PRINCE EDWARD ISLAND LEGISLATIVE ASSEMBLY

Speaker: Hon. Francis (Buck) Watts

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Standing Committee on Health and Wellness

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LOCATION: COMMITTEE ROOM, J. ANGUS MACLEAN BUILDING, CHARLOTTETOWN

SUBJECT: BRIEFING ON PEI SUICIDE PREVENTION 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:

Kathleen Casey, MLA Charlottetown-Lewis Point

MEMBERS IN ATTENDANCE:

Bradley Trivers, MLA Rustico-Emerald

GUESTS:

Canadian Mental Health Association, PEI Divisoin (Amanda Brazil, Pat Doyle)

STAFF:

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

Edited by Hansard

The Committee met at 10:00 a.m.

Chair (J. Brown): I'll call the meeting to order.

My name is Jordan Brown. I'm the Chair of the health and wellness committee. In that capacity, I'd like to welcome everybody here today.

We have a briefing from the Canadian Mental Health Association, and in particular, Pat and Amanda. They're working on a new suicide prevention strategy, and we had asked that they come in to provide us with a briefing in relation to that. So we're very pleased to have them in today to do that.

Perhaps before we get going, what I'll do is I'll go around the room starting at Brad, and just ask for introductions as we go around and hopefully everybody will have a sense of who everybody else is and we can get on our way.

Mr. Trivers: It's Brad Trivers, and I'm the MLA for Rustico-Emerald, District 18, and of course have a keen interest in this subject and making some progress, see some action.

Dr. Bevan-Baker: I'm Peter Bevan-Baker, MLA for District 17, also with a keen interest in mental health generally and suicide prevention specifically.

Ms. Compton: Darlene Compton, the MLA for Belfast-Murray River, District 4, and I want to thank you for coming out. I think it's something we definitely need to review and see what can be done. We're hearing from our constituents constantly about this issue and I want to thank you both for your work.

Mr. Aylward: Hi Amanda, Pat. James Aylward, I'm the MLA for District 6, Stratford-Kinlock. Health critic since 20011, when I was first elected and a very strong advocate for moving forward with supports and programs that we desperately need in place here on PEI to help with, not only mental health, but also addictions, that as we know are so closely tied together.

Thank you for being here today.

Chair: As mentioned, I'm Jordan Brown. I'm the MLA for Charlottetown-Brighton, Pat's district, and happy to have you both here today to provide us with some insight as to what this strategy is going to shape up like.

Clerk Assistant (E. Doiron): Hi. I'm Emily Doiron, the committee clerk for this committee.

Mr. Palmer: Hi, I'm Chris Palmer. I'm the MLA for Summerside-Wilmot, and I'm happy to have you here today.

Thanks.

Mr. Dumville: I'm Bush Dumville, from West Royalty-Springvale, and thank you for being here today.

Mr. Perry: And good morning, my name is Hal Perry. I'm the MLA for District 27, Tignish-Palmer Road, and I look forward to your presentation.

Thank you.

Pat Doyle: I'm Pat Doyle. I work as suicide prevention coordinator with the PEI division of the Canadian Mental Health Association. I've been in that role now for 17 years.

Amanda Brazil: And I'm Amanda Brazil. I'm the director of programs and policy with CMHA PEI.

Chair: Great. Well, thank you everybody.

I'll call for a motion to adopt the agenda, unless there are any questions or amendments to it.

Chair: Peter, seconded by Bush.

The presenters have indicated that there are two portions, I think, if I understand correctly, to your presentation.

Amanda Brazil: Yeah, we might switch that now.

Chair: Well, we're pretty flexible. I'll put it to you this way. What I was just going to say is it's my understanding that it's your preference that we go through the presentation and ask questions afterward.

Amanda Brazil: It's okay to ask questions throughout, just bearing in mind that we might cover it later in the presentation.

Chair: Later on.

Amanda Brazil: But it might be, if that works for everybody, we can take questions as we –

Chair: Yeah, it's totally up to you. Typically what we would do would be any of the committee members that have questions would signal to me and then I'd indicate that – and I usually would try and wait for a pause – that there's a question, and then we might kind of go on a bit of a tangent from there, I guess, if you will.

If that's fine with you guys, that's typically, I find, the best flow for the committee's purposes; but if you would rather, it's fine to go right through your presentation and –

Pat Doyle: No, we're going with your format, and Emily said that she would keep us on track in terms of time, so –

Chair: She's pretty good.

Pat Doyle: – we're comfortable with that if you guys are.

Chair: Okay, no, that's great.

The only other thing I would remind you two is that this is recorded, and what happens after that is a translation's done of the recording of our transcription and it's recorded in Hansard, and kind of kept for posterity if you will.

I say that, as much as anything else, to basically indicate that before you start speaking again, you could indicate it's Pat and then start back into it, or it's Amanda and start back into it, and we can go from there. We try and coordinate the committee members to do that as well.

You see on the microphones in front of you, there's a little red light. That means it's on you right now.

With all that being said, just relax. We make things work as fluently as we possibly can, and we'll try and keep an eye on everything. Feel free to start at your convenience, and if you do need a break or whatever while we're going just let us know, and we're pretty flexible that way, too.

Pat Doyle: Great, thank you.

Okay, so we are kind of tag-teaming on this. I'm going to start, and I thought we would give you a little bit of the lay of the land, what we're going to – some of the things that we're going to be talking about today, just a little bit of an overview of the presentation.

We're going to give you a little bit of a better understanding of suicide to get started; what suicide looks like on PEI; numbers versus rates because those pieces of information tell us different things; who are in those numbers, who are we looking at here in terms of risk.

Then I'm going to turn it over to Amanda and she's going to talk more about the suicide prevention strategy plan that's in development, go into that into a little bit more detail, our steps, and then I understand we have lots of time for questions, too. So that gives you a little bit of sense of where we're going.

This is what we call the river of suicide, and we use this image – we use the river as an analogy for understanding the process of suicide. Now we know quite a bit about suicide. Thoughts of suicide don't start spontaneously without cause. There are some building blocks that lead up to that level of distress. Those building blocks generally take shape – I'm hoping that our, no, it's not working – in what we call the contributories.

We live in the contributories. These are where we have the issues, the problems, the joys of life. How we handle the challenges are different for everyone, but for some people, suicide becomes a way of dealing with the challenges, the obstacles, the barriers, the issues of life.

When suicide becomes an issue they move into what we call the river of suicide. Some people move along the river quite slowly, some people move very quickly. It's important for us as a community to get people out of the river of suicide. Because if they don't get out of the river of suicide,

then thoughts of suicide can be acted upon and that is going to result in either harm, result in the event of a suicide attempt or death. We know that that affects a lot of people.

Now, this river runs through each and every community in Prince Edward Island. It runs through work places, it runs through families, it can run through schools and there are things that we can and need to do about this river that runs through every community.

Let's look at after suicidal behavior occurs. Obviously somebody that makes a suicide attempt, they're going to need longer term – they're going to need support. They're going to need: How do they integrate that experience and move forward? Similarly, families that have been impacted by suicide, often their needs go unnoticed, but huge impacts there. Actually, the things that we do in postvention are in some ways, prevention for the next generation. Because if we can help those families that have been impacted by suicide or suicidal behavior to integrate that loss in a more healthy way, we're going to strengthen those families to deal with future obstacles or challenges.

Let's look up here in prevention because we often hear suicide prevention. But it's not just prevention, prevention is important because that's where we prevent people from becoming suicidal in the first place. For example, early detection and treatment of depression; excellent prevention strategy, but not everybody that dies by suicide is impacted by depression, there are other factors that can come in to play. Gun control, another excellent example of a prevention strategy and that has helped us here in Canada. Compared to the States, you'll see a huge difference in suicide by gun; another prevention strategy. That's what the dam represents actually, are those things that we do to prevent people from ending up in the river in the first place.

Then in the middle there's intervention. What about those people that are in the river that have thoughts of suicide? How do we get them out of there so they're not acting on those thoughts? How do we have people trained to intervene with those folks in an effective way so that they can become safe from suicide and access some of those longer term supports that are needed to work through some of those issues.

We felt that it was important to talk about prevention, intervention and postvention because our strategy is going to have to cover all of the spectrum of suicide, not just prevention. We also have to take into consideration research and what research can tell us about prevention, intervention and postvention strategies. Now this isn't something new, we've been working on this, as I say, for 17 years. A lot of our efforts have been community-based, but there are lots of things that we can be doing, system changes, those kinds of things. We'll get into it in a little bit. So that tells you a little bit about suicide.

Let's look at numbers now. Now we're using the iceberg. What do we know about icebergs? A lot of it is hidden, right? Nine-tenths of an iceberg is hidden and it's the same with suicide and suicidal behavior. A lot of that is unseen, unnoticed by the average person. This image says a picture for a year. We're not going to use a year. All other provinces in Canada, we could look at a year and get a pretty good snapshot. For example, in New Brunswick, every year they have approximately 105 suicides; it might be 102, it might be 109, but it's in that ballpark.

Our province, our population isn't big enough to have that kind of consistency. So what we see is we'll have one year we'll have eight, another year we could have 18. How do we get a consistent – a picture of what it looks like? On average, well we take an average of 10 years. I breakdown five-year periods, 10-year periods, every year to see what the trends are looking like. You'll see our population has gone up by 12,000; the good thing is our number of suicides have not. You would think that our population goes up, our numbers of suicides should go up, they have not shown that, which is a good thing. So, on average, we have 15 suicides each year on PEI. I don't know if that's a surprise. Some people it might shock, some people might think that there were more.

Now that's one part of looking at suicide, there are bigger numbers when we look at suicide attempts or unreported suicides, I should say. So, not all suicides are reported

as suicides. We may have situations like single vehicle car crashes, overdoses, drowning, fires, it's hard to determine. In the coroner's report there is a section 'undetermined'. It's estimated – depending on what report you look at – there would be between five and 25% more suicides than are actually reported. So, we'd be looking at two to four more on PEI that are not in those reported numbers.

Bigger numbers when we look at suicidal behaviours. For every one completed suicide, we're going to see – again depending on what report you look at – between 40 and 100 suicide attempts. Bringing that back to PEI, we would be looking at between 600 and up to 2,000 people that have made suicide attempts. The way that we get that data here on PEI is from hospital visits. But again, not all suicide attempts end up at the hospital.

Other numbers, when we look at the numbers of people affected by suicide and suicidal behavior. A study in New Brunswick a few years back estimated that six people would be profoundly impacted by a suicide death. How do you think that resonates here on PEI in our close knit Island communities? We just have to look at what happened on the weekend, we don't have to look far, we can – anyway. We have huge impacts relating to suicide on PEI, and in some cases the media contributes to those – the concerns in some cases that we see in the population about suicide.

The numbers that we can make a difference with, people with thoughts of suicide, people that are in the river of suicide that have not acted on those thoughts, 7,000, one in 20, between 5 and 6% of the population each year consider suicide as a way of solving their problems, of ending their pain. That's a lot of people that we have an opportunity to make a difference with.
That gives you a lay of the land in terms of numbers. Now numbers tell us one story – like I said: 15 suicides on PEI on average each year. That gives us a rate of 9.6 per 100,000. We talk about rates because it allows us to compare one province to another, one group with another. So, when we look at Canada, our rate is 11.3 on average per 100,000. Our Island rate is lower than our Canadian rate, which is a good thing. But there are some provinces that have quite high suicide rates, some territories. We have some of the highest rates in the world in our First Nations communities, our Aboriginal communities. Alberta has one of the highest suicide rates. A lot of our Islanders go out to work in Alberta. Their suicides are reported out there, they don't get tabulated in our coroner's reports.

We're fairly consistent with other Maritime Provinces in terms of our rate. Like I said, there are some areas, some regions that put the national or Canadian rate up. So, who are in those numbers? Young people are always a concern. Young people – we don't lose a lot of young people but the ways that they die are often violent.

