4 Centre is running off 30,600 a year. That's total
5 everything. If anybody heard that we have a
6 part-time employee, no we really don't. We pay
7 $5,200 for a bookkeeper and that's a must when you're
8 getting government funding. So, there's been a
9 little bit of a mixup, people thinking that we do
10 have paid employees, but it's not that.
11 Gerry Rogers:
12 So, are you getting any provincial funding right now?
13 Tammy Bourne:
14 Just the 30,600. That's our core funding and that's
15 it.
16 Gerry Rogers:
17 Okay. So, maybe speak to Colleen, as well today.
18 Colleen's smiling at me. But anyways, it's something
19 that we are looking at as the All-Party Committee,
20 how many services are provided by voluntary groups or
21 nongovernment organizations, community groups, peer
22 support groups, and that if we are serious about the
23 important role that's played there and the
24 downloading of services into the nonprofit sector,

1 then we have to look at how to support that properly.
2 Jeff Bourne:
3 And it's kind of sad because the government is
4 spending millions of dollars to put the treatment
5 centre in Harbour Grace which is going to make our
6 work load a little bit heavier because when they
7 comes out they're going to, I guess, tell them, like,
8 maybe you need to go to U-Turn while you're out for
9 an hour, come down with us. And then they're going
10 to try to get them to come to some of our nighttime
11 meetings, and our 12-step meetings and stuff, so our
12 workload is even going to get heavier. And I mean to
13 say, treatment centre, we can work alongside of them
14 and we can work together and make a big bang for the
15 buck out around the bay.
16 Gerry Rogers:
17 And I wonder too, with Bruce, the Office of Public
18 Engagement, because you seem to be doing
19 collaborative work with other organizations, that
20 maybe there's some possibility there.
21 Christopher Mitchelmore:
22 I would think that based on what you've said, the two
23 of you are really doing yeoman service to the region
24 there. I come from a small community and, certainly,

1 there is a lot of stigma in small communities when it
2 comes to mental health and addictions issues and
3 being able to do all that type of outreach and the
4 relationships that you've built. I would suggest,
5 just maybe, even on a short-term solution when it
6 comes to funded positions, I know that a number of
7 organizations that I deal with have utilized, like,
8 job creation partnerships, JCPs, where they've been
9 able to hire a person for up to 52 weeks and that
10 deadline is June 30th for this coming fall.
11
12 There is also targeted wage subsidies that exist
13 through the Department of Advanced Education and
14 Skills where you can get a wage subsidy up to, I
15 believe, it's $8 per hour to pay somebody up to $16
16 per hour for the first year, and that may even be
17 extended. So there's all kinds of program that do
18 exist within government that might be able to assist
19 beyond just seeking some type of core funding. So,
20 there may be avenues out there that can assist you
21 right now within the Departments.
22 Jeff Bourne:
23 Is there any way I can get a copy of some of these
24 suggestions to me after our meeting or?

1 Christopher Mitchelmore:
2 You give me your email and I'll make sure you can get
3 all those applications.
4 Jeff Bourne:
5 Because we just, we're only like, two months ago we
6 started a fundraising committee for U-Turn, so it
7 would be good for these people to look at the
8 resources that we can tap into to get funding, right.
9 Christopher Mitchelmore:
10 Absolutely, and there may be a couple of things that
11 you could benefit from.
12 Gerry Rogers:
13 And then also contact Sammy Slade's office, right,
14 because he's your MHA.
15 Tammy Bourne:
16 We've been in touch with Sam.
17 Gerry Rogers:
18 Okay.
19 Honourable Felix Collins:
20 Okay, thank you very much for coming. Appreciate it.
21 Tammy Bourne:
22 Thanks for having us.
23 Dr. Bruce Gilbert:
24 Thank you very much. Okay, next up is Meaghan

1 Barnhill. Meaghan, you've got 30 minutes. So I'll
2 show you a ten-minute card and a five-minute card
3 just so you know where you are in your time. Please
4 come up.
5 Honourable Felix Collins:
6 So, Meaghan, you've got a complement with you today.
7 Mr. Grouchy, I believe?
8 Mark Grouchy:
9 Yes.
10 Felix Collins:
11 Mark, is it?
12 Mark Grouchy:
13 How are you?
14 Meaghan Barnhill:
15 So, I don't know. Should we start now?
16 Felix Collins:
17 Go for it.
18 Meaghan Barnhill:
19 So, we're the Committee Coalition for Mental Health.
20 This is Mark Grouchy and I'm Meaghan Barnhill and
21 we're the co-chairs of the Coalition. So, I guess
22 we're here just to talk to you about what we're doing
23 and some of the stuff that we've found.
24

1 So, we actually formed out of, a bunch of us met
2 here, actually, in this hall for a mental health town
3 hall, that Gerry actually put off and from that --
4 Gerry Rogers:
5 A year ago. It was June. It was a year ago, wow.
6 Megan Barnhill:
7 It was a year ago. So, we've only been around for a
8 year. We're fairly new but we are a permanent
9 coalition. We've just established our steering
10 committee through elections that we just held. It
11 really came out of a concern of the state of mental
12 health in this province and what was happening with
13 cuts. The nonprofit sector and the individuals were
14 really feeling threatened and they didn't like how
15 things were being handled and so we formed together
16 to come together and really speak up about what was
17 happening. So, we've been pushing mental health a
18 lot in the community. Andy Jones was helping a huge
19 amount when, unfortunately, his son, Louie, died by
20 suicide.
21
22 So, yeah, we're made up of individuals, interested
23 parties, nonprofit groups and there's over 30
24 different groups. There's over 300 individuals and

1 we are constantly getting more people in. I've got
2 at least 50 people that I have to add to the mailing
3 list tonight. So, yeah, we're constantly growing and
4 we're right across the province. And, yeah, so we
5 put off the launch and we actually lobbied for the
6 All-Party Committees that we're happy to have. And,
7 yeah, so, that's kind of who we are and where we came
8 from. Anything you want to add, Mark?
9 Mark Grouchy:
10 No, go right ahead.
11 Meaghan Barnhill:
12 No, okay. Cool. So, we started in January with an
13 outreach initiative that we called Visioning Day
14 2015. So out of this we had a couple of things that
15 came out and these are kind of the main issues that
16 people wanted to make sure were addressed. One was
17 that 211 come here. It's absolutely necessary. We
18 have to have it. Shorter wait times. As people are,
19 I'm sure, aware, the longer you're on wait time the
20 more money you're going to cost the system over time.
21 So really, hiring those psychologists to get, to
22 shorten that wait time or the psychiatrists will
23 actually save you a lot of money and, so, it's really
24 something that's needed now.

1 There was a need for everything to start being
2 looked at through a mental health lens, because
3 what's happening right now is you're seeing that
4 everything is being looked at through health care
5 only, with a mental health lens and what actually
6 happens is, housing is the perfect example. People
7 are struggling to get housing and people are just
8 looking at it as strictly housing but they're not
9 looking at the other complex issues that are attached
10 to it, and mental health actually affects every part
11 of your life.
12
13 So, you can't get a job if you aren't in a well
14 enough state to work because you're in crisis. You
15 can't take care of yourself. Everything is just in
16 full crisis mode. So, if you're not looking at
17 everything, including education, including housing,
18 including every department that we have, their mental
19 health lens, then you're not getting the full
20 picture.
21
22 So, yeah, we wanted to also see more initiatives
23 to attract more mental health workers to Newfoundland
24 and Labrador with a particular focus on rural

1 Newfoundland, and this is to increase accessibility.
2 They also wanted education on mental health from the
3 K-12 system, as well as education for frontline
4 workers. So, when we say frontline workers, we mean
5 your GP, we mean police officers. Oftentimes when
6 someone goes in, the first contact you're going to
7 have with the mental health system is your family
8 doctor, and what we are seeing is happening is that
9 they don't fully understand how complex mental health
10 is. Right now, Memorial University, I think, spends
11 three days in a med degree to teach about mental
12 health and three days to learn about mental health in
13 medical school is not enough for actually helping get
14 people in through the doors.
15
16 So, what you're having happen is a doctor will
17 kind of shrug it off, not really think it's anything,
18 think you're going through kind of a phase or
19 something and so you continuously go back to that
20 doctor, and by the time that you actually get a
21 referral, you've probably seen your doctor six times
22 and that's six appointments that have been billed to
23 MCP that shouldn't have been billed for. It could
24 have just been one and you could have been straight

