PRINCE EDWARD ISLAND LEGISLATIVE ASSEMBLY

Speaker: Hon. Francis (Buck) Watts | Published by Order of the Legislature

Standing Committee on
Health and Wellness

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LOCATION: LEGISLATIVE CHAMBER, HON. GEORGE COLES BUILDING, CHARLOTTETOWN

SUBJECT: BRIEFING ON THE 2016-2026 MENTAL HEALTH AND ADDICTION STRATEGY

COMMITTEE:
Jordan Brown, MLA Charlottetown-Brighton [Chair]
James Aylward, MLA Stratford-Kinlock
Dr. Peter Bevan-Baker, Leader of the Third Party
Kathleen Casey, MLA Charlottetown-Lewis Point
Darlene Compton, MLA Belfast-Murray River
Bush Dumville, MLA West Royalty-Springvale
Chris Palmer, MLA Summerside-Wilmot
Hal Perry, MLA Tignish-Palmer Road

COMMITTEE MEMBERS ABSENT:
none

MEMBERS IN ATTENDANCE:
Richard Brown, MLA Charlottetown-Victoria Park
Bradley Trivers, MLA Rustico-Emerald

GUESTS:
Department of Health and Wellness (Hon. Robert Henderson); Health PEI (Dr. Heather Keizer, Verna Ryan)

STAFF:
Emily Doiron, Clerk Assistant (Journals, Committees and House Operations)

Edited by Hansard

The Committee met at 1:30 p.m.

Chair (J. Brown): We're going to call the meeting to order, folks. My name is Jordan Brown. I'm the Chair of the health and wellness committee and we certainly welcome you folks here today to give the presentation that we understand you're going to give.

So that everybody is aware and I guess the first thing that I would ask, particularly for folks in the gallery, is that you turn your phones off and if they're on vibrate, please do not place them on the benches beside you. It creates an issue for our recording staff.

On that point – and this is particularly a message for you folks as I appreciate, this isn't really the kind of presentation, probably, that you give every day and when I say that, what I mean is that this is recorded, both in video and audio. That makes it particularly an issue if two people are trying to talk over each other. What we do is we ask that before somebody speaks, they identify themselves, even if you just finished speaking, by your name and then proceed to say whatever it is that you're going to say.

That does two things. It allows a second for the AV staff to kind of catch up and put the microphone on in front of you and to get the cameras on you to record what it is that you're about to say, and it allows an effective transition time between a couple of speakers.

Unless there are any questions on that point, we'll move into the more formal part of the meeting. We may be here for a bit. I don't know if you have any expectations in terms of time, but typically we would proceed until a couple hours have passed or we're out of questions. I don't know if that causes any problems for you. No? Okay, great. That all being the case, if you do need to take a break for whatever reason, just get my attention and we are certainly open to doing that, too.

I'll call for a motion for the adoption of the agenda.

Ms. Casey: So moved.

Chair: Thank you, Kathleen.

With that, we'll move to the third item on the agenda which is the committee will receive a briefing on the 2016 to 2026 Mental Health and Addictions Strategy. The presenters include, Minister Henderson, Dr. Kim Critchley, Deputy Minister of Health and Wellness, Dr. Heather Keizer, Chief Mental Health and Addictions Services of Health PEI, and Verna Ryan, Chief Administrative Officer of Mental Health and Addictions Services PEI.

I see Dr. Critchley –

Clerk Assistant (E. Doiron): (Indistinct)

Chair: Okay, perfect – is in the gallery. So we'll just clarify that, that the presentation will be from the three of you.

In saying all that, there's a couple of ways that we can proceed; we can either proceed through your presentation and ask questions afterwards, or ask questions during the presentation, whichever is more convenient to you.

Mr. Henderson: I guess, Chair, from my perspective – I would advise to probably go through our presentation because there may be answers and more clarity on a particular question as you proceed through the presentation. But I would say that we're at the mercy of the committee, so if there's any process that they want to do to ask questions or intercede at any time, we're open to that too. That's just my only caution, is that some questions may become redundant if you go through the whole procedure of the presentations.

Chair: Thank you, minister.

So members, do your best to hold your questions, but if there's something that's burning get my attention or the clerk's attention and we'll go from there. With that, I turn the floor over to you folks for your presentation and perhaps a brief introduction and we can go from there.

I guess maybe before we do that, too, once we get the context, we had sent a letter and perhaps the clerk can refresh me in terms of the date, but it was a few weeks ago, essentially requesting this presentation.

The genesis of that was that we had heard, kind of in the public and at meetings that we have held, in particular, since last winter, that there are a number of, we'll say, identifiable issues that have been presenting in the community in relation, in particular, to mental health. We know that there is a recently new strategy that's been prepared and we also know that there's been other ongoing things in the community. So our letter outlines some of the issues that we've been hearing about over time and we're interested to hear, kind of between the department and the various different operating entities, how the issues that are kind of out there are being dealt with as we go along.

With that, I'll turn it over to you folks.

Mr. Henderson: Thanks very much, Chair, committee members and I would say, media and the people in the gallery.

Obviously, this particular subject of mental health and addictions as it pertains to Islanders, is a very interesting subject in lots of ways, but it also brings with it many diverse views and opinions and solutions and problems that we have as an administration and as a government.

I have with me to my left is my Chief Administration Officer for Mental Health and Addictions Services PEI, Verna Ryan, and I also have my Chief Medical Officer as it pertains to mental health and addictions, is Dr. Heather Keizer. We're going to go through a bit of a presentation to try to, hopefully, explain to the general public, the media, whatnot, about some of the issues, challenges and direction that we're heading as a department and as Health PEI.

I thank everybody for coming here today and I really do understand what a vested interest this has on the mental wellbeing of Islanders.

For those that maybe aware, that around half of Canadians experience some form of mental health problem at some point in their life, and it's certainly a common part of being humans. Therefore, good mental health is something to which we all can aspire. I don't think there's anybody that would be immune from when they watch the news or any issues around stories that you see in the news around trauma, the mental health breakdowns that some people have and it's almost becomes somewhat mind-numbing when you start to delve into some of these types of issues.

I would say the issue, when it comes to mental health and psychiatry, things of that nature, it's a whole far different issue that you're dealing with comparable to hip replacements or hearts and things of that nature. You're dealing with the brain, which is probably the most complex organ in the human body and that comes with a whole bunch of issues and how you find solutions and sometimes these things take a long time to heal, cure. If you looked at a certain surgeries and things of that nature, there's a process that you follow and there's usually a rehabilitation process that goes with that. Although somewhat similar with mental health, it's much more complex and difficult so I just wanted to make sure that people are aware of that.

As minister, I would say it's our number one challenge that I have as a minister and I think most governments do. When I talk to many of my colleagues across the country, they're all dealing with the similar issues of mental health, to the point of; even I would expand upon the federal government in the discussions around the health accord where they wanted to see targeted funding directed specifically to the mental health, as well as homecare. So it's a priority, I think, for everyone in this country and so improving the mental health and addiction services certainly is a key pillar for our government as we try to improve our overall health system.

We understand the toll that the mental health illness can have on many families. It can be very crippling and very crisis-oriented for those particular individuals that are affected, as well as their loved ones. We need to ensure that we are providing the supports for Islanders all across this province who are suffering from various levels of mental illness. We have to try to provide the coping mechanisms to be effective and productive for those individuals in society, as well as the families that may be able to deal with that.

I really want to emphasize that good mental health and wellness is more than just the

psychiatrists or the politicians. Everybody in Prince Edward Island – neighbours are involved, families are involved. You have to make sure that everybody understands that there's coping mechanisms that have to be developed and they have to be that to expect our compliment of psychiatrists to resolve every issue and solve that effectively is unrealistic. So we just have to look at it – it's a provincial issue that we all have to take some role and responsibility in.

Mental illnesses include a wide range of conditions that affect how we feel and think, and most of these are first experienced in our late teens and early 20s, but may not only emerge until much later in life. You try to deal with some of the issues that we're dealing with in society today; there's much more social media pressures than ever before. We hear about the Rehtaeh Parsons and things of that nature. Those are really newer challenges that we're faced with in society today that we probably aren't as used to as we have in the past. It is all our responsibilities to care for the wellbeing of every Islander.

We continue to work to strengthen our mental health system and build a continuum of care that is able to respond to the needs of all Islanders. The guiding piece of this work has been our 10-year mental health addiction strategy moving forward today, which was released last November. The report was intended to be a high-level roadmap to enhance and integrate mental health services in this province. It identifies the numerous challenges that face the system, lays out five strategic priorities and is guiding our decisions on how to make and overcome this in the coming decade.

As minister, this is one of my top priorities. I want to commend the staff that are here and the staff and professionals that we have in Health PEI, as well as health and wellness, as well as our affiliates, the Canadian Mental Health Association, and they have worked extremely hard throughout very difficult circumstances to enhance services to a wide spectrum of mental health challenges to Islanders.

There's been a great deal of excellent work on this file over the past year. New programs like Strongest Families, mental health walk-in clinics, enhanced recruitment efforts, stronger collaboration with community groups like the Canadian Mental Health Association, and new access tools like a revamped webpage and community promotions. Mental health and addiction is a very active division and we are striving to provide these essential services as best we can to Islanders.

It is our pleasure to be here today and provide the committee with an overview of our strategic decisions and actions and as a result of the moving forward together report.

I will now hand the microphone over to some of my staff here that are; Verna Ryan and Dr. Heather Keizer. I thank these two ladies here. They've put in really a yeoman's duties in trying to advise me as minister as well as to try to implement some of the policies and strategies.

Like I said before, I have the utmost confidence and faith in the two people here, as well as all our staff, because like I said, I have a good comprehension of the challenges that they're facing on a day-to-day basis and I know it's not easy. I really appreciate you being here to provide the support to our legislative committee on this important issue.

I'm not too sure which one is next; I think it's Verna, but I'll pass it over to you.

Dr. Heather Keizer: Thank you, minister and thank you, Mr. Chairman.

I wanted to thank you for the opportunity to present today. I'm very gratified to hear the minister suggest that this is probably one of our primary pillars of the delivery of appropriate health care in Prince Edward Island. Indeed, I think if we embrace the delivery of high quality mental health care and addiction services to Prince Edward Islanders, I think we will see a real revitalization and a revolution in terms of our ability to deliver good service of high quality at a national standard over the next number of years.

We are not there yet. We're working very hard and we've spent a lot of time developing a comprehensive plan that will service all Islanders, from pregnant moms all the way to childhood, children,

adolescence, adults and then the geriatric population, which is the burgeoning population on Prince Edward Island.

You'll see, as Verna launches into our slideshow, that it is constructed based upon the framework. But what we've done is we've taken quite a bit of time this summer to develop, actually, an accountability protocol so that we actually have timelines to show you where and who will be delivering the services that we're proposing. Because again, accountability is a really key piece here. There's one thing to sign on and say that this is a priority. It's another thing to actually deliver the service and that's what we're hoping to be able to do.

Without further ado, I'm going to have Verna share with you our presentation with regard to our ongoing strategy.

Verna Ryan: Thanks so much.

As Dr. Keizer noted, this mental health and addictions strategic framework is provincial in nature. Although, we are the co-leads on mental health and addiction services for Health PEI, this strategy was developed with community input, with the community organizations, with other departments – so the other social departments are all involved in the development, and then the implementation of actions from this point. We are here before you as two representatives of that larger group. The social departments representative include education, justice, family and human services and –

Dr. Heather Keizer: Health.

Verna Ryan: − and health. There we go.

Mr. Henderson: Don't forget us.

Verna Ryan: Don't forget us; multi-department approach involving the community with a focus on clients and the general public.

Approximately a year ago, Health PEI made a change, whereby mental health and addictions was brought to the senior management table as a division. They'd never been given that sort of profile before and this dual leadership role for the medical leadership as well as the administrative leadership was developed. So this has allowed us to lead in a more comprehensive way than I think what has previously happened.

In terms of providing you with a little bit of an overview of what the current mental health and addictions services on PEI look like, I just wanted to pop up a map of the Island. Here you can see across PEI, our in-patient mental health programming, which is Hillsborough Hospital, QEH, and in-patient at Prince County Hospital. You'll see our community mental health and addiction services all across the Island from Souris to Tignish; collaborative mental health care which is really the mental health and addiction clinicians supporting our primary care physicians and staff in their offices, whereby patients can have immediate access to services.

We have our addictions treatment facility, which is in Mount Herbert; a 34-bed facility there, and also three extended care houses in the Charlottetown and Summerside area; St. Eleanors House, Lacey and Talbot House. In the provincial realm, there are a number of programs including the INSIGHT program which is our adolescent day treatment program, but it's offered provincially; the behavioural support team, and the methadone clinics. Those are all listed there.

Dr. Heather Keizer: If you look at the map, you'll see the little brown dots are our mental health and addictions clinics across the Island. The little blue stars are in-patient units, and the little Ms are where we deliver methadone programming.

Chair: Thanks, Dr. Keizer.

Verna Ryan: In terms of the scope of services provided – and this is a very quick overview but I just wanted to situate the current landscape for folks before I move onto the plan. What you'll see here, the scope of services: Hillsborough Hospital, Queen Elizabeth Hospital, Prince County Hospital, and the provincial addiction treatment centre for a total of 142 in-patient, most of which are acute care beds. The 34 beds at the addictions treatment centre are not considered acute care.

Community mental health, which delivers adult, youth and family therapies; seniors'

mental health; community outreach group programs; and most recently, walk-in clinics. Addiction services, which offers outpatient withdrawal, opiate replacement therapy, adult, family and youth counseling and community reinforcement approach craft model, which is a current model we're using. Concurrent disorders programs and children and youth.

The pie chart in the middle, just to give you a sense of what sort of diagnoses are being addressed in the system; you'll see that depression is a big feature of the acute care treatment, substance use at 15%, and substance use we deal with in acute care, as well as at Mount Herbert. So we may have that go in-patient at Prince County Hospital, for example, and are actually detoxed and treated there, as opposed to coming to Mount Herbert.

Stress reaction and adjustment: so major life events that people are dealing with and are struggling with; bipolar and schizophrenia are both 12 and 14%, and anxiety at 6%.

Dr. Heather Keizer: What I really want to highlight with this is the programming that you see listed there is currently being delivered and much of it has actually been established in this past year. So the programming that's outlined there is currently being delivered.

The other thing I'd like you to note is that schizophrenia is ranked at 12%. That is significantly higher than the national average and that has been supported by research done in Prince Edward Island here. The national average is usually 10% and we have a higher incidence with a genetic predisposition in much of our Prince Edward Island population and this is an illness that has very significant and profound consequences with regard to long-term care.

Chair: Mr. Aylward.

Mr. Aylward: Thank you, and I'm sorry to interrupt.

Before we get past this slide, I just wondered because we're hearing a lot more now about PTSD –

Dr. Heather Keizer: Yes.

Mr. Aylward: Where does PTSD fall into under (Indistinct) –

Dr. Heather Keizer: PTSD is considered an anxiety disorder and so it would probably be classified under anxiety. At the moment with regard to the collection of the data, it probably isn't delineated at the discharged diagnosis specifically in some cases, but it certainly is something – for instance, I have a specialty area in training of PTSD. There are a number of us in the psychiatric complement that do, and certainly it is a significant issue with regard to complex depression.

If we have families and individuals who are struggling with, say, post-traumatic stress because of childhood sexual assault, that sort of thing, and that would be encompassed under depression as well sometimes. But it's not, at the moment, not collected as data specifically.

Mr. Aylward: So right now within the pie chart it could either go under anxiety or depression?

Dr. Heather Keizer: You couldn't really delineate that clearly. It would never fall under – very rarely would it fall under specifically under schizophrenia. Often you'll see that, particularly in the female population, that substance abuse often is a way of coping with PTSD and often they are very co-morbid in the general population as well.

Mr. Aylward: Thank you.

Verna Ryan: Although we've mapped them out, these are sort of the lead conditions and there may be concurrent disorders that are happening for folks.

Chair: Just remind you folks –

Verna Ryan: Oh, sorry.

Chair: – when you transition back and forth just to – I see them scrambling over in the corner there to get back so I just remind you to take a second and identify yourself (Indistinct)

Verna Ryan: Sorry, okay. I'm Verna Ryan; I'm back on.

Mr. Henderson: You follow instructions good.

Verna Ryan: This is a very quick overview of what we're going to be talking about today in this plan – it's a busy slide, I know that. But essentially, wanted to give you a little bit of a roadmap to consider what has been achieved to date and what's ongoing.

The actions that are currently underway, so that we've either initiated, we've done the planning around, or that we've done training – so we're actively engaged in the actions that are underway and then the proposed actions, they may be ones that we've developed, we've done the leg work on. We've gathered the data. We've looked at models, and that we have proposals ready for.

That's kind of the very quick overview, and also to note that while this Power Point is comprehensive, it's not exhaustive and so there are other things that we're working on and that are underway in other departments, or with community organizations that are not represented here. Also, there's the day-to-day that's happening alongside and throughout all of this work.

Dr. Heather Keizer: We've made the analogy sometimes that we're speeding down the highway in a car that we're trying to actually change the tires on and so that is a challenge for us. We've achieved and we have ongoing work, but we're continuing to move forward, as at the same time, trying to deliver services, so it's an interesting and challenging piece before us.

Verna Ryan: Thank you, Dr. Keizer.

The minister talked about the five pillars that were included under the mental health and addictions strategy released last year. We've added one more because this issue kept coming up for every action item and that's leadership monitoring and evaluation. There were no specific components built in in terms of an overall evaluation model to look at the outcomes that were important to us. So it's really about vision, monitoring how we're progressing and evaluating what it is that we're trying to reach; so a clear evaluation of our goals.

The other pillars include: invest early, a focus on children, young people and families; access to the right service, treatment and support; mental health promotion and prevention for all ages; fostering recovery and well-being for people of all ages; and strengthening and supporting an innovative and collaborative workforce. So these would not be new to you.

Under the pillar down the left-hand side you'll see which pillar is being referred to. Under leadership monitoring and evaluation, we've committed to conducting the annual review of the strategic actions. As we were doing our work in preparation of the action plan, it really was a need to build in a mechanism where there was accountability. A yearly reckoning, if you will, of how the many initiatives are going, what the progress has been, what the numbers are, what the outcomes are, what the barriers are – all of those sort of things.

So we've set up a September to November annual planning cycle, whereby in September, that meetings would be held and we would gather the information needed and in November, have an annual meeting and review all of the initiatives.

One point, too, is to define the mental health core services and develop and communicate the continuum of mental health and addiction services on PEI. What this is talking about, really, is looking at what are the diagnoses? What this is talking about really, is looking at what are the diagnoses? What are the issues that are before us that we are dealing with and these can be the illnesses themselves; the mental health conditions; they can be trends that are happening. They can be one-offs, like bath salts when that exploded in Pictou, Nova Scotia. It can be things like that, drug monitoring.

From that information, and from what is being presented, make sure that our core services are identified and aligned to address those issues. For example, our addiction services, we did some work on something called the CRAFT model. That really is a model that supports the families of people who are dealing with addiction issues, but don't want to seek treatment.

In previous years, families felt pretty isolated. They felt they were called enablers, but they really were quite powerless, other than to accept what was going on. With the CRAFT model we're able to support them to develop coping skills to manage behaviour in the home, and to deal with their loved one when they're actively addicted, in a different way. It increases the chances of someone coming forward for treatment by 75%. We've seen those same outcomes in the courses that we've offered so far on PEI.

It's that sort of core services outlined so that everyone knows what the core services are; we're training our staff to them; the public knows what services we offer very clearly; they know we to go to get them. These are evidence-based services that are supported in evidence. They've been tested; tried and tested.

Develop and implement a multi-year plan to establish a mental health and addictions campus that defines our program scope and addresses needs beyond a hospital-based facility, and positions the facility as a teaching centre.

To this end, we really felt it necessary to have a provincial scope on what is within the program of mental health and addictions and what is not, so that we can appropriately plan a future state of facilities and/or services in the community; be culturally relevant, and regionally specific to needs.

We sent out a request for proposals earlier this year. We are in final stages of reviewing and ready to award that request. What that looks like, will be for the next six to 12 months, a plan in process, whereby, the community would be consulted. We are looking for a 30-year trending, in terms of the population and what the needs are. And then, once the program is very clearly outlined, we'll look at what are the facilities that will be needed to support those.

Dr. Heather Keizer: This is probably one of our most key pillars of our plan in terms of master planning. One of the things that Verna and I did not want to do was to race into building a structure. A new Hillsborough Hospital, for instance, without actually having a good sense of the scope of services that we're going to need into the future, and having something that is going to actually be integrated and provide a continuum of care and be sustainable on the long-term.

This is not an easy fix; we had to kind of dive deep with this, and this master plan is going to allow us to do that. That what we're doing is, responding with capital investment in response to actual need and actual forecasted needs in the future. We need to do it in a way that really supersedes political issues, supersedes that to be able to deliver a sustainable program for mental health and addictions.