The first leading cause of death is accidents, the second leading cause of death for young people is suicide – so the ways that they die. It's not the highest-risk demographic on PEI, but it is something that we're – I was saying to Amanda, when I started in this position 17 years ago, I may have seen a youth suicide once a year, maybe once every two years. Now I'm seeing them at least once a year, sometimes two or three in that younger – and it's not always young, young people. It's in their 20s. There are some subtleties there.

Chair: James has a question.

Mr. Aylward: Thank you, Chair.

Pat, I'm curious: When you're referring to young people, what age range are you speaking of?

Pat Doyle: That would be 10 to 19, that age group and then generally the coroner's reports will be in 10-year segments, so 10 to 19, 20 to 29.

Mr. Aylward: Now the reason I ask is because you have a category young people, and then a little further down on the fourth bullet you jumped to middle aged so –

Pat Doyle: I'm going to talk about that.

Mr. Aylward: Yeah, so I was just –

Pat Doyle: That's a high-risk group.

Mr. Aylward: I wanted to determine where the cutoff was and –

Pat Doyle: Yeah, so that would be young people –

Mr. Aylward: − what's captured in between there.

Pat Doyle: − but what we are seeing is that it's not just young, young. There was concern about youth suicide in the 1980s and it started – 1960s, 1970s, and 1980s it was growing and then it started to level off and it hasn't been increasing. Actually, the group that has been increasing exponentially is seniors. I'll get to that.

GLBTQ populations, 70% - and this is particularly relevant to youth. We don't have a whole lot of data on adults because it's not covered. It's not collected in coroner's reports, but we do have information on (Indistinct), 70% attempts, 30% and a suicide attempt, we have that on there – the biggest predictor of future behaviour is past behaviour; a previous suicide attempt. I will talk about that, just if you allow me while we're talking about it I might as well say, four out of five suicide decedents would have had a previous suicide attempt in their history. Once somebody has made a suicide attempt, their risk increases 40 times, so it's really important to prevent that first attempt, that first engagement with suicidal behaviour.

Now I'm, going to go back to males. Four out of five suicides are male; 80%. It's starting to – I'm starting to see subtle changes in that. We are seeing an increase, a slight increase, in, like I said, young females. That's a group that we're seeing a bit of a rise. They are kind of catching up with the males. The males, they would use more lethal means, less likely to be able to be rescued. Whereas women tend to use less likely, less lethal means and there's more opportunities for rescue.

They engage in suicidal behaviour at the exact same rate. It's the outcome that's different. Men tend to die by suicide because they use more lethal means.

Middle age – by saying males, that's not to say that there is no risk for females. Their risk continues to build until they're in their middle ages and then it starts to level out. Men; however, the risk never goes down. As they age the risk continues to go up. Middle-aged men are our highest-risk demographic, and that's not on PEI, that's across the board. I think the only place that would not be is in Japan where they have totally flipped on the other side because of their cultural – anyway.

Middle-aged men: 39 to 59. That's our highest-risk group on PEI and across the country for that matter. Those with mental health, mental illness or a substance abuse issue – 10% of those groups will die by suicide; 90% of those with mental illness, whether it's diagnosed or undiagnosed. Often it is undiagnosed but after speaking with the family it is quite evident that they were struggling with a mental health issue, they can determine that by psychological autopsies, but 90% have been impacted or struggling with a mental health issue and many of those are on the depressive sides of those.

Chair: Can I just ask you a question back to the middle-aged males being the highest group? Is that like a mark difference or is it like just a few percentages kind of thing?

Pat Doyle: No, it's a mark difference, wouldn't you say?

Amanda Brazil: I would think so. They are less likely to seek help.

Chair: Okay, and is there a percentage or whatever of –

Pat Doyle: I think it's around 55% were in that category.

Amanda Brazil: We'll have to check and get back to you on that.

Pat Doyle: We'll have to check. We could get back to you.

Chair: Okay, Bush has a question.

Mr. Dumville: Just a follow up.

Are males prone because they're in a mid-life crisis? They are assessing their success or lack of success in life and they are making an adjustment?

Amanda Brazil: Some –

Pat Doyle: There are many factors −

Amanda Brazil: Yeah –

Pat Doyle: − that can come into play.

If I had to give you a profile, could I say – could I do a profile of your –

Amanda Brazil: There are different contributing factors. There was a recent report released, I believe in June, talking about masculinity and that sort of hyper-masculinity or feeling like you have to remain tough and strong; it increases suicide risk in men.

That's one example.

Pat Doyle: When they have lost their role in the family, the changing role of men's role in the family; changing of dynamics of families in general, has impacted men's mental health. They are less likely, as Amanda said, to seek help. When they go to the doctor they will be talking about everything but mental health issues and how they are feeling. They will be talking about physical symptoms, perhaps, but they don't talk about mental aspects of those.

Amanda Brazil: (Indistinct)

Pat Doyle: Those are some of the factors.

They are very individual. Every suicide is very individual and has individual factors that come into play, some of which we know, some of which we have no idea.

Chair: Thank you.

I might ask this as maybe an anecdotal or maybe a scientific question depending on what you know. I'm curious as to whether things like Bell Let's Talk day have impacted those numbers or proportions or whatever ,in any way since, say, in the last 10 years or –

Pat Doyle: I think they would contribute in terms of sending the message that it's okay to reach out for help. I certainly feel that the sharing, lessening the stigma that's attached to mental health issues and suicide has certainly done a great deal of work in moving that stigma forward.

Amanda Brazil: I think it depends on how you look at it. You could look at a reduction in people seeking help and saying that's a good thing. People don't need help, or you could look at an increase in people seeking help and saying there are so many issues, but now people might be feeling comfortable to seek help. So it just depends on how you look at the numbers, right?

Chair: Yeah, I mean the reason I asked the question is it would be my perception and perceptions, of course, are based on personal circumstances but that now versus 10 or 15 years ago, we are a lot more open about mental health issues, I think, and maybe that's different across different demographics too –

Pat Doyle: Yeah.

Chair: − but it's certainly something that seems to be more recognized as kind of a health issue, that a good portion of society will go through over time.

Pat Doyle: I agree, and keep in mind we started talking about suicide awareness and prevention in our schools 17 years ago with grade nine students. Since that time, every student on Prince Edward Island has had that presentation on suicide awareness and prevention; how to talk about suicide, how to talk about mental health issues. Those 14-year-olds are now 31 and having families of their own. I would like to think that some of the work that we have been doing over the past couple of decades has made a difference and has made – contributed to that shift in attitude and allowed people to share and feel comfortable.

Even families that have been impacted by suicide are now able to say things like: He died as a result of his struggles with depression.

Amanda Brazil: Sorry, I just wanted to – and I think you're correct in saying any sort of mental health promotion or mental illness prevention is suicide prevention, right?

Pat Doyle: Yes.

Amanda Brazil: They are very much tied together so –

Pat Doyle: Good point.

Amanda Brazil: – Bell Let's Talk would be a promotion, prevention initiative but it also would be a suicide prevention initiative.

Chair: Yeah, and I didn't mean to just point to it, but there seems to be a big trend, like a bunch of different things. I remember Clara Hughes, linked again to Bell, but coming out talking about it and making it kind of a front page issue.

There's a lot going on right around that same time that it seemed to get a bigger push than it had. You know, everything kind of goes in waves when you ask questions –

Pat Doyle: Awareness and prevention makes a huge difference, and we can actually bring this closer to home to our own Island help line, for example.

Amanda Brazil: I think there's a stigma around mental health issues and mental illness; but there's also a different stigma around suicide. It's not necessarily – we might be talking more about getting help for mental health, or lots of people are depressed, but then there's still a stigma around suicide. There are different types of stigmas around different things, so we can be making a lot of inroads on one and still need to focus on others.

Chair: Bush had a question here, too.

Mr. Dumville: Do all suicides have to go into the mental illness class? Say, if – versus a rational solution to a problem. In other words, if it's social-economic, if somebody just doesn't want to live with the shame of –

Pat Doyle: Yeah.

Mr. Dumville: – or if somebody has the solution that does not want to live in community care or nursing care and makes a rational decision that this is not for me, they enjoyed the past, I don't just want to hang around. Why does it always have to be classed as mental illness?

Is it a (Indistinct) –

Pat Doyle: Not everybody –

Mr. Dumville: – or can you have a rational decision to say: I have decided that my life is not worth living because of problems that have built up. That may not – is that necessarily depression, or is that just circumstance and I can make an informed decision that my circumstance is very, very bad, I want to move on, but I don't want to be classed as having mental illness.

Amanda Brazil: Each suicide is unique. You can't lump experiences together, but I mean you would hear. (Indistinct) you would hear about situations where there was maybe a financial concern, and that was the decision that that individual had made.

We're just talking around the statistics that – what is it, 90%?

Pat Doyle: Ninety per cent.

Amanda Brazil: – have a diagnosed or undiagnosed –

Mr. Dumville: Yeah.

Amanda Brazil: So they're struggling –

Pat Doyle: So there's 10% there that there was no mental health issue identified. Even talking to the family afterwards, there was no incidence of mental illness or alcohol abuse. It seemed like it was a rational decision that they made.

Mr. Dumville: Yes. So like, say, the crash of 1929. People were living high, they were happy with their lives, everything was going great, then all of a sudden their world was ripped out from under them. So they made a rational decision. It wasn't a mental illness decision. They didn't become mental illness like that.

Pat Doyle: But that's why we need to have people properly trained to intervene with people that are at risk of suicide, because they can tease that kind of stuff out. We are trained to intervene with people that are thinking about suicide because they have a mental illness or because they're faced with a financial crisis.

Amanda Brazil: A loss.

Pat Doyle: Or a loss of –

Mr. Dumville: So there's –

Pat Doyle: There's generally loss.

Mr. Dumville: They're separate, but they're separate.

Pat Doyle: They're all the same when we're talking about trying –

Mr. Dumville: End result.

Pat Doyle: – to save somebody's life.

Mr. Dumville: Yes.

Pat Doyle: We want to build safety around that, and we have to address the things that are threatening their life Do they have a plan? Do they have a mental health issue that's not being addressed? Do they have resources that can support them? There are a lot of things that we look at.

That's why we want to have people trained to intervene in a helpful way so that we get to that result where they can see a way, they can see a plan forward supported with the caregiver that's provided that life assistance.

We call it magic, but it is really the work of the program, the model, in doing intervention. That's why people choose life. It's not because you've changed – you've given them a $100,000 or you've made their mental illness go away. It's because we're skilled in meeting their needs, and they need somebody skilled to understand where they're coming from so we can get them to a different place. That's the magic. It is the relationship between the caregiver and the person at risk in that intervention that helps them to choose life.

Amanda Brazil: Pat's speaking specifically to a (Indistinct) –

Pat Doyle: A program.

Amanda Brazil: (Indistinct) a program –

Pat Doyle: That's how we've trained thousands of our health professionals here on PEI to intervene, so that's important.

Mr. Dumville: Thank you.

Pat Doyle: Does that –

Mr. Dumville: Thank you, Chair.

Chair: So Hal had a question next, that or –

Mr. Perry: Thanks, Chair.

I had a question, just following up on that, about people being trained to intervene. I totally understand that, but what about – let's say there's someone in my past that I knew that committed suicide and I didn't see the signs; and I would say: I wish I could have seen the signs, there's something I could have done, I could have intervened. But the general public, we don't see those signs, and each case as you mentioned earlier is unique.

Amanda Brazil: Most of the time, a lot of the time, there are signs.

Mr. Perry: So what –

Pat Doyle: Eighty to 90%.

Mr. Perry: – are those signs?

Amanda Brazil: So the thing is, is that the way I – because a lot of people say we didn't see, there weren't any signs –

Mr. Perry: Yeah.

