EXCERPT OF VERBATIM NOTES OF THE FIFTEENTH MEETING OF THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION, HELD IN THE ARNOLD THOMASOS ROOM (EAST), LEVEL 6, (IN CAMERA) AND THE J. HAMILTON MAURICE ROOM (MEZZANINE FLOOR) (IN PUBLIC), OFFICE OF THE PARLIAMENT, TOWER D, THE PORT OF SPAIN INTERNATIONAL WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON WEDNESDAY, JUNE 07, 2017 AT 9.45 A.M.

PRESENT

Dr. Dhanayshar Mahabir	Chairman
Brig. Gen. Ancil Antoine	Member
Miss Ayanna Lewis	Member
Miss Khadijah Ameen	Member
Mrs. Glenda Jennings-Smith	Member
Mr. Julien Ogilvie	Secretary
Miss Kimberly Mitchell	Assistant Secretary
Miss Vahini Jainarine	Legal Officer I

ABSENT

Mr. Esmond Forde	Vice-Chairman [*Excused*]
Mrs. Christine Newallo-Hosein	Member [*Excused*]
Mr. Rohan Sinanan	Member

10.33 a.m.: *Meeting resumed.*

TRINIDAD AND TOBAGO REGISTERED NURSES ASSOCIATION

Mr. Idi Stuart	President
Ms. Letitia D. Cox	Social Marketing Officer

Mr. Walt Murphy	Mental Health Officer

LIFELINE

Dr. Lucretia Gabriel, PhD	Chairperson

TRINIDAD AND TOBAGO NURSING COUNCIL

Mr. David Murphy	President

TRINIDAD AND TOBAGO ASSOCIATION OF PSYCHOLOGISTS

Dr. Khatija Khan, PhD	Coordinator, MSc Clinical Psychology Programme/ Lecturer in Clinical Psychology

Mr. Chairman: Good morning. Welcome to this the Fifteenth Meeting of the Joint Select Committee on Social Services and Public Administration.

This morning we have with us representatives of the Trinidad and Tobago Registered Nurses Association, a representative from Lifeline, the Nursing Council of Trinidad and Tobago and the Trinidad and Tobago Association of Psychologists.

This is the Fifteenth Meeting and it is our second public hearing, pursuant to our enquiry into the state of mental health services and facilities in Trinidad and Tobago.

On our prior public hearing we engaged the Ministry of Health, the Chief Medical Officer at the St. Ann's Hospital, other officials responsible for mental health in the public sector, and today we are looking at mental health from a different perspective, a perspective of stakeholders outside the medical profession who are actively engaged in treating individuals who are experiencing a mental health problem.

At this time I would like to welcome the officials who are here with us, but also all of our viewers, faithful viewers on the Parliament Channel and those who are interacting with us on social media. There is the YouTube channel, *ParlView* that we also broadcasting. And we invite, in the interest of democracy, individuals

who are not before us but who have a vested interest and who have solutions that they would like to offer to the Committee, to send to us their own solutions during the course of this hearing, their own solutions to some of the problems that the Committee is addressing.

There are really four objectives of this enquiry. The first, to determine the prevalence of mental illness in Trinidad and Tobago. We needed to emphasize that because in the public domain we are very much aware of illnesses other than mental, be it HIV, STDs, cardiovascular, hypertension, diabetes. We are familiar with the incidence and the prevalence of those, but the issue of mental health is something, from the perspective of the Committee, remained underexplored, and it is the objective for us to understand what really is the prevalence of this particular ailment in the Republic of Trinidad and Tobago.

With that understanding, we are then interested in assessing the adequacy of services and facilities available to support mental health and well-being amongst the population. And, three, to determine the adequacy of the existing cadre of medical practitioners who specialize in mental health, and other practitioners as well, who may not be members of the Medical Board of Trinidad and Tobago, but we understand that the issue of mental health is broad, and that there may be other practitioners outside the medical field who are contributing in a significant way towards the mental health treatments in the Trinidad and Tobago.

Finally, since we are the Parliament, we are always interested in assessing the adequacy of the legislative framework, the laws governing mental health. We wish to determine from the perspective of practitioners whether these laws need to be amended, if so how, why and that then forms an important component of the work of the Committee.

We did observe some issues with the Mental Health Act from the perspective of the Ministry of Health officials, medical doctors of the Ministry of Health on the

last occasion. So we would seek to solicit from you what are some of your concerns, if any, with respect to the legislation which governs how you conduct your professional activities.

At this time I will ask the representatives who are with us to introduce themselves, and then I will ask for brief openings remarks, once all the introductions are made. May I start with Ms. Cox, the Social Marketing Officer.

Ms. Cox: Good morning, Chair, Dr. Mahabir. My name is Letitia Cox. I am by profession a registered mental nurse. I am the Social Marketing Officer of the Trinidad and Tobago Registered Nurses Association.

Mr. Chairman: Could you repeat that. You are a mental health nurse.

Ms. Cox: Registered mental nurse.

Mr. Chairman: Very well, thank you very much.

Ms. Cox: I am also the Social Marketing Officer of the Association and the Chair of the northern branch of the Association. It is indeed a privilege to be here, because I am actually an activist for mental health, and TTRNA has an awesome role. We are both interested in the rights of patients and the rights of nurses.

Mr. Chairman: I will ask you subsequently for that brief opening, but I would like all members to introduce themselves with respect to their organizations and their professional background, and then I will ask members to give us a brief opening remark before we start the questioning. Thank you. Anyone else who could introduce themselves. It does not have to be in any order, but introduce yourselves. Yes, colleague on my left.

Mr. W. Murphy: My name is Walt Murphy. By profession, I am a mental health officer of 32 years. I am in the mental health profession.

Mr. Chairman: A mental health officer. What does a mental health officer do?

Mr. W. Murphy: A variety of jobs.

Mr. Chairman: Very well, you will tell us what.

Mr. Stuart: Good morning, my name is Idi Stuart, the new President of Trinidad and Tobago Registered Nurses Association, a registered mental nurse also, but left that field about two years ago, spent 10 years in mental health.

Dr. Khan: Good morning, I am Dr. Khatija Khan. I am the President of the Trinidad and Tobago Association of Psychologists. I am a neuropsychologist by profession, and my full-time job is as a lecturer in clinical psychology in the Faculty of Medical Sciences at UWI, where I coordinate the clinical psychology programme as well. I am also a member of the North West Regional Health Authority, Regional Mental Health Committee.

Mr. D. Murphy: Good morning, Chair and members of the Committee. I am David Murphy, the younger brother of Walt Murphy. I represent today the Nursing Council of Trinidad and Tobago as its President. I have also been in mental health for the last 32 years, and subsequent to this I will share the rest. It is my pleasure to be here.

Dr. Gabriel: Good morning, Dr. Mahabir, good morning members of this select committee. My name is Lucretia Gabriel. Yes I have a PhD, but not in psychology or medicine. I am an analytical chemist. I am the Chairperson of Lifeline. It seems that my sins have caught up with me, because I have been associated with Lifeline for 40 years. We befriend the despairing and the suicidal.

Mr. Chairman: Very well, thank you very much. Before I proceed to ask the doctor to make a few opening remarks, I would also ask members of the Committee on Social Services and Public Administration to introduce themselves.

[*Introductions made*]

Mr. Chairman: And I who have been talking all the time without introducing myself, I am Independent Senator, Dhanayshar Mahabir, Chairman of the Committee. I will now proceed to ask, starting with Mr. W. Murphy, Mental Health Officer, to start with a brief opening remark of what you do and what are the perspectives you are bringing to the investigations that we are undertaking.

Mr. W. Murphy: I am here as part of the TTRNA delegation. I am bringing to bear my vast experience in the area of mental health. A mental health officer, so that it could be better understood, is the equivalent of the DHV, which is the brownie nurse in the general nursing sense. The mental health officer is that equivalent in the mental health field.

Mr. Chairman: Very well.

Mr. W. Murphy: My role involves—well I am generally counselling clients and their relatives on mental health issues. I am doing lectures in schools and other public interest places, inclusive of churches and any other entity that is interested in the aspect of mental health.

Mr. Chairman: Just for clarification, your profession really allows you to deal with the mentally ill patient on a day-to-day basis?

Mr. W. Murphy: Yes.

Mr. Chairman: Very well, thank you. Could I ask Ms. Cox, before I interrupted her.

Ms. Cox: Thank you, Dr. Mahabir. Yes, as I was saying, I am a registered mental nurse, and I was saying that TTRNA has an awesome responsibility, in that, as an association we not only look after the rights of nurses, we also talk about and engage discussions about the quality of care that is dispensed.

I am also intimately involved with the day-to-day care of the mentally challenged, or those persons who have mental health challenges. I am au courant with all the difficulties, the challenges that are in the mental hospital, as well as, in some part, the community.

So I see myself as an activist, and I see this forum as a very wonderful and positive step in the right direction, and I am here to actually put forward solutions in the area of the nurse practitioner.

Mr. Chairman: Very well, thank you very much. One question, since I am not

familiar with the field at all, is it that the training for mental health nurses in Trinidad and Tobago is complete, and you can, if you wish to become a mental health nurse, undertake all training within Trinidad and Tobago?

I am talking about the training for someone with your specialty. Is there training within Trinidad and Tobago to provide full certification for you to be become a mental health nurse?

Ms. Cox: Yes, however, it is limited in that this is a specialty area. It is not considered a specialty area here locally. This is actually an area of a nurse practitioner. It is something usually internationally you would start off as a registered general trained nurse and then specialize in mental health care.

Mr. Chairman: To get it clearly, there is training available in Trinidad and Tobago?

Ms. Cox: Yes, there is training available at two schools.

Mr. Chairman: For a registered nurse who wishes to specialize in your field?

Ms. Cox: Yes, there is.

Mr. Chairman: Very well, thank you very much. May I move on to your colleague.

Mr. Stuart: Once again it is a pleasure to be in here. As President of the TTRNA we have been representing nurses over 87 years of the organization. But recently we attained union status in the last two years, 2014, so we are attempting to pick up that arm of negotiating and settling disputes of our nursing personnel. There are a lot of issues, I hope we have the opportunity to ventilate them here today. I will be focusing more on the policy side of what the Ministry of Health, the Ministry of Education—who is a big stakeholder in this and also what the Parliament, through the review of the laws, could do to treat with some of these shortfalls in nursing and health care on our own.

Dr. Khan: On behalf of the Association of Psychologists, we would like to say thank you very much for this opportunity to contribute to the discussions.

Our Association was incorporated by an Act of Parliament in 2000, so we are

the representative body for psychologists in the country. Our members of psychologists work in all sectors in the public and private sector and in my different fields as well, in health, education, social services. We deal with a variety of populations of mental health, spanning the whole age range. So with our combined membership we do have a lot of, I think, field experience, but also and personally as an academic, as a researcher and clinician, we also have contributions to make with respect to research and policy and advocacy for mental health. So we do look forward to the rest of these discussions today.

Mr. Chairman: Thank you. Mr. Murphy.