1 into your referral. So, there needs to be more
2 education for your GPs. There needs to be more
3 education for police workers, policemen, sorry, and
4 policewomen and for any frontline worker in any
5 department.
6
7 So, the Waterford building, programs and treatment
8 approaches. The Waterford, we kind of sum it up as
9 just the Waterford but we really are talking about
10 the building, we're talking about the programs, we're
11 talking about supporting staff, we're talking about
12 supporting patients and we're talking about new
13 treatment approaches that haven't been looked at.
14 And then Her Majesty's Penitentiary, which I think is
15 pretty self-explanatory. It's a pretty old building,
16 just like the Waterford, and it does need to be
17 replaced, as well, and it's no longer adequate for
18 helping inmates with any mental health issues that
19 they're facing.
20
21 So, that's kind of an overview of that. So, we
22 just wanted to kind of touch on a few things. 211,
23 it's right now, if you have any issue, no matter what
24 it is, it's really difficult to find the services

1 that you need. So, if you are dealing with a crisis,
2 you're already overwhelmed with what you're going
3 through, how are you supposed to even start to think
4 about how you're going to find help. You're so
5 swamped with everything going on. So 211 is really
6 important that way because it's a number. It's like
7 calling 911. It's like calling 311 for the City.
8 This will get you straight to the services that you
9 need and it's a holistic approach.
10
11 You could call saying I've got a housing issue,
12 I've got a mental health issue, I don't know, I need
13 to get on a social income, I need all of these other
14 things and they'll be able to put you in contact, in
15 one phone call, with all of those, instead of having
16 to figure out who you're going to for this and then
17 who you're going to for this. So, it really takes a
18 process that could actually take you, like, a couple
19 of weeks, if not more. If you're, like, moving fast
20 it's a couple of weeks, and it breaks it down to one
21 phone call. So, that's why we need 211 and it is
22 super important and it gives people a sense of hope
23 because they know where they can turn, because right
24 now, I know when I was going through an issue and I

1 didn't know where to turn, if I didn't call my MHA,
2 and it was Gerry who I called, I had no idea where to
3 go because I really, like, it was so overwhelming to
4 deal with these issues because, no offence, but your
5 government website isn't very friendly. I mean
6 trying to find answers is really difficult. So, 211
7 is definitely, I think, the best approach that we
8 could take to really breaking down these barriers and
9 increasing access.
10
11 So, yeah, so, accessibility. So, accessibility
12 really fell into a couple of categories, and so one
13 of the things is if you're not living in St. John's
14 or Corner Brook it's a lot more difficult to reach
15 out and get help. Corner Brook has a fantastic
16 program with their acute crisis unit, but that's only
17 for a small portion of people who are in, like,
18 extreme crisis at that moment and we're still finding
19 that even in these areas where there's hubs, you're
20 still getting really big difficulties getting access
21 to these services.
22
23 So, yeah, everything is so centralized, as well,
24 in St. John's. Like, mostly it's in St. John's. So

1 it's really, like, if you're beyond the overpass
2 you're not getting the help that you deserve. And
3 for the fact that the community, for Newfoundlanders
4 and Labradorians, are all paying taxes, I think it's
5 sad that they have to travel out of their communities
6 to get help when they really should be in their
7 community because that's where their support network
8 is.
9
10 The deaf community, they've been speaking to us a
11 lot about their specific struggles. Not having an
12 ASL translator onsite is really difficult because
13 they have then, in the middle of an emergency they
14 have to go find an ASL individual, a translator, to
15 come with them. So there really needs to be an ASL
16 interpreter onsite at all times for this community
17 because they're feeling very, I guess, isolated from
18 it, would be a good way to describe it. So, sorry if
19 I'm talking too fast. So, yeah, you can start.
20 Mark Grouchy:
21 I want to make sure I understand this device first.
22 Meaghan Barnhill:
23 Press that.
24

1 Mark Grouchy:
2 That's the next one, eh? I'm no good with these.
3 I'm Mark Grouchy, I'm co-chair of the Community
4 Coalition for Mental Health with Meaghan and we have
5 been for, I guess, about a year, together. Is that
6 about right?
7 Meaghan Barnhill:
8 Yeah.
9 Mark Grouchy:
10 As she just said, we just had our first permanent
11 election, so we're on the current steering committee
12 and things are going to form up and continue and that
13 entity, the Coalition, is historically unprecedented
14 and will continue to exist. It will be a permanent
15 entity and it's important that it exists because
16 there has been an historical difficulty in
17 articulating on large scale, common-cause issues in
18 the mental health community to government and to the
19 House of Assembly when necessary in this province.
20
21 There are a lot of fractures in the mental health
22 community and we tend to lose sight of the big
23 picture issues, when we get drowned in a sea of
24 complexity that defines mental health issues. So,

1 that's why we're here and what I hope we can
2 contribute to all of this.
3
4 I'm also a defence attorney by trade. I work
5 pretty well exclusively in criminal law. I have been
6 in the penitentiary more times than I can count. I
7 have represented people with mental illnesses in the
8 penitentiary. I have represented people who have
9 developed mental illnesses because they're in the
10 penitentiary. I have been in the Waterford more
11 times than I can count. I have bipolar disorder. I
12 finished high school in a program that no longer
13 exists because it was slashed to pieces and
14 privatized that was between Eastern Health and the
15 College of the North Atlantic which gave me my first
16 deep exposure to the Waterford and what goes on in
17 there.
18
19 It's in my family as well. My dad had bi-polar
20 disorder and his brother and so on. All very
21 successful people but it runs very strongly with us.
22 I've seen this issue personally, professionally,
23 through every stage of my life and I'm doing my best
24 to work in it now.

1 I'll start by talking about the education slide we
2 have here. Over the course of the last six months
3 I've spoken at five or six major school events and
4 we're talking the entire auditorium filled. We had a
5 huge event organized by Patrick Hickey and others at
6 Holy Heart which brought all, virtually, all of the
7 high schools together in a gigantic mental health
8 summit. And what I would like the All-Party
9 Committee to understand is that at every event I was
10 told after the fact that there were factions of
11 adults involved who didn't want it to happen. The
12 kids were driving it forward because they want it to
13 happen and they were saying things like we want to be
14 the first generation to end stigma and they always
15 had a very supportive faction of adults backing them
16 up but there was always some static.
17
18 That underscores why we need more education in the
19 K-12 system in a very big way. I think it has
20 dramatically improved from when I was in high school
21 back in the late '90s, by the look of it, at least,
22 from what was happening at these presentations and so
23 forth, but we need a lot more.
24

1 I also know, we have a note there about education
2 for frontline workers. I know that with the police
3 force in this province, for example, is crying out
4 for as much educational support as they can possibly
5 get in this area. I have had personal contact with
6 people at all levels in the police forces in the
7 province and they really care about it and they
8 really want to do it right.
9
10 I'll say a few words about the Mobile Crisis Unit
11 which currently exists. This unit is being
12 conceptualized as the solution to the blunt
13 instrument represented by the *Mental Health Act* that
14 gets activated in police service calls to mental
15 health events. My read of the situation is the
16 police forces want that unit empowered and expanded
17 to be able to actually do something productive and
18 substantive to assist people with mental health
19 issues that they respond to. The current scenario is
20 that the crisis unit is only available some of the
21 time. It's essentially overwhelmed. It has been
22 expanded from its previous state but still needs
23 more. And further, it is being conceived as the
24 solution to the problems inherent in the *Mental*

1 *Health Act*. An actual way to diffuse crises far
2 beyond what can otherwise normally be done.
3
4 Her Majesty's Penitentiary is, in my view, beyond
5 failing to deal with mental illness. It is, I think,
6 creating mental illness. I believe I would
7 characterize it as an ongoing disaster that is
8 entirely likely to turn into a much bigger disaster
9 abruptly at some point in the future. We have a very
10 serious problem at the penitentiary and the problem
11 is, is that it is ancient and it is attempting to
12 deal with a changing category of offender who are
13 being produced by a very changed society and that is
14 a society that has gone from a more traditional
15 economic base of fishing and so forth, to an
16 oil-based economy which involves a lot of migratory
17 workers in a completely connected, for want of a
18 better term, information age-defined environment.
19 And what you're seeing happening at the penitentiary
20 now is new. It's new and the building is Victorian.
21 And the men and women who are working in the facility
22 want to do their best, and I believe that they're
23 having their own mental health problems as a result
24 of trying to operate under those conditions.