Amanda Brazil: Well, if you're not trained to recognize them, then there might as well not be any signs; but there is awareness training and intervention training that can train people to start recognizing some of those signs.

Mr. Perry: How do we access that training?

Amanda Brazil: We offer it.

Pat Doyle: We do it.

Mr. Perry: So you can contact – so if I have a group, I can just contact your organization and say: Can you come and put on this training session?

Amanda Brazil: Yes.

Pat Doyle: Yes.

Mr. Perry: And do you do many?

Pat Doyle: Or we do –

Amanda Brazil: We do –

Pat Doyle: – we actually host them annually. We do many.

Amanda Brazil: (Indistinct)

Pat Doyle: We're (Indistinct) trainers, actually.

Mr. Perry: And this could be right across the Island.

Amanda Brazil: Yes.

Pat Doyle: It is.

Mr. Perry: Perfect.

Pat Doyle: It's actually well known. It's the most well known, well researched, well recognized suicide intervention program in the world, by LivingWorks.

Amanda Brazil: And a lot of the other provinces are recognizing sort of having gatekeeper communities so the more people you can train up, the safer your community's going to become.

Mr. Perry: Excellent.

Pat Doyle: That's how we contribute. That's how we –

Amanda Brazil: It's just one of many –

Pat Doyle: – create suicide-safer communities.

Amanda Brazil: – (Indistinct) that can be done, but –

Pat Doyle: That's one of the things.

Amanda Brazil: Yeah.

Mr. Perry: Okay, great.

Thanks.

Chair: I might just put in a shameless plug. They do a fundraiser every spring, too, a golf tournament, the Signals of Suicide golf tournament.

Mr. Perry: No, I'm aware of that. I just wanted to make sure that others were aware of it.

Pat Doyle: Thank you.

Mr. Perry: Yeah.

Amanda Brazil: We deliver this program. We have been delivering it twice, three times a year. We delivered it six times last year.

Mr. Perry: Like I said, in my case, it was back probably 20 years ago. You carry that with you, where you keep saying: I wish I had of known the signs.

Pat Doyle: Yeah; and when I took the training I felt I was fairly skilled, but when I took the training I said: Man, why didn't I have this 15 years ago –

Mr. Perry: Exactly.

Pat Doyle: – when I started working in this field, because it's very practical, very user-friendly.

Mr. Perry: Thank you.

Pat Doyle: So –

Chair: Just before you get going again, Peter with a question and then Bush and then Brad, so we'll jump around a little bit here.

Dr. Bevan-Baker: Thank you, Chair.

You used the analogy of the river of suicide earlier, and that I think you said it's everywhere. We live in a global society now that's more connected and more uniform than it's ever been before; but are there cultures currently here today in the world, or historically – and I understand it would be more difficult to have reliable data from history – but are there cultures where suicide has either been entirely absent or at much lower levels? If so, what are the traits, what are the features of those societies?

Amanda Brazil: I'm not aware right off the top of any culture that would have virtually none or very low, but you can look at some of the indigenous communities across the country that have actually lower suicide

rates. One of the big contributing factors for those cultures is connecting people back to their culture, connecting them to their spirituality, belongingness and that type of thing. So there are things that are culturally specific but that also can be done to help. I don't know if that answers your question.

Pat Doyle: It's something that has been part of the human condition forever, in all cultures.

Dr. Bevan-Baker: I had read, Amanda, as you've just said, that traditionally, historically, native cultures were – suicide rates were much lower, which of course is a horrible irony given that –

Amanda Brazil: (Indistinct)

Dr. Bevan-Baker: – Nunavut, of course, is the territory where the suicide rates are off the scale, like hundreds of people per hundred thousand, rather than the nine or ten which is the national average. It strikes me that that sense of community and belonging which you are creating, in part, though the program you just described, is part of that.

You also mentioned a few minutes ago about a school program where every Island student has been exposed to a suicide discussion or a talk on suicide. I'm wondering who implements that, whether that's teachers within the schools, is it counselors there, is it CMHA, is it –

Amanda Brazil: It's us.

Pat Doyle: Yea, we work with the Department of Education and the school board, they allow us to offer this to all intermediate schools in the province and they're very happy to take us up on that. We have a very high participation rate among the Island intermediate schools.

Dr. Peter Bevan-Baker: Thank you, Chair.

You mentioned a statistic that I just want to clarify, Pat, about, we know that males die from suicide at a high rate from females, but attempts by males and females, I think you said that they are about equal but the statistics I read are that females actually attempt suicide –

Pat Doyle: The behaviour, the amount of behavior we have among the sexes is the same.

Amanda Brazil: So they're like, sort of equally suicidal –

Pat Doyle: So for –

Amanda Brazil: – that women tend to attempt at a higher – there's more attempts with women and more completed suicides with men.

Pat Doyle: For every four suicide attempts of females, we would have one completed death by a male.

Dr. Peter Bevan-Baker: Can you say that again?

Pat Doyle: For every four suicide attempts – it's almost like reversed: men complete suicide at a higher rate, they attempt it less. Women attempt more; die less.

Dr. Peter Bevan-Baker: I just wanted to – because I was under the impression that it was – the attempts are equal between the sexes but they're not.

Pat Doyle: No, suicidal behavior –

Amanda Brazil: They are but –

Pat Doyle: – the amount that they engage in the behavior is the same, the outcomes are different.

Dr. Peter Bevan-Baker: Okay, thank you, Chair.

Chair: Just before we go on. I just want to make sure that everybody is aware, when we are talking and they are trying to record, we need to kind of talk, finish, let the next person go. Because if not, they end up with a jumbled piece of people jumping in all over each other. Just try and be remindful, we're not going to bring the hammer down or anything like that if that happens again, but it just makes go a little bit easier.

Do you have any further questions, Peter?

Dr. Peter Bevan-Baker: No, I'm fine.

Thank you, Chair, for now.

Chair: Going back to Bush then.

Mr. Dumville: Thank you, Chair.

I'd just like to go into a little bit about you rely principally on family or friends, or is there a more organizational way of – like triggers. Like in other words, if somebody has a personal tragedy or they lose their social status or they enter the criminal justice system, those things that are very traumatic, if family and friends aren't picking it up or something, your organization, is there any way that you intervene? Or, is it kind of like an unwelcomed intrusion into this person? Like, you pick up the newspaper –

Amanda Brazil: We will reach out to families that have lost someone to suicide. We have resources available.

Pat Doyle: We may reach out.

Amanda Brazil: We may reach out depending on –

Pat Doyle: We may be creative.

Amanda Brazil: Right. If we know somebody who knows somebody, we will offer up our – like please let this family know we – we will use the networks to try and –

Pat Doyle: But after the fact.

Mr. Dumville: Yeah, well take suicide, like I mean you read through the paper, you kind of have an inkling –

Pat Doyle: That would be the role of family or clinicians that they're working with or the people that have delivered that news. I've had many conversations with police officers, for example. They've learned that somebody that hasn't ever had any involvement with the criminal justice system and you're just delivering, you're going to be apprehended. They have learned from experience that they need to ask those questions.

Amanda Brazil: I mean our organization can do what we can do and mental health can do what they can do, but to reach out to – I mean there is so much loss and so much pain in our communities, it would be virtually impossible to go – but that's why it's important to understand that this is just not a CHMA effort or mental health and addictions effort, this is community. Our communities have to step up and look out for each other, right?

Mr. Dumville: Yeah. One further question.

Chair: Sure.

Mr. Dumville: Just curious of how the Island Helpline, how it's working and is it working in collaboration for, say the new mobile crisis response team? Are they working in collaboration?

Amanda Brazil: We can speak to the Island Helpline –

Mr. Dumville: Yes

Amanda Brazil: – and how it's working.

Pat Doyle: We're actually really pleased. I don't know if you – some of you may recall we launched a public awareness campaign around the Island Helpline for World Suicide Prevention Day two years ago, 2016. At that time we were getting about 100 calls to the Island Helpline a month; about 1,200 a year. We've been hammering away at that public awareness campaign and the province has recently jumped on board and started some using some of the materials that we developed. We've refreshed the materials, the promotional materials, made them more current, more user-friendly and created a website. (Indistinct)

The last four months – we get the statistics from the line – in the last four months we have had – there has been a sizeable increase in the amount of calls, people reaching out to the Island Helpline. In the last four months we've had equal to the amount that we'd had in previous years in that four-month period as a result of the increased promotion, perhaps the increase in people talking about mental health issues and suicide. But people are reaching out.

What would usually be around 100, we're at 334 calls last month to the Island Helpline. We're really proud of that; we think it's a great thing that people are using that because that prevents people from – we want to intervene with people sooner upstream so that they don't get to that point

where they're having to use emergency departments or mobile crisis because it's more expensive. If we can get people supported earlier on then it's going to save us.

Mr. Dumville: Thank you.

Chair: Brad had a question and James has one after that.

Mr. Trivers: Thank you, Chair and thank you for your presentation.

Since we were talking about training, I wanted to ask a couple of questions. I'm really focused on solutions and taking action to make things happen. There are at least a couple of people that have reached out to me and put forward solutions. One lady is Alana Stewart and she was talking about the non-violent crisis intervention training and mental health first aid, and specifically within our hospital's emergency department. I wanted to find out: Is that offered to say, security, within the emergency departments today? She seemed to think it wasn't and that was her solution. I wanted to find out from you if it is.

Amanda Brazil: Mental health first aid, it's a good program, but it's sort of mental health one-on-one. It helps people to maybe recognize some signs and symptoms to certain mental illnesses, but it doesn't create – they're not a counsellor, they're not – it really is an awareness program. It does what it does, it teaches sort of the basis.

Pat Doyle: It would be a good one-on-one for a teacher in a school.

Amanda Brazil: We offer mental health first aid, we have been for awhile. Groups can contact us and we can put the training on for them. In terms of it being mandatory training, it maybe for certain organizations, I'm not aware of that. But mental health first aid is not suicide intervention either, right? Each of these programs have very specific sort of outcomes. So, if that –

Mr. Trivers: That does help. It sounds to me like we really need to look at whether mental health first aid and non-violent crisis intervention training should be offered to, security, for example, within emergency departments. That's not information that you necessarily have to say whether it's mandatory or not today.

Amanda Brazil: I mean it can be a benefit to anybody to have that basic knowledge of mental illness, absolutely.

Mr. Trivers: The second question I had, so Carson McManaman was sort of advocating saying: What was really a value to him was working with – just talking with other people in a confidential support group who had mental illness essentially. In his particular case, he had experienced the suicide of his father and had potentially those sorts of tendencies himself.

You had mentioned several times about the fact that you have the training as a councilor and the skills to work with suicide prevention, but is there value in volunteer type support groups like that, and I know there are people here today from the UPEI Student Union and they are looking at things like, I believe they call them friendship benches, so these are essentially untrained volunteers who are going to be there, whether it's in the support group or a room at a university or a bench just saying: If someone goes and sits down, I need to talk to someone, I will go and listen confidentially.

Is there value in that? Or do people need to have the training, I guess is my question?

Amanda Brazil: Essentially, you're talking about what we call peer support.

Mr. Trivers: Okay.

Amanda Brazil: There is always value in self-help groups and people coming together. Peer support, self-help groups, there's evidence suggesting that they work for some people. We would – peer support sort of falls along the continuum. There's very informal peer support where two people have the same lived experience, the same experience beit whatever, it doesn't – whatever that experience is, and can provide support to each other just on a very informal capacity.

Peer support now nationally is being recognized and is becoming formalized. Now there are peer support trainings and certifications that are being offered. There is

a place for peer support or self-help groups all along the continuum.

Mr. Trivers: Okay.

Amanda Brazil: It can be beneficial anywhere along the continuum. Bringing students at UPEI together – the problem – the thing you need to be careful of is people's safety and you know, you said: You're councillors. We're not clinicians. We're not councillors.

