HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Tuesday, February 11, 2020

LEGISLATIVE CHAMBER

Youth Mental Health Outreach Program (CaperBase)

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STANDING COMMITTEE ON HEALTH

Hon. Gordon Wilson (Chair)
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[Hugh MacKay replaced Keith Irving]
[John Lohr replaced Colton LeBlanc]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Mental Health and Addictions, Nova Scotia Health Authority

Samantha Hodder - Senior Director
Ruth Harding - Director of Policy and Planning
Nadine Wadden - Eastern Zone Director
Tara MacDonald - Manager, Child and Adolescent Services (Eastern Zone)
Robert Graham - Northern Zone Director

HALIFAX, TUESDAY, FEBRUARY 11, 2020

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Hon. Gordon Wilson

VICE-CHAIR
Suzanne Lohnes-Croft

THE CHAIR: Order. I call this meeting of the Standing Committee on Health to order. This is Tuesday, February 11, 2020. My name is Suzanne Lohnes-Croft, and I am the Chair for this meeting. Today, we will hear from the Mental Health and Addictions Program of the Nova Scotia Health Authority regarding the youth mental health outreach program CaperBase.

I would like to remind everyone to have their phones off or on vibrate. There are no photos allowed during the proceedings except by members of the media. In case of an emergency, please exit through the back door and walk down the hill to Hollis Street and to the Art Gallery of Nova Scotia courtyard. We will all meet there.

I would like to welcome our new member to the committee, Ms. Chender. This is her first meeting, and she will be a regular member from the NDP caucus for the Health Committee.

I will ask committee members to introduce themselves.

[The committee members and witnesses introduced themselves.]

THE CHAIR: I'll remind members to wait for me to say their name to have the red light on your microphone turned on. I will ask Ms. Hodder to give her opening remarks.

SAMANTHA HODDER: Good afternoon, members of the Standing Committee on Health. My name is Sam Hodder, and I hold the position of senior director with the Nova

Scotia Health Authority's Mental Health and Addictions Program. We would like to thank you for extending the invitation to myself and my colleagues to talk about the Mental Health and Addictions Program, more specifically our CaperBase outreach and adolescent outreach model.

In 2015, the former nine district health authorities in Nova Scotia merged to become the Nova Scotia Health Authority. The Nova Scotia Health Authority is committed to achieving excellence in health, healing, and learning through working together. Also in 2015, the Mental Health and Addictions Program was identified as a priority program and participated in a health services planning process. The goal was to strategically plan for a continuum of services and system supports to better meet the needs of Nova Scotians.

In 2017, jointly with the IWK, we released a report titled *Milestones on our Journey*, which outlined the planning process and key priorities for improvement. You received a copy of that within your package.

The Nova Scotia Health Authority's Mental Health and Addictions Program also recently released our new strategic program plan called Direction 2025. Central to Direction 2025 is improving access to the right level of care so that people can better manage their conditions and work towards recovery. A positive recovery journey requires that people get access and are matched to the right service at the right place at the right time, and by the right provider. Matching the level of service to the needs of people includes everything from upstream health promotion and early intervention strategies to therapy in community and outpatient settings to specialized treatment that may be provided in an in-patient care environment.

The CaperBase, an adolescent outreach service, is one of the services that exists within the broader Mental Health and Addictions Program. It consists of a multidisciplinary team of health professionals designed to address the needs of youth aged 13 to 24. The team works closely with youth, schools, families, and the community to create solutions and opportunities and supports that provide them with the building blocks to live healthy and productive lives.

CaperBase Outreach Services originated from Health Canada's drug treatment funding strategy in the mid-2000s and works within Health Canada's best practice framework which identifies four domains of practice: screening, early and brief intervention, outreach, and community linkages. The team has made significant progress over the years in engaging youth and they had to take on a new approach which is going where youth are at.

It is critical that we reach out and intervene early in order to change or improve the trajectory of the lives of our youth. The outreach worker supports youth in a safe, confidential way to improve personal goals and to take concrete actions to achieve them

through individual and group-based work. Staff also help with the navigation to more intensive clinical services where they're needed.

We also provide and make referrals to other community-based organizations. In addition to providing services in schools, CaperBase opened Access 808 which is a one-stop resource centre aimed at reaching youth who may be not connected with the formal school system.

The evaluations of both of these services show to be very promising and youth were accessing and developing strong connections that allowed them to build and improve resilience and see their full potential. Based on the results, the Department of Health and Wellness provided sustainable resources to ensure that these services would continue.

In 2017, Dr. Stan Kutcher - an expert in the field of child and youth mental health - submitted recommendations at the request of the Departments of Health and Wellness, and Education and Early Childhood Development to address the gaps in mental health supports in Nova Scotia. One of these recommendations included enhancing the existing services in the Eastern Zone and the expansion of services in the Western and Northern Zones. Since the release of these recommendations, the province has invested $3.4 million over four years to expand outreach services and we have since been able to hire just over 14 full-time employees to complement this team. Currently we're working in 99 schools in Nova Scotia.

The team is offering three evidence-based programs which focus on promoting healthy living, coping, and exploring and discovering their strengths. Recently, we asked a youth who had accessed the adolescent outreach services to share how it has impacted their life and they stated: "We started off with a safety plan, which really helped in the long run, so I know what to do if I am having a moment of panic or stress. It also helped with my self-evaluation because I'd never seen myself as worth it. Seeing the [the AOW] over time has not only improved that but improved my mood with it."

As you can tell from this quote the impact that this service has had on youth, their families, and the communities in Nova Scotia is immeasurable. We thank you for giving us the opportunity to share and talk more about this today.

THE CHAIR: Thank you, Ms. Hodder. We will start with our round of questions with the PC caucus for 20 minutes. Ms. Adams.

BARBARA ADAMS: Thank you very much for being here and I appreciate that this is a very sensitive topic. I encourage anybody who is actually watching at home with children that they might want to consider watching it with them or taking note of the subjects that are going to be raised here because some of them may be upsetting to children.

I want to refer to the January 2020 framework for Nova Scotia on the Preventing and Reducing the Risk of Suicide. Just so we're all clear on what we're talking about, in that report it says that in the previous year 112 Nova Scotians died by suicide. The report goes on to say that 1,124 lost their lives to suicide between 2007 and 2016. Those are the ones that we know about for that reason. The report goes on to say that the number of people who attempted suicide is far higher, so that's what I want to start with.

The stats that we were given say between 2011 and 2016, there were 13,746 Nova Scotians who attempted to take their own lives. That means that there are 2,749 people in Nova Scotia trying to take their own lives every year. When you do the math, that means there's seven and a half people who are trying to take their own lives every day. I just want to put that in perspective. That's a lot of people every day. That means seven and a half people are going to try today. Those are the numbers that we were given.

We read a press release yesterday from the Department of Health and Wellness about an improvement in the numbers of mental health services at the IWK. The wait times around the province have not improved significantly that I'm aware of. The first question, and it's open to whoever wants to answer it is, can you tell me what the wait times are for non-urgent care for youth and adults in the industrial Cape Breton area?

SAMANTHA HODDER: We have made significant improvements in relation to access to services and in relation to our wait times. Fortunately, we have our director, Nadine Wadden, here to speak specifically around the Cape Breton industrial area wait times. That is an area that we are certainly aware of that is having challenges in relation to meeting our standards in relation to waits. She'll speak specifically about the wait times in that area.

Many of the improvements that we have seen across the province are meeting the standard for our waits, and I can go into a little bit of detail after Nadine answers the specific question in relation to the waits for the industrial Cape Breton area.

NADINE WADDEN: As Ms. Hodder has said, we do want to acknowledge that we are working very hard to reduce our wait times, especially in the Cape Breton industrial area. In our most recent quarter, from October to December 2019 - I think it's important to start by noting that the average wait time for urgent, within the seven-day standard, is six days' wait for child and adolescent in the industrial area. Once they have been triaged as urgent, the average wait is six days, so we are meeting that standard 93 per cent of the time in the Cape Breton area.

Where we have much room for improvement is in our non-urgent cases, in which we have seen a recent rise from 62 days as our average to an average of 125 days. Again, we know that is too long to wait for our non-urgent cases.

SAMANTHA HODDER: I'll just talk a little bit about some of our provincial improvements, and then I'll talk a little . . .

BARBARA ADAMS: Actually, I didn't ask about the improvements. I asked about the wait times. That's the answer that I was looking for.

I want to clarify that when you talk about the urgent wait times, you're referencing that 50 per cent are meeting the target, which is six days. I have it right here in front of me, which I printed off from the website yesterday. The actual wait time for urgent is eight days. According to your stats, the only time that any region or clinic is meeting the non-urgent wait times is one clinic, Colchester Regional Clinic. According to what I see here, it says your non-urgent target is to be seen within 28 days. In industrial Cape Breton clinics, it's 285 days for adults and 204 days.

That's not anywhere close to meeting the targets. You just said that the average rise went from 62 days to 126 days. We're moving way in the wrong direction. The only one that's even close is Colchester, at 21 days for 90 per cent to meet that, which is what we're talking about here.