Verna Ryan: Work towards a seamless service across the province. So, this really is about working together with our partners because the prevalence of mental health and addiction services right now, really necessitates everyone owning the issue and the different parts that they can impact. Health PEI, the department itself, education, justice and family and human services, and within that, certainly, child protection, disability support, income support, those areas, whereby, we're all talking together. We're all addressing the issues in a meaningful way and that we're leveraging investments. For example, training, and we'll talk about trauma-informed training later on.

If child protection has a need for trauma-informed training and we're doing trauma-specific training, and corrections is doing something in that, as well, traditionally, everybody will bring a speaker in, and have their own expert, and we'll have three sets of approaches and maybe three sets of language to deal with those approaches. The public, or the people we serve –

Dr. Heather Keizer: If you think –

Verna Ryan: – don't know which one is, you know, the right one. Are we talking about the same thing? We're really talking about coming together in a different way to support each other, to bring about the best service so that people are having an easier time accessing the service, but it's also very cohesive in its approach.

Develop and implement mental health and addictions communication strategy. One of the things that I've certainly noticed is that we don't get the word out very well to

people about the services we offer. We don't have a calendar online that shows people where and when they can come and take the Seeking Safety trauma course, or where the walk-in clinics are, or any of those pieces; coping skills programs.

This is a big issue for us. We want to, not only, do this work, but make sure that everyone has access to the information through clear messaging. When there are issues in the public, we need to balance with the information that is relevant to people that need service.

Dr. Heather Keizer: We'd like to be a clearing house, too for that information. If we're delivering service, if we built the infrastructure, if we have the expertise, which we do, we would like to also be the voice to the public in terms of education. In terms of, sometimes, doing preventive education to the general public as to: when should you see your family doctor for something; when is it appropriate to seek a psychiatrist? What do counsellors do in outpatient services; how long if I want to come off of cocaine, how long would I expect to be in the transitional program at addiction services?

Those kinds of basic pieces of information, I think, we need to be able to deliver more effectively. That's why we're looking at developing an effective communication strategy. Again, this is something that is going to be an ongoing and a sustainable piece and an important piece, I think, going forward.

Verna Ryan: That's really targeted internally and externally –

Dr. Heather Keizer: Yes, as well.

Verna Ryan: – because, as any of you know, big project work, it is easy to get caught up in what's happening and not everyone knows what it is that – what progress is happening.

A multi-year evaluation plan for mental health and addictions; we are looking at building a framework, as I mentioned earlier, on a yearly basis, but also, building – monitoring the activities and outcomes.

We have some significant challenges with our data within, certainly within mental health and addictions and I would say across other departments, have some challenges, as well. We have a couple of data systems that don't talk to each other –

Dr. Heather Keizer: Cerner and CI – RISM –

Verna Ryan: – RISM, which make it really challenging and cumbersome for our clients and patients. Information cannot be readily shared between the community and the hospitals, for example. Those are some of the issues, though, that we are looking at.

Quite often, when data is requested, we will need to do a manual count on some very basic services in terms of numbers. We really need to move beyond that in order to make some progress.

Dr. Heather Keizer: We're a very attractive location for ongoing study nationally. I was just recently at the mental health – what is it now? In Ottawa, the mental health commission –

Verna Ryan: The Mental Health Commission of Canada.

Dr. Heather Keizer: And I've made contact with principal investigators across the country, and we are an attractive place for them to come and actually invest in studying our population; however, we need to be able to manage the data well. The truth is, if we don't have baseline data, if we don't know our numbers, then it's very difficult for us to plan, it's very difficult for us to evaluate. So this is really a priority. It doesn't sound like it's mental health, but in fact it really is.

This is where we come and go with regard to our planning and our forecasting and with regard to our investments for financial investments from the federal and provincial government, as well as from academic institutions.

I spoke with the principal investigator from U of T in mental health delivery services, as well as the principal investigator from Vancouver last week; and again, they're very interested in coming and working with us, but we need to be able to manage our data well, and so this is a priority for us.

Verna Ryan: As Dr. Keizer mentioned, she participates on the Mental Health Commission of Canada activities – federal, provincial, territorial meetings. I participate with the Canadian Centre on Substance Abuse and coming up in November, actually, there will be a meeting of both organizations, and that's really helpful just in terms of national indicators and connecting with other provinces in terms of what sort of research is happening there.

We are also doing some initial work with UPEI and looking at a couple of projects there, and we do have – we're going to build on the pockets of really strong information that we have on our children and youth who use the child and youth services at mental health, as well as the Strongest Families Program.

All of that data is very strong, so we'll be looking at that as an initial step to supporting. We're hoping that with the new student well-being initiative, that that information will be captured there as well.

Speaking of the Student Well-being Program, this is a significant initiative that has been undertaken over the past nine months or so, whereby, we have developed an approach and teams of resources who are going into each family of schools.

As you probably know, this fall is phase one and the Montague families of schools have a team of five who are a clinical social worker, two comprehensive school nurses and two youth workers attached to them. The same thing is happening in Westisle. This builds on services that are already in schools. So for example, corrections has youth workers who go into the schools and deliver programs, as does Mental Health and Addiction Services.

We had started the walk-in clinic at Westisle this past winter with a staff person who's shown great initiative, so we're continuing to build and work on the work that's already happened, including the Multi-Agency Support Teams, or the MAST teams, who are representatives from various groups and services, police and other community organizations who come together to address students who are having issues. So those teams are all staying in place for now, and the program will roll out over the next three years to all the other families of schools.

It is very collaborative in nature. The teams are coming from different departments, so the social workers and the nurses are situated with health, the youth workers are with Justice, education is providing a coordination role, a provincial coordinator role, and then there's been involvement from public health, from primary care, from all sorts of other areas in turn. The Canadian Mental Health Association's been involved as well. So this program will continue to roll out over the next three years.

Evaluate the continuum of services for children and youth in terms of ease of access. So we've been, over the last couple of years, have been looking at and implementing services focused on children and youth. They include Triple P parenting, which is a highly researched program. It's a population health approach, and the evidence there shows significant impacts in terms of reduction of family violence, of child protection issues, of involvement with probation or with justice, mental health issues, family breakdown. So we've done a lot of training in that area and are currently delivering that service across the province.

The Strongest Families Program, this is an interesting, innovative approach. It's been recognized by the Mental Health Commission of Canada, and it's a tele-health coaching program, whereby, families have zero wait time, essentially. It's within 24 hours. They can access approximately 12 sessions. The child who's involved can access a coach as well.

I'll give you an example. One of the targeted issues is bedwetting, which can be related to anxiety and other issues. They actually receive a workbook in the mail. They get a monitor, a moisture monitor, and a pair of pajamas for the child, and then the coach is working with them in situ any time between 6 a.m. and 1 a.m. at the family's convenience.

We started it in November 2015. We've had a total of 403 referrals to the program since then, but it really took off last April and we've had 236 referrals since last April, which is basically 10 families a week accessing this, which is really –

Dr. Heather Keizer: Very –

Verna Ryan: – really powerful.

Dr. Heather Keizer: Very satisfied families.

Verna Ryan: Yeah.

Dr. Heather Keizer: One of the big assets of this is that it's done by telephone, delivered in the family's home. So they don't have to find childcare, they don't have to drag their children off to the doctor's office or the clinician's office according to the clinician's schedule. They can call when it's convenient for them to talk to the coach from their home. So if you've got six little screaming children you can call for help in the middle of the evening at your convenience. It's been extremely well received.

Verna Ryan: And as I mentioned, the data is there to support this program, so what we're seeing is a significant reduction in symptoms. The symptoms would range from anxiety, levels of anxiety, to the family cohesion and functioning, the level of cooperation, attendance at school, those sort of things. So what's being monitored is with the intervention, are those symptoms being reduced, and we are seeing that they are in, I would say, over 95% of the time.

With the Student Well-being Program just getting going, the Mental Health and Addictions Services which are current services; we have our Behavioural Support Team which was established last year, which again, is a more intensive programming for parents and children who have significant behavioural issues. We've had 60 families through that program.

The Insight Program, which was the newly established adolescent day treatment program, this is a feature that is really what we call stepped care. So we have youth coming out of Unit 9 into Insights. We have kids coming out of school, or they're out of school and they're going into Insight so they can step up or they can step down from more intensive services, and we've had 20 youth through that program. It's an extensive program and it's very intensive led by Dr. Jackie Goodman.

Then the Strength Program, which has more of a focus on addictions. It's an in-patient program, four to six months in length, and some really good work happening there in terms of addressing concurrent disorders. By that, I mean both mental health and addiction issues being addressed there. So we've built the capacity as not just about addictions anymore.

We've had some very complex cases go there. We have had some good partnerships. We've had a young person who was in Unit 3, in the acute care unit at Hillsborough Hospital, very complex mental health issues, but she was able to go to the Strength Program and receive trauma-specific care, that Seeking Safety, and at first she was outpatient from the Prince County Hospital and she would go back to the mental health unit there. Now, in the community with the support of Housing First through the Canadian Mental health Association, and in her own apartment supported through our outreach teams in the community.

Dr. Heather Keizer: The big advantage of the Strength Program, which is quite robust now, is that we're able to have residential care. We didn't use to have that as a piece with Strength, and that's a new change in the last year.

As a result of the efficiency and effectiveness of the Strength Program, we're now not sending youth out-of-province. We're actually delivering services in-province for youth, near their families, near where they'll have to reintegrate back into the community. We've actually had some requests for people to come from other provinces to join into our Strength Program here because it's so good.

That's a huge win for us in terms of delivering the programming where our Islanders need it.

Verna Ryan: Yeah.

I would note, that just coming through the accreditation process with Health PEI, that this program was mentioned specifically by the accreditors as an outstanding program that they've seen in their journeys across Canada. Kudos to the staff there and the –

Dr. Heather Keizer: These are national accreditors –

Verna Ryan: Yeah.

Dr. Heather Keizer: – so they've seen all the way across the country, and they felt this was superb.

Verna Ryan: Okay, we're on pillar two, I'm sorry, we changed over to that. Invest early focusing on children and youth, for a little while longer.

We're partnering with the Women's Wellness Program, the newly established Women's Wellness Program, and really around the focus of facilitating access to mental health and addiction services for new mothers. Improve screening, intervention, so the folks that are working in that program are very closely tied to our community mental health and addiction services, as well as to psychiatry, who have specialization in women's wellness in postpartum depression and those sorts of issues.

Again, we're closing loops. We're bringing together the people with the specialization in order to address specific needs.

Dr. Heather Keizer: We've invested in training. We've brought over one of the psychiatrists from the maternal health program at the IWK to train our staff here on Prince Edward Island this past year, and to deliver programming. That was sort of a high-caliber level; Dr. Joanne MacDonald is a professor at Dalhousie, actually an Islander from Borden-Carleton.
She came over and did training with our staff. And, as well, Dr. Dhillon, who is a psychiatrist in Summerside, has actually stepped up as an available consultant psychiatrist for maternal mental health.

Verna Ryan: The partnership between maternal mental health and addictions initiative with public health nursing refers to the training that Dr. Keizer mentioned. And the implementation of a screening tool early on as part of public health intervention when they're doing home visits following the birth of a child. They are the health folks, who are in the homes, who are very focused on these women, so they are seeing them up close and personal in their homes and it's an excellent opportunity to do some screening.

That has not been fully implemented yet, but as Dr. Keizer mentioned, the training has happened and we are just working through the detailed work that needs to happen so that they can begin.

Partnering with public health and Children's Developmental Services to implement the Ages and Stages social-emotional screening; this is a screening that takes place at age four-and-a-half that public health delivers. Again, one of those trips in to the public health office.

In 2019 – this is just really early stages for this tool, and we're hoping in a year or so, in 2019, that we'll have everything in place to have the collaborative use of data. What has happened is public health does this terrific screening, but that data is not shared necessarily with kindergartens, for example. So, you've got some data that could really help with early indicators of issues that could be addressed at age four-and-a–half, five, but, to date, hasn't been shared with the schools. The sharing of that data, again, will be very useful in early interventions with children.

Dr. Heather Keizer: This addresses early interventions of cognitive delay issues, early interventions of autism, Asperger's Syndrome, those sorts of things, which previously to this have been sometimes a little bit late in being identified. This would help to alleviate some of that issue that has cropped up in the population.

Verna Ryan: Expanding the trauma-informed care model for Island children. Trauma-informed care, as some folks have mentioned earlier, PTSD is – what we hear about in the news and the media.

Trauma can happen during childhood and frequently does. It can happen because of some of the tougher issues like domestic violence in the home, sexual abuse, neglect, those sorts of issues. It can also be caused by witnessing accidents or deaths in families. There are multiple reasons why children might need access to trauma support. Again, this is coming from the child protection group as identifying this issue as one they'd like to advance.

In mental health and addictions, we've adopted a trauma-informed and a trauma-specific, so that means it's an actual treatment that we do. Again, we're just aligning ourselves across departments, obviously, education and definitely corrections have a need for this sort of approach.

Child Protection Act review; the Department of Family and Human Services has done a review and has priorities laid out, so that work will be continuing over the next two years. That's all I can say about that at this point.

Everybody's doing okay?

Mr. Henderson: Still with us?

Verna Ryan: Yes? Okay.

Dr. Heather Keizer: Everybody's awake still.

Verna Ryan: This is a big one. This is a big one for us; it's improving the access to community mental health and addiction services. This is an issue that we've heard repeatedly. We've heard it from many areas. It's a strategic priority for Health PEI. Really, we really need to open up the access for people to get the help when they need it.

An example I heard last week by Todd Leader, who was doing some work here on PEI was: let's say you go to an elevator and you press the button and the door opens and the elevator is full. You decide you'll wait. The elevator goes up, comes back down, and you try to get on, but the elevator is still full. No one has gotten the elevator. This can continue for quite an indefinite time because people need support and they need to feel well enough and supported enough to move on.

We're doing things like caseload reviews, for example, whereby, we're reviewing the caseloads of our clinicians and if they've carried cases for a long time. So, if they've had someone who has been coming in since 2002, to a short-term counselling service or treatment service, then we need to look at why that's happening. Sometimes, it's because they feel they might have challenges coming back into the systems, or that the supports won't be there if they need them.

With setting up the walk-in clinics, what I'm hearing from clinicians now, is that it's okay to close service for someone, because if they need something on a one-off basis, or they just feel like they need that support, they can come into a walk-in clinic now.

Dr. Heather Keizer: One of the things that we noticed when we took over our leadership was that for a long time there hasn't been sort of global oversight of the delivery of service of mental health and addictions on Prince Edward Island.

What Verna has really brought to the table is an ability to sort of look at the big picture and dive deep in terms of actual operations, which I have greatly appreciated.

What I've brought to the table is standard of practice, and the idea that we can actually have a menu of services that we're going to offer and have manualized services with set delivery of service times. This hasn't really been done before with the diligence, perhaps that we're pursuing it now.

The other piece that I've been very gratified by in the last year is that our clinicians on the ground have come up with ideas on how to be innovative in terms of delivery of service. A lot of these initiatives that we've been taking this year have really been spawned by the requests of the clinicians themselves and of the family doctors in the community.

Our goal is really to be responsive to the actual patients that are coming in, as well as the families and family doctors who are trying to get appropriate services for their clients.

Verna Ryan: Absolutely.

Chair: Richard Brown.

Mr. R. Brown: Thank you, Chair.

I asked that same question at the meeting the other night, about the elevator. So you indicate that you have a team now that evaluates each case and determines whether the person is to get off the elevator or to stay on the elevator. How many people are on

that team and what are the processes that tells that person to get off the elevator?

Dr. Heather Keizer: You really want to get into (Indistinct) today?

Verna Ryan: Yeah, sure. We have managers, supervisors and clinicians on staff already. They are doing the reviews, so we haven't brought in teams. However, there are standards of practice, usual lengths of time, where if you're using evidence-based approach to address a certain issue, then there's usually a general ballpark of the length of time that should be used to address that issue.

We're starting with the outside ones where cases have been open for years. So you move beyond treatment-based approach into something different, which is ongoing supportive counseling, and that is not the best use of your clinicians to have them provide supportive counseling. That is great use for a peer support program in the community where people can come and you can have some time with somebody who's supportive and you can unload and, okay, you feel all right.

Dr. Heather Keizer: But that's not psychotherapy.

Verna Ryan: It's really about realigning the services somewhat. We will not be sending people on who are not stable, obviously, and we'll work with them as well to see: What do you need on an ongoing basis? Do you need the services of our outreach team? Do you want to just come in at a walk-in clinic? But it really is to match up the best service for the person.

Dr. Heather Keizer: An example might –

Mr. R. Brown: So how many people have left the elevator?

Verna Ryan: How many people? That's –

Dr. Heather Keizer: (Indistinct)

Verna Ryan: I'd have to look at that to give you an actual number of cases that we've closed. Yeah, I don't have that information in front of me right now.

Dr. Heather Keizer: You've got to recognize that this is actually somewhat revolutionary to the delivery of service now. Even acknowledging that we need to empty the elevator is a new concept.

But for example, if you wanted to deliver a manualized therapy for somebody who is agoraphobic, afraid to go to the grocery store, you can deliver exposure therapy in about six to 12 weeks with one to two sessions a week with a therapist who uses a manual. But if that patient goes to a service that is more supportive, they might be there for five to six years, maybe 10 years, talking about how they're afraid of the grocery store and they never actually address the issue, and that's really what we're trying to change.

Mr. R. Brown: Thank you, Chair.

Verna Ryan: And I don't know if I'm really addressing your question, Mr. Brown.

Mr. R. Brown: Well, I just want to make sure, on the elevator thing, my concern is we're not pushing people out of the elevator too early.

Verna Ryan: Oh gosh, no.

Mr. R. Brown: And that's why I want to know what is the team, who is the team made of.

Dr. Heather Keizer: It's our managers.

Mr. R. Brown: Managers.

Verna Ryan: Managers, supervisors –

Mr. R. Brown: So it would be all psychologists, psychiatrists?

Dr. Heather Keizer: These are experienced clinicians, right? That's why they're in managerial positions.

Mr. R. Brown: Sure. Good.

Thank you, Chair.

Dr. Heather Keizer: They're new.

Mr. R. Brown: Thank you, Chair.

Verna Ryan: As I said, there are a number of different elements to this. Then, again, this is another really big one and I'll be deferring to Dr. Keizer and her in-depth knowledge on this one, but improving access to quality and appropriate psychiatric care on the Island.

Dr. Heather Keizer: Want me to talk about it?

Verna Ryan: Absolutely.

Dr. Heather Keizer: This is probably one of our hot points at the moment. As you may be aware, we have a complement of 15 psychiatrists designated PEI. I'm applying to PRPC to increase that complement to 17 because two of the psychiatrists currently on PEI, are and will be, unavailable to do in-patient service or on-call service.

The goal, really, going forward is to hire psychiatrists who have solid capacity to provide education and teaching to psychiatry residents who could potentially be on faculty at Dalhousie, as we're a teaching hospital, and would provide us with some sustainability.

If we're able to recruit solid psychiatrists with their fellowship exams, for instance, then we can also recruit residents who might be able to return as locums and as psychiatrists in the future. This is the goal.

Currently, we are, as I've mentioned previously, we are in a trough. We are at the moment very low in psychiatrists in Prince Edward Island, perhaps the lowest we've seen in a very long time. We've had some attrition of psychiatrists this year with retirement currently, with some illness, as well, as with psychiatrists, who, for a variety of reasons, have moved on, among which are the issues around passing their fellowship exams.

Again, that has to do with how we select and where we go to recruit, and moving forward I think we're doing better. At the moment, unfortunately, we do not have adequate psychiatry care on Prince Edward Island and that is true. I can get more specific as we go forward if you wish.

Chair: Richard Brown.

Mr. R. Brown: I'll try to limit.

So we require 17 and we have a complement of 15. How many current psychiatrists do we have on Prince Edward Island?

Dr. Heather Keizer: We currently have 9.5 fulltime equivalent psychiatrists here. Of that 9.5, we have 4.7 fulltime equivalents who are able to do on-call in the emergency room.

Mr. R. Brown: There was, and there continues to be a crisis, probably, or a shortage of doctors, medical doctors in the past. I believe that in the past we said: Okay, we had a recruit problem and we had a difficult time finding doctors to fill the complement.

At the time, we said: Well, let's look at the system and see if we can share the responsibility of the doctor's role, medical doctor. We looked at the continuum of care along it and we said: Okay, maybe a nurse practitioner can take some of the load of the doctor under the supervision of the doctor, maybe the nurses below the nurse practitioner can do some functions, and maybe the LPNs can do some functions.

