HANSARD

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STANDING COMMITTEE

ON

HEALTH

Tuesday, February 9, 2021

Via Video Conference

Emergency Mental Health Care/Services

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STANDING COMMITTEE ON HEALTH

Ben Jessome (Chair)
Keith Irving (Vice-Chair)
Hon. Margaret Miller
Bill Horne
Rafah DiCostanzo
Barbara Adams
Colton LeBlanc
Susan Leblanc
Kendra Coombes

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Karen Kinley
Legislative Counsel

WITNESSES

Department of Health and Wellness

Francine Vezina,
Project Executive - Mental Health and Addictions

Nova Scotia Health Authority

Samantha Hodder,
Senior Director - Mental Health and Addictions

Dr. Andrew Harris,
Senior Medical Director - Mental Health and Addictions

IWK Health Centre

Maureen Brennan,
Director - Mental Health and Addictions

Dr. Alexa Bagnell,
Associate Chief - Child and Adolescent Psychiatry

North End Community Health Centre

Marie-France LeBlanc,
Executive Director

Megan MacBride,
Social Worker

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, FEBRUARY 9, 2021

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Ben Jessome

VICE-CHAIR
Keith Irving

THE CHAIR: Order, please everyone. I'd like to start by acknowledging that we're in Mi'kma'ki, the unceded and ancestral territory of the Mi'kmaw people.

My name is Ben Jessome. I'm the Chair of the Health Committee and MLA for Hammonds Plains-Lucasville. Today we are to receive a presentation on Emergency Mental Health Care with guests from a few different organizations.

A little housekeeping before we begin: I want to remind all members to keep their video on during the meeting. It's important that you also, as much as possible, stay on camera. This will help us to know that you're there, that we're maintaining quorum, and in the event of a vote, to ensure that members are present. If you've got any nearby devices, please make sure that they are on silent or vibrate.

Anybody who is a member of the staff team should not have their videos on. Anybody who runs into some technological issues, please phone or text Ms. Kavanagh. Otherwise, we can proceed into some introductions. We'll begin with our Vice Chair, Mr. Irving, please.

[The committee members introduced themselves.]

THE CHAIR: At this time, I would invite our witnesses from the Department of Health and Wellness to introduce themselves, please.

FRANCINE VEZINA: Thank you and good afternoon, Mr. Chair and committee members. Thank you for inviting the Department of Health and Wellness and our health authority colleagues to meet with you today.

My name is Francine Vezina. I am project executive of Mental Health and Addictions for the Department of Health and Wellness. I'm joined today by my colleagues from NSHA, IWK, and representatives of the North End Community Health Centre who will introduce themselves shortly.

Government's role is to set the strategic direction for Mental Health and Addictions and to provide funding for the health authorities to plan and deliver services across the province. Services are also delivered by community-based not-for-profit organizations like the North End Community Health Centre along with many others.

Those organizations provide essential services in communities across the province including those that specifically serve diverse populations. We are committed to ensuring better access to mental health services for all Nova Scotians. That includes improved integration amongst service providers, a strong continuum of care from health promotion to illness prevention, and crisis and emergency services.

In 2020-21, more than $310 million was budgeted for mental health and addictions. That budget has increased by more than $35 million since 2016-17. Crisis and emergency mental health services has been a key area of investment over the past number of years. We're working with our partners, we have continued to identify challenges and find opportunities for improvements.

We are making progress. Together, we have improved services like the provincial crisis line, crisis and urgent care and emergency mental health services. More clinicians have been added to mental health crisis and urgent care teams at regional hospitals and the IWK Health Centre, as well as on the Provincial Mental Health Crisis Line, which has grown their capacity to respond more quickly to calls from people experiencing a mental health crisis.

Our efforts to address wait times have also led to substantial improvement over the past couple of years. People who are in crisis and need emergency care are seen right away. Nearly all people triaged as urgent cases have had their first appointment within seven days of a referral. We've also seen improvements for those triaged as non-urgent, and we've seen a significant increase in adults who have their first appointment within 28 days of referral. These timelines are evidence-based standards. In short, these improvements are helping people access the care they need more quickly.

This past year has been a challenging one for many Nova Scotians. We fully recognize the impact of mental health on our citizens as a result of COVID-19. We continue to provide information about the mental health system and its crisis support at every COVID-19 briefing.

I want to thank the North End Community Health Centre for the work they do in our community, and in particular their partnership with us to support vulnerable populations throughout the ongoing pandemic. Despite the challenges of the pandemic, we continue to make progress toward our goals for mental health and addictions, including emergency and crisis services. While we are making progress, there is always more that we can do. We will continue to work with our community partners and the health authorities to improve access to care for Nova Scotians.

Thank you for the opportunity to appear before the committee today.

THE CHAIR: Thank you, Ms. Vezina. I appreciate that introduction. Now we'll move on to our guests from the Nova Scotia Health Authority. Ms. Hodder.

SAMANTHA HODDER. Thank you, Mr. Chair, and committee members. Thank you for inviting us to speak about emergency mental health and addiction services in Nova Scotia. My name is Sam Hodder. I'm the Senior Director of Mental Health & Addictions with Nova Scotia Health. I'm pleased to be here today with my colleague, Dr. Andrew Harris, Senior Medical Director for Mental Health & Addictions.

At Nova Scotia Health, our Mental Health & Addictions program offers a continuum of high-quality services across the lifespan to meet the needs of individuals, families, and communities. Our goal is to ensure people can access the right care at the right time in the right place by the right provider.

As COVID-19 impacted health care here and across the country, the Mental Health & Addictions program responded. We continued to offer high-quality care and supports to clients. Our provincial Intake Service line is a single-entry-point toll-free telephone number answered by trained mental health clinicians. Individuals can self-refer to Community Mental Health and Addictions clinics, withdrawal management services and our opiate treatment and recovery programs.

So far this year, intake teams across the province have completed over 10,000 assessments and have responded to over 26,000 calls. With new initiatives focusing on access and flow, we now routinely meet our urgent care wait time standards of seven days in every zone across the province and have reduced our non-urgent wait times by 42 per cent and 43 per cent for children. On average, we see 79 per cent of adults and 75 per cent of children with non-urgent needs within the 28-day standard: 18 days for adults and 8 days for children.

So far this year, our outpatient teams conducted approximately 271,000 visits, servicing over 42,000 people. Our crisis and urgent care teams are located in the regional emergency departments across the province to provide vital consultation service. In the past year, our teams have conducted close to 10,000 interventions. Our provincial Mental Health and Addictions Crisis Line team connects people to trained clinicians 24 hours a day, seven days a week. In a typical year, we manage roughly 20,000 interactions. This year, utilization has increased by approximately 30 per cent. We responded seamlessly to that increased volume by re-deploying extra resources.

The mass casualty and other tragic events affected many Nova Scotians deeply. We put into place additional services and supports and pathways to respond. In March, we made several e-mental health online tools available to Nova Scotians. In June, we launched our new Mental Health & Addictions website, which provides access to resources and information.

We continue to make significant improvements and adjustments to our services to meet the needs of Nova Scotians. These are made possible by partnerships with the IWK and the Department of Health and Wellness, and collaborations with community groups like the North End Community Health Centre.

We will be happy to answer any of your questions this afternoon.

THE CHAIR: Thank you, Ms. Hodder. Mr. Harris, did you have anything to add at this point?

DR. ANDREW HARRIS: No. thank you.

THE CHAIR: On to our friends from the IWK.

MAUREEN BRENNAN: Good afternoon, and thank you so much for the invitation to speak with the Health Committee today. My name is Maureen Brennan and I'm the director of the IWK Mental Health and Addictions Program. I am pleased to be joined today by my program co-lead, Dr. Alexa Bagnell, the IWK's Chief of Psychiatry.

The specific focus of the IWK Mental Health and Addictions Program is to provide children, youth, and families with quality of care that best meets their needs as close to home or school as possible, to partner with other key community providers, to strengthen important connections, ensuring the smooth, safe transition and opportunities for improvement in the services, and to constantly adopt and adapt best practices from around the world and within Canada in a context that's appropriate for Nova Scotia.

The IWK emergency Mental Health and Addictions Service is located within the emergency department here at the IWK and provides a full suite of clinical services delivered by well-trained child and adolescent psychiatrists, residents, mental health and

addictions nurses, and clinical social workers 24 hours a day, seven days a week. The team completed over 1,350 mental health and addiction assessments in the emergency department last year. The IWK is the only 24/7 psychiatric crisis service for children and youth in Nova Scotia and works closely with our EDs across the province.

The IWK has a partnership with Kids Help Phone and continues to work closely with them to respond to the increase in mental health crises throughout the pandemic. We continue to work diligently with our Nova Scotia mobile crisis service to improve how we support patients with their transfer of care and coordination to other non-urgent services across our program. Our urgent care clinic provides responsive follow-up to patients and families who are in need of more immediate access to mental health and addictions treatment.

