HANSARD

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STANDING COMMITTEE

ON

HEALTH

Tuesday, September 12, 2023

COMMITTEE ROOM

Implementation of Additional Mental Health and Addictions Supports

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HEALTH COMMITTEE

Trevor Boudreau (Chair)
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[Danielle Barkhouse was replaced by Tom Taggart.]
[Hon. Brendan Maguire was replaced by Lorelei Nicoll.]
[Rafah DiCostanzo was replaced by Braedon Clark.]

<u>In Attendance</u>:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Office of Addictions and Mental Health
Kathleen Trott
Associate Deputy Minister

Francine Vezina
Executive Director

Nova Scotia Health Authority
Dana Pulsifer
Senior Director, Mental Health and Addictions

IWK Health Centre
Maureen Brennan
Director, Mental Health and Addictions

Mental Health Foundation of Nova Scotia

Starr Cunningham
President and CEO

Canadian Mental Health Association Nova Scotia Division
Karn Nichols
Executive Director

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, SEPTEMBER 12, 2023

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Trevor Boudreau

VICE CHAIR
Kent Smith

THE CHAIR: Order. We'll call this meeting to order. This is the Standing Committee on Health, and I'm Trevor Boudreau, the MLA for Richmond and Chair of the committee.

Today we will hear from witnesses regarding the Implementation of Additional Mental Health and Addictions Supports. I'd ask everyone to make sure that your phone is on silent. What we'll do first is we'll have an introduction of committee members. I'll ask them to introduce themselves, stating their name and constituency, starting on my left with MLA Smith.

[The committee members introduced themselves.]

THE CHAIR: Thank you all, and for the purposes of Hansard, I'll also recognize the presence of Chief Legislative Counsel Gordon Hebb and Legislative Committee Clerk Judy Kavanagh.

As I mentioned before, the topic for today is Implementation of Additional Mental Health and Addictions Supports, and we have a number of witnesses here with us. I'd like to welcome all of you here, and I'll actually get you all to introduce yourselves first, starting with Ms. Brennan on my left.

[The witnesses introduced themselves.]

THE CHAIR: Thank you all. I do believe that we have a number of witnesses who have opening remarks, and so at this time we'll have those opening remarks, and then we'll move into the Q&A section of the committee meeting.

I'll start with Associate Deputy Minister Trott, if you would like to start with your opening remarks.

KATHLEEN TROTT: Thank you, Mr. Chair, and thank you for the opportunity to join you here today to talk about and answer the committee questions on the work we're doing in addictions and mental health in the province.

As I introduced myself, Kathleen Trott, Associate Deputy Minister responsible for the Office of Addictions and Mental Health, and I'm here to talk about the progress we are making toward universal mental health and addictions care. As you can see, I have a few of people with me today to help answer questions that you've just met, with Francine Vezina on my team and in partnership with Dana Pulsifer and Maureen Brennan.

We're a small team at the Office of Addictions and Mental Health, but we have a big mandate: To create a universal mental health and addictions system of care. When we talk about universal mental health and addictions care, we're talking about finding solutions so more people can access the care and support they need. We're talking about services and service delivery models tailored to the needs of our population. It's about addressing gaps at every point along the continuum of care and making it easier to move between services as needs change.

The goal is a system where every Nova Scotian has access to the services and supports they need, when they need them. I find it helpful to think about the work in three categories. The first is our traditional health care system where we're expanding to reach more people, adding new services, making the ones we have better. Some examples: our new day hospitals in Halifax and Sydney; five new recovery support centres in Dartmouth, New Glasgow, Middleton, Lunenburg, and Evanston; the expansion of our new preschool autism services; the Integrated Youth Services expansion implementation; the new clinicians we've hired, including six new psychiatrists in Cape Breton; and the connections we've made between rural EDs and mental health and addictions clinicians all over the province and so much more.

The second category is about tapping into the capacity we know exists in Nova Scotia already. Whether that's psychologists and social workers in private practice, community-based organizations, like the Canadian Mental Health Association and Mental Health Foundation of Nova Scotia, and, of course, our colleges and universities. For example, the pilot project we announced yesterday that's helping address the wait-list for autism and ADHD diagnostic assessment.

We've made increased investments in community-based organizations so they can do more of what they already do so well, while at the same time creating a community wellness framework to guide and focus this work going forward.

