HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Tuesday, February 8, 2022

LEGISLATIVE CHAMBER

Auditor General's 2017 Recommendations
Re: Mental Health Services in the Province

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HEALTH COMMITTEE

Trevor Boudreau (Chair)
Kent Smith (Vice-Chair)
Chris Palmer
John White
Danielle Barkhouse
Hon. Zach Churchill
Rafah DiCostanzo
Susan Leblanc
Kendra Coombes

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Kathleen Trott, Associate Deputy Minister
Dr. Sam Hickcox, Chief, Office of Addictions and Mental Health
Francine Vezina, Executive Director, Office of Addictions and Mental Health

Nova Scotia Health

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

IWK Health Centre

Dr. Alexa Bagnell, Chief, Psychiatry
Maureen Brennan, Director, Mental Health and Addictions Program

HALIFAX, TUESDAY, FEBRUARY 8, 2022

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Trevor Boudreau

VICE CHAIR
Kent Smith

THE CHAIR: We'll call this meeting to order. This is the Standing Committee on Health. I am Trevor Boudreau, the MLA for Richmond and Chair of this committee. Today, we will be hearing from the Department of Health and Wellness and some of their colleagues on the topic of the Auditor General's 2017 recommendations regarding mental health services in the province.

Members, witnesses, the Legislative Committee Clerk, and Legislative Counsel should keep their video on throughout the meeting with their microphones on mute unless I call for them to speak. Please turn on your own microphone before speaking and then put it back on mute afterwards. All other staff should have their audio and video turned off.

If you have another device with you, such as a phone, please put it on silent. Please try not to leave your seat during the meeting unless it's absolutely necessary. If you do, please leave your camera on but your audio muted. That way, we can know if we have quorum, and we will know whether you are present if a vote is called for.

If I need to confer privately with the clerk or counsel, or if members wish to confer before a vote, I may call a brief recess. If any members are having technical problems, please phone or text Judy, the clerk.

I will now ask committee members to introduce themselves for the record by stating their name and constituency. We have a membership list that was circulated, and we'll follow that list. I can prompt you as well just to help everybody if you don't have that list in front of you. We'll start with Kent Smith.

[The committee members introduced themselves.]

THE CHAIR: I haven't seen Mr. Churchill on yet, so he's not here to introduce himself. I will also recognize the presence of Chief Legislative Counsel Gordon Hebb, and Legislative Committee Clerk Judy Kavanagh, who are with us today as well.

As I said earlier, today's topic is the Auditor General's 2017 recommendations regarding mental health services in the province. I'd like to welcome the witnesses who are here to speak on this topic today. We will have some opening remarks, but first I'll get you to introduce yourselves based on department.

[The witnesses introduced themselves.]

THE CHAIR: Thank you, everyone. We will give you a bit of time for opening remarks. I think you have spoken to our clerk, Judy, who has requested that we'll try to keep this within a 10-minute time frame, so we'll do the best we can. I know there's a number of you who would like to speak, but if I feel like we're running out of time, I will give you a bit of a nudge just so that we have time for questions from members. With that, I will let you do your opening remarks for the next 10 minutes.

KATHLEEN TROTT: I'm going to lead, and then my colleagues will follow. We'll keep it as close to 10 minutes as possible.

Good afternoon, Mr. Chair and committee members. Thank you for inviting the Department of Health and Wellness and our colleagues from the provincial health authorities to meet with you today.

My name is Kathleen Trott and I am an Associate Deputy Minister of Health and Wellness. I am joined today by Dr. Sam Hickcox, Chief of the Office of Addictions and Mental Health for the province, and Francine Vezina, Executive Director with the office. Also joining us are Sam Hodder and Dr. Andrew Harris with Nova Scotia Health and Dr. Alexa Bagnell and Maureen Brennan with the IWK Health Centre.

I'd like to take a minute to give you some context on the role of government and our work. We set the strategic direction for mental health and addictions in the province. We also fund the delivery of health care for Nova Scotians and make additional priority investments where and when they are needed. This funding enables health authorities to plan and deliver services across the province and supports community-based programs.

The Office of Addictions and Mental Health was established in February 2021, reflecting a commitment to a more proactive approach in dealing with mental health and addictions. In August last year, a dedicated minister was assigned to oversee the office, ensuring even greater focus on mental health and addiction services. The office, while overseen by a separate minister, maintains a strong connection within the Department of Health and Wellness and the broader health system.

We are happy to be here today to discuss progress on recommendations from the Auditor General's November 2017 report. This work, and many other initiatives, is helping to create a more consistent provincial approach and to better meet the needs of Nova Scotians.

Before I hand things over to our health authority colleagues, I'd like to invite Dr. Hickcox to say a few words.

DR. SAM HICKCOX: I too would like to thank the committee for giving us the opportunity to speak to some of the great work that's happening both within our office and across the province.

The delivery of mental health and addiction services involves a collaboration between government, health authorities, clinicians, and community organizations. Collectively, we deliver a provincial system of care, promoting mental wellness and addressing individual mental health needs.

This system is built on a tiered model of care, which includes mental health promotion, self-management and community care, and formal more intensive care for those experiencing moderate to severe and complex disorders.

Much of this care, of course, is delivered on the front line by dedicated health care workers. They have shown up every day throughout the pandemic, meeting the growing demands and complex care needs of Nova Scotians. I think it's important that we acknowledge and thank them for their work.

We continue to explore ways in which we can better support clinicians in providing mental health and addictions care. An example of this is our work on the Atlantic Mentorship Network, which involves mentoring family doctors and other health care professionals across the province to enhance their capacity to care for patients living with chronic pain and addictions.

There is certainly much more we can point to in terms of the work under way to improve the system. I know we'll have time to touch on some of this during our discussion this afternoon.

I'd like to share the remaining time allotted for remarks with our partners in Nova Scotia Health and the IWK. I'd like to turn things over to Sam Hodder with Nova Scotia Health.

THE CHAIR: Ms. Hodder.

SAM HODDER: Good afternoon, Mr. Chair and committee members. Thank you for inviting me and my colleagues to speak about the recommendations outlined to Nova Scotia Health's Mental Health and Addictions Program in the 2017 Auditor General's Report on Mental Health Services.

As mentioned earlier, my name is Sam Hodder. I am the Senior Director of the Mental Health and Addictions Program with Nova Scotia Health. I am really pleased to be here today with my co-lead, Dr. Andrew Harris, Senior Medical Director.

We recognize the importance of the work undertaken by the Auditor General, and remain committed to ensuring safe, high-quality mental health and addictions supports and services for all Nova Scotians. We are happy to report that all recommendations assigned to Nova Scotia Health's Mental Health and Addictions Program have been completed and accepted by the Office of the Auditor General.

As a program, we offer 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 care at the right time, in the right place, and with the right provider.

We continue to make significant improvements and adjustments to our services to meet the needs of Nova Scotians. These are made possible by close partnerships with the IWK Health Centre and the Nova Scotia Government Office of Addictions and Mental Health. Through our partnership with the IWK Health Centre, we have developed a protocol, for example, and pathway of care for patients under the age of 19 to ensure equitable and broadly consistent practices for all children and youth requiring admission for psychiatric care within Nova Scotia. It outlines information and protocols in relation to admissions and transfers that will ensure smooth and timely access to the most appropriate care setting based on their mental health and addictions needs.

As a program, we are committed - and we strive - to improving access to service delivered for people experiencing moderate to severe mental health and/or addiction issues across the province. Our strategic plan documents, entitled *Milestones on Our Journey* and *Mental Health and Addictions Direction 2025 Program Plan*, have been built on a foundation of needs-based planning. This planning has helped us to identify gaps and opportunities for investment, in turn allowing for financial investment in mental health and addiction services and supports to address those gaps or those opportunities.

We have further developed action plans including objectives, targeted timelines, resource allocation - including budget and key performance indicators - that will assist in measuring and reporting on our progress.

In closing, together with the IWK and the Office of Addictions and Mental Health, we continue to design a responsive, accessible, and effective public system informed by evidence, and one that must be easy to navigate while keeping the recovery, well-being, and positive mental health of individuals and communities, the focus of our efforts. Thank you. I'd like to hand it over to my colleague Maureen Brennan from the IWK.

THE CHAIR: Ms. Brennan.

MAUREEN BRENNAN: Good afternoon, Mr. Chair and committee members. Thank you for the invitation to speak to the committee about the recommendations identified in the 2017 Auditor General's Report on mental health services.

As mentioned, my name is Maureen Brennan, and I am the Director of the IWK Mental Health and Addictions Program. I am pleased to be joined by our program co-lead, Dr. Alexa Bagnell, the IWK's Chief of Psychiatry.