The IWK has made significant, continuous quality improvements in the emergency Mental Health and Addictions Services by reducing wait times and streamlining our assessment process and medical clearance procedures. We have introduced wellness checks, safety plans, and special patient protocols to improve our response and follow-up to patients and families in crisis.

We are pleased to report through the hard work of our teams that over 98 per cent of children and youth are seen within the seven-day wait time standard for urgent care appointments. Eighty-seven per cent of children and youth are seen within 28-day wait time standard for non-urgent appointments. All emergent cases are seen right away with ongoing improvement to reduce wait times.

The past year has been a challenging one for many in our communities. IWK Mental Health and Addictions was the first to adopt and implement virtual services offering families appointments in ways and times that work for them while improving access to care. I'm happy to share through our COVID-19 pandemic, our program has continued to provide all emergent, urgent, and non-urgent services. In addition, we work very closely with our partners in the Nova Scotia Health Authority, the Departments of Community Services, Education and Early Childhood Development, and other system colleagues to respond to specific mental health impacts of the pandemic and the mass tragedy.

As always, there is much work ahead for the IWK, the Nova Scotia Health Authority, and all our partners. We are focused and committed to improving access to evidence-based services, quality of care, and improved patient outcomes. My colleagues and I welcome your questions. Thank you.

THE CHAIR: Dr. Bagnell, did you have anything to add?

DR. ALEXA BAGNELL: I don't have anything to add, thanks.

THE CHAIR: Now on to our guests from the North End Community Health Centre. Ms. LeBlanc.

MARIE-FRANCE LEBLANC: My name is Marie-France LeBlanc and I'm the executive director of the North End Community Health Centre. We did not prepare formal remarks, however, we wanted to share a little bit about who we are.

The North End Community Health Centre is celebrating its 50th anniversary this year. We provide services ranging from primary health care to dental to housing support for those who are experiencing homelessness and extreme poverty, and we have a special emphasis on the African Nova Scotian and First Nations populations.

[1:15 p.m.]

As I said, we've been here now 50 years and over those years, we've had great partnerships with NSHA and the IWK Health Centre. Over the last five years in particular, we've had a very strong partnership on the mental health front. I'd like to introduce Megan MacBride, who is our senior social worker and will talk more about our mental health supports.

MEGAN MACBRIDE: Good afternoon, Mr. Chair, committee members, and our colleagues at the Department of Health and Wellness, NSHA, and the IWK Health Centre. As I must say, we are very, very happy to be here to answer your questions about the work we're doing in the community around mental health.

In 2018, we began our Pause: Mental Health Walk-in Clinic. That clinic is based on the model that I worked with in Ontario. Essentially, it's a very low-barrier mental health service. We operate in the evenings. Folks don't need appointments to come and see us. They come, they have an appointment with a counsellor for an hour. We don't restrict what topics folks can come and talk to us about. We see everything from folks struggling with grief and loss to more diagnostic criteria like anxiety and depression.

With Pause last year, we very quickly were able to adapt to the restrictions that were put in place because of COVID-19. We were very quickly able to move our walk-in services from in-person to an on-the-phone model. At that time, we were also able to partner with the Nova Scotia Association of Black Social Workers to run a province-wide health and mental health line for folks of African ancestry and African Nova Scotians. It was a very popular program.

We continue to offer online counselling services to keep up with the restrictions in place by Public Health. We operate two nights a week as of right now. We, again, are getting calls from all over the province. We usually see about eight to 10 folks in an evening through our over-the-phone services. Our hope is to grow that program and increase the

amount of nights we're able to offer to the community, as there's been a high usage of that service.

Also, in the last year, we provided a lot of on-the-ground mental health and addictions supports to the community, most notably during the first wave of COVID-19. We were very active in the pop-up shelters and provided a lot of support to the group of folks who had to self-isolate for two weeks at the Lord Nelson Hotel. We were able to do some counselling out of the hotel. We provided a lot of addiction supports there, as well, to make sure that folks could successfully isolate in that set-up.

Because of that, we were also able to run an emergency managed alcohol program that started last April. For those who aren't familiar with managed alcohol, that's essentially a program for folks with severe alcohol use disorder who've tried multiple treatment methods and have a lot of very risky lifestyle effects because of their alcohol use such as drinking non-beverage alcohol or medical complications related to alcohol use.

That pilot was very successful. We were very proud to say that during the period of the first wave of COVID-19, we had no alcohol-related admissions. No falls, no withdrawal symptoms or anything that required further medical assessment at that emergency department. Also, we had no alcohol-related charges during that time, which, for the folks who we have on that program, is a huge accomplishment and a huge protective factor that they were able to offer to decrease the burden that other emergency services were having.

Since then, we've undergone another phase of that program. We're still offering our managed alcohol program. We have 24 folks who are on that program right now. We're currently meeting all of our outcomes as a result of that decreased association with the justice system, decreased burden on emergency services, and an increase in positive health outcomes for those folks.

Again, we're very happy to be here. We're very happy to answer your questions. Thank you very much.

THE CHAIR: Thank you both for those remarks. Excuse me, everyone - I failed to introduce Committee Clerk Judy Kavanagh and Legislative Counsel Karen Kinley, who are with us as well today. Perhaps our friend, Margaret Miller, who is with us can do a quick hello before we get on to questions.

HON. MARGARET MILLER: Apologies to the committee - my screen froze up totally and was giving me a little bit of problem getting back. I'm glad to be here and listening to all the comments and questions. I'm Margaret Miller, MLA for Hants East.

THE CHAIR: Thank you. A further bit of housekeeping before we get started. If committee members could make an effort to address their questions to an individual or organization specifically, I think that would help.

We are going to begin now with our friends from the PC caucus - Mr. LeBlanc.

COLTON LEBLANC: Thank you to our witnesses for joining us in this important discussion on mental health and addictions services. We're dealing in the emergency context here in Nova Scotia. Here we are, less than two weeks ago, we were having Bell Let's Talk Day. It's a day that it's important to discuss on that day, but it's an important discussion to continue the dialogue on this matter each and every day.

Although the Mental Health and Addictions budget is 6.4 per cent of our provincial health budget, mental health and addictions impacts each and every one of us in different ways.

I'd like to first start asking about putting it in a little bit of context regarding the growing demands on the mental health system. There's an article from Global News that stated that there was a 35 per cent increased demand on the provincial mental health crisis line from July 2019 to July 2020. I'm wondering what that looks like now and then in general within the health care system, whether it be in the emergency room context, out-patient services, whatnot. Potentially maybe a question for Ms. Hodder.

SAMANTHA HODDER: Thanks for the question. Since the state of emergency was announced, we have been tracking key performance indicators - prior to the pandemic, but much more closely, weekly and during periods of time of the peak of the pandemic, we were monitoring sort of daily. The reason why we were doing that was we were really wanting to ensure that we had the ability to shift capacity to where that demand was.

You have referenced the provincial crisis line. That is a particular service area as part of our continuum that we definitely saw higher rates of utilization. I think I commented on this in my opening remarks, but roughly we see about 20,000 interventions done on a yearly basis within that line. During the peak of the pandemic, we saw a 35 per cent increase month over month for a period of time. When that looks like a year to date - like up until December 30th - it's about a 30 per cent increase in call volume and interventions on that line.

It was really important for us to be able to flex resources so that we could respond to the demand. I am pleased to report today that we were able to do that successfully. We added additional resources to the crisis line so that we could keep up with the call volumes on a 24-hour basis, seven days a week. That was something that we saw in terms of utilization.

In relation to presentations or people presenting to the emergency department, at the peak of the pandemic - or actually at the very beginning of the state of emergency announced - there was actually a slight decrease in people accessing our crisis services that are located in the emergency department. That has kind of resumed pre-pandemic level.

When we look at the data, about 3 per cent of all presentations coming to the emergency departments represent somebody who has identified a mental health- or addiction-related issue or concern or problem. Also in relation to our intake volumes - and thankfully, we had invested in that central point of access and had been able to stand up our intake service the year prior to the pandemic.

What that offered was sort of a toll-free number, but it was so much more than a toll-free number. We had teams of clinicians trained across the province to be able to assess a patient, a family member, or a referral that was coming in, then have that clinical conversation and essentially determine from the people who were reaching out for help how quickly we needed to respond to their need, and what services were essentially going to best meet their needs.

That would have been from our outpatient Community Mental Health and Addictions clinics. That would be our psychotherapy, talk therapy programs, to our opiate treatment and recovery programs for people who are living with an opiate use disorder, to withdrawal management services.

We have roughly about - year to date this year - about 10,000 intake assessments that have been done. In terms of how many move on to sort of a level of care within the Nova Scotia Health Authority, that rate is roughly about 80 per cent to 85 per cent of people who make a decision to continue on with our service. We also provide grief intervention services during that clinical contact as well.

I also have referenced that we have stood up many other supports and services this year, and a lot of them were in the e-mental health space. A lot of self-management services and self-management tools are available and can be accessed very quickly and free of charge through our website. We have a number of tools that are a lower intensity of service provision that are available for people, but it was really important for us in this past year, as was stated by the IWK Health Centre as well, to maintain a level of access for the citizens of Nova Scotia, not just in the inpatient and the emergency environment, but also very important within the community setting as well.