Where we have so many of these people who are waiting such an extended period of time, I want to talk about the actual budget that we're putting towards this because the budget is going to dictate wait times. According to Statistics Canada with respect to the reporting of perceived need, in Nova Scotia there are 94,000 who are reporting a perceived need for mental health services in Nova Scotia.

[1:15 p.m.]

According to the NSHA's By the Numbers for 2017-18, 325,593 Nova Scotians got mental health visits. The next year it went up to 369,000 in terms of total visits but when you actually look at the number of people who got that care, it dropped from one year to the next from 44,300 down to 42,998. So we have fewer people in this province getting access to mental health care and the wait times have doubled.

Can you tell me how much the Department of Health and Wellness has changed the budget for mental health services over the last five years and whether you think that's enough money to have in the budget for mental health services?

SAMANTHA HODDER: To answer your specific question, we've seen a budget increase over the last five years of around 14 per cent for mental health and addictions. We're operating with a combination of lead sheet/off lead sheet resources. Our total budget for mental health and addictions for last fiscal year was just under $186 million.

BARBARA ADAMS: Great. I appreciate that number.

According to Statistics Canada, the amount of budget increase between 2009-10 to 2017-18 across the country was an average of 25 per cent increase in budget. In Newfoundland and Labrador, they increased the budget over that period of time by 39 per cent; P.E.I. 87 per cent; in New Brunswick, 23 per cent. Nova Scotia was 12 per cent according to those stats, so it may be 14 per cent.

We are way behind every other province in terms of spending on mental health services. Do you think the amount of money that's being spent by this province has impacted the wait times, especially in Cape Breton?

SAMANTHA HODDER: I think that the investments have been significant over the last five years in relation to mental health and addictions. We've been identified as a priority in the province and have seen more investment over the last five years in mental health and addictions than we had in previous fiscal years.

In terms of the impact on wait times and access to services, I do believe we have seen significant improvements across the province in relation to both adult and child services. We do have an area, which you have pointed out, that is significantly challenged and the primary reason for that challenge is not a financial resource. It's in relation to a significant and critical shortage of human resources, and that directly impacted our wait times.

We have significant vacancies within that area of Cape Breton - hard-to-fill positions - and that has significantly impacted both the wait times in child and adult community mental health and addictions.

BARBARA ADAMS: I'm a little confused because you said that there was a significant spending increase in mental health. Yet I just quoted the stats that we are far behind every other province at only 12 per cent the year before and maybe 14 per cent last year when the average across the country is 25 per cent. I don't see that as a significant increase when we're that far behind everybody else.

You also just said, if I'm correct, that there was a significant reduction in wait times and yet we were just told that on average, there was a rise in non-urgent wait times from 62 to 125 days across the province. I don't see how that marries with what was just said.

The Auditor General in his 2017 November Report on Mental Health Services asked about the budget spending and he has the budget listed on Page 37. One of the comments says, "Health Authority management told us funding is generally based on the prior year budget. Necessary funding adjustments are made if required to mitigate short-term risks. Basing funding levels on historical values is not an effective approach to budgeting . . ." and should be a correction for how the budget for mental health services is done.

I'm wondering if anyone can tell me if there has been a change in how the budgeting for mental health services is being done?

THE CHAIR: Can you table that report, please? Ms. Hodder.

SAMANTHA HODDER: Just a point of clarification: the wait times have not increased across the province. We have one area in industrial Cape Breton that has seen a peak or rise within their wait times. All other clinics across the province have seen a significant decrease, so I would like to have that on record. We have not seen that trend in relation to our urgent response in terms of access, nor our non-urgent across other clinics for mental health and addictions within the adult or child space - just a point of clarification around that.

In relation to the overall budget, the Department of Health and Wellness would probably be in the best position in relation to decision making over the budget allocation of resources. They're not here today to speak to that, but in relation to overall planning we certainly do that in a collaborative way in terms of identifying needs and areas for improvement and where resource investment would be.

We have seen that in the last five years where we have identified priorities in relation to our intake services, our school's mental health, the topic that we're here to discuss today in terms of CaperBase and adolescent outreach where there has been a crisis in urgent care, where there have been strategic investments made in terms of enhancing those services within the Nova Scotia Health Authority.

BARBARA ADAMS: Thank you. I appreciate the distinction between significant increase but as a researcher, the public when they see that it's 284 days wait time for non-urgent care - a significant increase from whatever it was to 284 days doesn't feel like very much.

I wanted to ask you to clarify for me and for those watching how you define what is considered triage Level 1 emergency care versus triage Level 2 urgent care where the target is to be seen within seven days? What does someone have to say or do in order to be identified as a triage one emergency versus an urgent?

THE CHAIR: Who would like to take that? Ms. Hodder.

SAMANTHA HODDER: We have spent a significant amount of time in this province in creating our triage criteria and guidelines for access to community mental health and addictions; that was through our access and navigation initiative. Today with us we have our project lead, Robert Graham, and he will provide some detail in relation to those three triage categories which is emergent, urgent, and non-urgent.

THE CHAIR: Mr. Graham.

ROBERT GRAHAM: When we're triaging people for services, we look at a number of factors - both risk and protective factors - that may be in place for them. We ask people a series of questions around how they're currently functioning and what their previous diagnosis may have been if they've had one before, any medications that they're taking, how is their home life going, what supports they have in place, and if there were any previous suicide attempts or thoughts or risks of suicide.

We throughout NSHA do have a suicide risk assessment policy and procedure that all staff follow. We use that to form the basis of whether or not somebody would be emergent and we'd be looking for them to attend to a local emergency department or we may in fact be calling the police to attend to them on an urgent basis. It is around that risk piece for the emergent.

For urgent, it would be that there is not an imminent risk right now but we do feel that this person should be seen in the next several days. There are risk factors present, but there are some protective factors as well that would deem we do need to see them quickly, so it is not an emergent situation that needs to be dealt with right now.

Our last category would be our regular or our non-urgent. Those are people who may be suffering from moderate to severe mental illness that's impacting their daily functioning, but there are no particular risk factors there right now that would deem that they have to be seen within the seven-day standard. There wouldn't be a current risk of suicide or other factors that the team would be considering when making that clinical judgment. We use those three categories consistently amongst the team, following the policy that's in place around that.

BARBARA ADAMS: I have time for a couple of questions, I think. These are true stories. Somebody comes into emergency having tried to take their own life. What's the standard length of time that they would be in emergency? I have several people that I know who have come into emergency having done something to try to take their own life. They weren't successful, thank God, but they were sent home within 12 hours to 24 hours. In one case, they were told that they couldn't be held at the hospital or provided with any immediate or urgent services because "there was no room at the inn" was the quote.

If someone has come into the hospital -and we have 7.5 attempting every day - showing up in emergency, which ones are going to be held there for care? How do you decide who gets to be sent home?

ROBERT GRAHAM: We work very closely with our emergency departments, which will be doing the initial triaging of anybody who is coming in through the ED. Their staff will do that initial work and make a decision on whether or not they want to consult Mental Health and Addictions to come and have us do an assessment or if the emergency room physician feels confident enough in their own assessment.

Either of those scenarios can take place, where it's the ER doctor's assessment, and he or she is making a decision around discharge and future steps. If they do consult with our crisis team, a member of our crisis team would go. They would also do an assessment and then meet with the ER physician to determine next steps. They may consult with a member of the psychiatry team as well if they feel the person warrants that level of assessment.

If, after psychiatry is done their assessment, they feel that an in-patient stay is necessary, we now have a provincial bed management system for mental health and addictions. We would look to see where the closest available bed is for that person, and the psychiatrist would do up the admission orders around that and then work with our provincial bed management coordinator to send that person to that specific location.

We do get reports on a regular basis, and bed availability has not been an issue in quite some time. When we look at those numbers, we see every day where beds are available in the province, and consistently over the last number of months, there has always been a bed available . . .

THE CHAIR: Order. Time has elapsed for the PC caucus. We'll turn it over to the NDP caucus for 20 minutes. Ms. Leblanc.

SUSAN LEBLANC: Mr. Graham, I'm happy if you just want to finish your thought, go ahead.

ROBERT GRAHAM: I was just going to say that because we do now have that data available, we're in a much better place to be able to provide somebody a bed if they require that level of care.

SUSAN LEBLANC: I wanted to start with a question based on the release that happened two days ago or so, and there was an article today or yesterday - I don't know what day it is - about the better news in wait times at the IWK. My understanding is that those wait times have been significantly reduced, and that's great. I know that there have been new positions added, which is obviously a big part of it. There are people to see people when they come in, which I applaud.

My understanding is that you go in, and you get your choice appointment first or within the right amount of time or a small amount of time, which is great. But then my understanding is that we don't have as much data on what happens then. Someone presents at the IWK, gets their choice appointment, and it's discerned that a course of therapy appointments with a certain social worker or a certain counsellor is what's appropriate. Can you outline what is happening now following the first-choice appointment? How long do people wait for the second appointment, and how does it look?