The IWK values the role of the Auditor General's Office and the importance of social accountability in the delivery of mental health and addictions services. We are pleased to share that the IWK has completed all recommendations which have been accepted by the Auditor General's Office. The IWK is committed to providing high quality care to women, children, youth and families that best meets their needs as close to home as possible, adopting and adapting the best practices from around the world in a context that is appropriate for Nova Scotia.

Mental health and addictions care intersects with government and community organizations. Collaboration and partnerships are essential in this work. We are pleased to share a strong partnership with our Nova Scotia Health Authority colleagues. Together with the Office of Addictions and Mental Health, we are working to build a comprehensive and connected mental health and addictions system of care in our province.

We are happy to report on several improvement initiatives as we benefit from the collective wisdom of our community partners and feedback from our youth and families. Child and Adolescent Services have adopted the Choice and Partnership Approach (CAPA) model, which has helped transform and align child and adolescent services across Nova Scotia. CAPA organizes services in a stepped approach so that the needs of children and youth are matched to the right evidenced-based intervention at the right time with the right people.

IWK and Nova Scotia Health have one central intake service, which identifies the concerns of youth, children, and caregivers, and matches them to the right help. For

example, help with anxiety could include Strongest Families distance-based intervention, connecting with an individual clinician for skills in managing anxiety, or a referral for an anxiety group. Through this stepped approach, our mental health and addictions system continues to ensure that quality interventions are provided while expanding the capacity and access of our system.

[1:15 p.m.]

We are committed to a continuous quality improvement framework and a data-driven approach that informs our program direction and service provision. We engage children, youth, women, and families in all that we do, and are committed to co-design principles to improve the experience and care provided. The morale and well-being of our amazing staff and physicians leading and delivering the care is supported and routinely monitored. We are grateful for their hard work, expertise, and commitment to excellence.

As always, there is much work ahead for the IWK. With our partners, we are confident and well positioned to meet the challenges, and remain dedicated to providing high quality, accessible service for Nova Scotians.

Dr. Bagnell and I welcome your questions. Thank you.

THE CHAIR: Thank you for the opening remarks. That was great. It was well done under the 10-minute time frame.

We will now move into the question-and-answer period. Typically, how it works with this committee is that each caucus is given 20 minutes of initial questioning, followed by a second round of questioning, depending on how much time we have left after those three 20-minute question periods.

We will start with the Official Opposition - the Liberals - followed by the NDP and then the Progressive Conservative caucus.

Before we get going though, Mr. Churchill was able to log in, so if he wants to introduce himself, he can do so, and then we can get into the 20-minute questioning.

HON. ZACH CHURCHILL: Thank you so much, Mr. Chair. I'm Zach Churchill, MLA for Yarmouth. I had the pleasure to briefly work with Dr. Hickcox during my time with the Department of Health and Wellness. Happy to have been the one who hired him, too.

THE CHAIR: Thank you, Mr. Churchill. With those remarks, we'll get going with the Liberals for their 20-minute question period, starting now.

ZACH CHURCHILL: Thank you so much, Dr. Hickcox. It's a great pleasure to see you today. I'm very pleased that you're in the department and that the current government is carrying on with the important appointment of yourself and the team under you. That gives me some confidence in this file. That's for sure.

I do want to talk about the government's commitment of allocating $100 million primarily to ensuring that there are billing codes for private providers to accomplish the universal mental health care plan that the current government committed to. Could you please inform the committee in terms of how that is progressing - the allocation of those funds, and the important work to secure those billing codes for private providers to achieve that universal mental health care coverage that was committed to?

SAM HICKCOX: Thank you for your question, Mr. Churchill, and thanks for hiring me. I appreciate that, and for your kind words - I really do appreciate those as well. It's an excellent question. We know that this is one of the most significant items within the government's mandate that they want to carry out.

First of all, I just want to speak to the core intention behind this. There's a recognition that there are a host of mental health care practitioners working in the community privately - psychologists, social workers, registered counselling therapists, and others - who right now are providing excellent, high-quality mental health care. Often, they are situated in locations and working with populations who for various reasons are deeming it necessary to access those clinicians rather than the mental health care system that is currently universally available to all Nova Scotians.

What we are left with is the current state in which there are individuals who can access those clinicians solely on the basis of their ability to either afford to pay privately for those individuals or, in some cases, to have some support from an extended health plan. This has created a de facto two-tiered system.

What the intention of universal mental health care is - the end state that we really want to get to - is to take advantage of that health human resource that's out there in the community as much as possible, and bring those folks back into a publicly-funded framework so that individuals can access those clinicians on the basis of need, rather than on the basis of their ability to pay.

That's the chief intention. As you can imagine, the amount of work required to do this right is astronomical. We're making it a priority in our office right now. We have been doing some specific work within the office to create a framework to actually guide all of our work on a go-forward basis.

If it's acceptable to our Chair, I'm going to invite our Executive Director, Francine Vezina, to speak to this item in more detail. She may have some more information to provide specifically around how that progress is occurring.

THE CHAIR: Ms. Vezina.

FRANCINE VEZINA: Some of the logistical activities that are taking place behind this, as Dr. Harris had mentioned, is the design of a framework that will guide how we go about piloting different aspects of the implementation of both universal mental health and addictions, as well as the billing code or how billing will happen.

We're doing an internal legal review at the moment - some jurisdictional scans to look at what might have already happened or is happening in other jurisdictions that we might be able to learn from. We will look to the pilot to implement some various items, try some different things, and use that to inform how we go forward.

ZACH CHURCHILL: Thank you so much. Hi, Francine - it's nice to see you as well, and congratulations on the great work that you're doing on this file. This, of course, is a priority for Nova Scotians, for all political parties. Everybody recognizes the pressure on individuals and on the system around mental health.

In terms of how we're conceptualizing this framework at this point, is it going to be through billing codes that this universal mental health care coverage is accessed? At this point, do we think that's going to work - to allow the providers to have billing codes like they would if they were in the public system - and do we think that there are any challenges in regard to doing that?

Also, another question I have is about achieving the universal access, which is very important - a laudable goal that we certainly support. How many of those private providers that are currently out there in the marketplace would we need to bring into a publicly funded framework to achieve that? Do we have any estimation on what that number would be yet?

The two questions are: is the framework going to be primarily built around the billing code system available for private providers, and how many of those private providers will be needed to achieve a truly universal access?

THE CHAIR: Ms. Vezina or Mr. Hickcox.

SAM HICKCOX: I'm happy to take that. To start with, we're doing something that I think is really unprecedented in Canada by trying to really bring these folks back into universal coverage. In doing so, we are going to be very mindful of initiating a pilot that will examine the question of whether billing codes are the most appropriate and effective way to remunerate clinicians.

We really want to ensure that we collect data and information - including the actual experience of those clinicians - such that we're able to remunerate them in a fair way, in a

way that actually draws people into actually wanting to do this work, and in addition, in a way that actually is cost effective.

Billing codes, as you know, are in the mandate and they are on the table. Exactly to what degree the final state will include them, and what codes are going to be implemented and so on - that remains to be seen. We're really looking forward to trying some things out, and really making outcomes measurement into anything that we pilot, just to really learn from that. That's really the answer to the first question: it remains to be seen, but we're going to be definitely looking at that very closely.

Your second question was, Mr. Churchill - I want to make sure I'm clear on that question - that you are asking how many clinicians or how many health care providers do we think we need to bring in to really meet the needs of Nova Scotians. Am I getting that all right?

I'm going to be giving you one of those "that depends" answers here. In part, it depends on the amount of work that any one clinician does to those who are actually accessing those clinicians and the government actually remunerating them. It may be that we have a host of clinicians who do a percentage of this kind of work, similar to lawyers who perhaps do some work for legal aid, but also work in private practice. We may see a number of clinicians who embrace this wholeheartedly, in part because they may be mindful around issues of equitable access and actually wanting to make this a substantial part of their practice or not. That also remains to be seen.

We know, as I'm sure you wouldn't be surprised to hear, that Nova Scotians are looking for more and more service. More and more Nova Scotians are seeking help as an outcome of the stressors of the pandemic. The demand is a moving target right now. That's the answer that I give to you.

ZACH CHURCHILL: Thank you so much. I appreciate your candor and the info on that. I do want to give some time to my colleague to ask some questions as well, Mr. Chair, please.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: Thank you, Chair, and thank you, Mr. Hickcox. If I can continue on the same line as my colleague, Mr. Churchill, I believe the new government's promise is to have eight walk-in clinics for mental health. Is that in the plans as you're recruiting? How is that working, how many are in the city, where are you putting them? If you can just elaborate on that for us, please.

SAM HICKCOX: Thanks for the question, Ms. DiCostanzo. Give me a seven out of ten on that one?

