PRINCE EDWARD ISLAND LEGISLATIVE ASSEMBLY

Speaker: Hon. Francis (Buck) Watts

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Standing Committee on Health and Wellness

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SUBJECT: BRIEFINGS ON MENTAL HEALTH AND ADDICTIONS

COMMITTEE:

Janice Sherry, MLA Summerside-Wilmot [Chair]
James Aylward, MLA Stratford-Kinlock
Dr. Peter Bevan-Baker, Leader of the Third Party, MLA Kellys Cross-Cumberland
Kathleen Casey, MLA Charlottetown-Lewis Point
Bush Dumville, MLA West Royalty-Springvale
Pat Murphy, MLA Alberton-Roseville
Brad Trivers, MLA Rustico-Emerald, replaces Darlene Compton, MLA Belfast-Murray River

COMMITTEE MEMBERS ABSENT:

Darlene Compton, MLA Belfast-Murray River

MEMBERS IN ATTENDANCE:

none

GUESTS:

Department of Health and Wellness (Dr. Rhonda Matters); Health PEI (Verna Ryan, Dr. Richard Wedge)

STAFF:

Emily Doiron, Clerk Assistant

Edited by Parliamentary Publications and Services

The Committee met at 10:00 a.m.

Chair (Sherry): Good morning, everyone, and I would like to call the meeting of the Standing Committee on Health and Wellness to order.

Before we get underway I would just like to note that this week in Prince Edward Island is Family Violence Prevention Week. As leaders in our community and across the province there's lots of different activities happening to raise awareness around this very important issue, and I would urge people to pay attention and remember the support that we bring and the clarity that we bring to these very important issues for all Islanders. So let it be known that this is the week of all kinds of activities and I hope people will get involved with that.

Without further ado I'll certainly ask for adoption of the agenda.

Ms. Casey: So moved.

Chair: Thank you.

Have a seconder?

An Hon. Member: Sure.

Chair: Thank you.

I guess we're going to get right into business. We have two presentations this morning, very important presentations, and I believe we've moved them around a little bit. We have Dr. Rhonda Matters, the Chief Mental Health and Addictions Officer, and also Dr. Therese Harper, who are here to update us on mental health issues across the province.

I would like to welcome you to the table. I know that you have about a 15-minute presentation, I think, that you want to proceed with, and then following that presentation if you'll hold your questions till then that would be wonderful. So I turn the floor over to you.

Dr. Rhonda Matters: Great. So I think you received the slides in handout. For some reason what we're using is not working so we did pass those around.

What I wanted to talk a little bit about is the work that's been happening in the office over the last year or so. A little bit of background in terms of how we've been moving forward. The work has been guided by the Mental Health and Addictions Advisory Council, and I'll talk a little bit about who's on that council, but also we've continued to do consultations with Islanders, with our community partners, with government departments and services.

We've looked at numerous past reports and consultations in the area of mental health and addictions. Over the last probably five to 10 years there have been a number of reports that have been conducted or consultations that have occurred. I won't list those all. We have looked at national and international evidence and strategies from the other Canadian provinces and from other countries as well.

What we're focused on is having a whole of government approach to mental health, which also, I will say, should include our community partners. Most of the departments also have strong connections to some community groups and community partners. That's our focus or our intent.

In developing the priorities we have two important groups. One I mentioned is the Mental Health and Addictions Advisory Council. That has 12 members, six members from the community and six government members including myself. We have representatives from Justice and Public Safety, from English Language School Board or department of education, from Family and Human Services, from Health PEI, as well as community people in terms of we have someone from Canadian Mental Health, and we have someone who works at UPEI, we have a representative from the Mi'kmaq Confederacy, and we have some advocates or lay members from the community.

I'm on the overview sheet now. The mental health and addictions vision that was developed by the (Indistinct) – they don't have that page?

Unidentified Voices: (Indistinct).

Some Hon. Members: Yeah.

Dr. Rhonda Matters: Oh, you do. Good.

The overview page – we'll go through each of these in a little more detail later – but our vision is at the top. It talks about the fact that all people living in Prince Edward Island will have the equal opportunity to achieve and maintain the best possible mental health and well-being throughout their lifetime.

We've identified five strategic priority areas, and we'll go into each of those in more detail, but they're listed across there: better access, better care; working together and putting people first; intervening early with a focus on youth; supporting recovery and upholding rights; and mental health promotion.

The principles that underlie all of these priority areas are: actively using current resources more effectively; prevention being a central tenet in all of the areas, which includes things like reducing risk factors and enhancing protective factors; ensuring the distinct circumstances, rights, and culture of diverse groups are acknowledged and their needs are met by the mental health and addictions services that are provided; accountable governance and monitoring of the strategy initiatives; and eliminating stigma.

While the priorities were being identified work has continued. There are many caring and committed people working within community in our community partners, and within government agencies and departments. In each area, in each of those priority areas we identified some gaps or some areas where we though improvements could occur, but I think it's also important to note that there is important ongoing work that's occurring. As we go through each one we'll talk a little bit about some of the things that have been going on and some of the recommendations that would be there for going forward.

Under better access and better care, the first priority area, we know that outcomes are better when people receive the right care from the right person at the right time. We've heard a lot about waiting lists, especially for some particular professionals – psychologists, psychiatrists, for example – and we've noted that there is a gap in some mid-intensity services like day treatment or specialized teams.

Several of the recommendations involve ensuring that we have an evidence-based care pathway that supports the stepped-care approach. The stepped-care approach involves the idea that the person gets the most effective but least intensive intervention initially, offered by the appropriate professional, and then they step up to the next level when that's required.

Some example of the current work that's already happening in this priority area is the development of our first youth day treatment program. Steps have been undertaken to develop that, to design that, and they're in the process of – I'm sure Health PEI will talk about that, about hiring.

There has been training done in things like CRAFT, the Community Reinforcement and Family Training for families. That's to help people who have a loved one struggling with addiction.

Some of the future recommendations involve: having an adult day treatment program in addition to the adolescent one; creation of additional specialized teams, for example, initially a forensic team that could provide more assessments and services here on PEI; and also a plan to try to use our internal psychiatry services or resources that we have to better meet the needs of our provincial system. Those are some examples of some of the things that would fall under that pillar or that priority area.

The next one is working together and putting people first. We realize that wholly addressing addictions and mental health is bigger than just the health care system. It involves everyone working together in a coordinated manner to support Islanders. We need to work with our community partners and with the other social departments to ensure that people's needs are being met.

Example of some current work that's going on in those areas is the integration of mental health and addiction services within Health PEI. That has been ongoing. Housing First is another example of different organizations working together.

Some of the future recommendations under this priority area would be ensuring that the provincial housing strategy addresses the needs of that vulnerable group, folks who have mental health and addiction difficulties, and around standardizing out-of-province mental health and addictions so that we provide as many of the services here as we can, and then ensure that the decisions are person-centered and use our resources effectively when folks have to go out of province.

The third priority area is intervening early and focusing on youth. It's estimated that of those who develop a mental health and addiction difficulty that 70 % have their onset before the age of 25. There is strong evidence that focusing on children and youth, in all areas and all ages, from promotion to recovery, can produce significant benefits and reduce societal stigma.

Some of the work that is currently underway is: the creation of the behaviour support team in the community – again, those positions are now being filled; the development of the adolescent day treatment; and the expansion of the Strength Youth Addictions Program, which is completely up and running at full capacity as far as I know.

Some of the future recommendations under this priority area would be delivering evidence-based interventions and collaborative mental health and addiction services for children, as well as addressing critical service gaps for vulnerable children and youth, especially those in the care of the province, and ensuring that children and youth who require psycho-ed assessment receive one in a clinically acceptable time frame.

Those are some examples of recommendations that have been identified.

The fourth area is supporting recovery and upholding rights. Consistently upholding the rights of people living with mental health difficulties is an integral part of fostering recovery and well-being, and all people deserve to live in supportive community that's free from stigma. Some of the current work that's already going on with the recovery focus: Health PEI has been doing a lot of work on creating a welcoming culture, which is a recovery focused approach.

Some of the future recommendations would be: enhancing and delivering standardized evidence-based peer support programming – that would likely be done in connection or collaboration with some community partners; developing a way to objectively respond to complaints and perceived infringements of rights; and ensuring that child welfare is clearly mandated.

The last priority area is mental health promotion. There's consensus that greater investment is needed in mental health promotion and prevention. Advancing mental health promotion requires a multi-sectoral approach where all Islanders work together to address the underlying determinants of poor mental health.

Some of current work that's occurring would be Triple P, the positive parenting program which is bringing sort of early intervention and advice to parent. It involves all four social departments as well as many community partners. Family violence prevention efforts would certainly fall under this category.

Some of the future recommendations would be: to explore models to promote independent living for people who have serious mental health diagnosis; supporting poverty reduction efforts; and improving the psychological health and safety of Island workplaces.

I think it's the last slide – is Where to Next. The Advisory Council work on these priority areas has been completed. Those priority areas have now been forwarded to other government departments and agencies. What we'll be trying to do is to get some collaborations and feedback from those other departments and to move to the next stage of action. We're working together to determine an implementation plan, an idea about how we can move forward to continue to see improvements.

Chair: That it?

All right. Thank you, Dr. Matters.

I'll open the floor for committee members that have questions. Who would like to go first?

Peter Bevan-Baker.

Dr. Bevan-Baker: Thank you, Chair.

You finished your presentation by saying continuing to see improvements. Mental health is an area where it's notoriously difficult to measure success. You also mentioned a couple of times in your presentation there evidence-based treatments.

Can you tell us what jurisdictions or what places you're looking at for where there are models where success in whatever metrics we use with that are used and which ones you are hoping to emulate, if any?

Dr. Rhonda Matters: Sure. I think that there a number of jurisdictions and I think it depends on sort of which area we're looking at. I think given our size and our closeness to Nova Scotia that is one province that we do have a lot of contact with and ask a lot of questions from. Ontario has done a lot of work in this area, and BC would be another one. Really we've looked at – and I sit on several federal- provincial-territorial advisory groups so we have the opportunity to discuss with all. But I think those are the three that we've looked at a lot.

Dr. Bevan-Baker: Are there any jurisdictions further afield, perhaps, where their success rates are better or where the approach is quite different from the North American conventional approach?

Dr. Rhonda Matters: Sure. We've looked at or received all kinds of research from the UK, from Australia, New Zealand, Ireland. We have attempted to look at other countries as well in their approaches.

Dr. Bevan-Baker: Were there any of them that stood out to you as offering perhaps a vision of where Prince Edward Island might go with its approach to mental health and addictions?

Dr. Rhonda Matters: Again, I think what I would say is there are pieces from different – depending on sort of what we've identified as the initial priority area.

One of the priority areas, for example, is children and youth. We would look at sort of some ways to deliver services to that area, but not at the whole. We haven't found a country who we believe that the whole plan would exactly fit for PEI. It's more picking the pieces that we think would fit for our needs.

Chair: Go ahead (Indistinct).

Dr. Bevan-Baker: Thanks, Chair.

You also mentioned earlier about timely intervention and how important it is for the youth of Prince Edward Island to be given what they need. Currently the wait times in our school system for children to have psychological assessment are measured in years. Could you explain the discrepancy there?

Dr. Rhonda Matters: My understanding is that there have been a number of factors that have led to that. One has been that there have been some unfilled school psychology positions for a number of years. I believe that this year more of them are filled than they have been in previous years, so that would have been part of it.

I think partly it may also be that there aren't a lot of psychology positions within other areas of government as well. I think there have been some shortages in community mental health or in justice. I think, then, a lot of those needs fall to education.

Dr. Bevan-Baker: Chair, thank you.