We've added new services people can use virtually, like Access Wellness, peer support, and PSPNET which is a therapy program for first responders, and a suite of new e-mental health tools, like Tranquility and Togetherall.

The third category of work on universal mental health care is about integration - bringing all these pieces together - the formal health care system, the online tools, the pilot projects, the community-based services - on a solid foundation to make it easier for people to get the right care to match their need.

We currently have a central intake line where people can call and self-refer. They don't need a referral from a primary care provider. They can call our toll-free number and speak to a clinician who will do an assessment over the phone and get them connected to the right program or service provider. The right care - that's important.

When it comes to mental health, it isn't always about in-patient psychiatric services. In fact, that kind of care is needed by only a small percentage of people. There are so many other options. Maybe it's clinical care through the Nova Scotia Health Authority or IWK Health Centre, ongoing support from a registered psychologist, or counselling from a registered social worker. Maybe it's peer support. Maybe it's a service offered by a community-based organization just a few minutes down the road from your house. That's what universal mental health and addictions care is all about. The goal is the right service from the right provider at the right time and available to everyone.

THE CHAIR: Ms. Cunningham.

STARR CUNNINGHAM: I'm very happy to be here today representing the Mental Health Foundation of Nova Scotia. The Mental Health Foundation is a charity that exists to increase financial support to community initiatives throughout Nova Scotia while providing hope - that's our key word - and eradicating the stigma surrounding mental illness and addiction. Our vision is simply to see Nova Scotians who are living with mental illness and addiction thriving in our communities - not surviving, thriving, and not in our hospitals but in our communities.

We do that by providing grants. We have community grants, Nova Scotia Health Authority Mental Health and Addictions program grants, named grants, mental health literacy grants, and episodic grants. In 2022-23, the Mental Health Foundation of Nova Scotia approved 241 grants totalling more than $3 million. Most recently, we closed our application period for second-round community grants. We received 137 applications, touching every area of the province. Those applications are now being reviewed and scored by our volunteer grant selection committee. This committee is made up of seven

individuals who represent our board of trustees, Nova Scotia Health Authority Mental Health and Addiction, Black, Indigenous, and people of colour, and 2SLGBTQIA+ communities.

Later this month, the scores will be tallied, decisions discussed, and all applicants will be notified of their decisions. Our goal is to get the funding in the hands of the successful organizations as soon as we possibly can so that their mental health programming can get under way.

The programs that we fund really range. We fund everything from peer support to one-on-one counselling, mental health education, community engagement, music therapy, art therapy, recreation therapy, employment support, sexual health supports, trauma support, and more. As I'm sure you can appreciate, these additional mental health and addiction supports will have a significant and measurable impact in every area of Nova Scotia. They will make our communities stronger and more resilient. They will raise mental health literacy, change lives, and in many cases save lives.

We are not the providers of the programs and services. We are the enablers. The Mental Health Foundation of Nova Scotia provides the money. Simply put, we do the fundraising so that people and organizations that have the skills to help, people like Karn and her team at CMHA Nova Scotia, can do what they do best, and that is support the mental health and addiction needs of Nova Scotians.

The Mental Health Foundation of Nova Scotia has the unique opportunity to hear directly from organizations and individuals who are on the ground in their communities, the people who are doing the work and detecting the gaps and identifying priorities. The Foundation creates hope and help for improved mental health. We work with individual donors, corporate funders, other foundations, government - including the Office of Mental Health and Addictions - and community event volunteers to make it more efficient and more effective for mental health and addictions experts to provide their services and programs.

We are incredibly proud of the difference we make in the lives of Nova Scotians by funding mental health and addiction initiatives in our communities. We strive each day to change the way people think about mental wellness, mental illness, and addiction.

THE CHAIR: Ms. Nichols.

KARN NICHOLS: I'm deeply appreciative of the chance to share a bit about who we are, how our work impacts Nova Scotians, and how we can work together to serve the mental health and well-being of folks in communities all across the province. I'm Karn Nichols and I'm the Executive Director of the Canadian Mental Health Association Nova Scotia Division.

You may not know this, but CMHA Nova Scotia is part of the most extensive community-based mental health network across Canada. We are a federated charity, which means we're a collective of organizations that are bound together by brand and by mission. Together, we identify and respond to Canada's most pressing mental health priorities. At the national level, we push for nationwide system and policy change, and at the community level, millions of people in Canada rely on our extensive grassroots presence.