RAFAH DICOSTANZO: You didn't say "DiCostanza," which is Seinfeld. (Laughter)

SAM HICKCOX: Okay, thank you very much. I just want to be clear, when you speak of walk-in mental - are you talking about mental health walk-in clinics or are you thinking of the recent announcement for the Dartmouth Support and Recovery Hub, along those lines? I'm not quite sure.

RAFAH DICOSTANZO: I understood that one of the items that this new government is bringing is walk-in clinics for mental health. To me, that was a very exciting thing, and it was going to be across Nova Scotia. From my experience working as a medical interpreter, the number of times that I saw mental health patients at emergency was incredible. They were there for hours before they got seen because they're not considered very urgent. There was nothing for them, and they should not have been in emergency. They should have walk-in clinics. Are you thinking of that? Is this something we can achieve in Nova Scotia?

SAM HICKCOX: We're looking to generate as many different doorways as possible for people to access care when they need it in a timely fashion. Your point is very well taken. I'm going to hand this one over, with the Chair's permission, to our colleagues at Nova Scotia Health, specifically Sam Hodder, who can speak to some of the work under way regarding this.

THE CHAIR: Ms. Hodder.

SAM HODDER: I'm going to just address two elements of the question. One was a fundamental question around need and what essentially are the gaps, and what are the needs and relations meeting those gaps.

One of the things I'd like to share with the committee today is that we are collectively doing a needs-based planning initiative as part of a national project. Essentially, it is looking at population-based data and looking at the self-identified needs within that population-based data and overlapping that with service utilization across all levels of care, or tiers, and determining how we are doing in relation to that space - are there gaps? That will essentially inform us as to where the opportunities are for enhancement or creating those other options.

That is actually under way right now in our current space, and we're working on that as collaborative partners with the national group in relation to doing that. Actually, we participated in a similar exercise back in 2016-17, so we're doing a needs-based planning 2.0, which will really inform us on future opportunities. I'd love to share the results of that needs-based planning exercise with folks of the committee once complete.

[1:30 p.m.]

The other piece is around options. One of the investments we have up and coming is providing more opportunities or more options for other types of services. One of them is a lower-intensity, community-based mental wellness option. Essentially, we put out a call for a request for proposals in relation to setting up those wellness sites that are going to exist across the province. We received funding in 2021 from the Government of Nova Scotia in relation to the development and implementation of these services.

There are two elements under these, what we would frame up - the final name is to be determined, but lower-intensity type services. One is a peer-support telephone line, which will be a toll-free line that will be available in the form of non-crisis social supports, and that will complement some of the intensive clinical services that we have and will be available for all Nova Scotians. That will be staffed by experienced peer supporters. This was something that was actually identified during our stakeholder consultations and community consultations as a gap in the current options that we currently have within Nova Scotia, so that's one thing that's coming down.

The next piece that is coming down is around those lower-intensity clinics or lower-intensity wellness service. Essentially what that is, is really rapid access to low-barrier service designed to provide a safe space within the community to speak to somebody confidentially about what's going on right now for that person, to get referrals and information about other services that can help. It also allows for a conversation to happen around some of the strategies they can incorporate within their day-to-day lives to help deal with any forms of distress, and provide that navigation opportunity if there's another more intensive service warranted.

Right now, those grief counselling, coaching, information, and referral services are under way in relation to what we've established in our request for proposals. That is closed, and we currently have a collective team of experts who are reviewing those proposals to make sure that mental wellness service is actually available and stood up to Nova Scotians right in their communities.

RAFAH DICOSTANZO: I didn't really understand when you said wellness centres. Is this for everything, or just for mental health? Are they walk-in clinics for mental health and staffed by mainly psychologists - I would assume? Or is this wellness in general, like a health team that we have in Halifax?

SAM HODDER: This is a mental wellness service specifically, and the thing that I'd like for the committee to realize is that what we're trying to do is provide more options. We have psychologists that work within the Mental Health and Addictions Program. There are also other care providers, service providers, that can actually complement those clinical services.

In terms of the complement of the service providers that would be in that space, that really is to be determined by our request for proposals that will be there, but they essentially will be there to provide that grief counselling, coaching, information sharing, and deal with the situation at hand for that person in need.

It's a complementary service, if you will. It's all about creating additional options and opportunities that complement the existing services that are in that space and available to Nova Scotians.

RAFAH DICOSTANZO: My knowledge from the past, as a medical interpreter, is that the waiting list to get in if you're not suicidal, as we called it at the time - if you were suicidal, you got services right away. If you were not, then it was a year, year and a half waiting. Where are we now with that list, and how well are we doing in addressing that issue of not leaving it to the last minute, until it becomes so serious that it will become suicidal? How are we dealing with that issue?

SAM HODDER: I can provide a response to that. I may get cut off with time, but I'm sure this will come up again.

In relation to the wait times for Mental Health and Addictions, they are available on the Nova Scotia Government website, so I'd encourage folks to take a peek at those. It's important to provide context about what those wait times are actually measuring. They are a type of service that we have - intensive psychotherapy services - so they don't represent the entire continuum of services and supports for mental health and addictions. They represent a piece of the continuum, if you will, the intensive psychotherapy services.

They're broken out into two categories: urgent and non-urgent. Our urgent wait times are seven days. That's the standard that we've set. We meet that standard 100 per cent of the time in Nova Scotia, for both the child and the adult space.

Our non-urgent standard for the psychotherapy component of service provision is 28 days. That would be for a non-urgent service. At present, we're not meeting that target, or that standard, across Nova Scotia. Right now, our median wait time is about 20 days for child and adolescent services and 39 days for adult services. We are outside of that wait time standard of where we'd like to be. Our goal is to bring that closer to standard and closer to target. The other thing is, again, to put more options . . .

THE CHAIR: Ms. Hodder, I will stop you there. The time has expired for the Liberal caucus.

I'll just remind everybody that I'll try to direct you with speaking, as we want Legislative TV to make sure that they are picking up who they're supposed to be picking up.

I see Ms. Leblanc's hand up for the NDP. You can begin now.

SUSAN LEBLANC: Thank you to our guests for joining us today. I feel like you're old friends. You're all old hat at this committee business. It's nice to see you all again.

I just wanted to start with a couple of clarifications. I'm heartened by what I hear, frankly, in many cases. I just wanted to double check on a couple of things and ask for a bit more information.

Mr. Churchill did not know this, but I was also going to ask about billing codes, so I'll just follow up on a couple of questions he asked. I heard Dr. Hickcox say that the goal is to bring current service providers back into a universal system of mental health care. This is a huge amount of work, but the goal is a universal mental health and addictions program. Can I just confirm that's correct, Dr. Hickcox?

SAM HICKCOX: Yes, excellent. Congratulations on pronouncing that name. It's not a Nova Scotian name, and people do struggle with it at times.

When we talk about a universal mental health care system, we know, first of all, that our system really constitutes the formal Nova Scotia Health Authority and IWK Health Centre's programs of care that provide specialized care. The core business being providing care and treatment for individuals who have moderate to severe psychiatric disorders, including addictions. That doesn't mean that's all they do, but that's their wheelhouse. That's their core work.

Part of the priority of the office is to conceptualize the health care system as something that exists along all of those tiers of intensity that are required - everything from health promotion and prevention for our healthy, well population. If you think of mandate items - for example, providing enhanced education, working with EECD to improve mental health literacy and specifically education around addiction and education, designed to prevent the development of substance use disorders amongst youth - that would be Tier 1 work, health promotion and prevention.

Tier 2 work - there's a broad umbrella that covers that. It would include individuals who have psychiatric diagnoses but are more on the mild end of the spectrum in terms of the degree of severity of symptoms - and in particular, how much it's actually impacting their ability to function. What that really constitutes is a lot of people who are under a lot of stress, who are suffering and are kind of like walking wounded. They're limping through life.

I think many of us are feeling this way with respect to the last two, two and a half years of COVID. It may be people who are depressed or have an anxiety disorder but are still able to function. It could also include people who don't necessarily fit into a diagnostic category but require mental health supports: for example, people who have been victims of

domestic violence or sexualized violence. They don't necessarily have a diagnosis, for example, of post-traumatic stress disorder, but they need supports. That would also live within that Tier 2 space predominantly.

When we think about that space, it does include the provision of health care from other health care providers working in the community, such as community-based clinicians, like psychologists or social workers. It also includes family physicians and those working in actual integrated primary care collaboratives, et cetera. It also includes care provision or work that's being done by community-based organizations, such as those that provide long-term housing for those in recovery from substance use disorders.

It would also include interventions such as those that really enhance people living in community to help each other. I think that's really where we need to start reconceptualizing how we think of a mental health system. It's not just being a system of formal provision of care, but something that collectively we all take responsibility for.