COLTON LEBLANC: Thank you, Ms. Hodder, for that detailed response. You're checking away all my questions with that answer.

Can we look back historically very briefly? Has there been an increase in services rendered under the Mental Health & Addictions line within the Nova Scotia Health Authority over the last five or six years, let's say?

SAMANTHA HODDER: For the provincial crisis line, we're really kind of pretty stable around sort of the 20,000-call volume since the initiation. I wouldn't say that we've had a significant increase in relation to the provincial crisis line that we've seen this year. That spike is definitely something new for us in relation to up-taking utilization that we've seen this year. We haven't seen spikes like that in previous years.

COLTON LEBLANC: Thank you, Ms. Hodder. When we look at data, the Need a Family Practice registry - we have almost 14,000 more people, just 9,000 last year without a family doctor. Do you think there's any correlation with not being able to access care, chronic management of issues, whether it be physical or mental health due to Nova Scotians not having access to a primary care provider?

SAMANTHA HODDER: One of the really important components of our work is around that collaboration and partnership with primary health care, and so we have a number of initiatives in which we work very closely with primary health care at the local level as well as at the provincial level in ensuring capacity building for both the child and in the adult space, and that would be both for mental health as well as addiction medicine.

[2:30 p.m.]

One of the things that we actually stood up that was identified as a need was addiction medicine consultative service - it's a new service that's available. We've hired addiction medicine specialists who are physicians who are essentially available to participate and engage with primary health care in a consultation about best practice advice in relation to helping to support and manage substance use disorders.

We also have a number of collaborative opportunities with the Atlantic Mentorship Program, so those are some of the things that we do, just some examples that we do. But I will say that one of the things that we identified very early on in relation to access to our services were we were hearing a recurring theme around challenges with access and navigation, and this is not unique to Nova Scotia - this exists right across the country, it's important to highlight that. When they have the courage to reach out and ask for help, where do I start with that?

When we stood up our intake service line as part of our access and navigation project, one of the things that we identified at the very onset was that you did not need a primary health care provider or physician to actually make the referral to our services. You can self-refer, a family member can refer a concern they may have about one of their other family members, and/or we accept of course referrals from primary health care or other community partners in relation to that.

One of the things that we are really trying to do is facilitate and remove any barriers or challenges that people may experience in relation to accessing and navigating the care and support that they need. That was an identified concern that we heard early on and really

tried with our intake service to remove any barrier concern or thinking that you would actually need a referral from a physician or from a primary care provider to access our level of care.

Dr. Harris, would you want to add anything to that?

THE CHAIR: Ms. Hodder, I don't know if I'm the only one that missed that there, but was that clear for everybody else? Show of hands. Okay. Excuse me folks. Dr. Harris, please.

DR. ANDREW HARRIS: I have little to add to that, except we have also stood up a provincial training and education service within Mental Health and Addictions too, and provide supports to family physicians in the community to up-skill them in various different types of interventions, such as cognitive behavioural therapy, and that's ongoing. We're going to layer on more supports for primary care across the province through that venue.

COLTON LEBLANC: Thank you both for your responses. I guess when we're looking at the chronic management of either a physical injury or illness or a mental injury or illness, I think that the research would show that if we have access to a primary care provider that we have better outcomes, so for the 56,000 Nova Scotians who don't have a family doctor, I think it's difficult to have effective follow-up on a wide scale of their conditions.

I guess if it's high blood pressure or whatever it may be, in a time of crisis you often, in rural parts of Nova Scotia at least, have to go to an emergency room to access care. We've seen that, since 2012-13 to 2019-20, that ER closure hours have nearly quadrupled. Back in 2012-13, there were 15,555 hours, and the last fiscal year was 63,332 hours.

I guess for those who are seeking care in an emergency room, if that emergency room is closed and they are going to an adjacent facility for example, some of these facilities - whether it's regional or general - may not have the care or services that they need there. We talk about the crisis intervention teams. If the facility's not open, they're not accessing these services. I guess, how is the significant increase in ER closure hours having an impact on Nova Scotians' lives to access timely mental health services? The question is for Ms. Vezina for the department.

FRANCINE VEZINA: Thank you for the question. The EDs in provincial regional hospitals are always open and the crisis teams are consultants to those emergency departments. Those locations would always be open. Other emergency services that are always available would be through EHS, 911, 811. Between those, the provincial mental health crisis line - then there are some other avenues in terms of folks accessing services 24/7.

COLTON LEBLANC: Thank you for that response. My previous professional background is a paramedic so I'm familiar with the landscape here at least in southwestern Nova Scotia and how the pre-hospital service works with the emergency room service to provide mental health services.

Let's take Roseway Hospital, for example. It's frequently closed. Whether it's closed or not, the nearest regional facility is an hour away. They don't have a crisis response team, I should specify, at that facility because it's a general facility. How is the rural geography and the access to these specific types of treatment, interventions and consults that are required - how does that pose a challenge within our health care system? Do you have any suggestions to improve access for rural Nova Scotians?

FRANCINE VEZINA: Again, through the provincial crisis line in terms of an access (Inaudible) point, and then folks would be connected to local services (Inaudible) describe that process a little bit more. Other investments that we've made, as we've seen through COVID-19 and folks not having that much, we have invested resources in e-mental health care. Various programs have been made available online for folks in rural areas.

Adolescent outreach is another program that government has invested in that gets out to - in this case, it would be youth - so that there is more outreach service. We've made some intentional investments in mental health and addictions to ensure access to services becomes more available and more accessible to folks in rural areas.

COLTON LEBLANC: Thanks for that response. I guess with the couple of moments that do have left, our Party has been a strong advocate for improvements to our pre-hospital health care system - the ambulance system as we know it, the EHS system. Have there been any discussions at the department level at looking to improve the ambulance system?

Let's say we have a call in the Shelburne area, which is an hour away from the regional facility. There are no psychiatry consultation services at that general facility, that paramedics could divert to an appropriate facility. Same thing that happens when a patient has a STEMI. You're not going to go a general facility to arrive there and be seen by the ER physician to be later told you need to be back-transported by paramedics to another facility.

Is that an opportunity for improvement to decrease the numbers of transfers that are required and improve the immediate and timely access for Nova Scotians to mental health services?

FRANCINE VEZINA: What I can do is commit to go back and get more information on that for you. I'm with the Mental Health and Addictions program so I'm not as familiar with (Inaudible) may or may not be happening as far as the ambulance system is concerned.

THE CHAIR: Thank you. Did you have a quick comment, Mr. LeBlanc? We're going to wrap up in 40 seconds.

COLTON LEBLANC: I'll pass on my time, I guess. I'm not going to have time to ask a question, so thanks very much for your responses.

THE CHAIR: Thank you, Mr. LeBlanc. We'll move to Ms. Leblanc with the NDP caucus, please.

SUSAN LEBLANC: Thanks all of you for being here and most of you for being here again. It's nice to see you all. I'm going to sort of pick up where Mr. LeBlanc left off, in a way, and ask Ms. Hodder my first question.

I think I started asking this question, or asked a similar question, in the Public Accounts Committee last month but I didn't really get a clear answer, so I'd like to ask again. I just want to say before I ask it that if you don't have the information right now, that is totally fine. You can always follow up with the committee and get us the information.

The first question is: across the province, what proportion of calls made to the mental health crisis line have an initial interaction with police instead of a mental health clinician?

SAMANTHA HODDER: Unfortunately, I do not have that information. I will go back to our analysis team to determine whether or not that that is data that we can provide yourself as well as the rest of the committee.

SUSAN LEBLANC: That would be much appreciated. You'll know that for many people, particularly racialized people and other marginalized groups of people in the province, that the prospect of police involvement in a crisis will be a major barrier to accessing service.

I'm wondering if there is a consideration of the impact of that dynamic on the users of the service. Is there an evaluation of the service that takes this into account, specifically? Are there conversations taking place, either at the provincial level or the Nova Scotia Health Authority level, around adjusting this police involvement and seeing if there's a way to make investments in the system so that anyone who calls with a mental health crisis is first talking to a mental health clinician?

SAMANTHA HODDER: I'll start off the conversation and then I'll pass it over to my colleague, Dr. Andrew Harris, as well, to add.

We have a high degree of partnership and value for our colleagues both working in municipal police and in the RCMP. That relationship between Mental Health and Addictions has been fostered through many initiatives over the years, whether that's

working on alcohol policy or take-home naloxone kits in distribution for overdose prevention, as well as police liaison. In the Central Zone, there is a mobile unit where police are embedded and integrated right into the team.

It does vary across the province in relation to the level of involvement. What I will say is that we do have a group of us who are connected to look at this very issue that you have raised in relation to our current state in terms of the model that we are offering. Essentially, we're looking at what is any best practice that exists within Canada or internationally about models for service delivery in relation to wellness checks and involvement in relation to crisis response.