There are 330 CMHA divisions and branches across the country, and these branches and divisions employ 7,000 staff and are supported by more than 11,000 members and volunteers. We've been active in communities across Canada for over 100 years. In our combined Nova Scotia operation, which includes the division - which is what I'm responsible for - and our branches, we employ about 55 staff and 72 volunteers.

I begin by sharing this information because I found that the CMHA brand is well known, yet there's a lot of confusion about what we actually do in community - just ask Starr. It's not unusual for the general public and in particular, our funders, to be deeply confused about the respective missions and mandate of CMHA versus the Mental Health Foundation of Nova Scotia. So maybe we have clarity today.

In Nova Scotia, we're a small but mighty team supporting over 10,000 individuals over the past couple of years in communities around the province. With our branches in Halifax-Dartmouth, Colchester-East Hants, and Southwest Nova, we deliver safe and inclusive evidence-based programming, training, and support services that address the social determinants of health, including safe and affordable housing, sustainable employment, food security, access to education, and most importantly, human connection.

Our vision is a Canada and a Nova Scotia where mental health is a universal human right. At the division level, we have three strategic pillars. They are advocacy, education, and resource navigation. At CMHA Nova Scotia, we are responsible for working in collaboration with our government and our community allies and partners to align and strategically deliver relevant services and programs across the province.

If you think about our mental health continuum, where our mental health is measured in terms of thriving at one end, where we're sleeping well and eating well, where we feel normal, to surviving, then struggling, and then to crisis, the centre of gravity for our work is building capacity in our communities so that we all have the tools to thrive and survive. We operate in a Tier 1 or Tier 2 space of the stepped care model. By doing this, we support the health care system to keep people out of hospitals and out of emergency rooms, both before mental illness can occur and after the crisis has passed.

What does this look like in the community in terms of program delivery and direct service delivery? Under program delivery, we have a core operation of education and mental health literacy, so in addition to things like First Responders Assist and safeTALK for addressing suicide prevention, we have courses that are evidence-based, such as

Changing Minds, Living Life to the Full, Rebuilding Our Resilience, Stress Management, Community Suicide Awareness, and Mental Health in the Workplace. We also custom-build as required in community.

As a backbone to that, we have what we call Recovery Colleges, which are free programming. It's a virtual learning centre that anyone can access free workshops to learn, gain new skills, and connect with others in their community. They're developed by subject-matter experts with lived experience, in collaboration with individuals who have experience in developing the programs. Topics in our workshops range from understanding anxiety to self-care and anything beyond that.

As mentioned previously, we do a lot under what we call CAST, which is Communities Addressing Suicide Together. We know that suicide is a permanent response which is often part of a passing struggle. That's where intervention is really critical. We play a role in prevention and intervention through providing subsidized training and Assist, Resilient Minds, and safeTALK across the province. These are often subsidized by our friends at Starr's organization so that we can actually make it available to many more people.

Peer support has been mentioned, and that's a piece of what we do across the province. Then the other piece that we are currently giving funding, through the Office of Addictions and Mental Health, which we're quite excited about, is two pilot projects - one in southwest Nova Scotia and one in Cape Breton.

We're being intentional about two things. One is not reinventing the wheel and creating a framework of support for the informal mental health systems that already exist in these communities. The barbers, the pharmacists, the church leaders, the Rotary Club members are all part of our mental health system, when you think about it. We are working with these communities to design programs to support them in this important work and provide them with the tools so that our social net in rural Nova Scotia is strengthened. Our approach will also allow us to innovate these programs with a decolonized lens, giving voice to those who've been traditionally underserved, underheard, and underrepresented.

In the direct service piece, what we do is we work with a couple of programs. One is Project H.O.P.E., which is housing outreach and peer empowerment, and throughout the Valley we work to reduce homelessness, and working with those who are living with mental illness and struggling with mental health, we have At Work, which is addressing those who are unemployed due to mental illness or living with mental health issues. We have a variety of social clubs across our branches and the province, community and outreach work which is based primarily in Colchester and East Hants, and independent living support as well, which houses 40 individuals in independent living situations.

[1:15 p.m.]