It's about having stronger communities and thinking about ways to really bolster the resilience of communities so that people who aren't necessarily health care professionals can help each other. I just wanted to lay that out as a really significant, strategic priority for the Office of Addictions and Mental Health - to really look at that Tier 2 space - and then we partner a lot with our colleagues in Public Health with respect to the health promotion and prevention side of things.

We haven't worked out all the answers to all of these questions yet. The way that we're conceptualizing those who work in the community who are working privately right now and pulling them back into the system - it's not necessarily to say that they all need to do work in the specialized mental health system. It's that they're providing significant service for people who are suffering. Some of those people may end up with moderate to severe disorders.

A lot of the work that they may be doing in community - the social workers and psychologists who are doing psychotherapy, for example - is to prevent people's problems from actually getting worse and for them to lose access to employment and for their interpersonal relationships to be disrupted by a worsening mental illness. As part of a system, we think about ways that they may be able to impact those who are actually in the communities.

In addition, we know that there are diverse populations in Nova Scotia that are equity-deserving, that historically have not been accessing mental health care as much, proportionately, in the formal system. There are a number of factors for that, including the legacy of hundreds of years of institutional racism and the way that Indigenous Nova Scotians have been treated for hundreds of years. That includes internal stigma in communities. It includes a host of other factors such as the very practical issues around geographic access to formal systems.

[1:45 p.m.]

We also want to think about being very strategic about improving access to those equity-deserving groups by looking at clinicians who are working in the community outside the formal system, but then we actually want to support providing care for and with communities, particularly marginalized and vulnerable populations.

With all that said, I just wanted to say that one of the most important dependencies for this universal mental health care to exist as a system and not as a siloed, separate tier of care is to ensure that we have integration, excellent communication and collaboration with the formal mental health system. It's absolutely essential that we enjoy good collaboration, communication and co-design with our colleagues in leadership with the Mental Health and Addictions Program, both at the IWK and Nova Scotia Health Authority, and in addition that we have collaboration and we think of innovative ways that we can integrate these clinicians with primary care settings as well.

We've already done some initial work to reach out to leadership in primary care. I think everyone is excited about the potential for this and really wants to see this as a part of a singular, seamless system as much as we can, as opposed to a siloed system.

SUSAN LEBLANC: Briefly, if you could just tell me in terms of the planning of all of that - I mean, it all sounds great, but what's the timeline? Do you have a five-year plan where you're trying to accomplish certain goals or certain measures by a certain time?

SAM HICKCOX: We have things under way in terms of our ordering, sequencing - different actions, different aspects of the planning. We have some of that, quite a bit of it, worked out in terms of timelines. I'm going to invite Francine Vezina to speak to that, if it's all right with the Chair.

FRANCINE VEZINA: What we're looking at for the overall implementation is a phased approach. I had mentioned the pilot earlier. As we go through the completion of the needs-based planning, we're looking from a geographical perspective at deprivation and pilot site locations. We're looking at HHR, for example. We're looking at scope of practice for various professions in what gaps have been identified, and how some of those gaps might be met through a variety of professionals.

As we go through the process, I think we'll know the timelines a little bit more definitively. Our mandate, of course, is a four-year mandate, and so we're aligned with that. We will do our implementation in a phased approach beginning with likely early Spring, in alignment with the budget cycle. Once it's approved in the House, then we'll definitely have more details around timelines.

SUSAN LEBLANC: I just wanted to add: When you started talking about not siloing and having good integration between mental health practitioners and family

practitioners, I will - pin that for a second - also say the Office of Health Promotion. I've worked a bit with Dan Steeves on stuff in Dartmouth North, from that Office of Mental Health Promotion. He's incredible, and I love what he's doing. That kind of work is really important. I would suggest also that it integrates with housing, with food security, and with recreation opportunities and parks - that kind of thing. I hope that of all comes into play when you're thinking about that stuff.

I want to turn to a totally different - well, not totally different - thing, but different track right now. I want to talk about emergency mental health for a second. We know that suicide rates in Nova Scotia are extremely troubling, and we know that there's only one emergency mental health service in the province - or at least a mobile mental health service, and that's the Mobile Crisis Team in the HRM.

We know that many times police are not trained to respond to mental health calls, and yet they're routinely asked to. I actually called 911 on behalf of a constituent last week who had suicidal ideation, and the next person to call me back was the police officer who was the first responder to the call. That system is not perfect.

We know that police services across the province have asked that there might be a different way to respond to mental health crisis calls, and other jurisdictions are implementing alternatives to police response. I'm wondering what the plan is for Nova Scotia to increase in-person, non-police mental health crisis response in the province.

THE CHAIR: And who are you directing that question to, Ms. Leblanc?

SUSAN LEBLANC: I guess I'll direct it to the associate deputy minister or Dr. Hickcox, as well.

KATHLEEN TROTT: I think Dr. Harris is actually the best person to speak to this one.

THE CHAIR: Dr. Harris.

DR. ANDREW HARRIS: Great question. Suicide is always a contentious issue, Ms. Leblanc, and suicide is often a symptom of many different mental health disorders, including serious and persistent disorders like psychosis. Suicidal ideation is also very common. A number of studies suggest that its incidence or prevalence is close to 50 per cent. It's not uncommon for someone in the midst of a stressful situation to experience those types of thoughts.

We have stood up and made available crisis support services. We have a crisis support line which is very well used in Nova Scotia. That's often the first point of contact for many people who have these experiences. Every emergency department in the province is open - the regional hospitals at least - for 24/7 coverage, and all have psychiatry, and

almost all except one have crisis response services there, so people can be seen immediately and emergently.

We have been in a number of discussions with justice partners around the issue of appropriate training for first responders, particularly police officers, and we have embarked on some education around that. If you don't mind, I could hand that off to Sam Hodder to fill in a little bit of that. I think that's an important point for us to make exactly to your questions about what we are doing about this and why the police are still being asked to respond to mental health calls.

THE CHAIR: Ms. Hodder.

SAM HODDER: Just this past December 2021, we held a crisis intervention team program training, known as CIT in New Glasgow for 18 officers. It was over a four-day period and it was open to all sworn-in officers. What we are recognizing, as you described, is the relationship with mental health and policing is really important, as police are being asked to respond and make quick decisions in the face of mental health emergencies. Often what we hear is that officers are faced with limited resources. So part of the purpose of the CIT training was to enhance the officers' toolkit, if you will, in responding to these types of calls - not just for what to do, but also where to go in relation to that navigational support in relation to helping people reach the right care destination.

Some of the training topics that were covered in the CIT training were stigma and signs and symptoms of mental illness, personality disorders, addiction services, suicide risk assessment, which you had mentioned before, and youth mental health services.

The other thing I would like to share is that in addition to this training, we've also provided police agencies with local consultation phone numbers and supports with crisis teams that Andrew had spoken to earlier to help provide some of that guidance around certain situations. This type of training has also been available within the Central Zone area for some time now. Our focus is that we can actually expand this as one other opportunity in relation to enhancing capacity and building on our partnerships and relationships with police.

THE CHAIR: Ms. Leblanc, you have three minutes and a bit.

SUSAN LEBLANC: I hear that. I think it's great if police want to take training. I'd be interested to know how many. You said it was open to all registered police officers. I'd love to know how many actually took you up on the training. I'm actually not talking about police. I'm talking about non-police responses that can be dispatched in an emergency - like the way the mobile mental health crisis unit works in the HRM. Yes, I know there is police support there, but there are social workers and clinicians who are dispatched in a mobile way. We know that when that happens and it's working well, it works very well, but we also know that program needs to be expanded, and certainly outside of HRM.

I will also say that I am surprised, Dr. Harris, respectfully, to hear you say that people are able to access emergency mental health at the emergency departments. From what I hear from people - like for the person that I called for whom I just referenced - it was a weekend and they were taken to Dartmouth General in an ambulance, and there was no one for them to see. So they were sent home with no treatment and not feeling much better. That's very concerning. I've heard that a lot more from a lot of other stories.

Anyway, I just want to reiterate that we're talking about non-police responses and wondering what the Province might be doing to amplify those programs. I guess I'll send that back to Dr. Harris.

ANDREW HARRIS: I'm not in a position to question the information you have, but I do know that any person who would attempt to access care at any emergency department will be assessed by that emergency department. If the emergency physician does make a determination that they require mental health supports, then those will be provided. It's unfortunate that your constituent didn't receive that. I apologize if that didn't happen, to you and to them.

I'm sorry. Having said that, I'm not sure what your question was. Could you just quickly repeat it?

SUSAN LEBLANC: I just wanted to ask specifically about non-police intervention. Ms. Hodder was talking about the training that police are being given, but I'm wondering if there is thought or an attempt to expand mobile mental health crisis teams that are non-police-oriented outside of HRM.