That work is commencing right now. We actually do have cross-representation of stakeholders including Justice, municipal police, Mental Health and Addictions, emergency departments, the Nova Scotia Health Authority, the IWK Health Centre, and the Department of Health and Wellness. We do have a stakeholder group that has started this conversation and is formalizing in terms of committee work to look, essentially, at what is the art of the possible around that. That work is to be determined in relation to that.

We have certainly initiated those conversations and continue to do all kinds of things with our police partners and our justice partners around education, supports, making sure that they know and are engaged in our training offerings. Our crisis team - I had mentioned they're embedded and integrated right into that model, as well as ongoing. We participate in walk training for all constables, where we actually provide education around mental health first aid and the range of services that are available. We are looking at those very things, so thank you for your question on that.

[1:45 p.m.]

SUSAN LEBLANC: Thank you very much, it's good to know that it's on the radar. We also talked at Public Accounts Committee, and since then, by the way, I've had a productive meeting with other staff people at the Nova Scotia Health Authority about the possibility of bringing satellite mental health services back to Dartmouth North, but I just want to raise this issue again here: the issue of mental health services in Dartmouth that are being relocated to Portland Hills.

I completely understand the advantages of co-locating the services and the benefits of a brand new space. I love all those things. The RFP process has been explained a number of times so I also understand the practicalities of the move. But given all that, I just want to say that it's indisputable that the decision to take all the mental health services from downtown Dartmouth to Portland Hills will create major hurdles for a lot of service users and a lot of people in Dartmouth North, and in many ways it's a deeply inaccessible change.

I keep hearing about how accessible the new building is going to be, and that's awesome, but that's like putting Access Nova Scotia in Bayers Lake or Baker Drive, where it's highly inaccessible to anyone without a car.

My question for you is this: for the health and mental health leadership in your organizations, what have you learned from the process of this, and what will you do to make sure that in the future the whole process of the RFP and the decision making will work better to serve the folks who need the services?

SAMANTHA HODDER: I would like to provide a bit of information and context around the question. We have three locations: one was an addiction services primary outpatient service for community Mental Health and Addictions, the other was like a mental health services. There has been movement in this province as well as across the country around co-location and the benefits in relation to provision of treatment services when clinicians have the opportunity to collaborate, do case consultation, and essentially that continuity of care and effectiveness of care, so that has been a movement.

The opportunity for us was when those two leases were expiring with no option to renew, that we were going to put out a request for proposal for an integrated site. We did put in all of the requirements, as you had outlined, that we would be looking for in our new space.

The third service that is going to be integrated was our Connections Dartmouth program, which is different than our psychotherapy. It's part of our recovery and integration component and has a significant portion of outreach, which it will maintain in relation to the delivery of services in public spaces and homes. With that particular space, the physical space was not accessible - no elevators, no washrooms - so for anybody who had any sort of mobility concerns, this site really did not serve them well. It was not in good condition and actually was quite stigmatizing toward patients.

When we put out the RFP, the new location was set out, it was within the geographical boundaries that we had set, and actually was established on the highest density of patients based on postal code. It is next door to a transit hub, it is fully accessible for people who are living with disabilities and will have a customized design.

You are correct of course that it is the removal out of the downtown core, and the conversations that our leadership team have participated in in relation to sort of the possibility around having a satellite opportunity is really the opportunity of great collaboration and partnerships, and we definitely welcome that. Anything we can do to add a level of accessibility, we are open to those conversations and those partnership opportunities.

Part of our relationship, and it was spoken to at the beginning of this, with the North End Community Health Centre, we've offered satellite services out of that space for many

years or for a decade. If there is an opportunity for further collaboration within a Dartmouth area, we would welcome that opportunity.

In terms of doing something different in relation to the RFP, we would still be required to go through the same process that we have done. I would say that maybe we could engage in further consultation with community partners around the other opportunities that we could leverage and potentially offer up a satellite clinic or something like that, in relation to space.

The other piece that I would just like to highlight - and I know it was raised a couple of times in relation to access at our last appearance for the Public Accounts Committee - I do think it is important to note here the expansion of virtual care this year. We had always been engaged in virtual care. About eight per cent of our visits were done in a virtual space prior to the pandemic. At the peak of the pandemic, we were about 75 per cent. We still had some face-to-face offerings that were happening in relation to our therapy and our services. We are kind of stabilized around 50 per cent now - 50 per cent offering in a virtual space and 50 per cent offered face to face.

Our plan is to continue that. That is around making services more accessible to people, making it accessible right in their home or whatever private or confidential space that they have available to them. I do just want to also note and highlight that. It is not all virtual and it's not all in-person face-to-face. We need to have a balance. One other critical component for us in relation to maintaining that level of access is utilizing tools like virtual care to bring services essentially into people's homes.

SUSAN LEBLANC: My next question is for the folks at the North End Community Health Centre. The first question I have is: what proportion of people who use the services at Pause are seeking mental health support and also dealing with issues around other social determinants of health - for instance, housing or income inadequacy? I'm wondering if you could talk about what you observe there and about the relationship between the mental health supports and those other supports - to Ms. LeBlanc or Ms. MacBride.

MEGAN MACBRIDE: What we recognize as a collaborative health practice and as a space where the social determinants of health inform our foundation practice - in our Pause program, we do see a lot of intermingling between folks looking for mental health support and also going through other struggles related to the social determinants of health. By using this type of best practice model, we've been able to integrate social work service into our Pause mental health clinic.

At different times, we will have a social worker present doing our intakes, so we're getting information up front about what the client is here really looking for and how we can best serve them.

We also run our Pause mental health clinic in conjunction with our drop-in social work program. On Tuesdays, we have Pause; Wednesdays, social work drop-in; and then Thursdays, we have Pause again. We really do recognize that all of these things are often happening together.

At certain points as well, we have to be able to have our clinicians be able to make that clinical assessment as to what is, in fact, a diagnosable mental health issue or what is the situational circumstance that someone needs support in managing the very natural reactions that we have to some of the circumstances like poverty, for example, that we find ourselves in. We try to holistically look at what the client is bringing to the table and support in all the different ways that they might need help.

SUSAN LEBLANC: I would imagine that one of the benefits of the Pause program is that there's no wait time for access. It sounds like that's one of the most important parts of it. Are there other parts of the model that you want to highlight that you think that are of a specific benefit to the population that you serve? You've already mentioned a lot of it, but is there anything else?

MEGAN MCBRIDE: Absolutely. I think for us using this type of model, we recognize that there is a positive effect for folks to receive any sort of services within their community. That, from the beginning of Pause, has been something that we've tried to integrate into our service. Before the pandemic started, we were operating one of our sites here in north end Halifax and also a site in Spryfield. That's definitely a benefit.

The other benefit that we find by offering this type of service is destigmatizing mental health within our communities. We are very active on social media. We are active in the community. We make that waiting room session as a spot where people aren't just coming for service; they might be popping in because they know we have the coffee pot on. Those types of things. We're destigmatizing, we're supporting folks where they feel comfortable and that allows us to be thoughtful in the types of wraparound services. We're adding to that.

SUSAN LEBLANC: I know that your centre is working hard on advocating for nurse practitioners to be funded to work to the full scope of their practice. I'm wondering if you can talk about the impact that change would bring to the centre? What other changes are a priority for the North End Community Health Centre to better support more people?

MARIE-FRANCE LEBLANC: Yes, we are working strongly. We support a caseload of about 7,000 people with only four physicians and the rest of our wraparound supports. One of the things that we have been looking for is to add support from a nurse practitioner to better help us in triaging and supporting our patients.

As you know, we have a location now in North Dartmouth. That is one of our priorities in North Dartmouth right now. We will be running a pain clinic - which is an

NSHA partnership and it's run through NSHA - with one of our physicians, Dr. John Fraser. We also hope to run our Pause clinic there at least once a week as well as the Nova Scotia Brotherhood Initiative will be running a clinic out of there once a week.

However, there is no primary health care, per se, that is being planned for there. So one of the things that we've been looking at is adding at least a nurse practitioner if we're unable to add a family physician to our offering. For us, as Megan just mentioned, our philosophy is that it's very important for us to bring the services to where the people who need those services are located. That's one of the reasons that we're in North Dartmouth, that we're in North End Halifax, and that we're in Spryfield. One of our key priorities right now is to provide additional primary health care services to our North Dartmouth location possibly in conjunction with Pause or with our pain clinic.

SUSAN LEBLANC: Lastly, I'll just quickly ask: Does the Pause program have permanent operational funding?

MARIE-FRANCE LEBLANC: The quick answer is, we think so. (Laughter)

We did get a wonderful phone call a week ago letting us know that our funding will likely increase and that it is foreseen to be sustainable. We're in the process right now of finding out what those details are, but we're very optimistic and pleased with our preliminary conversations.

THE CHAIR: Excellent. Ms. Leblanc, with 20 seconds, do you want to close us out for this round?

SUSAN LEBLANC: Just with a lot of thank yous for your time. I look forward to the rest of the conversation.

THE CHAIR: We're going to move to Mr. Irving from the Liberal caucus, please and thank you, for 20 minutes starting now.