Mr. D. Murphy: The Nursing Council of Trinidad and Tobago is the regulatory body for both nursing and midwifery. [*Inaudible*] We provide licensure and give permission for—

Mr. Chairman: Please activate your mike. Could you repeat for the record what you said prior.

Mr. D. Murphy: The Nursing Council is the regulatory body for the practice of nursing and midwifery in Trinidad and Tobago. We not only register and license persons trained locally, but those who are trained in the region who desire to work in Trinidad and Tobago, and those who are also trained internationally to work here. We regulate the profession by setting standards, and in today's context, I am here yes as the President of the Nursing Council, but I will also use my other role as the Principal of the Psychiatric Nursing School, so issues of curriculum, discussion and so on I am sure I can make a meaningful contribution.

Mr. Chairman: Thank you very much.

Dr. Gabriel: Thank you. Unlike my colleagues, I am not trained in psychology or medicine.

Mr. Chairman: You are trained in chemistry, yes.

Dr. Gabriel: Yes, and if I treated you, you would die for sure because my specialty

is the analysis of pesticides. Lifeline really operates on the basis that ordinary people can do extraordinary things, and one of them is to listen rather than hear, and by listening and meeting those who feel that nobody would listen to them, nobody would understand, and therefore they will kill themselves, we help to save lives.

Lifeline is basically, I would say crazy, because in 1976, 10 of us got together and decided we would like to start such an organization. We realized that the great system that we had in the Caribbean and in Trinidad and Tobago was in danger—that is, the family or families have generally taken care of those things. But all of us were on it and realized this was breaking down.

We talked to an equally mad person in May 1977, who was Chad Varah who started the Samaritans in England in 1953. We expected him to say you are crazy, you cannot start a telephone helpline when you live in a country that has a moratorium on new phones. He said no, he said start with whatever you have and do whatever you can. We did. We got a new phone. We started listening in June 1978 and we got a new phone in June 1985, and we have been doing that kind of thing ever since.

I would say that in terms of what my other people at the table do, we refer to them as consultants, but it is the equivalent in their terms of if you have a road accident and you are badly injured, we know enough not to move you. We will be the people who will come and visit you in hospital. We will listen to you at all hours of the day and night, but we are not the doctor to do the orthopaedic work. That is what we do.

10.50 a.m.

Mr. Chairman: Thank you very much. And I would like, as usual with leave of the Committee, of course, I always like to open the questioning by a first preliminary question and that is, in our discussions with the Ministry of Health on the last occasion we were informed that the mental health and wellbeing of

children in Trinidad and Tobago is not perhaps what it should be. We know that the adolescent period, the ages between the teenage years can be very, very difficult and traumatic for children. Could you advise me and, by extension, the rest of the country, what are the facilities which are currently available for treating with children who are experiencing traumas of all types, mental difficulties and who are finding it difficult to cope with the challenges of growing up either in the school, in the home or in the communities? What are the facilities that are available to assist our young children who may be the victims of bullying, incest, sexual abuse, a number of issues affecting children? Are the facilities available? If they are not, what would you recommend? And the floor is open to any one of the representatives who are with us today, from your experience, if you can speak from your experience with treating with children?

Dr. Khan: So, I also work at the Eric Williams Medical Sciences Complex at Mount Hope, and I would say that services, and we have put it in our written comments to the this Committee, there is a glaring lack of child and adolescence mental health services across the country. Medically, if there is a medical problem with the child, so if we have a child who has sustained an injury or if they are suicidal, then they could be admitted into hospital, but, past that, there is very little that is available.

Also, the cut off for adolescence is 16 years, so after age 16 they are treated as adults, but you cannot put a 17 year old on an adult ward, they have needs that are still pertinent to their developmental age. So with respect to psychological counselling services there is very little that is available.

The programme that I coordinate which is the masters in clinical psychology, unfortunately, does not have a component to train psychologists for child therapy. So, we always advise our trainees that if you go out and when you

get employed you need to receive further training and further supervision for that. That, unfortunately, is not done to the standard that we expect. So I think there are insufficiently trained people who do deliver child therapy.

The services that are currently available at the two child guidance clinics, so that is on Pembroke Street and at Pleasantville in San Fernando is part of the SWRHA, I think, have a long waiting time. So there is, at least, a minimum six months waiting period and that is due to demand, the demand thus far exceeds the resources that they have available. And they also, to the best of our knowledge, deliver more assessment-related services. So again, with respect to therapy, with respect to counselling I would say I am at pains to think about where a child in need can get those services in the public sector.

Mr. Chairman: Right. One of our first doctors, one of our first enquiry was with respect to school violence and bullying and it was revealed to us that the Ministry of Education does have the social workers, the school guidance counsellors who are supposed to be visiting the schools. Do you think that if these social workers and school guidance counsellors are given some kind of training from your unit, for example, to simply identify children who are at-risk that that, in fact, may be the first stage of identifying the children who ordinarily will fall through the cracks?

Dr. Khan: I think, yes, in part. One, I think they are doing, they are collecting data on children at-risk. So, for example, at the recent PAHO suicide prevention panel it was revealed that there are currently over 400 students on suicide watch across our primary and secondary schools. So, we already have an idea of how critical the problem is, but then as to what is happening to these children, what treatment are they receiving, what intervention, what follow up and monitoring, I think, that is where we fall short. So, I agree with you, yes, definitely we need

to be able to detect, to flag these kids and get them the help they need.

With respect to the training definitely. For a guidance counsellor, you do not require these specialized. You can become a guidance counsellor with a bachelor's degree in psychology, so it is not a specialized training to deliver services. So certainly, I think, we can augment the training of guidance counsellors and social workers for the already fantastic work that they are doing, but we definitely need to increase that because, as we are seeing, the problem is great. So suicide is a public health crisis in the country and it is extending to our very young and our very vulnerable students as well.

Mr. Chairman: Okay. And further question, as a fellow academic, we always work with numbers.

Dr. Khan: Yes.

Mr. Chairman: If the school age population, the children writing the SEA exams amount to some 18,000 students, what percentage of those students do you think experience some kind of mental issue or mental trauma in their teenage years? So we are taking a cohort, 18,000 writing the SEA exam, they are going to spend five years in secondary, out of the 18,000 how many of them, from your research, do you think will experience a trauma which requires some treatment?

Dr. Khan: I do not currently have any study or data that I can refer to, tangible data, but if I were to estimate I think the stressful nature of the SEA exam and the current nature of schooling in Trinidad where people feel if you do not pass for a certain school your academic trajectory is dismal, puts a lot of pressure on children and parents. So, I think, certainly for children if we just go at a modest—we are talking about those, I think everyone experiences stress, but in terms of those who go on to have a level that where it becomes dysfunctional and they are incapable of coping, I do not want to speculate, but I would say it is very

significant and worthy of looking at.

Mr. Chairman: Because it was revealed on the last occasion that 20 per cent of the population, the adult population, is statistically expected to suffer some form of mental issue or another, and I was wondering whether the percentage amounts, the child cohort, the teenage cohort was higher or lower. That would be valuable information as to whether, in fact, the children population is in keeping with the overall population or whether there are certain child specific issues that will make children more at-risk maybe 25 per cent of them, 30 per cent to them, that kind of information will certainly inform public policy.

Dr. Khan: I think it is definitely not going to be less. So, yes, that 20 to 25 figure is the figure that is bandied about, and I would also say that children who have mental health issues if they are unresolved and untreated go onto become adults with mental health issues. So as to the point you are raising as to the role of the SEA exam in contributing, I think that is also a valid argument and needs to be held.

Mr. Chairman: I am not really casting aspersions on the SEA, I am simply taking them because I know the numbers of students writing the SEA are around 18,000, and basically on a longitudinal study I would like to track them from primary school to high school until they finish Form 5 and see over that five-year period how did 18,000 fare. How many of them cope; how many of them dropped out; and how many of them suffered mental ailments, but I am sure that will inform your research agenda in your unit.

Dr. Khan: I was just going to say, Chair, that sounds like a great study proposal.

Mr. Chairman: Thank you. It is the old academic in me coming out looking at opportunities. Sen. Ayanna Lewis would like to come, through the Chair has many more questions, but Sen. Ayanna Lewis wants to come in. So, Senator, yes.

Miss Lewis: Small comment and question to Dr. Khan. You mentioned 400 students are under suicidal watch. I want to find out in terms of age group of the 400, what is the breakdown?

Dr. Khan: I do not have that specific data because when I found out from the social workers' data we also wanted to get. I did however, ask and the age, the lower age limit was as young as seven. So, of course, I expect that it is going to span the whole age group of primary and secondary school, but we are looking at very young children as well.

Mr. Chairman: Very well. And Sen. Ameen would like to come in now.

Miss Ameen: I have a question, but just as a follow up to this discussion. Are you, Dr. Khan, in a position to recommend to be included in the studies at UWI specific for children for your speciality programme?

Dr. Khan: To include training for children?

Miss Ameen: Well, training to deal with psychological problems.

Dr. Khan: Yes. Yes. There is a gap that we recognize, but I will tell you frankly, this programme is actually we are not accepting an intake come September, and it is largely because of financial reasons. So I think it comes down to that, that is the "brass tax" that right now we cannot afford to run the programme. The programme is in heavy demand. There is no shortage of persons who want to come into the programme and not just for Trinidad, but the Caribbean region as well, but, unfortunately, at this point we have had to put a stop to it.

And yes, we are in a position, while the programme is being stopped what we are going to do is to go back to the books, look at how we can improve it and that has always been identified as a gap. And yes we do, we can access the resources should it come on board again to include that component for child therapy, child assessment, looking at specifically mental illness in children.

Miss Ameen: Mr. Chairman, if I may, my own question well it would go to Dr. Khan because it comes out of the submission made by the Trinidad and Tobago Association of Psychologists and it has to do with whether the association has embarked on any initiative or programme to create awareness among the public about the prevalence of mental health in our society and the importance of mental health assessments, and also if any programme has in terms of reducing the stigma surrounding mental illness?

Dr. Khan: So, we do a number of things. So, first of all, the association is voluntary for psychologists. We are currently working on establishing a registration and licensure. So, as such, we are a voluntary body, all of us who sit on the executive are voluntary members as well, so we try to do the best with the resources and personnel we have. Every year we embark on a series of activities. One of the things on our calendar which is always very popular is during psychology awareness week which coincides with World Mental Health day in October, we do public conferences, and for the past two years they have been hosted at the UWI and we cover a number of topics. So whether it is parenting, whether it is Asperger syndrome, Alzheimer disease, last year I did two topics on depression and anxiety. So we continue every year to have these talks and, as I said, they are very popular. One interesting thing we noted was the years that we have the talks free to the public, they are less well attended than when we charge a nominal cost. So, we have taken that into consideration for our future.

What we also do is we have also had—we also do outreach. So wherever we are invited, we go. So we participated this year—the Trinidad and Tobago Group of Professional Associations had professional services day and every year they go to different parts of the country. So two years ago it was in Debe, last year was in Arima, this year was both in Arima and Sangre Grande. So, we also

give out brochures, we do consultations with members of the public. I also do a lot of invited talks. So, for example, I delivered the technical talk for the Ministry of Health's public campaign for World Health Day because depression was the theme. So, I have been giving a lot of talks on depression, this year just trying to emphasize to break down some of these stigma, to start the conversation more. It is one of the things that we have been—

Mr. Chairman: Very well. I will put a—the stigma issue has to be addressed and we will come back to it over and over again. But I would like to bring in Brig. Ancil Antoine at this time.