As with all things it comes down to dollars and how we distribute those dollars in the most effective and efficient manner. I think those are words you use here. I'm wondering whether you can assess – or what metrics you use to assess – the efficacy of, for example – I'm going to bring this up now – a psychiatrist who earns over a million dollars versus front-line workers who – I'm not sure how many psychologists we could hire into the school system for that amount of money, but my guess is a lot.

Do you do any sort of analysis of whether the money that's being spent is being spent in the most effective manner?

Dr. Rhonda Matters: At this point I would say that we're not at the stage in the work to be evaluating in that sort of going forward way. I think that certainly, though, we – based on the research and the information we have from other provinces – I mean, the stepped care approach is about that. It's about sort of that idea that if there are interventions and supports that can be provided in a less expensive or less intensive way. But we haven't looked at PEI data specifically at this point, but we certainly believe that that will be important going forward.

Dr. Bevan-Baker: Thanks, Chair.

I want to make it clear, I don't envy you your task, Dr. Matters, and mental health is a terribly complex, multi-layered, difficult thing to deal with. I like a lot of what you said, a lot of the words you used, and the approaches that are outlined in your presentation here resonate really well with me – the holistic approach, the idea of peer support groups of intervention, prevention being critical.

In reality I don't see that currently on Prince Edward Island. I realize that you're at the beginning of a process here and I don't want to sound too confrontational or aggressive here, but I really hope that some of the ideas – in fact, all of the ideas that you have in here – will be brought forward.

I'd just like to finish with one further question please, Chair.

You mentioned peer support and how important that is. Certainly other jurisdictions have data that show that that is a very effective – and not to mention cheap – way of helping people with mental health and addiction problems. Is there money set aside in the budget specifically for, perhaps, a pilot project in that regard?

Dr. Rhonda Matters: Not that I'm aware of.

I think, though, that what I would want to clarify is that right now there are some folks doing peer support in our community partners. My suggestion is about it sort of being done in a broader, more standardized way. I don't want to leave you with the impression that there aren't some community groups that do have peer support as part of what is being provided. I think it's to sort of move forward in a way that really boosts that up, makes it more standardized, so that we can evaluate whether it's having the positive effect that we want it to.

Dr. Bevan-Baker: I'll let somebody else have a (Indistinct).

Chair: Pat Murphy, you're up next.

Mr. Murphy: Thank you. I have a couple of questions around addictions, I guess. Access to prescription drugs, is that a big issue in this province, legal access, like, doctors over-prescribing pain medication?

Dr. Rhonda Matters: That is an area that there is ongoing work on. I believe it was in the fall of 2013 there were a number of sort of steps forward to attempt to address that. There is ongoing monitoring to try to look at sort of who's being prescribed what by whom and trying to sort of make some moves in providing other education or following up on that.

Mr. Murphy: The methadone – am I saying that right, methadone? –

Dr. Rhonda Matters: Methadone, yeah.

Mr. Murphy: – program here in the province, is that working, is that paying dividends, is it helping? I assume it is.

Dr. Rhonda Matters: My understanding is that our wait times in that area have significantly decreased and that there's a much – I guess anecdotally we hear that it's a much smoother way for people to access service, that they're not waiting or in between services. Our understanding is that it is leading to some positive.

Mr. Murphy: They have to pay a fee, do they, the patients have to pay a fee each time they get methadone? Or how does the program work?

Dr. Rhonda Matters: I'm not exactly sure of all the details. My understanding is that there are two different clinics or two areas where it's prescribed. I think if it's in a private clinic it may have to be covered by either the person's insurance or some out-of-pocket. But I think there are a number of

different ways for that to be funded and Health PEI might be the better people to ask that.

Mr. Murphy: One more thing. I know you're working collaboratively with other departments. The justice system, now, if somebody that's a repeat offender that obviously has an addiction problem, is it compulsory for the judge to enforce some kind of addiction rehabilitation or is it just up to the judge's discretion on how he handles that?

Dr. Rhonda Matters: That's more than I can answer, I'm not sure whether it's up to them or whether there's –

Mr. Murphy: Should that be something that maybe should be worked on together? There's a lot of - I'm just going by what I read in the media – a lot of repeat offenders, they're identified as having addiction problems of some type.

Dr. Rhonda Matters: Yeah. I think raising awareness or doing some education with judges or other folks in the legal system would be a great idea. I think that my work as a front-line professional would tell me that we're better if we can engage people voluntarily, we have better results if we do that. But maybe there's some combination of also figuring out how we could engage people in a way that wasn't a forced thing.

Mr. Murphy: Thank you.

Chair: James.

Mr. Aylward: Thank you, Chair.

Dr. Matters and Dr. Harper, thank you very much for your presentation. I know since I guess it was back in October 2014 when you were announced as the new Mental Health and Addictions Officer here on PEI you had a lot of work put on your plate. As Peter says as well, I don't envy the work that you have to do.

I was wondering if you could give us an update on a couple of – and three particular announcements were made back in October 2014, the first being the establishment of a new 12-bed provincial youth recovery centre in Summerside, and how that's going?

Dr. Rhonda Matters: My understanding is that that is fully up and running, that all the new staff have been hired. Again, Health PEI might be able to provide more specific operational information about that. But what I hear is that's up and running and going well. Again, able to have people enter more fluidly so that people aren't waiting. There's what they call rolling intake so that people are able to start the program at regular basis and getting the residential support as well.

My understanding is that – again, it's always hard to tie for absolutely sure that this caused this. My understanding is that we have had fewer out-of-province treatments, fewer Islanders going out-of-province for those kinds of treatments. I would assume that it's meeting a need.

Mr. Aylward: That's also where the Strength Program is provided currently?

Dr. Rhonda Matters: Right. That is the same thing. Strength was the program provided here in Charlottetown. This is sort of an expansion of Strength. It moved location to be able to provide the residential component for all.

Mr. Aylward: (Indistinct), right, okay. It's housed in the youth correctional facility though, correct?

Dr. Rhonda Matters: It is, yeah, on a separate wing, I guess I'm going to call it.

Mr. Aylward: I find it ironic. I understand that dollars play a lot when we're dealing with these issues, but on one of your slides, in particular overview, one of the last bullets you have: eliminate stigma. To me, when you have a youth addictions treatment facility that's attached to a correction facility it really sends the wrong message when we're trying to ensure that, in particular, our youth are going to have a successful journey. It sends the wrong message, to me. I don't know how others feel about that.

The second announcement that was made was a youth mental health unit with up to 12 in-patient beds in Charlottetown. How is that going?

Dr. Rhonda Matters: Again, I think I might talk about that.

What is in the process of being set up is a day treatment hospital, I guess, or day treatment program and an infusion of additional resources into our current in-patient. I think between those two services that will meet that need so that kids who need a more intensive level of service – and generally day treatment is Monday to Friday, 9:00 a.m. to 5:00 p.m. – so that they'll be able to access that through that program rather than being hospitalized. But that for the youth that are being hospitalized there's been an infusion of more clinical resources or they're in the process of posting those positions and getting those filled.

Mr. Aylward: It's not currently up and running, then, the 12 in-patient beds in Charlottetown?

Dr. Rhonda Matters: The 12 day treatment? No.

Mr. Aylward: Well no, it was actually, it was described as: a new dedicated youth mental health unit in Charlottetown will see the number of in-patient youth beds increase from four to as many as 12. The new unit will enhance access to therapy and specialist services. It will also offer a new day treatment program to help youth transition back into the community following in-patient treatment.

Dr. Rhonda Matters: I think the thought at the time was that perhaps there could be one unit that included all, that had day treatment and beds. As the planning continued for that it appeared that that just wasn't going to work.

Really, there are going to be, I believe, 12 in-patient – 12 day treatment spots – and that the current I think four or five in-patient beds that exist will continue to exist and will have more of the clinical services there.

Mr. Aylward: Where would this be located, then?

Dr. Rhonda Matters: Where would the day treatment be?

Mr. Aylward: Correct.

Dr. Rhonda Matters: The day treatment is going to be at Enman Crescent, the previous location of Strength.

Mr. Aylward: Okay.

Dr. Rhonda Matters: That's set up in a way already that suits that need really well.

Mr. Aylward: Okay, and then the last announcement that was made on October 2014 was: a new behavioural support team to provide intervention and support for youth with behavioural conditions.

Dr. Rhonda Matters: Right.

Mr. Aylward: What's been the progress there and how is that operating?

Dr. Rhonda Matters: Health PEI is currently in the process of filling those positions. They've been posted, or at least one of them's been posted, so they're getting ready to fill those and get that up and running.

Mr. Aylward: Okay. On your last slide you had mentioned that the Advisory Council work is completed. Is that report published? Is it available for individuals such as ourselves to access or for the general public to access?

Dr. Rhonda Matters: It's not completed yet. The last step of that is the consultations that we're doing with the work that we're doing with the other government departments, agencies, and community partners, so it's not yet completely finished.

Mr. Aylward: Just maybe one or two more.

We've had a lot of discussion – in particular the last number of years, and the media have facilitated bringing it really out of the shadows as well, and I thank them for that, but individuals all across PEI have been really sharing their stories now with mental health and addiction issues.

One of the continuing issues that I still hear is an individual might present to one of the primary ERs here on PEI, whether it's PCH or QEH, and when they present they're redirected to addictions because they're told: You need to go to Mount Herbert because you have an addiction. They'll go to Mount Herbert and they'll be sent back to the ER saying: No, you need to go back because you have a mental health issue.

One of the things I talked about before in the Legislature in the last year or so was the possibility of – and I'm not talking about a completely separate unit, but having some kind of specialized training within the ER so that you could have a triage person on duty that could take those individual cases rather than being just bantered back and forth like a ping pong ball. Because when you say better access, better care, and it needs to be in a timely manner, when someone's looking for help ,regardless of it's an addiction or a mental health issue, which quite often go hand in hand, we need to make sure that that person's getting help right away.

What kind of things are in place to eliminate that from happening?

Dr. Rhonda Matters: I think there are attempts right now to try to make sure that no matter where someone presents, whether it's addictions, whether it's community mental health or whether it's the emergency department, that staff have training, I guess, in both mental health and addictions so that they are able to assist that person in moving forward. There's been a lot of work I know done on that concurrent training.

I think that whole range of services from access in the community to day treatment to folks presenting at the emergency department, I think that really investments in almost every area will help that. Because what we hear is that sometimes people go to the emergency department because they're not sure where else they can access services and the emergency department is open.

I think as we continue to address the wait times in the community and ensure that there are better and better services available in the community, hopefully we'll be meeting more of their needs there. But I would agree it would be ideal if, for the folks who do present at the emergency department, that we ensure that the staff there have the appropriate training and resources to help the person in need at that moment.

Mr. Aylward: Pat brought up the methadone program earlier, and I do applaud, in particular, the doctors that have set up the clinic here in Charlottetown, and of course for Dr. Ling as well who does yeoman's work as far as going back and forth between Charlottetown and Summerside to provide the methadone program.

But I'm wondering: What measures are in place to ensure that we have a gradual withdrawal program for individuals that go on the methadone program? Because the last thing we want is to have –

Chair: Three hundred and twenty people on it.

Mr. Aylward: Yeah, well, eventually four, five, six, 700, 1,000 people on methadone for the rest of their lives. We need to make sure that we have a program in place where they have a gradual reduction in the methadone so that they don't have that dependency for the rest of their life. Can you speak on that somewhat?

Dr. Rhonda Matters: I'm not familiar with that. I know that there are guidelines that exist, methadone treatments guidelines, but I believe it would be up to each practitioner and on a case-by-case basis sort of. So there are guidelines, but I believe that decisions about that, those are treatment decisions or clinical decisions.