KEITH IRVING: Thank you all for being here. Obviously, the world that we live in is creating more and more mental stresses on our families and individuals throughout Nova Scotia and particularly this past year, so I really appreciate all the work that you do in your various organizations and levels of the organization, because this is all about making people healthier. On behalf of us, thank you for all the work you do.

My first question should probably go to Ms. Vezina, and that's just to give us a little bit more of a broad look at the funding. You mentioned that $310 million was spent on mental health with an increase of about $35 million over the past several years. Could you give us a broad lay of the land in terms of how that funding is spent?

FRANCINE VEZINA: Thank you for the question. Yes, key areas of investment that we need to improve both access and coordination of services include adding clinicians to community-based Mental Health & Addictions. We've invested in having more clinicians serving First Nations communities. The Opioid Use and Overdose Framework has been a large investment.

[2:00 p.m.]

Community organizations as well - we invest in a lot of community organizations, youth health centres, mental health centres and urgent care. We've added a number of additional clinicians to schools in the most recent years, so now there's a total of 54 physicians that are in schools. Also intake services and (Inaudible) care. (Inaudible) a number of examples of recent investments.

KEITH IRVING: Forgive me, it's either Ms. Hodder or Ms. Vezina here that mentioned the seven-day standard that we are now meeting. A few years ago there were lots of headlines and conversations from my Opposition colleagues about the very long wait times, so I was just wondering where we were at one point, and now obviously we're at seven days meeting a standard.

Describe that journey and what you did to improve those times. Was it additional funds provided? Was it system changes? Could you describe a little bit about how we got from where we were to where we are now?

FRANCINE VEZINA: I would actually also defer a big piece of this to Sam or Maureen, who could specifically speak to the initiatives that were implemented to improve wait times.

What I can say from a departmental perspective is that it continues to be a priority for us to ensure that folks receive the care when and how they need it, and we meet with the NSHA, IWK, and a number of community organizations on an ongoing basis to ensure that we have that integrated continuum of services available to all Nova Scotians. I think specific to the wait times and what those look like now, I would defer to Maureen and Sam to provide you with those details.

THE CHAIR: Ms. Hodder, please.

SAMANTHA HODDER: I'm happy to share the journey, and we haven't arrived fully yet. I think that's important. It's a continuous quality improvement piece, so our goal actually is 100 per cent, right? The first thing was when we became one organization, Mental Health & Addictions became a program of care, we actually didn't have standards that were set in relation to a response time. That was the first step. We have been collaborating with the IWK Health Centre as well as national partners across the country in relation to reporting on standards and by triage level.

You'll hear us talk about urgent, and you'll hear us talk about non-urgent response times. The first thing really was about collectively as a system - and two organizations actually agreeing upon what those standards should be - and balancing that off with what the evidence shows on a national level and international level.

When we talk about wait times, it's important to put that into context of where that is in the continuum of services. The wait times that are available on the public website that get referenced a lot of times are in relation to our Community Mental Health and Addictions clinics for both adult and child. That's essentially the talk therapy or psychotherapy that's provided within a community context. It doesn't account for wait times with our opioid treatment and recovery program or our inpatient services or emergency or crisis services. It is wait times for a type of service or a level of service that we offer within Mental Health & Addictions.

We have set the standard of our response for urgent of seven days and we routinely meet those 100 per cent of the time within the Nova Scotia Health Authority. We may have a slight variation between 98 and 100 per cent over a quarter. Usually, when we actually look at the data, it may be a case that is outside of the standard by a day or so when it's not 100 per cent of the time.

Standing up our intake service was critical to that. Having those trained clinicians that exist right across the province to be able to have that conversation, participate within the clinical interview and identify what the needs are for the patient, and to be able to actually offer them an appointment. We call it a single call resolution. What that means is that the assessment is conducted by the clinician, but they're not waiting for a call back from us for an appointment within Community Mental Health and Addictions. We actually offer the appointment right over the phone in that very moment, so they know leaving afterwards what the next step is in their care journey or plan.

Our response time to urgent, as I had noted, is seven days. Non-urgent is the 28-day standard. We have some work to do within our non-urgent standards, as I referenced. We are 75 per cent in meeting that non-urgent standard within the child space and 79 per cent within the adult space.

Just to give you a sense of where we came from, at the onset we were meeting that standard when we actually set the standards about 35 per cent of the time when we started this journey. We have seen significant improvements in relation to that.

How we did that in relation to our response time was there were additional investments made within Community Mental Health and Addictions, and so there were additional clinical resources that were added right across the entire province: psychologists, social workers, clinical nurses, occupational therapists. We had expanded our urgent care team. There were 13 full-time employees that were added to our urgent care clinics across the province. We actually standardized the work of that team in relation to whether training,

the clinical interview, the care pathways that exist, so that we can have really good transitions for that longer-term therapy within a community context.

We stood up a provincial training and education centre. We call it our Provincial Centre for Training, Education & Learning. That really has served us in two streams. One is our existing workforce from that quality domain is that we're investing in really high-quality, ongoing education, learning and development in relation to the most evidence-based and most effective therapies that are offered and available for people. That's the ongoing investment in that quality piece.

The other pieces that have served us well from a recruitment and retention perspective - we had a number of vacancies that were in existence. We're a big organization. We have roughly about 2,000 employees across that full continuum. We had areas across the province that had significant vacancies that had existed. That does help us in terms of a recruitment and retention component. We've also partnered with our People Services team within human resources within the Nova Scotia Health Authority to also offer recruitment incentives to bring people into NSHA.

I had mentioned the pandemic and our response within that, and our increasing utilization uptake around virtual care, which was another opportunity for us in terms of investment, but it also helped us in relation to our wait times, because what we were able to do was flex our resources provincially. Not all people will benefit from virtual care, but there is a good portion of people who actually prefer to have their clinical services delivered in the virtual space by highly-trained clinicians.

What we're able to do is areas that had greater access, we're actually able to then service those people in need in other areas across the province. We took that a step further in that we actually said, we've got some positions that are really difficult to recruit and we should actually create a clinical virtual care team that essentially offers a model where they can work and provide clinical virtual care all the time, and where there's areas where there's problems with access, they can provide that support to where those needs are.

It really was a combination of multiple things in terms of our access and navigation, really utilizing an improvement in relation to our scheduling and registration, investment within our team members, our employees, as well as our policy and protocols in relation to our response times, and then also really leveraging that opportunity from the clinical virtual care space, and we have seen significant gains, actually quite remarkable gains within the program area.

As I had mentioned, our goal is 100 per cent, so it's continuous improvement and we are going to strive to meet that goal of ensuring access and a response time no matter where you live 100 per cent of the time meeting the standards.

THE CHAIR: I think Dr. Harris had something to add, and then we'll move to Ms. Brennan, please.

DR. ANDREW HARRIS: I just wanted to say one key component to this has been our data systems. We currently collect 100 per cent of all the data, so everything that's going on in our Mental Health & Addictions system. This, comparatively across the country - nobody else reaches this. Some provinces are around 15 per cent, so what they make decisions on is a sampling of information. We're able to make decisions based on the totality of information, so it's high fidelity to our services and the fact that these wait-list times are actually reflective of exactly what people are having to wait for our services.

MAUREEN BRENNAN: Thank you for the question. Very similar to the IWK Health Centre - our central referral service at the IWK is directly connected in with our provincial central intake system, and what Dr. Harris mentioned about data and how people are being registered is a really key component to understanding accurate wait times.

[2:15 p.m.]

The IWK central referral system has been in operation for over 25 years, and it is staffed with a group of social workers and access navigators that are well-trained in complete evidence-based tools to understand what the clinical need is. When that happens, they get an actual appointment and/or they get matched, and the key piece that we started to see improvements is when we started to look beyond within our own service and look at mental health living across the system, across Nova Scotia. We have very strong partnerships with our SchoolsPlus, with our community schools, with community organizations, with the Departments of Community Services and Justice colleagues who actually also have services in courts.

In collaboration with them, the access navigators identify what the issue might be and match that youth or that family to a resource that best meets their need. We also strategically linked in staff to those organizations, so for example, our colleagues with the North End Community Health Centre and the MacPhee Centre for Creative Learning and various family resource centres have clinical staff that are working within those organizations for part of their FTE to become more knowledgeable of the organization and a better way to engage children and youth earlier and support families earlier.

With that, we're actually improving access to care, but then also we're understanding how we can, if we need to step up the level of care, then we can improve that flow. That flow really helps the system of care, and then we start to see wait times and access to care, children and families are being connected to the right level of service and care earlier. Then if it has to escalate to a different level, then that can happen within our system and our strong partnerships.

The other thing is it's not too long ago - probably 24 months ago - I would say our wait times were beyond 12 months. Our wait times mostly now, 87 per cent non-urgent are within 28 days and we're meeting all urgent care appointments. We're pleased with that and we're thankful for the investments from the Department of Health and Wellness, but also it's changing how it is the team has worked.