Brig. Gen. Antoine: Just a correction with Dr. Khan. The Professional Services Day took place in Sangre Grande and D'Abadie/O'Meara, my constituency.

Mr. Chairman: Okay. Very well.

Dr. Khan: My apologies, and the correction is noted. Thank you very much.

Mr. Chairman: Very well. Thank you. But I do wish to bring in the nurse practitioners here, and we will move on from children to adults. But I want to find out from the nurse practitioners, the mental health practitioners, what, how do you treat a child who is experiencing a mental ailment which requires institutional care? Do we have facilities in Trinidad for that or is it that you place them in a general hospital and you treat them separately?

Mr. Stuart: Through you, Chair, before I hand over to Mr. Walt Murphy to give more of the specifics, may I just give a little background. Children with mental illness used to be admitted at St. Ann's Hospital. Following the Children's Health Authority Act and passage and the whole roll out of that it has resolved one problem and created a different problem. So that no longer the mentally—children with mental disorders are placed in St. Ann's Hospital because that issue was—there were no wards specific for children. The two children's wards

actually housed subnormal patients with sub-normalities which really, in a true sense, they were no longer children, they were 18, 19, 20 and they were still housed in the institution, so they were no longer children. So there were really no wards for children. So with the whole passage of the Children's Health Authority Bill, they were removed from the institution, but now they are no longer in the institutions where you have mental health nurses or—

Mr. Chairman: Okay. So the question is: Where are they placed at this time?

Mr. Stuart: At normal children homes for children.

Mr. Chairman: And is there a recommendation from the nurse practitioners, the professionals who deal with the problems on a day-to-day basis that there should be consideration for having a separate unit somewhere in some hospital dealing with children with mental illnesses? Do you think that there is a sufficient number of children to justify such a public policy position?—a ward in a hospital such as the Mount Hope. We do have Dr. Khan working at the Mount Hope unit, but do you think there is a ward where we could provide the dedicated services so that we could treat more efficiently children who are experiencing these mental ailments and who need hospitalization or hospital care?

Mr. Stuart: Yes. Well I would say, yes, in my own opinion, because placing them in the standard children's home, they would bring added problems to those homes with their shortfalls. So, I would say, yes.

Mr. Chairman: Okay. Before I take that submission I would like Dr. Gabriel to ask a question. Do you get calls to Lifeline from children under 16?

Dr. Gabriel: Yes. Of course.

Mr. Chairman: Oh, you get them. All right. And is it from your knowledge that they are aware of this service or is it that someone refers them to this service? Is it that they grow up knowing that there is Lifeline? How do they come to the

information if they feel very depressed that there is a number to call?

Dr. Gabriel: [*Laughter*] Nobody grows up knowing there is Lifeline.

Mr. Chairman: Okay.

Dr. Gabriel: There is simply not enough promotion of the service for that, but it happens in that children do call. What we are getting at present is where an adult calls and says, "Will you talk to this child"? And we say, well what you have to do for us, is that you have to first persuade the child that if they want to talk to us, and also if the child talks to us, it is in complete confidence. We will not tell the parent or another adult what that child tells us.

Mr. Chairman: Okay. Just out of curiosity, the young members of our society are all now on social media.

Dr. Gabriel: Yes.

Mr. Chairman: I am not there. You will not find me on any of those things, but they are there. Do you have a promotional campaign on things like Facebook that children will be aware of?

Dr. Gabriel: Yes.

Mr. Chairman: Is there a Facebook page and so on?

Dr. Gabriel: Yes. We have a Facebook page. Our Facebook page has 18,500 likes on it and we put posts that the population is 13 to 17 and that is one of the populations that has the highest number of responses, so it goes direct.

Mr. Chairman: But still you are saying that it is an adult who encourages the child.

Dr. Gabriel: It is quite often it is an adult, and then also you get the child themselves. So we are very aware of the need to reach out directly.

Mr. Chairman: Yes. Okay. Any other contributions on this subject. Yeah.

Mr. W. Murphy: Okay. I myself, you know, I am taking leave from TTRNA.

I actually work at the Child Guidance Clinic on Pembroke Street and much more than assessment takes place, there is also treatment, but I think it would be remiss of me, as a practitioner, I am not to make this statement. Now, usually when we hear the term mental health we think of mental illness. There is that promotional preventative aspect of care that is not given any prominence. I guess it is not as good for business. But our next generation of mentally challenged persons are currently at school and we are simply sitting and waiting until the next incident to intervene and treat. Whereas there is a role for prevention, for setting up a school contact system where persons, young people can be guided on healthy choices; where they can be guided on risk prevention; where they can be guided to avoid certain red flags in order to give themselves the best chance. Here I am putting in a plug because I myself have visited schools and have conducted several lecture discussions, take questions from children. There is a role to go into the school and to do preventative programmes.

Mr. Chairman: Okay. Could you elaborate on that, and is it that these programmes are not being currently being administered by the school guidance officers, the social workers or individuals who interact with the child on a regular basis?

Mr. W. Murphy: Well, in my humble opinion, the course curriculum for these two specialities you have mentioned, does not entail any depth of mental health.

Mr. Chairman: Okay.

Mr. W. Murphy: And so the professionals in the field, as a matter of fact, there needs to be collaboration between both the Ministry of Education and the Ministry of Health so that we can significantly do prevention to reduce these numbers instead of waiting to intervene after the problem has already emerged.

Mr. Chairman: Could you then, for the benefit of the Committee, in writing,

indicate what that intervention can be, that collaboration between health and education? What can that programme entail? Because it will involve collaboration between two Ministries.

Mr. W. Murphy: Yes. Yes.

Mr. Chairman: And it will involve maybe the intervention of professionals such as professionals trained by Dr. Khan and people who are on the ground working in the school environment. Okay.

Mr. W. Murphy: All right. So, in writing, it would come to whom?—the secretary.

Mr. Chairman: Yes. In writing to the Secretary of the Committee. I would personally, as Chairman, would like to see what your proposals are that we can suggest to the Ministry of Education and the Ministry of Health, as a collaborative exercise dealing with adolescent problems of mental health.

Mr. W. Murphy: Okay. Beautiful. It is almost complete actually, but I did not know such would have been needed today.

Mr. Chairman: Right. Yes.

Mr. W. Murphy: Sorry.

Mr. Chairman: Very well. Sen. Ameen.

Miss Ameen: Chair, my question goes up to the Lifeline representative and I want to commend Dr. Gabriel on this initiate because for as long—well all of my life Lifeline has been around and it operates in the background and you have been doing tremendous work. I recall in this Sunday's *Newsday* there was an article that indicated that since October of 2016, the number of callers who were high risks in terms of suicide increased from less than 10 per cent to 80 per cent, and, in addition, that over the past three months the number of calls to Lifeline has increased. Can you share with us whether, you know, what you feel or if you are

in such a position, what you feel may have contributed to this dramatic increase; whether it is, you know, the whole socioeconomic atmosphere in our country and what supports we can put in place to treat with this dramatic increase?

Dr. Gabriel: The increase, I think, is that people's—the basic problem that comes across is the person who is suicidal it is their personal relationships, the family, the partner, very few is their work. So that if somebody has a stable relationship and we have an economic downturn which is what we have, the relationship stays. However, looking at it over 40 years, this particular economic downturn has been brutal. It has had an impact on those things when people struggle for their daily food, et cetera, and it seems as if our resilience has eroded over the years.

Mr. Chairman: I need clarification and I would like to put a class structure to it. Are you finding individuals who are middle income earners experiencing greater difficulty today than, say, 10 years ago or is it confined to low income earners?

Dr. Gabriel: It is not a matter of class, it is a matter of people being accustomed to, for example, a man who is accustomed to paying his bills and he has income that should come in and it does not, therefore, it tips over his relationships because it affects his sense of self. It is having to struggle, women having to struggle to feed their children, so it is across the board. It is not a matter of class. We have been available, more since October than before, and we always tracked the calls. Before that it was 7.3 per cent, it is now about 80 per cent.

We have got a toll free number, it has been available publicly since June the 1st, and the number of calls we get has increased and people have come to see it. They actually know more the line, and you really have to say and this is where you tackle the stigma of mental health and suicide that they will say, if I have this

problem this is the line I call, and they call in. And for each call we take, we assess how suicidal is this person and that is what we are getting. Really and truly, we get about an average of 10 calls per day, it could be less than a minute to six hours. So the number of calls, it is also the length of the calls and, really and truly, if the service was promoted as it should be, we should get 151 calls a day. We have a long way to go.

Mr. Chairman: Before I ask, our colleagues would like to come in amass, but I need clarification with respect to the procedure.

Dr. Gabriel: Yes.

Mr. Chairman: A call comes through and an individual is in need of professional help, is it that the individual who is taking the call at Lifeline has the authority to call a professional and indicate, well I think you should see this person?

Dr. Gabriel: No.

Mr. Chairman: So it ends with Lifeline.

Dr. Gabriel: No. It does not.

Mr. Chairman: Okay. What is the procedure?

Dr. Gabriel: The procedure is, the person calls you, calls Lifeline and they remain in the control of their lives at all times. So basically we are listeners. We will listen and that is the critical point. When we do not listen to reply, we listen to give emotional support, so we steer into the person's feeling of anger, fear, et cetera, and when that calms down then the person feels able to talk about other things they want to do, but that is the critical thing. We only refer if the caller says, "I want to be referred to a psychologist to a psychiatrist", then we refer. We do have consultants we can refer to, but it is the caller who decides that.

Mr. Chairman: Very well. One follow up. I know we have to, but there is a

follow up to my follow up and that is, all of us can speak, but few of us can listen.

Dr. Gabriel: Yes.

Mr. Chairman: What kind of training is offered to the individuals who are on your end of the line so that they can listen with empathy and listen in a manner that will prevent someone from engaging in a most horrific act?

Dr. Gabriel: The key to the service is the selection of the listeners. It has to be somebody who listens. The vast majority of people in our society take action. It can be very frustrating to somebody who wants to rush out there and they are going to save somebody, call the police "duh, duh, duh" to sit and listen to the person. So that is the first thing. It takes initially up to three months for somebody to be approved to be a full Lifeline listener. It is a continuing process, but it is rigorously done, this is why we are always preparing people to be listeners. That is a continuous process.

11.20 a.m.

Mr. Chairman: And so the order of questioning I would ask Brig. Antoine, MP Jennings-Smith; and then Sen. Ayanna Lewis, you would go last.

Brig. Gen. Antoine: And this is a follow-up. In your responses to the question in terms of the availability of mental health and resources, what is the relationship between your organization and the Ministry of Health and the Ministry of Social Development and Family Services? Are any of the resources available at these Ministries, state resources, made available to you, as your organization deals with the people who call in to your service?