1 I can tell you what it's like to go to the
2 penitentiary as a defence attorney and all I will say
3 to you is that I will never forget the smell. There
4 is a very distinctive, beyond institutional, odour
5 when you walk into that place that is unique in my
6 experience, and I'm still not used to it, after going
7 there many, many times and I don't work there every
8 day.
9
10 There was a report in 2011 by Dr. Philip Klassen
11 which was produced by the government of the day under
12 Premier Dunderdale which was assessing the quality of
13 mental health care being delivered in the
14 penitentiary, and what was found in 2011 was that the
15 penitentiary met the minimum standards, essentially,
16 of care for psychiatric and mental health care in the
17 country. At the same time it found that, it found
18 that Dr. Craig, who is doing his best, admitted
19 unfamiliarity with the recovery model and wanted
20 help. He wanted assistance. The response at the
21 time, under premier Dunderdale, as I understand it
22 was, well, that's fine, we're adequate now. Okay.
23
24 So, subsequent to that report there has been, if

1 you've been following the news, four civil
2 disturbances in the penitentiary. Okay. There have
3 been four significant events which are being called
4 riots which have produced court cases. I don't think
5 you need to have a degree to understand that there's
6 a problem at the penitentiary right now and, of
7 course, we all know that the penitentiary is supposed
8 to have been replaced.
9
10 The reason I have to tell you this is that you
11 cannot disentangle the very, very serious traumas of
12 mental health from what is going on at the
13 penitentiary. You can't separate it. You got to
14 confront it. You got to deal with it. And my view
15 of it is that something has to be done sooner rather
16 than later to directly address the deficiencies in
17 that facility. I had to communicate that to you and
18 speak truth to power because I see it, a lot of
19 people see it, we all know it and the governments,
20 for the last 11 years know it. They want to replace
21 it. Everyone has wanted to deal with it and now we
22 find ourselves in a situation where economically the
23 wind has changed and we're being told we're going to
24 have to wait, but what you really need to appreciate

1 is that we can't wait much longer because that
2 facility is in dire straits, in my view.
3
4 I think there are some short-term measures that
5 could improve things but, obviously, at the end of
6 the day, long-term the problem has to be addressed in
7 a major way, we need a new facility.
8
9 It's not just about bricks and mortar and
10 buildings, it's about the fact that buildings
11 themselves start to carry an aura of desperation
12 which pervades the services that are provided within
13 and it's about the fact that buildings
14 institutionally have to be designed to actually
15 facilitate the delivery of modern programming. And
16 the pen, by no fault of its own, it's 156 years old.
17 It can't. We have very limited rehabilitative
18 capacity and it's completely incompatible with the
19 recovery model which I'll talk about in a moment.
20 And I'd also like to point out that according to
21 police report of crime statistics that I'm aware of,
22 I believe right now, we're the only province in the
23 country that reported rising armed robberies last
24 year. So, this goes to the issue associated with the

1 social disruption based on economic transition, all
2 right. The people who go into the penitentiary,
3 mental health concern or not, come out eventually and
4 we got to deal with it. It's got to be dealt with.
5
6 The Waterford is the other prong of the social
7 system which deals with mental health concerns and
8 trauma and so forth, next to the pen. I mean, we
9 always hear about prisons being the new asylums and
10 that is the truth. It is the truth. It's not that
11 mental illness leads to crime, it's that the forces
12 that generate mental illness and the forces that
13 generate crime are socially linked, okay. You can
14 look into it from a sociological perspective at any
15 time, but they're conceptually linked to changes and
16 disruptions in the society as they rise.
17
18 I think you talk to anybody at any of the health
19 authorities in this province right now, and you will
20 find that there is a dramatically increasing number
21 of intake calls for mental health issues. It's all
22 part of the same wrenching transition that
23 Newfoundland has been going through as a result of a
24 very major change in its economy, and in order to

1 offset the negative aspects of that major change in
2 economy you need to have appropriate, sharpened,
3 galvanized social tools to ease the transition.
4
5 The Waterford Hospital is not one of those tools.
6 It is 168 years old. It is one of the oldest
7 hospitals in North America.
8 Meaghan Barnhill:
9 It is the oldest hospital. Sorry.
10 Mark Grouchy:
11 Meaghan researched it.
12 Meaghan Barnhill:
13 It is the oldest hospital.
14 Mark Grouchy:
15 It's ancient. It's ancient and it is not a facility
16 which was ever, it was not conceived at a time when
17 the notion of what I'm going to refer to here as the
18 recovery model was even known of.
19
20 The recovery model, people often have difficulty
21 disentangling the issue of the building and the
22 bricks and mortars and the programs within. Think of
23 the recovery model as the aegis or the overlay, if
24 you will, that defines all the programming. The

1 recovery model says that a person has to be developed
2 to the maximum of their individual potential to
3 operate in society. That's all it says. I am a
4 product of the recovery model. That school that I
5 went to, run by Donna Kavanaugh and John Kelly at the
6 time, was the embodiment of the recovery model. What
7 do I mean? I mean that it helps people regain their
8 dignity and to reintegrate into society and to make
9 the most of who they are, "independent of whatever it
10 is they have wrong with them".
11
12 That could be mean somebody becomes a cook and it
13 can mean somebody becomes a defence attorney and the
14 co-chair of the Community Coalition for Mental
15 Health. The point is, it helps you become who you
16 can be. It's a development activity. Not simply a
17 treatment activity like a broken arm or what have
18 you. It's developing, essentially, talent that in an
19 education-like sense, and I'm saying to you that
20 those elements have to be integrated into mental
21 health wholesale because that's what happening all
22 over the western world right now.
23
24 This runs face and eyes into the fact that in

1 Newfoundland we have about five to five-and-a-half
2 percent of our health care budget being proportioned
3 to mental health. I believe the majority of the
4 country is now at seven to eight percent. I don't
5 know why we're lagging at five to five-and-a-half
6 percent. And the Mental Health Commission of Canada,
7 which is the authority on this issue, says which we
8 should be at ten percent. Places like New Zealand
9 already are at ten percent.
10
11 So, when we talk about the deficiencies in the
12 system, we have to realize that when the problem
13 raises in terms of the magnitude of issue it
14 represents, you have to raise the proportion of
15 spending within the system to address it.
16
17 At the end of the day I'm very concerned that if
18 we keep trying to solve these problems in a
19 piecemeal, patchwork, quilt fashion, which is what
20 we've been doing for 200 years with mental health in
21 this province. I published an article in the
22 Independent, I'm a columnist, some time ago, which
23 talked about how back at the very commencement of the
24 168-year life of the Waterford, people who were

1 patients were actually used to dig the ditch to bring
2 the water supply to the building because nobody else
3 would pay for it.
4 So, we're at a point now, I think, where we have
5 to start realizing that it is a governmental and a
6 democratic responsibility to ensure that we have fit
7 and modern standards for health care. It got to be
8 dealt with and it got to be dealt with quick and it
9 got to be dealt with fast, because this facility
10 can't convert itself to work within the recovery
11 model. If you want to see what the recovery model
12 looks like, go YouTube to Tuckamore Centre in
13 Paradise right now, for youth, with mental health
14 concerns. It is a different planet than what is
15 happening in the Waterford.
16
17 I have many contacts inside the Waterford who have
18 worked at facilities in the mainland that are more
19 modern than that. They've actually darkly described
20 it as a different planet. Just the structure itself.
21 I mean, I even hear concerns raised about lines of
22 sight within the building for purposes of safety,
23 things like this. So, all of that functionality
24 issue is popping up and then it represents a huge

1 stigma, a massive stigma. It has such a pall over it
2 that it is driving people away from it. People don't
3 want to be there. Even within the mental health
4 community, people who have active concerns, the
5 preference is to go to the Health Sciences, if you
6 can at all avoid the Waterford. It's the last place
7 you want to end up and it's wrong that the primary
8 mental health care facility in Newfoundland and
9 Labrador is being regarded this way, when there is
10 such great work being done both on the mainland and
11 in other countries. We know that the Waterford was
12 supposed to be replaced and it was supposed to
13 incorporate an erosion of the barrier between the
14 public and the community and we need to confront
15 another reality.
16
17 I was interviewed about this and I was explaining
18 the recovery model to folks in the purpose of the
19 interview there and I was asked upon explaining it,
20 well, will there be facilities for people who are
21 more seriously mentally ill. And what I'm here to
22 tell you is the recovery model works for everybody.
23 I don't care how serious your mental illness is. We
24 can't even, we've got to get past that. We need to