ANDREW HARRIS: That's a good question. As you are aware, Nova Scotia has a distribution of urban and rural locations. Mobile crisis works well in Halifax because we have sufficient population within a fairly . . .

THE CHAIR: Sorry, Dr. Harris. Time is up for the NDP caucus. We will move on to time for the PC caucus. I see Mr. White's hand up. You can start.

JOHN WHITE: First off, I'd like to thank the witnesses we have here. My God, we have an amazing amount of wisdom on this line right now, so thank you very much for taking the time to speak to us.

As we know, mental health is important to all Nova Scotians. When we talk about mental health, we talk about a person's ability to maneuver and work through challenges or opportunities that exist in our life. When we're talking about mental health, we expect it to be up and down. We expect it to be their ability to have resilience. That is the word we use in the field. We talk about building resiliency.

I'd like to know if you could help us understand a few of the issues with respect to the current mental health system that we have right now. I guess I would direct the question to Dr. Hickcox, but I'm not sure, so if anybody else wants to answer it, feel free.

I'm wondering about the ways in which it can be cost-prohibitive for an individual to seek care. Can somebody answer that for us?

SAM HICKCOX: I'm happy to take that question. First of all, I think from the point of view of building resilience in community, it's very important. I'm going to take this opportunity to talk a little bit right now about the need for us to broaden our conceptualization of mental illness and mental distress.

I think the pandemic has really highlighted that many people - even prior to the pandemic - have an increasing awareness, ability and permission in our culture to talk about mental illness and mental health. Stigma is reducing. More and more individuals - some of them prominent public figures, like sports heroes, et cetera - have felt it really important to talk about their own struggles with mental health. I think that that's been a tremendously positive thing. A lot of folks now are asking themselves: Do I have a mental illness? I'm suffering right now. I have symptoms of anxiety or low mood or, as Dr. Harris alluded to, thoughts of ending their lives.

[2:00 p.m.]

What I think we need to do in response to this increasing ability to have a conversation about how we're all doing is to help to foster an understanding of the difference between those who have a diagnosed mental illness and those who are experiencing mental distress.

It's quite normal under circumstances such as what we're all facing right now with the pandemic for us to feel anxious, afraid, unsettled, isolated, lonely and depressed. That doesn't mean just because it's normal that it's a good thing. It's really important to recognize that what those emotions are telling us is that we need to come together as a society. We need to reach out to other people. This is something that Senator Stan Kutcher would talk about. The emotions actually have a function for us. They are actually there to tell us that things aren't right, and for us to actually try to do something to make ourselves feel better.

The reason I mention this is that when we talk about resilience and building resilience, often the response to people experiencing mental distress is to respond to that individual and to say, well, you need to do X, Y, and Z to build resilience. Our mental health system has stood up quite a number of tools, many of which are available online, for people to actually work on their own mental well-being. There are applications that help people to understand their thoughts and their behaviours in order to improve their mood, to understand the strategies like the use of mindfulness to improve well-being.

I think what's really important to understand is beyond putting the onus on the individual, that resilience for Nova Scotians ultimately will only come if we continue to come together as a community and support each other. Not only does that help people who are in great need, it actually helps the people who are doing the supporting as well.

I think about the collective response to the devastating events that happened at Portapique and beyond. I just want to highlight that what came out of that was something that I found to be really quite inspiring, which was a very common narrative: that we are bearing the suffering together, that together we can be Nova Scotia Strong. That image of the map of Nova Scotia with that heart in the middle of it, I think that really tells us a lot about what it means to be resilient. I think that really demonstrates how we, in the midst of tremendous suffering, can continue to bear that suffering and support each other through it. That's what we have to do for the pandemic. Honestly, I think that's a lot of what we have to do to really build resilience in our society.

For those who are in need of more specific supports, I also want to outline that support is available through the universal mental health system that we have through the Nova Scotia Health Authority. We know that there are a host of people who are seeking care and are having challenges accessing the public system, particularly those who perhaps aren't in that Tier 3, Tier 4, Tier 5 type of space. We're seeing that's the cohort of people who are seeking care from private practitioners. For some of those people, they're having to spend a lot of money to see those individuals. We want to ensure that anybody who would be a candidate to see a private practitioner can do so without having to think about whether or not they can afford it. That's really what's at the core of the work that we want to do.

JOHN WHITE: I raise the concern because it also has the impact of extended wait times. If we consider the highs and lows of life - and, as you suggested, the pandemic today that we're going through, which is what I was actually talking about - we're at a low, for sure. With the highs and lows of life, can you tell us any more about the impact that extended wait times has on people who are seeking assistance and waiting on a long wait-list?

SAM HICKCOX: Whether the degree to which waiting impacts people's overall health or how well they're going to do, there's a lot of variability there, Mr. White. With that said, nobody should suffer if they don't have to. I think that's where all hands are on deck, including our colleagues at the IWK Health Centre and in the Health Authority, to do everything that we can in our power and to work with our colleagues to improve access to care in a timely fashion.

JOHN WHITE: With the cumulative effect, it must have a toll on resources as well, if we're not getting to them when they're somewhat struggling, and it exaggerates. At that point, you must need more resources. Would that be a fair assumption?

SAM HICKCOX: Yes, I think that's a fair assumption for some. It goes back to the notion, that if folks with a particular physical medical condition, like high blood pressure for example, can get that addressed in primary care by their family doctor with medication and guidance around exercise and diet, then what you're going to do is reduce the number of people who end up going on to develop some of the negative outcomes of having uncontrolled high blood pressure, which would include heart attacks and strokes.

The more people who have heart attacks and strokes, not only does that mean more suffering and loss of productivity for those individuals, and tragic events, but it also puts more strain on the health care system as a whole.

The more that we can do to help to improve community resilience, to help improve the ability of our colleagues in primary care and with community-based organizations to provide doorways into getting support, the better off that we are.

I was wondering if maybe there might be some opportunity for our colleagues at the IWK to speak a little bit about some of the things that they're doing to help build resilience with their clients, and some of the work that is under way to prevent problems from getting worse.

THE CHAIR: Mr. White, is that okay to direct to the IWK as well?

JOHN WHITE: It's okay for me, yes.

THE CHAIR: Maybe Ms. Brennan or Dr. Bagnell?

MAUREEN BRENNAN: I can speak to that. Thank you for the question. It's important to recognize - and I think this was discussed earlier - that the program of care sits within the Nova Scotia Health and IWK, but the system of care sits and cuts across the community. Opportunities for strengthening a stepped model of care requires that collaboration and partnership with our community schools and community organizations.

It's important to ensure that we connect around care and ensure flow happens into our system and then back out into the community. This requires a shared approach and understanding of mental health and mental illness. It's important as we think about the concept of resilience as helping our system that lives in community and schools. For the IWK, for example, working with the youth, helping our school system that spends so much time working with youth to understand what resilience is, how we can strengthen the mental health literacy of our teachers, of our guidance counsellors.

We have a wonderful program and a partnership with the Department of Education and Early Childhood Development, the IWK and Nova Scotia Health called SchoolsPlus. This model is an integrated model in which different system players come together to work and coordinate to support children and youth, to provide them immediate access to care

when they're needed, and to provide a response to clinical services if they need to come into our formal system.

It also focuses on the capacity of our schools, our counsellors, to build their knowledge and awareness of how they can respond to kids to provide skills and strategies to deal with stress, to understand the best approach to supporting youth in the classroom, and to help maintain a level of resilience, and a set of tools and strategies to support them.

These are all ways that we can enhance the resilience of our system. It also requires a shared understanding so that we can approach and give guidance and support to children and adolescents in a way that can enhance their ability to manage and to cope, so that they don't advance to requiring more additional intensive services.

We're also happy to share that one of the things that we have recognized is access to low-barrier, community-based services and supports has been an identified gap within the services in the Tier 2 space. We are happy to report that the IWK is beginning to build an initiative to respond to that gap and to work in a coordinated and integrated way to support services earlier on before they come into our system. A solution that we looked at is integrated youth services in Nova Scotia.

We're beginning this work. Essentially, integrated youth services is a community-created and -led service that provides places where young people aged 12 to 25 can receive walk-in access. We purposely went beyond the age of 19 because we recognize that's a very fragile time in transitioning to the adult system. It's a high-quality, integrated, essentially one-stop shop for mental health and substance use services, as well as other health, social, and employment supports.

This is essential and provides opportunities for us to catch children and youth early and to provide low-barrier access to immediate services. It also builds on the skills that you're talking about with resilience and strategies, so that we can enhance their capacity and prevent them from coming into our services, to prevent them from landing the emergency department in crisis.

