June 5, 2015

Honourable Steve Kent:

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

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

So I would want to welcome you on behalf of the

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

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

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

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

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

bring back to the House of Assembly this fall.

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

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

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

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

Dr. Bruce Gilbert:

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

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

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

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

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

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

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

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

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

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

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

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

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

You've got about 30 minutes to do that and I will check in when you're getting closer to the end. Thank you. Take it away.

(Thirty-minute break for group discussion).

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

Honourable Steve Kent:

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

So I was at two different tables. Talked a lot

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

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

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

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

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

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

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

probably unnecessarily. Almost definitely unnecessarily.

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

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

Dr. Bruce Gilbert:

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

Gerry Rogers:

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

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

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

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

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

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

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

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

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

get there?

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

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

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

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

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

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

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

Dr. Bruce Gilbert:

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

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

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

Mr. Parsons?

Andrew Parsons:

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

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

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

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

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

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

Community navigator. And again, Gerry and Steve

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

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

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

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

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

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

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

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

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

Dr. Bruce Gilbert:

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

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

Colleen?

Colleen Simms:

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

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

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

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

Other things that were wonderful were the St.

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

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

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

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

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

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

Dr. Bruce Gilbert:

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

Cameron:

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

Both tables, we heard about supporting housing

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

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

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

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

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

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

Dr. Bruce Gilbert:

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

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

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

Yeah. So Peggy, come on up.

Peggy:

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

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

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

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

Dr. Bruce Gilbert:

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

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

Honourable Steve Kent:

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

welcome for that.

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

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

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

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

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

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

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

(Lunch Break)

Honourable Steve Kent:

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

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

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

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

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

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

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

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

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

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

Dr. Bruce Gilbert:

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

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

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

So, that's it.

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

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

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

Dr. Janine Hubbard:

Ten minutes would be great.

Dr. Bruce Gilbert:

Ten-minute mark, okay.

Dr. Janine Hubbard:

Yeah.

Dr. Bruce Gilbert:

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

Dr. Janine Hubbard:

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

Gerry Rogers:

Can everybody hear?

Dr. Janine Hubbard:

Oh, sorry.

Gerry Rogers:

Can everybody hear?

Dr. Janine Hubbard:

Can you hear me okay?

Gerry Rogers:

No.

Dr. Janine Hubbard:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Unidentified Female:

(Inaudible).

Dr. Janine Hubbard:

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

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

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

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

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

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

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

Honourable Steve Kent:

Well said.

Dr. Janine Hubbard:

I didn't get the hook.

Dr. Bruce Gilbert:

Wow, you are a model of presentation efficiency. You're ahead of my 10-minute sign. We have 12, 14 minutes to carry on.

Dr. Janine Hubbard:

Excellent.

Honourable Steve Kent:

Go ahead. No, you go first.

Dr. Janine Hubbard:

Yeah.

Andrew Parsons:

Thank you so much. Can you guys hear me? Sorry. Thank you so much for that. I have some specific questions, just when you mention there's 200 here. What is the wait list time?

Dr. Janine Hubbard:

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

Andrew Parsons:

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

Dr. Janine Hubbard:

I can tell you we have one psychologist in Labrador. I can, I can find out those numbers for you, if you'd like.

Andrew Parsons:

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

Honourable Steve Kent:

Yeah.

Dr. Janine Hubbard:

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

Andrew Parsons:

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

Dr. Janine Hubbard:

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

Andrew Parsons:

I'm not good at math.

Dr. Janine Hubbard:

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

Andrew Parsons:

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

Dr. Janine Hubbard:

Yeah.

Andrew Parsons:

What does that get you in terms of time?

Dr. Janine Hubbard:

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

Unidentified Female:

Two hours per year.

Dr. Janine Hubbard:

Two hours per year.

Andrew Parsons:

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

Gerry Rogers:

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

Dr. Janine Hubbard:

Absolutely.

Gerry Rogers:

Can you tell us a little bit about that?

Dr. Janine Hubbard:

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

Gerry Rogers:

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

Dr. Janine Hubbard:

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

Gerry Rogers:

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

guidance counsellors in the schools as well, yes?

Dr. Janine Hubbard:

Yes.

Gerry Rogers:

So, that's not to take over from guidance counsellors?

Dr. Janine Hubbard:

No.

Gerry Rogers:

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

Dr. Janine Hubbard:

Exactly. That's the experience on the mainland where most of the schools have both educational psychologists and guidance counsellors providing services. And actually, a lot of schools also have social workers in the schools.

Gerry Rogers:

And social workers, yeah. There used to be social workers in the schools. So you're talking psychologists, guidance counsellors and social workers?

Dr. Janine Hubbard:

Yeah.