Dr. Gabriel: When it comes to the Ministry of Health, it is that we would tap the general services that the Ministry of Health provides, and we are slowly building a relationship with them. For example, the South West Regional Health Authority, that we would have a formal relationship with them. When it comes

to the Ministry of Social Development and Family Services, they have given Lifeline a subvention since 1990. At present we are waiting for it to be renewed. We are very thankful to them for their continued support over the years, and that is a closer relationship. Does that answer your question?

Brig. Gen. Antoine: Could you elaborate what is the value of the subvention? How does it impact your organization?

Dr. Gabriel: [*Laughs*] My being an analytical chemist means I am very much into figures. So, we did an analysis, we looked at how much it cost in terms of volunteers' time, the works to provide the service. We have asked for 16 cents in every dollar it costs to provide that service. We are grateful for the fact that in 2011 to 2013 we were given six cents in a dollar. It has not come to anything like that since then. We are grateful for it, because the Government, whichever government, has given us six cents. The private sector has not given one. So, we are grateful for whatever we are given. But that is a matter, and this is something I would like to say, that this is why I am grateful too for the opportunity to present to you, that I hope that you will lead on the breaking of the stigma on mental health and suicide. If that is broken, then not only will Ministries give more money to emotional support, but so will the private sector in terms of not only in cash, but in kind. There is a need for leadership from whoever is in Government to break that stigma.

Brig. Gen. Antoine: I do not want to put you on the line, but you talked about the 2011 to 2013, when was the last time that your organization received a subvention from the State, the last year?

Dr. Gabriel: We received part subvention in 2015, that was for April 2015 to September 2015. In 2016, we got $50,000, a one-time grant; in 2017, so far we have received $20,000.

Mr. Chairman: Thank you very much, and I will ask MP Jennings-Smith to pose her question.

Mrs. Jennings-Smith: I want to go back, through you, Chair, and I will keep my questioning with Dr. Gabriel. I compliment you for the hard work you are doing, because Lifeline, I believe, is a place where you listen, something that most of us cannot do. But, I want to draw us back to the point where you referred to 10 per cent—suicide increased from 10 per cent to 80 per cent, and I want to ask you if you and your organization did any data collection in terms of numbers over the years where you can really compare numbers? Because when we speak percentage it really does not give us a correct picture of what is exactly happening. Can you tell us, or provide us—the Committee after, not really today—with the numbers that you speak of? Because I am concerned about the numbers, because I know a lot of people will call Lifeline to have someone listen to them. They have problems. And from the question posed to you it would suggest that we want to go along the line of socio-economic and things like that, and did you do a study to really capture that result, or is it just mere speculation?

Dr. Gabriel: I am sorry. Again, you come back to my profession. I do not speculate on figures. It is that we look at the figures we have. We collate the figures, the numbers we get, and then at every call, when somebody calls us, we ask how suicidal are you, and therefore 10 per cent—7.3 per cent of our calls are from people who are normally highly suicidal. A percentage is a good figure because it says per 100. No matter the number, how many have that, and this is about the same thing for the Samaritans in the UK who get seven million calls a year, they have 122 centres.

So, I would only use figures that I am reasonably certain have some accuracy and some weight to them. But the major thing of knowing whether

somebody is suicidal is to simply ask them. When it comes to the figures for Trinidad and Tobago, the CSO used to be the most reliable source for our suicide figures. As far as I know, the last reliable figures they produced was for 2009. We are at present using an estimate, I think, that PAHO did, which is 14.4 per 100,000, which makes us the third highest in the Caribbean. We used to be the highest. It makes us that. What they do too is if you want to go look at figures, they say that every 20 to 50 people, if you look at your people who appear in the statistics, 20 to 50 people are at high risk of attempting suicide. If you take the lower level, which is 20, it means that 2,800 people in Trinidad are at high risk of suicide. If you then make that 7.3 per cent of the calls you would expect us to have, and that goes from the silent call, the person hears your voice and they put the phone down immediately, to talking for up to six hours, you are then looking at a 151 calls per day, before anybody can say that Lifeline is doing—is covering all the people who are highly suicidal in this country. Never.

Mrs. Jennings-Smith: I want to ask you, based upon what you concluded, the reason for suicides going up?

Dr. Gabriel: The reason for suicides going up is people's—they tell you it is the problems within their personal relationships. You have both men and women who, their personal relationships with their partner, boyfriend/girlfriend—our family systems are under tremendous pressure, and so when there is a fallout, if you look at it, the tighter the family structure, the more dependent they are on each other, and when that starts to rock, the person can feel totally alienated, and in that sense of alienation get to the state where they will become suicidal.

There is significant family trauma within families which is kept very quiet, and it is when somebody talks to us it will come out. It will come out that somebody may have been—a girl may have been raped as a child by a family

member, it was covered down, and then everybody says, well, you know, you should get over that. But it has not been treated. There has been no psychologist to go to, no psychiatrist to deal with, but that girl becomes disturbed at 18, 19, and says nobody listens to me. Nobody will hear me. I said this happened to me and nobody reacted.

Mr. Chairman: It brings to point what our colleague from the nursing profession has indicated, that we do need to catch the children, because children with problems will grow up to be adults with greater problems.

Dr. Gabriel: That is right.

Mr. Chairman: So, that is one of the proposals coming out. Now, Sen. Ayanna Lewis has been silent for quite a while and she must be given the floor at this time.

Miss Lewis: Thank you, Chairman. To you Dr. Gabriel and to the nursing association, based on the feedback that you were given earlier and the main cause of the callers calling in to Lifeline is really the breakdown of relationships, do you know how many lives you would have saved? Do you have that figure, like a follow-up on the persons who would have called?

Dr. Gabriel: I think the way we would measure that is call by call. The fact that somebody calls us, and by the end of the call they feel they could live one day longer, that is how we do it. Because, it is an anonymous caller. We do not keep phone numbers, we do not ask for names, so that is how you do it.

Ms. Lewis: So, would you consider though, at least offering that information at the end of the call, like who you can contact just in case, instead of asking them if they want a follow-up?

Dr. Gabriel: What do you mean by follow-up?

Ms. Lewis: Okay, so I know you mentioned that when persons call, you ask them

if it is they want a follow-up, or they need some kind of a—

Dr. Gabriel: No, no, no. We do not ask them if they want a follow-up. If during the call they determine that they need to be referred to a psychiatrist or psychologist, then we suggest it. But that has to be very, very carefully managed, because people react so negatively to the thing that there could be anything mentally wrong with them. You cannot just say that, so that is a different case. The person may feel much better and say what we would do, is to say will you give permission for us to call you back, and then we would do that when we feel they are really down, because we realize that the suicide feeling goes up and down. The fact that at the end of our conversation the person feels okay, does not mean they feel okay forever, so we would call back. We do long-term befriending of a caller.

Miss Lewis: Thank you for your feedback, and this is for the Trinidad and Tobago nursing association. In light of the police officers and the situation whereby someone was shot recently for dealing with a mental care patient, I know a lot of police officers are not trained in dealing with mental health patients, is there some kind of collaboration that could happen in the future in which the police service then, dealing with mental health patients and being able to at least deal with them in the medical way that you would recommend?

Mr. Chairman: Before you answer that, Ret. Brigadier has a follow-up to that question.

Brig. Gen. Antoine: The Minister of National Security and the Commissioner of Police say that police are now being trained at the St. James Barracks to deal with mentally ill patients, my question, a follow-up is, is there an input from any of your organizations into this training as being provided for police officers to deal with mentally ill patients? For instance, last night I read on the news that a

mentally ill patient who was throwing stones was shot by the police, so is there any input you all have into the training of the police officers?

Mr. W. Murphy: Well, I am not into the education aspect of things, but as a mental health officer that is one of my roles in apprehending clients. Now, the Mental Health Act is very clear on the functioning and who does what. The mental health officer, if there is need, can call upon the police officer to assist. The Mental Health Act is clear, the police role in a situation like that is one of assisting. In terms of what is done in the training component at the police barracks, I do not know, and I do not know who is doing it. But I recall when I worked on the clinical area, namely the forensic ward at St. Ann's Hospital, where I spent nine years, at intervals policemen, prison officers were brought unto the forensic ward for part of their practical experience, and also had the privilege of sharing with them our own expertise and what is contained in the Mental Health Act. I do not know if that practicum is still afforded. But there is no better component than the practical components.

Mr. Chairman: One follow-up, and that is, are you in the nursing profession or in the psychology profession aware of any of your colleagues who have been invited to the Police Training Academy in St. James to offer modules of training on dealing with mentally ill individuals in Trinidad and Tobago? Are you aware of any instance like that?

Mr. W. Murphy: I am not, but if it exists, kudos. If it does not, then as a matter of emergency it needs to be.

Mr. Chairman: So, basically, again colleague, to reiterate you are saying that there is a need for collaboration between the Ministry of Education and the Ministry of Health, and now the Ministry of National Security and the Ministry of Health. Very well, thank you. Yes, and we have response from—[*Inaudible*]

Ms. Cox: Yes, I am seeing here that the word "collaboration", stakeholders need to be aware of these modules. As far as I know, as the Social Marketing Officer, the association is not aware of any training that involves the police officers, and we would be quite interested to be involved in that so we can also have our input to know that the best curriculum is being afforded to the police officers, because we had some unfortunate situations recently in the media with regard to the loss of life of mentally ill persons. I would like to also say and endorse, with regard to the children, it was burning in my heart that we are underutilized as practitioners. That is the registered mental nurse.

In our role as teacher and educator, we are well able to counsel and share information that would help the child and the adolescent. As an association, we have been invited to career fairs at various schools, and I have been a part of it, and I have encountered the teenager who would ask about cutting. I have encountered the teenagers that would be asking about, or may try to evade about substance abuse, such as marijuana and alcohol. I have had students who broke down in tears after I shared about mental illness, and the signs, and come to me after saying I am experiencing this. And, it was really touching, and I knew that this was a ripe opportunity for the registered mental nurse to go out in the community—and this is part of the role of the nurse practitioner, the promotion of mental health, and we are not given that opportunity in lieu of what is going on.

And, there was a group that came out of such career fairs, called itself ATNA, a drama group. We used drama therapy to reach the young ones, and that group was stopped by the specific regional health authority. We went out there, we shared drama, we talked about mental illness, depression, suicide. All those topics were dealt with, but the group was stopped from going out. So I say, there

are things there, there are persons who are willing within the field of mental health to go out and reach the school-age child, be it teenager or the young child at the primary school. And we need the support, as I said from the other team, the Ministry of Education, the Ministry of Health, to give the approval for us to do these things. So, that is my input.

Mr. Chairman: Before the psychologist comes in, you are saying that you need the approval, is it that there were overtures to the Ministry of Education to visit schools to discuss with students the issues of mental health and the treatment which may be available, and that you are finding it difficult to get the approval to visit schools? Or is it that you think there will be a difficulty getting the approval?