SAMANTHA HODDER: I'll start with a response to that. I can't speak in relation to the IWK because we are two separate organizations within the province - the Nova Scotia Health Authority and the IWK - but we work very, very collaboratively together in relation to the provision of child services and operate utilizing the same framework, which is the Choice and Partnership Approach which is what you have referenced there.

In relation to our wait times for Child and Adolescent Services across the province, which we term wait one, which is the time from the referral and the intake - that initial contact between "I need help" and the response time in relation to a mental health clinician providing that response and determining that triage criteria that Robert Graham had just described. We track and measure that wait period.

Come this April, Spring 2020, we have our infrastructure in place where we're actually going to be able to be publicly reporting on wait two, which is the point in time between that first-choice visit and what we would call a partnership within the adult services. Those wait times will be able to be publicly available in July. We have to get through the first quarter of visits in order to actually report on those from April onwards.

I can turn it over to Ruth Harding to provide a little bit more detail in relation to that overall process if you'd like a little more information.

SUSAN LEBLANC: I'll just ask maybe a clearer question. I totally get that you're a different entity than the IWK, and I made a mistake there. I was thinking that someone from the department was here to talk about the overarching, so I apologize for that.

Perhaps if you could translate the question then to adult services in the Central Zone, let's say. Can you sort of answer the same question, or maybe you're saying you can't answer that until July?

SAMANTHA HODDER: That's correct. Just to be clear, we do provide child services within our Eastern Zone, Northern Zone, and Western Zone for Community Mental Health and Addictions. IWK provides the provision of child services within the HRM area for Community Mental Health and Addictions where those wait times for scheduled appointments are. Just a point of clarification that the Nova Scotia Health Authority provides provision of child services within our rural zones.

In relation to that question, we can't report on that by zone or provincially right now, but we will be able to share that information with the public in July 2020.

SUSAN LEBLANC: Can you just explain to me again the reason you can't report on that? Clearly, you're seeing people and people are waiting and people have wait times, so how come that information is not available? Is it a new data management system or something?

SAMANTHA HODDER: The first piece of our infrastructure and our registration build within the Enterprise system of our Meditech within our rural zones was to get the wait measures in place and consistency around that for our point in time between referral and first visit. That was our first level of accountability. Getting that data and consistency around the tracking and reporting of that for our wait two measure was our next step within that overall process.

SUSAN LEBLANC: I just want to go back to the wait times in Cape Breton for a minute. I really appreciate the collaborative work that the CaperBase program is doing with schools, but I understand that the focus is working on the needs of youth who require support as opposed to treatment for a mental disorder.

I'm wondering if you could talk a little bit about how the NSHA is addressing the gaps in accessing service for the youth who require treatment.

TARA MACDONALD: In terms of the gap for treatment, it really does come back to actively recruiting clinicians. As Ms. Hodder mentioned, the issue is that there is a lack of human resources. When you look at the data in terms of being able to offer services, it's the clinicians that are offering those services in the community clinics.

Without the clinicians, the wait times grow, so the focus in Cape Breton has been on actively recruiting. We have been looking at incentives. We have been recruiting nationally and trying to go to actual schools where we have Master of Social Work, Master of Psychology, Ph.D. psychologists - trying to recruit to be able to fill the recruitment challenges.

SUSAN LEBLANC: Can we dig a little bit deeper down into that? As we have already heard, the wait time in industrial Cape Breton for non-urgent care is 204 days currently. It's about recruitment. You're doing incentives, you're doing all kinds of things. Where are we? How many positions need to be filled? What are you hearing about why those positions are difficult to fill? How come people aren't coming to take those jobs?

NADINE WADDEN: I would be happy to answer that. In terms of recruitment, absolutely, looking at the level of service that something like outreach can provide. Your question is really looking at access to when it becomes at that clinic level and needs treatment within the community clinics. My colleagues have shared that certainly there is a gap in recruitment resources.

The reasons are multi-faceted in terms of living in a rural community. We're often faced with clinicians who are looking to move into bigger cities and relocate. I would say a large proportion is based on our geography and where we're located in terms of being able not only to recruit but then retain even newer grads to our area. Often, we will try to offer return-of-service agreements so we can have some sustainability for a number of years, especially looking at targeting some of those newer grads.

As Ms. MacDonald had mentioned, we need to go that next layer in terms of partnering with our universities and our education system in terms of looking at what else we can do to recruit those individuals. Of course, we have other standard leaves of absence from work as well. That also comes into play in terms of having vacancies on a temporary basis as well in terms of adding a layer of challenge to recruiting into temporary positions when individuals are on leaves of absence, I would say.

Really, looking also at some of the negative narrative that has come around in terms of working in Cape Breton, the clinicians, the staff, and the employees that we have are working very hard and are very dedicated to this service. In terms of trying to recruit, we all play a role in trying to lean into that and make Cape Breton an area where people want to come and work and start their career or stay in their career in Cape Breton.

SUSAN LEBLANC: It's like the work that my colleague Claudia Chender and I are doing to try to get doctors to come and live and work in Dartmouth. I understand it.

Given that, I'm wondering if someone could provide us a list of the physicians within the NSHA working in child and youth mental health by region and if you can, in those lists, identify any vacancies. Is that something that you could provide to us later or now?

SAMANTHA HODDER: What we can do is provide that detailed information to all members of the committee in relation to our vacancies across the province, by clinic. Within the child and adolescent community mental health and addictions clinics are outpatient services, and we can also provide that for adult as well.

SUSAN LEBLANC: It's not just the vacancies but actually all of the positions and then which ones are vacant. That would be great.

I just wanted to talk a little bit about a fact sheet from PROOF, which is a research program on food insecurity in Canada. It indicates that household food insecurity is strongly related to mental health. I have just come from meeting with a number of people in Dartmouth North who are facing eviction right now. I would tell you 100 per cent that affordable housing and more than affordable but stable housing is also directly connected with mental health. Canadians living in food insecure households are at greater risk of poor mental health than those living in food secure households. This increases with the severity of the insecurity. Not surprisingly, the health consequences of food insecurity are taking a huge toll on our health care system.

The April volume of *The Walrus* magazine reported that with nearly 20 per cent of its population affected, Halifax has the highest rate of food insecurity among Canadian cities and we have the highest rate of food bank usage. I know that in Cape Breton where wait times are the longest and people are having the most difficulty with access to mental

health services, child poverty is higher than in most places in the country and most places in the province. Where there's child poverty, there's food insecurity.

I'm wondering if you can tell me a little bit about how food insecurity is showing up in the work that's happening on the ground level in mental health and addiction services and particularly with youth.

TARA MACDONALD: The adolescent outreach model is looking to try to provide a service to at-risk youth. When we look at who is at risk, children living in homes where there's limited food is certainly a risk factor.

It affects outreach and treatment in a variety of ways. From a treatment perspective, it's hard to do treatment with a youth when they're hungry. In terms of even being within a classroom, teachers report that it's very challenging for children to have sustained attention, to be able to engage in an effective way when they're hungry. One of the things that our outreach program does is in terms of all of our group programs, we offer a nutritional snack that's provided to all of the youth who engage in the program.

We worked with our partners in terms of breakfast programs and food banks. In Cape Breton we have Access 808, as Ms. Hodder mentioned, where youth are able to come and access emergency food resources when needed. Certainly when we look at how we're going to impact mental health, looking at food security is one of the primary things that we need to address including all of the social determinants of health.

SUSAN LEBLANC: Yes, I totally agree that snacks at programs and things like that are really important, obviously. As someone who is often hungry, I am always grabbing something and I'm lucky that I'm able to grab food here and there. However, it's a more systemic problem than someone being hungry as they show up for treatment. So often at this committee I bring issues up of the social determinants of health and everyone nods their head as you are doing now because all of the people working on the ground understand that it's a serious issue. Then we still see it as a serious issue three and four years later. What is happening?

My question is: Is the NSHA having these conversations with the Department of Health and Wellness? Is somebody saying, look people can't function, mental health is deteriorating because people can't find places to live? Mental health is deteriorating because people aren't able to eat enough food to stave off the stress of being hungry. I'm wondering if those conversations are happening and I'm wondering how the NSHA is working with government departments - not just the Department of Health and Wellness - to address the issues understanding that we know there is a direct connection?

SAMANTHA HODDER: Certainly within the Nova Scotia Health Authority and with our colleagues at the IWK, we're having those conversations and looking at the policy

opportunities to work collaboratively with other departments, within the schools, and the community response in relation to those social determinants of health.

This is a high priority for us to be involved within those conversations and make contributions based on the provider experience. What Tara had said in relation to what we're experiencing in relation to the delivery arm within that.

We also have within Mental Health and Addictions, a group of health promotion specialists that work within our program area who collaborate very much with public health services in relation to having community conversations, working with municipalities, and pulling on those policy levers essentially to create those supportive environments in relation to that. There are resources that are dedicated towards having those conversations and identifying it from an influencing perspective and an advocacy perspective about all of the critical things that you're talking about in relation to the social determinants of health.