1 start looking at the circumstances in which people
2 live and operate, and we need to maximally develop
3 them to their potential and we're not doing it. Even
4 though there's lots of professionals of all
5 generations, in particular the young ones, who
6 really, really want to and even though the culture
7 has changed at that point. We have to stop doing
8 that. We have to stop allowing a state of affairs to
9 exist in this province whereby people are being
10 driven away from the mental health system.
11
12 It goes, of course, beyond the Waterford,
13 generally. We have problems, as we've heard from
14 Meaghan and others all over the province with respect
15 to access. We have problems with respect to
16 accessibility in the deaf community, as Meaghan just
17 mentioned. I grew up as a resident of Paradise and
18 in the late '90s it felt at the time that accessing
19 an appropriate mental health service was,
20 essentially, a survival-of-the-fittest scenario. It
21 seemed to me that your likelihood to access
22 appropriate mental health services was directly
23 linked to the ability of your parents to both have
24 enough patience to not want to throw you out into the

1 street, as well as their ability to work at advanced
2 levels in the English language. So, essentially, I
3 was lucky, because my parents were government
4 employees who actually had the mental health of their
5 own and wherewithal to care about me, despite the
6 fact I was being an unholy terror and they fought for
7 me, to get me into a program that I was not told
8 existed even by my doctors. That's how fractured the
9 system is, okay.
10
11 I learned about the program that saved my life as
12 a result of the drama club that operated out of the
13 basement of the program. That's how fractured is.
14 They did a thing called “Picasso's Mirror”, very
15 popular and famous at the time, back in the '90s. It
16 was going around to high schools and so forth.
17 That's how fractured it is. This goes back to 211
18 that Megan was talking about and the ability for
19 people to access services and know what is there and
20 how to get into it and how to get at it.
21
22 I was saying for many years, we didn't need to see
23 the dramatic slashing of the school that saved my and
24 countless other lives. We needed to see the

1 expansion of that school-type program to other parts
2 of the province, to rural communities, to places like
3 Carbonear and so forth where young people were having
4 similar problems. You need to appreciate that in
5 this school there were people who were trying to
6 finish their high school who were 30 years old who
7 hadn't left their bedroom for eight or nine years,
8 who were just as intelligent and as capable as I am
9 but essentially had a very extended version of what I
10 had gone through. There are people like that all
11 over the province, and how easy is it to salvage them
12 to develop them and to save them by simply deploying
13 a teacher or two with specialized knowledge into a
14 one-room schoolhouse, essentially? Why is this so
15 complicated? I don't understand why but I do
16 understand that the program that saved my life was
17 privatized and slashed, and I do understand that the
18 continuity was lost and I do understand that it is
19 not being deployed all over the province right now.
20 And at the same time that it isn't, we're not,
21 apparently, getting a new psychiatric facility for
22 five to ten years and we have all these problems at
23 the penitentiary. And it is very concerning and I
24 have to admit, frustrating, to me to be experiencing

1 this.

2

3 What, I think, the All-Party Committee needs to
4 appreciate is we have reached a watershed moment in
5 mental health in Newfoundland and Labrador, and in
6 the broader, I guess, western culture and in Canada
7 where the average Joe and Jane in the street is not
8 going to put up with this anymore. This is affecting
9 everybody - relatives, children, brothers, everybody.
10 There's absolutely not anyone in our society who
11 isn't affected by this in some way. So it has to be
12 the number one catchup issue in health care because
13 we have a lot of catching up to do to get to a point
14 where we're even on par with our neighbours in Nova
15 Scotia. They already have 211 in Nova Scotia. This
16 is a province that's supposedly not doing as well as
17 we are economically, even now. They have 211
18 already.

19

20 So, one of the things that I'd like to point out
21 is that I think that perhaps what has been happening
22 in mental health in Newfoundland and Labrador is
23 because things were so terrible once, in Newfoundland
24 and have now, apparently, improved dramatically,

1 we're only starting to wake up to the fact that we're
2 still lagging behind Nova Scotia.
3
4 I had an experience with peers of mine down in
5 Manitoba recently, and my government working friend
6 had to explain to her mate, well, yes, well, mental
7 health is still a major issue in Newfoundland.
8 They're still dealing with things. That's how she
9 sees it. So, at this point we really need to take
10 the bull by the horns here and do something about
11 exactly where this is and what needs to be done. We
12 have to realize this is not a charity issue. This is
13 not a novel issue, it's not complicated either. It's
14 an issue which falls squarely within the jurisdiction
15 of the provincial government and it will be, whoever
16 is the government will ultimately be held accountable
17 for failing to deal with it, because Newfoundlanders
18 are not going to put up with it anymore.
19
20 And it's sad but I had to say it that way. I want
21 to see as many creative solutions to make this work
22 as good as I can as this unfolds but we really got to
23 face the fact that we've been dealing with 200 years
24 of creative solutions and we now have resources. We

1 have money, we have oil, we have the ability to
2 dramatically improve this system simply by increasing
3 the proportion of funding to the rest of the
4 country's standards. Just two percent would be a
5 world of difference. And at that, Meaghan do you
6 have anything?
7 Meaghan Barnhill:
8 I have two more things I was going to say. One of
9 them was that, I believe it's Norway, they built
10 their entire huge mental health system when oil was
11 less than five dollars a barrel. So if they can do
12 it, we can do it, for sure.
13
14 And the other thing I was going to say, one of the
15 major key things that I think is missing from almost
16 everything in the health care system is that there is
17 nothing really put in place to help people connect in
18 the community when you go back. So, when you take
19 somebody out of whatever situation they are in and
20 you try to give them the services that they need and
21 help them with their recovery, what often happens is
22 you put them back in and they're in the exact same
23 situation as before and then they relapse. So, it's
24 really important that they are making connections out

1 in the community so that when they finish their
2 recovery in the hospital or in the program that
3 they're in, they can take those tools and still apply
4 it to outside in their regular life, so, yeah.
5 Questions?
6 Mark Grouchy:
7 If I could just add one last thing. Just to be super
8 clear, I mean you can distill a lot of what we've
9 been saying and what I was just saying into, I think,
10 that the minimum standard here that people are going
11 to tolerate here is ongoing substantial movement
12 toward parity with the rest of Canada. I mean, it's
13 completely wrong to conceptualize that this is a
14 money pit that requires an inordinate amount of
15 unreasonable funds being thrown at it. I'm just
16 talking about having the same standards as the rest
17 of the people who share my citizenship. So, that's
18 it.
19 Honourable Felix Collins:
20 Okay. Well, thank you very much. I'm sure the Panel
21 may have some questions but I just have one. We
22 certainly share your observation with regard to the
23 Waterford and the Penitentiary, I mean, that goes
24 without saying. We've heard it many times and we're

1 aware of it and I don't think there's anybody going
2 to change it. I want to go back to something, I
3 think it was Meaghan had said in one of your slides,
4 the need for more training for frontline workers and
5 you mentioned GPs.
6 Meaghan Barnhill:
7 Yeah.
8 Honourable Felix Collins:
9 We've met with family physicians and they tell us
10 that the majority of diagnosis, assessment and
11 treatment can be done by the GP and it can cut down
12 the necessity of referrals to psychiatrists and so
13 on. I got from you a little bit of a different
14 picture, that, basically, GPs work with a number of
15 businesses paid by MCP and so on that could have been
16 avoided. And can you expound on that a little
17 further?
18 Meaghan Barnhill:
19 Right. So, what I was trying to explain was that GPs
20 who are currently going through the system of
21 education and trying to become GPs have three days of
22 training. So if we were to give them better training
23 they would be able to recognize the signs faster, so
24 they would be able to refer to where they need to and