Pat Doyle: We are trained –

Amanda Brazil: We are trained.

Pat Doyle: − to intervene, but we are not clinicians. We're not therapists. That's the formal system (Indistinct)

Amanda Brazil: So you've got two people with lived experience, you just have to make sure everybody is safe in those exchanges and those – in terms of their own – whether it be mental health or their own state of recovery or that type of thing. Does that –

Mr. Trivers: It does.

Maybe just to put it more simply: Should folks like the UPEI Student Union go and set up friendship benches at their university?

Amanda Brazil: Sure.

Mr. Trivers: Yes?

Pat Doyle: Sure. It's any way to have people connect.

Amanda Brazil: Connect, absolutely.

Mr. Trivers: If I'm a principal at an elementary school should I have a room where if anyone wants to talk they just go sit in the room and somebody will come talk to them? You would say: Do that.

Pat Doyle: Yes, but it has to be monitored.

Mr. Trivers: It has to be monitored? Okay.

Thank you, I won't take − those are my questions.

Amanda Brazil: I just – sorry, when you look at isolation, and I don't know – there was recent research out around people who are alone and isolating themselves is as bad for their health as – I can't remember if they compared it to smoking or – people need to be connected. So any types of ways that you can connect people to create support systems or friendships is going to be a good thing.

Mr. Trivers: And again, Brad Trivers here, I'm looking for ways that people can take action now −

Amanda Brazil: Yeah.

Mr. Trivers: − to help – that are, let's face it, low cost and easily implementable, right? These sort of things that they are suggesting seem to be that way, so I want to make sure that you, you're the experts in this area, see value in them before people would take those steps.

Pat Doyle: I'm going to give you an example of something that we're working on now that is changing as a result of research and what it's telling us about what's most effective. For the last number of years since I came into this position, we have had self-help groups for survivors of suicide, monthly groups where there's not a clinician involved. It's people, like Amanda said, coming together; they're all – the common experience is they've lost someone close to them to suicide.

Those groups have come and gone. I have had some concerns over the years about the safety of those groups and what's being shared, what people are leaving with afterwards. The last couple of years I've been searching around for a new model: What are people doing to help support these people who have been gravely, profoundly impacted by a suicide death? And what other communities are doing, other areas, what seems to be the trend is not having drop-in groups, but having closed, knowledge-based, content structure-based groups, closed groups that you start with a closed group and they work together supporting each other with clinicians. This is with clinicians.

We've partnered with Health PEI, with the Department of Health and Wellness. They are providing us with clinicians because we don't have clinicians. We don't do that. That's not our role, but we want to

collaborate so this is a beautiful example of collaboration. They are providing the clinical support; we're providing the expertise on how to do it. We got the program for them from one of our partners in Calgary, a newly-revised, nine-week structured, clinically-based program that we're going to be rolling out for World Suicide Prevention Day.

Amanda Brazil: Which addresses some of the postventions. But in saying that, we also have a self-help group for people with depression, anxiety and bipolar that is peer-led, but there's some structure around it and that helps to keep people safe and the focus remain the focus and that type of thing.

To answer what you're saying, there's benefit anytime you bring people together.

Mr. Trivers: Okay, thank you.

Pat Doyle: But you have to find what is –

Amanda Brazil: Right for them.

Pat Doyle: − the end – what are you trying to accomplish with that group?

For example, we didn't find that the support group for survivors was meeting their knowledge needs and they were coming together and sharing. In some cases, the intimate details, which is not the place to be sharing. You don't want to be having people leave heavier than when they came. So there are other places for that kind of sharing to happen.

It's providing people with what they need at the time so that they can move forward. We've talked about a pathway of care, of suicide care, not just for those that have been impacted by suicide, but also those that are at risk of dying by suicide. What does their pathway of care look like?

Amanda Brazil: You're more confused.

Pat Doyle: It's a complex (Indistinct) −

Amanda Brazil: It is complex.

Mr. Trivers: It is complex, and sorry Chair, I really am looking for concrete steps to move forward and you mentioned some of them there –

Pat Doyle: We are too.

Mr. Trivers: I know you are as well, so thank you for that.

Pat Doyle: We're working on – it's something that's – you can't kind of just stop and work on a strategy. You have to be continuing to work on the things that work and we're continuing to do that as well, so thank you for the question.

Chair: Thanks, folks.

James had some questions as well.

Mr. Aylward: Thank you, Chair. James Aylward.

The Island Helpline, is that administered through your organization?

Pat Doyle: No. It's provided – our provincial government contracts with Chimo Helpline Services in New Brunswick to provide that service.

Mr. Aylward: Do you know offhand if there's any stats or if they have a mechanism in place for tracking non-answered or missed calls?

Pat Doyle: Yes, they do.

Mr. Aylward: Okay, do you have any information on the frequency of that?

Pat Doyle: There had been some concern expressed about the number of what they call engaged calls. For example, if one of their staff or volunteers is engaged in another call and our Island Helpline rings in and they can't pick it up, they'll get a voice message and that is recorded as an engaged call. We have been tracking those. It's not our responsibility because it's not our contract –

Mr. Aylward: Yes, no I understand.

Pat Doyle: − but we are concerned about that and we have voiced that concern with Chimo Helpline Services and they have taken steps to increase their staff complement and their volunteer complement. Most crisis lines use a hybrid model of both. It's just economically, financially impossible to run a helpline with

all paid staff, so they use a hybrid of paid staff and volunteers.

Mr. Aylward: Thank you.

The reason I ask that is I know of an instant here just within the last week or so where a young lady actually phoned the helpline four times before somebody actually answered the phone, so it's very alarming to me.

Pat Doyle: I'm sure that that the increase in calls –

Mr. Aylward: Yes, from 100 to 300.

Pat Doyle: − and that's why they are looking to bump up resource as well so thanks for sharing that though. We've heard that too and that's why we asked the question about it, the engaged calls.

Mr. Aylward: There has been an official complaint put into Health PEI as well –

Pat Doyle: Good.

Mr. Aylward: − on that.

Pat Doyle: Good, they need to do that.

Mr. Aylward: Quite often it's a family member or a friend that's taken them there and I know from my own experience that that individual will be kept in a certain ward of the ER for approximately 24 hours. Then quite often after they are deemed to be physically stable enough to be released, they're allowed to go with a family or a friend.

Is there any referral from the ER to the Canadian Mental Health Association for follow-up or just to reach out to make sure that individual is still in a good place?

Pat Doyle: It doesn't go to us. It would actually go – if they have been seen in the ER, that documentation would get sent back to their family doctor if they have one.

Mr. Aylward: If they have one.

Pat Doyle: If they have been seen by a physician and it has been deemed that they need to access community mental health for counseling that can happen in the ER. They can make that referral and it sends an alert to the file, particularly if they're already a client of the mental health system then it will flag their file with community mental health that they have to reach out.

Amanda Brazil: We do not offer clinical services.

Mr. Aylward: Yes, I understand.

Amanda Brazil: We don't offer counseling. I mean we have lots of people that come in, are looking for help, but we don't have any sort of formalized counselling that we can provide. We can connect people to some of our self-help groups or some of our programming, but in terms of follow-up counselling, it's not something –

Pat Doyle: It's not our role.

Amanda Brazil: It's not our role.

Mr. Aylward: All right, thank you.

One last question. Mr. Dumville had spoke about the mobile crisis team. Do you know offhand when that was activated or engaged here in Prince Edward Island? I haven't −

Amanda Brazil: I'm not aware of a mobile crisis unit (Indistinct)

Mr. Aylward: All right, yeah because it's something I have been asking for for some time now and I just was surprised that it was happening and I didn't even know about it.

Pat Doyle: We're not aware of anything.

Mr. Aylward: All right, thank you.

Chair: You're good?

Mr. Aylward: Yeah.

Chair: We went down a bit of a path there, thank you very much for our indulgence.

Pat Doyle: That's okay.

A lot of the stuff has been covered. I'm going to be very quick with the rest. This is my last slide and then – so we talked about mental health and substance abuse.

Seniors is a group that we are seeing the suicide rates rise exponentially because they

are living longer with more health issues and they have access to some pretty heavy duty drugs in some cases. Exposure to violence or a history of violence towards others, we see that in terms of trauma, we see it with soldiers returning with PTSD, individuals that have grown up in a home where there's family violence, sexual abuse, those types of things.

I had already spoken about previous suicide attempts and the increase risks associated with. Indigenous groups, I had mentioned that too, that in some cases they have suicide rates that are three, in some cases six times the national average. But as Amanda has pointed out, some groups have done an incredible job. They've recognized and they've put a lot of resources and money into prevention and they have managed to lower their suicide rates to actually being lower than the general average and our Canadian average.

These are groups and it's not groups of people that kill themselves, it's individuals, and the factors that come into play. Some people, you don't see any of that. They're not in any of those groups and they take their life, the 10%. Maybe it's something else that we haven't identified. I don't want – and I always say this because we don't want this to blind anyone from the fact that anybody can be at risk and you only know if you explore how you (Indistinct) –

I'm going to pass it over to Amanda and she can tell you more about the strategy and the plan.

Chair: If I might, Pat, and it looks like Peter's got a question too.

Pat Doyle: Oh, sorry.

Chair: Two kind of particular questions, if you will or if you know anything about them or they may be addressed in the second part or a thought given to them, two things I have seen in my district that seem to have had a very positive impact on the area would be the program that the Charlottetown City Police through Officer Keizer are running at Colonel Gray High School – I can't recall the name of it right off – but they essentially developed a program that had some of the aspects of the DARE program in it and have begun to implement it, and it's been quite successful from everything I understand.

Then the methadone clinic having been kind of ramped up and what, if any, impact that harm reduction strategy has had on people particularly with substance abuse issues that have been accessing that care, you know, as they – I guess maybe a subset of that, whether or how overdoses play into kind of the statistics related to suicides.

Pat Doyle: Do you want to start?

Amanda Brazil: Well, I mean overdose – suicide by overdose can be difficult to determine –

Pat Doyle: Unless there's a note left, it will be undetermined.

Amanda Brazil: I mean, any harm reduction measure or any sort of work towards improving people's situation is definitely a good thing, but in terms of stats I don't know if we can speak to that.

Pat Doyle: I will talk a little bit about the initiative; the city police initiative. Just in terms of referencing DARE, because there has been research, more recent research, DARE is not effective in reducing drug use. In fact, it has been shown that young people that are exposed to the DARE program are more likely to engage in drug use and alcohol.

Chair: Right.

Pat Doyle: I just wanted to make that point about the DARE program so I don't know that –

Amanda Brazil: That's not dismissing the work that's being done. Obviously there's –

Pat Doyle: I don't know that they are actually using that model –

Chair: I can comment on that. Tim Keizer was here and he – again, I forget the name of what they are using. They are not using that model. That model has been discontinued by the RCMP.

Pat Doyle: Oh okay, good.

Chair: They have developed a new –

Pat Doyle: Maybe it's the bridge?

Chair: I can't remember. I don't think it is, but I can't remember what it is called. They have developed a new model and I think, based on what we heard from Andy Cook with the RCMP, they are looking at now taking that out to other schools within the province too, but basically it's something they developed kind of with that mindset, that kids in this age bracket need some help and they've started to implement a program, again, with Officer Keizer. I think Colonel Gray originally, and I think he had indicated that it's now going into Charlottetown Rural as well.

Pat Doyle: I guess I could comment –

Chair: Healthy Me (Indistinct)

Pat Doyle: − in general, it doesn't have to be a police officer to be trained to connect with an individual that's at risk of suicide. Anybody can be trained to connect with somebody at risk of suicide.