An example would be about three years ago, the IWK Health Centre adopted a Lean methodology and our pillars around that is that we wanted to ensure improved access to maintain our quality in evidence-based care to ensure that the morale of our staff is good and strong, and that we're focused on productivity to ensure that we have efficient and supportive services that are responsive to the needs.

An example would be access to care that sometimes we would have lost opportunities from an excess of cancellations or no-shows. At one point around two years ago, there was over 28 per cent of cancellation and/or no-shows. We had two different strategies - one on cancellation and one on no-show. Together with patients, families and staff looking for opportunities to fill those and really strong teams working hard, they're down consistently below 8 per cent now, and so we're able to realize and fill those opportunities with appointments. That again helps with access to care, as well as reduce wait times. Those are some examples of the improvements that have led to reduced wait times.

KEITH IRVING: I had another question, but I'm going to turn it over to my colleague and we'll come back to my question if there is any additional time.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: You only gave me three minutes, Mr. Irving. Okay, thank you. My question is actually to the North End Community Centre. You mentioned that you started 50 years ago - happy anniversary. I didn't realize you've been in service for that long.

I heard about you about 10 or 15 years ago as I was an interpreter and working with a few of the doctors at the refugee clinic who also worked at your north end clinic. I would hear a few things that they would say and it's always very positive things that they loved about the clinic.

My question is: how did it start? Was it just like the refugee clinic - a few doctors that started this idea? How did it develop? I hear that you are run as a non-profit organization. If you can just give me some ideas. You said you have 7,000 patients with four doctors serving them. Are these just mental health patients or general? Outline how it started and how do you differ from a regular walk-in clinic?

MARIE-FRANCE LEBLANC: First of all, I wasn't here 50 years ago. I just want to go on record as saying that. (Laughter) We started with three physicians and they were three women associated with Dalhousie University. They really felt that there was a need. The focus was really on African Nova Scotians at the time.

They started with a small office on Gottingen Street, then they moved across the street to a bigger clinic. We actually moved into a building about three and a half years ago because our location was inadequate. We're now on two floors of the building at the corner of Cornwallis Street and Gottingen Street.

We are called the North End Community Health Centre because this is where we started, however, we now run across all of HRM. We are not a walk-in clinic at all - although pre-COVID-19, we did offer walk-in services in the evenings. We haven't resumed those, but I'm assuming that we will in better times.

We kind of have what we like to call - we are a not-for-profit, as you say. We're run by a board of directors. Actually, we're run by our management team, but we have a board of directors as our governance model.

We are a community health centre, which means that we're guided by the social determinants of health and we really keep adding services as we see fit through our community advisory committees and our various partners. We're very steeped in partnerships, not only with the NSHA and with the IWK, but also with Direction 180, Stepping Stone, Adsum House and Shelter Nova Scotia.

I know we don't have a whole lot of time, but we basically have five lines of business, as we like to call them. We have a primary health care clinic, which is a collaborative clinic, which was our first line of business. This clinic not only has 4.25 FTE physicians that are made up of 10 doctors that fill those 4.25, but we also have three nurses, two nurse practitioners, a mental health nurse through our partnership with the NSHA. Every two weeks we have 0.5 of a mental health nurse from the IWK.

We have a social work team now. Megan is our social worker, but through grants, we've added enormously to that with a rapid response social worker that services the African Nova Scotian population. We have an intensive case manager that is a grant program. We've managed to raise some funds to have that. We have a full-time dietician. I think that's it for our primary health care clinic.

We also run a dentistry program. We are the only free dental program east of Winnipeg, and it's completely unfunded, that we scramble every year to try to fund. This program provides free dental service to anyone who comes. We do mostly those living on the street, but we also care for those in poverty. We don't ask questions, quite frankly.

We have MOSH, which is the local outreach street health team that services those experiencing homelessness. We provide outreach services through our van. We have a brand new mobile clinic that was donated to us about a year ago, which has been - with the timing - fantastic with COVID-19. It has an examining table in it. It's fully equipped with EMR. We have refrigeration, electricity. It's a great vehicle.

We also provide clinical care a couple of times a week through that program. We have a nurse practitioner assigned to that program, two nurses, an occupational therapist - and that's it. That's our Mobile Outreach Street Health program. We do a lot of on-the-street mental health crisis response through that program.

Then we have our Housing First program, which provides supportive housing for those experiencing homelessness, trying to transition them to some sort of transitional housing. With that group, we have six housing support workers or intensive case managers. We have a bit of a mix of the two. Recently, we were the recipients of Rapid Housing Initiative funding so that we could provide transitional housing for 15 African Nova Scotian men. We're in the process of purchasing a building right now and we are going to be doing the renovations for that.

In the meantime, we're also running another transitional housing program, mostly based on COVID-19, to try to assist with the influx of people experiencing homelessness right now. We're doing that on Barrington Street. Our foray into providing housing is brand new to us, but it's one that we felt was necessary because of the need right now and because of the trust that we have in the community, and the relationships and the partnerships that we have. I hope that answers your question.

RAFAH DICOSTANZO: Amazing.

THE CHAIR: Thank you very much. We're going to move into our second round of questioning with seven minutes, seven minutes and then three minutes respectively to the PC, NDP and Liberal caucus. We'll start it off with Ms. Adams.

BARBARA ADAMS: Thank you very much and welcome, everyone. I would like to request, though, that since the previous questions went over by four minutes, that they be added on to my time.

THE CHAIR: With respect, I just noted that the final period for the Liberal caucus would be reduced to three minutes from seven minutes. Thank you.

BARBARA ADAMS: Okay. The one thing that I'm conscious of is that - and I'm getting messages from people as they're watching this - it does not match the practical experience that people in Nova Scotia are telling us they're experiencing when they have a mental health crisis. It doesn't match the phone calls. It doesn't match the reports that

someone might get an initial phone call and get off a wait-list, but that they then sit on a long wait time for actual care.

What I want to do is talk about what happens when someone comes through the door in terms of getting taken off a wait-list. The reports that we're getting are that, yes, I might get called within the 28 days, but then I'm giving a half-hour visit every two weeks and I was ready to take my own life.

You mentioned that you're tracking the wait time to get that through the door, but what we're hearing in our office is that the follow-up care is not something that the constituents themselves, their family, their teachers, their doctors were expecting.

I'm just wondering - and I'll leave this open to one person - what are the statistics like in terms of how many visits on average somebody who is receiving mental health services gets now and perhaps compare that to a few years ago in terms of the number of visits you might get. If you were in getting mental health services this year, how many visits would you get over the entire year versus, say, four years ago?

THE CHAIR: Do you want to direct that?

BARBARA ADAMS: Can I direct it to Ms. Brennan?

MAUREEN BRENNAN: Thank you for the question. I can tell you that when anyone comes into our central intake and they get triaged, they go through evidence-based triage assessments and get matched to a particular care provider. In this case, coming into the system, they would be matched to a clinician who would then complete a choice appointment. After the choice appointment, that person is then matched to a partnership clinician. That partnership clinician may be the person who did the choice appointment or it may be someone else who might have expertise or knowledge in the particular area that family or youth has identified.

At that point in time, depending on the goals of that youth or family or what the issues are, there is no set number of visits that are identified with that particular problem area that was brought. It depends on the issue - what is the appropriate evidence-based treatment approach. That can be - for example, if it was someone who had a primary trauma, it could be up to 35 to 50 sessions in our system where if it was someone who had an anxiety or an adjustment issue, it might be something that might be within seven to ten sessions.

Again, it becomes a collaborative discussion with the family at the centre, deciding on the plan going forward. The clinician then would continue to readjust and evaluate that particular plan.

That hasn't changed for the IWK over the last number of years. That has been our model for the last seven years - probably eight years since we brought in the CAPA model. Again, it can change, depending upon the acuity, the complexity and the goals of the patient and family that come into the service.

[2:30 p.m.]

BARBARA ADAMS: Thank you very much for that answer. I guess what I'm specifically looking for - we've seen this in home care where fewer people are getting less care. It looks like there's a reduced wait time when, in fact, the same person who might have gotten 100 hours of care a month from home care is now only being assigned 70, and in fact, only receiving 50 hours of home care a month. That's a common thing.

What I'm specifically asking is, are people in this province getting more hours of care for mental health services per person? Or, is each person getting less care in order to get more people through the door, but don't actually get increased care once they've gotten through the door? Ms. Brennan, I'll ask you that again.

MAUREEN BRENNAN: Again, that wouldn't be a predetermined level. Anyone who comes through our system is assessed and matched to the care that they require or that has been identified.

If someone comes through that requires an urgent care appointment, they would be transitioned to the urgent care clinician immediately and depending upon what is presented in that, they would get immediate access to the right level of care. If that clinician felt that they didn't have the expertise or knowledge to continue to respond to that patient, then we would then refer that on, perhaps, to a psychiatrist for collaboration or consultation or to an intensive level of service.

With us, it's really about the goals of the treatment and what the clinical care path would be for the mental health challenge that has been brought into the session. That hasn't changed for us, but every person coming through that door would have a unique circumstance and situation that might look different.