Mr. Aylward: All right. Thank you.

Chair: Okay, Bush.

Mr. Dumville: I'd like to thank you very much, Drs. Matters and Harper, for coming in today. I appreciate it.

I'd just like to ask some questions, tack it from another point of view of the police community. Back in the day the police community – well, all that I can remember from my training was if you got into a situation with a mental patient you do not handcuff that individual. I got in a bad situation. I was lucky. There's a lot of domestic violence, and it's worse today because back in the day it wasn't so prevalent.

I'm just wondering, has the police community got input into these programs and how they're supposed to act in a certain domestic situation? Because one instance I had is the shotgun was broken over a kitchen stove. I talked the guy out of there and had

to stop the car on the Trans-Canada Highway because he was seeing flying saucers. When I got him to the mental institution, once he realized where he was he went crazy and it took about six staff to hypo him.

I'm just wondering. I know the officers today are in more peril in domestics because of the proliferation of addiction and drugs and what affects them. Are there any instructions given for a particular officer out there that comes across the situation? When they go to some home or residence where there's violence because of this, do they have a plan of action? Have they had input into the mental health? Because they're dealing with the last possible cause when it turns into violence. Do they have a plan of how to deal with that?

I don't know, I haven't checked on the police force's training as of late other than I just had that one little thing that popped into my head when I got caught was: Don't handcuff the individual. I did a lot of talking. In other words, if you came across a very serious situation – and a lot of our officers are alone in the evening or whatever – what advice, what direction do they have of getting that person out of that family situation and where do they take him and what do they do with him?

Dr. Rhonda Matters: It's my understanding that the police academy is doing much more training in that area about how to interact with and sort of calm someone who might be having either mental health or addiction difficulties, and that even for current officers that they're continuing to do some ongoing training in that area.

I know there are a number of I'm going to say projects or plans that are committees that do involve folks from Justice and Public Safety or from policing because I think they're a really important partner in this because they do have a lot of contact with folks who are sort of at the extreme levels having difficulties with mental health and addictions.

I think we always make an attempt to try to involve and collaborate with those folks in making plans and moving forward.

Mr. Dumville: Thank you. Thank you, Chair.

Chair: Okay. Brad.

Mr. Trivers: Thank you, Chair.

I wanted to echo the thanks of the rest of the committee here. It's great to see you here and it's an excellent presentation, Dr. Matters. Dr. Harper, it's great to see you in here all the way from Rustico in District 18 Rustico-Emerald. Great to see a constituent of mine in here, of course. I want to recognize that.

A quick question for you. You talked about youth and children. Can you clarify what a youth is versus a child, how you define those?

Dr. Rhonda Matters: That is a tough question. There's I guess a movement across Canada now to think about youth as being much – I think in the past we thought of youth as being sort of like 12 to 18. But I think more and more we're realizing – if you know many 18-year-olds you would probably agree that there's still a lot of growth and development that happens even for kids that aren't struggling. The definitions of youth sort of vary from province to province. But I would say on average most people are thinking about youth as being up to 24, 25.

The Strength Program, that's the age group that they continue to. The other term that people are often using for that age group is emerging adults.

Chair: Brad.

Mr. Trivers: When you talk about a strategic priority area to intervene early and focus on youth, I would like to see that further clarified that it would include children. I feel that probably prevention is one of the key things that can happen.

I wanted to comment on how level these strategic priority areas are and very soft in nature. Like I think, let's work together, put people first, uphold rights. Then you get into using resources effectively and then acknowledging circumstances, rights, cultures, and accountability. I think of those

almost as underlying principles that should be in all our government.

I wondered, along those lines, whether you think one of the strategic priorities should be implemented first above the others. Is there an order of implementation or are you just going to try and tackle all of these all at once?

Dr. Rhonda Matters: I think it's important to do something in each of the areas, so I see it as more like that there'd be first steps in each one and second steps and third, more that way than tackling it just one priority area at a time.

Mr. Trivers: Do you have a timeline of when the report's going to be complete? Then, when you see the next step, the action step taking place, an implementation plan, and then the implementation itself?

Dr. Rhonda Matters: I would think that the strategy framework would be complete hopefully soon, within the next number of months.

Mr. Trivers: This year?

Dr. Rhonda Matters: Yeah. The implementation, I think, really will begin – in some ways there have been – there's been work done in each of the areas anyways, so the implementation would begin right away.

Are you asking me though – in terms of all the recommendations that we have are probably longer term than that. They're probably 10 years.

Mr. Trivers: I guess maybe my question is more about the process that you see. You mention now that you're going to try and tackle the priority areas sort of all in parallel and implement a couple of objectives in each one as you move down. Do you see this is a 10-year plan, a five-year plan?

Dr. Rhonda Matters: A 10-year plan.

Mr. Trivers: Ten-year plan. Okay, that's the long-term strategy, 10-year plan. In the first year, 2016, you're going to have the report complete from the Advisory Council, so do you see the first objective in every strategic priority area implemented by the end of 2016 or maybe the end of 2017, with 10 objectives that are going to be complete within 10 years, one per year kind of idea?

Dr. Rhonda Matters: I think that's what we're trying to figure out now in conjunction with all the departments and all the community partners. That's what's currently being determined as how – and I think it would depend on some objectives might be more immediately addressed or accomplished and some might be much longer term.

Mr. Trivers: Another question I had, not being an expert in mental health and addictions at all, how much do you see when it comes to mental health is due to nature versus nurture, sort of, genetics versus environment, and how does that play into the strategic priority areas?

Dr. Rhonda Matters: That's a big question. I think the answer is yes, both are important in different circumstances. We know the research would tell us that there are a number of mental health difficulties that are genetically biologically-based. But we know that also some experiences or some circumstances that people find themselves in increase the likelihood that they will.

Mr. Trivers: I guess what I'm getting at is: Are there base line numbers within mental health that say, really, only 1% of mental health issues are really due to genetic issues and the rest are due to environment? If we address the environmental concerns we're going to solve the vast majority of our problems here on PEI.

Is that a proper way to look at it?

Dr. Rhonda Matters: I don't think there are stats like that. I think that what we would think about is that we know that across Canada, across the world, the incident of mental health concerns is quite high. Many people will have a mental health difficulty. I think what we want to be looking at is how do we ensure that is as quickly addressed and that person has the supports they need to recover and to live as independently as possible.

I think it's about sort of making sure that even if someone has a mental health difficulty that it has as limited effect as we

can because they are given the supports and the treatment initially.

Mr. Trivers: I guess what I'm hoping is if there is a focus on prevention, especially intervening early with youth and especially children, then we can eliminate a lot of the down the road problems, and if we can address the mental health concerns maybe we can get rid of addictions altogether.

I'm not so sure maybe that is the right approach based on your answer, but I was hopeful that might be the case.

Chair: Thank you.

Kathleen Casey.

Ms. Casey: Thank you, Madam Chair.

Dr. Matters, there's evidence that youth are presenting earlier with mental illness. With the success of the Bell Let's Talk program, I'm just wondering: Have you seen a rise in Prince Edward Island in the people who are coming forward because the stigma is being reduced? Because of the success of the program, is there any evidence that you're being inundated with more people? What are the stats between before the Bell Let's Talk program and now and after? Are you seeing more people coming forward?

Dr. Rhonda Matters: I think that, anecdotally, we do see people being more open. I think the stigma around acknowledging that you're having a mental health or addiction struggle is decreasing, and that's excellent. Because if people are struggling what we want them to be able to do is to talk about it and to seek help.

I would say that our referral rates overall sort of would continue to hold (Indistinct). It's hard to know because there are different places where people are seen. I think Health PEI is going to talk about the referrals in community mental health and addictions, but I don't know if we have a way to track how many people who also seek help in that area from their primary care physician or any community partner agency. There are a number of places where people could be going to access that help. It's hard to really know for sure what the numbers are for referrals.

Ms. Casey: Switching now to – you talked about in your presentation, under the mental health promotion area, poverty reduction methods. I know a lot of people say that if somebody is presenting with mental health issues, if you have a stable home that kind of helps. It's not going to take away the issue, but it kind of helps if you know that you have a stable home environment. There's lots of talk now about livable incomes. What's your feeling on livable incomes and how it can help poverty reduction, thus helping with mental illness?

Dr. Rhonda Matters: Difficulties with mental health and addictions occur in all socio-economic statuses. But we do know that adding on top of that sort of struggles with finding safe and affordable housing and not having to worry about whether you're eating sort of adds an additional strain to that. We really see that as being an important part of what we need to do to support Islanders. As well as living in poverty. That's one of those life's circumstances which creates extra strain and difficulty and, in fact, may be related to the likelihood of developing a mental health and addiction difficulty.

We see that part of it as being very important ensuring that all Islanders, but in particular those that have mental health and addictions, do have some of those basic needs met. The Housing First project that I referred to is just that idea. It's about rather than trying to put the supports and things in place to help someone with their mental health and addictions and then find them a home, it's about getting them into a home so that then they can start to address some of those issues.

Ms. Casey: Thank you.

Chair: I have a couple of questions that I would like to ask, points that I'd like to make.

When it comes to Mount Herbert and the program that's offered there, my understanding is it's a seven-day stay maximum at Mount Herbert if you're –

Dr. Rhonda Matters: Well, I – are –

Chair: For addictions.

Dr. Rhonda Matters: No, I don't think so. The provincial addiction treatment facility has a number of – so there's in-patient withdrawal management, and Health PEI may be better to answer this.

Chair: In-patient, seven-day in-patient.

Dr. Rhonda Matters: But then there's also the transition unit.

Mr. Aylward: (Indistinct).

Chair: That's right.

Dr. Rhonda Matters: So there's withdrawal management, or detox is what it was referred to. There's a transition unit now that allows people to stay for a longer period of time as a discharge plan is put in place. In fact, now, I believe that depending on particular needs folks could be in the transition unit for several weeks while plans are being –

Chair: Do you find that you're getting better outcomes with the changes there from the seven-day detox to the additional unit?

Dr. Rhonda Matters: Our understanding is that, again, wait times have significantly decreased for withdrawal management, for detox. The sense is that that's probably related to the fact that again we have a more seamless system of care for people so that they, if it's required, can – again, back to least intensive, though, right? Some folks can do an in-patient withdrawal management and not need transition unit, but for the folks that do, they're able to go from that service to that service and then to out-patient care. I think it's providing that pathway that sort of meets people's needs better, and that that's perhaps, then, why the waiting list at in-patient withdrawal management has decreased. Because people are not having to go through that potentially more than once because there's this new pathway that meets their needs.

Chair: So they have less admissions to Mount Herbert as a result of the changes, is that what you're implying?

Dr. Rhonda Matters: Yeah. I haven't looked specifically whether we do have the data about repeat (Indistinct) versus out, so this is more – my understanding is that anecdotally that's the (Indistinct).

Chair: My next questions are around the methadone clinics and the methadone programs.

I know that there's a large number of people who are part of the methadone program. Is there specific criteria that allows people to access the methadone treatment as opposed to not?

Dr. Rhonda Matters: I'm not familiar with that information. That may be a question that Health PEI could address.

Chair: Okay. The other question, then, I guess – maybe I'll have to leave it for Dr. Wedge – is the efficacy of that program. Do we have any numbers or anything that's indicating the effectiveness of the methadone clinics for those who are utilizing them here in PEI? Do we have any hard numbers on that yet?

Dr. Rhonda Matters: We know across the country that there are numbers showing that that's a good intervention, but I'm not sure about the PEI numbers.