The service is an integrated model that requires partnership and collaboration. The work is before us. It's important to note that this will not be led by the IWK. This will be led by communities. A process of an RFP will be going out whereby we'll be looking for communities that can see themselves as leaders in championing this organization. We will provide the level of support from behind. The services can range from single-session, individual family therapy, peer support, coordination, outreach and matching to services, virtual services, and supporting others.

What we recognize in our system and across both the community and in our formal program of care is an unintentional disconnection. We're really wanting to ensure the coordination and the integration. I think you're hearing that today. Much of what we're

investing in and what we're trying to do is improve that coordination flow and early intervention. I'm happy to talk more about that, but those are exciting initiatives that we have under way.

THE CHAIR: Mr. White, you have four minutes left in this round.

JOHN WHITE: I have to pass it on Chris Palmer.

THE CHAIR: Mr. Palmer.

CHRIS PALMER: Great comments today. It's very apparent your knowledge and your passion for getting better outcomes for all Nova Scotians in mental health crisis is very clear.

My questions are pertaining a little bit more to the technical end of people's ability to access the access points for those crisis moments that they have when encountering a mental health situation. We all know that when people face an emergency, we have access to 911, as was referenced by my colleague earlier. It's a simple number that people can call police, firefighters, first responders of all types. They know where to go and they know where to call in times of crisis. Our mental health line has been a toll-free 10-digit number, and I think in a time of crisis it might be hard to remember a line like that.

One of the things that I know our government was committed to was implementing a 988 emergency line as an access point for people who have a crisis at the moment that they need it. My question, and I'm not sure if it would go to Ms. Hodder - she had mentioned talking about crisis points, or Dr. Hickcox. Can you elaborate on the impact a dedicated line, like a three-digit line for mental health emergencies, would have for Nova Scotians who are in crisis mode when they need access to it? I'm not sure who would like to take that question.

THE CHAIR: Mr. Hickcox.

SAM HICKCOX: I'll just reiterate what we've already said, Mr. Palmer, which is that we do have a 24/7 dedicated 10-digit crisis line that's currently in place. We know that they're receiving many calls. They've really been able to absorb some of the need that's come out of the pandemic as well, with the increasing use of that line. We know that the line's being well used.

All we can do at this point is intuit that having a three-digit line would be advantageous. Clearly it will be easier to remember. I think one of the potential impacts for that would be that if you had a three-digit line that was shared across the country the way that everybody knows that no matter where you are in the country, you can call 911 for an emergency. If we had that continuity across the country, that would be tremendously

helpful - for those who are moving from other parts of the country to here and vice versa, for example.

[2:15 p.m.]

At the moment, there is a review that's under way for approval for a three-digit line from the CRTC. It's sitting right now with that body and we're waiting to be able to take next steps after we find out about decisions from the CRTC about that. Can I just ask if Sam Hodder had something to add there?

SAM HODDER: I just wanted to make the committee members aware that the Mental Health Commission of Canada actually did a review just in 2021. That's actually publicly available. It's a policy brief entitled *Considerations for Implementing a Three-Digit Suicide-Prevention Number in Canada*. Essentially it looks at several considerations and recommendations around that three-digit line.

That's available if folks are looking to read additional material around access, visibility and capacity in relation to that - the training for staff and those sorts of details. I just wanted to note that document is publicly available for your viewing.

THE CHAIR: That is perfect timing. It's been 20 minutes for the PC caucus as well. We don't have time for a full 10 minutes for each caucus. It looks like about seven minutes is what we're going to try to do for each, so that we can be finished by 2:40 p.m. and the witnesses can have a quick closing statement.

I will provide the Liberals with seven minutes, followed by the NDP, and then the PCs. Mr. Churchill, I see your hand.

ZACH CHURCHILL: Thanks for answering our questions today. Listen, we are seeing kind of an unprecedented pressure on our health care system with this wave of COVID-19. We're hearing from hospitals across the province that this is the worst, operationally, that it's ever been - a ton of pressure in that system. ICU units are being flooded with COVID patients, impacting other services, like heart surgeries even.

Has there been an impact to our mental health capacity in our hospitals as a result of this really detrimental wave of COVID-19? How is the system responding to make sure that people are getting what they need, from a patient perspective?

Also, our health care workers - and this goes for those in the department and Public Health - have been under incredible pressure now. We're in year two of COVID-19. They're not getting time off. That was certainly happening during the previous government as well. I worry that we're getting to a point where a lot of our own staff who we're relying on and have been relying on heavily to run our health care system and look after everything are maybe reaching a breaking point.

Are we getting any indications that there are some mental health needs that aren't being addressed for our staff in the health care system, as well as the operational impacts to patients seeking mental health at this time, when our hospitals are being overrun by COVID-19 and all procedures and services are being impacted?

THE CHAIR: Who would like to address that? Dr. Hickcox.

SAM HICKCOX: I'll begin with a few comments and then I would like to pass it over to Sam Hodder, if that's acceptable.

We do know that the pandemic has had an impact on everyone, particularly our dedicated front-line health care workers. Several of them are on the call today - myself included, actually - who have been working through the pandemic. These health care workers have continued to work tirelessly to care for Nova Scotians across all sectors, both those working in Mental Health and Addictions as well as generally in the hospital system. I think they deserve our ongoing gratitude and support, so thank you so much for bringing this up, Mr. Churchill.

We have implemented infection prevention and control measures in all provincial health care facilities to protect both patients and staff. These measures continue to be in place. Their health and safety, from a COVID point of view, is a high priority for us. We obviously also know that health care workers aren't any more immune to this disease than any other Nova Scotians. It's taken a toll on people's mental health. We know it's been difficult for them.

Many health care workers have also been on the receiving end of many frustrations. Any kind of violence or threat of violence to mental health care workers, or to health care workers in general, is just completely unacceptable. I think it's fair to say that we're seeing staffing impacts across the health care sector.

I would like to pass it over to Sam Hodder to speak to some of the impacts in the hospital and some of the supports in place.

SAM HODDER: I just want to share with committee members that Mental Health and Addictions has had a really critical role to play in relation to the public health response to COVID-19. In very early days within the first wave, and then in subsequent waves afterward, we made a decision to make sure that our access points - particularly within a community - were available and in step with the IWK. We transitioned a large part of our workforce to work from home and to be able to provide clinical services in a virtual space, which offered an accessibility to people in relation to supports and services, but also added a layer of protection to our workforce.

I do want to share that there has been an increased demand in relation to service provision and to share at a high level some data with you. Since the onset of the pandemic

until today, our provincial crisis line we spoke about earlier has actually seen a 44-per-cent increase in call volumes. I am pleased to report, though, that we've been able to maintain our standards in terms of response times for that provincial crisis line. All calls are answered within a minute and 20 seconds and any sort of message that's left is returned without 30 minutes.

We've also seen an increase in the last year to our intake service, which is our toll-free line that we have available for people who are accessing and self-referring or family doctor referring to our psychotherapy community-based options and/or withdrawal management services. We've seen an over 20-per-cent increase in relation to call volume to that service area. I'm also pleased to report that we're still continuing to meet our standard in response time to that service as well.

Our urgent care service, and we spoke about that earlier, has also seen an increase in demand. We're up over 30 per cent in relation to access to that service area and over 10 per cent increase in relation to our non-urgent services. Our discharges from hospital have also increased. This past year - 33 per cent discharges from hospitalization. In relation to overall demand and capacity in relation to the system, we've certainly seen folks reaching out and accessing services that are available.

One of the elements I would like to address in relation to wait times and having more options, and I spoke to that at the very beginning: in June 2020, we actually responded by also standing up a provincial website for Mental Health and Addictions. That is really well utilized by our Nova Scotians. We had over 800,000 page views since the website has been stood up. Also 44,000 . . .

THE CHAIR: Ms. Hodder, that is the seven-minute time for the Liberal's second round of questioning. We are now moving on to the NDP caucus. I see Ms. Coombes has her hand up. You can begin.

KENDRA COOMBES: I'm going to talk about wait times in relation to youth. Wait times to see a school psychologist, are incredibly long, we've heard, and they have been since prior to the pandemic. I know many parents who have been told not to bother trying to get into the public system. Wait times have become long in the private system as well. Assessments can cost upwards of $3,000. I'm sure I don't need to explain to you what is problematic about this or how it will, and can, exacerbate inequalities for children.

I'm wondering if either Ms. Brennan or Dr. Bagnell can answer this question: What is being done to improve the access to school psychological services?

THE CHAIR: Ms. Brennan or Dr. Bagnell.