Gerry Rogers:

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

Dr. Janine Hubbard:

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

Again, when I was talking earlier about that idea

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

Gerry Rogers:

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

Dr. Janine Hubbard:

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

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

Gerry Rogers:

And it works.

Dr. Janine Hubbard:

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

Gerry Rogers:

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

Dr. Janine Hubbard:

Absolutely. I mean there are a couple of different

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

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

Gerry Rogers:

(Inaudible) models, yeah.

Dr. Janine Hubbard:

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

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

Gerry Rogers:

Oh, great. Thanks.

Honourable Steve Kent:

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

Dr. Janine Hubbard:

That's okay. We can chat again.

Honourable Steve Kent:

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

Dr. Janine Hubbard:

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

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

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

Honourable Steve Kent:

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

Dr. Janine Hubbard:

Certainly. And again --

Honourable Steve Kent:

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

Dr. Janine Hubbard:

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

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

Honourable Steve Kent:

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

Dr. Janine Hubbard:

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

Unidentified Female:

(Inaudible) - not by microphone).

Dr. Janine Hubbard:

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

Honourable Steve Kent:

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

Dr. Janine Hubbard:

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

Honourable Steve Kent:

Like in the evenings, on the weekends, whatever.

Dr. Janine Hubbard:

Yeah.

Honourable Steve Kent:

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

Dr. Bruce Gilbert:

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

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

Crista Brook Burnett:

Yes.

Dr. Bruce Gilbert:

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

Crista Brook Burnett:

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

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

Gerry Rogers:

Wow.

Crista Brook Burnett:

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

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

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

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

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

Gerry Rogers:

That know what?

Crista Brook Burnett:

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

Honourable Steve Kent:

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

Crista Brook Burnett:

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

Honourable Steve Kent:

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

Crista Brook Burnett:

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

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

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

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

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

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

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

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

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

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

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

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

Honourable Steve Kent:

I have in the last year.

Crista Brook Burnett:

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

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

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

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

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

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

(Video of Ontario 211 website is played)

Crista Brook Burnett:

I found his voice a little smarmy. That explains it

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

Ed:

(Inaudible - not at microphone).

Crista Brook Burnett:

Anybody else? Purple shirt?

Unidentified Female:

(Inaudible - not at microphone).

Crista Brook Burnett:

Yeah, the youth directory of services.

Unidentified Female:

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

Crista Brook Burnett:

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

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

Catherine:

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

Crista Brook Burnett:

I was getting to it.

Catherine:

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

Crista Brook Burnett:

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

Megan:

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

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

Unidentified Female:

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

Crista Brook Burnett:

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

Unidentified Female:

Thank you very being here.

Crista Brook Burnett:

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

The Saskatchewan 10 Year Mental Health and

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

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

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

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

Gerry Rogers:

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

Crista Brook Burnett:

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

Gerry Rogers:

So they would like dispatch your call?

Crista Brook Burnett:

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

Gerry Rogers:

And how is 211 paid for?

Crista Brook Burnett:

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

Honourable Steve Kent:

You can go first, if you want.

Undientified Male:

(Inaudible).

Honourable Steve Kent:

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

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

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

logically should be part of the discussion right now?

Crista Brook Burnett:

Just off the top of my head?

Honourable Steve Kent:

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

Crista Brook Burnett:

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

Honourable Steve Kent:

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

Crista Brook Burnett:

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

Honourable Steve Kent:

Yes.

Crista Brook Burnett:

You definitely have to be contacting 211 National.

Honourable Steve Kent:

Yes.

Crista Brook Burnett:

The national director of 211 who is responsible for

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

Honourable Steve Kent:

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

Crista Brook Burnett:

Yeah. Lisa Zigler.

Honourable Steve Kent:

And my second -- Lisa Zigler?

Crista Brook Burnett:

Yeah, there is a whole list of people.

Honourable Steve Kent:

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

Crista Brook Burnett:

There's no best model because every 211 is according

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

Honourable Steve Kent:

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

Crista Brook Burnett:

Very much so.

Honourable Steve Kent:

Okay.

Crista Brook Burnett:

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

Honourable Steve Kent:

But they look and feel the same pretty much today?

Crista Brook Burnett:

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

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

Honourable Steve Kent:

Cool. All right, thank you.

Crista Brook Burnett:

Any other questions? No.

Andrew Parsons:

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

Crista Brook Burnett:

It seems so obvious, doesn't it?

Andrew Parsons:

Yes, completely. What's the ballpark cost that

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

Crista Brook Burnett:

Five thousand dollars off the bat for icarol software.

Honourable Steve Kent:

Yeah, it's varied from jurisdiction to jurisdiction.

Crista Brook Burnett:

It's very variable.

Honourable Steve Kent:

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

Crista Brook Burnett:

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

Honourable Steve Kent:

That's probably the biggest stumbling block.

Crista Brook Burnett:

There's a lot of details.