Chair: I guess the intervention is one step, but then I guess my question is more about those who use the methadone program. What's the long-term effect on them being able to stay clean or dry as a result of the methadone program on the long term, and then sort of having a good quality of life as a result of that form of treatment for their addiction is more my question.

Dr. Rhonda Matters: I'm not familiar with whether there are PEI stats about that, but I know that there would be research studies that would demonstrate that that does lead to more effective change and positive outcomes.

Chair: There's a lot that I could ask, but I'm just trying to keep them fairly high level and more simple.

When you look at youth on Prince Edward Island – and I know it was mentioned today about whether or not it's a really good fit to have addiction services in the same place where we have the youth detention, so to speak – I think if you look at that picture

there's a tremendous number of young people who probably end up in the youth justice system as a result of committing crimes in order to feed their habits of addiction to either drugs or alcohol.

I do see that there's a correlation there, and we also know that if people get treatment their chance of recidivism drops a tremendous amount. If we can intersect at that level and help our youth they may never go on to serving time in a provincial corrections centre or federal. So I think it's really important to recognize that that work, I think, is valuable, and having those two facilities at the same place I think is also effective.

I don't think that – the bottom line is that we want to get our youth well and we want to ensure that they have treatment, so I think that it goes well, and we don't want them to continue on in a life of crime in order to survive and end up in a lot worse circumstances.

Dr. Rhonda Matters: And the youth at Strength would be youth that are requiring a quite high level of intensive service.

Chair: Yes.

Dr. Rhonda Matters: It's not an out-patient service, it is a residential, so I just want to be clear that that's not where all out-patient addiction services are occurring.

Chair: Absolutely.

Dr. Rhonda Matters: It's that residential part.

Chair: When you say intervene early and a focus on youth, when you talk about intervening early, what is it we're exactly saying when you talk about intervening early?

Dr. Rhonda Matters: So I think both, we do want to – we would think generally about sort of intervening more when it is with children or with adolescents, when they first, you know – having a focus on providing services there. But I think it's also the idea around ensuring that we provide the intervention as soon as we possibly can to decrease wait times and be able to intervene early in the life of the challenge or the difficulty.

Chair: When you talk about children I know that it seems that school-aged children, there seems to be a tremendous rise in behavioural issues with school-aged children. I know over the years across the country they've done some very intricate work around identifying children with Attention Deficit Disorder and Attention Deficit Hyperactive Disorder, that in some cases, when they trace adults with mental health issues, that some of those precursors were there that were indicators of perhaps being diagnosed as a young adult or an older teen, I guess, older youth, as having either bipolar or schizophrenia.

Are you involved in any of that work or do you see any of that sort of work happening to indicate that these behavioural problems in younger children are sometimes indicative of what may come down the road?

Dr. Rhonda Matters: I think the whole idea behind the intervening early is very consistent with what you're saying, that if we can intervene when a child is having some mild behaviour difficulties, what we hope is that that trajectory or the path that that child takes is the best one, right? We want to intervene when they're having mild behavioural difficulties to hopefully alleviate any behavioural difficulties or to have them continue to be mild difficulties not unaddressed that then become maybe more serious and interfere with school and lead to – so it is that idea about sort of as soon as there's a difficulty identified putting appropriate assessment and intervention and supports in place so that we don't have sort of the worst trajectory occur but sort of the best.

Chair: My last comment is just around the justice system in general. From my observation – I worked in mental health for 16 years before coming to government, and as you know, my last portfolio was justice so I spent a great deal of time around those national tables with justice ministers across the country. From my own view here in Prince Edward Island the number of people who would be incarcerated who also would have mental health and addiction issues and

that the percentage of that would be extremely high.

I guess my curiosity, when you talk about advisory councils and looking at the long term around this issue, and it is a very serious issue, and some would like to say that it's almost an epidemic in Prince Edward Island. There's a tremendous amount of concern.

I guess my question is you mentioned that anybody who comes to receive services if they come on their own sort of will to be treated that the outcome is much better. Would you say also that, when you're saying coming in your own will, that admitting that you have an alcohol or a drug issue is the first step to a successful or possible recovery?

Dr. Rhonda Matters: I think it's an important step. It may or may not be the first step. I think it's part of what helps motivate people to work at it or to make next steps.

Chair: I think if you don't admit it, then you're never going to be able to help treat it. I guess where I'm going with this is in terms of therapeutic courts. When you talk about the Advisory Council is that one of the things that is being considered? In therapeutic courts, you have people coming in – whether it's domestic violence issue, whether it's other types of violence, whether it's break-and-enters and that sort of thing that's feeding their habits – coming in to a therapeutic court, and the first step of overcoming it is admitting it and then getting treatment.

Do you see therapeutic courts as something that would help us deal with the sort of epidemic issues that we have around mental health and addictions in Prince Edward Island?

Dr. Rhonda Matters: I guess what we identified with that group, with folks that are involved with the justice system, is that we need to do everything we can to make sure that they're getting the supports and the services they need. We haven't been, at this point, specific about how that would be delivered, but just identifying that we need to make sure that people involved with justice who have mental health and addiction services are able to access those, both if they're currently being incarcerated or once they're out. We haven't been as specific about that, but we identify that group of people as being a vulnerable group of people who need a seamless way to access services.

Chair: Because, again, I'm going to go back to the whole issue that when somebody comes into the justice system for the first time, whether it be a domestic violence situation or petty crimes in order to feed their habits, if the interjection happens there and they admit guilt, and then have to do treatment, that would then reduce their chances at recidivism in the justice system, and also give them an opportune chance to perhaps make life-changing decisions. Because there is a certain value to take into a good hard look at self and maybe they will not have any more issues with the justice system, but they would also access treatment for their addiction problem.

Dr. Rhonda Matters: In that case they are choosing that.

Chair: That's right.

Dr. Rhonda Matters: Choosing that option.

Chair: Well, they have to admit guilt first and then they would have the opportunity to receive treatment. If they were effective at that then you may get them on the right track.

James is next and then –

Mr. Aylward: Thank you, Chair.

Just a couple of quick questions. The first one I had asked back a number of years ago, and at that time the Strength Program was so new that stats weren't readily available. We know, for example, Portage and Homewood, they have stats that they've actually published. When I talk stats I'm talking about their success rates versus relapse. With the Strength Program now – and I realize the program has evolved in the last couple of years from sort of being a day program to now an in-patient program – but are there any current stats available to show us how that program is working via success rates?

Dr. Rhonda Matters: I'm not aware of any, but that might be something that the folks from Health PEI could answer.

Mr. Aylward: Another question I had – and the Chair spoke quite a bit about the judicial system. Of course, the judges here on PEI have been quite vocal as well with regards to what's happening in their courts and the high volume of cases that come before their bench with regards to drug addictions and/or mental health issues. Again, as I said before, they're quite commonly tied together.

Within the provincial correction facilities, what programs are currently available to those individuals being housed in those facilities for counselling or for treatment?

Dr. Rhonda Matters: There is a clinical services team within Justice and Public Safety that includes – there are addiction counsellors or addiction workers, there are social workers, there are youth workers. I think they have a vacant psychology position. There is a team of clinical services folks within Justice and Public Safety and then there's also connection or collaboration with folks within Health PEI.

Mr. Aylward: All right –

Chair: Can you hold your question because Bush is waiting and so is Peter, so I'll let him go and then we'll (Indistinct).

Mr. Dumville: Just a quick question, Chair.

PTSD, are there many cases on Prince Edward Island and is there a program to address it? Or is there any correlation between PTSD that other mental health issues might be – is there a correlation there?

Dr. Rhonda Matters: Again, I don't know if I have specific stats because, again, I think people would seek service in different places. Anecdotally we know that lots of people are suffering with PTSD. That's one of the things I think that we've begun to work on as making sure that our care is trauma competent, that people are aware of when we're providing care what would be best for folks that have a history of trauma or PTSD specifically. But that's an area that I think we can continue to do some work in sort of across all agencies and government department. Because folks with trauma in their background or PTSD don't just present at mental health, they present in the hospital, and they present at income support. So, continuing to make sure that people are aware of sort of the kinds of things they can do that are helpful.

Mr. Dumville: Thank you, Chair.

Chair: I just want to sort of wind up here because we still have Dr. Wedge to come before us.

I'm going to Brad and then Peter Bevan-Baker and then, James, you'll get the last question.

Mr. Trivers: Just a very quick one. Looking at the strategic priority areas, better access, better care, mental health promotion, things like that, will you be creating specific measurable and time-specific goals related to each one of those areas, the two, to show how the long-term plan is going to be measured in terms of success?

Dr. Rhonda Matters: I think evaluation and measurable goals and outcomes is very important as part of the strategy.

Mr. Trivers: So that is part of the plan. I just want to be sure.

Okay, thank you.

Chair: Peter.

Dr. Bevan-Baker: I'll follow right on from that. I was kind of surprised, shocked actually, to hear that you weren't aware of the statistics of the success rate of the step program. Because if we're not keeping statistics we can't be measuring whether they're working or not, we can't have an evaluation of whether it's working, and therefore there's no accountability. I think if we're talking about real accountability and measurement and doing evidence-based approaches, then we have to be able to tell if what we're doing is successful.

Can you tell me what accountability mechanisms are in place now in the department to measure whether what we're doing now is successful or not?

Dr. Rhonda Matters: I think that going forward that's what we'll be trying to do with all the departments and agencies that are involved in things related to the mental health and addiction strategy.

Dr. Bevan-Baker: I asked if there are any accountability mechanisms in place now, though, to measure whether the approaches that we're advocating on PEI are successful.

Dr. Rhonda Matters: I think we're at the beginning stages of that.

Dr. Bevan-Baker: Okay. Chair, I have a specific question on fentanyl which is now on the market, and instances of accidental overdose and death in some other provinces. Is the province doing anything to warn Islanders about this really dangerous opiate, because of its potency, which has arrived?

Dr. Rhonda Matters: At this point I think there are discussions about how we might best do that, but I don't believe there's been a statement at this point.

Dr. Bevan-Baker: One last question, thank you, Chair, promise, and this is to do with the Hillsborough Hospital.

Are you or have you ever done an ethical assessment of the Hillsborough Hospital, and is there a watchdog for that facility?

Dr. Rhonda Matters: So have I done an assessment of Hillsborough –

Dr. Bevan-Baker: Or the department.

Dr. Rhonda Matters: No, I –

Dr. Bevan-Baker: An ethical assessment.

Dr. Rhonda Matters: No, I believe that Health PEI has done some work in that area.

And is there a watchdog? I don't think. I'm not sure.

Dr. Bevan-Baker: Okay.

Thank you, Chair.

Chair: You're welcome.

James.

Mr. Aylward: Thank you, Chair.

I just want to go back to the programs that are available to those individuals that may be incarcerated, and again it goes back to evaluating or looking at the success rates. Because quite often we hear of individuals that appear before a judge and they actually ask for federal time because they know that they've already served time here provincially and whatever's offered here just is not effective enough.

I guess this is going to be more of a statement than a question. I think we really need to look at what we're offering to those individuals that unfortunately have gone down that road and are now serving time, because if we can do that provincially versus having them to go to a federal institution, I think their outcome would be much better.

My last question would be around youth. I've heard this time and time again, particularly from parents, and from some young people that presented to our standing committee when we toured the Island, that quite often it's as early as the years that the youth are in junior high and they start experimenting.

Essentially what they're doing is, or the way they've described it is, they didn't realize that they had a mental health issue until later on, like in high school or post-high school, but what they finally realized was that in junior high they started self-medicating, and quite often they were self-medicating with marijuana, and then from that they eventually moved on to other substances such as opiates and different things.