Finally, we have a program called BounceBack, which is a national program that is available to folks in Nova Scotia. It's a free skill-building program that's provided through us by CMHA National. It's designed to support adults and youth 15+ to manage low mood, mild to moderate depression, anxiety, stress, or worry. They work with a coach and a guidebook, and it's based on these sort of CBT principles. CMHA is a not-for-profit charitable organization that delivers these mental health programs and services to anyone who needs them. Funding from federal and provincial grants and donations allows us to keep most of our programs free or low-barrier.

I came to this organization just over two years ago, and I learned quickly that our current mental health system is a complex web. In any one day we could be wrestling with housing a young pregnant mother in Kentville, developing programs of caregivers for the 2SLGBTQIA+ communities in rural Nova Scotia, working with folks from Portapique to develop a story trail to nurture community resilience, reporting to funders, sitting on panels, discussing mental health in the workplace, building relationships with the informal systems in our First Nations communities, meeting with domestic abuse survivors who are finding agency in running their own peer group in North Sydney, doing the same with newcomers in Yarmouth, advocating for universal mental health, and coordinating the board while managing the day-to-day operations of a growing organization.

This sector is known for being collaborative, yet sometimes we struggle to coordinate our efforts in service of our communities. We are more than our programming: We believe that we are an integral part of the mental health care continuum. We are committed to continuing to advocate for the social determinants of health, reducing stigma, mental health literacy, and mental health parity - universal mental health care. However, there is no doubt that there's an increasing demand on charitable services that are outpacing the sector's ability to meet that demand, and with less available to cover charitable needs, our social fabric starts to feel not-so-secure.

We believe the solutions to many of our issues are with the resources that are already in place, but in order to leverage these solutions effectively, we need to stabilize the operations. Then we can focus on coordination and strengthening our social fabric by delivering our services to people who need it the most.

I think we all recognize that as a province, it's important to continue to invest in community-based mental health initiatives. By investing in the work of CMHA and all of our sister organizations across the province, we're actually supporting the health care to keep people out of the hospitals, out of the emergency rooms, both before the mental illness can occur and after the crisis has passed.

To this committee, I'm so grateful for the opportunity. I know I speak on behalf of all my CMHA social impact sector colleagues across the province when I say we look

forward to working alongside everyone in this room to serve the mental health needs of all Nova Scotians.

THE CHAIR: Thank you, Ms. Nichols. Now we're on to the question-and-answer period of the meeting. Each caucus gets a first 20 minutes of questioning - and I think I mentioned to some of you, it's kind of a hard stop at that 20 minutes. I apologize in advance if I do cut you off. Then, depending on what time we have left after those 20 minutes, each caucus will get an additional eight to 10 minutes probably to ask questions. We're going to try to wrap up questioning somewhere between 2:45 p.m. and 2:50 p.m., and then you have an opportunity to speak. Then we go on to some committee business.

With that being said, the Liberal caucus will be first with the 20 minutes and I see Mr. Clark pointing to Ms. Nicoll. Ms. Nicoll, you have the floor.

LORELEI NICOLL: My name is spelt this way, not that way. I always spell - everyone always puts the "h" and the "s" at the end, so nice to have another Nicoll in the house.

I just want to thank you for your presentation. Full disclosure: I'm sitting here with some anxiety because I have generalized anxiety disorder. Yes, I went into politics, so that's an interesting mix. (Laughter) That being said, you spoke, Karn, about the lived experience and hearing from people, but I hear from people in mental health issues that they don't feel that they have an opportunity to have their stories heard, and that they wish that they could provide them to somebody so that you would understand what they went through.

I actually had a psychiatrist once who told me I should become a psychiatrist because I know what it's like to have lived through an episode and he didn't. At the same time, he said: Oh, you're depressed. Did you think of killing yourself? When all these things happen, you're kind of like - you don't tell that to somebody with anxiety, in my opinion, because it's like, oh, is that a possibility?

Therefore, I was struck with Dr. Sherry's article in today's paper in that regard: "Suicide rates are increasing across the province and it cannot be attributed to just population growth. In 2020, the suicide rate dropped to 12.3 per 100,000, but quickly jumped to 14.8 in 2021 and then 15.5 in 2022. The big question is why?"

As a lead-up to my question, I would like to ask anyone who wants to answer his question as to why there's still an increase.