Gerry Rogers:

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

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

Crista Brook Burnett:

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

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

Dr. Bruce Gilbert:

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

Angela Crockwell:

Sure.

Dr. Bruce Gilbert:

Okay. Thank you very much.

Angela Crockwell:

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

Honourable Steve Kent:

Yeah, green button will change your slides.

Angela Crockwell:

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

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

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

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

good things happening.

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

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

issue.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Honourable Steve Kent:

Does that funding come through Eastern Health or?

Unidentified Female:

Department of Health.

Honourable Steve Kent:

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

Unidentified Female:

SWSC.

Honourable Steve Kent:

Oh, SWSC, okay.

Gerry Rogers:

What's that?

Honourable Steve Kent:

Seniors Wellness Social Development.

Unidentified Female:

(Inaudible - no microphone).

Honourable Steve Kent:

Okay, all right.

Angela Crockwell:

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

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

Honourable Steve Kent:

That's excellent.

Dr. Bruce Gilbert:

So we have a couple of minutes.

Gerry Rogers:

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

Unidentified Female:

(Inaudible - not by microphone).

Angela Crockwell:

So, my understanding, and there's probably people

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

Unidentified Female:

(Inaudible - not by microphone).

Dr. Bruce Gilbert:

Okay, we have a couple of minutes.

Honourable Steve Kent:

You guys go first.

Gerry Rogers:

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

Angela Crockwell:

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

Gerry Rogers:

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

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

Angela Crockwell:

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

Gerry Rogers:

I do have one more question.

Honourable Steve Kent:

Go for it.

Gerry Rogers:

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

Angela Crockwell:

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

Honourable Steve Kent:

Is there time for another one?

Dr. Bruce Gilbert:

Yeah.

Honourable Steve Kent:

Thanks.

Dr. Bruce Gilbert:

A short one.

Honourable Steve Kent:

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

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

Angela Crockwell:

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

Honourable Steve Kent:

Yes.

Angela Crockwell:

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

Honourable Steve Kent.

Right, right.

Angela Crockwell:

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

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

street.

Honourable Steve Kent:

Right. Good point. Thank you.

Angela Crockwell:

Thanks.

Dr. Bruce Gilbert:

Okay. Thank you very much. Okay, next up we have Mr. Dave Banko, Executive Director of the Schizophrenia Society of Newfoundland and Labrador. You can use the podium.

Dave Banko:

I'm a little old school because I tend to have technical difficulties, so you're stuck looking at me. Essentially, these are a number of issues that were brought forward after consultation with some of our membership. The first one will be brief. It's essentially the Waterford hospital needs to be replaced. (Clapping).

The next issue is family and caregiver supports. Often times we see ... hold on a second here. Oftentimes we see family members or I'll get phone calls from family members where their loved one is being released from hospital or discharged and they

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

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

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

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

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

school system, and that includes assist training as well.

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

Gerry Rogers:

Yeah. There they are.

Dave Banko:

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

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

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

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

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

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

Honourable Steve Kent:

Lots. You want to go first?

Gerry Rogers:

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

Dave Banko:

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

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

Gerry Rogers:

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

Dave Banko:

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

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

Gerry Rogers:

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

Dave Banko:

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

Honourable Felix Collins:

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

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

Dave Banko:

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

Andrew Parsons:

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

Dave Banko:

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

Andrew Parsons:

Up to forty minutes.

Dave Banko:

So, like Holyrood is essentially the boundary, going

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

Honourable Steve Kent:

Thank you.

Honourable Felix Collins:

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

Dave Banko:

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

Honourable Felix Collins:

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

Dave Banko:

Yeah, that was about two years ago.

Honourable Felix Collins:

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

Dave Banko:

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

Dr. Bruce Gilbert:

Thank you very much. That was excellent. I'd like to invite (inaudible) to the stage ... Take it away, thank you.

Bruce Pearce:

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

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

Shawn Skinner:

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

Bruce Pearce:

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

All-Party Committee.

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

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

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

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

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

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

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

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

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

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

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

to be true.

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

be at imminent risk of homelessness.

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

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

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

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

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

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

Shawn Skinner:

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

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

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

Gerry Rogers:

Yeah, Dave.

Shawn Skinner:

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

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

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

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

Gerry Rogers:

Great.

Shawn Skinner:

And I thank you for the time.

Dr. Bruce Gilbert:

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

Gerry Rogers:

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

Shawn Skinner:

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

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

Bruce Pearce:

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

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

Gerry Rogers:

I have another question.

Bruce Pearce:

Yeah.

Dr. Bruce Gilbert:

Steve Kent?

Gerry Rogers:

Sorry.

Honourable Steve Kent:

You can go ahead.

Gerry Rogers:

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

Shawn Skinner:

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

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

Honourable Steve Kent:

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

Bruce Pearce:

Thank you.