There was a remodeling of the system, and I think that has avoided a crisis in the medical system. So would we not look at the same sort of restructuring of that care in terms of saying: We have well-educated psychologists which are doctors, why can't we share the responsibility with them?

Dr. Heather Keizer: Let me clarify, all right? Psychiatrists are medical doctors and we have the same amount of training as surgeons do. So we do four years of training in medical school and five years of training in our specialty, and what makes us different than psychologists, is that psychologists are not doctors. They do not have hospital privileges and they do not have the capacity to write prescriptions for patients, nor do they have psychiatric training. They have psychology training.

There is no question there's a very important role for psychologists on our psychiatric units and in our outpatient services, but remember that the psychiatrists do a special role. We are responsible for in-patient beds in hospitals. We are the most responsible

physicians, and in Charlottetown there are 90 in-patient psychiatric beds between QEH and Hillsborough Hospital for which we require psychiatric supervision.

At the moment, we have one on-site psychiatrist at QEH and one tele-psychiatrist delivering child and adolescent care, and we have one on-site psychiatrist delivering oversight for 69 beds at Hillsborough Hospital. We are extremely shorthanded, and that job cannot be done by nurse practitioners, nor can it be done by psychologists.

Mr. R. Brown: So nowhere else in Canada or in North America, psychologists are allowed to prescribe?

Dr. Heather Keizer: No, well not – no. They're not physicians. So recognize – psychologists do treat something very important, but they are not doctors. They haven't gone to medical school, nor have they had five years of specialty training post-medical school like a surgeon does. I'm a fellow of the Royal College of Physicians and Surgeons as are my colleagues in psychiatry. It's a different sort of service that we deliver, and psychologists don't treat schizophrenics, for instance, don't treat patients with bipolar disorder, don't tend to treat dementia, and don't tend to treat complex medical and psychiatric illnesses.

Mr. Henderson: Maybe I'll add a little bit to this, too. I think I know where the member comes from and I have to admit, from my perspective as becoming minister of health, I had to sort of get the same understanding of the difference between a psychologist and a psychiatrist. But, I would also say, as minister, we have had discussions with the college of psychiatry and that's what was another little bit of a learning –

Dr. Heather Keizer: College of psychiatrists.

Mr. Henderson: Psychiatrists, is it?

Dr. Heather Keizer: The association, yes.

Mr. Henderson: Okay, the association of psychiatrists.

So there are all these other groups that are out there from the medical society and such, but I would say there is some interest in having a nurse practitioner work with a psychiatrist – under the guides of a psychiatrist – to allow them to maybe do more difficult issues maybe, or whatever – or not the nurse practitioner – Dr. Keizer, do you want to –

Dr. Heather Keizer: I would suggest one of the other issues at Hillsborough Hospital at the moment is we do not have sufficient medical coverage for the patients there – recognize the patients we have – a geriatric unit with 17 patients who require medical, as well as psychiatric care and we don't have adequate medical coverage.

I think this is a wonderful location where we could have nurse practitioners provide on-site support medically for these cases in collaboration with a family doctor, but that does not in any means replace the need for psychiatrists on-site.

Mr. Henderson: I think it's about that collaboration again using these skills.

Dr. Heather Keizer: Yes, but we need psychiatrists to deliver – it's true we talk about psychiatrists being sort of the top of the pyramid and they provide leadership and diagnosis and intervention, but what we do as psychiatrists is quite distinct from what is done, and is able to be done, by nurse practitioners or family doctors, or psychologists.

If you look at outpatient services, we have at the moment, or will have, only point four psychiatrists in Richmond centre, although I would like to have at least three full FTEs in Richmond centre and we have point nine psychiatrists at McGill centre, who is delivering service to chronic care and we have two other psychiatrists, full FTEs, in the community who are delivering outpatient services, but both of them are post-retirement age and both of them are unable to provide on-call service to the emergency room or in-patient services. We're down quite a few at the moment and it is an urgent issue.

Chair: Thank you, Dr. Keizer.

Darlene Compton had a question.

Ms. Compton: Thank you, Chair.

Dr. Keizer, you mentioned a little bit earlier and made the comment: How we select and where we go to recruit is an issue.

Dr. Heather Keizer: Yes.

Ms. Compton: I'm just wondering if you could elaborate a little bit on that.

Dr. Heather Keizer: Well, one of the things that has been a bit of a stumbling block for us over the last number of years is that on occasion we have gotten perhaps a little desperate in trying to fill our complement and in desperation, perhaps, we have not recruited, perhaps, as robust candidates as we could.

We've had some candidates who perhaps were unable to fulfill their capacity in their role and struggled to pass their fellowship exams. Our license here in Prince Edward Island requires that a psychiatrist must complete their fellowship exams with the Royal College of Physicians and Surgeons within five years or within three tries, whichever comes first. If they are unable to do that they lose their license. This is important because it maintains a standard of practice. It allows them to be clinicians who are able to teach and support residents and medical students and individuals who can come in and also maintain some continuity, as well as long-term stability for our department.

It does make a difference. Practicing in Canada is different than practicing elsewhere; you have to know the law. In psychiatry we have a different role; again, distinct from psychology, in that we are accountable, not only to the department of health, we're also accountable, according to the medical health act, to the department of justice. So as a psychiatrist, you have to be able to fulfill a legal role and a mandate to provide care, not only to the individual, but also to the community. We have a responsibility to make sure that the community is safe, as well as the individual is safe. So it is sort of a specialized role.

When we've recruited them past, perhaps – well as we go forward, I'll put it that way, I think one of our moves is to look more to our Canadian-trained psychiatrists who have passed their exams prior to getting here and who have a good sense of the law in Canada. For those who we recruit from other countries; we want to recruit those who have shown leadership, have shown vision, have an ability, perhaps, to bring something to the table that enhances our service.

Chair: Darlene, follow-up?

Ms. Compton: Yeah.
So we understand we're at a crisis. Maybe we need to change the way we're recruiting, as you just talked about. Have there been actions taken to make that happen and how do we as little old PEI feel that we're going to recruit the Canadian psychiatrists that we need?

Dr. Heather Keizer: So, specifically – I've got my little cheat sheet here.

Specifically, in the last 12 months we've had 12 WebEx interviews; myself with the department of recruitment, and we've had three additional ones that are actually scheduled for tomorrow, so that will be a total of 15 by the end of this week of interviews of clinicians, both abroad, and in Canada.

We've had six site visits. We've had three people work as locums here who still retain licenses in Prince Edward Island but are currently working full-time elsewhere. I personally have gone to Ottawa and interviewed six residents from the University of Ottawa, had great interest in that group. Of that group, one of those is an Islander who will be returning to do a six-month community placement with us this year. Of the other five, they're all interested in coming and working as locums, having had direct contact and heard about our programming.

Myself and the department of recruitment, actually visited Dalhousie last fall and met with 25-plus residents in psychiatry at Dalhousie. Of that group, one will be coming, actually, in November to do a community elective. This is a new initiative. We've never had a program for community electives in PEI before for residents in psychiatry and I've had really good uptake, actually, with the program directors at both Dalhousie and Memorial and Ottawa and I

think this is a really rich option for us going forward.

The thing with recruiting people from Canada is you really need to go out two years. You can't do it at the last minute because when someone is graduating they've already got their plans made. So you've got to get to them when they're in, say, their second and third year of residency and you need to meet with them personally and have a talk.

In addition, we have recently seen the potential in a couple of other international recruits. I would say our most recent visit, a site visit, from a colleague in the US, I think, went very well, because one of the things that attracted him; although he's a graduate of Harvard and of Yale and a very well qualified clinician, he was attracted to the idea that he might be able to be involved with master planning. He's a geriatric psychiatrist with a lot of vision and he wants to be part of a delivery of a service that is of national standard, of excellent standard, and we have that potential here. This is a wonderful opportunity in mental health and addictions to actually recruit, based upon vision, and to bring in people who are willing to bring to the table, not only their vision for their own practices, but their vision for the system based upon best evidence and best practice nationally and internationally. It's a wonderful selling point and it's actually worked.

Ms. Compton: Thank you.

Chair: James Aylward.

Mr. Aylward: Thanks very much, Chair. Thanks for your presentation thus far.

I have to say, as compared to the one we received a couple of years ago when the individual that was in your chair, Dr. Keizer, at the time presented us with three slides and I thought it was very inadequate.

Dr. Keizer, you had mentioned you've done some web interviews. Are they exit interviews?

Dr. Heather Keizer: Exit interviews? No. These are entering -

Mr. Aylward: I'm just wondering with –

Verna Ryan: (Indistinct) WebEx.

Mr. Aylward: Okay, but I guess what I'm wondering, is with the psychiatrists that we have lost and that we continue to lose, is there exit interviews being conducted to find out what the root cause is, or if there's a root cause, or why are they choosing to their leave practice here?

Dr. Heather Keizer: Indeed there has been.

Mr. Aylward: Okay, and is that information available or –

Dr. Heather Keizer: I don't want to be indelicate about that. Those who have exited have exited in response to a performance review.

Mr. Aylward: I can read between the lines there, thank you.

I'm wondering too, there is always so much focus on recruitment, and I'm always prone to talk about: we have to retain, as well. I can understand that if something happens in a performance review then maybe that individual isn't a candidate for retention, but –

Dr. Heather Keizer: Correct.

Mr. Aylward: – are there any new initiatives or incentives taking place to make PEI more attractive? Like, the ones that you're trying to recruit, and maybe they're saying no, are we determining why they're choosing not to come to PEI, or what other provinces or cities or states, for that matter, are more attractive than PEI to come to?

Dr. Heather Keizer: I would suggest that this is currently a significant point of discussion between myself and the department of health.

Mr. Aylward: Yeah.

Dr. Heather Keizer: In that, although CIHI would suggest that the average salary of psychiatrists on Prince Edward Island is amongst the highest in the country at $366,000, that is, as a result of a very small proportion of psychiatrists delivering ongoing service to a very large population of fee-for-service billings. Some of my

psychiatrists are working very long hours, seeing more people than they normally would see because of the demand and the lack of manpower. So it averages out that they have a very high income for the fee-for-service clinicians.

The average salaried physician on Prince Edward Island, on the other hand, a psychiatrist on PEI is approximately the second lowest salary offered in the country. At the moment we are in – we're going to be doing a – and maybe Mr. Henderson can speak to this – but we're going to be having a review of our offerings for salaried physicians.

In addition to that, our on-call on Prince Edward Island at the moment is extraordinarily onerous. I was on-call yesterday, and we had 10 patients in the emergency room, all of whom were very complex, and it wouldn't be uncommon for me to do on-call and see between 15 and 20 patients in the emergency room.

Recognizing that these are complex cases and often take an hour each, you can see where people go unseen on occasion and it is very onerous.

When I was in residency, and this is, perhaps, an unfortunate admission, I chose psychiatry because I had one-in-fourteen call, and I had two calls a night. It would be the rare resident who would expect to have this level of work in the emergency room in psychiatry. Now, that cannot only be addressed by properly remunerating the psychiatrists to do on-call, but it also needs to be addressed by the system, and that is a larger piece. We do need Verna to continue to show us how we're going to address some of those issues.

Mr. Henderson: I guess the only thing I want to add to it is, once again, Dr. Keizer and I have had discussions about remuneration and salary as it comparables, and you know, I want everybody to be aware that it's a competitive marketplace out there.

The reality is, is that you've got Newfoundland, Nova Scotia, other jurisdictions that are also recruiting psychiatrists and they have shortages of psychiatrists. I do say that for us to be in the starting salary range for those psychiatrists that choose the salaried option, we have to be more competitive than we are. I think right at the moment, that's part of what we're reviewing to try to determine what is the optimum salary to give us the maximum opportunity to have a reasonable shot at attracting psychiatrists to the province. That is underway at the moment; meeting on Friday, so we're starting that process, at the moment. But, I say: competitive marketplace elsewhere, too, just be aware of that.

Chair: James, do you have a follow-up question?

Mr. Aylward: Yeah. There was, with great fanfare, earlier this year the announcement that we had a new psychiatrist coming here to PEI with extensive experience within a mental health mobile crisis –

Mr. Henderson: Correct, yeah.

Mr. Aylward: – team, which is something that I've been talking about in the Legislative Assembly and advocating for because I think it's something, a resource that we desperately need here on PEI, especially when you hear the stories from families.

Minister, I believe you had said that that individual was here on PEI as of around September 3rd –

Mr. Henderson: October 1st something like that –

Mr. Aylward: – working –

Mr. Henderson: – around the end of September.

Mr. Aylward: – but is that individual, in fact, here yet?

Mr. Henderson: No. That individual is not here at the moment. There have been some issues. They've signed their offer sheet, everything is all done there, but the visa has been a problem, has been the holdup at the moment. So, we're hopeful we can get that, and maybe Dr. Keizer can explain more further on that.

Dr. Heather Keizer: Might I speak to that a little bit, Dr. Nachnani, Mahesh Nachnani, is of whom you speak –

Mr. Aylward: Right.

Dr. Heather Keizer: He is a psychiatrist working in Lincolnshire, England. He came in the dead of winter, during one of our worst snowstorms, and yet he decided he wanted to come and sign with us.

He does have some experience in mobile crisis units. I really do want to correct the record, however, that our establishment of a mobile crisis unit has not hinged on his coming.

Mr. Aylward: Yeah.

Dr. Heather Keizer: And, in fact, I, myself, as a director of psychiatry in Huron-Perth County Ontario, had a mobile crisis unit there while I was in Ontario and we've talked about this, since I've arrived here into this role.

Actually, Huron-Perth County delivered Canada-based, a mobile crisis unit there for 20 years to a population of 150,000, which is both urban and rural, not unlike Prince Edward Island. This summer my program director from Huron-Perth County actually came and met with both Verna and I, on her vacation time, to help us establish and do the planning around mobile crisis. So that has moved forward quite aggressively, actually, despite the fact that Dr. Nachnani remains in Lincolnshire England.

He may, or may not come and slide into the role. He will require getting familiar with the Canadian system; getting familiar with rural Canada and his coming or not coming does not preclude the movement forward on this file.

Chair: James, do you have a follow-up question?

Mr. Aylward: Thank you, Chair.

You've talked quite a bit, too, about the walk-in facilities, the walk-in centres across PEI that have been established.

Can you remind me what the hours of operations are for those facilities?

Verna Ryan: They're different at most sites. They tend to be 10:00 a.m. to 6:00 p.m.

Mr. Aylward: Thank you.

If an individual is experiencing self harm or suicidal thoughts, and one of the clinics across PEI is not available, obviously they are going to present to one of our primary care facilities, PCH, QEH –

Verna Ryan: Emerg –

Mr. Aylward: – emergency rooms.

Is there ever a case where we would have somebody present to the ER with suicidal thoughts, with a plan in place, that they would be brought into the ER, be there for maybe two or three days, not see a psychiatrist, and potentially discharged without having seen a psychiatrist?

Dr. Heather Keizer: It's conceivable because of our short staffing, it's conceivable. It's unusual.

Recognize that emerg physicians are well trained in psychiatric risk assessment for suicidality, as well. Though, someone may come in with a plan and suicidal ideation, doesn't necessarily mean that they will be at acute risk 48 hours out.

I'll give you an example. If someone comes in who is an alcoholic; has been drinking heavily; has just lost his girlfriend and his job, and feels overwhelmed and is angry and drunk and then comes into the emergency room. It's not unusual that that person should be kept, absolutely, for at least 48 hours until they dry out, and after 48 hours to 72 hours, they're not suicidal anymore and they might go home without seeing a psychiatrist, if the emerg doc is checking in on them and rechecks them once they've dried out and they're no longer suicidal. That does happen on occasion, particularly in the context of substance abuse.

Generally speaking, most patients who present with that kind of a presentation would see a psychiatrist. But again, family doctors and emerg physicians are also trained to assess for suicidality.

Mr. Aylward: Yeah.

Chair: James, follow-up.

Mr. Aylward: I understand what you're speaking of, Dr. Keizer, as far as maybe if they're suffering from alcoholism and they've, the young–

Dr. Heather Keizer: It has happened.

Mr. Aylward: – man has just – I can relate to that, but if somebody actually has a case file where they have been diagnosed with a severe mental health issue and they're presenting. Let's say it's PTSD or schizophrenia or bipolar, what have you, and they present and they have a plan, but they want to talk to somebody because they don't want to carry through with this, but they still have this plan and they have these thoughts of self harm and ending their life.

I guess I need to know from you if they're going to see a psychiatrist because –

Dr. Heather Keizer: Again, not necessarily. Recognize what a psychiatrist does. So, our role in the emergency room is to diagnose and to determine whether somebody should be – I'll be really blunt, because I just came off- call. I was in the emergency room until 10:45 p.m. last night because I'm on-call very regularly.

My role in the emergency room is to determine whether or not a patient needs to be admitted; if they need to be admitted, whether or not they need to be admitted voluntarily or involuntarily. That's my main job.

If an emergency room physician has already determined that they are going to be admitted to a medical bed, they may not be referred to me. If the emergency room physician feels that they're too dangerous, too aggressive, too drunken, they may be kept for another 48 hours before they see a psychiatrist. That's not unusual, because I can't take a full assessment until they've settled down and are medically cleared.

My role in the emergency room is not to provide counseling per se. It is actually to determine whether a patient requires admission or is able to go home, and if they are going to go home, what appropriate follow-up there should be for them. For instance, we have crisis nurses who often will do contact with the patient and spend a lot of time doing some counseling and assessment as well.

That's a role that sometimes is taken by the emergency room physician, and also recognize we are extraordinarily shorthanded so we're having to triage. Everyone is triaged that goes through emerge. Whereas, we should have 15 psychiatrists on call in our emergency room, we have 4.7.

Mr. Aylward: Right, and potentially less, soon.

Dr. Heather Keizer: Well, that's based upon my number for, say, this coming October 13th.

Mr. Aylward: Yeah. Does Dr. Terry Cronin work in the ER?

Dr. Heather Keizer: Dr. Terence Cronin does approximately one call a month and has done – in this past year, at my request, he previously had not been choosing to do call because he was past retirement age. He's been very generous in allowing us one or two calls a month. He's now choosing to retire, although it's possible he may come back as a locum physician in the next six months.

Mr. Aylward: I'll probably have more questions later on, Chair, but I'll move on.

Chair: Great, thank you.

Peter, you're next on my list.

Dr. Bevan-Baker: Thank you, Chair.

Thank you for the presentation. I'd like to echo what James said earlier.

Dr. Heather Keizer: We're not done.

Dr. Bevan-Baker: I understand that, a long way to go, but this is – both the mental health strategy and this new document that we've been presented today, really admirable, very comprehensive vision of what can and should be done on Prince Edward Island.

But when Sherry Jean Ball took her life in 2013 and there was consequently an inquiry

in 2016, there were 14 recommendations. The very first recommendation was this:

That an optimal complement of psychiatrists and medical staff is necessary to ensure an appropriate and consistent level of care.

Clearly we have gone backwards rather than forwards since that time.

I also notice that in the strategic document that we're presented today, that the timeline on many of the issues or the bullet points that we've looked at up to now is being early 2018, June 2018, November 2017; but when we come to enhanced supports to deliver national standards for psychiatric care, the timeline for that is December 2020. So we're looking at more than three years out from there before we're even planning to get there.

My question is this: The complement of psychiatrists which has decreased quite considerably, you've sort of alluded to the fact that some of them were perhaps not voluntary retirements.

Dr. Heather Keizer: (Indistinct)

Dr. Bevan-Baker: Did Health PEI terminate any of those salaried positions, and if so, why would you do that at a time of crisis?

Dr. Heather Keizer: No. None of those positions were terminated. All of them were voluntary resignations or retirements.

Chair: Peter.

Dr. Bevan-Baker: Thank you.

I think it's important that we understand that medical health care does not equate with psychiatric complement, there's far more to it than that. I'm very interested and concerned that the team collaborative approach is not – and I know there are many lovely words in here about that – but I want to challenge something you said a minute ago about clinical psychologists.

I understand they cannot be prescribers. I get that; but they can indeed diagnose, and they can plan interventions. They can provide many of the same services that psychiatrists do.

So would it not be better to use those people who are available – and of course, we're down on psychologists as well, it's not just psychiatrists that we're short of – but would it not make sense for those clinical psychologists to take up some of the slack where psychiatrists are now working? You mentioned earlier how over-stressed you all are.

Dr. Heather Keizer: Well indeed, I would suggest that we've already done that. So we do have a clinical psychologist, Dr. Jackie Goodwin, who is our director of our insight program. We do have Dr. Rhonda Matters who's the director of our behavioural support team, and we do have Greg Purvis, who has taken over the directorship of our addiction service. I, personally, was there myself and I've given over the work to him and he is a psychologist with expertise in addictions.

I absolutely endorse the use of psychologists regularly within the system. I think it's a wonderful idea, but they cannot replace some of the pieces that are necessary to be filled by a psychiatrist. I do, I agree with you.