1 the people who don't need to refer, they could do the
2 in-house counselling that needs to be done with them.
3 Honourable Felix Collins:
4 Okay, so you're talking about the current medical
5 crowd coming through?
6 Meaghan Barnhill:
7 Yeah. Sorry, I was trying to speed through that
8 part.
9 Honourable Felix Collins:
10 Because I spoke to my GP about a month ago and I said
11 whatever situation, my son is graduating next year as
12 a medical doctor.
13 Meaghan Barnhill:
14 Congratulations.
15 Honourable Felix Collins:
16 And I talked to my own family physician about it and
17 he said make sure he does a good concentration in
18 psychiatry. And I know he's doing a rotation, as a
19 matter of fact, as we speak. Is there recognition on
20 the part of psychiatrists, Mark, to recognize and
21 appreciate the role of the MD? Do you see any kind
22 of a conflict there?
23 Mark Grouchy:
24 No, I would expect that they would appreciate the

1 fact the GPs are essentially the first responders for
2 complex cases for sure. I would expect that they
3 would concur with that because that's obviously the
4 way it's going to be. I mean, that's the way it was
5 in my own case. I mean, generally you're going to go
6 to your family doctor first and if it's sufficiently
7 complex in their view or persistent, that's when you
8 find yourself in the presence of a psychiatrist,
9 right.
10 Honourable Felix Collins:
11 That's the second time we've heard the very minimal
12 amount of training for psychiatry for medical a
13 student. That's quite astounding really.
14 Meaghan Barnhill:
15 One thing as well, with that is that oftentimes what
16 you're seeing is that, I guess it's like, for me
17 personally, like, I went to see, like, six different
18 GPs before I found one that actually believed me that
19 I had depression, and I was diagnosed with depression
20 over like, what, I was in Grade two when I was
21 diagnosed with severe depression and none of them
22 would recognize it. And I was here in this province
23 for seven years before I got anybody who was going to
24 help me.

1 So, I mean, those GPs clearly didn't know enough
2 about mental health. The one that I have now, the
3 only reason why she knows about mental health is
4 she's going through it herself. So I happened to
5 stumble into the right doctor's office to get help.
6 It shouldn't be a gambling thing where it's like you
7 stumble in and just happen to find the magical doctor
8 who's going to wave her wand and give you that
9 referral that you need, so.
10 Christopher Mitchelmore:
11 The Canadian Mental Health Association, I guess, in
12 the presentation earlier raised very similar issues
13 around the Waterford, around the penitentiary around
14 supportive services and things like that. I guess
15 they're working with your organization or how you all
16 become partners, I guess, will unfold or is part of
17 the process. But one of the things that came across
18 is the 211. I think it's the first time that I've
19 sat in any presentation that 211 has been mentioned
20 as a request for service. So you mentioned Nova
21 Scotia has it. Do all other provinces and
22 territories have such service and do you have any
23 idea of what a such a service would cost?
24

1 Unidentified Female:
2 Is Krista here?
3 Gerry Rogers:
4 Yeah, we actually --
5 Unidentified Female:
6 There's only three right now that don't have it. And
7 it did come up at another presentation.
8 Honourable Felix Collins:
9 It did. It did.
10 Gerry Rogers:
11 Christopher, we actually had a full half-hour
12 presentation exclusively on 211.
13 Meaghan Barnhill:
14 I was going to say, if Krista was here you should
15 definitely chat with her because she's got every
16 answer that you ever need to know about 211.
17 Gerry Rogers:
18 And we had a full, full presentation on it.
19 Honourable Felix Collins:
20 We had a presentation on it.
21 Mark Grouchy:
22 If I could just explain, as you'd asked some
23 questions about the interrelationship, for instance,
24 between the CMHA and the Coalition. The Coalition

1 has 30 groups in it, right. So, for instance, I, and
2 I just actually ceased to be President of the CMHA
3 but I'm the longest-standing CMHA president in the
4 organization's history. I've been with them for
5 almost ten years. Right now on our steering
6 committee, I believe there are four or five members
7 of the CMHA of the 20 group, 20 people there but
8 there's a lot of other groups too.
9
10 So, one of the purposes behind the Coalition was
11 to gather the relevant information to be able to take
12 the pulse of where everybody's head was at on these
13 issues, and we're trying to hone it down. When it
14 comes to things like 211 and so forth, I think it's
15 important that any government that grapples with
16 these issues appreciates that it is very easy to go
17 down the rabbit hole of fragmentation and complexity
18 when asking questions about this issue. You really
19 have to look for the big picture and focus because,
20 otherwise, you're going to hear from a million
21 different silos and we're trying to overcome the silo
22 effect with the Coalition and other organizations are
23 doing it, too. But the silos exist because of
24 deficiencies in service of past. People just

1 scrambling to hold it together as it shakes apart.
2 It's quite tragic, I think, and people have done some
3 amazing humanitarian work, and are doing it, as we
4 saw earlier in the presentations here about U-Turn
5 and so forth. That's just the nature of mental
6 health advocacy and service provision in Newfoundland
7 and Labrador. A lot of that is going on. So in
8 trying to piece it all together, you've got to keep
9 that history and that landscape in mind, I think.
10 Honourable Felix Collins:
11 Good point.
12 Gerry Rogers:
13 And it's going to be awhile before we see, no matter
14 if we even started today it's going to be awhile
15 before we see the doors open on a new Waterford or a
16 new HMP. And Mark, you had said something -- and
17 also, thank you for this presentation. Thanks so
18 much. But you had said that there are some interim
19 things that we can do and I keep asking that
20 question.
21 Mark Grouchy:
22 Yes.
23 Gerry Rogers:
24 What can we do?

1 Mark Grouchy:
2 The penitentiary is easy. I think you could
3 immediately substantially expand mental health
4 service provision in the penitentiary with minimal
5 effort. Frankly, you could put in two or three, at
6 least two other psychiatrists. You could increase
7 the psychologists and so on. You could, likely, make
8 more sustained efforts to get people off the unit to
9 relieve tension from time to time. But, really,
10 right now, it's pretty bare bones down there. So I
11 think you would see a very substantial change and I
12 think that we need even more. I mean, Ron
13 Fitzpatrick is down there with Turnings. He needs as
14 much help as he can get. He's already there. The
15 CMHA has a justice project. We do case worker work
16 in there with people. We're already there. You can
17 enhance all of this preexisting infrastructure by
18 simply adding to it a little and I think it would
19 have a meaningful impact on what's happening at the
20 pen.
21 Gerry Rogers:
22 And if we did housing and other kind of wrap-around
23 supportive services, we might keep more people out of
24 there which would be a help.

1 Mark Grouchy:
2 Oh yeah.
3 Gerry Rogers:
4 And what about the Waterford, is there anything that
5 can be done? Like, I also think of other spaces,
6 other, like, supportive housing again, getting people
7 out of there. Getting some of the services out of
8 those horrible buildings.
9 Mark Grouchy:
10 Right.
11 Meaghan Barnhill:
12 I would just say, one of the, I know that at one of
13 the last presentations I ran up and gave you guys a
14 number to call, but I really think that the work
15 that's being done in Corner Brook at the Acute Crisis
16 Unit is something that we need to take exactly as it
17 is and bring it here. Don't put it in the Waterford
18 because in the Waterford it's too constrained in
19 there. Find another location you can put it in and
20 make it exactly the same, because what they are doing
21 there is working and what they are doing there is
22 helping about the same amount of people that the
23 Waterford helps, and they've only been at it for a
24 year and have had more successful stories come out of

1 that place that I've heard of than I've heard of here
2 at the Waterford. And, on top of that they're doing
3 it and they're totally understaffed.
4 So, give them staff, create exactly what they've
5 got there and bring it here because that's working
6 and it's giving people the tools that they need to
7 overcome the hardest time of their life. I said
8 earlier today, to someone, it's basically you're
9 building the community that's going to support and
10 carry you out of your crisis because they get what
11 the recovery model is, they get what you need to be
12 doing and they've got the resources there that are
13 easily copied to be brought over here.
14 Honourable Felix Collins:
15 Just talk about that for a minute, the Acute Crisis
16 Centre in Corner Brook.
17 Meaghan Barnhill:
18 I won't be able to talk about it for a minute, I'll
19 be able to talk about it for five hours. (Laughs).
20 Honourable Felix Collins:
21 You don't have five hours.
22 Megan Barnhill:
23 It's awesome. Okay, so you want me to talk about --
24

1 Honourable Felix Collins:
2 Before I ask you to do that. Bruce, do we have time
3 to do that?
4 Dr. Bruce Gilbert:
5 Well, yes, but you're leading into your break. So I
6 think you're perfectly okay.
7 Honourable Felix Collins:
8 Okay, if he waves a big stick at you then you got to
9 ....
10 Meaghan Barnhill:
11 Okay, cool, sounds good. Okay, sorry, repeat your
12 question?
13 Gerry Rogers:
14 Tell him what the program is.
15 Meaghan Barnhill:
16 What the program is?
17 Honourable Felix Collins:
18 Yes.
19 Meaghan Barnhill:
20 Okay, the program is incredible, I think at least.
21 And I had Colleen, Mrs. Simms, wherever she is.
22 Honourable Felix Collins:
23 Colleen Simms, she's here somewhere. She's down in
24 the back here.