I know that isolation during the pandemic played a key role. I'm not sure if there's data out there that shows what the pandemic actually resulted in with regard to everyone's mental health, but every day they talk about anxiety. It's health anxiety - it's a thing. Now

we have climate anxiety. There seem to be many terms being added to the word anxiety, but it's still anxiety.

I don't know at the end of the day how you tell these people, when you actually listen to them, how you determine whether they're - what was your chart - whether they're thriving, surviving, or in crisis. Those are my questions at this point.

THE CHAIR: MLA Nicoll, I'll ask you to table the document that you have there. I will open it up to the floor. I see ADM Trott first.

KATHLEEN TROTT: I think there are probably some others who will want to contribute too. We read that same article and we're looking at the numbers as well. Really, any loss or injury from suicide is a tragedy and not what we want to have happen.

I think it speaks to the need for us to continue to focus on increasing access to supports for folks not just in crisis but across that whole continuum. We use tiers and numbers, but I love how you have spoken about the continuum.

I think that the last few years have been very difficult for Nova Scotians. We've seen a large increase in demand and in acuity and complexity. It's not just that there are more - there are more dealing with more things. It's a challenge for sure.

I think there are some things that we're focused on, and there are some things that we are here at the table with that we would want people to know about, so if they're getting into that situation where they're feeling like they want to end their life, that we are there for them. I'll ask Dana Pulsifer to maybe speak about the provincial crisis line and our work around the 988 hotline that's coming that we think will make a difference for sure.

I also think there are some things we're doing around men. In the data it shows that men of a particular age range are highest statistically. We do have a campaign that's been developed that's coming this Fall to help promote some help-seeking behaviour. Just trying to build literacy, as you say, and help folks understand what they're thinking maybe is normal, and there are people you can talk to about it, and just really trying to build that literacy and reduce that stigma and build that resilience.

I think too, for Starr and Karn, you both do work in suicide (Inaudible), so this may be a good opportunity for you to highlight some of that as well. Maybe over to Dana, if that's okay.

THE CHAIR: Ms. Pulsifer.

DANA PULSIFER: I'd like to talk a little bit about our crisis line. We have specific access points for folks who are struggling to that degree, who are in a crisis, who may be

contemplating suicide, may have suicidal ideation. Our crisis line is 24/7, seven days a week.

The goal of that person on the other end of the line is to calmly and clearly and safely walk through a process with that person who is struggling at that moment to find out what their needs are, to possibly even do a safety check, to find out what is their next step, whether they should go to the emergency department to be further assessed, whether some other supports can be provided to them, whether they have a support person with them.

I think there are several interventions and several service areas and access points that we can provide through our NSHA Mental Health and Addictions program. I would say those are really important to continue to enhance and implement and provide more access. We also, in the Central Zone, have the Mental Health Mobile Crisis Team, and I know that they're very compassionate folks who go out into the community. They do some of those wellness checks. I think that's something that has been needed and asked for across the province. I think we try to provide different routes based on the ruralness of the rest of the province, but that crisis line, I think, is one of the first steps. We continue to promote and hope that people would be able to call that line.

With changing the number to 988, we're hoping that the promotion and the uptake and the remembering of the number will be really helpful. The actual service provision will remain the same, and I think we get a lot of feedback from folks who call that line and find it very helpful.

I would also add I'm very impressed and passionate, and I think we're in a place right now around that whole continuum of care that Karn was talking about, as well as Starr, and just how mental health and mental wellness and addiction care really are across that continuum. To even think about tackling and studying and understanding the numbers that came out yesterday is really a larger plan of action, one that is needing to take place across all of the levels of care, all of the tiers. We have to also start with those prior to being in crisis. We have to provide them the services and supports, like our colleagues do in that Tier 2 with the mild, community-based organization areas, which we're really proud of - having those community-based organizations as part of that overall system of care.

I really think in order to answer the question of why, we need to study that more. We need to understand more around those social determinants of mental health and health. We know about the housing crisis, we know about the tenting encampments, we know that the price of housing has gone up. We know that we have more people coming into Nova Scotia with their own health and mental health issues. While that might not be the sole reason for the increase in the numbers, all of that certainly contributes to the reality that we're in today. I would just say that I'm very hopeful - somebody used that initially - that collaboration and partnership around working together across all of this continuum of service provision and supports and care will help reduce the risk and reduce the numbers of folks who contemplate suicide.