Chair: Verna, do you want to say something?

Verna Ryan: I would also note that we have a number of psychology positions across government that we have not been able to fill. Actually, just last week, the deputy minister and I met with the psychology association to draw on their ideas and their input as to how we can better address those shortages. I would like to see those positions filled before we start stretching that group too thin as well.

Mr. Henderson: I'd like to add a couple of things in, too. One of the issues I think we talked about is actually the minister of education and myself and our departments have had some collaboration when it comes to the recruiting of psychologists as it pertains to the education system.

We have a recruiting and retention division within our department, and we want to be able to be as efficient as we possibly can. When we have a lead on a psychologist, we're not afraid to say that maybe they'd be a good fit for the education system, as well

as the education system may provide some psychology services to our health system, so that's one of the issues.

The other point I wanted to make was about when it comes to adding to the complement, it's not a mythical number that you just say: We're going to add three more psychiatrists to the complement. We have a committee; it's a physician recruiting and complement committee –

Unidentified Voice: (Indistinct)

Mr. Henderson: – retention committee, and the – any time that there's a request for more of a complement, whether it's a complement of family physicians to a certain region or specialty physicians where there's a gastrointestinologist, the list goes on, there's a request that gets made. It goes to that committee, and that committee would review the validity of the request. I guess the issue – then that comes back to the minister. The minister, then, would sign off on it or not.

If you look at the issue of psychiatry where we have a complement of 15 which we don't have filled at the moment, we are looking at the possibility of going up to a complement of 17 and that was the question I'd asked: Does increasing the complement change anything when you have vacancies below it? Now the argument would be is that if you had a higher complement, it may attract more because then they know that if it was a full complement they would be able to spread out the workload over a greater amount and things of that nature.

That's the type of stuff that recruiting and retention would look at doing, as well as the PRCP committee. Basically that request is going to go ahead to that particular committee. We'll see what comes back; but myself, as minister, if there was an agreement by that committee to recommend increasing the complement to 17 and there are valid arguments for that, I would sign off on that. So that's kind of where we're at.

Dr. Heather Keizer: There's another piece that I think is important, and it's about work-life balance. Again, this work is extremely exhausting and tiring and it does lend itself to collaborative work, there's no question about that.

One of the things I noticed when I was chatting with the psychiatrists in Ottawa, the young psychiatrists who are interested in potentially coming and doing locums here or settling here, many were going to be young parents. I just today met with a young parent, and in that context, sometimes being a full FTE is not going to work out so easily.

One of the reasons why I, in addition to dealing with the two psychiatrists who are unable to do call or do in-patient work, the other thing I wanted was some flexibility to be able to have some job sharing. The clinicians who do not want to work a full FTE could, if I had a little flexibility, be able to job share in positions, and that's something that most other centers aren't providing.

Most other centers are not very parent-friendly, and if we could be a parent-friendly center, we could attract young, enthusiastic clinicians who would come with their young families, would settle here, their children would be in schools here, and as their children grew up they could take on more responsibility and take on a larger FTE. But if we had that opportunity to job share, I think it would be very innovative and potentially very attractive to a lot of the new graduates coming out.

Chair: Peter.

Dr. Bevan-Baker: Chair.

Along with yourself, Chair, and Mr. Brown, I was at Todd Leader's presentation last week which his paradigm, of course, is client-centered rather than a system-driven care and I think that's a really great thing. His name has come up several times today. I'm wondering whether Todd Leader's model will ultimately reduce the need for some psychiatrists here on the Island.

I know that the original mental health and addiction strategy, Todd was not one of the authors of that. He has since come on board with the province and is one person who is offering advice and leadership as we develop the program going on. Have you done an assessment as to whether Todd's ideas will ultimately reduce the number of

psychiatrists? If so, where will you put that money?

Verna Ryan: We have been working with Todd Leader. Actually, we took a site visit to the South Shore where he was working three years ago when we had heard about a sort of model that he was implementing there and we liked what we saw. It definitely increases access. Nowhere have I really seen – although he did mention it in his presentation at UPEI – that the right cure at the right time can sometimes reduce the need for more intensive care if things get into a crisis mode. I don't have an assessment and I don't believe that he offers any sort of assessment on the impact of psychiatric care in what he's pulled together in his book.

Dr. Heather Keizer: I would suggest – this has been a question I've pondered quite a long time. I was the director of mental health and addictions, as I said, in Huron-Perth County, Ontario, where we had a population of 150,000 and provided comprehensive care, both in urban and rural centres. When I was there as a director, we had at maximum six psychiatrists delivering superb care through the life cycle for our patients. We had an excellent mobile mental crisis unit. We had very robust outpatient services. I've pondered: Why could we do that with six psychiatrists and we can barely get by with the psychiatrists we have in Prince Edward Island?

I've got 9.5; we're below complement of 15. I prefer a complement of 17 based upon the demand. Why was it so much easier in Ontario? I came up with a couple of answers to that question. One was that the burden of illness was less, frankly, where I was practicing in Ontario. Since I've moved here I've seen more severe, more illness more regularly in the emergency rooms in Prince Edward Island than I did in Ontario. That may reflect just the demographics of PEI and maybe some of the predispositions of our population.

The other piece that I realized was an issue was that in Ontario with that population, we had 18 in-patient beds only and we weren't a province. We had no responsibility to forensic care. We had no responsibility to the cognitively delayed population or the adult protection population. Here, we have 90 in-patient beds in Charlottetown, whereas in Huron-Perth County I had 18 and in total we have 90 beds in Charlottetown and we have 14 beds in Summerside. That's a lot of in-patient beds and in-patient beds drive the number of psychiatrists.

Hence the reason why a few years ago we looked at an INSIGHT program for the delivery of adolescent care because if we put it in an outpatient setting, a psychiatrist consults once a week but it's otherwise managed by outpatient services, led by a psychologist and there's no need to have a physician managing beds; whereas if you have beds, then it drives the number of psychiatrists.

Also, you need to remember that although 90 sounds like a lot of beds in Charlottetown, we are now still, still today, transitioning from an asylum model in Prince Edward Island which didn't exist where I was in Ontario. So in 1990, we had 300 beds at Hillsborough Hospital and that was the model. You got sick; you went and lived in the hospital. That is no longer the model we're using, but we're still in transition from that.

So when we look at our master planning going forward, we have to think about whether we're going to retain 90 in-patient beds which drive psychiatrists' numbers or whether we're going to look at more innovative programming on an outpatient basis that can actually circumvent the need for in-patient beds to that degree.

However, whatever we do we still have a responsibility to forensic care, which I know I didn't have in Ontario. We have a responsibility to the cognitive delayed population, which I didn't have in Ontario, and we have a burgeoning geriatric population that sometimes will require in-patient services. Those, I think, are factors that make us significantly different and we have driven psychiatry numbers here.

Chair: Peter.

Dr. Bevan-Baker: Heather, you just talked about how the attitudes and the approaches to psychiatric care and psychological care have changed over the years dramatically and incredibly quickly relative to other specialties, medical specialties. I was

intrigued – I'm going to go back a little bit in the presentation to what you called the mental health and addiction campus, which I find an intriguing term.

Correct me if I'm wrong, but I read into that that we're talking about the replacement for the Hillsborough Hospital, although perhaps more in the bricks and mortar here, also, perhaps a research facility or something with a broader primary care preventative collaborative approach. I'm not quite sure, but I'm quite excited at the prospect that we could build a world class, cutting edge facility here on Prince Edward Island to replace an aging facility.

Could you talk a little bit about what the mental health and addiction campus is?

Dr. Heather Keizer: Is that going to be later on in your presentation?

Dr. Bevan-Baker: Or is that –

Verna Ryan: (Indistinct)

Dr. Bevan-Baker: I wasn't going to go there, but you brought up the asylum and I was interested in what you had in mind.

Dr. Heather Keizer: Again, if you look across the country, asylums, psychiatric facilities, if you look anywhere across the country, are on beautiful real estate, you'll notice. That was true of the Nova Scotia Hospital in Nova Scotia. It's true across the country, they tend to be on beautiful waterfront properties and that's very much the case at Hillsborough Hospital as well. So beautiful was it, in fact, that we've actually hosted our first wedding there a couple of weeks ago which was wonderful.
That is a beautiful, province-owned area. It is therapeutic just by its very nature. So when we think about planning ahead, I think one of the things that Verna and I really agreed on was we didn't want to race into a build that would be an ugly box on a beautiful location. We wanted to do this in a way that would reflect master planning and actual need, and also would reflect what the population of Prince Edward Island wanted.

One of the things that I would see going forward as we design this is it that we would love to have the input of Islanders across the Island as to what they could imagine for this. We would like to probably roll it out in somewhat of a modular fashion so that it doesn't get bound up in our election cycles, but in fact could continue to be invested in and supersede politics and actually provide truly comprehensive care.

I guess one of the appeals that we would make here, Verna and I, is that we really do need those on either sides of the House to really invest and to recognize that this is an issue that supersedes politics and really requires investment in something that is sustainable, something that is green, something that's integrated with the community and actually, is collaborative, across a number of sectors within our government provincially.

Dr. Bevan-Baker: Thank you, Chair.

I do have many more questions, but I know we have a lot to go through.

Chair: Richard Brown you were next on the list.

Mr. R. Brown: First of all, I've been around here a long time and this has been a great – we're having a great discussion here and it's long overdue and I thank Dr. Keizer for coming here today and I've talked to her in the past – and the RFP that's out right now for the consulting services for the development of a master program and master plan for a mental health campus, I understand by the document the agreement was to be signed September 15th.

Has the proponent been selected?

Mr. Henderson: We'll let Verna speak to that.

Verna Ryan: No. We're in the final stages, actually. We are meeting tomorrow just to go over the final marks. We did a referencing process and we had asked for additional examples of the work from the submitters so (Indistinct) -

Mr. R. Brown: Just one final question then.

With the current proposed – we're hearing a tremendous amount of discussion around recruitment and the need for recruitment here in Prince Edward Island, and I'd have to agree with the doctor that it's vital that we

get onto this. So with the current proposed tax changes Ottawa is proposing, do you think it's going to hinder your ability to hire doctors, psychiatrists here in Prince Edward Island and in Canada?

Dr. Heather Keizer: I don't know if I want to wander into that loaded question. I have an opinion, but I'll save it for later.

Mr. R. Brown: We'd like to hear your opinion.

Mr. Henderson: I just want to comment to that; it's probably (Indistinct) to make us any less competitive within Canada, but for international doctors that are looking to come to Prince Edward Island or to Canada, it might be a factor. The publicity probably would make them look at that a little more detailed, so it's a concern.

Dr. Heather Keizer: Certainly, Dr. (Indistinct) –

Dr. Heather Keizer: – opinion, but I'll save it for later.

Mr. R. Brown: We'd like to hear your opinion.

Mr. Henderson: I guess – I'll answer that. It's probably not (Indistinct) us any less competitive within Canada, but for international doctors that are looking to come to Prince Edward Island or to Canada, it might be a factor, the publicity probably would make them look at that a little more detailed, so it's a concern.

Dr. Heather Keizer: Certainly, Dr. Nachnani got wind of it and actually sent me some emails of concern.

Mr. R. Brown: Thank you.

We'll send that on to Ottawa.

Chair: Richard are you (Indistinct)

Mr. R. Brown: That's it, thank you, Chairman.

Chair: Chris Palmer.

Mr. Palmer: Thank you, Chair.

My question is around the psychologists and psychiatrists shortage and you'd suggested that that is not unique to us, it's happening in other places.

Do we do best practice reviews to see how other jurisdictions are dealing with that, or does everybody just wish they had more? Are there strategies out there that we could adopt, and I guess at the baseline, is anybody out there constantly looking at those best practice pieces to see if there are things we can adopt here?

Mr. Henderson: I guess from my perspective, I'll weigh in on that one.

Once again, if you do look at the issue of compensation, it's usually a factor. We do know that there are many jurisdictions, especially in Atlantic Canada, that are under the same challenge that we are in trying to recruit and retain specialty positions, as well as, rural physicians, so that's not uncommon, as far as that goes.
If you look at one of the provinces and territories that has probably, the closest to their complement would be Saskatchewan, and one of the issues there is remuneration. I think that's part of our discussion on Friday was to how do we address that issue.

Anyway, I don't know, what's this here?

Dr. Heather Keizer: That's the funding.

Mr. Henderson: Yeah, so like you say, when you look at the comparables, we are the second lowest in starting compensation so that's definitely a factor. And, that's where, you know, I've instructed the department to reevaluate that and, at least, be in the competitive edge within Atlantic Canada.

I would say that Prince Edward Island is a wonderful place to live. We have all kinds of other components that make it an attractive place to work and practice your profession here, but compensation is a component of that.

Dr. Heather Keizer: I wanted to just comment on something Verna cued me to. Another potential solution will be in telehealth.

Although, I guess, on the surface, makes people a little nervous to have their child, or have themselves be assessed by at psychiatrist over a screen. I would suggest that our use of Dr. Kizilbash, who is a full FTE locum psychiatrist, and is signed now for a year with us, has been a lifesaver.

In fact, he's been generally very well received. In the morning he does rounds on our four adolescent beds in the QEH and in the afternoon, by telehealth, he delivers outpatient services at the Richmond Centre. One day a week he works at INSIGHT, again by telehealth.

For him, he doesn't have transportation costs, and he's able to actually deliver his service to Prince Edward Island while still living in Ontario where he's got the family connections that he wants to sustain.

One of the things that may be a hope for us, and it's unquestionably innovative and unquestionably different, but I think something worth investing in is the use of telehealth across the board within psychiatric services, including in-patient services, because that may allow us, and I think it will allow us, to tap into high quality psychiatrists from across the country, who can come and work with us by telehealth as consultants.

It'll also be helpful, for instance, if we want to pursue research work with colleagues in say, Toronto and Vancouver, to maintain communications. It is a new and innovative approach, but I think one that will have a little bit of capital investment reaping a lot clinical rewards.

Mr. Henderson: I think I'd like to add to that, too, the respect that I had the opportunity to witness this myself.

We're talking high-definition screens. We're talking like the confidentiality; all of those issues have all been addressed on this.

Dr. Heather Keizer: Yes.

Mr. Henderson: This is not Skype –

Dr. Heather Keizer: Good point.

Mr. Henderson: – on a computer. I just want to say that it is a possibility of some greater usages based on the advances of technology. There have been many people who have been advocating for more telehealth, and we are looking at trying to expand our technologies across the province.

I think, recently, in O'Leary the foundation purchased all the technical equipment to integrate that into the O'Leary Community Hospital and the services at primary care there. These are things that I think as technology evolves, but I want to emphasize that it is, you know, highly confidential, it meets all of those criteria and it's crystal clear, it's not Skype.

Dr. Heather Keizer: Indeed, this was a huge body of work that was done by our staff to do the work with the privacy commissioner, and the development of our pathways to deliver telehealth services. It was an enormous piece of work.
We had hoped to get telehealth up and rolling by October. It took until February to get that in place because of the depth of work that was done with regard of information management.

Chair: Chris had a follow-up question.

Mr. Palmer: Thank you, minister for the answer, but I don't know if my question really got to where I wanted it to be, which is: Are we looking at other jurisdictions and seeing what they're doing and taking those best practices and bringing them back here?

I think what you had told us earlier is that other jurisdictions don't have the FTEs in place either. How are they dealing with it? And, do we have, again, I guess the core of the question: Do we have anyone who is doing the best practice reviews that are looking at other jurisdictions for those innovative, or maybe not innovative models, that are able to help us solve some of these?

Mr. Henderson: I guess my only point is, I've certainly met with recruiting and retention on numerous times to try to look at how we are addressing these types of issues. Are we competitive in salary? Do we offer the incentives for moving and all those types of things? My understanding is, is that we are competitive in most categories.

Now, if I take psychiatry, we are probably not where we need to be from a

compensatory perspective and that's where we will review that and hopefully get that to a number that makes us more competitive.

It is a competitive marketplace in those regards and all these types of incentives have to always be reviewed, but it's kind of a – everybody's upping the ante all the time to try to address that. If you take the issues of even trying to create more, whatever the profession is, psychiatrists, nurses, the list goes on, there are big challenges even with our post-secondary institutions in being able to expand the amount of students that they have. There are a lot of issues that we're working through that. But, all I am saying is that we are no different, and yes, recruiting and retention does review what other competitive areas are.

If you're asking: Are we going to be competitive with British Columbia? Are we going to be competitive with Ontario? You're asking a lot for a jurisdiction like Prince Edward Island. My mandate, generally, tends to be: can I be competitive in the Maritimes and Atlantic Canada?

I think we've got lots of edges; that we're a nicer jurisdiction than others, our sister provinces, probably, but to try to compete with the bigger jurisdictions, that's going to be tough.

Chair: A lot of fingers up.

Verna Ryan you want to make a comment.

Verna Ryan: If I may, in response to your question, we are, as I mentioned, part of groups that meet with the Mental Health Commission of Canada and the Canadian Centre on Substance Abuse. Those are FTP groups, so I meet with counterparts in all other provinces, with the exception of Quebec, frequently.

One area, the Yukon, for example, is quite similar, in terms of the resources that they do or don't have, and how they're dealing with those issues. They use telehealth and we've also been in conversation with the Ontario telehealth network in order to advance a couple of different approaches; one being an e-consult service, which would connect primary care physicians and psychiatrists in Ontario. There is another program, which would provide outreach between Ontario psychiatrists and our patients here.

A third piece that we currently do is connection with the Operational Stress Injury Clinic in Fredericton, which is funded by Veterans Affairs, and provides services – is responsible to provide services to veterans and still-serving members on PEI. We facilitate that connection through our community mental health sites so veterans do have access there.

The other piece that we are doing on PEI is making use of multi-disciplinary private teams. We currently have access to – instead of looking outwards all the time to: where can we send someone out-of-province, we're really trying to focus on the capacity within the province.

Serene View Ranch, for example, which is a private facility, employed mainly with psychologists, have been receiving our clients and patients for approximately a year now. They report that they are working with some of the most complex cases that they have ever seen with good results. We really are trying to maximize services in those areas.

But in terms of the models, we also use CCSA and the Mental Health Commission of Canada do scans across the country on all sorts of things. I recently just looked at addictions services and emerg departments and what the best screening tools are and models to use in departments. That's an example of the type of work.

It's a great question. There's lots of good work happening across the country. We're not, well, rich in terms of our research capacity within mental health and addictions, but we certainly have our finger on the pulse there.

Chair: Kathleen, you had a question.

Ms. Casey: Thanks.

Dr. Keizer, I'd like to go back to your comments about when you go on recruiting missions and you're talking to schools and young psychiatrists. You talk about work-life balance and a lot of them are more in tune with that than they may have been a

generation ago, and I think you're on to something as a recruitment tool.

It's known that young doctors and young lawyers, young professionals, are really paying attention to that work-life balance, and they're not going to want to work 80 hours a week. They are paying attention to the work-life balance, so I think you're on to something.

Maybe our expectations, maybe there has to be a paradigm shift with our generation of the expectation of the number of hours that they may be required to work. So when you talked about the job sharing, I thought that could be our recruitment tool –

Dr. Heather Keizer: Oh, yes.

Ms. Casey: – because young psychiatrists know they're in demand and they know they can go wherever they want, but if we were to designate a number of positions for job sharing, I think you're on to something and I wish you luck on that because I think that paradigm shift is already out there. I think they are really paying attention to their work-life balance, and so maybe we have to take a look at how we recruit.

Dr. Heather Keizer: If we think about what makes people take jobs, people take positions for financial remuneration, because they want to pay off their debts from medical school or from residency and because they want to have a good lifestyle.

People also take work and keep work because they have a good balance and they enjoy the work, and because it can be fulfilling, and people take work because it's meaningful. They also take work because they are engaged by the leadership in sharing their ideas and innovations.

So I think if we can have that package where we have reasonable and competitive remuneration, we engage people who can have a life balance and not be working on call every third day, and also be engaged in being part of a master planning for a better program in the future and a better national class delivery of service. I think we do have a good package to offer.

Mr. Henderson: (Indistinct) to be noted that within our department with recruiting and retention, we are as accommodating as we can possibly be in respect that if any particular person that's interested in coming to Prince Edward Island whether it's psychiatry or any of the positions, we'll do what we can to accommodate and I see some of the staff here in that regard.

So we're open to a discussion. Does it always work out? I can't say it does, but we're open to those options, to make that life-work balance, to deal whether a doctor would rather be an emergency room doctor or a family physician or whatever the specialty. I just want to emphasize that.

Chair: Kathleen?

Ms. Casey: I'm good.

Mr. J. Brown: I'm actually going to take just a brief moment here. I've kind of held my tongue on this for a little while, but since we've stayed on the subject, I have some pretty particular thoughts on this, having had this conversation with my brother who was recently recruited back here and a couple of my best friends who are doctors who have been recruited here after a period of time.