If you were to average out the session length of one person to another, it might land somewhere on eight to ten sessions average, but for the most part, we don't put a number of sessions that are limited or not. We try to make sure that the patient and family gets the right level of treatment. That continues until those issues are resolved and/or their goals are met.

BARBARA ADAMS: I am going to suggest that tracking those number of visits is something that all health professionals do in terms of, say, even a total hip joint replacement, you would know a typical number of visits that someone might need from a physiotherapist.

One of the questions that I wanted to ask was - and I apologize, I think it was Ms. Vezina - when a call comes into 911 that's more of a mental health crisis, does it get diverted to the Provincial Mental Health Crisis Line, and if so, how many of those would get diverted in the run of a year?

FRANCINE VEZINA: It would be diverted to the Provincial Mental Health Crisis Line,. There is a patch through 811 to the crisis line, if that's what they should need. I don't have the numbers. However, Ms. Hodder may have the volume on that.

THE CHAIR: Ms. Adams, would you like Ms. Hodder to respond?

BARBARA ADAMS: Do you have the numbers?

SAMANTHA HODDER: I do not have those statistics with me.

BARBARA ADAMS: I would like to suggest then having a separate line so that we can actually get people to the care that they need quicker. One of the plans that we have is to have a separate line for people who are in crisis to call, rather than 911 so that we can get people the care that they need the quickest.

What has the amount of money been increased to in terms of treatment for addiction services in this province? I'll ask Ms. Brennan for the youth.

MAUREEN BRENNAN: We have a couple of services that offer addiction concurrent disorders treatment. We have additional clinicians that have been invested in that program. We've invested in capacity and competency for all our mental health and addictions clinicians across our urgent care clinics, as well as our community mental health and addictions clinic to be able to respond to those who might have a concurrent disorder - that being a mental health and an addiction issue.

More specifically - I'll pass it over to Dr. Alexa Bagnell, who can speak a bit more about our specific care clinic and our concurrent disorders clinic that actually has resources and can respond to those levels of complex patients as well.

THE CHAIR: Unfortunately, that's all the time we have for that round of questioning. We'll move to the NDP caucus with Ms. Leblanc, please.

SUSAN LEBLANC: I'm just going to ask one question and then send it over to Ms. Coombes. One thing that we've been waiting for from the Department of Health and Wellness that has been promised is the African Nova Scotian Health Strategy. I'm wondering if any of the folks here representing mental health and addictions units can talk about whether you've had any input into that strategy and when we can expect to see the strategy. That would be Ms. Hodder, Ms. Vezina or Ms. Brennan.

THE CHAIR: Ms. Hodder, do you want to kick us off, please?

SAMANTHA HODDER: I think specifically in relation to the strategy that Ms. Leblanc has mentioned, I think that would probably be better answered by the Department. However, I can speak on behalf of our organization in relation to our equity, diversity and inclusion framework.

THE CHAIR: Perhaps we'll go to Ms. Vezina and then we'll leave it to Ms. Leblanc to decide if that works. Ms. Vezina, please.

FRANCINE VEZINA: No, I can't say to where that would be at this point in terms of - they have seen it here at the department or any input in the development from my perspective in mental health. I was not involved in the development so I can't speak to that.

SUSAN LEBLANC: That's fine. I'm going to turn it over to Ms. Coombes.

THE CHAIR: Ms. Coombes, please.

KENDRA COOMBES: The Auditor General, in 2017 and again last year, pointed out that the reporting of wait times for mental health services is not adequately available. This means that Nova Scotians are left with an incomplete picture of the availability of mental health services, and left with an unclear expectation should they be waiting for services.

Specifically, wait times for the second urgent appointment in the Western and Eastern Zones are absent despite being asked for four years ago. When will these be available? That is for Ms. Hodder.

SAMANTHA HODDER: The wait times for Wait 2 are publicly available for all zones. In relation to specifically for Eastern and Northern Zones for non-urgent, they are available. Regarding why there's not a report on the urgent would be that we actually don't record on counts of less than five, what that means is that within Community Mental Health and Addictions service, that next step within the treatment journey didn't require an urgent response under the Community Mental Health and Addictions service level, so the count would have been less than five, and so we would have suppressed that count.

KENDRA COOMBES: Okay. My understanding is for this, just to say this, you didn't deem it urgent after the first - it doesn't get counted. Okay.

I also need to draw attention to the mental health service wait times here in Cape Breton. In rural Cape Breton, you could wait over three months for the initial appointment. In industrial Cape Breton, you could be waiting seven months for the initial appointment. I will admit that is down from a year-long wait before that. What is the targeted wait time for these areas, and when can we expect to see more improvement here?

SAMANTHA HODDER: I just would also like to clarify for the committee, it is not that it wasn't - it was just that the number of people triaged as urgent wouldn't have required an urgent response time. If we had greater than five, that would have been reported on, and that's per our information sharing, so on that urgent piece. The non-urgents are available across all zones because counts were greater than five.

In relation to the question around our non-urgent response times in Cape Breton, we have made significant progress in relation to that, and it does speak to the work that I had referenced in relation to our wait time journey. I will note that we still have a way to go within meeting that standard of non-urgent. I did, and what is publicly available right now is around our response time for both child and adult within the non-urgent space, and we have significantly reduced that amount of time.

You're going to see another significant improvement within Quarter 3, which will be publicly available, and our 50th percentile is at 29 days for the Quarter 3 reporting period, and I did - that's not fully run yet in terms of the data capturing, but I did get that specifically around Cape Breton, as I had anticipated we would get a question around our progress to date, so it's another 60 per cent reduction.

KENDRA COOMBES: Thank you for that answer. I'm just wondering, with COVID-19, it's had an incredible impact on mental health of the public in general, but it has a big toll on our front-line workers. That includes doctors, paramedics, nurses, and people who are working in long-term care are pretty much what come to my mind.

It's my understanding for paramedics specifically, of course, that it's possible that recently commissioned Fitch and Associates report provided for some solutions to this issue and there was a challenge facing that workforce, but to date, the government has refused to release it.

Can you talk about whether the department is taking any particular approach into supporting people who work in front-line care?

THE CHAIR: Unfortunately, that's all the time that we have for that round of questioning. Now the Liberal caucus with three minutes, please. Mr. Horne.

BILL HORNE: I've been sitting here this afternoon wondering how we coordinate all our mental health and addictions programs with each of the departments and the private sector, too. I'm just wondering if Ms. Vezina can talk about how that's coordinated? Is it clear lines that are set down well back in time to indicate where people will call and who will call? I'm just wondering if you could give me a quick rundown on that.

FRANCINE VEZINA: Just a quick clarification related to this around the Provincial Mental Health and Addictions Crisis Line. It is a separate dedicated number.

It's just that if you go through another venue, such as 811, then you will be patched through so that they don't have another number to call. Just to be clear on that one.

We do work with partners across the system in terms of looking at access to care, continuum of care, and reducing the fragmentation. In terms of our relationship with the NSHA, as mentioned in opening remarks, we provide the oversight, the funding, and strategic direction to the health system. Most of the funding, certainly a good portion of the mental health budget, to the health authorities is to provide those services.

We also work with other government departments and community organizations around reducing (Inaudible) ensuring continuity in that there are roles for lots of different people to play in it. We witnessed that even in responding to the Portapique tragedy in terms of working with victim services and the Department of Justice.

There are relationships with emergency departments and with Mental Health and Addictions as consultants to those departments to ensure that when people enter the system through emergency departments, that that is a smooth experience for them. Working with the Department of Community Services (Inaudible) at clients who may have more complex needs. Of course, as I mentioned, the community organizations and those partnerships in terms of lower-tiered services that folks may need.

THE CHAIR: Thank you. That's all the time that we have for questions this afternoon, folks. Thank you so much. At two minutes a pop, let's go through our representatives here with closing remarks beginning with you, Ms. Vezina, at the Department of Health and Wellness.

FRANCINE VEZINA: Just briefly to say that access to care and ensuring folks get the right care when they need it and by the right provider continues to be a priority for us. The team here at the Department of Health and Wellness, and the many folks that work in Mental Health & Addictions, are very committed and very passionate about ensuring that Nova Scotians get the care they need.

THE CHAIR: Thank you kindly. On to Ms. Hodder with the Nova Scotia Health Authority, please.

SAMANTHA HODDER: Thank you very much for the opportunity to speak with everyone here today. I am happy to answer any questions or comments outside of this meeting, as well.

Ms. Coombes, I know you didn't get a response to your question in relation to the psychological supports, so I am available to have a conversation with you around the federal Safe Restart Agreement resource at $1.5 million that's been allocated to the Nova Scotia Health Authority through the Department of Health and Wellness around what we're doing to provide provision of support for first responders. I'm happy to follow up with you

after this session to have a deeper conversation about that particular initiative and the steps we're taking there.

We will continue this as a continuous quality improvement journey for us. We continue to make strides in relation to ensuring that we have services that are highly accessible and that we ensure that transitions across care with our community partners and within the Nova Scotia Health Authority and the IWK Health Centre are seamless, and that we have a really high level of patient engagement and patient experience and family experience.