LORELEI NICOLL: My next question was just that, about data. Are there any data that exist that guide all of you in your decision-making? I know this government said they were going to establish universal mental health care. Universal to me means it doesn't matter where I live in Canada, I will get that help and that care that I need. What is the timeline per se on getting to that place where we all need to be for our mental health? Are the data available now for you as to establishing a plan going forward to actually say yes? Should we be talking to federal organizations to see what other provinces are doing as well?

[1:30 p.m.]

THE CHAIR: I see Ms. Nichols's hand up. Is that okay?

LORELEI NICOLL: Yes.

THE CHAIR: Ms. Nichols?

KARN NICHOLS: Would it be okay to refer - I have a little bit of data. It's national data, but it's from August so it's somewhat relevant and it speaks to some of the things that you were talking about. I also wanted to speak about some of the things that we would do to address it in the province as well. Is that appropriate at this time?

THE CHAIR: MLA Nicoll, I see your hand up.

LORELEI NICOLL: I would, but at the end of the day - you're doing great work - but I would like to know from the government actually what they're doing when it comes to creating a universal health care plan.

KATHLEEN TROTT: We've been working very hard over the last two years around this very significant mandate to introduce universal access for addictions and mental health and we are making progress. We are seeing action happening that I'll share with you, and then we can talk about the evaluations that we're doing and where that is going to be leading us.

Really, our work fits into three big categories. I sort of talked about this before, but the first is within the former health care system. Things that we would be doing around universal - it's really about looking at that full continuum, identifying the gaps, and finding solutions to fill the gaps. A great example would be the new mental health day hospitals. Previously, there was in-patient and then outpatient. Now we have an intermediate step, which allows folks who need more intensive services throughout the day to come back to the hospital and get treatments and services and all of that, but then they go home at night and are with their families. It's a nice transition out to community organization, giving folks what they need to be successful versus staying in in-patient too long, which we know can hurt, or being bounced out so fast that they're struggling with that. The other pieces

would be the recovery support centres, the autism service, and a great youth service expansion, connections between rural EDs and expertise all over the province in hiring more clinicians.

There's been a lot of activity happening and a lot of pilots happening. We have some pilots under way around what we announced yesterday with clinical psychologists, the Dalhousie Centre for Psychological Health today. We've got other pieces in play around our e-mental health tools, Tranquility and Togetherall. What we're doing is looking at - as we create these pilots - what are indicators we're looking for, how we can learn from those and then transform them to be either spread and scaled or tweaked because they didn't quite do what we had intended for them to do. There are data. Data are a key area of focus, and then the other piece would be a bigger area of data around routine patient outcomes. We're piloting that now, but the IWK Health Centre has actually finished their pilot and are moving forward with expansion. It's really more about actually what does the patient want to achieve and how do we help that patient achieve that, and we measure that over their treatments and get, really, more meaningful outcomes from success from programs.

LORELEI NICOLL: I would like to give the opportunity to the IWK Health Centre now to speak because mental health services at the IWK will take you up to age 18. Therefore, how does it transition back to Ms. Trott?

THE CHAIR: Ms. Brennan.

MAUREEN BRENNAN: Is your question about the transition to the adult services? (Interruption) Okay.

I'd like to provide comment on your first question around data. Data are very, very important to how we design our service and how we understand the needs of children, youth, and adults right across Nova Scotia. Universal mental health has taken that data so we understand where there are gaps and where there are opportunities for us to improve. That's embedded in our daily operations, but also in our improvement opportunities.

Specifically, the evaluation of - for years, there were questions about how do we know our services are working and/or effective, and how do we understand that experience over making a difference? The IWK Health Centre has implemented the Greenspace Mental Health Ltd. platform, which is an electronic platform that is set up at central intake. We have one provincial central intake portal into which anyone can make a referral. An evidence-based triage happens at that point of intake, and at that point in time, they are matched to the right care provider and/or supports that are required.

It's really organizing our system of care, matching the right identified need with the right person at the right time. My colleagues here who do tremendous work in the community - sometimes the right care is absolutely matching them into a

community-based resource. Other times, it's coming into our system. If they do come into the formal system of Mental Health and Addictions Services at the IWK, they come in through an evidence-based triage tool and then they're matched into a first appointment.