Personally, can I say personally however (Indistinct) -

Amanda Brazil: Yeah, but I just – were you talking about this program in relation to suicide prevention or you said –

Chair: Well, I guess more what I was trying to do was ask the question as to what kinds of impacts programs – so the program is called Healthy Me and I thank the clerk for reminding me of that. What kinds of impacts those programs – so anecdotally what I can tell you is this: There's an officer in the school that has a very close connection with the kids at the school and generally has a finger on the pulse, so that was the starting point.

He was recognizing issues within the school and they developed a program to – and this is just my understanding of it – to try and combat or help deal with some of those issues that are there in the hopes that, just to use your analogy as you were saying, the contributories wouldn't get into the river I guess –

Amanda Brazil: That's right.

Pat Doyle: Deal with them up stream.

Chair: − early on and so I was just wondering whether there's, anecdotally or otherwise, any noticed impact in the Charlottetown area of those kinds of programs?

Pat Doyle: I think people – the individuals at the school have said that they are seeing impacts. Those officers have been trained in ASSIST so they are trained to intervene with people that are at risk of suicide. That can't be a bad thing. They are dealing with it at the school. Like I said, it doesn't have to be a police officer. It could be other people and that's, I believe, what the plan is for this coming year. They are piloting a program that's going to put more people in the schools that are going to be trained to identify and support, which I think is a good thing.

Amanda Brazil: I think any time there's a new program or a new initiative, if there's an evaluation component or a framework put in place, (Indistinct) could be measuring the success of that. It sounds like it's wonderful and it's doing what it's supposed to do, but in terms of numbers and (Indistinct) – we wouldn't have those, and I'm not sure if we can say that we're seeing it reflected in rates, but the school might be able to say.

Chair: Yeah.

Pat Doyle: But it's helping them in some way.

Amanda Brazil: Yeah.

Chair: Yeah.

Pat Doyle: The thing about rates and numbers: How can you track a non-event, something that didn't happen? There are other ways, other indicators that we have to use that tells us if we're being successful or not in – we have to identify what success looks like, and then have other measures in place –

Chair: Yeah.

Pat Doyle: – beyond suicide rates, because suicide rates don't tell us a whole lot. They tell us, certainly, if we're – but are people reaching out more, are we actually, is there less mental health issues, you know –

Chair: Yeah, and part of the reason I ask the question: my impression is that those programs are doing great things. Particularly in my area, from everything I hear, they are. You had referenced the DARE program, and an allusion to the fact that sometimes programming like that – and I don't know enough to speak specifically to that programming – but if you kind of raise ideas in people's minds, that can impact the paths they choose to go down. With every kind of intervention you have to be careful about any impact that you might have, and that's part of the reason we ask those questions or I was asking that particular question.

I had Hal next on my list for a question, then Peter, and then Darlene.

Mr. Perry: Okay. Thank you, Chair.

First a comment and then a question: The comment is back to what Brad had mentioned earlier about the friendship benches with peer support. We already have those in some of the schools in West Prince right now. They're called Buddy Benches, and they're really a welcome addition to the schools and to that environment.

My question is about – earlier this spring, the province established three mental health walk-in clinics in Prince County: Summerside, O'Leary and the Westisle Composite High School. I'm hearing that there's good response from residents of Prince County on that. What have you heard on that?

Amanda Brazil: It's another resource that we can – a place that we can tell people is available.

Pat Doyle: What have I heard on it? When is it going to come to Queens County and Kings County?

Mr. Perry: That's exactly – and that's what I was going to get, because I think because of that positive response, Health PEI is now looking into establishing those walk-in clinics in other communities across Prince Edward Island. So to you – and I guess in response to what you just mentioned, or your reaction – that's a positive.

Pat Doyle: I think if you're providing resources to people that don't have them, that is a positive thing. A lot of people – what is it now, 8,000 Islanders don't have a family doctor? So if you're providing them a route to get to see a health care professional, I think that's a good thing.

Mr. Perry: Yeah. I was very proud and happy to see this in Prince County and I'm glad that they're looking into sharing it with the rest of the province.

Thank you.

Chair: I had Peter next.

Dr. Bevan-Baker: Thank you, Chair.

I wasn't planning on mentioning this, and follow-up to what Hal just said, that the walk-in clinics up west didn't actually add any resources there at all. They reassigned people, and it's not a 24-7 service. It's sometimes there, sometimes it's not, and one of the problems in the mental health service here on Prince Edward Island – one of the big ones, as far as I'm concerned – is that we don't have pandemic access to on-time, critical acute care for people who are in crisis.

So yes, this is perhaps a nice idea, but we need to be aware that it in no way is sufficient to meet the problems that exist.

Mr. Perry: But it's a positive step forward.

Dr. Bevan-Baker: A small positive step forward.

Mr. Perry: Still moving forward.

Dr. Bevan-Baker: But it's important to note that it's not consistent, and it wasn't an addition of any further services; it was just a redistribution.

But my question: the Canadian Association for Suicide Prevention has been lamenting for a long time the fact that Canada is almost alone in developed nations in not having a national suicide prevention strategy. I know we're about to get onto our provincial one here, so I'm going to hold my questions on the specifics of that for now. But they claim that almost all suicides are preventable if you have access to the care and kindness and community structures that you're talking about that are in part created through the

awareness strategy that seems to work so well and is certainly affordable.

I am wondering whether the CMHA awareness training that you were talking about, whether our general practitioners here on Prince Edward Island take advantage of that.

Amanda Brazil: They can.

Dr. Bevan-Baker: But do they?

Pat Doyle: Yes they do.

In terms of our statistics, between 50 and 60% of the people that come to our ASIST trainings are from the formal system, i.e. –

Amanda Brazil: But GPs, doctors.

Pat Doyle: We don't get doctors, no. We get social workers, we get psychiatric nurses, we get school counselors, we get police officers.

Amanda Brazil: If you looked at –

Pat Doyle: We've gotten one doctor.

Amanda Brazil: – sort of the statistics, even, there was the report on mental health and suicide in PEI that was released in 2013, and also in New Brunswick. Most people who have taken their lives have been visiting their family doctor.

So that would be definitely something that we would flag just in terms of what can be done to equip them to recognize – because people might present for a bunch of health concerns or physical health concerns, but really that's not why they're presenting. So what can we do and what can be done to start educating practitioners around recognizing that this might be something else. That is something that we have flagged.

Pat Doyle: To add to this, we know it's unrealistic in many cases for a doctor to take two days out of their practice to come to an ASIST training. So the Canadian Association for Suicide Prevention, in concert with the Mental Health Commission of Canada, has developed an online training tool for physicians that they can do. It's free. It was just launched last month.

I've made connections with – I've had some pretty good connections with the medical society of PEI, but my doctor suggested that we do a presentation through Grand Rounds to make physicians aware of that training, but that will definitely be coming out in our strategy because the research is indicating (Indistinct)

Amanda Brazil: Provincial statistics are showing that we've repeated visits through the six months prior to their doctor.

Pat Doyle: So that's an important piece of the puzzle.

Chair: Go ahead.

Dr. Bevan-Baker: Thank you, Chair.

And absolutely, because the first point of contact for many people struggling with pain or helplessness or despair, hopelessness, is their own GP. I think it's really important that those individuals have the best training possible to recognize the signs and symptoms of mental health and distress and potential suicide thoughts.

I'm also wondering in the same vein – I mean there are some high risk groups, you have seniors up there for example – are the geriatric care workers, home care workers, people who are in contact with that high risk group, are they also taking advantage of your training?

Pat Doyle: They are starting to. To be honest, it generally takes a tragedy for them to recognize. That is often the catalyst that gets them to look at what they've been doing in terms of training for their staff that are seeing, hearing the stories on a daily basis.

We've had conversations with several of the larger home care facilities, senior's homes. They're starting with their coordinators, having them trained in ASIST, and then kind of – that's how generally it starts. They send somebody to ASIST and the light bulb goes off: Why didn't we have everybody trained in ASIST? Then they start sending – they see the value in having their staff trained to respond so that it doesn't get bigger than it needs to be.

Dr. Bevan-Baker: I notice that absent from – well, it's not a high risk group – but new

mothers is not mentioned there, and we know that 40% of mothers will have a low period after birth, and up to 15% can end up with post-natal depression.

I'm wondering also whether obstetricians, gynecologists, home care workers who will support new mothers, that the same thing – are they, should they be hooked in? Perhaps an all encompassing question might be: Would you be in favour of your suicide awareness training being a mandatory part of safety training in all workplaces?

Amanda Brazil: I think there's some –

Pat Doyle: (Indistinct)

Amanda Brazil: There's some statistics or there's – and don't quote me on where, but we've heard that people are more likely to use suicide first aid than physical first aid in their lives. There's a better chance they're going to have to intervene on that than –

Dr. Bevan-Baker: (Indistinct)

Amanda Brazil: Right, or somebody has a wound or that type of thing.

Pat Doyle: I guess my concern would be you need to train people for the role that they're in. If they're in a role, they have to know what the pathway to care is and what their role is in it. Sometimes that's dictated by their employer: I don't want you doing suicide intervention, I want you to be –

Amanda Brazil: But it –

Pat Doyle: – able to recognize it, but I want you to be able to pass it on to somebody who is trained –

Amanda Brazil: But at the same time, that individual could use that in their personal life, and that's what we remind people that we train all the time. You might never use this in your job, but you might use this with a really good friend tomorrow.

Dr. Bevan-Baker: Yes.

Amanda Brazil: So it just – it's not –

Pat Doyle: (Indistinct)

Amanda Brazil: – (Indistinct) people can be directed to the training through their place of employment, but what they're ending up doing is the community's becoming safer.

So for example, we're delivering this training to a group of volunteer firefighters at the end of October; not only to build capacity within the departments, because a lot of these people might not ever have the opportunity to take this training as a farmer or a fisherman, but building capacity within the departments to recognize this in their own membership, but also they've now – we've built capacity in that community. So it's capacity building.

Pat Doyle: There are different levels of training, depending on what your goal is. That's why, like I say, they've developed an online tool because they know that they're not going to get doctors to a two-day training but they need that information, so they put it in a way that they can access it.

Amanda Brazil: We're delivering a suicide awareness session to all the new student orientation kids at UPEI. What this training does, it's just a half a day, it doesn't teach them to intervene if somebody's suicidal, but it teaches them to recognize the signs and symptoms so that they can refer that person on to somebody who has been trained.

Again, it's building capacity in these students to recognize this, and all of the new students that are coming in that they'll be working with. There's lots of opportunity to –

Pat Doyle: Similarly, our SOS program in Grade 9, it doesn't teach intervention. It teaches warning signs, and what they can do if they're worried about a friend – if they're concerned about themselves, what resources they can reach out to.

We don't want to put people in a position where they're not comfortable. We want to put them in a – we want to give them the tools to do what they would be expected to do in their role.

Dr. Bevan-Baker: Pat, if I could just make a closing comment, and I thank you for that, I think it's all of our responsibilities to build

resilience in our community here on Prince Edward Island so that we can help; and we have a tradition of that here on PEI, looking after our neighbours, being a close-knit community. So I think the more people who are exposed to your awareness training, the more resilient our community will be.

Thank you, Chair.

Amanda Brazil: That's recognized in best practices.

Chair: Thank you.

Darlene, you're next on the list.

Ms. Compton: Thank you, Chair.

I'm listening with interest, and I guess I want to thank you for the work the Canadian Mental Health Association does, but I'm thinking about the disconnect between your organization and Health PEI and the ability to access the professionals that are needed.

You talk about the helpline and the increase in calls, and I'm wondering how many of those calls – if you can give an average – how many of those calls would need to be referred to a professional that we don't have, really, that we don't have access to.

What I keep hearing as an MLA is: I can't access. It's great to have Let's Talk and have all that awareness and to accept the fact that this is part of our health –

Pat Doyle: That's the Catch-22.

Ms. Compton: That's the Catch-22, so I just – the work you're doing is wonderful, and the awareness, and the making us all feel that this is just a natural part of our health and our wellness or the need for health and wellness.