Ms. Cox: Now, the group that I talked about were under the specific RHA, regional health authority, and, of course, they are under the CEO and the board's regime, so they need the approval to go out under the name of the North West Regional Health Authority. Now, if it was a private group established as an association itself then they can do it on their own. But because it was under, and the board made a decision based on some anomaly that the group will no longer go out. The group actually won a competition held by the Ministry of Health with actually sharing drama on anxiety disorders and so forth. You know, it was really sad to see the end of that group, because it was doing a really great job.

Mr. Chairman: We appreciate the information, and now we realize, as usual, in all our Committee hearings, what we know is that various agencies in Trinidad and Tobago operate independent and they are compartmentalized, and what is coming out from the discussions this morning is that there is a greater need for the practitioners on the ground to integrate with various arms of the State, and there is a need for some kind of effort to smooth the relationships so that we can streamline what you can do for the rest of the society. I will ask Dr. Khan to come

in and then Sen. Lewis to pose further questions.

Dr. Khan: So, in responding to your question about Trinidad and Tobago Police Service, one of our past executive members was the clinical psychologist for the police service, but then she left and there is currently a vacancy. I am not sure if it has been filled, because we shared the vacancy with our members. As to the role of the psychologist, I am not fully clear as to whether their role is to treat members of the police force, or how much they are involved in the training as well, because I think those are two separate strands. I read the same article that member Brig. General read, and my thoughts were that, it is good to hear that they are getting training in the academy, but I wondered about the continuing and ongoing training, because I think there is also a need for ongoing psycho-education, both for in terms of dealing with mental health populations, but also for officers themselves, and dealing with the stress and how it is exacerbated when you deal with a mentally ill person. I did some work with the Jamaica constabulary force some years ago, and they have a dedicated psycho-education unit for their officers, and they do regular periodic training. We also worked on a technical manual for a helpline for officers—

Mr. Chairman: Officers who are having problems, or officers who are dealing with people who are having problems?

Dr. Khan: All and every. [*Laughter*] I think they are interrelated. If you have an officer who is having a problem and is not dealing well, then that is going to exacerbate and compromise the ability to handle somebody who is a little more challenging. So, I think definitely both strands are essential. They are also at risk given the nature of their work, and the rest of the protective services are at risk for mental health issues. There is also an increased stigma for mental health issues within the protective services.

So, when I did read the article I said I wanted the association to reach out to the TTPS to find out more about the nature of their training and how we can play a role, because to my knowledge we do not currently have an input into that training model that they spoke of. I also wanted to comment briefly, and asking about the two members who asked about the figures with respect to suicide. So, at the university and at Mount Hope we have been doing some research, so Prof. Hutchinson and myself, and our trainee students—so we currently are looking at two things. One, completed suicides, and looking at the demographics and collecting the data for a five-year period. Since we have—well, it is not an official psychiatric ward, but since it has been there at Mount Hope in August/September 2015, we have been looking at the data of the patients there, and we are looking at, in the past over a one-year period, we had approximately 121 admissions for attempted suicide. And of those, about the 80 to 90 per cent were impulsive suicides, meaning that there was not a plan. This was the stressor, became overbearing, and impulsively they made the attempt, and this is across a variety of methods as well.

What we are also noticing is the age group. So, the vast majority of those are 18 to 26 years. So, we are looking at a very young population. So, we want to compare as well, the persons who completed as well as those who attempted, to see if we could identify what are some of the predictors to help us understand, one, how to target intervention, and identify the at-risk populations. As to the reasons as well for why, I think a lot of things are pointing at poor coping, that when the stressor becomes too overbearing, people do not have—so, it is lack of resilience, and I think with the economic stressors, with personal stressors, et cetera, what we have is a lack of coping skills, and it is something that redounds to early childhood and development in childhood.

And, to my final point, where you asked about the training in the schools, I think there is definitely a need for health and family life education in the curriculum. So, just as much as social studies: math, English, et cetera, we need to have an aspect, starting from primary school where we involve mental health and well-being that is not optional and does not vary across schools. But we have a minimum standard that is implemented across the entire education system.

I did a research study with a student a couple years ago, looking at—and I am very happy to share these findings in more detail with the Committee—we asked teachers in public and private secondary schools, if they would be willing to implement, to teach about mental health in classrooms, and what would be the factors, whether it would be personal factors or school-related institutional factors. And a couple of the things we found was that every single teacher had encountered a child, at least one in their classroom who had behavioural or mental health problems, and also the teachers were quite happy to deliver those programmes as well. What it depended on was the principal support and the school support. So, if principals and schools and the Ministry of Education provide that mandate and the support, teachers were willing to add this to their duties as well.

Mr. Chairman: We need to follow up from the Chair, before we go onto the floor; the follow-up is, on the last day when the Ministry of Health addressed us, they indicated that they were in the process of implementing a suicide surveillance system which entailed, inter alia, monitoring and tracking the effectiveness of interventions—are you aware of this system? Are you a part of it? Do you know at what stage they are?

Dr. Khan: Yes, I am aware of it and I am a part of it. I sit on that committee as well. At the last meeting we were in the process of drafting that

national suicide plan in term of agreeing on terms, and standards, and the remit, and about the surveillance and monitoring as well.

Mr. Chairman: Could I ask MP Jennings-Smith to come in and they you come in there, Sen. Lewis, again.

Mrs. Jennings-Smith: I want to ask a question—

Mr. Chairman: Is it a follow-up from this?

Mrs. Jennings-Smith: Yes, it is a follow-up, but it goes further. Basically, what you have been saying to me, it seems as though mental health is a word that people do not like to associate with, because we look at stressors—you spoke of stressors, you also spoke about identifying predictors, and another point I want to draw along with that is to the nurses association, where there seemed to be a problem in attracting persons to go into the field of mental health nursing. So, the entire regime there, of mental health seems to be a not-attractive place for people to identify with. Nurses, we have a shortage, because people do not want to go into mental health nursing, because it is stated here, and now the schools, when we talk about going to schools and doing a topic on mental health, people will say "I am not mad, why you telling me that". But, we must admit that we have things like stressors and inability to cope with it, which would lead to the said behavior. I am certain that you all would have recognized that before me saying this today, what are your recommendations to deal with these particular—these issues, one? How you approach schools to make it attractive for them to be responsive? And two, how do we encourage people to get into that area of mental health nursing?

Ms. Cox: I would like to address the, how do we approach schools? There is a term used in mental health, self-disclosure; that is quite popular when I go and speak to the children. They tend to listen to you when it is relative. So, at times when I speak to them I start off with some of the challenges I encountered

as a child and as a teenager.

11.50 a.m.

And I start off from there and I said, mental illness, people tend to think it is somebody running around with a big stick with some loincloth. But it is not that, you know. Do you know I have persons as young as nine years old, nine years, with mental health challenges and I think that wakes them up. Fourteen years, and then I would ask a question: Why do you think they are there? And they answered it themselves. Miss, alcohol; Miss, drugs; "Miss, somebody geh horn" and down-to-earth just like that. So you start off by being down-to-earth with the children and we approach the school. Once we have the permission, once we have the co-operation with the school administration and with the Minister of Health then we can really go in there and help the young people. It is all about reaching them where they are and being real and, as registered mental nurses, we learn this in our curriculum. We are taught how to deal with, how to counsel, how to reach persons of every strata, no matter rich, poor—[*Interruption*]

Mr. Chairman: Could I intervene, because I think one of the questions imposed by our member was how do you make the field attractive to individuals—

Ms. Cox: I was giving it over to the President. I was dealing with the schools.

Mr. Chairman: Yes, and after that, Sen. Lewis, you definitely will be coming again.

Mr. Murphy: One of the first things we must admit is that we have a society that perhaps strives on taboos. The church sometimes does not help and when I say the church I say the church in plurality. If the Minister, for example, believes that somebody who behaves different to what is considered to be normal, is a person who is demon possessed and not mentally ill, they may treat the person as somebody who is demonic. One of the things we must appreciate in this country is that Ministers of religion are very powerful people and I have long argued that we have got to get into

the churches, the temples, mandir and speak to the religious leaders, could be powerful figures. If we can convince our religious leaders that a lot of what perhaps even presents at the very congregation and in the congregation as not being persons who are demon possessed necessarily, but persons who are genuinely mentally ill, then we will get the co-operation because the church is an audience in itself. That is one.

We have a society that believes that anything mental is mad and then one of the first things we need to do as well is to see whether we can change our vocabulary from being mad, being crazy, to being mentally ill. And because of that we got to start to provide incentives to people to enter our School of Nursing, but let me even leave the School of Nursing and go into medicine, for example. The pool of physiatrists in this country and I suppose outside of this country, the pool is generally very shallow, meaning, that there are not many psychiatrists around.

One, it is not a profession that is so lucrative in medicine. In fact, it is perhaps the least lucrative of the specializations of the medicine. Why? Because the people who need the care most are those who can least afford it. The very said thing in nursing. So I remember one year the Ministry embarked on an experiment, because you would also appreciate that the men are the minority in nursing and for a group of—an intake of psychiatric nurses the Ministry limit it to only males. And a number of males applied. What we discover happening is that once you send out an advertisement to recruit nurses most of your applicants are going to be those who apply to do general nursing. And my argument has been for years now, advertise only for psychi nursing and you would be shock to see how many more persons applied because that is the only field that you are offering training for a particular cohort.

My other argument is—and I concur with Ms. Cox—and that is the services, the resources are grossly underutilized. A psychiatric nurse is trained either at the

diploma level, the associate degree level or at the bachelors' level. These are persons with vast experience, with vast knowledge, but they are usually confined to in-house and in-care facilities and that is confined to health centres or confined to hospitals. In other words, the person must become mentally ill before there is an intervention.

So it is more at the secondary level than it is at the primary or the preventative level. And it is a resource that is grossly underutilized. We have begun, even at the level of the nursing council, whenever schools have their career days, they would ask for input from the nursing council in terms of sending nurses who can speak to the young people in terms of career pathways and we have been very mindful not only would we send nurses to encourage persons to get into general nursing, but also into psychiatric nursing and indeed we are making a significant dent.

Mr. Chairman: Sen. Lewis, it is your turn.

Miss Lewis: I think Mr. Stuart—

Mr. Stuart: Yes. From the Association point of view also, psychiatric nursing, like nursing on the whole, has been challenged to attract the correct persons into nursing. Nurses are a kind of unique profession where you really need to have that sense of care to really get into nursing otherwise you will end up with a number of problems which would have been evident over the years due to poor nursing care, because the correct persons did not really get into nursing. And when you have persons coming out of school with—well, to get into nursing, first to begin, you need five O levels, but the majority of nurses have more than five O levels, A levels. So what would make those persons come towards nursing rather than to some other profession? What would make an individual coming out of school having to go through four years of training to get a bachelors in nursing education and then want to go and do psychiatric nursing, having to deal with an environment—work in an environment that is over 100 years old; St. Ann's Hospital is 100 years old.