Peter speaks on fentanyl, but one thing that we really need to start talking about here – and I'm going to have a recommendation later on to the Chair – is what's happening on our streets with crystal meth right now. Because although fentanyl is prevalent in a lot of cities, particularly Calgary, Vancouver, it's crystal meth right now that is really taking hold of our youth.

Backing up from that somewhat, and again talking about youth self-medicating because of a mental health issue, what's your stance on the potential legalization or decriminalization of marijuana?

Dr. Rhonda Matters: That'll be a federal decision. That's not –

Mr. Aylward: As a professional and the Chief Mental Health and Addictions Officer for Prince Edward Island, I guess I'm asking you what your thoughts would be on that.

Dr. Rhonda Matters: I'd definitely have to do some more research before I was prepared to give advice or feedback on that.

Mr. Aylward: Nice avoidance, thank you.

Chair: Okay, in conclusion, obviously, Dr. Matters, we could probably keep you here for another hour or two. It's obvious that there's a lot of passion and concern around this area in the province and among us who are legislated to effect change, to improve the lives of Islanders. We feel the road has been long and continues to be long, so I think everybody's a little impatient to start to see some marked results of some of the work that we're anticipating or doing at the present time and recognizing that it is a very serious issue.

To mention what's already been mentioned a number of times before, is sort of that early intervention. That's one of the things that really stands out on your overview here, and has been alluded to by all members with our youth and self-medicating and realizing it was actually mental health issues that started the ball rolling.

It gets people into our justice system. For all intents and purposes we deinstitutionalized in the late 1950s, but we now have a lot of people, unfortunately, with mental health and addictions issues in our corrections facilities, right or wrong.

I would urge those who are at the table making decisions, recognizing that the people that are incarcerated on PEI are people's brothers and sisters and fathers –

Mr. Aylward: Children.

Chair: – and all of that really impedes on the family structure as well which is something that creates stability in young people's lives. We need to really start focusing on making some real steps with real goals and outcomes so that we can move forward past this.

So thank you very much –

Dr. Rhonda Matters: Thank you.

Chair: – for coming.

We're going to recess for five minutes.

[Recess]

Chair: I'll ask everyone back to the table. Can I get all the committee members back to the table so we can get underway?

Some Hon. Members: (Indistinct).

Chair: Obviously we have a lot of questions. We're still missing one. I think Pat's in the washroom (Indistinct).

Pat will be along to join us in just a couple of minutes there. I guess we'll get started.

Obviously there's a lot of questions and a lot of interest in this subject, so I'll start by welcoming both Dr. Wedge and Verna Ryan here with us this morning at our Standing Committee on Health and Wellness. Without further ado I will turn it over to you to make your presentation. I ask people to wait until after the presentation is completed to come forward with your questions. The floor is all yours.

Dr. Richard Wedge: Thank you, Madam Chair, for the invitation to come and give an update to the standing committee on health regarding mental health and addictions.

Just to introduce Verna, Verna is our director of mental health and addictions for Health PEI, so she's in charge of that division within Health PEI. Just based on some of the comments just prior to from Dr. Matters, just for clarity for the committee, it is government's role to provide the policy direction as to where they want to go in health care in the province. It's the role of Health PEI to then deliver those health care services to Islanders. We have a health delivery role versus a policy role, although we're obviously in close contact with government to try and implement programs and tweak programs and seek money for programs, that kind of thing. We're the health delivery versus the policy development that's there.

As you know, there's been a tremendous increase in demand, as Emily Casey has pointed out. The Bell Let's Talk and a number of other initiatives out there have really brought out that stigma and the increase of demand here on PEI. We've done a lot of work over the last three or four years to increase capacity to be able to meet that demand, so we're going to go into some of that with the presentation.

I'll provide some general comments around that, but really Verna's the one that's going to give you the technical expertise on this particular presentation, so I'll turn it over to Verna.

Verna Ryan Director: Great, thank you.

Now, I just want to make sure that I – okay.

The purpose of the presentation this morning is to provide you with a brief overview of mental health and addictions. I just thought that might be useful so that everyone has a basic understanding of what mental health and addictions as a system really is. I know there are new members to this group that would not have been here during the previous presentation. Actually, I wasn't here during the previous presentation, not being in the position, so we'll have a look at that. We'll look at the work that's underway, some of the highlights of work that's underway, and then an update on some of the initiatives that are related to the mental health and addictions strategy that were announced previously.

A profile of our division. The division is made up of Acute Mental Health, Community Mental Health, Addictions Programs, and Community Addiction Services.

Under Acute Mental Health, of course, we have Hillsborough Hospital, 69 beds there; an in-patient unit at Prince County Hospital, we have 14 beds there; Unit 9 at the QEH, 24 beds there, four of which are adolescent; and Crisis Response, which is crisis response in the emerg departments at both Prince County and QEH. As well we have – there is one crisis response person in Montague as well, at Kings County.

At Community Mental Health we have community services at the Western Hospital in Alberton, in the O'Leary Health Centre, in Charlottetown at both McGill and Richmond Centre, the Douses Road in Montague, in Souris, and we also have community initiatives through primary care. Those are pilots where we're working with primary care physicians in clinics to increase the capacity and access for mental health and addictions.

Under the Addictions Program we have our provincial addiction treatment centre, Mount Herbert; the methadone maintenance program out of Mount Herbert; and Health PEI also funds the private clinic in Charlottetown; and there are also services out of Summerside. We have the extended care recovery homes and those are Talbot House, Lacey House, and St. Eleanor's House in Summerside, so those are our transition from treatment to community for individuals, as well as the Strength Program which is targeted at youth.

In terms of Community Addiction Services, again, we're in Alberton, O'Leary, Mount Herbert, Prince County Hospital, Douses Road in Montague, and in the Souris Hospital, and the Souris Hospital and the Alberton and Prince County, it's a section attached to the hospital, so that's how it's laid out.

When we think about mental health and addiction services, the approach that we've chosen is a levelling or tiering system out of Australia. We look at the fact that there is movement when you have mental health and addiction issues. While some may have episodic periods of addiction or mental health issues, some may have chronic and long-term issues, so we look at need, risk and interventions.

In tier 1 is our low risk: health promotion, universal prevention, some of those activities.

In terms of mild risk, we're looking at transient or stable mental illness. So this could be someone who's had a mental illness for a very long period of time but they're stable. It could be someone who's been on the methadone program for a long period of time and they're stable. It could be also someone who's just starting on those programs or early intervention. They might need brief intervention, treatment, and the

episode is dealt with. It supports self-management, so looking at mental health and addictions sometimes being long-term chronic diseases where self-management is extremely important. People take ownership in the recovery approach to look at their triggers, to notice their symptoms, to have plans to deal with those, to seek help when they need to.

Tier 3 is moderate risk: mental illness and mental health conditions that are impacting your functioning on a day to day basis. May need relapse prevention. So it may be that you go back in to see a counsellor at a certain period of time. You may need a period of brief treatment or intervention, and secondary prevention. Secondary prevention really is you've got a condition but you don't want it to get any worse. So that's Tier 3.

Tier 4 we consider moderate to severe need: so these are mental illnesses that are having a serious impact on your functioning. It could be intense, episodic but ongoing, and they have increased complexity and rehabilitation needs, so this is where we're getting into more specialized need.

Tier 5 is where we see our most complex and high-needs patients who need intensive rehabilitation and support treatment in order to stabilize and improve their condition.

Then to help you understand the way PEI currently is organized, I've taken our services and lined them up with those same tiers. In Tier 1 is really – well, it's everyone's business. It's not usually part of our current day-to-day except as we work with our clients, but it's collaborative mental health with primary care which I referred to, which is also referred to as collaborative care. You may hear where mental health clinicians support and build capacity within primary care physician clinics working with the staff because we do know that many people, probably 70%, will appear in their physician's office with a mental health and addictions issue. Our primary care physicians, they're a huge way of managing that population.

This is an approach to work together to – it's prevention, it's early intervention, it's access, it has a lot of impacts. The private methadone clinic as well, we would consider in that Tier 2 of mild need transient or stable mental illness and addictions.

In Tier 3, that's where we see most of our community services. There is a moderate need but it's manageable. People may move through these tiers, but having people manageable in the community managing their disease is where we want to see most people.

In Tier 4, those are: our Prince County in-patient mental health unit; our in-patient withdrawal unit at Mount Herbert, PATF; mental health, a sort of outreach team, so that's our team that works out at McGill who work with chronically and persistently mentally ill to help them and support them manage their illness; the seniors' mental health outreach ream, which, again, is out at McGill, and we're newly expanded to Summerside, and they work with a – it's a multidisciplinary team that works to support people who are currently in their homes, seniors who are in their homes or in community care or long-term facilities; the methadone maintenance program, out of PATF, the program there, because they do have in-patient induction there – where the community doesn't – that would deal with more complex, more high-risk folks; the Strength Program – so our 12 beds currently in Summerside is an intensive support or treatment program; and the addictions transition unit at PATF, which is relatively new within the last two years; and the extended care recovery homes, recognizing that those periods of transition are very important for folks that may need that structured living environment while they're moving from treatment back to the community.

Tier 5, that's our most acute care focus, so we have: Unit 3 at Hillsborough Hospital; Unit 5 and 7 and 8, so the four units at Hillsborough Hospital; plus the QEH in-patient mental health unit there.

In terms of some utilization data, I wanted to provide just a broad overview of some of our data. If you look, these are 2014-1015 data sections there. We currently don't have the 2015-2016 data at this point in time, but you'll see in the in-patient services we have a very high occupancy rate. The occupancy rate is usually recommended to be around 80%. In most if not all of our units it's

operating at 95 to 103 or 105%, which means that we are into over-capacity and that's on a regular and consistent basis.

You can see there is fairly high admission rate in terms of acute care. In Unit 3 there's quite a high turnover rate at in-patient mental health which is at the QEH and at in-patient adult mental health at Prince County. Some 660 adult admissions in that year. The adolescent – we saw approximately 45. Our adolescent numbers are actually going down a little bit but lengths of stay are up. There's multiple factors with that. But we are seeing a slight reduction in this past year. And bed-based withdrawal, so in-patient withdrawal at Mount Herbert is at 978. We see that currently continuing. The big shift with PATF in the in-patient unit is once the methadone program was set up in the community, instead of having opioid users coming in to PATF for withdrawal, we're now seeing those folks more stable in the community and we're seeing a huge increase in alcohol addiction. Just a swing back to that.

In terms of community-based services, mental health and addictions, community mental health, we had over 4,500 referrals in 2014-2015; for children, 1,248 referrals and with out-patient addiction program seeing that at about 2,700.

There's a very high volume. There are also folks who are referred and maybe triaged to a different sort of service, maybe a community-based service, but we try to have people going to the right service at the right time.

Mr. Dumville: (Indistinct). On the 1,248 classed as children, up to what age?

Verna Ryan Director: I believe that goes up to 16.

Mr. Dumville: Thank you.

Verna Ryan Director: I can clarify for you, though.

In terms of some of the factors that we look at in terms of monitoring how we're doing, one of the things we look at is wait times for all of our referrals, but for urgent and semi-urgent in particular. Now, with psychiatry – I have a slide on this, I believe it's a little later – it's separate from mental health and addictions. We have a director of mental health and addictions, that role that I'm currently in, which is the program. Then we have a medical director of mental health and addictions who is a psychiatrist and who essentially is in charge of the psychiatry cadre.

I have a breakout here for the average wait times for psychiatry, for adults being 75 days, for urgent and semi-urgent being 58. Average wait time days for community mental health psychiatry for youth is 50 days for urgent and 94 for semi-urgent.

The average time for triage for clinical services – so this would be from a mental health clinician – for urgent it's 15 days and semi-urgent would be 40 days. Average time by triage for youth is 25 days for a youth to be seen and 67 for a youth who is considered semi-urgent to be seen.