Needless to say, I know a few kind of health care providers and have done recruiting myself for our law firm in the private sector. I'm firstly, very pleased to hear the kind of language and approach that certainly Dr. Keizer is advocating in looking at this.

I think I can tell you almost universally what I've heard back from people is that remuneration is very much not the key to recruiting anybody anywhere unless it's someplace that they don't want to go, and that leads to the kind of – in this case doctor that was mentioned earlier – that's really just a band-aid to fix a temporary problem.

Specifically, I'd say – it's not the same thing, but it's analogous – we have offered sweet deals to lawyers to come over here, and typically you'll find that they'll be two or three years and they're gone, typically to where their family is.

That's the one thing I have not really heard too much focus on, and it's probably, to be honest, the one big criticism that I would have of the recruiting department within Health PEI, and that's that there does not

seem to be an emphasis, as an example, to reach out to Island doctors who are, say, at Dal or Memorial or Ottawa or whatever, when they're in their initial four years of their medical degree and say: Hey, what about psychiatry, and by the way, would you like to come back to PEI in your summers to do the parts of your training that require you to come back here?

In our experience, it's all about either establishing those roots or firming them up after they've been established. I'll just give you further examples of that. Within the group that I just mentioned, my brother came back here within eight months and his wife, who's a emergency nurse too, within eight months they were due to have a child and had the child since they've been back.

My other friend and his wife who came back came back for family reasons as well. My wife's a schoolteacher, back for family reasons. Probably if it wasn't for family, I'd be in Toronto or something.

We don't seem to be appropriately focused on that, and it starts right from the initial kind of medical school experience with the matching programs through Dal and MUN and all the rest of it that we seem to be kind of letting the matching program dictate what we're going to end up with at the end and going along with that, and I just don't get it.

Dr. Heather Keizer: If you go back into the CBC archives, *The* G*uardian* archives to 1989, you'll see there in CBC Radio that Dr. Forsythe, who is at that time the director of mental health and addictions or at that time called the director of psychiatry, did a radio interview regarding the desperate need for psychiatrists on Prince Edward Island, and the other person who was interviewed was me.

At that time, I was a senior graduating science student at UPEI, and subsequent to that we had a – I set up a form for the preparation of aspiring medical students, so graduating science majors coming out of UPEI who might go on to Dalhousie medical school. At that, Dr. Forsythe spoke and talked about the need for psychiatrists.

It goes back that far. That's a quite a little while ago. That's 1989. So this isn't a new issue, and I think your point is well taken.

Mr. Henderson: What I would say, though, Chair, is that with recruiting and retention, we do indentify physicians that are in medical schools, as an example, especially those that are from Prince Edward Island. We do have the residency program, which has been a new program that's been launched by our government; and as we move forward, we do have good successes out of the residency program, but not every resident doctor does decide to stay from PEI or otherwise if they're from the Island; but I will say that we do track those graduates and students.

Now also, I do want to make it clear, too, there's also an issue with residency and Island students in the respect that if they're trained outside of Dalhousie, that's also a difference in whether – there's only so many seats available for residents that are trained outside the country or the province, so those are the little issues that sort of create little challenges that are out there. Once again, Island students trained in foreign institutions still have to go through the medical exams to practice in Canada, so those are other factors that go into it.

But we do track them, I just want to make that clear, and any Island physician that wants to contact us, we're happy to have discussions.

Mr. J. Brown: Well, and I see Dr. Keizer's point (Indistinct). I'll say they're not just little issues. They're big issues, and I think we might as well call them what they are. In my experience is that if ultimately the cart is driving the horses, we're into a big problem.

I appreciate that we have the residency program from Dal. That's great. It's great to have it, but if you want we can talk after about a few situations I'm very aware of where physicians were recruited to Prince Edward Island – actually, I can think of one right off the top of my head where an individual had actually bought a house here, matched only for Prince Edward Island, was a foreign student but was from Prince Edward Island, and he was outmatched by somebody else who ultimately came, was here for six months and left. Your hear of that –

Mr. Henderson: That can happen, yeah.

Chair: – more often than we'd like to, given the issues that we have here on Prince Edward Island. It's, I think, a symptom of the way that that matching program works. I recognize it's not an issue germane to Prince Edward Island, but it's something that I think we need to figure out. Anyway, that's – I'm up on my soapbox and as I said: I was holding my tongue for a while, but I felt that comment needed to be made.

James, you had a question or (Indistinct)

Mr. Aylward: Thanks very much, Chair.

Verna, back a short while ago you talked about: we're not really sending Island patients off-Island anymore for treatment. I know we used to rely on Edgewood, Homewood, Portage, as well, and other facilities. You specifically mentioned Serene View Ranch, which I have visited and it is a wonderful facility, beautiful setting, but it's not in-patient, correct?

Verna Ryan: No.

Mr. Aylward: No, okay.

Similar to the Strength Program when it first started, that was one of its biggest downfalls, it wasn't an in-patient, but we evolved to that.

Can you tell me when we stopped the practice of sending Islanders out-of-province for treatment and was it a medically-based decision or was it a government decision, a political decision?

Verna Ryan: Sure.

There has been a longstanding history, as you alluded to, of sending some people to out-of-province private facilities; Homewood, in particular, which is a very expensive private option that costs approximately $80,000 per treatment round. And in some cases there has been very good outcomes relating to this. However, they did undergo significant change, and Dr. Keizer can speak to this, she has in-depth knowledge there, in-depth changes to the way the program was being run to the psychiatrist-patient ratio. The other issues we were finding was the continuity of care. People might go off for four, six months and come back, but their discharge planning was not connected to the community. They had lost contact with the families. Families couldn't visit when they were in-patient. The communication between the facility and the community services was lacking. And, in some cases, the patients are free to go outside the facility on the weekends, and some evenings unsupervised, and sometimes with quite negative results.

With that experience, again, our out-of-province committee requires that people have exhausted all of the in-patient services that we have. Again, if we are pouring money into services that are off the Island and not putting them into our own services and increasing our own capacity, we're perpetuating that dependence and the lack of service for Islanders.

There are requirements that are made before someone can go out-of-province for particular services. That being said, we absolutely still send people out-of-province for services when our own are outstripped.

Severe eating disorders, for example, we do send people out-of-province. We've used the IWK frequently for those. We are looking at some other options, as well. Sort of in the stable of choices there were just these very expensive private services that were considered.

We are, again, trying to increase our flexibility around the most appropriate services. Services that are evidence-based and have good outcomes, keeping the family in mind and the impact of being, kind of, isolated and away that that has on a person's mental health and addictions status, and then the reintegration into the community and the ability to support the discharge planning that's been prepared.

Dr. Heather Keizer: There is a piece around fairness, as well. When we talk about Islanders in need we think of all Islanders. All Islanders should have equal access to services available when they're in need. Unfortunately, sometimes the way this is played out that on occasion, patients who have been able to make connections with people in positions of power, or make particular unique appeals have been given, sort of, this Cadillac service, albeit hasn't

turned out to be a Cadillac sometimes, whereas others haven't had that same access.

I think what we would like to see is those $80,000 per patient might be able to reinvest in enhancing our services here available for all Islanders, as opposed to a rare few who get to go off-Island.

Verna Ryan: You brought up Portage, for example. Portage is a longer term facility in New Brunswick, It doesn't have access, or it has limited access, to psychiatry or psychology support. But once we extended the program, the Strength Program and made that a four-to-six-month in-patient – or not in-patient, but treatment facility, and people did not have to leave on the weekends. The previous program was three weeks long. People got out on the weekends, so parents that had struggled so hard to get their youth into a program, were saying: Oh, okay, well, they got in there on Monday. It's Friday now and here they come again. What has changed?

We really have seen significant improvements in terms of that and we've only sent, I think, one person in the last two years over to Portage. That was because of a relationship, like a personal relationship with another person in the program, and there was conflict there.

Mr. Aylward: Chair.

Chair: James (Indistinct)

Mr. Aylward: Thank you.

I've been asking for information on the Strength Program for a number of years now and with regards to what you're talking about Verna: Is there any quantitative data as far as the number of young people that have gone through the program; the results because –

Dr. Heather Keizer: They're excellent.

Mr. Aylward: – I've seen surveys online, and I mean, I know you can turn around and say: well, you know what? Online surveys are just what they are. They're not scientific, but I've seen, and I've talked to people that weren't happy with the Strength Program –

Verna Ryan: Oh, is that right?

Mr. Aylward: – and the high level of relapse, as well, after completing the program. Versus, what I saw myself from young people that had gone to Portage and experienced that type of rehabilitation with their addiction, if there is that data out there, I would love to be able to access it to see it because I still have a lot of people that do contact me. I mean, yes, I am an elected MLA. I don't want to be an individual that is constantly trying to get a hold of the minister, hoping he might return my call. Hoping. I'm still waiting, okay, to advocate for, not just one of my own constituents in my district, but for many Islanders all across PEI that are frustrated. They're asking for help now, but they're continually being told: the help isn't there.

Dr. Heather Keizer: That's not really what we're saying. I do think that Prince Edward Island's an interesting place because I think Islanders are all very interconnected. We all have less than seven degrees of separation –

Mr. Aylward: Yeah.

Dr. Heather Keizer: – and we all feel it is our right as Islanders to be able to approach an MLA at the farmers market, and, you know, chat with the Premier at the grocery store. That's charming –

Mr. Aylward: Yeah.

Dr. Heather Keizer: – but it also belies a little bit of unrealistic views around what an MLA can actually do with regard to delivery of service.

Mr. Aylward: Yeah, I totally agree.

Dr. Heather Keizer: I think one of our pillars, with regard to our presentation – I'd really like Verna to return to it –

Mr. R. Brown: You're doing great.

Dr. Heather Keizer: – is with regard to communications. I think, really, as we move forward we really need to be able to communicate effectively what the services are; how to access them; how to access them effectively. Unfortunately, there is some misinformation out there as to what is available and what's not available. And we

have had good outcomes. We're going to continue to improve that. We're not where we need to be, yet. This is not a one-year project. If we're going to really do this right, this is an issue that is going to have to be evolving over the next number of years. And we are moving forward. It is not that we are not using outside services, we are, but we are doing them quite judiciously and quite carefully. Just because someone believes they need to go to Homewood, doesn't necessarily mean that Homewood is the right place for them.

Mr. Henderson: I think that's the point. Sometimes Islanders will assume that just because a service is provided off-Island it's better. I think that's the point, just that there is an assessment that decides whether that's the appropriate spot, or the appropriate location for service for all our off-Island medical services. It doesn't only mean it's dealing with psychiatry, but once again, we review these things, we monitor those things quite closely and we base a lot of the information on the empirical data, the feedback we get over a period of time. I just want to make sure people don't assume, because it's off-Island, it must be a better service.

The Strength Program is doing wonders here, too.

Verna Ryan: The other piece on the Strength Program is that is it voluntary and the nature of addictions does mean that the road recovery has lots and lots of relapses and that's why we have our services in the community and I think we do have some great people that are bridging those gaps.

So if someone is getting out of INSIGHT you might want to make sure they're hooked up with someone in the community who is going to be supporting them, but relapses absolutely do happen and it's really tough for families and that's why we're trying to build up the services for families as well. Instead of doing sort of a mild psycho-education program with them, we're really engaging with families around (Indistinct) model and the community reinforcement approach in terms of having them do what they can do and looking after themselves as well. It's a much more comprehensive approach, as opposed to just sending the individual and kind of just a wing and a prayer, because we'll keep trying as long as the individual does.

Mr. Aylward: Just one more.

Chair: (Indistinct) quick.

Mr. Aylward: Thank you.

My last question, quick, is I'm just trying to get my head around how this is all flowing together. So in the fall, almost a year ago, approximately a year ago, this was launched, right? This was paraded out and it's the Mental Health and Addictions Strategy: Moving Forward Together 2016 to 2026. So today we have in front of us the Mental Health and Addictions 2017 to 2020 strategic Framework.

So was this document essentially –

Dr. Heather Keizer: It's an outgrowth of that.

Mr. Aylward: Okay, all right.

Mr. Henderson: (Indistinct)

Dr. Heather Keizer: So that doesn't have action plans, this does.

Mr. Aylward: Okay, and that was one of my concerns with this one that came out; it didn't have action plans.

Verna Ryan: And it also doesn't have budgets and –

Mr. Aylward: It was a pre-document, yeah.

Verna Ryan: − that sort of monitoring the development of models, those sorts of pieces. Some of the proposals that we have coming around the mobile crisis unit and forensic unit, supported housing and adult day treatment, those are all models that we have developed. We've designed the programming that's appropriate for those proposals. We've costed them and we're submitting those proposals.

While the strategy aims us in that direction, we're putting rubber to the road, if you will.

Mr. Aylward: Thank you.

It gives me a much clearer understanding of where we're going here.

Just my second part – I didn't have two questions. The second part of that question was: The Canadian Mental Health Association, I believe, it was awarded $50,000 grant – am I correct – to do some research as well, or to do a study? It was announced back in the spring sitting.

Mr. Henderson: (Indistinct)

Dr. Heather Keizer: (Indistinct) the suicide prevention piece.

Mr. Henderson: Yeah.

Chair: I think maybe –

Dr. Heather Keizer: That is embedded in this.

Mr. Aylward: Okay.

Verna Ryan: That is part of it.

Chair: On that note, it's now 3:50 p.m. What I'm going to suggest is that –

Verna Ryan: Is that all?

Dr. Heather Keizer: We're only half through.

Chair: − we take a five or 10 minute break, regroup. We covered a lot of ground in the last hour and it's not been in the most logical order, perhaps, but we may have to come back a different day. If we do, that's fine, but what I guess I'm going to suggest is that we come back, go through the presentation, if we can get through it today, and then members save our questions back up so that we're doing it in a more logical order because we are jumping all over the place. It's getting (Indistinct) –

Mr. Aylward: Chair?

If I can just put something forward. Perhaps we can ask the presenters how long that they feel it would take to – because we're at what, 3.2, and that took – without this Q&A that we've just gone through, there were very few questions during that first part of your presentation and that was an hour and a half.

Chair: I have 3.5, but fair question, I think: Do you have an idea of how long you might have left?

Verna Ryan: Well, if you just wanted me to present – some of these pieces are following out of other pieces so it would be fairly quick. I can probably run through the remainder of the presentation in a half an hour if there are no questions. That being said, it's a really important topic and I want to make sure that this is an opportunity for us to share information directly with some very important people and the public, and I want to make sure that it gets the time that it deserves.

Chair: Sure.

Dr. Heather Keizer: We really do welcome the questions because I think we need – we can put meat on the bones and I think that's really important.

Chair: Okay, so if everybody's okay with this, I'm going to suggest we take a recess until 4:00 p.m. We come back. We proceed through the presentation and members, to the extent that they can, hold their questions until the end. We'll see where we're at. If there are more questions –

Dr. Heather Keizer: We'll be back.

Chair: − by reasonable time, we'll be back as Dr. Keizer says.

Is that fair? Okay. Everybody seems to be okay with that so we'll reconvene at 4:00 p.m.

[Recess]

Chair: We will reconvene. We're actually a few minutes after 4:00 p.m. so we'll make that up on the other end I guess (Indistinct).

I think what we're going to do is to keep an eye on 5:00 p.m. and we'll see where we're at at that point in time, if that's all right with everybody. As we say, if we need you back, we'll have to look at that and if we can get it done within a few minutes after that, then great, too.

Proceed. Don't feel like you're being pushed out the door, and members, to the extent that

you can, it would be great if we can hold questions until the end of the presentation.

Verna Ryan: Great, thank you.

We're currently staying with access to the right service, treatment and support; one of the pillars of the strategy.

3.3: strengthening collaborative care provided by primary care physicians and staff. These are your family doctors, nurse practitioners, nurses where folks go to a very trusted relationship and basically, what we've been doing – it's not a true form of collaborative care because of the lack of psychiatry consult, but we are moving in that direction.

We've provided clinicians to various multi-physician clinics and our mental health clinicians will go in. They'll train the nurses and the physicians to increase their comfort and capacity to deal with mental health and addictions issues. Many people are treated in their primary care physician office for these issues as it is, so we are finding this to be an effective way to deal with some of the mild to moderate issues.

Dr. Heather Keizer: It's a really good model. The share care model is one that's been rolled out across the country and internationally. We had a doctor, Dr. Janet (Indistinct), who was recruited here in the winter from Harvard. She didn't end up signing with us, but she actually made a presentation to the family doctors in Charlottetown on the share care model. I've maintained a working relationship with her none the less and she's interested in doing some ongoing research on the use of the share care model in family doctors' offices.

It's quite compelling, and the financial savings are actually significant, as well, because you use a psychiatrist really as a consultant to the clinicians as in nurse practitioners and counsellors who are delivering service and the psychiatrist can directly consult with the family doctors who can prescribe. So you end up using the best of the family doctors as well as the best of the clinicians with the support of a psychiatrist, and really efficient use of the psychiatrist's time.

It's a model we would really love to roll out. We need a little bit more redundancy; a little bit more grace with regard to the number of psychiatrists to be able to do that at this juncture, but it would be a goal for us going forward.

Verna Ryan: But it is an example of us doing the maximum scope of the mental health clinicians that's possible at this time.

3.4: I think we've talked about national standards for psychiatric care at this point.

3.5: We know that we have some significant gaps in our mental health and addictions continuum of care. An early psychosis team would be an example of that. So early psychosis, there is a high prevalence on PEI where we're quite worried with marijuana and the legalization of marijuana now that we will see more and more. In fact, Dr. Keizer sites examples in the emerg room of drug induced, marijuana induced psychosis and –

Dr. Heather Keizer: Very regularly.

Verna Ryan: − on a regular basis, and so this would be a team that focuses particularly on that issue and provides support to the families.

We've reached out to Halifax, to the team in Halifax, and have done some preliminary work. We've consulted with them, but we are looking at developing a team.

Dr. Heather Keizer: I was part of the early psychosis team in Halifax when it was established. It was the third early psychosis team in the world at that time under Dr. Lilly (Indistinct) and it was a very comprehensive team.

Basically, the idea is that you actually identify psychosis early in a patient's life and then a wrap around services, both medical and psychiatric and social, to prevent a significant loss of functionality.

We did discover in the work over the last 15 years that despite the fact that we were able to identify patients early didn't necessarily circumvent – you can't prevent the onset of schizophrenia necessarily, but you can actually reduce the amount of morbidity. So you can reduce the amount that the illness

may affect their ability to function in the community. You may be able to enhance their ability to have vocational training and you can provide them good community supports and housing; all of which are significant determinants of health going forward with this population.

In Prince Edward Island we have a particularly significant concern. The reality is, is in PEI we have a high instance of psychosis such that Dr. Anne Bassett did a study on PEI. Followed 300 families for 30 years here and she's an international researcher in psychosis, and discovered that we have an unusually high incidence of what's called DiGeorge Syndrome which is a deletion 22 genetic disorder in Prince Edward Island that is more common here than it is across the country and so we have a higher incidence of psychosis in the genetic makeup of Islanders specifically.

In addition to that, we have a very high use of marijuana and we know from the work of Dr. Heather Milligan that patients who use marijuana early in life actually present with psychosis earlier than they would naturally present. I'm not exaggerating when I say: when I am on call, in the emergency room I'm on call very regularly, I would say there has not been a night I've been on call that there hasn't been at least one case of an individual with psychosis secondary to marijuana use.

When I say psychosis I'm not talking about depression and sadness. I'm talking about seeing things, hearing things that are not there, paranoia, causing behaviour that is abnormal, what looks like schizophrenia. In fact, marijuana can precipitate out schizophrenia in individuals younger than they would normally present with it. Not only that, I see individuals over the age of 55 presenting with psychosis secondary to marijuana use. So this decriminalization of marijuana is going to have an impact on Prince Edward Island.

We have a vulnerable population genetically and we have a high incidence of marijuana use in our population. I'm not saying everyone uses marijuana has psychosis. They do not. But, there's a large enough proportion of the population that it increases the burden of illness in Prince Edward Island significantly, and these individuals need often to be retained in hospital, started on long-term antipsychotic medications for the rest of their lives. This is not something to sniff at.

One of the things going forward is we look at the early psychosis team establishment. I have had some contact with, as Verna says, with Halifax. There's a few young doctors in the psychiatry program who want to pursue this in PEI, but in addition to that, we are thinking about perhaps using – piggybacking a early psychosis identification in the education of our student wellness programs. Because the earlier we can get in and use our tools to identify psychosis, the less the morbidity is and it's very important that these students get educations, get vocational training and get supports as they go forward with their lives.

Verna Ryan: We will be submitting a proposal around that development, the adult mental health day treatment program in the community. So this is again, it's a gap; it's not a service. We've developed one for adolescence. We want to see the same service be available for adults and again, a stepped-care approach, whereby it can help move them towards reintegration into the community or can keep them in the community by supporting them on a daily basis. So we have developed a proposal around that program and that's going forward to government.