[1:45 p.m.]

SUSAN LEBLANC: In 2012, the NDP Government established Nova Scotia's first mental health strategy based on extensive community consultation and collaboration. The 2017 Auditor General's Report found that the strategy was poorly managed by the Liberal Government, that aspects of the strategy were not completed within the five years, and that there was no evaluation at the end of the strategy to determine its impact or effectiveness.

One might think or state that this government's reorganization of the Health Authority took priority over the provision of actual mental health services. There were three actions in the mental health strategy which had not been started when the Auditor General conducted his review. No work had been started on sex, gender, and diversity review of services.

Has there been any gender-based and diversity review of services conducted since 2017? If not, does the NSHA have any sense of whether existing mental health services are accessible or appropriate for women, including trans women, non-binary folks, or LGBTQ+ communities, generally?

SAMANTHA HODDER: A piece around that, from an accountability perspective, is the Nova Scotia Health Authority doesn't own the *Together We Can* strategy that was released in 2012. However, we do utilize it as a fundamental document in relation to our planning. There's a significant amount of consultations in key priority areas that we have mobilized within that in working with the department and the IWK. I'll just note, that strategy is still a foundational document in relation to our work and all of the consultations that went into that piece of work.

Within Mental Health and Addictions in the Nova Scotia Health Authority, we have mobilized a Provincial Center for Training, Education, and Learning, which was just launched this year. It's really about competency development, not just for new employees and clinicians onboarding, but also for our existing employees and the practice supports. Working with women and having a trauma-informed care approach for both child and now adult is certainly an area of priority for us in relation to our Provincial Center for Training, Education, and Learning, in relation to the approach and the therapies that we utilize when delivering services to both child and adult.

I wouldn't be able to comment on specifically whether that deliverable had been achieved or not from the perspective of the Department of Health and Wellness, respectfully.

SUSAN LEBLANC: Are there any thoughts on mental health services for trans people, either pre-transition or through transition?

ROBERT GRAHAM: We've been actively working with the IWK on having staff actually trained in doing the trans health assessments, so we now have staff in each of the zones who have that training and are providing that resource now.

THE CHAIR: Order. Time has elapsed. We'll move to the Liberal caucus for 20 minutes. Ms. DiCostanzo.

RAFAH DICOSTANZO: Thank you for all the information. I'd actually like to start to look at how mental health has been in the last 10 years. My kids went to high school 10 years ago, and there was very little compared to what there is now. As more time passes, we're hearing more of the things that are happening within high schools.

Can you highlight for me, the programs in SchoolsPlus and the new adolescent - how are they working together? The things that I hear are amazing. Where are they happening, if you don't mind?

TARA MACDONALD: The SchoolsPlus is overseen by the Department of Education and Early Childhood Development, and it really looks to do inter-agency collaboration between a number of service providers that are within the school. This includes the Department of Education and Early Childhood Development, the Department of Justice, folks from the Department of Community Services, as well as Mental Health and Addictions.

What you'll see within schools is, you have staff that are really looking at trying to coordinate services for youth so that there isn't duplication. We hear from principals, administrators, and guidance counsellors that there's actually a number of professionals providing youth services within the schools. One of the focuses is making sure that those services are coordinated and that there are no gaps existing.

Adolescent outreach, which is why we're here today, is a piece of that. We work collaboratively with SchoolsPlus. Our focus is really looking at providing service to middle and high school students who are at risk for mental health and substance use issues. That is one of the distinguishing factors between us and SchoolsPlus. We're really focused on mental health and substance use concerns, where SchoolsPlus is looking at the broader continuum of supports. We partner very regularly. What that could look like is that we provide group programming together, we sit in on case conferences. The two services certainly are very collaborative and complementary of one another.

RAFAH DICOSTANZO: This is really an amazing thing for our kids at this time. I know stigma is really one of the biggest issues when it comes to mental health. For these kids accessing it, how are you monitoring? For example, if the kids end up in emergency, the adolescents, is there a question about whether they have accessed what's available at SchoolsPlus, or are they accessing it after they end up in emergency? I just want to hear about the access. We can provide all the programs in the world. If there is that stigma that's related, kids are not accessing it. What are you doing to make sure they access it?

TARA MACDONALD: The staff work really hard to establish initiatives within the school that are looking at reducing stigma. One of the fundamentals is that we want to be visible. We want the youth within the school to know that if they need support and they need accessible support in their school, they can go and see a particular staff person because they work with mental health and addictions.

There are a number of initiatives. HeadStrong is certainly one that has been quite successful in Cape Breton and is expanding to other areas, where you bring together a group of students to talk about what we can do to increase mental health literacy and how we can look to reduce stigma within the schools. I had the opportunity to sit in on a session in Cape Breton, and I think there were over 90 youth who were together, true leaders in their schools and really caring about how to improve mental health services and to hear their voice in what's working for them.

We have dedicated resources and focus on stigma within the schools. If a youth goes to the ER, and they're connected with our service, certainly that communication is happening between providers. Right now, the focus is on doing global stigma reducing initiatives within the school.

RAFAH DICOSTANZO: I know you're doing it in the Western Zone and the Northern Zone - you started in Cape Breton, which is the Northern Zone. How did you come up with that area? There are four zones, if I understand it correctly. What is happening in the Central Zone, which my riding is in? I was excited to hear that they're bringing the mental health program, but it ended up at Citadel High, not at Halifax West. How are these decisions made? When will it be at every high school?

TARA MACDONALD: The CaperBase outreach service initiated actually in the Eastern Zone, in Cape Breton. As Ms. Hodder referenced, it was developed as part of the drug treatment strategy funding, and we had a number of positions that were based in Cape Breton.

In 2017, there was a number of suicides of Cape Breton youth. The Department of Health and Wellness had commissioned Dr. Stan Kutcher to come to Cape Breton and have community conversations with youth and with families that were struggling. One of the things that Dr. Kutcher heard was about CaperBase, which had been being implemented for a number of years. Youth actively talked about the benefit of having outreach within the schools. That then led to the recommendation for the expansion into Western and Northern Zones, which is what we have done.

In terms of Central Zone, that would be covered by the IWK. While I'm aware that the IWK has outreach programs, and they have SchoolsPlus, they wouldn't be covered under this initiative within the NSHA.

RAFAH DICOSTANZO: The other question I had - in your opening remarks, you mentioned Direction 2025 and Access 808. These are things that I'm not familiar with. If you could expand on those, I would be really appreciative.

SAMANTHA HODDER: Direction 2025 was initiated about a year and a half ago amongst our program leadership team within the Nova Scotia Health Authority and in collaboration with the IWK. It was essentially to look at the specific things that we want to do for improvement, access being one of the top areas of improvement that we're trying to influence over the next three to five years. It was our strategic plan, essentially, that will guide our direction over the next three to five years. We have a number of initiatives that are essentially bundled within that, looking at things around our relationship with primary health care and collaboration around that.

We haven't talked about e-mental health here today, but that is on the horizon for us in relation to providing high engagement with a low intensity of service for Nova Scotians. We're really excited about the launch of that. That's going to be happening in April of this year. We will be able to provide e-mental health services to Nova Scotians, which will be another access point for people, with no wait. They will be able to access it immediately.

Other things that were identified within Direction 2025 was that we must meet our urgent criteria that were set out. We will have targets set to reduce the non-urgent criteria for wait times in relation to that. We're looking at our Withdrawal Management services and how those are delivered within our current program, our data in terms of our wait two measures, as was referenced earlier in the conversation today, our training and development - I did reference some of that in my previous conversation.

Essentially, that is what Direction 2025 is. It's our road map for the Nova Scotia Health Authority's Mental Health and Addictions program over the next three to five years: where our goals are and where our targets are, so that we can monitor and make adjustments in relation to resource allocation, funding opportunities, and all of those sorts of things over the next three to five years.

I'll let Tara MacDonald speak a little bit more about Access 808. Essentially, that was referenced in my opening remarks, and it's recognizing that in the Cape Breton area, there was a gap in service for children and youth who are not necessarily connected up with the school system. The age range for the house is between 16 and 24. They do offer a group drop-in resource centre. We have mental health care professionals who work within that drop-in centre. It's a hub essentially.

Tara spoke a little bit about that earlier in relation to looking at the goals and meeting the youth where they're at, helping them connect up with community-based resources, referrals, and/or connections with more intensive clinical services if it's something that's required or needed by that youth. I believe that started in 2012.

TARA MACDONALD: As Ms. Hodder referenced, it's a drop-in centre, so youth come, and the premise behind it is that they get their needs met at the school, whether it be looking at connections to other community supports. For example, we do a lot of work with income assistance, because primarily the population that's utilizing the house is youth who might be couch surfing, youth who may be struggling from a financial perspective and having food security issues.