At that first appointment, and at intake, they are registered into the Greenspace platform, through which they get a battery of measures that are collaborated on by that caregiver, by the youth, and by the system that actually identifies the goals for their treatment. The evidence-based measures actually match what they want to have happen in the system.

Those measures then follow them through multiple episodes of care. If they're coming in for a community-based ambulatory episode of care that might last six to ten months, depending on those goals they have for service, those measures will follow them into the clinician's office, and they'll be able to - with the caregiver and their family - pull those measures out so that they can understand how they're making progress or not on the care. It actually provides real-time data for that clinician and family to see where they're making improvements, what they need to shift, what they need to focus on, and if the services are making a difference.

When we lift that up and we cut across, we're able to tell lots from that data about whether our services are being effective. We can actually pivot and change services when we're recognizing that they may not be as effective for that person, so we're able to quickly, in real time, make that change and maybe match a different treatment that might better suit their needs.

Just giving you an example of data and how we have it now at the client-facing in real time, but then also to help our program development and identifying the needs across Nova Scotia.

THE CHAIR: MLA Nicoll, you've got about a minute and 20 seconds.

LORELEI NICOLL: Well, I could pass it to him, just to have a quick question.

THE CHAIR: MLA Clark.

BRAEDON CLARK: Just a quick question for ADM Trott around the universal program. I'm sure I speak for all of us when I say that obviously we want to see that succeed. I think it's an incredible opportunity for the province.

I'm wondering, is there a timeline - I know these things are difficult and they're moving targets - but is there a year on the wall in the office, or is there something towards which you're working, at which point you hope to say: Look, we've achieved this and we've actually established this universal program in Nova Scotia? Is there a timeline attached to that at this point?

KATHLEEN TROTT: There's not a hard and fast timeline, but we're working very hard on all of the mandate items to make progress right across the board. Some of them are more complex than others - like service codes are a bit more challenging because it involves a whole system around it and some legislation needs to be changed and all of that. But we . . .

THE CHAIR: Order. The Liberal time for questioning, the first 20 minutes, is up.

We'll now move on to the NDP caucus. MLA Burrill, you've got 20 minutes.

GARY BURRILL: Thank you, Mr. Chair. Ms. Trott, would you like to complete your thought there, before we begin?

KATHLEEN TROTT: Many things are in play, and some are more challenging. We are making progress, though, in particular areas. Some of the services that you've seen us introduce over the last couple of years - like Access Wellness, as an example. When we think of universal along that continuum, it's not just about more psychiatrists and more psychologists. It's actually about how you create access right across so that we're meeting people where they are and where their needs are, and hopefully not having to have folks escalate up that continuum.

Access Wellness would be a great example. It's a single-session counselling therapy that plays a role in the continuum. So for someone who needs quick access to one or two sessions of counselling, that's going to really help them get on with whatever they were dealing with, then that keeps them from escalating up and needing a higher level of care. We're really trying to create a system that does match the needs of individuals when they're ready for them or what they need, and be able to move up and down. As we know, folks sometimes can get sicker or better, so they still have that opportunity.

The other big piece for us is we're adding all these services, which is great, but we also need to make it easier for people to get matched to services - so really working together on system integration and with our partners in community-based organizations as well. It's really that whole system that we need working together to create the universal. It's not one thing, it's all of these things. We're making investments right across the board for that. Does that help?

GARY BURRILL: Now that we're a week back in school, I wonder if we could turn to the question for a moment of mental health in schools. I wanted to ask the representatives from the NSHA and from the office about this. I'm sure you're aware that lots of concerns have been expressed through the Nova Scotia Teachers Union about the inadequacy, in their view, of mental health services available in schools. We know that there was some increased funding made available last year, but it comes to the hundreds, not thousands per school.

I want to ask: Are there plans to increase the number of resources and services that are available in this critical area of mental health supports in the school system?

THE CHAIR: Ms. Vezina.

FRANCINE VEZINA: There have been a lot of investments that are kind of across, so I just want to give you a little bit of information on what's currently available first. We have the SchoolsPlus available. There are 54 clinicians across the province right now who are already providing services in schools. There's Adolescent Outreach Services, which is available in 99 schools across the province, as well as youth health centres. There are 72 youth health centres across the province. There are various mental health and addiction supports already available through those structures.