[2:45 p.m.]

We also need to know when things aren't going well, and so I would invite folks that if there are things that you want us to be aware of outside of this forum to please reach out to me or other leaders within your community to share those so that we can essentially look into that further and ensure that we have that continuous quality improvement lens on the service provision that we offer within the Nova Scotia Health Authority.

Thank you for your time. Again, I'm happy to be available outside of this forum to provide any additional support that I can.

THE CHAIR: Ms. Brennan, please.

MAUREEN BRENNAN: I would also like to thank the Health Committee for the opportunity to discuss the program of care within the IWK. It is really important to have public accountability and transparency in publicly funded organizations. I think the questions and the ongoing dialogue are so very important. It is important for folks to begin to have confidence in the services we're providing, but then also understand that we need to continue to improve. We need to continue to receive feedback and we need to continue to make services that are more meaningful and meeting the needs of citizens across Nova Scotia.

That is the goal within the IWK and I know our partners in the Nova Scotia Health Authority and the Department of Health and Wellness. It is also important to note that, in fact, we have a provincial table that the Department of Health and Wellness, the Nova Scotia Health Authority and the IWK Health Centre sit at to ensure that we're walking in step and planning in step, and that our strategies match and connect, and that services offered from Sydney to Yarmouth are standardized and have the same quality of care. We're committed to ensure that continues to happen and that we move to improve services that will matter.

I would like to thank all of you for your time. Again, similar to Ms. Hodder, we always encourage feedback. We have a lot of ways to engage with ideas and with feedback

that families and community partners have. We welcome that, and again, we thank you for your time and conversation today.

THE CHAIR: Thank you. Last but not least, to our friends at the North End Community Health Centre - Ms. LeBlanc.

MARIE-FRANCE LEBLANC: Thanks for including us in this conversation. We really value the partnerships that we have with the various organizations. As a community health centre, our expertise is to provide low-barrier services in communities where people need them. We've grown extensively over the last 50 years. We now provide services in Spryfield, the north end of Halifax and in Dartmouth North. We cherish the partnerships and we value the partnerships that we have and really appreciate the opportunity to share what we've been doing and how we work in particular in the mental health realm, but also in the primary health care realm.

If anybody wants to come visit us, come see us. You know where to find us. Thanks very much.

THE CHAIR: Thank you, everyone. Our guests are free to depart at your leisure.

We've got a little bit of committee business. Just before we dip into that, in fairness to Ms. Coombes, I know that I cut off your answer there, so perhaps I'll ask Ms. Kavanagh to review that last-minute statement and put the question into writing - in fairness to Ms. Coombes and for the benefit of the Committee. Then we'll seek that response through Ms. Hodder.

On to our committee business. We have a few items that I'm going to get through. We have an email from Anne Gillies regarding long-term care. This was forwarded to members on January 26th and again this morning. Was there any discussion on this particular correspondence? Ms. Adams.

BARBARA ADAMS: I think it's really positive that people are writing to our committee with their concerns. I'm just wondering if it's possible for us to consider a motion writing to the Minister of Health and Wellness to ask about one issue, which was the update of the long-term care expert panel's report. The last time it was updated was September of 2019, and when I asked Ms. Lopez if it had been updated, she said that it had not been.

In discussion, after reading this woman's letter and speaking with her, one of the recommendations was to request that the long-term care expert panel update the updated, given that it's been 16 months since it was last updated. I would like to propose a motion to the committee that we write to the Minister of Health and Wellness requesting that Ms. Lopez update the long-term care panel expert report.

THE CHAIR: Is there any other discussion on that motion? Can I clarify what the motion is again there, please?

BARBARA ADAMS: Yes. There was an expert report released December 2018 on long-term care. Then there was an updated report on what had been achieved as of September 2019. It has not been updated since then, so I would like to request that our committee write to the Minister of Health and Wellness to ask them to provide an update on what has been achieved from the expert panel's long-term care recommendations.

THE CHAIR: Okay, so an update on the achievements of the expert panel is what the motion is regarding. Any further discussion? Mr. Irving.

KEITH IRVING: I don't particularly have a concern with this, although Ms. Adams, do you know what the update in 2019 was relative to 2018?

BARBARA ADAMS: No.

KEITH IRVING: Was there a whole series of things that were continuing to be worked on that you felt in this subsequent year it's valuable to get an update?

BARBARA ADAMS: Yes, there are a number of things that were indicated there that were already checked off that we know have not been accomplished. One would be the Continuing Care Assistant Program, where the government had given 150 seats. That was to hope to raise the training from the current level of 550 seats up, and we just learned that there are going to be less than 400 CCAs graduating this time around. The department's perception of what has been accomplished from those recommendations as of 16 months ago may not, in fact, be what has been accomplished now.

It would be nice to have an update given the fact that at the last Health Committee meeting on long-term care, the Deputy Minister of Health and Wellness indicated that the government's plan to produce a five-year plan for long-term care did not materialize. They said they were focussed on expert reports, so I think it's important that we have an update on a report that was released nearly three years ago.

THE CHAIR: Thank you, Ms. Adams. Any further discussion? Would all those in favour of the motion please raise your hand. Contrary minded, raise your hand.

The motion is carried.

We've got another piece of correspondence from our Minister of Health and Wellness regarding organ donation and communication strategies in response to the question made at our December 8th meeting. Was there any discussion on that item? Ms. Adams, please.

BARBARA ADAMS: One of the things that we had wanted to encourage was to be sure that people who were able to get through, if they did not wish to be an organ donor - to be able to have enough information to know that they could call in. Subsequently, there have been a number of people reporting that they're waiting on the phone for over two hours in order to get through.

I'm wondering if our committee could write to the department now that the program has started, which is wonderful, to ask for an update on how many people have called in to take themselves off the list and if they worked out the problems for the call delays. Even I called in to see how long it would take me to get through that line, and I had to hang up after an hour and a half.

THE CHAIR: Given the timeline, is that something that we might table for a couple months down the road, or is it something that you want to . . .

BARBARA ADAMS: I think my concern is that there a lot of people I've talked to who wanted to call in and they got frustrated. They don't have access to the internet, possibly because they don't have phones and the internet that they need in order to do that. I'm concerned that the number of people who might want to opt out are not getting that opportunity because of the phone delays.

I'm certainly happy to find out, in a few months from now, how many people have opted out but I would like to know now two things: one is how many people have opted out, and have they fixed the delay of an hour and a half to two-hour wait time in order to get through on the phone?

KEITH IRVING: I believe that was released maybe a couple of weeks ago. There were news reports on that. They were expecting five or seven per cent and only one per cent - they had those numbers. That was released.

This is early days here yet, I'm not sure that there's a systemic problem here that needs investigating. I don't have any problems if we wait a few more weeks. Obviously, in the initial weeks, the lines would be crowded. I would imagine over a period of time that that would quickly reduce.

We can write letters, but I think we should give a little bit of time for it to work its way through. This is relatively new.

BARBARA ADAMS: I understand that philosophy, but one of the things that we were concerned about after the last Health Committee meeting on this was the education piece in terms of getting the message out to the public.

If there are phone delays right now and that discouraged people from calling in, what's the plan moving forward in order to continue to educate people that this program

has, in fact, started and that there is this process in place if you want to take yourself out from being an organ donor.

THE CHAIR: I think Mr. LeBlanc wanted to add something.

COLTON LEBLANC: I just noted that we're coming up short on time. I'm not sure if we want to make a motion to . . .

THE CHAIR: I'll probably table our last couple of items for today. We'll wrap this discussion up. Thank you, Mr. LeBlanc.

COLTON LEBLANC: Just a comment on Ms. Adams' motion. I do agree with Mr. Irving that it is a new program. With that being said, there are still a number of people who are calling back to my office with uncertainty about the program and they're seeking information.

As there's more and more discussion in our communities about the program and its intent, I think the issue of trying to access via phone to register their wishes may persist longer than expected with the department. I just have that to say.

THE CHAIR: Is there any further discussion on that? I think what we'll do is, perhaps, Ms. Adams, we can write to the department to request an update with respect to the phone inquiries and the phone engagements and then perhaps table, I'll call them, the results for a month or two down the road at the discretion of the committee.

We're closing on two minutes here. I'm going to just say that we've received the organizational chart from the Department of Health and Wellness. We have a request for a more robust organizational chart from the NSHA. As Chair, I would like to have a little more of a broader discussion around what, specifically, we're looking for. By comparison, we've got a one-pager versus a 75-slide PowerPoint presentation. We'll table that for today.

Our next meeting is Tuesday, March 9th from 1:00 to 3:00 p.m. We've got the Yarmouth & Area Chamber of Commerce regarding local efforts to welcome doctors to the community. If the House is sitting on that date, the meeting will take place from 9:00 to 11:00 a.m.

Unfortunately, that's all the time we have for today's regularly scheduled program. We'll see you folks again in the not-too-distant future. Have a great day. We're adjourned.

[The committee adjourned at 2:59 p.m.]