MAUREEN BRENNAN: What's being done is we're working very closely with our schools to understand what the need is and responding to it earlier. For example, I

spoke earlier about our SchoolsPlus model. We actually have school mental health clinicians that are connected to all schools across Nova Scotia. We have a provincial advisory committee that the Nova Scotia Health Authority and the IWK sits on in partnership with our Department of Education and Early Childhood Development to understand the current needs of youth and what's happening across the schools, so that we can make sure that we have a stepped approach.

The SchoolsPlus model has outreach workers and support workers as well as supports in the clinical round, which would be school mental health workers. Together we put a plan in place and, importantly, coordinate that plan to respond to those needs. If assessment for treatment is required, then that can happen in a timely way with the right person.

We've noticed incredible opportunities because too many people were coming into our system maybe not requiring that level of clinical service. They might require something early on, and we're able to provide that in a more responsive way through that partnership and through that stepped approach.

Services for assessment - everyone coming in through our central intake system, they're triaged, they're assessed and identified about what their need is, and they're matched to the right level of service. We recognize that we have been impacted by the wait times with respect to the COVID increases in demand, but we are ensuring that youth are being matched to the right service. We're ensuring that they're getting the proper assessment, and they're getting in as quickly as they can to the right service and assessment required.

KENDRA COOMBES: I'm still staying on wait times here. It was mentioned before that for the IWK, the seven-day target is met 100 per cent of the time; however, wait times in the 90th percentile is 11 days, which exceeds the seven days. It only meets 100 per cent of the time if you look at the 50th percentile. Under the 90th percentile, 31 days for the second appointment, and therefore, again, exceeds the target.

My question - I'm wondering if maybe Dr. Bagnell can answer this. This means that if you bring your child to the IWK and they are in a state that may escalate to self-harm or acute psychotic distress, they cannot get an initial appointment inside the targeted wait time of that one week. They are then likely to wait more than four weeks for their second appointment. I'm wondering what is being done to mitigate this and when will these wait times fall within the target. I guess I'm directing that to Dr. Bagnell.

DR. ALEXA BAGNELL: I'm glad to start, and then I can see if Maureen Brennan has something to add, because I think you've covered two things here. One is serious psychiatric illness presentation such as psychosis, major depressive episode with acute risk, severe OCD where someone is not eating or severe eating disorder that's deteriorating and medically becoming unstable. That's one group. We have a path in terms of both

urgent care but also psychiatric services in our specific care clinics to address those very ill presentations. That's one area.

We do have different paths depending on the level of need identified at that initial point, and that initial point actually is in different places in our system. It could be in a school, as Maureen Brennan spoke to. It could be in our emergency room. It also could be in central intake when they call in. We have a standard screen we do for all self-referrals and also family doctor/pediatrician referrals that lets us know where on the need level this person is and where they need to go next.

That's just to answer that question of the very serious. I think your other question is around waits and people waiting beyond what should be our standard. From our data, which we follow very closely, we have had increased demand, especially in the last four or five months. We've also had increased demand on our very hard-working staff, but just like any staff, we've had COVID implications in terms of people not being able to maybe work the same amount. That's affected all health care professionals. Mental health care professionals, as we've said, are not immune to that. We have had some increased waits, which we are really working on.

I think we are following that data very closely, and we've been moving resources around to try to address it. We're also constantly hiring as well to try to fill those gaps because we don't want the waits to increase. We want them to be at that standard. We know that the longer someone waits, the more distress for that young person and for their family. Also, the loss - the loss of a month of school for a young person is very significant.

I hope I've answered the question. I think right now we do see some increase that we don't want to have happen, and we're doing things in our system to try to change that. I don't know if we have time for Maureen Brennan to speak, but I'll send it back to you, Mr. Chair.

THE CHAIR: The time has ended for the NDP caucus at this point, but thank you, Ms. Brennan. We will now move on to the PC caucus for their last seven minutes. I see Mr. White's hand up, and you can begin.

JOHN WHITE: I just want to sum up the questions we were talking about earlier. My line of questioning was basically around cost, wait times, and resources. I'm wondering if Dr. Hickcox could give us a summary of what universal mental health will do now - how it will address these three issues.

SAM HICKCOX: If we succeed in enacting this vision that we'd talked about before, we will eliminate the need for people to be excluded from accessing community-based mental health care from clinicians who are outside of the Nova Scotia Health Authority and IWK's programs of care, based on their ability to pay or not. From a justice and equity point of view, we're hoping that we land there.

We also know that if we can get more clinicians working in ways that make sense from the point of view of what our population needs to optimize their mental health, we can think of that as harnessing an enormous store of health human resource that's right now sitting outside of any publicly funded strategies. From the point of view of access, it's simple math. If we have more clinicians offering care, that means more doorways to access.

I think that there are a lot of ways this could be done wrong. It could be done to the detriment of our very robust, high-functioning, and high-performing mental health and addictions programs, the leaders of which you've heard from today and with which we collaborate very closely. It could also be done in ways that don't necessarily efficiently benefit the population of Nova Scotia, particularly those who are the most vulnerable and in greatest need. It's our job to ensure that the investment that's going to be made in this endeavour is done in a way that there's an excellent return on the investment from the point of view of the mental health of Nova Scotians.

JOHN WHITE: I just want to thank you for the answers and considerations here. You guys are amazing. I have no doubt you'll do it right.

THE CHAIR: Mr. Smith, I see your hand up. You can ask a question.

KENT SMITH: Thank you, Mr. Chair, and thanks to everyone for being here today - a wealth of knowledge.

I think I only have a couple of minutes left, so I'm going to skip a long preamble and get directly to a question - directed toward the IWK team - about outcome monitoring. It's an important piece of Mental Health and Addictions services. Can either of you speak about how the IWK is monitoring outcomes, please and thank you?

THE CHAIR: Dr. Bagnell or Ms. Brennan.

MAUREEN BRENNAN: I can begin and I can pass it over to Dr. Bagnell for further comment. Evaluation is an important part of our Mental Health and Addictions Program. Mental Health and Addictions has a research outcomes and evaluation team that routinely evaluates and monitors services around effectiveness. We provide evaluation through a measure called SDQ, which is a Strengths and Difficulties Questionnaire. It looks at, from the parent experience and the youth experience, how they responded to the service and if it was effective.

We are just launching a new electronic outcome monitoring platform called Greenspace. This is a digital platform that improves mental health treatment and outcomes. We're excited because it'll provide effective measurement of our client care. Clinicians have been asking for that for a very long time, wanting to bring electronic measures into their treatment so that they can work with a client around goal-based outcome, and see how

they're moving and advancing towards those goals. It also provides an opportunity for us to have actionable data and insights for our organization so that we can make changes and do things differently based on data.

It also allows for improved collaboration with providers, because we'll be rolling this out right across our program. We're excited about that.

Results - I'm happy to share - it's important that the experience of patients and families is positive, so we regularly evaluate the family and patient satisfaction. We call that an ESQ, which is an Experience of Service Questionnaire. Consistently, the IWK rates at 98 per cent of patients and families reporting satisfaction in the quality care they're receiving from clinicians and physicians.

I'll pass it over and see if Dr. Bagnell wants to add anything further.

THE CHAIR: Dr. Bagnell?

DR. ALEXA BAGNELL: I think Ms. Brennan covered it very well, but I will just say that the other thing we've been measuring through the pandemic is the morale of our staff and our physicians. I will say that at the very beginning of the pandemic, some of that was pretty hard to take because we were all under stress. We really worked hard across our teams to address that and continue to monitor it and really look into what's going on with our teams and morale. It's been tough on health care professionals across all of our population, as we've talked about, and really addressing it as we see it.

Having those trends has really helped us. As we all know, our recruitment is very important, but our retention is incredibly important, because that's the service we provide and that's a tool, our people. We've really worked hard with that. I know the Nova Scotia Health Authority has been doing that as well to really address things early in our workforce.

THE CHAIR: Mr. Smith.

KENT SMITH: Thank you, Mr. Chair. How are we doing for time?

THE CHAIR: Thirty seconds.

KENT SMITH: Rapid fire, then. I'm curious to know about the new addiction recovery support centre in Dartmouth. Can someone just give me some updated feedback on the first few weeks of that initiative from our government, please and thank you?

THE CHAIR: Ms. Hodder.

SAM HODDER: We're very pleased to launch the first one January 25th. I checked in with the team and we've seen over 80 people serviced within that service right now. We're so pleased to be partnering on this and are going to be offering more recovery support centres across the province.

THE CHAIR: That is time, Ms. Hodder. That concludes our questioning. Thank you. It was very informative. Obviously, a lot of information. Certainly our members seem very engaged and interested in what our witnesses have to say.

I will give the witnesses the opportunity for a brief closing, if you have any closing remarks.

SAM HICKCOX: I can begin, and if no one else has remarks, I guess I can end as well. I'll leave that to my other co-witnesses, if they want to add anything.