When youth drop in, we're able to connect them with other supports in the community as well as Mental Health and Addictions clinic services. We've got showers available, laundry services as I mentioned, and access to food. The idea is that youth can come to a place where it is very youth centred and safe and secure, and get their needs met.

[2:00 p.m.]

RAFAH DICOSTANZO: Is this hub similar to a peer support kind of team? I know at Halifax West, they started a peer support about three or four years ago. A group of girls started it and it's amazing. Can you tell me what other schools, if you can, in the rest of the province that started through the actual students seeing a need? To me, that will bring access. If they see their peers who have gone through it and talked to them, it's more likely others will come and open up. Is this happening in other schools?

TARA MACDONALD: Absolutely. I think that one of the biggest successes that we can speak to is when you have youth that are in school that are referring one another. They go to the clinician and say I heard you spoke with this person and were able to help. Certainly, the peer word of mouth is significant.

In terms of all of our programs, though, the staff that we have providing outreach have specialty in how to do that in a youth engaging way so they do a great job in terms of trying to provide opportunities for leadership within students and be able to support one another. Within the schools, it could look like committee work where the youth are getting together and supporting one another, and our staff person is the adult that's responsible for kind of overseeing that.

In terms of the house, I recently had the opportunity to go to Laing House that's in Halifax. They use a peer leadership model as well, so that's something that we're looking to explore at Access 808 in terms of youth that regularly access the house and they are the biggest supporters. When we have new youth that come in, oftentimes they'll greet them at the door and say it's nice to see them, ask them if they have been there before, and offer to show them around and show them what the house can offer.

We want to be able to build on those youth leadership qualities and strength particularly at Access 808. Also throughout all the work we do in terms of really having opportunities to strengthen that leadership within youth and for them to be able to talk to one another and to have open dialogue around mental health and substance use issues is one of the priorities.

RAFAH DICOSTANZO: This is wonderful. Can you maybe highlight stories or different high schools where this is happening? What can we do as MLAs in getting in touch with them so we can promote that so that it is something positive? When kids hear that somebody has done something wonderful and I can acknowledge them in the House. It's a positive thing for kids so that other kids look up to this and not feel afraid of actually saying they have a mental health issue and become another leader within that school.

What other schools, what other stories, and how I can help as an MLA as well.

TARA MACDONALD: As Ms. Hodder said, we're in 99 schools. When you think about the expansion of adolescent outreach, it has been quite a short period of time when you think about it. It's really been since September 2018. We've been successfully able to hire folks and have them embedded in the school. It takes some time to establish those relationships in the school so that others within the school really are aware of the service as well as the youth.

What we're focusing on in some of the newer areas - in some of the Western and Northern Zones - is one of the first things is that staff meet with all administration. Anyone that's providing youth services within the school, they get together to say here's what I do, this is my role. What can you do? Where can we collaborate together? Really to get the awareness out there because that's critical so youth and people who are embedded within the school are aware of the service.

I would encourage, from an MLA perspective, to be having conversations with the local schools and to be reaching out and asking if they are aware of this service and to be having those conversations. In some of the areas, it is quite new, so establishing those relationships where people know one another is one of the first things we've tried to accomplish.

SAMANTHA HODDER: Tara MacDonald had referenced the expansion and the increase in terms of access, and I just thought I'd share a little bit of data or context around that.

When we initially started CaperBase and the adolescent outreach services back in October 2018 - which is when we were able to get employees hired, contacts made with the schools, and those relationships built with school administration, et cetera - we saw around 9,000 patient contacts within that time frame. We're up to about 25,000 youth engaged within that service area since October 2018 until December 2019.

This is just to kind of give a bit of context behind the direct contact that we've had with youth and children within the service.

RAFAH DICOSTANZO: This is very encouraging, and I'm sure a lot of stats that we have right now are really between 2007 and 2016. When will it be reviewed, and when would these statistics come up again? When do you expect an update to the 2016?

SAMANTHA HODDER: I'll take that comment. One of the really exciting things that we're doing is we're constantly evaluating the service provision. One of the things that we've been working very closely with the Department of Health and Wellness around is a comprehensive evaluation.

When CaperBase had initiated under the drug treatment funding initiative, we had done the evaluation at that time. We have since embarked on another evaluation, so what we will do is once we have those results, which will be in the Spring of this year, we will make those available if you'd like to review those.

That will include utilization, focus groups, and interviews with children and youth, as well as other providers that we would have had contact with in the school system and school setting. Also, some experiences from the providers themselves about what the opportunities are and what the challenges are so that we can keep an eye to that continuous quality improvement.

TARA MACDONALD: To add to that, after every program, we have an opportunity to survey youth. The premise of the program is that we're really trying to meet the needs of youth, so we have to be asking youth what they need in order to be successful at that. At the end of every program, as Sam referenced, we've got over 25,000 contacts since October 2018.

We hear from youth in terms of what was helpful, what was not helpful, what could be changed, did it meet their needs in terms of them meeting their goals. That will also be encompassed within the evaluation that's been in collaboration with the Department of Health and Wellness.

THE CHAIR: Order. Time has elapsed for the Liberal caucus. We'll move to the PC caucus. Mr. Lohr, you have 14 minutes.

JOHN LOHR: I'm very pleased to hear the presentation today about this very important subject and to have the opportunity to ask some questions. I do want to begin by recognizing that many do receive good treatment, and I know that your front-line workers care very deeply about outcomes. I do want to acknowledge that.

I do think this is a question of access and resources, though. I notice that in the October 2019 blueprint for Mental Health and Addictions, which is the plan that I believe we're working on right now, the number one key area of focus - the first one mentioned - was to increase access to mental health and addictions clinics.

I guess the first question I have is something that's been in the news recently: the North End Community Health Centre's Mental Health Clinic, which was in danger of being closed. The Minister of Communities, Culture and Heritage said that he would find funding to keep it open, which is great. I really don't understand why Communities, Culture and Heritage is funding this clinic at all. How come it isn't the NSHA or the Department of Health and Wellness?

Perhaps, Ms. Hodder, you can shed light on this bizarre funding model. Maybe I should not cast aspersions on the Minister of Communities, Culture and Heritage, but I just don't understand why they're in this funding model.

SAMANTHA HODDER: I'm not actually able to comment on the agreement that was made in relation to that. The Nova Scotia Health Authority doesn't hold accountability for that particular service in Dartmouth, so I can't comment on that in relation to the funding model for that service. My apologies.

JOHN LOHR: The question would be, is it the plan of the Health Authority to increase access to Mental Health and Addictions clinics in the province?

SAMANTHA HODDER: Yes.

JOHN LOHR: This was a walk-in clinic. Specifically about walk-in clinics - and I realize there are not that many Mental Health and Addictions walk-in clinics in the province to my knowledge. Maybe this was the only one; I'm not sure about that. Maybe

you could shed light on that. Is it the plan of the Nova Scotia Health Authority to fund Mental Health and Addictions walk-in clinics?

SAMANTHA HODDER: We don't fund those services. We're not the funding arm, we're the delivery arm in relation to the service provision as a point of clarification around that. At this time, we do not offer walk-in service, as you spoke about with the Dartmouth walk-in clinic.

Just to give some context about our clinics across the province that we have accountability for, we do have 53 community Mental Health and Addictions clinics that provide therapy services to both children and adults right across the province. In our rural zones, they have responsibility for both adult and child. That would be Western Zone, Northern Zone, and Eastern Zone. In the HRM area, we provide adult services for community mental health and addictions.

JOHN LOHR: In a rural area, then, I'm just wondering how a person would access that. I presume what would happen is they would go to the ER, and then in the ER they would be diagnosed as triage Level 1 or 2, urgent/admit or urgent and then would go to be seen at a clinic. Would that be correct?

SAMANTHA HODDER: In relation to our intake service, what exists is a telephone number. That is the way that we would process a referral. We offer barrier-free access. It is not necessary for a person to present to the emergency department to access our community Mental Health and Addictions clinic. We have a 1-855 number that is available to all Nova Scotians. They call that number to reach out for help. Somebody can self-refer. We get referrals from primary health care. We get family referrals as well. When you call that number, you are connected with a mental health professional, who is either a social worker or registered nurse. They essentially conduct a clinical interview, which is a conversation with the patient or the person in need of help or assistance. We determine at that time if we have something that would meet their needs and how quickly we need to respond to them within that triage criteria. Then our aim is to provide that appointment right at that point of contact. We call that a single call resolution.

We do have, as you have described, our provincial crisis line available as well. That's 24 hours a day, 7 days a week. On average, we see roughly 20,000 people who call the provincial crisis line. That's another access point for Nova Scotians with really high success rates. We recently increased our staffing resources to that so that we could meet the standard of a 30-minute response time in relation to calling a provincial crisis line. That would be the maximum amount of time.

There's the provincial crisis line and the intake service to access our community Mental Health and Addictions clinic. We also receive a number of paper referrals that come in from primary health care. Then our intake clinicians, who would be the social workers or the registered nurses, would be contacting the patient to conduct that interview with the

patient in relation to assessing their needs and giving that appointment time for community Mental Health and Addictions.