The one piece that is not factored in here, which is always the piece with data that leaves some lack of clarity, is the fact that this includes the time it takes to get in touch with folks. They can be referred by a physician or self-referral or from another health provider. Sometimes there are challenges in terms of reaching people to set up appointments. We may have phone numbers that are disconnected, we may have people using throw-away cell phones, that sort of thing. Those numbers are reflected in that as well. The data is not cleaned from actual point of contact with the person to their appointment time.

Mr. Trivers: You don't cut off outliers and just take the middle portion of the –

Verna Ryan Director: No. Not in this.

Mr. Trivers: – for the average? You include everything, like, there could be somebody way out there. Okay.

Verna Ryan Director: Yes, right now.

Mr. Trivers: Yeah.

Verna Ryan Director: We're dealing with a fairly dated information system so it presents a lot of challenges.

This is the program structure that I referred to, just to help provide some clarity for folks on, again, just what this is. I think I (Indistinct). Okay. I changed the PowerPoint a couple of times.

The program director is the role I'm in. I report to the executive director of acute care, mental health and addictions, Pam Trainor, and then the program medical director would be the co-director in management of mental health and addiction services.

In terms of some highlights in relation to what we're currently doing – and these are highlights, there are some samplings: increased integration and collaboration: I know that may sound like a soft thing, but if you consider the context that mental health and addiction services were previously separate services in the province up until a couple of years ago, so they truly weren't integrated, so mental health folks were still treating mental health issues and addiction services were treating addiction services. That crossover to look at a person holistically and look at the social determinants of health really hadn't been in full play.

Some of the work that we've done over the past year includes creating a vision statement for the service. Again, it doesn't sound like a big thing but it really speaks to the culture of the service, what our priorities are, how we deliver our service, and what we're moving towards is a truly integrated service.

Where you show up in your system will not matter in the future. You will receive mental health and addiction services together, and you will be assessed for those, and that's really the direction that we're moving towards.

The expansion of collaborative mental health. We've had pilot projects in Montague, in O'Leary, in several sites. We have Tyne Valley, Hunter River, and a couple of other sites where that's happening, and we're just rolling out in Summerside area right now. Again, that's that collaborative mental health with primary care.

The seniors' mental health resource team expansion. We are looking at demographics and we realize that the seniors population is growing, of course, by leaps and bounds and we wanted to be out there supporting the other efforts that are happening for seniors, but recognizing that seniors are experiencing mental health and addiction issues just as strongly as other groups.

These are community-based services. We're focused on keeping people in their homes as long as possible. When issues move them forward to community care or other services, again, we're working with them to ensure that their mental health and addiction issues are being addressed.

I recently was at a rounds on one of our teams and I'll tell you that they are very holistic in their approach. Prior to the snow coming and the winter weather the discussion at the table ranged from everything, to whether or not one particular lady had the proper medication to how many visits she was getting a week, what supports she had, and was her woodpile big enough to heat her throughout the winter. That's the type of care that this team is providing.

Continued expansion of evidence-based programs, training, and interventions. Dr. Matters referred to a number of the trainings that were focused on. This past year we've done a great deal of evidence-based training. That's included DBT, which is dialectical behavior therapy, so we're training clinicians in that. We've introduced the CRAFT program, so that's the Community Reinforcement and Family Training program, mainly on addiction services, but its focus is to support families and give families coping skills so that if they have loved ones who are not seeking treatment that, by changing their behaviour, it actually increases treatment-seeking behaviour upwards to 75% in the evidence. So we're quite excited about that program.

We've had a focus on Triple P parenting, and have a number of clinicians offering that as a value-added focus. In terms of newer interventions, because we do have a wait list in the community and because we were doing this training which of course takes our clinicians out of service temporarily for those training periods, we introduced a new program called Strongest Families, which is a program that initiated at Dalhousie University. If the group is willing I have a

brief clip at the end of the presentation. It supports families early on in their home. It's a tele-health approach. It deals with areas such as bedwetting, oppositional defiance disorder, ADHD, and anxiety. It's in situ. The families are set up with a coach and they receive the phone coaching in their homes at their times, when it's convenient for the family. As I said, that's just new in the fall, and we're pleased with how that's going, but because it's so new we don't have a lot of reaction on that yet.

Work with community mental health and public health in pre-and-post-natal mental health issues and substance abuse. We've trained approximately 40 public health nurses and mental health and addiction clinicians on a program, again out of Dalhousie, that is a wellness kit for mothers. It, again, is done in home and we've been strengthening our response in that area in collaboration with public health.

We've also in September re-launched the Island helpline with the Canadian Mental Health Association. That line has been in effect for some time, but we partnered with them and also brought in bilingual, it to be a bilingual service as well in terms of the website and information.

We're continually improving the Transition Unit, so when I mentioned the change in demographics that we're seeing at PATF, we are seeing an increased demand for the transition unit as well. Not just in patient withdrawal but also wanting to use that unit. We are looking at ways to make that a more flexible unit, to not be limited by how many beds are in one unit or the other but to take a combined approach to that.

Standardize and increase programming in the addiction extended care program. Those operated again as separate entities, those three homes I referred to earlier. We've been working over the past year to ensure that the programming is consistent across the province so that everyone has access to the same sort of care and follow-up there. And pilot of the Strongest Families program which I referred to.

Just watch my time.

Progress on the recommendations. I know that this was discussed previously so I'll go over this quickly, but if you have questions I'll certainly address those.

Expanded Strength Youth Addiction Program. There was obviously a great deal of work in a short period of time to take the day treatment program and the home that was attached to that and expand it into Summerside. We focused a great deal on creating a separate space, so that actually is in the youth centre. It's not within the secure envelope of the corrections piece of the facility. It's actually a separate pod with a separate entrance, and we took efforts to design the interior so that it would be a youth-friendly – it's still institutional, but it's very youth-friendly with bright colours and very welcoming. I think we were successful in that and offer tours any time you might like to come and see that.

With the behavioural support team, again this is going to be a specialized team that will deal with professionals, support professionals who are dealing with children who have behavioural issues. We're currently having challenges with recruiting for the Ph.D. psychology position which is the lead for that team. That will also have two MSWs and a youth worker attached to that team. Those positions have been interviewed for and we're hoping to have – we're doing some recruiting out of Dalhousie, as well, for that psychology position.

The youth day treatment. This is refocusing of the original announcement to look at a step care approach. We believe that if we have strong community treatment and supports that we will need less beds ultimately. Really we don't want our youth – we don't want our adults either, unless it's completely necessary – in hospital. We, as much as possible, want to see people receiving what they need in the community. We're currently working on the youth day treatment program and that includes staffing and the development of the program itself.

Enhanced in-patient services and supports. With the adolescent unit in Unit 9 at the QEH, that service has traditionally been staffed by a nurse and then the staff of the unit were used as well. Now we have dedicated staff for the adolescent unit. Again, that includes a social worker, a .6 psychology position, and we'll be able to

offer some support to the pediatric unit as well who deal with younger children, children under 12 who have mental health issues.

Questions?

Chair: Thank you, Verna, for that very informative presentation.

I will open the floor for questions. I do have one person on the list so I will pass the floor over to James and begin my list.

Mr. Aylward: Thanks very much, Chair.

Verna, thanks for your presentation and Dr. Wedge, great to see you here as well.

I have a few questions sort of all over the map here so I'll just sort of tackle one at a time.

There's a committee that's responsible, it's an advisory or approval committee, for out-of-province treatment. As of late I've been hearing from individuals, constituents, that have been trying to access out-of-province treatment and they've been referred by their doctors or psychiatrist. In one case this individual, their employer is actually, through their health plan, is willing to pay for part of the treatment. This individual has gone through all of the programs available here. It's an alcohol issue, substance issue. This individual has been now waiting for close to a year to get approval to go off-Island. It's a very sad circumstance. She's a young mother of two small children. She has a very supportive home life with her husband, but yet just what's available here on PEI hasn't been enough for her to move forward.

I'm just wondering: Is there a way for this individual to advocate on her own to see if she can finally get off-Island for the necessary treatment that she requires?

Verna Ryan Director: I would encourage her – do you know if she's currently attached to one of the (Indistinct)?

Mr. Aylward: She has a (Indistinct) yes, she does.

Verna Ryan Director: Okay, so that would be the avenue to advocate for that service would be through the counsellor, and the counsellor can actually present to the out-of-province approval committee which meets on a monthly basis.

Mr. Aylward: It doesn't seem to have worked, again. She does have that counsellor and she's told me in two subsequent meetings that the counsellor has told her that they have advocated on her behalf, but still it just seems like it's hitting a brick wall for some reason.

Verna Ryan Director: There's so many factors involved in situations like that. I don't know that I can address that particular one, but we are reviewing the criteria for the out-of-province treatment.

We recognize that sometimes people need more specialized treatment, the same as they do in every other health condition. Sometimes as a small Island we just may not be able to offer the level of treatment that's required. I just would suggest here to see if the client could raise it through the counsellor and ask to go through to their supervisor and manager.

Mr. Aylward: Okay. Thank you.

Some of the stats that you show in here, the wait times, urgent versus semi-urgent. It's quite concerning, obviously, and I'm sure it is to you as well, that whether it's urgent or semi-urgent, the extended period of time that people are having to wait. There's a situation in Summerside, in particular, where they had a complement of four psychiatrists up until about I think maybe as much as two years ago. There was a Dr. Matt Sommons had left his practice in Summerside. Summerside is still at three versus the complement of four that they used to have.

Is there a particular reason why that fourth position has not been filled in Summerside? Has the allocation been moved to another part of PEI or has it been eliminated?

Verna Ryan Director: Not to my knowledge. I don't know if you want to address that one, Dr. Wedge?

Dr. Richard Wedge: Not to my knowledge either. I think there still is four. There is a number of staff from psychiatry who travel

to Summerside to provide child services while they're waiting for that one. But there are a couple of vacancies in psychiatry in the province which is part of the issue. Once you have full staff it's much easier to stabilize the location of services. But to my knowledge the four that were originally planned for Summerside are still on the books.

I'm just going to point out, too, on the wait times, those are the wait times that we collect from Health PEI in terms of wait to see a psychiatrist. They do seem to be long. The majority of referrals occur direct from physician to physician. They may see a family doctor or pediatrician or an internist and a get a referral directly to psychiatry. Those ones are not in here. These are the ones that they refer to community mental health and then they're triaged to see a psychiatrist.

Mr. Aylward: So we're keeping stats on how it takes an individual to see a psychiatrist. Are we maintaining stats on the number of annual overdoses and/or suicides here on PEI?

Dr. Richard Wedge: That's done through the coroner's office, so it's not really through Health PEI. But we do get those stats from them.

Mr. Aylward: I know back about two years ago I tried to obtain those stats from the coroner's office and they weren't forthcoming at that time, or the numbers that they were tracking didn't seem all inclusive.

Verna Ryan Director: I think the provincial chief health officer has responsibility for surveillance of those sorts of issues and need to report nationally. There are national statistics around suicide where it can be proven or evidenced. Those stats are available.

Mr. Aylward: I'll have to go back and look at that again.

Chair: They are available.

Mr. Aylward: Again, when Dr. Matters and Dr. Harper were with us before we talked about some of the announcements that took place in 2014 and, in particular, the in-patient beds for Charlottetown.

I'm wondering if you can share a little more information as to why that – from that announcement back in October 2014 and there was great celebration and announcement around these three particular announcements by government, but this one in particular, the 12 in-patient beds for the mental health unit, didn't materialize.