The disconnect and how we make a difference in that, and is there a common thread or how much – it's across the country and probably worldwide, we need more help in health care, but is there something – you know, we're the health committee, so is there something that you can give us that we need to push with government as far as what can we do to take us from where we are to where we need to be.

Amanda Brazil: (Indistinct) –

Ms. Compton: Putting you on the spot.

Amanda Brazil: Well, and I mean –

Pat Doyle: That's why we (Indistinct)

Amanda Brazil: (Indistinct) – what we are prepared to offer is sort of limited – it's not always though, that we need more psychiatrists. It's not always – not everybody needs a psychiatrist. Sometimes people –

Pat Doyle: Not everybody needs a hospital.

Amanda Brazil: Not everybody needs to go to emergency. Sometimes – obviously we're a community-based organization. We would love to see more capacity within the community to do stuff, to prevent people from feeling like they have to end up in hospital. There's definitely a place for – we obviously need the care that's provided by Health PEI, but we don't necessarily need to bolster acute care when there is stuff that can done in the community to divert people away from the system.

That's, I guess –

Pat Doyle: More the upstream stuff again.

Ms. Compton: So how do we make that river a stream and then a trickle, and again –

Pat Doyle: Well, it's a kind of a strategy. We haven't gotten to the strategy yet. This is just giving you some background on what the lay of the land is, what we're dealing with, what the nature of the issue is. As you're kind of understanding, it's really complex and it's not easy, but it's doable.

Ms. Compton: So as a member of a community and you say this training is offered if we come as a community wanting to get the training, or some people in the community, and I don't know the training but the end result – okay, someone in our community we flag as someone who needs help, how does that happen? Do you –

Amanda Brazil: Well, right now I think people's sort of knee-jerk reaction, or without training, they sense or find out somebody is feeling this way, and it's

immediately you need to go to emerg. Some people need to go to emerg. Some people don't.

So this training – I mean, obviously you want to be able to say if we're going to encourage people to seek help, the help needs to be there, but not everybody has to take the same path to that help. This training helps people to determine maybe –

Pat Doyle: What needs to happen –

Amanda Brazil: – what needs to happen and maybe –

Pat Doyle: – to keep them safe –

Amanda Brazil: Right.

Pat Doyle: – for now.

Amanda Brazil: Maybe it is emerg, but maybe it's not. Maybe there are other things. Maybe there's other things the community can do or nonprofits can do that can keep them safe. Does that make sense?

Ms. Compton: Yeah, it does.

Pat Doyle: But whose responsibility is that? Ultimately, nobody has identified. It's whoever sees it and wants to – it takes a lot of courage to do that. That's what the training does, it helps you to have the confidence in approaching somebody that is struggling and you're concerned about to explore further what that could mean. Then to ask a question about suicide, to get some understanding about what has to happen, what things have to be put in place to keep that person safe in the short term so that we can work on a longer-term solution as needed.

Ms. Compton: Just one more.

Talking about seniors, and that's been my past career, and the difference that we would see in someone who probably doesn't want to go to nursing care but once they get there, their mental health improves immensely because they have interaction with people. I said it over and over again: people who wouldn't see another living soul from week to week, month to month, who now has interaction with people every day.

I'm just wondering; we see that once they're in a facility, but do you reach out to the seniors federation or would they have to reach out to you? How can we make that connection with seniors?

Amanda Brazil: One example that we had actually – CMHA a couple of years ago received a wellness grant to deliver a program. It's a cognitive-based, CBT-based program, for people that are not necessarily struggling with acute mental illness but they just might be down. Might be just –

Pat Doyle: They're not thriving.

Amanda Brazil: We received a grant to deliver this program to seniors, and we worked with The Voice to talk about the program –

Pat Doyle: Seniors federation.

Amanda Brazil: Yeah, and so they put this in the paper and we had lots of response and it was interesting because it's an eight-week program. We didn't lose anybody. We might have lost one person. They kept coming. These were seniors that lived in the community so a lot of them were either alone or they didn't have a lot of connects and the retention rate was great. What we did is after we wrapped up, six weeks later we brought them back just to see how everybody was doing and I remember I was with my co-facilitator and it was 45 minutes into the reunion and him and I hadn't said a word because they were all like – So this is another nice way of being able also to connect this group with other things that CMHA offers.

We've had members from that group who now participate in our depression and anxiety group, and have been there ever since, and their world has opened up because they've been connected to others. We do have sort of ways that we can connect, and that program has been delivered twice to seniors; once in the community and once in a home.

Chair: Bush.

Mr. Dumville: Thank you, Chair.

I'll be very quick.

Police and clergy, they're usually on the frontline, but also us as MLAs, we're on the frontline because a lot of people bring a lot of their problems to us and we kind of navigate them through the government bureaucracy as best we can and try to get them the help they need. Now, Mr. Trivers has mentioned two people came to him and talked to him in confidence in regards to their situation. It wasn't an identity problem.

I also had a person come to me and I tried to set – meet this person at a semi-private place, not a real private place but a comfortable, social place but still – we were afforded a certain amount of privacy and my background kind of (Indistinct) talked to me: Don't be looking at your watch while you're talking to this person. You know what I mean? I wanted to – time should not be an issue and I wanted to listen, but I guess basically I'm not a trained professional. I didn't want to do damage. I wanted to help and this person was screaming for help and this person told me that they had problems with their family in terms of previous suicides. This person had attempted it three or four times, according to them, and that person was in a very low place and I thought: If she left my – could be within an hour or it could be a week or whatever.

I didn't hardly know what to do other than the fact that I got on with the health department and talked to them and got somebody to come out and see this person as soon as possible and all of that.

Is there some form of training for us as MLAs, and I don't know – I'd like to hear this from my colleagues if they have got much of this. I haven't had a lot of it, but this was a very serious one and this really shook me up because I kept following up. I called this person the next few days, every day to: How are you feeling? Are you feeling low? Where are you at? Well, I'm pretty (Indistinct) in a bad place, but I'm getting along. So I was just trying to keep this person alive.

Is there any kind of training – I'll shut up right soon – that, not to identify it, but training that we, as MLAs should have, in terms of, we're not professionals, but how we deal with this? We don't want to make matters worse. We want to –

Pat Doyle: How much time do you have?

Mr. Dumville: We want to make matters better.

Pat Doyle: Can you come to a two-day ASSIST?

Mr. Dumville: Well, if we have to we should.

Pat Doyle: That is the standard of care. That is the gold standard for suicide intervention.

Amanda Brazil: So that if you went through this again, you would have –

Pat Doyle: You would know.

Amanda Brazil: − a framework to within to figure out how you're going to deal with (Indistinct)

Pat Doyle: If you want to just get them to the point where you ask the question and you want to take them to somebody else, like you did, Safe Talk would be the half day. That would be –

Amanda Brazil: So we have a suite of programs or of training that –

Pat Doyle: If you're going to be moving – if you're going to be working with this person after you've have kept them safe from suicide – you've done the intervention, what happens then? Well, that's a perfect time. You have that momentum. They want to live, so why not meet them with something that's going to help them to live. That's what Suicide to Hope does, which comes after ASIST.

So there's –

Amanda Brazil: It depends what – I mean, I think we have to sometimes step out of our role and say: We're human beings and we're dealing with other human beings. As a human being – and maybe sometimes in our role, what are we comfortable with and what are we able to do? Sometimes we can take somebody or work with somebody to a certain point, and then it's – we're better off to say: Okay, this person can help you, right? But, there's training that can equip you so that if you were ever in that situation again – and I think you raise a great point:

You all have people that come to you and you could be in this position at any given moment, so there is training.

Mr. Dumville: But not only we get the training to help these people, but if we get the training we understand this whole situation better.

Pat Doyle: Yes, and we've seen some really good results – that's why we've chosen ASIST. It is standardized so that people, caregivers, can be communicating using this same language even. Isn't it more efficient for – if I am coming into the ER with somebody that has been at risk and I'm meeting Amanda, nurse Amanda, and bringing this person in, that we can have a conversation about the same things; about risk, about factors, about resources, about mental health concerns? It makes sense.

Amanda Brazil: We train a lot of systems people, a lot of – we train police. We train clergy. These are −

Pat Doyle: All of the first –

Amanda Brazil: Yeah, the people that make up the training –

Pat Doyle: All of the hostage negotiators in both of the Summerside and Charlottetown, and RCMP departments, they all have a –

Amanda Brazil: Youth care workers.

Pat Doyle: We go to Holland College and train the youth care workers in ASSIST.

Mr. Dumville: I recommend you train all MLAs.

Amanda Brazil: Sure.

Pat Doyle: We'll sign you up. We've got a workshop coming up October 24th and 25th. I'd love to have all of you in it; lots of space.

Amanda Brazil: We haven't made it through the presentation.

Chair: Yeah, so I was just going to say that and we're about 11:35 a.m., so I'm going to ask you two things: One, do you have any idea how long the next part of your presentation will be?

Amanda Brazil: I can make it quick.

Chair: Okay.

Amanda Brazil: (Indistinct) what we're planning –

Chair: I don't want to –

Mr. Dumville: I apologize. I thought you were done.

Amanda Brazil: That's okay.

No, it's just what we're planning to do. Again, it's the change.

Chair: Maybe I'll tell you what I'm thinking and then we can go from there. I'm thinking that what we'll do is we'll run straight through your presentation, hold questions until the end and proceed that way rather than have an interrupted presentation, just kind of in the interest of time if everybody is okay with that.

Okay?

Amanda Brazil: It will be quick.

Chair: Does anybody have anywhere to be at 12 p.m.?

Mr. Aylward: Yes. Actually, 11:45 a.m., I have somewhere to be.

Chair: Okay.

So we're five minutes away. Are you – I mean we have two options. One, is we could adjourn and come back a different time if the committee wants to do that, or we can go through it and see where we get and see how we get along in the next eight minutes.

Pat Doyle: I think she is going to be – I know what she's talking about – she's going to do that in four minutes.

Chair: Well, let's go right to it then and we'll see how we get along.

Amanda Brazil: When we started working on this we had many lengthy brainstorming meetings around – and as – what we kind of wanted to demonstrate in the first part is how complex this really is. It can be looked at from so many different angles. These are

sort of just our plan; an environmental scan; a review of the research and work completed in the areas of suicide prevention strategies, frameworks; integration of community voice; stakeholder consultations and then the report.

Currently, we're working on looking across the province to see what's being done in terms of suicide prevention. What are we doing well? What's working? Then, are there gaps? What are the best practices that are missing or that we are doing? So, sort of trying to find – get a feel for PEI and what it is that's going on. That shouldn't have went down, but these are – we're also reviewing reports and research. This has been researched extensively. We do not need to reinvent the wheel here.

Here is just an example of some of what we're looking at. The framework for suicide prevention that was created by the federal government is a very solid document, but what we're doing is we're pulling out of these documents recommendations, finding some of the main recommendations in terms of what are the best ways to approach suicide prevention?

We are integrating community voice. We have established an email account that we released with our press release a couple of weeks ago where people can reach out to us, whether they've got stories, they've got information, research, they want us to consider something.

We want people to know that they can contact us, so we've created this email account. We check it regularly, but it's not monitored, so we have an automated response. We don't want people to think it's a crisis email. People can feed into what they think we need to be looking at. So we want to integrate community voice that way, sort of on a broader scale.

We're also drawing on the knowledge, and Pat's knowledge and the organization's knowledge of having worked in suicide prevention for 17 years. We do this every day. We work with the community every day around these –

Pat Doyle: I was going to say we hear things every day –

Amanda Brazil: Yeah.

Pat Doyle: – in our work and communities, so –

Amanda Brazil: Yeah.

In the fall, we are going to engage stakeholder groups to talk about: Here are what we're seeing are the recommendations, what do you think? In terms of your group, do you think this is good, what's missing, what wouldn't work, what would – we want to start engaging the stakeholder groups.