If somebody was experiencing a mental health emergency, we would be directing them to the emergency department. That is when that process would initiate in relation to the involvement with our emergency department colleagues

[2:15 p.m.]

Mental Health & Addictions has a crisis response and urgent care resources that are connected with the regional emergency departments; within that, we provide consultation. We're a consult service, so the emergency department teams can essentially reach out and get connected with our crisis response team to help provide that risk management and risk assessment of the patient. They may determine and help support that plan to be put in place.

Of course, there's access to our in-patient care environment. If an admission is required, as Robert Graham had described before, we consider our beds and operate on the principle that every bed is a provincial bed. If the psychiatrist makes the decision that somebody requires an admission to an in-patient mental health bed, we will find them a bed in this province.

JOHN LOHR: Thank you. I assume that with the referrals, that would be from a family doctor and I do want to point out that in some communities in the Annapolis Valley, up to 20 per cent of the population of the community do not have a family doctor.

In terms of ERs, I'm just wondering because what we've seen in our ERs lately is - and they have a term for it, I think it's called stage one overcrowding or stage two - they have absolute hallway-medicine overcrowding. We've seen that. I don't know if it's happening every month, but it's happening three or four times a year down in the Annapolis Valley, for example.

I'm just wondering what the policy is if someone was triaged and they said this is a person who is suicidal or whatever, this is an admit, but there's no room in that hospital. What is the policy on transferring them to another hospital? I say that because a couple of years ago, I heard a tragic story of someone in Pictou County who was actually transferred to Yarmouth. For whatever reason, that was the only available one or Halifax was not available for them to be transferred to. Anyway, I'm just wondering what your policy on those transfers is.

SAMANTHA HODDER: I'll just start by saying a point of clarification in relation to our referrals to our community Mental Health and Addictions clinics. We don't require that person to have a family doctor to access Mental Health and Addictions. We just would like to provide members of the committee, as well as the public, with that information. It

is not a requirement. You can actually do a self-referral and we don't require you to have a family doctor for the reasons which you stated.

In relation to our provincial bed management process, I'll turn it over to Ruth Harding to discuss that.

RUTH HARDING: Over the past two years, we have done a lot of work in looking at what our resources are provincially. We're trying to make the most of those especially when it comes to our in-patient services. We have actually implemented - and I'm sorry I'm just getting over a cold - and put in place two provincial bed managers and developed a provincial bed board. At any time, we can look across the province to see what Mental Health and Addictions beds are available. We use that information to work with the emergency physicians, psychiatrists, and the individuals in the emergency departments to make sure that we're able to make the best call as to where a bed might be available.

With regard to our patient flow for in-patient beds, that is another issue that we have worked very hard to address over the past few years. We're very pleased to say that nationally the target for unit bed occupancy is about 85 per cent. We are at this point in time holding steady at pretty much 88 per cent. We've worked very hard to achieve that patient flow both into our units and at discharge and discharging to community for continued care.

JOHN LOHR: Thank you. I appreciate your answers on that subject. I'd like to move on to the adolescent outreach program in our schools. I can tell you that it was about two years ago I was talking to one of our high school student teachers. That teacher told me that in the class of 21 students, nine of those students were classified as having attempted suicide. I realize that not every class would be like that, but I don't think it's that atypical. We have massive mental health issues in our schools.

When I look at the appendix that Ms. Hodder gave with the adolescent outreach review and I look at nine FTE positions for 42 schools in the Western Zone or five FTE positions for 15 schools, I just wonder how that is possibly adequate to meet the demand within the schools. I'm just wondering if you can comment on that. Is there any intent to increase that? How exactly are those positions attempting to even touch the demand that's in our schools?

THE CHAIR: Ms. Hodder, you have just over a minute to respond.

SAMANTHA HODDER: I'll turn it over to Tara to speak about how the schools were selected. One of the important points is that we work in collaboration so this is not the only service that's available within the schools. It's an important and valuable service, but we can't do this alone. I think one message that I'd like to get across is that it is in true collaboration with SchoolsPlus, family services, our intensive community Mental Health and Addictions clinics, and our CaperBase outreach services.

Again, in terms of the reach and our ability to provide and respond in terms of access, we're not alone in doing this. We're doing this in collaboration and that's really sort of one of the fundamental components of the adolescent outreach model and the CaperBase outreach model.

I'll turn it over to Tara to talk about the school selection.

TARA MACDONALD: I'll be quick. In terms of where we allocated staff to the schools, we worked with our partners in the Regional Centres for Education. We spoke with staff in education centres saying this is what we have, where do you see the greatest need? That's the starting point in terms of where we would allocate the adolescent outreach staff.

As Ms. Hodder said . . .

THE CHAIR: Order. Time has lapsed for the Progressive Conservative Party. We'll turn it over to the NDP. Ms. Chender, you have 14 minutes.

CLAUDIA CHENDER: Thank you for being here. This is helpful for us in terms of understanding more detail of all of these issues and this program in particular.

Maybe just to continue in a similar vein, we of course - as I'm sure you did in this area - have paid close attention to the Students First report that came out from the Commission on Inclusive Education a few years ago now. That was, we know, jointly funded by the Departments of Education and Early Childhood Development, Community Services, and Health and Wellness.

We have noted in particular the difficulty around tracking how the suggested courses of action have or haven't been implemented. That report was accepted by government but there was a quite specific timeline of the roll-out of projects that hasn't particularly been followed. One that I think is really relevant here is the idea of providing concentrated short-term in-patient and outpatient treatment for children and youth with severe complex needs.

The commission recommended an inter-agency, intensive program that would run in Cape Breton and Halifax that would do this. It was in year one of the implementation. We haven't seen that, but I'm wondering if there has been a discussion around this intensive inter-agency support program, as it was called there.

In your answer, I would just comment that I really take your point: we can't do this alone. So many of these issues completely transcend government departments. While I know that there are good efforts made at collaboration, we also understand the real silos that exist. I think recommendations like this of inter-agency programs really attempt to

overcome that and to make sure that all of government can be as efficient as possible in dealing with these multi-faceted issues. I wonder if you could comment on that.

SAMANTHA HODDER: Specifically in relation and just to provide context to the committee - I probably should have clarified this in my opening remarks - the Nova Scotia Health Authority operates within what we call a tiered model or step-care framework for both child and adolescent services. Basically what that means is that we looked at data to determine needs of the patient population, and we match the needs to the level of service that exists within that.

In terms of the delivery of service provision, we provide services for what we call Tiers 3 to 5 for the adult population in the Nova Scotia Health Authority across all zones. We're the provider of Tier 3 services for child and youth services in the three rural areas. The intensive services, which would be our Tiers 4 and 5, would be the delivery arm of the IWK.

Just a comment in relation to your reference to inter-agency collaboration, it's really important for us to be essentially very well connected with the IWK as collaborators. Children who are living within the rural zones may be required, of course, to access services delivered through the IWK. They return home, too, so we need to make sure that we have appropriate plans for the transfer to a lower intensity level of service into the areas when a child or youth returns back home with their family.

Just to provide a little bit of context in relation to what we have accountability and responsibility for within the child and youth space is really arranged by that intensity of services within that step-care model.

CLAUDIA CHENDER: What I hear you saying is that the proposed project I'm referring to likely falls within Tier 4 or 5, then.

SAMANTHA HODDER: We don't provide the provision of specialty intensive services. It's not within our mandate for children and adolescents within the Nova Scotia Health Authority. We have to work, and are gladly working in close collaboration, with the IWK to do that.

CLAUDIA CHENDER: That's helpful. You've talked a lot about emergency departments, and I know that's not specifically your purview. We also know that there are many emergency departments that, in fact, can't triage mental health, and the Dartmouth General is one of them to our eternal frustration. We were told that there would be mental health nurses hired there over six months ago. To the best of my knowledge, they still aren't there.

My understanding is that there are 10 hospitals that have access to crisis services in psychiatry. That would be the QEII, the IWK, and then all of the regional hospitals except Dartmouth. How do you interact with the emergency departments that don't have that?

SAMANTHA HODDER: As a point of clarification in relation to our service provision at Dartmouth General, I'm really pleased to say today that in February 2020, this year, we will have two full-time employees working as part of our Mental Health and Addictions crisis service. I would like to just add that point of clarification on that. That is taking place in February of this year, just as a point of clarification.

The way in which a patient accesses emergency and crisis service really does depend on where they're living. Of course, what we get them to do is essentially come to the emergency department where there is a crisis service available to provide that consultation. That requires a significant amount back to the principle and fundamental theme around collaboration and coordination with our emergency department colleagues. We have a really, really strong relationship with those emergency departments. We have to do that.

CLAUDIA CHENDER: February 2020 is now. Notwithstanding the pounding on the desk of my colleague, I am happy to hear that, but dismayed that until this moment apparently those staff haven't been there. Can you say a little bit more about the staff that you're referring to at the Dartmouth General?

[2:30 p.m.]