1 Meaghan Barnhill:
2 Candace was at our group when I was talking about
3 this earlier, so this might be a repeat for her, but.
4 Basically, what happens is you come in, they do three
5 days of assessments with you to figure out exactly
6 where you're at and then you sit down and you get
7 control over your recovery model, what you're going
8 to do to reach recovery. And the mental health
9 workers are there to support you on your journey.
10 They're not there to dictate to you how you're going
11 to reach recovery and it's a completely different
12 approach from what happens at the Waterford where you
13 go in and they tell you what's wrong with you and
14 they try to fix you. Whereas, this, you get to say,
15 no, I think this is actually what's stressing me out
16 the most. I want to work on this. And so they take
17 that and they give you, if it's depression, if it's
18 anxiety, if it's PTSD, if it's bipolar they've got
19 everything for every type of mental health label that
20 you could possibly have and they will work with you.
21 There's programs in the mornings and in the
22 afternoons Monday to Friday. The space itself is
23 lively. I went in there and I met with some of the
24 people who were in the psych unit, just when I was

1 walking through and none of them told me that they
2 were in a place they didn't want to be. They all
3 told me it was amazing. They felt like they were
4 actually getting help. There was hope there and to
5 the point, like, one of these people told me that
6 they had come into the unit a week ago and was ready
7 to kill themselves and had to be brought in by
8 somebody else, and they had found what they needed.
9 In a week they were already starting to build the
10 tools that they needed to turn around and to walk
11 away from that dark place that they were in. And
12 that's really what we need because it's literally
13 grabbing people when they're on break, on the edge of
14 breaking and pulling them back. And I mean, in a
15 province where we have one suicide a week, on
16 average, we need that everywhere. We cannot afford
17 not to have that there.
18 Honourable Felix Collins:
19 Do they have a set staff for that unit?
20 Meaghan Barnhill:
21 They've got like, I don't have the right notebook but
22 it's like they said they needed, it's like they're
23 working with four staff, I think, and they've helped
24 over 600 people. You've got to be careful they don't

1 burn out because that's scary that they are, because
2 they're doing incredible work and they really, they
3 need more supports. We need to bring that service
4 here. They're fantastic and the woman who created
5 that, like, you guys should give her an award or
6 something, like she's awesome.
7 Mark Grouchy:
8 If I could just add one thing very briefly to that,
9 and I fully support everything Meaghan is saying.
10 What you will find, I think, is going to be a very
11 common answer to Gerry's question about what can we
12 do now that the Waterford is not being replaced, is
13 you're going to hear a lot of people talk about,
14 well, there's this thing that isn't the Waterford
15 that we could do more of outside of the Waterford.
16 And it seems inevitable that people start talking
17 about programming and options that are independent of
18 that hospital, okay, and it underscores why that
19 hospital needs to be replaced.
20
21 The issue, basically, is this, though, and I've
22 been saying this at various talks that I've given and
23 I really feel morally obligated to say it because
24 Gerry had made a very logical comment about getting

1 more people out of the facility. That, of course, is
2 the very philosophy that emerged in the
3 institutionalization period which started the closing
4 process of the Waterford in 1971, because the
5 building has been closing since 1971.
6
7 The thing that we cannot lose sight of is that
8 there are still people in the Waterford in
9 therapeutic quiet today. There are still people who
10 are that ill who are being literally held in
11 cell-like structures who don't have a lot of hope
12 today. And I know that, yes, mental health has
13 exploded as an issue of social relevance and we're
14 seeing a very broad gamut of concerns and conditions
15 arise, but we, please, cannot lose sight of the fact
16 that there are still some very, very, very ill people
17 who have to call that place functionally their home
18 and they need a fit place to live and, hopefully,
19 transit out of.
20
21 It's easy. This is part of the danger of about
22 going down the rabbit hole of complexity that I
23 mentioned, but we can't lose sight of the fact that
24 that is one of the faces of mental illness. There

1 are people with conditions like severe schizophrenia,
2 even forms of dementia and so on that find themselves
3 in the Waterford right. So I just wanted to
4 underscore that, too.
5 Meaghan Barnhill:
6 And one last thing I'll add is one thing that I
7 always say this and I feel like I'm always repeating
8 myself on this, when you go into the Emergency room
9 for the Waterford, it looks like a bunch of holding
10 cells.
11 Gerry Rogers:
12 It does.
13 Meaghan Barnhill:
14 When I was in my crisis you could not drag me in
15 there. I would have gouged your eyes out before I
16 let you bring me into the Waterford because I was not
17 going to a place where I felt I had done something
18 wrong to get help, so.
19 Honourable Felix Collins:
20 Well, listen, thanks so much, Mark and Megan, for
21 coming in. We enjoyed the presentation, very
22 informative and I'm sure it will form an integral
23 part of our deliberations at the end of the day.
24 Thanks again for coming.

1 Dr. Bruce Gilbert:
2 Okay, I think we're in a position to take a short
3 2.35-minute break. So, maybe the Panel would like to
4 get a cup of tea or something like that and we'll
5 prepare our next presenter.
6 **(Off the Record)**
7 Dr. Bruce Gilbert:
8 Okay, we're going to start now. I'd like to invite
9 to the stage our last presenter for today. That's
10 Tracy Duffy, and Tracy is representing the Canadian
11 Counselling and Psychotherapists Association.
12 Gerry Rogers:
13 Oh great.
14 Dr. Bruce Gilbert:
15 So, Tracy, you have 30 minutes. I will give you a
16 ten- and a five-minute warning so you'll know where
17 you are. Okay, take it away.
18 Tracy Duffy:
19 All right. I'm also not good with the clicker, as
20 Mark said earlier. Thanks so much for this
21 opportunity. I'm glad I got in under the wire, so to
22 speak, last but not least maybe. I've laid some
23 handouts there for you so you've each got one of the
24 Power Points.

1 Gerry Rogers:
2 Oh, great.
3 Tracy Duffy:
4 And some little glossy inserts. I laid it up here,
5 Felix, Mr. Collins.
6 Gerry Rogers:
7 And Tracy, before you start, can you just tell us the
8 difference between you and Angie Wilmott's crowd?
9 Tracy Duffy:
10 Absolutely.
11 Gerry Rogers:
12 Great, thanks.
13 Tracy Duffy:
14 That's the first step. So, basically, Canadian
15 Counselling Psychotherapy Association is an umbrella
16 group for the NL Counsellors and Psychologists which
17 is the school counsellors.
18 Gerry Rogers:
19 Yes.
20 Tracy Duffy:
21 So, a lot of our memberships, in the province
22 certainly, but across Canada, are affiliated with
23 school counselling because we've done the same
24 educational programs, or many of the same. So,

1 myself, I did the Masters in Counselling Psych, so I
2 could have been a school counsellor.
3
4 I'll tell you a bit about me, I guess. I actually
5 work, currently I work with the Department of
6 Justice, the Division of Family Justice Services as a
7 counsellor and I also do private practice part-time.
8 So I am a Canadian certified counsellor and I've been
9 in the field, I've been an active member of CCPA for
10 11 years now, actually. So, basically, we've been
11 around a long time. We just celebrated 50 years,
12 actually, in May. We had our Niagara Falls 50-year
13 conference which was amazing to know that I'm with an
14 association that's got over 5200 members in all sorts
15 of remote and populated regions, of course. We have
16 a very, very diverse group of membership. Here in
17 the province we've got about 170. I would estimate
18 that at least 80 of those are what we would call
19 Canadian certified counsellors and I'll explain a bit
20 more about that. Some of our members would cross
21 over and also have conjoined membership with the
22 NLCPA, which is the school counsellors.
23 Gerry Rogers:
24 Sorry, just hang on a second. We've got a little bit