We are not doing open public consultations. It's not safe to do open public consultations to just bring in the general public –

Pat Doyle: (Indistinct) about suicide.

Amanda Brazil: – to talk about suicide. We don't know who's vulnerable. We can't ensure that when people leave they're in a safe spot. We feel we would be irresponsible to create these big, open public consultations, but we will be looking to meet with smaller stakeholder groups.

Then at the end, which we're aiming for the end of the fiscal year, we will be providing the report. We would like to include sort of an accountability framework, progress indicators and suggested implementation plan.

Some recommendations may be bigger. Some might be very small. If we just change this, if we collect this type of data instead of what we're doing now. If we have more of information sharing between these two parts like we can start to move forward.

I can't speak to what those are going to necessarily look like at this point or at the sort of beginning stages, but we talked about GPs. So we see that statistically, people are going to their GP. Keeping in mind as well that just because the strategy is under development, there is still suicide prevention work happening in this province.

There are still new things that are happening, so we're going to be keeping abreast of that throughout the plan. CMHA is going to continue to enhance the work that we do. It will now nicely be informed by what we're finding but also work with the

province to make change and keep in close contact with them as to what they're doing and what's coming down the pike in terms that can impact the findings of this report and the recommendations.

So there. You good, James?

Mr. Aylward: Yes.

Chair: That was quick, yeah.

James, go ahead.

Mr. Aylward: Thank you very much, Chair.

Amanda, can you make – I know there's just a couple, but could you make those slides available to committee members –

Amanda Brazil: Yes.

Mr. Aylward: – through the clerk?

Amanda Brazil: Yes.

Mr. Aylward: Thank you very much.

I guess my other question would be: Can you list the names of the stakeholder groups that you're going to be engaging?

Amanda Brazil: We will not list them all. As we work through all of the research and the reports, there will be some that are very clear that we need to be in contact with. We're obviously going to meet with the indigenous communities. AIDS PEI has reached out to us already; we've met with them.

It won't just be those groups that represent statistically higher individuals, but that will start to unfold as the fall comes and we'll start to identify those groups that we will meet with. Ideally, what we want to be able to do is to have – we want groups and people to see themselves in this strategy. This is not just a strategy for this group of people. People need to be able to see themselves in any strategy of a community where they live.

Pat Doyle: And if I could add, Amanda: We have a provincial suicide prevention committee that oversees, manages, contributes, shares perspectives on suicide, and all of those groups and more are represented around the table.
We have been drawing upon those volunteers since we started doing suicide prevention work, and we will continue to do that. They've been invaluable in terms of – they work, they live in communities, so it brings that back to us.

Mr. Aylward: Thank you, Chair.

I'm just curious: Will you be engaging with a group – we all know there is on social media out there, there is a very active group, #HowManyWade. Dr. Sarah Stewart-Clark is a volunteer that heads up that social media. Will you be engaging with individuals such as Dr. Sarah?

Amanda Brazil: Such as Dr. Sarah? Is there any other (Indistinct) –

Mr. Aylward: Well, she's one of the main individuals that is advocating for change and support and resources here on PEI, particularly around mental health. Also, the other social group that's attached to that is Island Mothers Helping Mothers.

She's very involved, even though she's not a resident of Prince Edward Island. She's extremely involved in the social fabric of PEI and –

Amanda Brazil: And Sarah's group's voice, that's one voice.

Mr. Aylward: Yeah. But –

Amanda Brazil: And so –

Mr. Aylward: Again, so would you consider her to be –

Amanda Brazil: That could potentially be –

Mr. Aylward: – potentially a stakeholder?

Amanda Brazil: – somebody that we would talk to.

Mr. Aylward: Okay.

Amanda Brazil: Like I said, we haven't finalized those groups yet, but we're not shutting any – like we're not saying that this point: Definitely not. We recognize that she has a group that is raising some concerns

and their voice around certain things and it's good that people are demanding –

Mr. Aylward: Engaged.

Pat Doyle: Lending their voice.

Amanda Brazil: Lending their voice. That could be a potential stakeholder.

Pat Doyle: I'll just add, if I may, that they can contact our team as well through that email –

Amanda Brazil: Yeah.

Pat Doyle: – to share any –

Amanda Brazil: At any point, people can –

Pat Doyle: – information, documentation, stories –

Amanda Brazil: – contact us, absolutely. So we're not saying: Wait. It's not that. We want this to be ongoing at any point along this (Indistinct).

Mr. Aylward: Right.

Pat Doyle: That's why we did the press release and wanted to make that –

Amanda Brazil: We are open to –

Pat Doyle: – portal public so that people can contact us and share things that they want us to know.

Mr. Aylward: Perfect.

Thank you.

Chair: Do you have to go now, James?

Mr. Aylward: I can stay a couple more minutes. (Indistinct)

Chair: Okay. Anybody –

Peter.

Dr. Bevan-Baker: Thank you, Chair.

I'm really delighted that this strategy is now underway, or work on this strategy is underway. I think it was April you started. Am I correct about that?

Amanda Brazil: Yeah, shortly thereafter.

Dr. Bevan-Baker: I'm wondering, given the timeline that I just looked at there, it's going to be beyond the next budget – that's the point I'm making here – before any recommendations come in. Is there any chance that you would have progressed to the point where you could make recommendations to the Legislature about the sort of budgetary increases you're going to require to implement part, or all of the strategy, so that we can talk about this in our deliberations next spring? Otherwise it's going to be another year.

Amanda Brazil: Right, potentially.

Naturally, there's going to be things that are going to come out, and that we're already seeing that this might be, but what those costs associated with that are, so, like data collection, what the coroner's collecting as data. We could be collecting different information, and that's come out in a lot of these recommendations.

Pat Doyle: That would tell us more about –

Amanda Brazil: It would tell us more –

Pat Doyle: – about suicide –

Amanda Brazil: – because you don't –

Patrick Daigle: – and thus –

Amanda Brazil: It's hard to create a strategy to prevent something when you don't really have a full picture of what it is you're trying to prevent. So we'll be looking at what data is collected in terms of people who have died by suicide.

Suicide assessment: I know that currently Health PEI is working on implementing a new assessment tool. So there's stuff that's happening already. There's stuff that will be recommended.

We would be – potentially we could, in advance of, talk about some of the things that we're seeing that might need some resources attached to them.

You look at community training, that's something, sort of gatekeeper community

training, training people up as a preventative thing. Who is going to pay for that, right? There's a cost –

Pat Doyle: There is a budget. Most organizations have a budget –

Amanda Brazil: But is it –

Pat Doyle: − for professional development.

Amanda Brazil: Is it businesses? Is it organizations? Or are we going to approach this on a broader scale? How do we reach the entirety of the Island? Those types of things we'll be looking at and we might have some recommendations prior to the final report.

We don't want work to stop because people are waiting on this strategy. This work has to continually be going on and moving towards change in this area, but –

[A cellphone rang]

Pat Doyle: We're also – I guess we'll add we're also cognizant that change is going to, in some cases, cost money so we're trying to look at – we're trying to be cognizant of that in our recommendations as well once we're –

[A cellphone rang]

Amanda Brazil: But if –

Chair: Sir, if you could just leave the room please it would be appreciated. Take your phone and go out.

Amanda Brazil: – there are costs associated with things. There are costs associated with things and we're not going to –

Pat Doyle: Shy away from them (Indistinct) –

Amanda Brazil: − shy away from them, but there also could be some very low cost things that can be implemented to start making change in some of these recommendations.

Chair: Go ahead, Peter.

Dr. Bevan-Baker: Thank you, Chair.

I think we all understand that, inevitably, there will be cost associated with change and my concern is that if we delay it beyond the budget of spring 2018 we are adding another year before we will be implementing any of this.

Amanda Brazil: Right.

Dr. Bevan-Baker: Probably.

Amanda Brazil: (Indistinct)

Dr. Bevan-Baker: And that's why I would really encourage you, if you can have even some suggestions to bring before next spring's budget.

Amanda Brazil: Yes.

Pat Doyle: Thank you for bringing that up (Indistinct)

Dr. Bevan-Baker: Thank you.

You also mentioned a little earlier that we don't really need to reinvent the wheel here. We know what the best practices are and I was hoping I would hear somewhere here the words 'tiered approach' or 'tiered model.'

Pat Doyle: Yes.

Dr. Bevan-Baker: I haven't heard that and I'm – when it comes to bang for your buck and dollar to improve mental wellbeing on Prince Edward Island, then the tiered model to me makes perfect sense.

Pat Doyle: Yes.

Dr. Bevan-Baker: We rely, in my opinion, far too heavily on psychiatrists. Somebody around the table mentioned that already and in terms of training individuals who may not be even mental health professionals, we talked about your access program. Also, I think we do not use psychology to the extent that we should.

Amanda Brazil: I agree.

Dr. Bevan-Baker: We don't use –

Amanda Brazil: Counselling.

Dr. Bevan-Baker: - social work as we – yeah. There are all kinds of much cheaper ways to spend public –

Pat Doyle: Like we said, not everybody needs hospital.

Dr. Bevan-Baker: So –

Pat Doyle: In fact, hospital is not a good thing for some people.

Amanda Brazil: Again, I think that as CMHA itself in our hiring, a lot of our recent hires have been social workers and there are you know – Catholic Family Services has counsellors available. Not everybody and I'm just speaking to the people that walk through our door looking for help, need a psychiatrist. They have relationship issues that they could work out with a counsellor or – you know – so we definitely −

Pat Doyle: (Indistinct) in some cases.

Amanda Brazil: We definitely recognize that and being in community and probably more so than the (Indistinct) person would recognize, that it's not just about the acute care system and psychiatry and that type of thing. It's a continuum of care and there's a need for people to be able to access care along that continuum.

Dr. Bevan-Baker: Just a comment to close it up, thank you.

When we talk about mental health on Prince Edward Island, all too often the conversation comes back to psychiatrists: How many psychiatrists? Why are we short of psychiatrists? In my opinion, we need to move that conversation away to creating a much – a commitment to a sort of community-based wellness promotion first and foremost because that's where we're going to get the best bang for our buck, so I hope that those sorts of suggestions from an independent body like yours –

Amanda Brazil: But that is –

Dr. Bevan-Baker: − would be forthcoming.

Amanda Brazil: − kind of the work that we do so what our major program within CMHA are the clubhouses and their psycho-socio rehabilitation models and it's really working with people who are struggling with their mental health or have mental illness and working to integrate them back into the community through employment and education and that is preventing people from ending up in emergency.

This is –

Pat Doyle: Crisis.

Amanda Brazil: Yeah, this is community – it's peer support at its very grassroots level. It's community integration. It's recovery. I think sometimes we were remiss in that we don't focus on recovery. People recover. Sometimes –

Pat Doyle: They get better.

Amanda Brazil: − people get better. People with addictions and mental illness, and people who are suicidal, can recover and that's got to be the focus. This is what we're talking about when we're talking about a continuum, right?

Pat Doyle: And the messaging − that goes back to messaging too. There's been a lot of not great messaging out there lately for people that are struggling, for example, and are vulnerable –

Amanda Brazil: But you can't get help.

Pat Doyle: There are a lot of people –

Amanda Brazil: There are a lot of people who get help –

Pat Doyle: − who try to get help and: They didn't answer my call or they didn't call me back. There's not enough – there are a lot of success stories out there as well and we hear those too, but they don't get shared as much as the (Indistinct)

Amanda Brazil: Granted, there are people that have been in crisis and they haven't had the care that they required.

Pat Doyle: (Indistinct)

Amanda Brazil: We recognized that and that is terrible, but we also have people that have been in hospital who people would have thought they would never – this is it for

them and they are out working and they have their own apartment and they are doing just fine, and so we thought: That's got to be our end goal. It's not just getting people over the hump of being in crisis, but getting them to live out their full potential and as an organization, that's the work we do.