Shawn Skinner:

Thank you.

Dr. Bruce Gilbert:

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

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

Ron Fitzpatrick:

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

Dr. Bruce Gilbert:

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

Ron Fitzpatrick:

Sure, yeah.

Dr. Bruce Gilbert:

There you go.

Ron Fitzpatrick:

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

about the -- now, okay.

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

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

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

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

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

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

of work, and thanks to Howard we've all come -- this is a fact that I'm going to give you now. Correctional Services of Canada is now, without a doubt, the biggest provider of mental health care in our country.

Gerry Rogers:

Wow.

Ron Fitzpatrick:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Gerry Rogers:

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

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

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

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

Ron Fitzpatrick:

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

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

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

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

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

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

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

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

Honourable Felix Collins:

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

Ron Fitzpatrick:

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

Dr. Bruce Gilbert:

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

Melissa Moore:

(Inaudible - no microphone).

Dr. Bruce Gilbert:

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

Melissa Moore:

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

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

Gerry Rogers:

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

Melissa Moore:

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

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

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

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

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

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

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

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

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

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

smokers start before they are age 16.

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

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

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

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

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

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

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

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

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

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

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

voice is just gone.

Mary Lynn Pender:

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

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

addictions.

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

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

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

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

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

Another misconception is that quitting is, like I

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

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

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

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

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

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

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

So, just in summary, why we feel tobacco should be included, here's the evidence. We know smoking rates are high. We know it's a drug. We know people are severely negatively impacted by their smoking. People can quit. There's guidelines, CAN-ADAPTT guidelines, that bring altogether all the evidence and recommendations and best practices to say what systems should be doing to support smokers and that recommends that every person that comes into a health care system should be asked about their smoking and linked with support to quit. And as I said, we know we do have the good supports in place to help individuals quit through the Help Line, and we encourage Government to explore all the options. We don't have to have all the answers here today, but we certainly put forward a few recommendations for you to consider. We know that mental health and addictions staff already have lots of skills and knowledge around addictions, and many of this would

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

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

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

Dr. Bruce Gilbert:

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

Honourable Steve Kent:

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

Mary Lynn Pender:

Yeah.

Honourable Steve Kent:

So, was there a time when tobacco addiction was under the Mental Health and Addictions, are you aware? Because since I've been in this role it hasn't been, which is a very short time, so I'm just curious. Was there a time when that was the case or no? No. Colleen is saying no.

Mary Lynn Pender:

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

Honourable Steve Kent:

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

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

Mary Lynn Pender:

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

Honourable Steve Kent:

But that's the challenge for some people.

Mary Lynn Pender:

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

Honourable Steve Kent:

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

Mary Lynn Pender:

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

Honourable Steve Kent:

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

Mary Lynn Pender:

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

Honourable Steve Kent:

Okay, thank you.

Mary Lynn Pender:

Managing that, right.

Gerry Rogers:

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

Honourable Steve Kent:

Yeah.

Gerry Rogers:

And so it's a complicated one, hey.

Honourable Steve Kent:

Yes.

Gerry Rogers:

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

Mary Lynn Pender:

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

who might want to speak to it.

Unidentified Female:

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

Mary Lynn Pender:

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

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

Honourable Felix Collins:

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

Mary Lynn Pender:

Thank you.

Dr. Bruce Gilbert:

This guy is eager. ... of Minister Kent's Provincial Mental Health and Addictions Advisory Council. You've got 30 minutes. I'll give you a 10-minute and a five-minute warning, if that's all right with you. Take it away.

Sheldon Pollett:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Central Intake System, I think people are

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

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

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

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

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

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

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

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

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

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

16 to 24 years, with significant mental health diagnosis.

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

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

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

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

Gerry Rogers:

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

Sheldon Pollett:

No.

Gerry Rogers:

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

Sheldon Pollett:

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

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

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

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

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

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

Gerry Rogers:

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

Sheldon Pollett:

Sarah, Jess and Kayla.

Gerry Rogers:

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

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

Sheldon Pollett:

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

Honourable Felix Collins:

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

Sheldon Pollett:

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

Gerry Rogers:

And to hold on to staff.

Honourable Felix Collins:

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

Sheldon Pollett:

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

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

Honourable Felix Collins:

Thank you.

Honourable Steve Kent:

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

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

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

Sheldon Pollett:

My staff will be more than happy to do that.

Honourable Steve Kent:

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

Sheldon Pollett:

Fantastic.

Honourable Steve Kent:

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

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

Sheldon Pollett:

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

Honourable Steve Kent:

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

Sheldon Pollett:

Not a problem.

Dr. Bruce Gilbert:

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

Honourable Steve Kent:

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

Gerry Rogers:

And morning.

Honourable Steve Kent:

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

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

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

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