If you get injured on the job, which is a frequent possibility in psychiatric

nursing, you do not have the resources to subdue persons. Well, you do not have some of the tools that the police officers would have and it was a comment made at a public forum about five years ago where the police officers or the prison officers bring the patient to St. Ann's Hospital in handcuffs, baton and guns and stuff on them and then they hand them over to the nurse and the nurse has nothing and they have to deal with some of these most violent persons that society shuns and stays away from. And you do not have risk insurance as a psychiatric nurse. You do not have, the mental health officers who have to go from district to district, they do not have mileage, kilometric allowance which may have been afforded to the doctors, but it is MH who actually visits these patients. The motor vehicle tax exemption was taken away from psychiatric nursing.

So there are a number of issues, continued education. If you are going into psychiatric nursing, it is a dead end job. There is no upward mobility, there is course in specializing once you become a psychiatric nurse. So most persons do not choose that avenue, they will go to the general aspect, because in general you could do ICU, theatre and all these other trauma nursing, but in psychi, it is a dead end job. There is the forensic unit, no nurse on the forensic unit is trained in forensic psychiatry. None. There was one nurse who was trained, went abroad and came back and trained and they did not even place that person and the person just got fed up and left and went away.

Mr. Chairman: Thank you.

Miss Lewis: All right, so—thank you for your contribution. I have about two or three questions.

Mr. Chairman: The floor is yours.

Miss Lewis: Thank you. First of all, I do not think anyone answered this question even based on your submissions, but how many persons register as nurses and then as mental, well, training for mental health care and how many persons gradate in the

nursing programme?

Mr. Stuart: I do not know if you recently see our last submission because we made modifications and presented it today for it to be photocopied. So I do not know if you got that update where we have some statistics from the—[*Interruption*]

Mr. Chairman: We did not receive that submission, it was sent—

Miss Lewis: No, we did not.

Mr. Chairman: It was sent just prior to the hearing. It is in our package but we had no updated to review.

Miss Lewis: Can you respond based on the submission that you would have had?

Ms. Cox: Yes, it was a little bit difficult but there are only two schools that provide training for the psychiatric nurses. From COSTAATT and under the Director of Nursing, DM, Mr. Rupert Jones, they send statistics for us between the years 2014 to 2016. They offer both the baccalaureate and the associate degree. Their intake for September 2014, was 11; for the baccalaureate and the associate degree was 10. For November 2014, they had 24 graduated, that is under the baccalaureate. Under the associate, they had five graduated. In all for 2014, 29 psychiatric nurses graduated for 2014.

For January 2015, the only intake was eight, for the baccalaureate and for the associate, seven. In 2015, 11 intake for the baccalaureate and zero graduated for that same year. The total graduated number was 11. For September 2015, only eight total was intake. For 2015 November, graduated, the total was 20 psychiatric nurses.

For January 2016, the total intake for that year was 15 and for September 2016, 34 psychiatric nurses were taken in. For November 2016, a total of 17 graduated. That is the statistics for COSTAATT. Now, what we were told from MTEST, the Director of Nursing Education, Ms. Joycelyn Clarke from her office that they deal with cohorts. Previously, COSTAATT took in cohorts but they stopped and it is whoever applied would have been granted to be a part of the

programme. The cohort for the Ministry of Health apprenticeship programme were 60 students. However, we were told by the office that they could not meet that figure in terms of persons who applied. So it was under 60. They did not give the actual figure, but it was under—

Mr. Chairman: Sen. Lewis has a follow up.

Ms. Cox: Yes.

Miss Lewis: I just have a question. Have you done a gap analysis based on how many nurses that have graduated and the need of the population?

Ms. Cox: Well, what the problem is, we did not receive statistics from the mental hospital, the main unit as to what their needs are, because you need to have that in order to know if there is a shortage. However, unofficially, because we were waiting for official information in order to present it here, we can only present official information, we were told that the shortage of RNs are 25 per cent and the shortage of enrolled nursing assistant is 55 per cent, but we wanted to have that officially so we can present it, but it will come after.

Miss Lewis: All right, so, thank you very much.

Ms. Cox: You are welcome.

Mr. Murphy: If I can just come in here because apart from the data that says how many persons would have been enrolled and how many would have graduated, there is a differential between your enrollment, those who graduate and those who eventually receive a licence to practise. For example, 100 nurses could probably graduate from any given school but yet there is a license examination administered by the nursing council of Trinidad and Tobago of which not all persons are going to pass with their first, second or even third attempt. So that the data that you probably would really need would be how many persons who were actually licensed to practise for the given years. And that I am here to say is just about 75 per cent of the total intake that Ms. Cox spoke about for the given years. So the numbers are

smaller.

Miss Lewis: Thank you very much. Everything that was said today was quite enlightening and I do want to commend you guys for all the work that you have done. Also a lot of the work that you have done so far has been tremendously volunteerism and you could never quantify volunteer work. Based on the feedback of treatment for persons with mental health care needed, most persons are put into a hospital, but what would be your recommendation, what kind of environment should be created to deal with persons with mental health issues?—and that is for any one can answer.

Mr. Murphy: Well, that is a broad question because mental health issues is so board, is so general. If we are talking about those who are mentally ill, who would have received a diagnosis of mental illness, then clearly we would have to first go the route of an in-house, in-hospital treatment, diagnosis treatment with a proper discharge plan to get the person back into the community and back into their homes. If we are talking about mental health, even mental illness issues which are much larger than admissions, then clearly there is need for the very things we spoke about— education in the schools, education in the community. I know there was some movements some time ago that spoke to the issue of decentralizing inpatient care. In other words, right now St. Ann's Hospital has an inpatient population of about 1,000 on a daily basis and there is a movement to get these patients out in the community. My question had always been, if you get them out of the institution into the community, do you have the necessary support? And a major component of that would be, you have got to go on a massive community public education programme because the whole issue of stigmatization and so on, people you are now taking folks from an inpatient facility to put them in the community and you are likely to get some resistance out there as well.

Miss Lewis: Dr. Khan you spoke about persons: One of the issues with a person

with mental health issues, is lack of coping skills and especially if the person is between the ages of 18 to 26 years old. Now that we have a serious social media community that is growing, the coping skills will be at a disadvantage going forward. Do you all have any kind of measures put in place to deal with such issues?

Dr. Khan: I will try to keep my comments as brief as possible because this response can go for hours, but just to reference your previous question and then I will answer specifically about that. With respect to what treatment is needed for people with mental illness, because I think we have to also think about it as a continuum. So there are those who are institutionalized and will require institutionalization, probably, for most of their lives. For example, the patients, Mr. Murphy spoke about at St. Ann's. But in addition to finding places to house them and communities that will be accepting, I think we have to go further in terms of not write people off and think that they just need to be safe and be medicated. There are different levels of rehabilitation as possible. We can have social skills rehabilitation for the severely mentally ill where they can function, where they can perform simple tasks where they can communicate with each other, they can perform activities so that we can have some measure of quality of life even with severe mental illness. Wards 12 and 13 at St. Ann's come to mind. I think the nurses are doing a fantastic job with what they have, but what we basically have are people who are just fed, kept safe with limited quality of life.

As we go down the continuum, for people who are high functioning, the vast majority of people with mental illness are not institutionalized. They are living, they are sitting, they are working, they are our neighbours, they are friends, they are relatives. So in terms of those services, they have to be able to access services within the community. A small percentage of people can afford to go privately but we need to have adequate public services for people and there is such a limit. So in the breakdown of the figures we submitted to the committee you will see that there are

no psychologists currently employed at Mount Hope. I work there but I am not employed by the RHA. I have clinical privileges, I supervise our students, I do some interventions, but there is no psychology clinic outside of what the programme offers.

What does that mean? People have very limited places to go. They go to Barataria Wellness Centre; there is one psychologist. So in terms of what they can offer, we use that as a practicum site. So there are two of our trainees there as well, but in terms of what they can offer it is very limited, you are cut off at the neck. In terms of whether it is assessment or when we think about therapy. Therapy is not a one shot. So what we are looking at is—you asked about attracting people to mental health for psychologists, we have no shortage of that. We have graduated and a number of clinical psychologists many of them cannot find jobs in the public sector. It is very simple. They cannot find jobs because there are no posts. So one of the strongest things I want to advocate for here is that we have a desperate need for psychology posts in the public sector. The Carenage Wellness Centre was recently opened; they have not yet appointed a psychologist there. So all of the psychologists in the public sector are overworked and what this does is it compromises the quality of service we could deliver.

Mr. Chairman: One clarification, doctor, and that is, do you have a professional body call professional body of psychologists where in order to practise you need to have certain certification and certain hours of practicum.

Dr. Khan: It is a very critically important point you are raising because we are working on that now. So the Trinidad and Tobago Association, while we are the representative body, there is currently no registration and licensing. And part of the reason for that has been in deciding what route we should go under, whether we should have our independent council or whether we should go with the professionals, like to the health sector and medicine.

So we are currently devising our scope of practice and what that document does is entail who is entitled to call themselves a psychologist, what qualifications and experience they need to do that and what remit they can operate in. And also as well, we currently have ethics guidelines but we are also devising our code of ethics. This will help with this process because then what we will need after, agreements and understandings with the hiring bodies and agencies with the Ministries that hire psychologists to work with us.

Currently, some of the Ministries do. So we do get requests from our members to get letters verifying that they are members of the Association because their employers have demanded this. So this has been a really positive sign for us because we do need to have the profession regulated.

With respect to the other services, just wrapping up, with what we need, currently mental health has been predominantly viewed under medical model. So the causes are biological genetic and therefore medical doctors need to deliver treatment. That has been changing and I think many people recognize the role of nurses, social workers, occupational therapists, speech pathologists and psychologists in playing a role, but there is inadequate multidisciplinary integration of treatment.

So we do not have a case where physiatrists and psychologists and social workers and occupational therapists are sitting down around a table and discussing treatment. We do not have established protocols of care. So, for example, schizophrenia, this is what we think is the best practice in terms of pharmacotherapy, in terms of psychological therapy, et cetera. So what we need is more integrated care across the disciplines. Very few organizations in Trinidad have multidisciplinary team. For example, the forensic Unit at St. Ann's does—

Mr. Chairman: Clarification again.

Dr. Khan: Sure.

Mr. Chairman: Doctor, can you administer a drug such as Prozac. Do you have that?

Dr. Khan: No, psychologists are not in the business of administering drugs, we administer therapy, we administer assessment and other such interventions.

Mr. Chairman: Do you think you should as a clinical psychologist?

Dr. Khan: No, there is no need. We have perfectly competent psychiatrists who handle that aspect of it. But as we put in our paper, all of the evidence suggest that medical treatment can be augmented with psychological interventions and, in fact, for sub-clinical, for those population who are at risk, you need not intervene with pharmacotherapy. You can be treated with psychotherapy and it can be quite effective.

Miss Lewis: All right, there is one question, social media. I just want to find out how you can deal with persons coping skills, coping issues, with persons who are more inclined to use social media to communicate.

Dr. Khan: Social media is just part of a ton of research now, both in terms of how it can be used to promote mental health but also how it is a factor in peoples' decreased coping skills. So I think looking at the positive, social media is certainly an incredible tool that can be used. In fact, our facebook page is one of our most popular tools. We share articles, we advertise events that are going on, we share what is going on with other agencies, so certainly in the consumption and because more and more younger people use it, at three and four they are very tech-savvy, so I think it is really important, where we need to go with it is to incorporate that into our campaigns.