1 of competition there. Okay, great. Thanks.
2 Tracy Duffy:
3 No, problem. So, many of our members might also have
4 cross memberships. We have several who would be
5 psychologists as well. We have pastoral counsellors,
6 marital/family therapists, art therapists. We also
7 have a fair number who work in various community
8 agencies such as Thrive, Murphy Centre, career
9 practitioners. We have a lot of behaviour management
10 specialists. So that's kind of the cross-section of
11 who our members would be, just to give you some
12 context.
13
14 Okay. I'll keep it as short and simple for the
15 end of the day. We, basically, we collaborate with
16 various agencies on different levels, nationally and
17 provincially. Again, we certainly work with a lot of
18 the community agencies such as the Murphy Centre. We
19 help do career planning and career assessments. We
20 also work with Janeway Family Centre. We
21 co-facilitate groups, some of our members do. We
22 collaborate nationally as well. We're involved in
23 CAMH, which you may have heard of, Canadian Alliance
24 of Mental Health. We're an active member of the

1 Health Action Lobby Group, HEAL. We're actually
2 partnering with the Canadian Psychological
3 Association next March to do a joint conference.
4 Last year, we were involved with the International
5 Counselling Association. So, we have a lot of very
6 big partnerships nationally.
7
8 We're also involved provincially. There are quite
9 a few of us who work in private practice as
10 counsellors so, of course, we're affiliated with a
11 lot of the employee assistance groups. We have a lot
12 of contract work as well. So, we essentially, we
13 promote anything that supports providing accessible
14 and appropriate mental health services. We're very
15 involved on different levels in helping address this
16 shortage in mental health, and my main purpose today
17 is to bring some awareness because I think that most
18 of the time because there are so many professionals
19 out there, we're not necessarily understood to be one
20 of the key associations where our members lie, so
21 that's my main goal.
22
23 So, essentially, we do advocate for Pan-Canadian
24 groups. We have a deft (phonetic) defined and

1 nationally validated scope of practice for our
2 counsellors. We've had three years' worth of
3 national symposiums where we defined our scope of
4 practice. Right now, we have multiple titles across
5 Canada. So we may have counsellors, we may have
6 certified counsellors, registered psychotherapists.
7 In Nova Scotia they're called registered counselling
8 therapists. So, it's a very broad group, just to
9 give you a snapshot. Some of the initiatives of
10 CCPA, and you'll see some of these in the glossy
11 leaflet that I gave you, we have developed a national
12 competency assessment which is, if you have heard of
13 the EPPP, which is the exam psychologists use. It
14 can be somewhat equated to that. So, we have
15 universities and colleges throughout Canada who are
16 interested in looking more at using this for when
17 their colleges are taking on counselling therapists,
18 whatever their title may be. So, that's one very big
19 accomplishment that we've done.
20
21 We have actually created and piloted for two years
22 now clinical supervision online program out of the
23 University of Ottawa. So, we've had, I believe, I'm
24 not positive, but at least 25 graduates who are now

1 gaining the designation of Certified Clinical
2 Supervisor, which is a key because in all different
3 parts of Canada there's a huge shortage in
4 supervision for clinical therapists. So, those same
5 clinicians would be qualified to supervise other
6 professions as well. It's an overarching program.
7 They've developed a textbook, a handbook where,
8 actually, they're coming here for the first time.
9 We're doing a workshop with several different
10 professions on supervision.
11 Gerry Rogers:
12 Oh, great.
13 Tracy Duffy:
14 So, those who go out into the field and are learning
15 to become counsellors, they will now have first level
16 introduction of how to supervise in counselling. So,
17 that's because of the partnership with CCPA, the
18 university counselling program and NLCPA and, also,
19 of course, the Department of Education, lots of
20 supporters there. And of course, the big initiative
21 that CCPA helps members achieve is regulation. We're
22 not regulated yet in this province which is something
23 we're definitely working towards but just in the last
24 three or four years we now have Ontario, Quebec and

1 Nova Scotia who are fully regulated as counselling
2 professionals. They have different titles but,
3 essentially, they have the full provincial
4 regulation. PEI is actively working. They've got
5 their legislation, I believe, passed. And of course,
6 in Newfoundland Labrador we're looking at that.
7 I've met with Ms. Simms, talked a bit about
8 regulation and how we can work on that.
9
10 But CCPA essentially supports any province that's
11 seeking regulation by providing the resources. We
12 have our national scope of practice and standards.
13 We have immense amount of support from the members.
14 We actually have a legislative support fund for
15 members who are seeking regulation. So, if there are
16 legal fees and stuff associated down the road, we
17 definitely put money in to that so that when the time
18 comes we can support them. So, that's regulation.
19
20 And just a bit more about the certification title.
21 This is the colleagues, the professional counsellors
22 who have achieved this national standard and they do
23 work under a defined scope of practice. We have a
24 Code of Ethics that's been nationally used and

1 modelled. The courses that you do in the counselling
2 psychology program will incorporate our Code of
3 Ethics as well as the Canadian Psychological
4 Association. So, it's a very well-known Code of
5 Ethics and standards. And, of course, we have an
6 ethical complaints procedure, so our members can go
7 through the ethics committee and figure out if there
8 are any issues when they're seeing clients, that they
9 can make inquiries. And also, if a client wanted to
10 make a formal complaint, it would go through our
11 process. We have all of that even though we're not
12 yet regulated. So there's a lot of things in place
13 that are already step-by-step. And this is what
14 they've done to support other provinces in
15 regulation, is that they've created many of these
16 templates and models that are able to be used.
17
18 We also have a directory, of course, for clients.
19 We've just, two days ago, relaunched our new website.
20 So the “Talking Can Help” website which is listed
21 there, is also being revised. So, if you have a few
22 glitches, if you go on that website it will be
23 remedied very quickly. Literally, it's within two
24 days that we've revised. So, it's a lot more

1 user-friendly now, the websites, but clientele and
2 colleagues can find who are certified throughout
3 Canada.
4
5 So, I guess key messages from today, one of the
6 big things we were hoping to bring awareness to is
7 the fact that we do have this association. We do
8 have, well, like I said, over 100 members in the
9 province, including rural areas, who could help with
10 the mental health shortage. We're well aware, myself
11 and many members have attended the forums and launch
12 of your CCM 4 H.
13 Gerry Rogers:
14 CC4MH, yeah.
15 Tracy Duffy:
16 But a lot of the awareness campaigns that are
17 happening, we've been around, we know what's been
18 happening and, really, it's just to bring awareness
19 that there's this other whole body of professionals
20 who may or may not be known, to help with this
21 shortage. One of the examples I can give you is how
22 we are working in private practice, we work in
23 government but there are not a lot of us who work as
24 mental health clinicians in health care. So, one of

1 the key things that we're looking to investigate or
2 looking to address is that if we can help improve
3 access to mental health, then maybe to revisit our
4 qualifications as certified counsellors.
5
6 We do work as behavioural specialist therapists.
7 We work as career counsellors. We do work with a lot
8 of these agencies and government mental health
9 workers and we know, also, and I think Mark said it,
10 looking at the shortage in clinical services, also
11 means that the staff are overwhelmed. We don't have
12 enough mental health workers. So instead of looking
13 at, okay, how can we pump more money into it, we know
14 there's a shortage in funds. Health care is the
15 largest budget, probably, in Canada for us, but I
16 think looking at how do we move it around. So,
17 that's something that we're asking to kind of revisit
18 is the qualifications that certified counsellors
19 bring and is there a way to either shift where we
20 work so that we can work more in direct mental
21 health, or if there's a way to work side-by-side with
22 those who are already doing it.
23
24 I do know government, I work for government. I

1 know part of the process now is this job evaluation
2 system. So, timing-wise might be good to look at
3 qualifications of certified counsellors, and if they
4 are able to work in mental health, because I think
5 the job ads that come out, most of the graduates who
6 come out of our program go outside of the Avalon to
7 do their work placements. I know of several students
8 who work in Central Health and Western Health as
9 mental health clinicians, but once they get on the
10 Avalon they're not eligible for employment. So, it's
11 something to certainly look at that could be very
12 cost-effective for government, especially given the
13 shortage. I heard the Psychology Association
14 speaking. Those vacancies are not easy to fill but
15 there's another whole group of professionals who are
16 qualified to do part of the work. We're very keen on
17 each person on the team has a job. So, it's not to
18 replace social work or psychology but it's to augment
19 it. So, we do very specific work as well. And the
20 majority of us, there are a good few clinical, sorry,
21 Canadian Certified Counsellors who are starting
22 private practice.
23
24 So, I'll give you an example as far as access to