SAMANTHA HODDER: I believe it's February 13th, I'd have to reference my notes. It is this week - February 13, 2020 - and they will be working very closely in collaboration with our mobile crisis team and our crisis service in the broader HRM at the QEII. Is there a specific point?

CLAUDIA CHENDER: I just was curious. What exactly are the positions?

SAMANTHA HODDER: They are two registered nurses.

CLAUDIA CHENDER: Well, that's great news. We've been waiting anxiously for that news, so thank you for delivering it to us today - three of us are from Dartmouth here.

Staying on Dartmouth for a second, we are aware that the cluster of mental health services in downtown Dartmouth is now moving to the Portland Hills area. That's our understanding. Belmont House, which I believe is one of the clinics you were referring to, and Connections - most of those are now moving to a much less centralized location that is less available to transit. Can you talk a little bit about that decision and how it was made?

SAMANTHA HODDER: In relation to our leased facilities, most of the ones that aren't connected or housed within a hospital are through a request for proposal. That would be through that overall process. There's specific protocol - not to get into too much detail - around the geographical area. We kind of have boundaries that are set when we're putting those requests for proposals out to meet that criteria.

Site selection right across the entire province is consistent in relation to the way that we're doing that. It would be through our request for proposals that would be going out for that. We work very closely with the Nova Scotia Health Authority in relation to our space planning for that. There is a process that's behind site location.

CLAUDIA CHENDER: With respect, I think that process probably deserves a bit of an overhaul because we're moving a cluster of services in proximity to a vulnerable low-income population with almost no access to walk-in or other mental health care towards a location that is predominantly high income and close to a number of other health service points. As I said, also not as available by transit.

We're quite dismayed to hear of that move. As you said, it may be one of those RFP issues, but I think it's one that's worth looking into. If someone's watching out there, please look into it.

Back to the emergency room issue. You said basically someone has to get themselves to an emergency room where these services exist if they are in need of that kind of care. I think that what I heard; if not, you can correct me. Would you say that access to Tier 4 and 5, which I know is what we're talking about here, is equitable across the province now? If not, are there plans to make it that way?

SAMANTHA HODDER: Just a point of clarification: it's not necessarily the individual person that has to get themselves to where a crisis service exists. For example, we would recommend that they present to any emergency department that's closest to home, of course.

It's determined, essentially, based on emergency department to emergency department. That would be within the mandate of the emergency department to help support that, but our crisis services are located within those regional emergency rooms. There might be a transfer of care arranged. It could be through EHS, it may be through a family member who would accompany their loved one and helping to support that transportation. It is kind of determined on a case by case basis around how we would help support on that coordination.

The other piece is that the emergency room physician may consult over the phone with the on-call psychiatrist because in this province we have psychiatry that are on call 24 hours a day, seven days a week. It is individual, on a case-by-case basis.

We do have a policy that outlines those circumstances about our consultation process. The crisis response and the urgent care clinics across the province have been able to onboard additional resources within those that we're really, really pleased about. Our complement has increased right across the province in relation to crisis response and urgent care. We know that there is a significant need.

That has allowed us to look at our hours of operation. In the Cape Breton area, for example, that does have a busy emergency department, we have our crisis response team member there seven days a week, 8:00 a.m. to 8:00 p.m. We look at trends in terms of when people are presenting and really try to flex our resources to meet the needs of when they would be presenting. In addition to crisis response and urgent care, we also have the 24/7 on-call psychiatrist that is available.

It is on a case-by-case basis on how those pieces are arranged in relation to transportation. We wouldn't be relying on the individual to be able to get themselves there. It is a collaborative effort between health care providers that may be working on different teams.

THE CHAIR: Order. We'll turn it over to the Liberal caucus for 14 minutes. Ms. DiCostanzo.

RAFAH DICOSTANZO: My colleagues allowed me to ask my last question, so I'm very grateful.

The last question that I didn't get a chance to ask - and I believe Ms. Hodder started to say something on this - is about social media and how our adolescents nowadays compare to before and are so dependent on. It's a medium that can be also negative when it comes to highlighting or affecting our kids. Also, we can use it as a method to reach them, because that is the first thing they reach out to.

I wonder if you can explain what you started - there was some kind of program that you're looking into. What is happening in other provinces? What other countries are more advanced that we are hoping to reach? Could you highlight how social media and this technology is being used for mental health?

SAMANTHA HODDER: One of the things we're recognizing is that we have to get innovative in relation to how we're reaching out and how people are accessing our services and different pathways for services as well.

Our e-mental health strategy is essentially based on that step-care tiered model that I described earlier around in-person visits but essentially would be online. It is another option or an opportunity for people to bring service or care directly into their home.

There are a couple of pieces with that. We were informed about our colleagues in Newfoundland. They've been doing some e-mental health work for the last number of years and are really trailblazers in relation to this. Our connection up with their team in Newfoundland has been instrumental in terms of guiding our strategy here in Nova Scotia and our partnership.

We also have a significant partnership with ACCESS Atlantic in relation to providing the foundation for our e-mental health strategy, which is our online portal or our website where people would be able to access the tools for service provision. They're helping us with resources to support that build in collaboration with the Department of Health and Wellness as another partner within that mix of things.

We'll have our website available for public consumption in the Spring of 2020. It will essentially host the e-mental health supports for Nova Scotians there. There's kind of a combination of self-directed work that's there and then also some therapist-assisted work, as well: coaching people and working with people in relation to their therapy and their treatment plan. It's really bringing it into people's homes in terms of our e-mental health work. We're really pleased about that.

It's also an opportunity for primary health care. We've been working very closely with primary health care in relation to the strategy. What we have heard is that they need some other pathways for intervening really early. We want to make sure that we're not waiting until people are so sick that they need the most intensive service available. We want to intervene earlier and really have that preventive approach. That's what e-mental health offers is that opportunity, another pathway, another option for people in relation to getting access to the supports and care that they need.

Ruth, is there anything further that you would want to add on to that?

RUTH HARDING: We're very much looking at our e-mental health solutions as addressing care across the continuum. We're looking at opportunities to increase mental health and addiction literacy, information about mental health and addiction illnesses, helping individuals find the information or answer the questions that they may have with regard to: Do I need help? Is my sadness more than sadness? Is my worry something that I should actually seek help for?

We're not looking at developing these resources ourselves but actually partnering with credible partners for individuals, services, and other health care providers to put the right information in the hands of those when and where they want it. The other thing that we're looking at is making sure that the information with regard to literacy, self-management, and self-management apps, making sure that they're available and accessible on a number of different technology platforms.

We did a survey recently and it showed that most individuals are actually accessing information from the Internet through their telephone. We are making sure that whatever it is that we're developing is able to work on a number of different platforms to provide that information.

THE CHAIR: Mr. Horne, you have eight minutes.

BILL HORNE: First of all, I have to say there have been very interesting discussions held here today. My interest is a little bit more into the addictions side of it. I know you've just spoken about it, so it's a good time to ask more questions on addictions. Do you keep statistics on addictions from all of the zones?

Maybe you could talk a little more about HRM. I think you have, in the sense of the hospitals and how they've helped you to keep resources as a way of helping people that have mental illness. I assume addictions, too, but we haven't talked about addictions that much. I'm just wondering if whoever could talk about addictions.

SAMANTHA HODDER: Just as a point of reference for our community Mental Health and Addictions clinics, which is most of the topic of conversation today about access, we provide an integrated program of care. People who are living with a mental disorder or living with a substance use disorder, it's an integrated program so we see both people who are living with a mental disorder as well as a substance use disorder or addiction.

One of the things in relation to some of our specific services that I'd like to share is that our participants or patients are engaged within our opioid treatment and recovery program that is accessible right across the entire province. We've seen a number of investments within that service area. What that has enabled us to do is essentially provide access to more patients.

We have over 2,000 people who are receiving an opiate substitution therapy for their opiate use disorder within this province. What we have been able to do with that is significantly cut our wait times down. When we started this journey in 2017-18 in relation to investments in the opiate action plan, we had about 248 patients that were waiting for service in this province. Their wait could range up to 116 days for that level of care.

Right now, 28 people are waiting for service, and our access is anywhere between zero and 11 days. When I referenced significant reductions in relation to waits and significant improvements in relation to access, that would be an example of where we have been able to provide direct access for people and the greatest needs in relation to addictions. That would be an example of that.

[2:45 p.m.]

The other thing is that in relation to substance use disorder, we have been leaders in relation to the Take Home Naloxone Program. Essentially, I'd just like to share with you in relation to the number of deaths that essentially have been reversed that are reported is 79 in Nova Scotia. From our patient population that have reported to us that they've utilized the Take Home Naloxone kits, they've come back and reported that we've had 79 reversals. We suspect that that's an under-reported number. Essentially, that's 79 lives saved in relation to that program being offered within this province.

BILL HORNE: Does the Central Zone take care of HRM too? The statistics look a little bit skewed for the Central Zone. You have all kinds of other community agencies that look after some of your work. I'm only seeing 535 to 536 clients in the Central Zone. There must be a lot more.