Verna Ryan Director: As we started to plan and explore that 12-bed unit, one of the first things we had to look at was location, but even more important than that was a need for – anytime you have a medical unit you need a physician to cover that unit as a medical in-patient unit. The availability of psychiatry also came into that. We had input into the process from psychiatry from the current – we looked at the current data in terms of the usage at the adolescent beds on Unit 9. Continued through that planning process, and ultimately we're working on those areas with that goal in mind. However, we could not secure a reasonable location that was within our budget and we could not, at that point, guarantee that we would have psychiatry services, which really led to the discussion about stepped care and looking at: Where do we really want to see our youth getting services? It really is in the community.

If someone is not well enough to be in school, where would they go? Do they go necessarily to the most intensive, expensive service that we have, which would be in-patient on the adolescent unit (Indistinct) Strength or is there a gap there where community-based services would better fill and meet the needs of the youth?

That's really where we went with that, realizing that there wasn't a mental health day treatment program in the province. With clinical advice that was really where the effort was seen to have the most benefit on a go-forward basis. I think when we have the day treatment program up and running that the impact that it has in terms of the demand for in-patient will really give us a better idea of the number of beds required if we do need more beds. It's really taking things back a notch and allowing the planning process and the data to accumulate before making that next big commitment.

Chair: I think we're just going to move, James, to Brad and then we'll come back to you so that everybody gets an opportunity.

Mr. Trivers: Thank you for your very detailed and comprehensive presentation. A lot of information to take in.

I had a question, looking at slide numbers four and number five, I was glad to see that Tier 1 does mention universal prevention in terms of the population tiers and need risk and interventions. But then on slide five, when you look at the services across the tiers of need, Tier 1 is absent, is missing, right? I see that as a problem because it doesn't look like there's any services that are focused on prevention, which in my mind is a really key area that needs to be addressed. Things like screening by teachers, coaches within sports, maybe church leaders, these sorts of things, Sunday school teachers.

I wanted you to comment on that: How come Tier 1 is missing on slide five?

Verna Ryan Director: Sure. On slide five these are the services offered by mental health and addiction through Health PEI, so we do not have a mandate per se for health promotion. Health promotion sits with the Department of Health and Wellness.

That being said, we certainly, in everything we do, try to promote health and wellness for our clientele as well as for the general public in our approach. But our services are focused through tiers 2 to 5, primarily. Where we see Tier 1 and Tier 2 it does happen with the work that we're doing in the primary care collaboration approach. It does happen in education and information sessions that we do with our colleagues. But mostly this would be the type of work that you would see coming out of Dr. Matters' work, but also the Wellness Strategy. There are a couple of focused areas in the PEI Wellness Strategy around moderate drinking and mental health there.

It's a great point because it helps to understand that we are in the treatment business in mental health and addictions per se. While health promotion is part of that in what we do, there are different levels of prevention and promotion. As I mentioned, it may be that someone has a condition and we don't want it to worsen, so that's why that block is not there.

Mr. Trivers: I see that as a fundamental problem that I'd like to learn more about myself and maybe talk about more in committee.

The second question I had, again, it focuses on this idea of youth versus children. I'm looking at slide six. We talk about community-based services that are available for children, and Bush clarified that: people up to age 16. But then when we look – first of all, youth seems to be absent in terms of community-based services. Can you comment on that?

Verna Ryan Director: Youth would be considered under children, I'm sorry, yeah. Youth would be considered grouped – it's just a wording, a matter of semantics there.

Mr. Trivers: Everybody up to age 16, youth and children are everybody up to age 16?

Verna Ryan Director: Actually, no. The definition – so in our Strength Program, for example, Strength offers services from 15 to 24. In community mental health that ranges as well. Depends on the definition of child and youth that is used. It may vary from program to program.

Mr. Trivers: I just would comment – I know when I talk to some teachers they're definitely dealing with elementary school aged children and they are concerned about the access to mental health services. I would comment that maybe we need to get more consistency with our definitions of youth versus children and make sure that children are not left out of the equation.

The same thing on slide seven. Again, we've got wait times for youth, but I mean, again, I have constituents who are teachers who talk about wait times for what are definitely children like under age 16.

I was wondering: Is that included in the youth on this slide again?

Verna Ryan Director: I'm sorry, you're on page –

Mr. Trivers: Slide seven.

Verna Ryan Director: Seven? Yes, that would include children as well.

Mr. Trivers: Okay, so that includes children.

Just one more question, Chair.

You mentioned that on slide nine you were talking about highlights of Health PEI initiatives. One of the things that was very important, although people sometimes trivialize it, was coming up and making sure you clarify the vision. I agree that that is important. The vision for service you came up with, is that what we heard in the long-term strategy in the previous presentation from the department of health where they talked about the mental health and addictions vision? All people living in Prince Edward Island will have equal opportunity to achieve and maintain the best possible mental health and well-being throughout their lifetime. Is that what you mean? Is that the –

Verna Ryan Director: That would be a shared vision, yes. The word I should have used is mission, what our mission statement is.

Mr. Trivers: Okay. What is mission statement? You knew I was going to ask that, right?

Verna Ryan Director: I don't have the actual statement right in front of me. The three main components are hope, health, and strength, and helping individuals to deal with mental health and addictions and their families to find hope, health and strength.

Mr. Trivers: Thank you, Chair.

Chair: Peter Bevan-Baker.

Dr. Bevan-Baker: Thank you, Chair.

As all of us around this table know, the health department is by far the biggest budget item provincially. It's important to me – I think one of our roles as legislators, is to make sure that we're getting value for money.

Could you tell us what the administrative costs of health care are on Prince Edward Island compared to other provinces?

Verna Ryan Director: I don't think (Indistinct).

Dr. Richard Wedge: Outside of mental health, you mean, just in general?

Dr. Bevan-Baker: No, in general overall.

Dr. Richard Wedge: In general, yeah. That is a lot of discussion in the media around this whole thing.

We use what's called CIHI, the Canadian Institute for Health Information, which has two definitions of health administration; one within the hospitals, one within health authorities. Within health authorities Health PEI is just over the national average, about point one, point two per cent over. So, it's around 4.3, 4.4. You could look it up, actually. Within hospitals we're just under, and that's about point one, point two under the thing. It's around 3.9, 3.8% of our budget is spent on administration. Now, after saying all that, the reason why we have such a variance out there compared to other places is that we have a single health authority on Prince Edward Island and we have centralized a lot of our things.

For example, procurement or human resources, financial analysts, all that kind of stuff, is all centralized. They're not within the hospitals, they're not within the primary care divisions where they don't exist in other provinces in terms of – they don't get recorded as administration that way. We, actually, are the only province who truly reports accurately our health administration costs.

Does that make any sense?

Dr. Bevan-Baker: Possibly. So you're suggesting, then, that the fact that, although you didn't it, that our administration costs are, on the surface, higher than other provinces, but we're not comparing apples with apples. Is that what you're saying?

Dr. Richard Wedge: What I'm saying is it's slightly higher but it's within point one or point two per cent higher, it's not three or four times higher as reported in the media.

CIHI, they actually did a fairly accurate description. There was a letter to the editor

of the *Guardian* last fall that explained it all much better.

Dr. Bevan-Baker: Could you tell us, Dr. Wedge, what the average salary of a general practitioner is on Prince Edward Island, a ball park figure?

Dr. Richard Wedge: Yeah, family docs under the Master Agreement, the salary, there are three tiers. But in general it's about 155,000 is a base salary. They get about 30,000 to 35,000 in incentive payments that most of them qualify for. Then there's about 20,000 to 22,000 in benefits in CME and that kind of thing. It's roughly 220, 225.

Dr. Bevan-Baker: I asked the question in the House about a psychiatrist who made substantially more than that, $1.3 million. I haven't had time to do the math in my head as to how many general practitioners that might buy. What I'm interested in is value for money.

Are there accountability mechanisms in place to ensure that we're getting value for money when we're paying doctors and that they're not frankly gaming the system?

Dr. Richard Wedge: There are. Throughout Health PEI we have an audit policy that pertains not just to physicians, but to procurement of goods and supplies, other professionals, work load measurements in terms of other staff within the system. But, yes, there is an audit policy that falls under physicians. When certain variances do occur it does trigger what we call value for money audit.

Dr. Bevan-Baker: Could you explain how they work, how an audit of a doctor might work?

Dr. Richard Wedge: Generally, the auditor will go into a physician's office. Usually there's prior notice to the physician. They'll randomly select the charts that were seen on randomly selected days. If a physician saw 30 people a day, for example, they might look through 100 charts that they randomly select three dates out of several months. Then there's some extrapolation that occurs to see whether – if there's, we'll say, aggressive billing or unusual billing patters or something that occurs. Then they extrapolate that over the billing period, and then some discussion occurs with the doctor.

To be honest with you, generally it turns out that they're just using the wrong codes and they fix the problems and repayments occur and that kind of stuff. It's very rare that it would proceed to garnisheeing wages or all those sorts of things because they generally are billing errors that are honest mistakes.

Dr. Bevan-Baker: I have had time to do the math and it would buy us between five and six family doctors. There's been a lot of talk recently in the media about patient wait times and access to family doctors. I have a request, actually, in with your department for a meeting to explain to me how the wait list works. But since you're here, can I ask you personally: How does the patient list work?

Dr. Richard Wedge: The patient registry, yeah. Just before I go on to that, just to clarify, the salary we talked about was for family doctors.

Dr. Bevan-Baker: Yeah.

Dr. Richard Wedge: Psychiatrists are specialists, they're paid at a different rate.

Dr. Bevan-Baker: Yes, but it's all part of the health care system. Absolutely, I understand the distinction.

Dr. Richard Wedge: In terms of the patient registry, that was put together about 10 or 12 years ago to try and provide some sort of regularity, standardization, to people who are moving into the province or moving from one place to the other within the province to be able to register, get a family doctor, rather than phoning all the different doctors' offices or showing up in emerg and trying to convince somebody to take them on. That was all put in place to do that.

Generally, it does work as long as the family doctors are taking on patients in a community. It comes to a slow when the complement is full and the physicians aren't taking on, it's very slow. But then somebody moves into a community, like, let's say, Alberton recently, then all of a sudden hundreds of people every month are coming off the list. So it moves very fast in those sorts of things.

The problem with the patient registry in the way we're doing it here in Prince Edward Island is that it's only as accurate as the day that somebody calls. If, for example, they go to a church event or something and they meet up with a family doctor and they say: I'm new to the community, can you take me on?, and they say yes, they don't necessarily call the patient registry and say: I found one so take me off the list. They may sit on there as being part of our number. But then we go to call them several months later and they say: I've already found one or something like that.

The other common problem that we have with the registry is people leave the province and they don't tell us. We think there are a number of people on the registry and they've already moved to Alberta or Ontario, or gone off to university, that sort of thing. It's not managed actively in that sort of way. If the flow was a lot faster, obviously, it would be much more accurate numbers.

Every couple of years we actually go through what we call a cleanup process. We call everybody and see whether they're still looking for a family doctor and then we clean up the list, but it's not done right away.

Does that make sense?

Chair: Before we continue, I guess I would urge your questions to be to the mental health field as opposed to general health care questions because we are very limited in time. If there is time at the end I'll allow you that option, but I think we need to stick very clearly to mental health and addiction today, just because Dr. Wedge is here and I know he's a great resource. We'll stay there.

Dr. Bevan-Baker: (Indistinct).

Chair: That's okay.

We'll go back to James, and anybody else who would like to have their name on the questions list please just indicate by showing a hand.

Mr. Aylward: Thank you, Chair.

I just want to go back to, again, the announcement that was made on October 3rd, 2014, with regards to the increase from four to 12 beds for an in-patient youth unit. Currently there's four beds in Unit 9, correct, that are dedicated towards youth or adolescent?