So we have been trying to do that but we are limited by the resources of the organization, but certainly if there is some integrated campaign because—one of the things we have is we have so many little groups that are coming up. People are interested, they want to help, but that diffuses the resource and we do not have a

critical mass. So if we had an agency that would take the lead—and I think the state has to play that role and committees like yours have to play—that takes the lead in devising a campaign that other stakeholders now can just add on to and it becomes a synergistic effect.

So, for example, World Health Day, depression is the theme. So if we have this national theme of depression so therefore we have all of this energy from all of the different stakeholders talking about depression, it is on social media, we have advocates. I know the Ministry has done some videos with users, patient users and patient advocates, but I do not know where they are, so I cannot access them to be able to share them.

Mr. Chairman: I get the gist of the argument, there is, Ms. Cox wants to come in and then Brig. Antoine. Sen. Ayanna Lewis, are you finish with your questioning.

Miss Lewis: I have one more.

Mr. Chairman: Okay. One more. Let us give Ayanna Lewis an opportunity to pose the last question.

Miss Lewis: Yes, this is my last question and it is concerning Alzheimer's, because we have been talking about mental health issues and we have not spoken about Alzheimer's and I want to find out if it is that in your lined different fields, how do you treat with Alzheimer's and is there some kind of collaborative work with the Ministry of Health and the persons with Alzheimer's, what would you recommend if anything? I know it is very broad but—I leave it there for you to respond.

Dr. Khan: So as a nurse psychologist, I have had a lot of experience dealing with dementia, worked in memory clinics outside of Trinidad for a number of years, so it is a growing epidemic for a number of reasons. With respect to our treatment, I think we still—one of the biggest problems with Alzheimer's disease is people present to health services when they are already at a moderate to severe stage and at that time there is very little you can do. Not even medication can help when you are in the

severe stages. So that has been one of the issues, that we need more awareness so that people can present at an earlier stage. So we need relatives, friends, caregivers to recognize the signs and symptoms. What we have is a lot of attributing it to old age. Well, you get forgetful when you get old and not recognizing that, no, if you are forgetting your route home, if you are forgetting your ATM PIN number, that is not normal. So we need to get people being seen earlier.

One of the initiatives they posed in the UK and I think it would be applicable to us here, is, they wanted to recommend that once you are over 65 that you are screened routinely for Alzheimer's diseases and dementia. So with respect to—so there are two aspects: one, if it starts early, presentation and early diagnosis and then the treatment and management. Part of the treatment and management as we need a lot more care facilities for people, not only residential but day facilities. There are many families who are quite okay to take care of their member while they work. So during the day they need somewhere. So I know that we have one or two senior day facilities in the country but we need more of those with staff who can cater for patients with Alzheimer's disease.

The other thing about Alzheimer's disease is in its most typical presentation often they lack insight. They do not know they have a problem so therefore the burden is on the caregivers. The family members who have to deal with this changing person and all the support that they need. So we also need a lot of support for caregivers. One of the things I am currently working on, we have a research project that is currently going on where we are recruiting patients with memory problems and also normal healthy people to compare them to. We are looking to identify valid instruments to measure cognitive decline. Because if we cannot detect it then, as I said, when somebody is severe you do not need a test. You can interact with them for a few minutes and you know. So we are doing some of that research and I think—[*Interruption*]

Mr. Chairman: I just want to intervene—I am looking at the clock and I do wish to finish at a reasonable time. But before I proceed to MP Antoine, Ms. Cox, did you want to come in briefly?

Ms. Cox: Yes, briefly.

Mr. Chairman: So as you come in, then MP Antoine will have the floor.

Ms. Cox: Ms. Khan had offered, because we did not speak much about the facilities and one of the suggestions in our thrust for decentralization, having day centres just as she said there. It was well explained. Also, psychiatric inpatients units within the community near to the persons' home. So instead of being in this central area or mental hospital, persons could come and bring food, they can visit their relatives, they can have their care for one week, two weeks and then go right back home, right there in the community. That is part of the thrust of decentralization. So we are talking about mental health and the adequacy of the practitioners. We realize that there is a shortage of psychiatrists. All research have shown in different countries that there is a shortage of psychiatrists but how have they dealt with it?

12.20 p.m.

We have looked at the Belize model, we have looked at Jamaica and some other foreign countries and we see the value of the Advanced Nurse Practitioner, who trains at a Master's level and they have both prescriptive and diagnostic powers, and they are able to work along with, and under the psychiatrist and they can work independently in the community and they are able to do health promotion and prescribe and they have been working quite well. As a matter of fact, Belize, in the introduction of the Nurse Practitioner, they have been able to close down their mental hospital and they have complete community psychiatric care that is integrated into their general setting. So there is no centre—you can walk into a health centre and have assessment.

Mr. Chairman: Could you send, for the benefit of the committee, any information

you may have on community care for the mentally ill? I was not familiar that that was a model that existed in a Caricom country.

Ms. Cox: Yes, so we will.

Mr. Chairman: And finally, Brig. Antoine.

Brig. Gen. Antoine: I just want to touch on a negative stereotyping. Mr. Murphy mentioned the situation with demon-possessed vis à vis mentally ill patients. But in the communities and in the cultural setting there is a pendulum that swings between people who are mentally ill but are classified as having a "tabanca" because his wife went to the States and left him or the husband left her for another man, as the case may be. But also there is the other side of the pendulum and we experience this in the military where a person would show that he has his papers from St. Ann's, so therefore the military may not discharge you, but then you are prevented from coming close to weapons as the case may be and you just carry on your life as, what we call, a barrack room assess soldier. So you just work in the barrack room. So there is a pendulum in terms of the communities.

My question is, as different organizations, what are we doing with the negative stereotyping of mentally ill patients? Is there any programme to deal with that, to educate the communities that these people are, in some instances, not violent as the case may be, but they would interact better if they are closer to their communities and their families as the case may be? Is there any programme afoot to deal with that?

Mr. Chairman: A brief response with respect to the profile, the behavioural profile of a mentally ill patient. Do you think there is a need for a public education programme to disabuse individuals that mentally ill people are behaving in a particular way; that they can look and behave normal? So who is looking to see—who should be doing that programme?

Mr. W. Murphy: Well, there is definite need and the first place we need to begin

is stop the labelling about "them" versus "us", because any one of us can become mentally ill in the morning. In fact—

Mr. Chairman: Three of us here, statistically, perhaps will be suffering from a mental ailment.

Mr. W. Murphy: And you are correct.

Mr. Chairman: Fifteen of us, divided by five, would be three. I "doh" know which three, but—[*Laughter*]

Mr. W. Murphy: I do not know either but if we have to use the diagnostic and statistical manual on mental disorder for five, published in 2014, there are over 18 categories of mental illness. That works out to over 375 discreet diagnoses of mental illness, which means that the statement we made a while ago could very well be true, and in fact it is true. So we need to stop the labelling. It is not going to happen overnight. It requires public education programme; we have got to get into the social media; we have got to get into the traditional media; we must get some air time; we are going to send our best professionals in. We have been doing it, but I think we need to increase the numbers and the frequency.

Mr. Chairman: I will ask Sen. Ameen to come in and then MP Jennings-Smith.

Miss Ameen: Chair, I have several questions but they really just are very short answers—

Mr. Chairman: And I will want very short responses because we do want to finish at 12.30.

Miss Ameen: You indicated that there is no register of practising psychologists in your report to us. If you can briefly indicate the reason for the delay, and in the absence of such a register, what mechanism is currently utilized by the association to record and track practising psychologists?

Dr. Khan: Very briefly, why there is no register, I think the fact of deciding which route to go in terms of being independent or going under the current Act has been a

significant factor. Under my stewardship we were going to pursue going under the existing Act, so hopefully that should change. We are having a public consultation with stakeholders in a few months' time to discuss that as well.

And the latter questions as to the breakdown of psychologists, based on what we know about who is graduating from the programmes—so from USC and UWI, which are the two programmes that graduate professional psychologists, counselling and clinical psychologists, so we have figures for those, and we also have figures for our historical membership. So 200 to 300 roughly over the time. So we can give further estimates of how many clinical counsellors are educational psychologists, school psychologists, work psychologists, et cetera.

Miss Ameen: And you also indicated that the legislation with regard to the Trinidad and Tobago Immigration Act, that it was so archaic and obsolete. Has the association been able to make any headway with its representation to the Ministry of National Security, to the office of the Attorney General to recommend that the Immigration Act be amended to reflect the contemporary views in terms of mental illness?

Dr. Khan: No, we have not, and it is something that we have to do. We are currently—most recently we have been in participation in the discussion on child marriages, so we have submitted our comments on that and we are going to re-submit based on the current discussion that is taking place in Parliament. So we have been tackling the Child Marriage Act and we are quite firm in our position that it should be 18 and no younger.

With respect to this Immigration Act, it is not one that is regularly discussed. I do not think many people even know that we have this statute on our law books. So yes, I think one of the barriers is because we are a voluntary organization, only supported by financial membership which varies. So something in that response we would want to have the assistance of a lawyer. So I think—so it is mitigating those.

But we will certainly start with just a letter to the AG's office saying, this exists, we think it is negative for all these reasons. We hope something will be done about it.

Miss Ameen: My other question is with regard to the nurses and perhaps the—you spoke about the absence of posts for psychologists in the public sector. My question relates to nurses—psychiatric nurses—and in many other spaces in the public service there are a number of positions that exist but are vacant while you have a shortfall and those who are in the system are overworked. What is the situation in terms of the number of nurses, trained psychiatrist nurses, who are practising in public institutions? Are the positions generally filled? Are there shortages?

Mr. Stuart: Yes. Briefly, well, first to begin, I think we should start with the Chief Nursing Officer. That post has been vacant for the past two years. That post is supposed to be at the Ministry and that is where an association like myself and other parties would be making our recommendations too, to get to the Minister. So that post has been vacant for the past two years, so that has caused a number of problems.

With regard to psychiatric posts, from the minute the individuals would have graduated from the nursing schools, they are hired by the various regions to fill the gaps. Those are of the lower levels. But in terms of supervisory levels, there is a serious problem in terms of, for instance, in St. Ann's Hospital, half of the nurses who are in roles of nursing supervisor, are retired persons who would have come back and now they are blocking the upward mobility of persons within that field. You would not get that situation in any other setting: in police, fire, what have you. But currently more than half are retired persons blocking the upward mobility.

In terms of—but what we will also like to see is—and it is in our recommendation—with regard to the mental health plan of 2000 by the Ministry of Health, where they speak to de-formalizing the establishment of the National Mental Health Committee which would incorporate the different professionals within this field to come up with the master plan instead of each organization just submitting

their different ideas. If we get that master plan coming out of this National Mental Health Committee, it would be more organized to suit.

Mr. Chairman: Thank you very much. Sen. Ameen, do you have any more burning questions? Could it be your last—very, very critical question?