Dr. Heather Keizer: We're the only province in the country that does not have a partial hospitalization and an adult day program for psychiatry.

An Hon. Member: (Indistinct)

Dr. Heather Keizer: We are the only province in the country that does not have a partial hospitalization – that's one name for this – or an adult day program for psychiatric patients. It's a very important element because at the moment, we have it black and white; you're either an in-patient or you're an outpatient with modest services in outpatient services.

The day program allows a step-care so that, for instance, my in-patient psychiatrist doesn't need to get the patient absolutely perfectly well to be able to live on their own in an apartment. If the patient can go from

in-patient services to a day program, they get habituated to the 9-5. We know that they are safe every day. We know that they're getting their medications. They can be oriented to vocation, and it actually allows us to move patients out of beds and allows flow out of the hospital for efficiently, and it also does the reverse.

Maybe when someone comes to get help, maybe they don't need to be locked down in a psych ward. Maybe they can go into a day program and maintain their connection with their family, come into our program from home and still get their medications, still get their training and still get their therapy, but also, not be as much of a burden financially or socially to the system and it's less disruptive to the patients.

This was the argument we put forward for the adolescent day program. It's a similar argument for an adult day program and it's very cost-efficient and it also is good medicine.

Verna Ryan: Also, the lead there would be a psychologist in terms of that team.

3.7: We've heard from the community. We've heard from the public. We've heard from communities that have great ideas around the need for a mobile crisis team to address mental health and addictions issues. We have built a proposal. We've looked at data from RCMP and police forces in terms of the calls that they're answering with mental health and addiction needs, and we look at the data from our emerg departments.

We also hear the stories from families who take those drastic measures to get help for their loved one, their family member, only to have them maybe released two days later without the outcome that they were expecting. We have built a proposal that would cover the province with 24/7 coverage, would have appropriate leadership, appropriate training in place and be responsive in the community in order to support people at home, or wherever they may be in the community, on an ongoing basis.

Dr. Heather Keizer: As a psychiatrist working in the emergency room, one of the things that I struggle with very regularly is, for instance, in the emerg, I have a patient who is doing okay. I have revised their medications, but I'm worried about the patient. I don't have any beds left in the hospital. The patient really wants to go home and really is tired of being in the emergency room and I would like to send them home, but I'm nervous because I don't have anyone who's going to follow up with that case in a timely fashion.

If I had a mobile crisis team, I could call that team up and they would check in on the patient tomorrow and the next day, until they get to connect to the outpatient service. It's a gap that we need to fill and I think we could fill it efficiently if this proposal went forward.

Verna Ryan: Our outreach teams do a wonderful job of follow-up and maintaining people in the community, but it's this mobile crisis team that I think would fill in that –

Dr. Heather Keizer: Gap.

Verna Ryan: − gap that's there.

Implement a bridge; so folks, I think, would be pretty familiar with the Bridge Model which is, again, a community, police and government approach to dealing with folks with escalated risk. Some, probably over 80%, of the cases that have come of this – I believe it was 75 cases that have reached intervention are involved with mental health and addictions or have mental health and addiction issues, so our people are very busy in responding to and dealing with those situations through this approach.

The PEI Opioid Action Plan: So, the Chief Public Health Office, along with the Department of Health and Wellness and the Department of Justice and Public Safety, have been working over the past number of months around the action plan. I believe it will be rolled out this fall and we've been involved with that as well. So part of the actions around this plan that we're currently seeing on the ground is a Naloxone take-home kit. They are in place in our – they're either in progress or they're in our facilities and services so that people have access to those. The training is in place so people can be trained on the spot. The needle exchange program is kind of the hub for it right now, but we are looking at where that's best

situated. We're pretty well situated on this issue.

Explore opportunities to develop the enhanced learning placement, school-based specialized program. This is led by the Department of Education, Early Learning and Culture. This is a program for children and youth who have significant and chronic behaviour issues, aggressive behaviours. It's a small program out of Birchwood, I believe it is, and takes currently about six students at any one given time. While each youth is very challenging in terms of their behaviours, the combination of six individuals in the same program increases that exponentially. That's an effective program and that will be explored in terms of whether or not it needs to be expanded, and if so, where and when.

Enhancing capacity to deliver treatment for intimate partner violence and sexual deviance being led by the Department of Justice and Public Safety, along with enhanced emergency sexual assault model of care being led by the Premier's Action Committee, so we're, for mental health and addictions, certainly part of this and see this as a priority in dealing with the interventions and prevention of these sort of incidences and then the long-term impact, which is more what we end up dealing with, unfortunately. There has been movement in terms of emergency room training protocol. Nurses and physicians, I believe, have been trained so these two issues are being acted upon and we're moving more aggressively forward in the next year.

Dr. Heather Keizer: It's quite significant in the sense that in my discussions with the department of justice prior to coming into this role, it was regularly brought up: Why isn't mental health at the table? Why isn't mental health at the table? And now, because Verna has great depth with regard to her experience in justice, we've now made a partnership with the department of justice in a way that really hasn't been established to the same depth as before. I think this is really a very positive thing because we all deal with very similar issues and we can actually collaborate and inform one another and going forward, the partnerships I think will be very fruitful.

Verna Ryan: It's true.

People are cycling through our systems. They're going – they may start then show up in emerg and we did some tracking around patient touches on the system in our work in preparing for a forensic program for the province and people will show up in emerg. They may come over then to detox or the in-patient withdrawal unit at Mount Herbert. We may next see them on Unit 3 at Hillsborough Hospital and then, because our data doesn't show it, they may be serving a six month sentence at the correctional centre. So we are dealing with the same high-risk individuals throughout the system and we really need to come together around them in any ways that we can, and wherever and whenever we can.

You'll see a note about a partnership we're doing at the correctional centre where we have staff from addiction services partnering with staff at the correctional centre to deliver programs on the weekends to people that are serving weekends sentences for impaired driving, for example.

Implement a mental health service agreement to help strengthen the mental health and addictions service capacity in First Nations communities. We've been working very closely with the First Nations communities, particularly in Lennox Island and Scotchfort. We have ongoing direct service delivery happening with them. One of their requests was around clinical supervision and support, so we provide that in the form of an MSW, Masters of Social Work, who goes to the communities once a week for the day. We have access to psychiatry consults on a monthly basis.

We recently took part in a program they were doing called Photovoice, which was a project focusing on trauma and intergenerational trauma and we were able to support them through that and that's something that has finished up, but the final reporting hasn't happened on; very beneficial on all sides. We really appreciate the opportunity to work so closely and with good relationships and we're all learning and advancing the issues there.

Mr. Aylward: Chair, I know we're supposed to wait but can I just ask a question on this?

Chair: It can't wait until the end?

Mr. Aylward: Well, I'm truly afraid that we're going to go through this and then we're going to say: Okay, well you know what folks? It's 5:00 p.m., it's 5:30 p.m., let's adjourn and we'll come back another day.

Chair: We'll get back to you before we do that.

Mr. Aylward: Okay, all right. But it is specifically on the bullet that was just discussed.

Chair: All right. Well, that's great. We'll hold it until the end –

Mr. Aylward: Okay.

Chair: – because if you ask a question then everybody will want to ask questions –

Mr. Aylward: No, I'm the only one asking to ask a question. Nobody else is asking.

Verna Ryan: 4.2: Continue to implement Tripe P Postive Parenting Program. I talked about that at the first of the presentation, so we'll continue on.

The Suicide Prevention Strategy; as I mentioned, this is not a Mental Health and Addiction Services Health PEI strategy, this is a provincial strategy. Community partners are certainly carrying a lot of weight here. We see that through the department having funded the Canadian Mental Health Association to prepare a suicide prevention strategy for the province.

We're being consulted on that. I know that there is a lot of work happening there. I believe that this group actually had an update from CMHA recently.

Improve the psychological health and safety of worksites using the Mental Health Commission of Canada standards. The Public Service Commission of PEI, the responsibility for that initiative sits with the public service. I think they're just doing some exploratory work at this point in time. This is a series of principles that creates and promotes and encourages safe work environments free of bullying and things like that, but also supporting people who are dealing with mental health issues and addictions.

Developing and publishing the Chief Public Health Office well-being of children report. This is one that I really cannot speak to, other than the fact that the report will be coming out this fall and we're really looking forward to the content there and how that will influence and inform our work on an ongoing basis.

5.1: We're now in the pillar called Fostering Recovery and Well-being for People of All Ages; Building capacity in senior's mental health and addiction resource teams. We do have outreach teams that are in our community mental health sites in the three counties, with Montague being the most recent one to receive funding and support.

Those teams actually do rounds. They have psychiatry consult; sometimes psychology consult. Really if you sit in on rounds with these folks, they will do everything they can to support seniors with mental health and addiction issues to stay in their own homes; to be adequately looked after and supported. I've seen conversations that cover everything from medication adjustments through to the size of the woodpile and is that going to get the senior through the winter.

These are teams that will go out to homes to community care facilities and to long-term care facilities to support the seniors.

Dr. Heather Keizer: One of the challenges we have right now with this particular pillar, although, one, is it's very important. If we look at our demographics, this is going to be our future in providing appropriate care for mental health and addictions for the senior population as our baby boomers age.

Our program on PEI was established, from a psychiatric point of view, by Dr. Shabbir Amanullah, who subsequently has moved on about five years ago, and is now the director of psychiatry in Woodstock, Ontario.

With the moving on of Dr. Otusajo and Dr. Oladapo, we now do not have a lead for this program on Prince Edward Island. Hence, we have a 17-bed unit at Hillsborough Hospital that does not have a psychiatrist who is supervising it other than me. And we

have an outpatient team that doesn't have leadership.

One of the stopgap measures that I have made is I have approached Dr. Amanullah to return to us. In fact, he was with us this past weekend as a locum; came and did rounds with the team with outpatients; did some consults, and also rounded on the in-patient unit at Hillsborough Hospital on Saturday of this past week. He is going to be available to us over the next six months as a telehealth psychiatrist to provide some leadership.

The advantage of that is that he knows the team very well. He knows the population very well because he's the one who set it up. He and I have been research partners, so he has been very amenable to giving us a hand in this time of crisis, frankly.

Going forward, however, we have a very fortunate connection with Dr. Salabarria, who is currently being courted by us. One of the things that really appealed to Dr. Salabarria, who is a senior geriatric psychiatrist from Connecticut, a graduate of both Harvard and Yale, and is a specialist in this field, one of his areas going forward was that one; he has liked to vacation on Prince Edward Island and is a cycler who likes to cycle in Tignish and O'Leary, so that Prince Edward Island was appealing to him. Secondly, when I chatted with him about our plan for the future and our master planning, and the idea that as we go forward when we look at planning a new seniors' mental health facility, for instance, that may have in-patient psychiatry available for a specialized population here, that he would be part of the master planning to provide insight in terms of establishing therapeutic environments. A therapeutic hospital with wandering gardens and really cutting edge services.

One of the advantages, of course, with psychiatry, is that it is not really highly technical, it's really about knowledge. It is about bricks and mortar to some degree, but mostly it's about knowledge and how you deliver this. This gentleman doesn't need anything extraordinary in terms of capital investment to provide us with, perhaps, cutting edge and really national, international standard service for our mental health population going forward. That's really what we're looking forward to having him as a consultant with us as we do our master planning in the next three or four weeks.

The hope is that Dr. Salabarria will be able to come as a locum as of January and subsequent to that, be able to come as a fulltime psychiatrist with us as of June.

In addition to Dr. Salabarria, we have an Island connection with a Dr. Ian MacKay, who will be coming and doing a community elective with us in November of this year, who is a geriatric psychiatrist, as well.

In the past we've had three geriatric psychiatrists on Prince Edward Island. We could probably use three into the future. These two people, I'm hoping to have as fulltime psychiatrists come July or so.

In addition, we have the benefit of a wonderful new provincial geriatrician, Dr. Carmichael, Martha Carmichael. We had good fortune to be able to introduce Dr. Salabarria and Dr. Carmichael and they were very much on the same page in terms of long-term planning and collaboration. I'm really looking forward to this work, and it's going to be quite critical, really, as we go forward.

Verna and I have had conversations with colleagues in Cardiff, Wales, where their population seems to have peaked a little earlier than ours. This is going to be an issue going forward; to provide appropriate and adequate mental health and psychiatric services to the geriatric population. We're investing now for the future.

Verna Ryan: Enhancing capacity to deliver culturally safe service to diverse populations. This includes our refugees, transgender population and other emerging populations. This includes; training, translation, specific resources. For example, we have Dr. Elizabeth Schneider, who provides resource to our newcomers association. Dr. Keizer has specific training in transgender populations. We want to make sure that as the fabric of PEI changes, that we are on top of that, and addressing the needs as they arrive.

Anything you want to add to that?

Dr. Heather Keizer: I would say my current dilemma is that I've trained in transgender medicine and I have been doing it for about 15 years. I would have had a clinic this summer for transgender medicine, but because we are so shorthanded, I couldn't. I couldn't do my clinic.

As we gain more psychiatric support here, I will have some freedom to do that. I have been training family doctors, however, in transgender medicine, as a trainee with the family medicine department over the last eight years.

In addition, we hope to sign Dr. Almasri, who is a psychiatrist coming from Ireland. What was very appealing about him for me is that he is Syrian, and Arabic speaking and it would be very helpful for this population to have someone who speaks their home language.

My other psychiatry wish list individual would be someone who speaks Mandarin. Dr. Shu who I recruited earlier this spring, did, indeed, speak Mandarin. Unfortunately, she didn't sign. If I had a wish list that would be my second on my wish list would be a Mandarin-speaking psychiatrist.

Verna Ryan: Develop a provincial forensic program. Currently, there has been a significant increase in terms of the forensic population. It's still not a big population, but it does run anywhere from 15 to 20 individuals. These are highly complex cases. There is an issue of public safety related to these cases. Sometimes, they come under the auspices of the Criminal Code Review Board, or the PEI review board, which has its mandate with the criminal code and directs the director of mental health and addictions to provide treatment to those individuals.

Hillsborough Hospital is currently designated as being a psychiatric facility that would respond to forensics or criminal code review board patients, and we are not equipped to respond to this population in a fulsome way. We have made some interim measures to make this environment safer and more secure for these individuals as well as for staff, and we've also seen great progress.

Again, these could be individuals who have been inappropriately in the correctional system, could have been in penitentiary for years, and they've come back to PEI and have perhaps committed a crime while they were very ill, and they are found not fit to stand trial or not criminally responsible. So they come under the care of our division.

There is also a population of mentally ill offenders who are in the correctional centre or under parole or probation supervision who really need a very strong program. Then we also have another population which we would consider under this program and that would be mentally ill patients who are violent and very aggressive. So we've developed a program and a proposal around that to have a program, which includes community-to-facility stepped care. PEI does not have a program right now. We have very capable staff who work with this population and we have good results, and the results being, that people are reintegrated into the community after they have been appropriately treated.

Dr. Heather Keizer: One of the things we don't have in Prince Edward Island right now is a designated and certified forensic psychiatrist. All of us who have our fellowship from the Royal College of Physicians and Surgeons all must pass the requirements for that general accreditation and all do forensic work as part of our exams. So, I had to fall into this role on occasion in the last year, more often than perhaps I would have liked. We do not have a forensic psychiatrist here who's so designated.

It is somewhat specialized work and if we were to attract a forensic psychiatrist, they'd probably have to take on some general psychiatry work as well, but that's not unusual. We do have someone in the offing who may be able to come, come July.

That being said, we have developed – I've been fortunate to develop a good relationship with east coast forensic facility in Nova Scotia with Dr. Aileen Brunet who is the director there, as well as a couple of the other psychiatrists who work there, whom I happened to have trained with. In going over and chatting with Aileen, one of the biggest issues facing us right now is that we have a memorandum of understanding

with east coast forensic. We typically in the past have sent our patients off-Island to be treated there and it's a secure facility with good psychiatric care. They have vocational training. They have transitional housing. They have very good relationships with the community.

The problem with that is that if we send an Islander there and the Islander progresses through the program, when they get to the point of transitioning to the community it's not the patient's community. What the director there would like to do is have the patient actually treated in Prince Edward Island with transitional and vocational adaptations here. We don't have that facility in Prince Edward Island. We do not have the capacity at the moment to – we've done it successfully on a couple of occasions, but really in a robust way, we do not have the housing to transition patients to the community. We don't have the funding to do that and we don't have the vocational training mandate to do that. So we have put together a proposal that's now going before the province.

Verna Ryan: Continuing with fostering recovery and wellbeing: Supporting the Reach Foundation in the delivery of youth addictions and mental health care. We do work with the reach centre and we do have patients and clients who attend this centre which is a social enterprise focusing on their recovery and work skills. I believe we've had some 49 or 50 people attending day programming there this year and again, helping to bridge to that transition back to the community.

Partnering with CMHA around their programs, their evidence-based programs, directed at supporting seniors, youth offenders and frontline staff and so we're actively partnering in terms of a post-vention group. Currently, that takes place at McGill. That was newly developed through a partnership between mental health and addictions and CMHA. We're working very closely with this important partner in the community and plan to continue.

Identify, support and expand housing initiatives that support the housing continuum.

Dr. Heather Keizer: Huge.

Verna Ryan: Huge issue on PEI. For students going back to school at UPEI, I know there was a big issue for them to try and find apartments and I've heard that the vacancy rate is less than 1%. Scale that down to someone on income support who's getting out of Hillsborough Hospital and what the options there are for them, they're pretty bleak and quite often they are substandard and will facilitate relapse and poor choices and poor health.

We are looking at housing initiatives, including supported housing on the grounds at Hillsborough Hospital, where there would be hospital support along the lines of a stepped-care approach where they have OT support and a variety of other supports to learn how to get closer to the community. We're also working closely with CMHA who is one of the province's largest providers of supported housing in the community for this population, along with their housing first program which is, again, a very supported approach to helping people secure housing on an ongoing basis; big issue.

Dr. Heather Keizer: Huge issue, I mean because when we talk about who shows up in the emergency room, who shows up in our services. This past winter a huge portion – I won't say huge – a number of women showed up in our addiction services because they were homeless. There's no homeless shelter for women in Charlottetown. The only homeless shelter we have is on Lennox Island. If you're not a woman who is able to go to Anderson House, that's not your situation, there's no homeless shelter for you.

I've visited patients in their homes. I visit my patients who've been discharged from Hillsborough Hospital and a room in a rooming house with people who are using upstairs and you're trying to stay clean and you struggle with staying on your medications, this is a very big issue and we really need to invest.

Verna Ryan: The Department of Family and Human Services has embarked on a provincial strategy, I understand, as well.

The community-based province-wide peer support program, again CMHA will be

taking the lead on that. I know they've done some work already and they're very well positioned to provide this type of support in the community on an ongoing basis.

5.9: Modernize key legislation, including the *Mental Health Act* and the *Adult Protection Act*, so that is a big piece for us on many fronts.

Then the last pillar is strengthening and supporting an innovative and collaborative workforce.

6.1: Is to align staff and clinician training and education to core mental health and addictions services.

We talked earlier about having those core services defined and delineated and training our staff to support those core services and then having the out-based training, encouraging the use of groups in our community mental health, and in-patient services, cognitive behavioral therapy. We just trained 40 people in dialectal behavioural therapy. Trauma informed therapies, I've talked about. All of these are evidence-based best practices that are happening across Canada and that our people are becoming quite proficient in.

Dr. Heather Keizer: One of the things we discovered when we took over these roles was that in the past, people sort of did their own thing in terms of the outpatient services and they took the training they thought was interesting to them, which is all right except that it doesn't necessarily meet the need of a population that's getting services. We've now put in place some accountability around this and set out goals as to what we need to deliver because of the needs of the population and then we'll have accountability around how often and how regular people have been trained and how they're rolling out their programming.

This is happening now, and it's innovative and a little challenging, I would suggest to those who have done it a little differently in the past. But I do think if we go out about six months from now we'll see more efficient use of our services and we'll be – sometimes if you train in something it doesn't necessarily mean the population needs it and so really we need to base our training of our staff on the actual needs of the population that are in front of us.

Verna Ryan: I think it's close to the last one, it's getting there.

Dr. Heather Keizer: It's a big one though.

Verna Ryan: Implementing the key recommendations of the safety and security review. We did do a safety and security review at Hillsborough Hospital as a result of many patient and staff concerns, incidents within the institution and occupational health and safety reports those sorts of things so –

Dr. Heather Keizer: We had 154 critical incidents at Hillsborough Hospital in the last year.

Verna Ryan: In the (Indistinct) -

Dr. Heather Keizer: Previous year –

Verna Ryan: - up to leading to that –

Dr. Heather Keizer: – which really inspired this.