Pat Doyle: Also, how do they cope with those crises going forward? We have to build skill in there, skills for safer living going forward. We can't expect – we can't say: Don't think about that anymore. Don't think about suicide.

Amanda Brazil: So we are not going to be developing a suicide prevention strategy that focuses on the acute care system. That's a part of it. That's a part of it, but that's only a part of it.

Chair: (Indistinct)

Dr. Bevan-Baker: Can I –

Chair: Yeah.

Dr. Bevan-Baker: Just in response to what you just said, obviously the human cost of suicide is –

Pat Doyle: Immeasurable.

Dr. Bevan-Baker: − incalculable, but there is also a financial cost and you sort of eluded to that there, Amanda, about lost work, about health costs to the health care system and to the justice system and to social services, and clearly putting money into prevention and intervention earlier on as with almost anything, actually, but certainly in the medical field. Putting your money up front to prevent problems, save society and governments an enormous amount of money down the road and you also mentioned, and this has been a recurring theme, how GPs are, for very many people, in distress at the first point of contact.

I want to come back to the two days of training. I don't think that's an onerous thing to expect. I think government should be paying for that. If the GPs are the first point of contact so many times, then if I were health minister I would recommend that that be a priority, that that be a mandatory thing for all GPs.

Pat Doyle: I don't think it's a cost prohibitive situation (Indistinct) situation. Take two days out of you practice is not easy, but some will. My doctor, for example, went to the psychiatric conference a few years ago and he said to me, I was surprised to see him there, he said: Where are all the other GPs. I said: Well, thanks for coming.

Dr. Bevan-Baker: Yeah, but that's alarming.

Pat Doyle: It is alarming.

Dr. Bevan-Baker: If they are in the community where the community in need goes to (Indistinct) they don't have to –

Pat Doyle: We have to meet people where they are at regardless – if they are going to GPs, we've got to have GPs trained. If they're −

Amanda Brazil: But, it's also sharing that knowledge. So if people are not presenting, necessarily, as being suicidal but then they take their lives and a week later – GPs might not – like it's also providing these statistics and making people aware that this is the path that people are taking prior to, right? So, knowledge sharing as well.

Chair: (Indistinct)

Dr. Bevan-Baker: Thank you, Chair.

Chair: Hal, I had you next on the list.

Mr. Perry: Yeah, thank you, Chair.

I just wanted to thank both Pat and Amanda for coming in today; very informative presentation. This is a very serious issue that affects families and communities and all Islanders from tip to tip, and as a rural representative, I have talked a little bit about the walk-in clinics which I was very happy to see in my area because any resources or access outside of Charlottetown in my area is welcomed. I was a little disappointed in Peter's negative comments on that and I know there's a lot of work to do and I recognize we have a lot of work to do and I look forward to seeing the strategy, but we have to work together and hopefully we decrease those numbers in the future.

Amanda Brazil: I think that's kind of what I want to sort of impress upon people. This is everybody's problem. It's not CMHA's, only their problem. It's not just Health PEI's problem. This is everyone's responsibility, right? If you look at the groups, and – really, suicide, it's across the board. Nobody's immune. We have to all take a responsibility for what we can do, and I think that will also come out in the strategy is that it needs to be a societal approach.

Mr. Perry: Thank you.

Chair: James, I had you next on the list.

Mr. Aylward: Thank you, Chair.

I'd like to, as well, thank you very much for coming in today and having great patience as we navigate through this and ask some questions.

Amanda Brazil: It wasn't what I thought it was going to be.

Mr. Aylward: It wasn't what I thought it was going to be, either.

In any event, just to follow up on part of what Peter was talking about: I, too, would applaud a very well-organized, tiered system here on PEI to address some of these issues, but with psychiatry – and I know we often say we're not enough psychiatrists here on PEI and we're constantly down compared to what we should have, the allotment, we don't have close to that – but psychiatry does play a critical role here on PEI, because currently psychiatrists are the ones that can prescribe the meds for an individual if they're in need of that; and the wait time to get in to see a psychiatrist is just alarming.

But what I'd like to say is more so on the psychologist side. I think psychologists can play a much larger role here on PEI in concert with psychiatry, but what I've seen so far from many people that reach out to me is that psychologists aren't necessarily an option for many Islanders because they can't afford $180 an hour to see a psychologist.

If you have to have foot care, somebody come into your house to do foot care, it's covered. If you need to see somebody because you have cancer, it's covered; but if you need to see a psychologist, can you afford $180 an hour? So that's one of the things that I'd like to see in your strategy moving forward, is that the government somehow looks at a much stronger role for psychologists, and to have it – even if it's means-tested, but we just have to make it more accessible to people that need that service.

Thank you.

Chair: Anybody else have questions?

I do. I have a question. We had originally – and this is as much a question as it is kind of a reach-out to you guys – obviously we're the health and wellness committee – we regularly do things like this that are health-related with a view to making recommendations to our Legislature as to what we can do to help to improve the system.

We're currently looking at different issues that are ongoing in relation to mental health that are probably interrelated or dovetail with the work that you're doing. One of the early kind of considerations we had in developing our work plan was – and I think there had been a call for going across Prince Edward Island, doing public meetings and that kind of thing – and just to speak for myself, and there are others in the group that have reached out in similar ways, but we had decided against that at least at that point in time for a few reasons.

One, you had mentioned the potential safety issue with it; and two, was that we had felt that now was a time to act, just further to Peter's comments that we needed to make some big wins kind of initially and to try and get going with recommendations.

I guess the kind of ask to you guys would be is there any way that we as a committee, that you see that we can help you do any part of your work or any recommendations you might have to us as a committee in terms of things that we may wish to do or look at going forward with our work that I would think would be slightly broader than what you're doing, but would encompass a part of it for certain, that we might want to take into consideration as we move forward?

Amanda Brazil: It's nice that you put that out, and I think definitely as we continue to work on this and more things are brought to light and things have become more apparent, then maybe others – it would be nice to be able to work with the committee or come back and speak with the committee and flag some of those things. Again, we don't want to leave all of this work left to be done next year if there are things that we can start doing or looking at as we go along. We should be doing that, so I would –

Pat Doyle: For example, too – to respond to your comment about trying to get something out before the next budget – if we could meet sometime between now and that time to show you, maybe to come together again, show you the progress, and maybe you can help direct us as to how we could put some dollar figures on these items because that would be (Indistinct) –

Amanda Brazil: There's definitely opportunity to collaborate as we move through this process, and it's not a really lengthy process, either. We're almost into September, so we would be very open to coming back and meeting again if the committee's interested in that.

Pat Doyle: I might suggest a small step. September 10th is World Suicide Prevention Day. This is the newly launched ribbon that was launched last year, and we wanted to provide them for anybody that wants to wear a ribbon. But recognizing World Suicide Prevention Day in the Legislature, we could submit a formal request around that but acknowledging the day, and perhaps sharing a little bit of your own perspective. That could help. It's a very personal issue, right?

An Hon. Member: Yeah.

Pat Doyle: So I'm sure every one of you around this table have a story. I'm not saying that you all have to share, but by acknowledging that day – and we have found, by acknowledging that day, by acknowledging that that is part of our community and that there are people grieving, people that are struggling, honouring that that exists in our community, that's how you start conversations. That's how you make connections and build supports that can help alleviate that struggle, that stress, that pain. That's a good step.

Chair: Yeah. I should just kind of take that one step further. Our current plan is to see what we can do by way of what I'm going to call standing issues or issues that we can kind of take public notice of, issues that we've all heard about or have been presented through the recent – I can't recall the name of it – but the report that led to the mental health strategy that's developed right now.

There was a committee in Newfoundland that did extensive work that reported – and I think I saw that in your list of reports there – roughly a year or a year-and-a-half ago, and it's our plan to raise these issues with the minister and Dr. Keizer likely, and perhaps Verna Ryan.

Kind of recognizing that, wondering – and not necessarily calling for a checkmark for an approval or whatever, but interested in your thoughts as to whether those sound like good things to do and whether they're helpful to you or there's other things that we could do that might be helpful to you along those lines.

Amanda Brazil: I think as an organization we can meet, our organization, and talk about those things further. We'd be open to that type of communication.

Chair: Great, yeah.

Pat Doyle: We have regular meetings with a lot of those folks, too, so –

Chair: I should say, too, I have had a lengthy conversation with your executive director as well. It was very helpful in moving our strategy forward in terms of the shape it might take and that, but it's great to be able to – Prince Edward Island and Charlottetown are small places, so to be able to pick up the phone and get that input, but we very much appreciate any input as you might have as we go forward, and likewise if there's anything that we can do to help your group with all that comes along with a legislative committee, then we'd be more than happy, I think, if I can speak for my fellow committee members, to undertake to do what we can to help your process and as Peter says too, if there's any kind of early advocacy that we can do, to do that as well.

Amanda Brazil: Thank you.

Pat Doyle: Thank you.

Chair: Does anybody else have any questions before we wrap things up?

Mr. Dumville: Just to thank you (Indistinct)

Pat Doyle: Thank you.

Thanks for listening and for your questions; very insightful for us, too.

Chair: Great.

On behalf of the group, Pat and Amanda, I do thank you very much and the Canadian Mental Health Association for making you available to come here today and to participate in our work and hopefully we can be of a mutual benefit to Prince Edward Islanders in moving the mental health strategy and the suicide prevention strategy forward and it's something that I think is near and dear to everybody around this committee and probably in this room and on Prince Edward Island. We thank you for your work that you're doing to improve the lives of Islanders as well.

Amanda Brazil: Thank you for having us.

Pat Doyle: Thank you.

Chair: Okay, so we'll give –

Pat Doyle: Feel free to give me a call and sign up for the next ASSIST. I'll leave my card.

Chair: Thank you.

Mr. Dumville: Looking forward to it.

Chair: We'll give you guys a couple of minutes to get kind of packed up and then we just have a couple of housekeeping items to finish up before the meeting is over.

Clerk Assistant: Do you want to recess?

Chair: Yeah, so we'll for two minutes, just to be clear. If everybody that's in attendance wishes to leave, feel free.

[Recess]

Chair: Looks like we still have a quorum so we'll proceed to number four on the agenda and perhaps I'll ask the clerk to say a few words about upcoming meetings.

Clerk Assistant: Yes, so I have been talking with the other presenters that have been invited in to meet with the committee, and so I have a couple of dates that work for some presenters and I just wanted to check with the committee. I can say the dates here but I can also send a note around to everyone so that we can verify that those work.

But, I'm looking at September 26th at 10:00 a.m. and on October 3rd at 1:30 p.m. So, if those seem to work for everybody – would you like me to send a note around to confirm?

Some Hon. Members: Yes.

Clerk Assistant: Okay great. I will do that.

Chair: (Indistinct) send out the calendar invite to the group internally and see if they're all (Indistinct)

Clerk Assistant: Okay.

Yes, so that's good. That's kind of my update on committee meetings.

Chair: Okay.

Clerk Assistant: But I'll send a note out to everyone.

Mr. Perry: (Indistinct)

Chair: Does anybody else have any discussion on that point?

I should note, too, that I just did have a discussion with the presenters that were here today and they are interested – and I'd this discussion already with Reid Burke just in terms of keeping in touch and he asked that we do that too. Anyway, as we move along they indicated, as they did indicate here, that they may have a willingness to come back in or to have a meeting with us which they had expressed it might make sense to do in camera at that point in time, too. Just to put that on the radar for everybody, that is something that we may look to do before we file a report for this fall sitting, I would guess.

Any other discussion on those points, anything that came out of today's meeting that we should be looking at as far as our planning is concerned?

No? Okay well, with that being the case, I'll call for any new business.

There being none, I'll call for a motion to adjourn.

Mr. Dumville: (Indistinct)

Chair: Bush, thank you very much.

The committee adjourned