1 mental health. If a child of yours or someone you
2 knew was seeking mental health services anywhere
3 under the age of 18, we know the wait lists, we know
4 the shortages, but Canadian Certified counsellors,
5 working in private practice - I know, I'm one of them
6 - I could see a child within two weeks on my evening
7 working part-time, but because we're not regulated
8 it's only five and six sessions or you pay privately.
9 So, the clients who would need to pay privately to
10 get seen within those few months that they're
11 waiting, they would have to come up with roughly $90
12 an hour to get seen. And it's a crisis. When your
13 children are in crisis you want them seen.
14
15 Many people come to us through Employee Assistance
16 Programs but, essentially, there's a gap there that
17 we certainly do fill already but if we can fill it in
18 other agencies as well, it would certainly help.
19 Honourable Felix Collins:
20 I don't want to, I hate to interrupt you.
21 Tracy Duffy:
22 Go ahead.
23 Honourable Felix Collins:
24 So, by being regulated, what's required for you to be

1 regulated? Are you a self-regulating agency now or?
2 Tracy Duffy:
3 No. Well, actually, we have met, there is a
4 Regulatory consultant with the Health Department. We
5 are looking at fitting under the *Health Professions*
6 *Act,* and we have discussed this with Ms. Simms. We
7 are actively now seeking, just to see if government
8 can support us either with information or resources
9 or just support for the cause of regulation. It's a
10 long endeavour but we're just starting looking at
11 that same umbrella legislation and we believe we
12 would fit. We have a committee of about 12 people
13 right now and we're looking at interprofessional
14 teams. So, it's not just CCPA members, we've
15 actually now gathered more diverse counsellors. So,
16 we have some pastoral counsellors, marital family
17 therapists. So, we're doing the work part of looking
18 at regulation and what we need more is just to make
19 sure that once we get some of this groundwork done,
20 that we'd have the support of government to know we
21 could seek regulation under that Act, right.
22 Honourable Felix Collins:
23 There's currently 100 or close to 100 members. How
24 many did you say you got in the province?

1 Tracy Duffy:
2 Roughly. And that's only the ones that I personally
3 know of as the Director for the National Board. I
4 just have the membership list. I've kind of
5 estimated. So there's probably more who would seek
6 regulation who have similar professional backgrounds
7 from others.
8 Honourable Felix Collins:
9 Because at first blush it would seem like a very
10 positive thing to have 100 professional people to
11 infuse into the system.
12 Tracy Duffy:
13 Yeah, for sure, and I think awareness is key because
14 largely many of our graduates go to work in school
15 systems or community agencies, that there hasn't been
16 a lot of awareness brought to the fact that we're out
17 there and able to work in other places as well. So,
18 it's something that I'm happy to bring some awareness
19 to, for sure.
20
21 So, essentially, looking at that, we do fit
22 within. One idea that we've had, and again, this
23 could be future meetings certainly, I know that the
24 School Counsellors' Association, or NLCPA, spoke to

1 the allocation for school counsellors.
2
3 I've learned of, I have a colleague, actually, in
4 private work who just came from Alberta, and one of
5 the programs that they had up there was that they
6 contracted private counsellors to go into the schools
7 and do the counselling that the school counsellors
8 did not have time. So, she was actually a play
9 therapist.
10
11 Myself, and there's several others, in August,
12 actually, there's the first time play therapy
13 training is coming to Newfoundland. So that sort of
14 idea of taking some of those other professionals and
15 being able to help with the burden in the schools. I
16 think we still need more school counsellor
17 allocations, definitely. We're the lowest in the
18 country, but even if the shorter-term solution is to
19 have something else available. Many of our certified
20 counsellors have gone in to do groups in schools. We
21 do a lot of raising awareness and doing prevention.
22 So, those sorts of things that schools don't have
23 time for. Like you said, there's a huge body of
24 professionals that would be probably willing and

1 available to do that kind of stuff.
2
3 So, just future talks, I'm sure, to try and figure
4 out a solution. I think I've touched on all of that.
5 Any thoughts?
6 Honourable Felix Collins:
7 You say you've already been in discussion with
8 Colleen on all of this?
9 Tracy Duffy:
10 We have, yes.
11 Honourable Felix Collins:
12 Very good.
13 Tracy Duffy:
14 That's one other person Colleen then will say you
15 should go talk to Colleen.
16 Felix Collins:
17 Everybody needs to talk to Colleen.
18 Tracy Duffy:
19 I know. Colleen is going to have a lot of meetings.
20 Yeah, and that's essentially, so, those are kind of
21 the key points that we're bringing from our
22 Association. And as far as the Regulation piece, we
23 know it's several years off but we're seeing smaller
24 provinces, like I said, PEI, New Brunswick is pretty

1 close. So, the curve is coming from the federal
2 angle and either we'll be grandfathered in federally
3 or we'll seek it ourselves and be able to control the
4 process and that's our goal.
5 Honourable Felix Collins:
6 Okay, Panel?
7 Christopher Mitchelmore:
8 Yes, Tracy, 170 members, I guess, is that a big
9 enough critical mass to have a self-regulating body?
10 Tracy Duffy:
11 Yeah, that's one of the key things that we've looked
12 at from the Regulation committee is making sure that
13 we have enough diverse membership. So, we've learned
14 from other provinces. BC, there's a group called
15 FACT BC. So they've made sure that they've kind of
16 carved the way to get the diverse memberships. So we
17 would have more than 170 because that doesn't
18 incorporate pastoral counsellors or other groups that
19 might also want to be regulated. So, that's what our
20 committee, and, again, it's 10 or 12 people trying to
21 actively seek those other associations.
22 Christopher Mitchelmore:
23 So, I guess without regulation you still see an
24 opportunity where your group, your organization, the

1 members can reach other members and provide
2 supportive services in the communities, whether it be
3 through the school system or elsewhere. That's what
4 I'm hearing from the presentation.
5 Tracy Duffy:
6 Yeah, and essentially, we do it now. We partner with
7 a fair number of the agencies that are out there and,
8 again, it's just a matter of recognizing that we have
9 the same sort of capabilities as other mental health
10 professionals, and not to be in competition but to
11 collaborate.
12 Christopher Mitchelmore:
13 Yes, I think we really need to see more of that
14 collaboration.
15 Tracy Duffy:
16 Definitely.
17 Christopher Mitchelmore:
18 And we need to recognize all the organizations that
19 are out there and get the best skill-set and bring
20 that together. And I think if people knew that all
21 these supports and organizations were out there to
22 help, I think it could find a lot of solutions going
23 forward.
24

1 Tracy Duffy:
2 And I think as far as the collaborative piece, that's
3 something that's so important but I think often that,
4 as I think someone earlier said, we work in the
5 silos. So bringing awareness that, hey, there's this
6 other association with professionals who could be
7 included on program and policy development. I
8 honestly don't know if there's anyone on the Mental
9 Health Advisory Committee from CCPA. I think Angie
10 is on it from the school counsellors. But even
11 looking at having a representative on those sorts of
12 committees and to make sure that they know of those
13 hidden gaps, where our members are. So that would
14 help, especially if we're looking at a directory of
15 mental health and a coordinator, I think I heard.
16 Christopher Mitchelmore:
17 Yes. I think it's really positive that you've
18 brought forward solutions and wanted to be heard from
19 your organization's perspective, so I really
20 appreciate the presentation.
21 Tracy Duffy:
22 Great, thank you so much.
23 Honourable Felix Collins:
24 Well, Tracey, thank you so much. And as they say on

1 the Open Line show, you have the last word today.
2 Tracy Duffy:
3 Well, thank you, it was a huge audience.
4 Honourable Felix Collins:
5 Thank you so much. And although, you're the only one
6 here, I thank all the groups who presented today and
7 the information, some very interesting and intriguing
8 presentations and very helpful, very informative.
9 And if there's anything you want to add or get to us,
10 there are ways and means to do it, and please do it.
11 Tracy Duffy:
12 The contact information is there.
13 Honourable Felix Collins:
14 Contact information is there.
15 Tracy Duffy:
16 Our national stakeholder is up there, too, so.
17 Honourable Felix Collins:
18 Okay, great. Thank you so much.
19 Tracy Duffy:
20 Thanks.
21 Honourable Felix Collins:
22 And thank you, folks. Thank you for today.
23 (Public Consultations conclude for the day)
24