Verna Ryan: So that is well underway. We've done things like fire – just some of the basic issues like a fire panel has been brought up to code. We've started doing cameras and –

Dr. Heather Keizer: Signage.

Verna Ryan: - panic alarms, yeah.

We have a new commissionaire security staff, so we have three commissionaires 24/7 who round on the grounds. That includes Deacon House, which is a homeless shelter, so we've taken some big steps there. We're continuing that work. We hope to be done by December.

Recruit and retain hard to fill positions, and this is in combination with other social departments, particularly around psychology. As I said, there's been some initial work started on that and we just needed to address – identify all of the positions that we currently have vacant and look at what the possibilities are there and working with the psychology association around that.

Implement leadership development and mentoring approaches to support staff development and succession planning. We are looking at a number of different mentoring and staff development approaches to support our staff and some of these positions are very hard to fill. Our staff are our key resource and in supporting that, they be included in any sort of strategic direction on a go-forward basis. We don't want to lose people who have put many years into this work because not everyone wants to do this sort of work, quite frankly, and we need to support and protect those people and encourage their development to be part of the leadership of the organization.

The rule for presentations, as I've been told, is tell people what you're going to tell them, tell them and then tell them what you told them. You've seen this slide before. I've talked about briefly about what's been achieved and what's ongoing work. I've talked to you about what actions are underway and what's being proposed for the next couple of years.

As I said, this is comprehensive but it's not exhaustive so if you hear of more work that we're doing don't be surprised because we couldn't fit all of it on here.

I guess we're open for questions at this point in time; up to the Chair.

Chair: Mr. Aylward.

Mr. Aylward: Thank you, Chair. Again, thanks very much for your time today and your presentation.

Back on page 18, 4.1, when you were talking about strengthening the mental health and addictions service gaps in the First Nations communities, my question there was: Have you seen an increase in Aboriginal individuals presenting particularly to the QEH ER since the federal government cut funding for mental health and addictions to First Nations here in PEI?

Dr. Heather Keizer: I don't believe we've tracked that. I know I haven't tracked that. I do know, because I just came back from the race relations action table at the Canadian mental health – I can never get the right name for it, but the mental health commission, and I just came back from there last week as well. One of the issues with indigenous populations and radicalized populations is that they tend not to present in traditional acute care facilities. So, really, you need to meet people where they're at and so that's kind of been the approach.

We were approached by some leaders from that community. Both Verna and I have been, in our previous careers, have been quite interested in cross-cultural work. We've both done cross-cultural work with refugee populations ourselves and so they were sort of preaching to the choir when they came to us. But initially, really, we had to hear what their concerns were and that's probably, I think, the biggest first step is to listen and listen to what they need and how they see the situation, but also how they would like to see services delivered. That's an ongoing process. But in terms of specific numbers as to who has presented in the emergency room, I cannot give you those.

Mr. Aylward: With who you met with, were they from the Mi'kmaq Confederacy or the First Nations PEI?

Verna Ryan: First Nations PEI.

Mr. Aylward: Okay and so –

Verna Ryan: I understand that the department –

Mr. Aylward: - it would have been Chief Cooper or –

Verna Ryan: The head of the wellness teams actually.

Mr. Aylward: Okay.

Verna Ryan: So the health centres, so we're working directly with them.

Mr. Aylward: Thank you.

Dr. Heather Keizer: There's an issue, as you know, with regards to jurisdiction around on-reserve versus off-reserve populations and that's an ongoing issue in a number of areas. A goal would be to provide culturally appropriate services to both on-reserve and off-reserve populations. Again, I would defer to my colleagues of indigenous

origin as to how best to do that and that's sort of an ongoing discussion we're having.

Mr. Aylward: I have a couple more if you want me to just run through mine and then you can move on, or whatever you want to do, Chair.

Chair: Go ahead.

Mr. Aylward: Okay cool.

The east coast facility, I'm sorry – page 22, 5.4, the provincial forensic program. The facility you referenced, the east coast –

Dr. Heather Keizer: Forensic facility, yes.

Mr. Aylward: that's the one in Dartmouth –

Dr. Heather Keizer: In Dartmouth, yes.

Mr. Aylward: Okay.

Cool, I just wanted to double check.

Verna Ryan: There's been a long standing contract with them and Health PEI.

Dr. Heather Keizer: There's been an issue there because the opioid crisis really hit Nova Scotia quite hard and so there's a lot of forensic opioid involvement and so their numbers kind of went exponentially up in the last couple of years. They had a harder time accommodating Islanders because they were filling their beds with Nova Scotians and so that's been a bit of an issue for us in terms of population and being able to utilize the facility as we had in the past.

Verna Ryan: They also contracted with Correctional Services Canada to hold six beds, or retain six beds for them so again, that limited our access.

Occasionally, we'll have a bottleneck when we need to get assessments done, but the last couple there was no problem whatsoever. Things happen in threes, though, for some strange reason and if we get one forensic assessment that needs to be done we'll usually get three and we have 30 days to get those done and our contract is with east coast usually to do those. We're usually able to do that but it's become a little more challenging.

Mr. Aylward: Here in our own correctional facility out in Sleepy Hollow, our provincial facility, what ongoing psychiatric services are available there for any inmates that may require services?

Verna Ryan: There's a psychiatric – I'll set that aside for a moment – but there is a clinical team within corrections that is led by a psychologist. The position is currently vacant, but they have a team that addresses issues there. But, it is one that I know they've tried to recruit to without success. As Dr. Keizer said, there is no forensic psychiatrist currently here. It's a specialty and again, not everyone is comfortable working with this population.

Dr. Heather Keizer: For instance, if somebody – I go out to Sleepy Hollow myself, not as a forensic psychiatrist, but as a garden-variety psychiatrist. For instance, if there is an individual who is lockdown who is voicing suicidal ideation, it would not be that uncommon for me to get a call and for them ask if I would come out and see the case.

I'll come out and see the individual and assess them and may make some medication recommendations and do follow-up on those cases. I would go out there with – I haven't been out there lately, but I've been out there with some regularity. I think I may be the only psychiatrist who has gone out to Sleepy Hollow –

Verna Ryan: Dr. Jay.

Dr. Heather Keizer: – but Dr. Jay has gone in the past, as well, I guess.

We used to have the patients brought into the emergency room, but that's a little bit risky, frankly.

Mr. Aylward: Yeah.

Dr. Heather Keizer: I have; however, seen folks come into my outpatient office, my outpatient office on North River Road, who have come in from the forensic facility

I would say that our communication is relatively good. There is a lot of cross-pollination; so we have justice people working on our 3b unit at Hillsborough Hospital, and we have nursing staff who

have worked through justice and now are back in mental health and addictions so we know one another quite well. We have very similar populations so I think our communications is quite good on that front.

A forensic psychiatrist is something again. That's around assessment of competency and criminal responsibility. That's a different set of skills than basic psychiatry. Forensic psychiatrists do those legal pieces and tend to be very comfortable testifying in court. I do it. I'm not as comfortable as a forensic psychiatrist might be.

Verna Ryan: We also, as I mentioned, have, on occasion, if there is an offender who is evidently mentally ill we can take them to Hillsborough Hospital, as well, and treat them in-patient.

Mr. Aylward: Okay, thank you.

Next question is still on page 22, just moving down to 5.5. I'm very happy to hear about the ongoing support for the Reach Foundation. I think it's a great facility; they do tremendous work over there.

My question is: Has there been any discussion at all about some kind of financial support for Lennon house, which is, hopefully, going to be up and running here soon.

Mr. Henderson: (Indistinct) credit (Indistinct) not that I'm aware of.

Dr. Heather Keizer: So Lennon –

Verna Ryan: I don't know if that would go to the department –

Dr. Heather Keizer: It might go to the department.

Verna Ryan: – perhaps, if that's a conversation (Indistinct)

Mr. Aylward: Yeah, no, like the minister is there, so I guess he was (Indistinct)

Verna Ryan: (Indistinct)

Dr. Heather Keizer: Lennon house is really a community initiative, which I think, again, some of this, Mothers Helping Mothers is a community initiative, as well.

One of the things that I think is wonderful is about the community embracing the need to support Islanders.

Verna Ryan: Absolutely.

Dr. Heather Keizer: And if Lennon house can be that and can grow into that I think it will be a potential resource.

At the moment they don't fall under our umbrella because they're a private community initiative. That doesn't mean, however, that we wouldn't be open to consultation with them and giving them support in consultation and support and advice around best practices, and around, for instance, potential therapeutic interventions. It depends upon how they see fit to grow that facility.

Mr. Aylward: All right.

That, essentially, is how the Reach Foundation started, as well.

Dr. Heather Keizer: True.

Mr. Aylward: It was born out of necessity, right? The services that they provide was not there, and a group of individuals, likeminded individuals, mostly mothers, came together and made this happen. Anyway, I'll – when we get into the budget I'll be talking to you about Lennon house.

You talked about Deacon House momentarily. That's the men's shelter behind the Hillsborough Hospital?

Verna Ryan: That's correct.

Mr. Aylward: Correct.

Dr. Heather Keizer: A little nasty.

Mr. Aylward: Yeah. I don't disagree.

Verna Ryan: But necessary.

Mr. Aylward: Yeah –

Verna Ryan: It's offered nightly in 12-hour shifts overnight, sorry.

Mr. Aylward: Yeah. It's kind of one of those facilities that is there, and people

pretend it's not, but it's there and it does serve –

Verna Ryan: Well –

Dr. Heather Keizer: We used it.

Mr. Aylward: – a wonderful purpose.

Dr. Heather Keizer: We use it from the emergency room when we can. I think it's got limitations around it, but, we really, at the moment, we are strapped for appropriate housing for our populations of patients who are homeless, and better to have Deacon House than to have nothing.

Mr. Aylward: Yeah, no, and I agree. Just luckily we're not using the same facilities that used to store medical files, because they –

Verna Ryan: (Indistinct)

Mr. Aylward: – Deacon House wasn't too far away. I know that was before your time, minister. So –

Verna Ryan: Was there a question, though about Deacon House?

Mr. Aylward: Yeah, I'm coming to that. I just want to know within the whole RFP here for this new campus design around Hillsborough Hospital; Deacon House is going to be replaced? I'm hoping – I'm assuming that we're going to have a better facility for this population.

Verna Ryan: I will definitely be considered as part of that master planning. That's why we're doing the planning –

Mr. Aylward: Yeah.

Verna Ryan: – because I don't have that answer at this point in time.

Mr. Aylward: Okay.

Verna Ryan: But it is – so we have connected Deacon House with the national homeless initiative that's being led here on PEI, I think, by a few organizations. So their numbers are now counted into the national numbers. It's recognized as a homeless shelter –

Mr. Aylward: Yeah.

Verna Ryan: – as are others. We have reduced the hours, but we offer 12-hour service from seven until seven overnight, and we have very regular use within that facility.

Mr. Aylward: Yeah.

Dr. Heather Keizer: There are other models across the country with regard to dealing with homelessness. There are very innovative models, all of which, I think, will be part of our discussions when we talk about master planning.

The tiny home movement has been very interesting in terms of providing housing and habituating people to living in the community. Again, we have to think about transitional housing and temporary housing versus permanent housing for populations that need security.

Housing security and food security are unquestionably critical to well-being of our population.

Mr. Aylward: Yeah.

Verna Ryan: I think PEI has had a bit of struggle in terms of their shelters for homeless people. Certainly, Bedford MacDonald House in Charlottetown has struggled over the years –

Mr. Aylward: Yeah.

Dr. Heather Keizer: Grandmother's House.

Verna Ryan: Yeah, so –

Mr. Aylward: Yeah.

Verna Ryan: It's really, it's an issue that we'll be looking at from a program-scope point of view first. Does it really sit with mental health and addictions? Or is it a broader issue, and should it be dealt with under the housing strategy?

When we're talking about the program scope, these are ideal questions for that. Like: Should we really be running a Deacon House? I don't know.

Mr. Aylward: Dr. Keizer, you mentioned Grandmother's House. That facility doesn't operate any longer, does it? No.

Dr. Heather Keizer: No, it does not. That's my point.

Mr. Aylward: Yeah, for several years now.

Okay, page 24, 5.9. You talked about the modernization, key legislation including the *Mental Health Act* and *Adult Protection Act*, the timeline is December 2020. Why so long? It's –

Dr. Heather Keizer: We've been advised.

Mr. Aylward: – so vitally important. I'm just wondering – this is three, 2.5 years out.

Verna Ryan: It involves lawyers, so, you know, that usually means there is some very detailed work happening –

Mr. Aylward: Billable hours.

Chair: (Indistinct)

Verna Ryan: – and the –

Mr. Aylward: Billable hours.

Verna Ryan: – department would be leading the work on that. Obviously, Health PEI would not be responsible for the development of legislation. That would sit, certainly, with the department.

Dr. Heather Keizer: Certainly, we have made – we have voiced pieces and concerns around what we feel more urgently needs to be addressed. Some of which can be addressed without entirely rewriting the legislation.

Again, it's about triage as to what is most important going forward. And it's true we have to sort of abide by the legislative lawyers timelines.

Verna Ryan: There are other pieces of legislation already in the queue –

Dr. Heather Keizer: Yes.

Verna Ryan: – thinking (Indistinct)

Dr. Heather Keizer: There are others ahead of us.

Verna Ryan: Yes.

Mr. Aylward: Last one, Chair, it's a pretty simple one.

Page 26, 6.2: Implement key recommendations of safety and security reviews. You talked about the Hillsborough Hospital and 154 critical incidents in 2016. You mentioned that you have three commissionaires there. Are they commissionaires, or are they Paladin staff, security staff?

Verna Ryan: Commissionaires.

Mr. Henderson: Commissionaires.

Mr. Aylward: Oh, they are? Okay.

Verna Ryan: We went through a separate RFP process –

Mr. Aylward: Okay.

Verna Ryan: – because the Paladin contract was already in place and wouldn't be wrapping up for some time, so that's – we wanted to get that security in place right away and they were successful.

Mr. Aylward: Very good. Thank you. Thank you very much.

Chair: Great. Peter.

Dr. Bevan-Baker: Thank you, Chair.

You said – thank you very much, by the way for this, I think you called it an exhaustive –

Verna Ryan: No, I said it's not exhaustive –

Dr. Bevan-Baker: – exhausting, maybe that's what you said –

Verna Ryan: – it's comprehensive, but not exhaustive.

Dr. Bevan-Baker: Comprehensive.

Indeed, the breadth and the depth of the document demonstrates how complicated this all is. It's very easy and sit here and be

critical of a system that is designed to meet the needs of something as complicated and bewildering and often as unpredictable as mental health is. I think we have to bear that in mind at all times.

Also, how far we have come? I mean, I have only been an elected official for two years, but this is so far ahead of anything we have come across before. Having said that, there are some acute problems that are creating, in many people's minds, unacceptable risks for a growing number of vulnerable Islanders and I know there are family members of such members of families here today.

You mentioned, Heather, the phrase you used was: This is a time of crisis, quite frankly. I saw you wince, minister, when she said that.

Mr. Henderson: (Indistinct) yes.

Dr. Bevan-Baker: But, those are large words; those are critical words. I know you mentioned many times throughout the presentation that you're courting various psychiatrists and psychologists to come here, but what gives you a sense of confidence that what we're doing now is going to be effective in a way that it has not been before and has led us to this time of crisis?

Mr. Henderson: Well, I'll start off with that. When you mentioned the word 'crisis'; and as the Minister of Health and Wellness in the Province of PEI, it is my responsibility to try to at least provide as much stability and confidence in the delivery of healthcare as we possibly can.

I've been reluctant to use that word in the Legislature and in other settings. I would say we do have some significant challenges that we're trying to address and I think we've had those types of meetings, as the staff here and my deputy, to try to see what we can do to make sure that we are providing at least some sense of confident services to Islanders. Every time when we do meet, we do get a sense that we are making some headway and we've got new initiatives, and we've got a lot of initiatives that have just been recently implemented and whether it's the nurses in the school system; that has just started. We're barely a month in.

Those are the types of things that we have to try to at least see how these issues and initiatives are having an impact on the overall mental health and wellbeing of Islanders. You don't want to be mixing the system up all the time, keeping it in a constant state of flux. You want to try to be strategic in your investments and your implementation of a number of initiatives. I would say that there's definitely – the concern that I have that keeps me up at night is the issue around psychiatry and our inability to attract, recruit and retain psychiatrists in the province.

Dr. Keizer has mentioned a number of names of people that she's contacted, discussed with. We know some of them are planning on coming. More than that, I'm not sure where you kind of go to get confirmation that everybody is coming. I'm sure the staff with recruitment and retention; Dr. Keizer, are all doing their level best to try to get people to come and be retained here until the long-term.

Dr. Heather Keizer: I think we have to separate out, as the minister says, acute crisis, if you will, or acute risk and concern from a longer-term vision and plan. I think we really, on the ground, have really gone deep and we have a good long-term vision and plan. In terms of the non-acute care, non-in-patient delivery of service, we are unquestionably making significant inroads.

When we talk about the delivery of service in the school system, when we talk about the enhancement of our delivery of service in outpatient services, when we talk about the initiatives of our clinicians on the ground in terms of innovative delivery of service of walk-in clinics; all of that is very positive and that will ultimately reduce the pressure on our acute care service in the emergency room and in in-patient psychiatry. That is positive.

The place where the rubber hits the road and makes me distressed is the piece around coverage of in-patient beds in psychiatry. At the moment, we do not have enough psychiatrists to do this in a safe way. I personally am by default the director of Hillsborough Hospital, medical director, and at the moment Dr. Cronin is covering unit three, which is our acute care unit with 17 beds, and he will be covering that unit until

the 13th of October. After he leaves, we will not have coverage for that unit. At the moment, I do not have a regular daily coverage for geriatric psychiatry, but Dr. Amanullah is covering those beds on the weekends now and will be doing so by telehealth in the very near future and that's 17 beds.

Dr. Jay is covering the patients on Unit 8, 17 beds, one day a week. I have no one covering the patients on Unit 7, 17 beds, because I have a colleague who has gone off sick. So my colleague who is off sick, will be back on the 23rd of October. Until that time, frankly, the responsibility is falling to me. That's 69 beds, essentially, on a daily basis for which I am on-call. Yesterday I was in the emergency room – I was on-call in the emergency room and I was also responsible for beds and I'm also the administrator and I'm having to do recruitment and this stuff, right?

Theoretically, I should right now be on Unit 9 covering 10 beds and I'm supposed to be at an LMAC meeting an hour ago. So no, it's not humanly possible. As well intentioned and as energetic as I may be, I cannot do this myself, nor can 4.7 psychiatrists do on-call for the level of acuity and illness we have in Prince Edward Island in our emergency room. Nor can 9.5 psychiatrists do adequate coverage of all of our services, even if we are at the top of the pyramid. It's a big pyramid and we do need more psychiatrists urgently.

I say this with reticence because I recognize that my colleagues at the department of health are uncomfortable to be so transparent about this. But on the other hand, I would suggest that they are aware and they have been meeting with me and they've heard me rant and they are doing their best as well and I think at the moment we are sort of going into significant outreach mode and appealing to our colleagues urgently in Nova Scotia and New Brunswick. This is an acute situation. This will, frankly, resolve come November-December, but we have to – I'm holding on by my fingernails for October, frankly.

The reason why we talk about having 15 psychiatrists is that we need a little bit of flex, a little bit of redundancy. So, if a colleague who goes off sick, the place doesn't fall apart like a house of card. Or, if I have a colleague who wants to go and get some upgrading in their training in dealing with psychosis, we don't fall apart. At the moment, my colleagues haven't been able to go for their CME training. They haven't been able to take their vacation leave, and now I've got a colleague on sick leave because, again, over-strapped. Theoretically, on Unit 3 at Hillsborough Hospital with 17 patients there, there should be two psychiatrists there. There's only one. In fact, in the past there's been three. On Unit 9 there should be three psychiatrists with 21 adult beds and four child beds. There's only one psychiatrist and I'm trying to fill in the gaps the best I can.

It's a product, as I said earlier, of many beds but recognize it's been downgraded from where we were a number of years ago with 300 in-patient beds. But again, the standard of practice was different. In those days, we basically warehoused people and we didn't do active therapy and try and get them out of the hospital. That's what we're doing now. We want to transition patients back to the community, but to do that effectively, we need enough psychiatrists to do that job.

So yes, we are in a crisis point. It's going to be a challenging October and I'm hoping come November, we'll see some light with the incoming couple of new recruits, but we really probably need six.

Chair: Go ahead.

Dr. Bevan-Baker: Chair, thank you.

Heather, you said − there was a sentence in there that jumped out at me and you said you do not have sufficient numbers of psychiatrists to provide safe coverage.

Dr. Heather Keizer: Yes.

Dr. Bevan-Baker: That's a frightening statement.