TARA MACDONALD: The utilization data that you're referencing is specific to adolescent outreach. That number looks like it's skewed because that area would be the responsibility of the IWK.

Where we do have some pockets within what is considered Central Zone is in West Hants. Why that data is represented is because when we met with the Annapolis Valley Regional Centre for Education, they highlighted that West Hants was an are that they wanted to have serviced.

While typically services for Central Zone for youth would be under the IWK, that's just one pocket because of where West Hants is located, and the connection with the community mental health clinic is out of the Western Zone. It's looking like it's skewed because typically outreach and treatment services for youth would be provided by the IWK, and we wouldn't have that data.

THE CHAIR: Mr. Jessome.

BEN JESSOME: Just a quick one. I'm referencing the table here in the Theory of Change document, in particular the last section focusing on governance, accountability, and continuous improvement.

I heard the commentary from my colleague and the response related to the IWK being kind of the focal group to take on the Central Zone and my previous colleagues' point about the importance of the Students First report with respect to an overall provision of care for mental health for youth.

I'm wondering if that initiative or that particular line item with respect to the governance group to guide decision making has a particular seat or seats for somebody from the IWK and the Department of Education and Early Childhood Development.

TARA MACDONALD: In terms of the Theory of Change document you referenced, that is the blueprint for the evaluation that we're currently undergoing for the adolescent outreach model. There is a representative from the IWK - I believe it's a manager of policy and planning - who sits on the evaluation working group ensuring that we are looking at similar outcomes and indicators, as would the IWK in terms of the work that they do.

THE CHAIR: Mr. Jessome, you have a few seconds.

BEN JESSOME: I'm not hearing that somebody from the Department of Education and Early Childhood Development is a part of that. I don't know if that's the appropriate place for them to be, but I guess I'm just looking for some feedback.

TARA MACDONALD: We wouldn't have someone from the Department of Education and Early Childhood Development sitting on the evaluation working group.

THE CHAIR: Order. Time has lapsed for questions. I will ask Ms. Hodder for some closing remarks.

SAMANTHA HODDER: Thank you very much for your questions. Children and youth are our future in Nova Scotia. By working together in collaboration, we can provide the best evidence-informed response to those who are in need of support, to their families, and really lay the foundation to build healthy and harm-free communities. The principles and the foundations of CaperBase outreach and the adolescent outreach model that we were talking about today is an instrumental service in terms of achieving that.

I'd like to take this opportunity to thank you all for your questions and your insights. They will certainly guide our thinking about how to continuously improve the care and support that we deliver and to grow and adapt to the changing needs of our population, specifically the child and adolescent population in Nova Scotia.

THE CHAIR: Thank you, Ms. Hodder and your team. We've had an interesting afternoon of questioning and we've heard some interesting programming that's going on. Thank you very much for being here.

You may be excused. We have a short business meeting to conduct, but I'm sure the media will be out in the hall waiting.

[2:51 p.m. The committee recessed.]

[2:53 p.m. The committee reconvened.]

THE CHAIR: Order. We will continue with our business meeting. We have one piece of correspondence and that is from the Nova Scotia Dental Association. I think you all received that.

Ms. Adams.

BARBARA ADAMS: I have a question and then I have a suggestion.

It says on here that the NSDA was aware ahead of time that the committee would be meeting last month and they offered to attend to assist the committee and that they also advised the pediatric dentistry specialist at the IWK and offered to have representation there. I don't recall us being asked.

THE CHAIR: Yes, we were and we turned it down because the topic was for dental hygienists to be here. That did come up in a conversation.

BARBARA ADAMS: In a conversation, but were we all polled?

THE CHAIR: Yes. I think it came up at a meeting and somebody brought it as a motion, was it not? There was discussion about it and it was turned down.

BARBARA ADAMS: Can you clarify for me? I don't personally remember receiving an email asking us to vote which is often what happens. We are all sent an email.

THE CHAIR: I think it was in a meeting. We discussed it in the meeting. It was brought up in a committee meeting, and I think it was brought up by your caucus.

BARBARA ADAMS: I know that I raised the question here about how come we're not including them, but it said that they - the NSDA - offered to attend the meeting. That's different than me saying how come we're not including them and having a discussion here. But I wasn't aware that they had offered to be here and that we didn't submit it to the committee for an actual vote.

THE CHAIR: I will ask the clerk if she any recollection.

BARBARA ADAMS: If I'm reading this correctly, it says, "we did offer to attend to assist the committee." That's not the same as when I asked here how come we're not including them. This looks like they made a specific offer to us, as well as to have the pediatric dental specialist, and frankly I still don't understand why dentists and pediatric dental specialists wouldn't have been relevant to the conversation.

What I'm concerned about is that we had a specific group reach out to the committee and offer to be here and I don't know whether we responded to them. We

certainly didn't respond as a group, so who actually responded to them from the Health Committee itself?

THE CHAIR: I'll ask our clerk.

JUDY KAVANAGH (Legislative Committee Clerk): As far as our records show, this is the first correspondence we've received from the Dental Association. I don't know what they meant when they said they had asked to appear. I don't think they asked the committee.

BARBARA ADAMS: Then can we, as a committee, ask them to clarify what they meant by that because I want to be sure that we respond to people who are reaching out to our committee to present.

The other thing is in the last bullet of their letter, it says, "The NSDA was not afforded an opportunity to provide feedback on the recommendations contained within the CDHNS 'prevent more to treat less' position paper. However, we would be more than happy to task a small group of oral health experts from within the NSDA to review and comment."

THE CHAIR: That's not our job, I don't think.

BARBARA ADAMS: My suggestion would be that we as a committee would write to them and ask them to do that. If the committee doesn't see that as its role, then I certainly would see it as something our caucus would want them to have an opportunity to do. I don't know why we wouldn't want them to comment.

I would like to make a suggestion that we take them up on their offer and that the committee write to them and ask them to provide a review and comments. I assume we would need to vote on that motion.

THE CHAIR: So you're making a motion?

BARBARA ADAMS: I'm making a motion that we accept the NSDA's offer to review and respond with comments.

THE CHAIR: Mr. Jessome.

BEN JESSOME: If we're putting a motion on the floor, can we defer it so we have an opportunity to look back at whatever correspondence came through? I don't remember what this conversation is about right now. I'm sure that we did, but we're lucky to have a Hansard record if we talked about it. If there's an email chain, I'm sure we can get a hold of that, too.

I would just say let's defer it until the next meeting.

THE CHAIR: Ms. Adams.

BARBARA ADAMS: So what I had asked the people who were here answering our questions was whether the Dental Association had commented on their recommendations. They indicated that they were not aware of any comments that the Dental Association might have made.

The NSDA is answering that question that I posed at the last session. They're saying that they were not afforded an opportunity to provide that feedback. They're making it clear that they didn't, but they would like to.

THE CHAIR: Ms. Leblanc.

SUSAN LEBLANC: I believe this last bullet is referring to the report that the Dental Hygienists Association released in 2016. That's four years ago. So while I appreciate the Nova Scotia Dental Association wanting to offer that expertise and comment on that report, I don't think it is a task for the Health Committee per se. This is a report that was referenced in the meeting . . .

THE CHAIR: Can I interrupt you to ask for an extension? Anybody.

Mr. Jessome.

BEN JESSOME: I move that we go another 15 minutes if we have to.

THE CHAIR: Would all those in favour of the motion please say Aye. Contrary minded, Nay.

Okay we will extend to no more than 15 minutes.

Ms. Leblanc, you may finish.

SUSAN LEBLANC: I just think that it doesn't seem like it's an appropriate task for this committee to ask the association to comment on a report that was released four years ago. I think that if the individual caucuses want to get that information from the Dental Association then that is something that the caucuses can look after on their own. I just think that it doesn't make sense to approach it as a committee.

THE CHAIR: Ms. Adams.

BARBARA ADAMS: We have the Dental Association commenting on a document that was from 2016 so it seems only fair that we would allow the Dental Association

(Interruption) You're welcome to vote once I'm finished actually explaining this; then we can take a vote on it.

[3:00 p.m.]

The Dental Association has offered to do this for the Health Committee, so therefore I'm making a motion that the Health Committee ask them to do that. If the other members of the Health Committee are not interested in that information, then they can vote it down but I'm going to make the motion now that we take the Nova Scotia Dental Association up on their offer to respond to the 2016 Dental Hygienists of Nova Scotia report and recommendations

THE CHAIR: We have a motion on the floor.

Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is defeated.

We will go on to our next agenda item. At our next meeting on March 10th, we will have an agenda setting. The clerk has asked that by February 27th our caucuses have submitted to her topics for the next agenda-setting meeting.

Please note our next meeting will be during the House Sitting, so we will meet in the morning on Tuesday, March 10th from 9:00 a.m. to 11:00 a.m. If there are any changes, you'll be contacted.

So with no further business, this meeting is adjourned.

[The committee adjourned at 3:02 p.m.]