I really want to thank the committee here for the opportunity for us to really share some information and for you to ask questions. I thought your questions were really on point and excellent. I wish we had more time. That's actually how I feel. I'm just sort of looking at some of the faces here, just remembering some of your questions.

This is my first time standing in front of a committee such as this, and maybe I'm a bit masochistic, but I'm willing to come back and speak more. Looking forward to more engagement in the future.

It's been such an honour to begin this work and to really address the enormous challenges that we're all facing even at the best of times, not to mention the challenging times that we're all under right now with respect to the mental health of Nova Scotians. It's such a pleasure to enjoy such excellent collegiality and collaboration with the leadership at the IWK and the leadership at Nova Scotia Health Authority in our mental health and addictions programs in both of those organizations.

As well, it's been a pleasure to work with such a strong team at the Office of Addictions and Mental Health. Just watch us. We've got a lot of work ahead of us, but I'm feeling confident that because we're working so well together we can do a lot that's going to be provincial in scope. Really excited about the future.

THE CHAIR: Any other comments from witnesses?

KATHLEEN TROTT: I think he ended us well.

THE CHAIR: That will conclude this portion of our meeting, and on behalf of the committee, I really want to thank you all for coming. This was very informative. As Chair, I don't get to ask questions, but I have a lot. I'm sure you'll hear from me at some point in

your work. We'll be watching. We're looking forward to seeing the success that we hope you all will achieve for our province.

At this time, witnesses are able to leave the meeting, and we will continue with committee business, as our agenda has been set. Thank you all for coming.

We have about 18 minutes to get through committee business. We will start with correspondence. There is an email from the Canadian Cancer Society, from February 2, 2022. They sent us a copy of their submission made to the Department of Finance and Treasury Board with respect to the Nova Scotia budget.

This was forwarded to members on February 2nd, and again yesterday. Is there any discussion on the submission from the Canadian Cancer Society? Ms. DiCostanzo.

RAFAH DICOSTANZO: I know it's agenda setting, but I would be very happy to bring the Cancer Society at one of our future meetings. We could try that as a Liberal topic. We shall see.

THE CHAIR: We can make a note of it. We will be getting to that at some point, but let's keep that in our mind for committee. Any further discussion?

The next item of correspondence, February 2, 2022 letter from the Minister of Seniors and Long-Term Care regarding report-waiting times for long-term care. This was a response to our committee's letter of January 13th arising from the motion that we passed on January 11th. Both letters were forwarded to members on the 2nd and again yesterday. Would there be any discussion on the correspondence? I see no hands up, so I will move on to other business.

The first item on other business is the venue for the March 8th meeting, whether virtual or in-person. Just like the last time, we had a discussion about the idea of hybrid or not hybrid, but Legislative TV isn't comfortable with that, so they prefer one or the other. I see Ms. Coombes has her hand up.

KENDRA COOMBES: Just with how everything is going right now, and it's situation-depending, I move to have the members polled closer to the meeting date about what we prefer. As you know, this is an ever-changing situation, and things could be different a month from now.

THE CHAIR: That's a motion, Ms. Coombes, to poll?

KENDRA COOMBES: It is.

THE CHAIR: Just so we know with our polling, we do have to have unanimous consent to go one way or the other. My understanding would be, if we don't have an

agreement today, we are basically saying to move forward in person or virtually before the poll - I just want to understand. If we don't have a decision today, then we need unanimous consent, or if for some reason we are flared up again and Public Health isn't recommending it, then it's going to - I understand where you're coming from. I just want to get a sense of your thoughts on that.

[2:45 p.m.]

KENDRA COOMBES: I hadn't thought about that specifically, Mr. Chair. I was thinking more that we would know where we are in that situation and it probably would end up being unanimous anyway, as to how people are feeling. But if anyone wants to go "around the room," we could do that now to see how people would feel about where we should find ourselves.

THE CHAIR: Thank you, Ms. Coombes. I saw Mr. Smith's hand go up.

KENT SMITH: I just wanted to chime in. We are fully prepared and excited to move back to in-person, but the intention of your motion, Ms. Coombes, is well received as well - that we don't know what the circumstances will be leading up to our next meeting on March 8th.

We would like to propose - the motion reads that we will go virtual and then we'll poll shortly before the meeting, hopefully getting unanimous consent to go in person. Just so we're clear, it is our intention that we want to be back in person as soon as it is safe to do so.

THE CHAIR: Any discussion? Ms. Coombes.

KENDRA COOMBES: There is a motion already on the floor. I'm just - did Mr. Smith intend to put that motion on the floor right now, or was it just what he was planning on doing?

KENT SMITH: I intended to. It's a friendly amendment just to say that we'd like to agree to go virtual so that it doesn't hiccup us having the meeting on March 8th. Then everyone can plan accordingly and then give us enough time, the first week of March sometime, we poll hoping to get unanimous consent to go in person.

THE CHAIR: There is an amendment to the motion. Any discussion on the amendment? Ms. DiCostanzo.

RAFAH DICOSTANZO: We're in agreement with Mr. Smith and what he proposes. We will wait. We're okay. With the Liberal party, we would love to go back when it's safe. We agree.

THE CHAIR: Thank you. Ms. Coombes.

KENDRA COOMBES: We're in agreement - well, I'm in agreement with the amendment as well. Let's go with this.

THE CHAIR: We can call the motion.

All those in favour of the amendment of the motion? Contrary minded? Thank you.

The motion is carried.

That is now the new motion. We will have to have approval of the amended motion as presented. Any discussion on that?

All those in favour? Contrary minded? Thank you.

The motion is carried.

Thank you, everyone. That was good.

The next item on the agenda - I just want to make sure I'm following it properly. Witness change for March 8th meeting. The Office of Healthcare Professionals Recruitment has advised the clerk that its new executive director is Ms. Suzanne Ley, who has replaced Ms. Vimy Glass, who was the previously approved witness. Do members agree to have Ms. Ley appear as a witness alongside Dr. Orrell instead of Ms. Glass?

I see Mr. Churchill has his hand up. Sorry - you're okay with it?

RAFAH DICOSTANZO: I believe we both are okay with that.

THE CHAIR: I just saw his hand up, so I wasn't sure. I think if everybody's okay with it and there's no discussion, we will just go with that. Perfect. Thank you, everyone.

The next item on the agenda is the motion made from January 11, 2022. That was a motion by Ms. DiCostanzo. I can read the motion, if you'd like, and you can say if it's correct.

Ms. DiCostanzo moves that the Department of Seniors and Long-Term Care provide details on staffing calculations that would achieve the 4.1 care hours per resident per day with 2,500 new single long-term care beds, as per the minister's mandate letter.

It was moved and we didn't get to vote on it. Ms. DiCostanzo, did you want to have a brief discussion on it and then we can open it up to everybody else?

RAFAH DICOSTANZO: We would love to get this information. I'd like to vote on it. We would love to put it through as a motion. Thank you.

THE CHAIR: Is there any discussion on this from members? Mr. Palmer.

CHRIS PALMER: I think I just wanted to reiterate that I believe our side of the committee would be acceptable to that, to accept that motion.

THE CHAIR: Ms. Coombes, I see your hand up.

KENDRA COOMBES: Just one question. I'm just wondering, maybe the Liberal caucus is looking at it in a full picture. Are they looking for 4.1 hours of hands-on care, or 4.1 hours of care overall?

RAFAH DICOSTANZO: In the mandate letter, our new minister is pushed very hard for the 4.1 care, and I believe that is according to the union - part of it was 1.3 as nursing care as well. Whatever is in the mandate letter, that is what we're looking for. Just information on how many staff would that mean, with the increased capacity of 2,500 new beds as well. What are the number of staff required to achieve the 4.1?

THE CHAIR: Any further discussion? All those in favour? Contrary minded? Thank you.

The motion is carried.

I guess we can draft a letter from the committee requesting that information - thank you, clerk.

That is everything on the agenda at this point. Is there any other business? Ms. Leblanc.

SUSAN LEBLANC: I just wanted to thank the clerk, Ms. Kavanagh, for providing us with the phonetic spelling of witnesses and the witnesses' preferred titles. It's excellent information. I hope that all the committees will adopt those procedures. Thank you so much, Ms. Kavanagh.

THE CHAIR: I agree wholeheartedly. Any further discussion? Seeing none, I will just say that our next meeting is scheduled for Tuesday, March 8, 2022, from 1:00 p.m. to 3:00 p.m. with Dr. Kevin Orrell and Ms. Suzanne Ley, the Office of Healthcare Professionals Recruitment.

With that being said, the meeting is adjourned. Thank you everyone, and have a great afternoon.

[The meeting adjourned at 2:52 p.m.]