Dr. Heather Keizer: Yes, it is.

Dr. Bevan-Baker: Particularly if you say that there's no immediate resolution for that. My original question was: What are we doing – I'm paraphrasing. I don't remember exactly what I said, but what are you doing different now from what we've done in the

past that's going to resolve this as soon as we possibly can?

Mr. Henderson: Well, I mean that's the issue. In the end of the day, psychiatrists are the people that we need. There is no replacement for psychiatrists. We have had the discussions about how can we enhance those services by having other professionals provide some collaboration, like nurse practitioners. We've talked about some of the things about the issues around compensation to try to increase some of those types of initiatives. We looked at – if we have to see if we can bring somebody in on a locum basis from Nova Scotia or New Brunswick, but they have challenges there too, so it's tough.

Now the other types of decisions – do we have to reduce our number of beds that we're able to provide services for? I mean at the end of the day, patient safety is the importance and we have to be able to deliver service to the public that they have some sense of confidence in and trying to create a level of service that we cannot deliver will be something − as we approach those times and dates we'll have to make some tough decisions. It's not much different than an emergency room that we didn't have coverage for in Montague recently. We have to shut down for the day. Those are the types of initiatives that we do. But once again, every other jurisdiction seems to have similar challenges by times and as a department we're trying to work through those as best we can.

Dr. Heather Keizer: One of the innovative things that we have discussed – I've discussed and our CEO has discussed with the department is the idea, again, of telehealth psychiatry. This is, again, perhaps not as much as what we would like but if it were possible for us to provide even telehealth coverage for our in-patient units at Hillsborough Hospital at least then we would have a consulting psychiatrist available.

We do have a few psychiatrists who are already licensed on PEI who may be willing to provide that, but wouldn't – for instance, I have a colleague whose family is in Summerside and he trained in Dalhousie, who came as a locum in the summer, who may be willing to provide some telehealth support because she lives in Northwest Territories and she's a fulltime director of psychiatry there but she may be able to willing to help us out a little bit in a pinch, which we are certainly in, if we had telehealth capacity at Hillsborough Hospital.

Again, my colleague Dr. Amanullah is willing to do that with our geriatric unit on the short term for the same reason. There may be some capacity there if we were able to – and that's a relatively easy investment on the very short term, and on the long term it could be used and it could enhance our services for research purposes and other things.

It wouldn't be a lost investment, and the nice thing about telehealth investment is that it's also movable. So once we look at replacing the facility physically, the telehealth equipment can all move elsewhere, and so that's not a lost investment, which I think is an important piece as well.

Dr. Bevan-Baker: Chair, I recognize the time. I don't know if we need to check in. I still have a number of questions.

Chair: How long − or how many questions do you think you have?

Dr. Bevan-Baker: Probably half a dozen or so.

Chair: Anybody else have any questions they intend to ask at this point in time?

You guys okay for another –

Mr. Henderson: Sure, yeah.

Chair: Okay, go ahead.

Dr. Bevan-Baker: Thank you, Chair.

The rest are not as high-level as the first ones I asked.

You brought up cannabis and the inducement of psychotic breaks related to the use of cannabis, and I'm wondering why you think with legalization those numbers are going to go up. That was sort of implied in here.

Dr. Heather Keizer: Indeed it was.

Verna Ryan: (Indistinct)

Dr. Bevan-Baker: Do you imagine that it's not easily available now to –

Dr. Heather Keizer: I would suggest that we still have a population of children and adolescents who do follow the rules, who don't drink alcohol until they turn 18 or 19 – mind you, maybe a smaller population than we might like – and there are those who might be willing to experiment with it more willingly if it were legalized than if it were not. I think there's some good evidence for that, generally speaking.

I think you're right, it's readily available, but it does take a certain level of rebelliousness and a certain willingness to break the law to actually use marijuana now, although I would suggest we've had a significant increase in numbers this year particularly with it being in discussions. I've seen a significant increase in the emergency room of children and adolescents, or adults and adolescents presenting with psychosis secondary to marijuana use, who are using it now and wouldn't have used it three year ago because the discussions are being had federally.

Verna Ryan: The other piece is that we don't have, nationally even, a strong, key messaging going out to youth about it. Even young movers, we see with the neonatal abstinence syndrome, they think it's quite healthy to use cannabis because that – you know, to control their nausea – because it's a natural herb, isn't it? That is what they'll say.

The other thing is, when you look at the opioid usage and prescription drugs, those are readily available in people's medicine cabinets. If cannabis is then part of your medicine cabinet, that makes it much more accessible to kids.

Dr. Bevan-Baker: Chair, a follow-up on that.

Given that, do you have an age recommendation that you would – yes.

Mr. Henderson: (Indistinct)

Dr. Heather Keizer: There's some good evidence to suggest that anybody who smokes cannabis under the age of 24, 25 puts their frontal lobes at significant risk. We know that we talk about ADHD children, and ADHD children have struggles with frontal lobe function, and we know that cannabis use can cause demyelization on the frontal lobes.

Demyelization is essentially taking this electrical cord – which would be, say, your neuron – and scraping off insulation so that they cross and fire inappropriately, right? So it means the frontal lobes don't function well, and these are children who are needing to develop their appropriate social interactions.

The other piece, for those who don't necessarily have psychosis as an outcome of marijuana use will often have apathy and avolition, such that, they don't necessarily follow through and finish their homework. They don't necessarily absorb that education like they might otherwise do.

Generally speaking, I think we would say abstinence is a great choice, but really into the mid-20s is probably the place where you would initiate use.

Dr. Bevan-Baker: Thank you, Chair.

I'd like to go right back to the beginning and I'm not going to go through this column by column, but strategic action 1.1, the very first one, which is for an annual review, and then there's 1.6 and 1.7 which also talk about annual reviews and evaluation of programs. Will there be – who will be doing that evaluation?

Verna Ryan: Well, we're just in the planning stages of this. As I mention, this is a provincial strategy. We're here presenting because much of the work sits with mental health and addictions, but there is a group of directors across the social policy departments who report up to the social deputies, so I would see that the director's group would be leading this evaluation.

As I said, we're just in the early stages. We wanted to build in a mechanism for accountability. That's going to be the mechanism, and that's going to have to

evolve, grow and develop over the coming year.

Dr. Heather Keizer: You sit with that directors group.

Verna Ryan: Yes.

Dr. Bevan-Baker: I'm really pleased that there's a performance monitoring element to this. I think that's really critical, to make sure to measure that the programs are actually doing what we hope they are.

Verna Ryan: Yes.

Dr. Bevan-Baker: I'll make this my final question, Chair, and it's to do with input of consumers in this evaluation process and ongoing monitoring. Will there be an opportunity for Islanders to get involved?

Verna Ryan: There will have to be. There absolutely has to be. Islanders have the biggest stake in this and we need to know, too, what are the outcomes that they're seeing. I mentioned the –

Mr. Henderson: (Indistinct)

Verna Ryan: – yeah, those in terms of outcomes around the specific approaches and symptom reduction that they're seeing, we have that input coming from parents and families. We have people who sit on our quality improvement teams right now in mental health and addictions so they are representatives from the community and sit on teams and have influence at the table in terms of the direction we're going in. What that looks like in this process I don't know yet, but it has to be a strong component, as does representation from the community organizations that want to have a say in this.

Dr. Heather Keizer: Even when we talk about master planning, I have this sort of vision. We talk about our master plan and we talk about our design going forward. I would love to see us appeal to all Islanders. I'm talking school children, mothers, families, to be able to have input in terms of design.

I think everyone wants to help in a way that they can help, and one way they can help us in our progress going forward is that – perhaps you don't know about mental health and addictions specifically. Perhaps you're not a caregiver; but you might be able to share with us artwork that reflects hope and strength for our population of patients.

You might be able to reflect something of what your vision might be for what would be a beautiful and inspiring piece of artwork, for instance, that could actually be incorporated into our design or could be shared with our population of patients. That's something any schoolchild can do. That's something anyone out there can do.

Even if they're not a care deliverer, everyone knows someone. Everyone knows someone who's touched by mental health and addictions, and everyone wants to help somehow, and that's one place where people can help by sharing their vision, by sharing their artwork with us, by sharing what they might imagine would give hope and strength to those who are affected by this.

Mr. Henderson: I'd also like to add that in our Health PEI board there's a public engagement committee within that board that gets feedback from the general public as well as our community health engagement committees. We have east and west committees there as well. So if those are initiatives that they want to take on as to get more feedback from the public, we would certainly encourage them to do that.

Dr. Bevan-Baker: Thank you, Chair.

Chair: Anybody else have any questions?

I have, I think, three that I'm going to ask, and I'll try to be as quick as I possibly can.

The first one's actually a follow-up to Peter's. When Todd Leader was in last week I asked him – he was talking about the elevator approach and indicating that we need to look at a client-centered approach. We talked about, essentially, bucking up and being bucked up by the kind of internal staff and say: Well, you buy into what you're saying, so we'll look to put it in place and see if it works.

To Peter's point and, in terms of the interaction with the public, my question to him was: How do you effectively buck up the public that is going to be the client in this situation and convince them? I'm not

sure I got an answer from him, and I don't expect that I'd get a better one from you, so I'm not going to ask that question today.

Mr. Henderson: Oh, good.

Chair: But, I do wonder and, and one I think you might be able to answer is: What level of importance does that, does the public confidence in your plan have overall in terms of our ability to carry it out?

Dr. Heather Keizer: If you think about the history of Prince Edward Island and the establishment of the sanatorium, for instance, on Prince Edward Island. That sanatorium was built with Islanders' contributions, right? To meet an Island need to deliver appropriate sanatorium services at that time.

Islanders are very engageable. We have a huge voting population. We all are connected, as I said earlier by less than seven degrees of separation, probably more like two degrees of separation. Everyone has a vested interest.

I think that the idea of having a communications strategy going forward to be able to communicate this well, but only this, but also basic information around mental health and addictions; basic issues around appeals to the public for support.

One of the things we're looking forward to is, perhaps, looking at grassroots initiatives and supporting them in communities, and community responsibility in taking ownership for delivery of services. We have already seen that burgeoning in the population. We may or may not agree with some of the things that are on Facebook; may or may not agree with some of the groups that have been established, but all of them are evidence of our population of Islanders who are concerned about this issue for Islanders.

This is, again, as I said before, this is not a party issue. This is not a political issue. This is an Island-wide concern and we need to, sort of, supersede that again and appeal to Islanders. If we don't have Island support than we probably won't be able to go forward.

Verna Ryan: I think, probably, we need to start here with a request from us to you to have an all-party agreement on moving forward. Whether it is to endorse this framework, this strategy, and support us in doing that work to make sure that it continues, while giving us all the good strong feedback that we have been getting and that we are using, but we need everyone to come together in order to advance this work. Particularly, if you think it's the right work going in the right direction.

Chair: Thank you for mentioning.

I will tell you we at – debated at great lengths what we were going to set out to do, I guess, in the late part of the summer, as this committee, or the early part of the summer I guess it was. We talked about going around Prince Edward Island and holding community meetings and all kinds of different possibilities. A lot of them in reaction to various talking heads, I'm going to call them, that would include ourselves probably, that sound intelligent and sound like they probably know what they're talking about.

I guess I would say, I don't think any of them were wrong. Their intentions were certainly likely well place, but seeing where we are here today you look at it, and you can't help but thinking to yourself, and I think I have heard some acknowledgements here today, that I think we were probably assuming that, you know, you folks weren't as far along in the planning process and the implementation process as you are.

All to say, and I'm not really looking for a response on this point, I just wanted to respond, I guess, in turn to the point that you had made. We'll certainly talk about this as a committee as we go forward. I think there is a kind of desire for leadership not just to be had internally, but to be displayed in a way that people can – you know it's tangible. People can understand what they're getting, and they know that we're headed in the right direction to have confidence.

We all don't know the answers to how we make that happen, but I think it's important.

I did have a couple of other quick questions. Marijuana psychosis, we talked about it a little bit earlier today, but, perhaps, for the

minister. Has anybody approached the federal government to say: Look this is being legalized; I recognize there is a federal-provincial aspect of it. The health care piece, in particular, is something that probably is not being adequately discussed or whatever, in terms of, as Dr. Keizer indicated, the impact on Prince Edward Islanders, and whether that's more of less, and in particular, you know, where we might be in terms of the complement that we do have here now.

I'm wondering if there is an indication that, you know, look we may be having an issue that we're going to have to deal with, and there will be dollars attached to that.

Mr. Henderson: I guess the reality is, I know the Canadian Mental Health Association has made, you know, recommendations that were certainly somewhat contrary to what the parliamentary committee and the recommendations that they've implemented.

I guess the reality of this, yes, we all have concerns as ministers of health in this country, and it has been part of our discussions with the federal minister. But the reality is, as we have been told, that by July 1st, 2018, that the recreational use of marijuana will be legal in this country. So, it's up to each province to put together the processes in place on what we would to do. As you are aware, we are in a consultative period at the moment. We're trying to get some feedback from Islanders to get a better sense from their direction on this, but the reality is it's going to be legal.

So, it's just a matter of – and here's the other reality is that, you know, if Prince Edward Island goes too far astray from what the other provinces and jurisdictions you're going to run into issues around black market, all of those types of things.

As I'm going out to the meetings of the provincial, and federal and territorial health ministers in the middle of October, it's one of the items on the agenda. But, you know, the lead player from the provincial side of this is the Department of Justice and Public Safety. We're collaborating with them to at least provide our feedback. Also, the Department of Finance and how, if there are revenues that can be generated from that where do those revenues go and we want to try –

Dr. Heather Keizer: To us.

Mr. Henderson: – to see what we can do, you know, make sure that we get our piece of the action in delivering with some of the side effects that might be impacted by – you know like we talked about earlier here, of the psychosis issues and things of that nature.

A serious issue, but, like I said, the reality is, is that it is happening. We have been told that unless there is something the federal government decides to change. We just have to try to be as prepared as we can.

If you take any of the issues around legislation, our department will look at some of the issues around the smoking legislation. We have to make some amendments and changes to those pieces of legislation to make sure that marijuana complies, in a form of smoking; that it complies with our tobacco legislation.

We have two chances at that between now and July. Obviously, the fall session and the spring session, and we'll meet those deadlines from our perspective, but there's a bigger picture, a bigger question that has to be addressed and we'll see what happens with justice and public safety on that.

Chair: Kathleen had a follow-up question.

Ms. Casey: Just a quick follow-up to that.

The Member of Parliament for Charlottetown is hosting a town hall on marijuana next week. If you have concerns or issues and you want to come out it's at the Holman Grand. I think it's Wednesday night.

Chair: James Aylward had a follow-up question on that.

Mr. Aylward: Well, not a follow-up question; more of a statement.

Yes, it's correct the CMA has come out and raised concerns about it. Very recently the Canadian police chiefs association have also come out and have asked the federal government to put the brakes on –

Dr. Heather Keizer: So has the Canadian Psychiatrist Association, the Canadian Medical Association have also spoken (Indistinct)

Mr. Aylward: They're all saying: we're not ready for this. You're rushing far too fast. Anyway, so I just wanted it to be on record those other associations have also raised very legitimate concerns.

Chair: Great, thanks.

I do have two other quick ones. One: Are we seeing increased incidences of PTSD or those kinds of issues with the refugee population that has landed on Prince Edward Island?

Dr. Heather Keizer: This population, many of them have been through extreme trauma. Hence, it's helpful to have a clinician who can actually speak their mother tongue.

I think the other piece here, and I think back to Mr. Aylward's earlier question, PTSD is a very significant diagnosis on Prince Edward Island. I do think that with so much media coverage, we are beginning to destigmatize it. So I have patients, as recently as last night in the emergency room, who have disclosed to me traumatic childhood situations who have never told anyone else before. These are patients, who, perhaps, have been long-term in care or not, and they're beginning to tell their stories with some confidence because they know that we hear them and we believe them.

It's not just the refugee population, but the population in general is now sharing their stories in a way that they, perhaps, didn't have the confidence to share in the past, particularly the male population.

For instance we know, statistically, that one in four women has had some sort of sexual assault, sexual interference in their lifetime. One in five men has, and that's a population that often has gone unidentified. These individuals are beginning to now identify and self-identify in the emergency room in ways they haven't in the past.

So, yes to your question.

Verna Ryan: I would also say that the education system is seeing the results of that as well, so the students who are in the classroom, teachers are dealing with issues around significant mental health issues, most likely anxiety and post-traumatic stress disorder on a daily basis, so I'm definitely hearing that from that angle.

Chair: Thank you, and final question from me: If we were, – we are building, planning to build, I guess, a new mental health campus. We're always talking about sending our people away to Homewood or –

Dr. Heather Keizer: No, we're not talking about (Indistinct)

Chair: – or Portage or whatever.

We have, traditionally, in the past. Is there any thought being given to the possibility that if we're creating a utopian campus, we can bring people here to help –

Dr. Heather Keizer: Absolutely, and in fact I've pitched this.

Verna Ryan: Earlier today.

Dr. Heather Keizer: Pitched that earlier today.

I really do believe if we build it, they will come; and if we have solid delivery of service, cutting edge national standards, I know in fact that my colleagues across the country would come and do research here, and I think it could ultimately be – if we as a province were to truly invest in this, it could ultimately even be a profit centre.

I'm not saying that we shouldn't serve Islanders first. I think there's a sense in which we really need to meet the needs of Islanders and give them good, solid services; but is it possible? Yes, because we're already getting requests. Our addiction services has come a huge distance in the last two years, including Strength but also with Mt. Herbert with our transition unit, and we are now already welcoming people from out of province to our service.

So we don't want necessarily out-of-Island individuals to bump Islanders out of the service, but absolutely I think we need to build capacity to be able to host others, yes.

Verna Ryan: And particularly with addiction services, where recently we had a request from Nova Scotia, I think there's opportunity for a regional approach because you do have people that work either in mental health and addictions or corrections or policing, whatever it might be, where there may be a direct conflict with them going into a local treatment centre.

So if we could look at exchanges between provinces where they'll take someone here who usually deals with this population and give them treatment in Nova Scotia where they're not known and we would do the same, so there's some possibilities there; and those, traditionally, would be the folks that would be heading off to a private facility, perhaps, so definitely open to new ways of doing things.

Dr. Heather Keizer: There's another huge opportunity as well. I happen to be a member of the Global Mental Health Network, and have colleagues who work around the world in crisis centres. There aren't a lot of facilities at the moment as beautiful as Prince Edward Island could be to deliver the service, but to deliver services to caregivers for those who are suffering burnout.

The caregivers who are with *Médecins Sans Frontières*, the World Bank, the WHO, Prince Edward Island would be a beautiful place to come to actually revitalize and do well. It's been a passion of mine for a long time to provide appropriate service to caregivers who are international workers, and we might be an ideal location for that.

That's not on our agenda here, but you never know down the road. Again, if we're able to provide solid, national-quality service, that could be a future piece.

Chair: Hal had a question there.

Mr. Perry: Actually, it's more of a comment.

Thank you, Chair.

I just want to thank each one of you guys. You sat there for four hours and did a great presentation, fielded many questions, and your confidence, your knowledge and your passion certainly make me feel comfortable that we're moving in the right direction.

Thank you.

Chair: (Indistinct)

Mr. Dumville: Chair? (Indistinct) echo what Mr. Perry said.

Chair: Without having a love-in, we do have people –

Mr. Dumville: No, that's it.

Chair: – that need to get out of here.

I am going to thank you, though, on behalf of the whole committee for your time here, and certainly your expertise and the thorough document that you've produced here. This is exactly what we were looking for in response to our request.

It's something that I'm sure our committee will take back, and hopefully we can rally some support behind you moving forward and figure out if there are any other ways that we can help you; and likewise, if there are ways that you think that you can help us, we'd certainly (Indistinct) –

Dr. Heather Keizer: Think about –

Chair: – we can help you.

Dr. Heather Keizer: Think about Verna's proposal about the joint party.

Verna Ryan: We're all in it together –

Dr. Heather Keizer: We're all in it together.

Verna Ryan: – and we're looking for feedback; and to Peter's questions earlier around: What are we doing to balance the psychiatry care and those issues? We're open to ideas if people have them and we're certainly open to feedback at all points.

Dr. Heather Keizer: Yes.

Verna Ryan: And I hope that for the partners that are not here today that are involved with the strategy, I hope that I've represented them adequately, but certainly we are two of a much larger group that is

moving this framework forward. So thanks for your time today.

Chair: Yeah.

Verna Ryan: We really appreciate it.

Dr. Heather Keizer: Yes, thank you.

Chair: Thank you very much.

Perhaps we'll do this all while we're here.

Is there any new business to be called? No?

I'll call for a motion to adjourn, then.

Ms. Casey: So moved.

Chair: Thank you, Kathleen.

Mr. Henderson: Team, put 'er there. We survived.

The Committee adjourned