Miss Ameen: My final question has to do with something that was mentioned earlier related to the safety of our nurses and medical personnel at St. Ann's Hospital. When you have prisoners who are brought in for treatment, are prison officers posted on the wards to house them, so that those—

Mr. Stuart: No. And that has been another main issue with psychiatric nursing. You have persons—well, you have two categories of persons, basically; persons who would have really been convicted and because of their mental health status they are warded in St. Ann's Hospital, and then you have the persons who would have been charged and the court would have sent them for 14 days for evaluation. So those two different categories of persons are within the St. Ann's institution and there is no prison officer. The prison van will drop them and come back for them 14 days later, and nurses have to take care of these persons who, some of them are not mentally ill after the diagnosis by the doctor. Some of them cause a lot of problems. There have been a number of riots in St. Ann's Hospital where we had to call the police. A number of nurses would have gotten injured over the years and there is no compensation, no avenue for redress.

Miss Ameen: Just a follow-up on this. I am shocked at the response.

Mr. Chairman: This is the last question.

Miss Ameen: Chair, through you—thank you for your patience. This is a very alarming situation where the safety of the psychiatric nurses and the staff of St. Ann's Hospital is concerned. Does the hospital itself have any mechanism to treat with the safety regarding these criminal people who are accused or convicted, who are brought to the hospital, to ensure the safety in the absence of prison officers being

posted—special security arrangements or staff?

Mr. Stuart: Well, let me just speak on it quickly for two points and I will just let Letitia Cox who is actually in the area right now. So, one, they utilize attendants, and basically the persons are untrained. They bring them into the facility to be the muscle, basically. So a violent incident is taking place on the ward, if the nurses cannot handle it they will call these attendants. They will come over and they will try. But they have no formal training in mental health. They have no formal training in managing aggressive patients and it is really up to the nurses themselves to really treat with issues like that. But in addition, the forensic ward, they recently rolled out camera surveillance systems to see what is happening. But that, basically, is the limit of it.

In terms of training in forensic nursing, there is none in Trinidad and Tobago. And in terms of compensation when nurses get damaged, I myself was damaged on the wards. Most psychiatric nurses would have been damaged at some point in their career on the wards and you have no compensation. In fact, we are dealing with a case right now at the Industrial Court where a nurse was injured. A nursing supervisor going on the ward to check on what is going on was tripped—

Mr. Chairman: Okay. Could we stay away—we tend not to interfere too much with court matters until there is a determination.

Mr. Stuart: Sure.

Mr. Chairman: But I will ask MP Jennings-Smith to pose her final question—final, final question.

Mrs. Jennings-Smith: I will be very short. I am going back to Lifeline and I am linking. Now, a lot of medical issues help in crime fighting, and with respect to suicide, the Ministry of Health had said they would be looking at implementing a suicide surveillance system. But with your interactions with persons, because you have seen suicides and where they would have murdered somebody before or

interfered with some members of their family and then went on to commit suicide, in your interventions or in your conversation, do you have a protocol that you follow in terms of when you get certain kinds of information for prevention of that kind of activity where you could put, maybe a stop, by having intervention? Did that ever occur from your interventions or from any other persons?

Dr. Gabriel: Could you explain to me what you mean by an intervention?

Mrs. Jennings-Smith: I mean your conversations, where you listened in to persons calling Lifeline and its relation to suicide, because you did say the number of calls increased to 80 per cent and you did talk about evaluating and assessing and determine how many suicides occurred, and things like that. Can you link it to the prevention of suicides in terms of its relationship to a person committing suicide but prior committing murder?

Dr. Gabriel: Yes, you can, because sometimes—

Mrs. Jennings-Smith: And what kind of intervention you have with the Ministry of Health?

Dr. Gabriel: It does not go to the Ministry of Health in that case. What you do have is a person who would ring and say that "I either commit suicide" or "I killed somebody". And in talking to that person, in listening to that person, they would finally get to the stage where they say, "Look, I will do X, Y and Z instead", and you then follow through with that person. But if they are really determined to do that, they will not tell you who they are or where they are. So they will make sure that you cannot track them. They would do that. The person has the right to anonymity and therefore we would—if you are talking about for the Ministry of Health, when it comes to somebody who says "I will kill somebody", just the same as "I will commit suicide", you do not let them go until they felt better. But to say, if they are determined to do that, they will make sure that you cannot track them.

Mrs. Jennings-Smith: Can you say from your experiences, because you would

have had the facts, that you could have linked it to any time when you saw a suicide committed followed by murders or a murder?

Dr. Gabriel: You cannot say because you would not have known who it was. The person would not tell you who they are.

Mr. Chairman: Thank you very much. We are past our time but as Chairman I do have some flexibility and I will exercise it. So what I will do at this time is ask members of the visiting panel to give us any brief closing comments they may like to leave with us that did not get discussed in the deliberations—a representative from the Nursing Association, a representative from Psychology and the Lifeline representative. So could we get a representative from Nursing to leave us with any closing comments that they may wish to have?

Mr. D. Murphy: At the level of the regulatory body, we are doing everything we can once persons would have applied, would have been qualified, so that we can grant them their licence to practise. But we must also do so in the context of not only qualification but to protect the public's best interest.

As it relates to the advanced practice nurse that Ms. Cox spoke about, the regulation has been amended. We now have on the statute the advanced practice nurse, or nurse practitioner and the council is prepared to enrol, to register, persons as advanced practice nurses once they would have met the requirement. And one of the areas at the council we have discussed previously would definitely be in the area of psychiatry and mental health.

Mr. Chairman: Thank you very much. The Lifeline representative, any closing comments that you would like to leave us with?

Dr. Gabriel: Basically one, that I hope that out of this that you will take a very active role in breaking the stigma associated with mental health.

Mr. Chairman: Very well. Thank you.

Mr. W. Murphy: From my standpoint, there is a cliché that guides us: there is no

health without mental health. What we need in order to carry the process of mental for both this generation and the one that is yet unborn is that so much more gets done when nobody is too interested in getting the glory for what gets done.

Mr. Chairman: Thank you very much and well said. Yes, Dr. Khan.

Dr. Khan: Thank you for listening to us today, and I think, apart from all the detailed comments we sent in, what I would like to see is after this, some continuity. So TTAP is very willing to continue to partner. We are very willing to participate wherever we are needed and I really do want to advocate for this committee having a say in terms of extending or expanding the range of services that are available in the public sector.

Mr. Chairman: Very well. Any other comments? Democracy reigns in our committee. If there is any comment—Ms. Cox?

Mr. Stuart: I just want to pull something from the Welch Committee. One of the findings and one of the things they are looking at is how to deal with the doctors who pursue private practice while in Government employment, and one of the solutions is increasing the scope of practice through the advanced practitioner nurse so they would not have that stranglehold. Because basically what it is, the doctors will walk out if you limit them to Government practice only, but if you have a cadre of professionals who could take up that slack in psychiatry and in the general setting, which is the nurse practitioner, which has been working successfully throughout several countries, and even in the Caribbean, namely Jamaica, that problem that the Minister has with rationalizing that system, could be solved.

Mr. Chairman: Okay. Could you elaborate on that just for my edification, how will that work? Is it that you are saying that the nurse practitioners can also work in the private sector?

Mr. W. Murphy: No, the nurse practitioners will take up the workload, because there is currently a shortage of—

Mr. Chairman: Okay, very well.

Mr. W. Murphy: Not house officers, but consultants. But the nurse practitioner could—

Mr. Chairman: So freeing up the medical doctors to undertake private practice.

Mr. W. Murphy: Yes.

Mr. Chairman: And Ms. Cox, I know you wanted to say something.

Ms. Cox: Yes, Chair. Just as he said that there are—you know in the international community that nurse practitioners have nurse-led clinics. They are well trained, but they will collaborate. You see, we have to come back to the place where there is this camaraderie among professionals. We are not at war with each other. We are lending that support and education. So there are nurse practitioners internationally working in the private setting.

I would also like to say that just like Ms. Khan said, I would love for this to continue and we would be invited again so that we can really share and make an impact in the community, because it is in my heart for the children and the adolescent, especially the teenagers, to reach them. So I applaud this committee, this forum and I hope it continues and is successful.

Mr. Chairman: Thank you very much, Ms. Cox. As is customary, I start a committee hearing not knowing very much and I end it with knowing a little bit more. What have I learnt—and committee Members by extension—over the last couple hours of deliberations? We do basically need to consider having a special ward for children who need institutional care or hospitalization. We certainly need to encourage more individuals in the medical field to pursue the field of psychiatry and to look at whatever impediments may exist there. We need to work closer with the social workers and the school guidance officers in schools who are in contact with the school age population more frequently than the nurse practitioners so that they would be trained to at least identify, very early, children who are displaying

symptoms of mental ailments.

With respect to Lifeline, I was very surprised to learn that the private sector is not more heavily involved in financing this particular NGO. So it is something we need to be looking at, to what extent we can actually encourage the private sector. There are certain incentives which can be provided at the level of the Parliament which will encourage private sector to be more involved in NGOs such as tax concessions and so on, something that we can be looking at.

What has emerged is that there is a greater need for collaboration between the Ministry of National Security, Education and Health, because what. Sen. Ameen indicated was that we need to understand how national security with respect to prisoners, is impacting the nurses at the St. Ann's institution, Ministry of Health. We need to look and sort out the problems with respect to the Ministry of Education. And a recommendation from Dr. Khan is that we need to place much more emphasis, and also Lifeline, on family life education. The breakdown of the family support unit seems to be a cause now for greater and greater mental problems and we need to be looking at how we could redress this situation via curriculum change.

We need to advertise more for psychiatric nurses. That seems to be something that ought to be part of policy, that specialist psychiatric nurses we advertise for. And what came out of the deliberations, at least for me, is that in addition to community mental health facilities and nurse practitioners helping medical doctors, is now a need—because mental health is so wide. It involves—we did not look at alternative treatments such as yoga and things like that, animal therapy. But I think there is a need for there to be an association of mental health workers in Trinidad and Tobago with its own social media pages made up of the medical professionals, the psychiatrists, the psychologists, the mental health nurses and individuals who may be engaged in alternative therapies, and with that association coming together maybe on an annual basis to interact, we should be able to determine what is the way

forward with respect to the assistance that each can give the other so that ultimately the health, the well-being and the wellness of the mentally challenged in Trinidad and Tobago can be addressed.

We have learnt a great deal and this will probably be the last public hearing of this committee which I have the honour of chairing for this particular session, but what has happened over the last little while is that we have now been alerted to the various multifaceted nature of mental health problems and we are going to be looking at what we in the Parliament can do with respect to legislation and also with respect to public policy on how we could provide to the national community an environment where mental health is treated on par with other aspects of health and where the mentally ill in Trinidad and Tobago can receive the kind of services that a developed country ought to receive.

At this time, 12.47, I call this meeting to a close. The conversation has now started and I want to thank all of our viewers, all of our listeners on radio, all of our participants on social media, the regular mainstream media and all our panellists for being here. It was a very edifying session.

I thank you and may there be an improvement in mental health in Trinidad and Tobago as we move forward. Thank you. And this meeting is now adjourned.

12.47 p.m.: *Meeting adjourned.*