Verna Ryan Director: Yes.

Mr. Aylward: I know it's happened in the past, I just want to know if it's still happening. Are young persons, adolescents or youth, still being housed in the pediatric unit because the four beds in Unit 9 are occupied?

Verna Ryan Director: That does happen sometimes, yes.

Mr. Aylward: How frequently does that happen?

Verna Ryan Director: The pediatrics unit would usually keep anyone that's under the age of 12. Okay? It happens – I don't have the numbers on that – on occasion. It's not frequent, but it's not unusual. As I just mentioned, we're just coming probably over the last two, three months during a period where our numbers were lower for the adolescents. We on average had three beds full so that hasn't been an issue. In the fall I know there were a couple of situations where there were two adolescents on pediatrics at one time, but it's quite episodic.

Mr. Aylward: Okay.

Dr. Richard Wedge: The other thing, too, with that is that not all – the pediatric mental health patients could be admitted to pediatrics for physical medicine reasons rather than for mental health reasons, but they need ongoing treatment as part of their physical treatment for asthma and those sorts of things. They do, actually, occur and staff go back and forth to try and help them as needed.

Mr. Aylward: I guess the reason it was brought to my attention is just dealing with some families and issues that they were experiencing in trying to navigate the system. They were quite concerned that – in one case their adolescent (Indistinct) was housed. I hate to use the word housed, but admitted to the pediatric unit when they had a severe mental health issue. They had restraints applied in a bed in the pediatric

unit and it just – I'm very concerned as well for the younger, the pediatric patients. I know they're not going into the room and those kind of things, but it's just – let's face it, it's not proper and it shouldn't be done.

So if we need to ensure that we have more in-patient youth beds in our system – and the government announced it in October of 2014. I'm assuming the government did a study on this before they would have done an announcement, so let's make this happen.

Which brings me to next question, where we're at with the Hillsborough Hospital. We all know the Hillsborough Hospital is one of the oldest health care facilities here currently on PEI. I've been called out there before when the elevator hasn't worked. I've met with the director of the facility and he's explained that the reason the elevator was down for an extended period of time is the equipment is obsolete. They have to actually have a machinist make new parts for the elevator and things like that, but that's just a small instance.

What's your current view or your current take on the Hillsborough Hospital and what should be done?

Verna Ryan Director: Can I just go back to the pediatric –

Mr. Aylward: Certainly.

Verna Ryan Director: – issue just for a moment?

Mr. Aylward: Yeah.

Verna Ryan Director: Because I don't want the impression being left that mental health patients are always violent and other people are at risk from them.

It's very appropriate to have children in a pediatric unit who have mental health issues, very appropriate. There may be occasion where constant cares are used, but I really do not want that impression left on the table, so just to clarify.

In terms of the Hillsborough Hospital, I don't know, Dr. Wedge, if you'd like to address that or (Indistinct).

Dr. Richard Wedge: Certainly from Health PEI's point of view it is a concern. It is a functioning facility and it does do very good work in terms of treating patients and the patient flow as part of our system. It's not, as you know, probably designed for modern day mental health care necessarily, same as hospitals change their designs on a regular basis, so we are waiting for some signal from government.

They do have a five-year capital plan, and in that five-year capital plan there is a bit of money set aside in a few years' time to do some planning around a replacement of the facility. Hopefully things will move through the system, but it's really a government initiative from our point of view.

Mr. Aylward: Okay, thank you.

Chair, I just have one last question.

Chair: Go ahead.

Mr. Aylward: Thank you.

Again, it comes back to I guess substance abuse. In particular I'm curious: Are there stats kept on how many newborns here in PEI are being delivered to mothers that have a substance abuse issue? It's a very unfortunate situation, obviously, and then the baby is coming into the world with a substance harm already. I'm just wondering where we're at on those numbers, if we keep stats and –

Verna Ryan Director: Yeah, we absolutely (Indistinct)

Mr. Aylward: – are they increasing, decreasing, staying stat?

Verna Ryan Director: I don't have the numbers on the top of my head, but the unit at QEH tracks those numbers for sure. We're currently in the middle of a project, working with the maternity ward there, around this very topic. Neonatal abstinence syndrome is what it's called. Through some federal funding through the drug treatment funding program we identified this as a priority area to do some work with service providers but also with young moms who are using.

Part of it is education. There is a notion in the community that it is safe for young moms to – their own notion – that it's safe for them to use marijuana when they're expecting to reduce the nausea, and that they're coming into hospital actually saying that. So there's some work to do in terms of educating them. We're partnering with public health, the hospital itself, and addictions and mental health to forward that project.

Chair: Go ahead.

Mr. Aylward: I promise.

Unidentified Voice: (Indistinct).

Mr. Aylward: I'm very happy to hear about the progress that's been made, particularly with the methadone program and what's being done there right out in our community, but I know previously when there was an extensive wait time to get onto the methadone program, I not only heard of but I know of specific examples where a young lady who may have an opiate addiction would actually purposely become pregnant so that they would be bumped up on the list for the methadone program. Again, that's something that I think that we should be keeping an eye on.

Verna Ryan Director: Actually, that strikes me as unusual because we have no waiting list for our methadone program.

Mr. Aylward: No, but I'm saying back previously that –

Verna Ryan Director: Okay.

Mr. Aylward: – that was a concern, and I just caution the health care professionals to keep an eye on that as well. Because the last thing we want are –

Chair: (Indistinct) do that.

Verna Ryan Director: Yeah. I think I would say that that situation's been rectified, hopefully. Again, with the availability through the private clinic as well as PATF and Summerside.

Mr. Aylward: Thank you.

Verna Ryan Director: (Indistinct) not an issue I'm hearing about, but thank you.

Chair: Okay, anybody else have any questions?

I just have a couple of comments or questions, Verna, if you don't mind.

Verna Ryan Director: Of course.

Chair: One of the things that's been brought to my attention in the last I'm going to say week to 10 days is the youth addictions facility in Summerside is not being used to its full capacity, that some of the shift is back to Charlottetown. Are you using that facility to its full capacity?

Verna Ryan Director: Yes, absolutely. As Dr. Matters referred to, we have continuous intake there which means there used to be two-week waiting period and there was an intake every two weeks so people had to wait that time period. We don't have that now. We've been operating at probably 75 to 90% capacity there on a regular basis. We've serviced – since last April there have been 50 youth who've come through that program and moved on to aftercare in the community both in Summerside and Charlottetown.

Chair: Do you have an option as to where you receive the services –

Verna Ryan Director: The in-patient?

Chair: – (Indistinct) – yeah, in-patient.

Verna Ryan Director: No. We do have patients who move between PATF and Strength. If they're in that younger up to 24, they may be more appropriately served at Strength depending on their needs. They've got that Charlottetown versus Summerside option, but there's just one youth facility, in-patient, in the province.

Chair: Which is in Summerside.

Verna Ryan Director: Yes.

Chair: Okay. Because there was just –

Mr. Aylward: (Indistinct).

Chair: Yeah.

Dr. Richard Wedge: So the part of the building, though, Madam Chair, that's not being used as a youth justice portion is declined. It is certainly –

Chair: Oh no, I realize that.

Dr. Richard Wedge: – less busy than it was because the judges now have the option to require them to go to a Strength Program rather than putting them in young offenders.

Chair: Which is great. Okay, this leads me to my next question. In your opinion, do you think that bringing in therapeutic courts in Prince Edward Island would be helpful to the issue around mental health and addictions treatment and issues in Prince Edward Island?

Verna Ryan Director: Quite possibly. I think our justice system currently has quite a leaning towards supporting those who are dealing with addictions and mental health issues. There's a strong component there.

There's also the criminal review board or the Criminal Code Review Board that's been in existence whereby those that are found not criminally responsible for their crimes are monitored under the Criminal Code Review Board. We've seen an increase in those numbers, a significant increase over the last 10 years, probably 100% increase, where we used to have one or two people under that review, and now it's in the range of 15.

We work closely as well with corrections, so you see addiction workers and probation officers working very closely together. Now, would that improve if there was a formalized court procedure around that? It may, but it would require some investment. There's definitely potential there.

Chair: My last question is also just your opinion. From your view, do you feel that the changes that have happened in mental health overall are happening quickly enough?

Verna Ryan Director: From an operational perspective and having to –

Chair: No.

Verna Ryan Director: – implement?

Chair: No, in the best interest of Islanders.

Verna Ryan Director: I think that there has been a long period of time where investments haven't happened in mental health and addictions and that we have some catching up to do. I think the recent investments are usually positive and I think they're having an impact. The investments started really more on the addictions side and we're seeing marked improvements there.

I think now we're really looking more with folks on mental health and we're going to see more improvements there as well. I see that coming along really well.

Chair: Thank you.

Anyone else?

Mr. Trivers: I have a question for you. Are we going to get electronic versions of the different documents we received today?

Chair: We can get them for you, yes.

Mr. Trivers: Thank you.

Chair: All right. Without further adieu I'd like to say thank you very much for coming in and bringing your presentations and allowing us to ask some very pointed questions about the services and the work that you do. But we do recognize it as invaluable to the quality of life for all Islanders.

On behalf of all of my committee, I say thank you very much for what you do and for being here.

Verna Ryan Director: Thank you for your time and attention, and I really appreciate it.

Chair: Committee members, I guess we'll just carry on here with the next things on our agenda.

Item number 4 is a discussion of the request from MLA James Aylward regarding the College of Physicians and Surgeons on Prince Edward Island.

As you saw there was a letter came out and I will read it for the public record. It's

addressed to me, Janice Sherry, the Chair of the standing committee:

"Dear Chair,

"As a member of the Legislative Committee on Health and Wellness, I am writing to request that our committee bring forth representatives of the College of Physicians and Surgeons on Prince Edward Island to update our committee on their roles and responsibilities under the PEI Medical Act.

"Thank you for your consideration on this matter.

"Sincerely yours,

"James Aylward, MLA
Stratford-Kinlock"

I guess the question is on the table: Are we interested in bringing in people from the College of Physicians and Surgeons?

Some Hon. Members: Sure.

Chair: Okay. Do you want them before the House opens or is it (Indistinct) –

Mr. Aylward: Preferably, I would like, Chair, to have them appear before.

Chair: Well, we can make an effort.

Mr. Aylward: Okay.

Chair: Emily, if you can do that that would be great.

Mr. Aylward: Chair, I did have one other thing I just wanted to bring up under new business just quickly.

Chair: Sure.

Mr. Aylward: I know that there was a lot of –

Chair: Just a second, just wait until we finish number 4.

Mr. Aylward: Oh, sorry. Okay.

Chair: I just want to make it known for the record that that was unanimous to bring representatives in from the College of Physicians and Surgeons, and we'll close that piece of business off.

You have something under new business, James? The floor is yours.

Mr. Aylward: From the discussion today there were a number of committee members brought up the concern or the discussion around what's happening currently with fentanyl and with crystal meth.

I would like to propose that we schedule someone from the RCMP drug unit possibly to come in and give us a lay of the land of what they're seeing out there now. It could be joint with –

Ms. Casey: Charlottetown City Police.

Mr. Aylward: – exactly, one of the municipal police forces as well.

Chair: I think there's actually a special committee, is there not, that looks at that? Might want to look into that through justice. I believe there's a special committee around – there's a number of people on in regards to drugs and crime. Maybe if we can do some research we'll get the right people representing this.

Mr. Aylward: Yeah, sure.

Mr. Dumville: Good idea.

Chair: Good. Anything else anyone has?

If somebody wants to move to adjourn.

Ms. Casey: So moved.

The Committee adjourned