What I also know in the school - through the Department of Education and Early Childhood Development - that there are also psychological supports available through there. I can't speak to what they may be providing there, but what would be new and upcoming for us would be the Integrated Youth Services as well, which will be available in communities, and that is again working with community-based organizations to ensure a network in communities where children and youth live, looking at high-risk youth and how to bring a wraparound approach to the varying supports that they need.

Often what we see is mental health and addictions issues don't exist in a vacuum outside of, as we mentioned earlier, the social determinants of health.

What I might do is pass it over to Maureen, who can certainly provide a little bit more detail on this Integrated Youth Services model, which is really a national effort going on right now and which we're pleased to be a part of.

MAUREEN BRENNAN: I'd like to comment on the integration of the SchoolsPlus model with Mental Health and Addiction Services as well before I jump to the other question. It's really important that there are many partners in the space of mental health and addictions, and the school is a really important environment in which we're connecting and coordinating care. It's about making sure that all of the key services and supports that happen in schools, community, and our system are connecting the dots.

We have a provincial committee by which the IWK Health Centre, Nova Scotia Health Authority, and the Department of Education and Early Childhood Development have a provincially aligned model by which we plan services, and we look at pathways of how we can connect the dots for all youth across schools so we can create stronger pathways, we can enhance the capacity of an integrated system. We're continuously meeting every month to improve that provincial model. That's been in operation for over seven years now. We're continuing to refine that. That's really in response to the question around the integration.

[1:45 p.m.]

The other gap that we recognized is within the community, there's an opportunity for us to introduce Integrated Youth Services, which is a low-barrier access that provides services that can be integrated within the community in one location where we have multiple partners that can come together in a model that actually connects the dots. What we recognize, when we look at the data, many of these youth are cutting across school, they're cutting across our community organizations, they're in mental health. There are lots of organizations, wonderful organizations that are connecting the community, but what we didn't have a necessarily good grasp on is a well-connected, coordinated system by which we can come together around our youth, so the youth isn't travelling in isolation, where they're experiencing unintentional fragmentation, but a place where we can come together.

Integrated Youth Services is that solution. It relies upon partnerships coming through the Departments of Justice, Education and Early Childhood Development, Health and Wellness, and the Office of Addictions and Mental Health together as we come around and provide services for kids beginning at 12 up to the age of 25. What's important about this model are two things that are unique: It actually covers up to the age of 25, when historically our systems were siloed in that there were youth services up to age 18 that you commented on, and then there were adult services. This provides opportunity for us to share care, to ensure smoother transitions, and to work with one another and learn from one another about how we can be more responsive in an integrated way.

The other important thing around this model is that it provides connection with the national federation across Canada, where we work in partnership. You asked about provinces. We actually have a federal-Atlantic provinces federation for integrated youth services. We're already working and having shared indicators, so we understand how our folks are building resilience, how our programs are being responsive, and how we can learn from one another. It's deeply embedded in research and data, so there's a huge component of research for us to understand how our youth are doing across Nova Scotia, how we're comparing against other provinces, and how we're comparing nationally and internationally.

The federation is completely an evidence-based federation that gives us access to national and international data banks to actually have opportunities to improve what we do here but learn from other countries that maybe have other solutions we haven't considered. We're not creating something new; we're building off the evidence and the lessons learned in other countries that have implemented this model.

Our hope is that over the next four years, we will have two of these Integrated Youth Services in each zone. The other component, which is really important, and I should have led with - these are community-led organizations. These are not government organizations "doing to." This is really about mobilizing the community expertise to

understand what their needs are unique to that community, working with community leaders, and providing them the support, the sustainability, and the resources to ensure this model can work for them. There are key tenets that the model has to meet, but there's a level of flexibility to make it contextually relevant to that community as well.

The work is already under way. We are in the midst of an RFSQ process, where prior to that there have been close to two months of engagement right across Nova Scotia with communities. There have been over 700 engagement emails sent out to all youth-serving organizations that might have an interest in becoming a lead agency for one of these sites. I'm happy to say that we've had over 500 people attend these engagement sessions over a seven-week period. The goal is to really engage communities in this opportunity to help us co-design what services would look like with not only the community, but with youth at the table and caregivers.

It's a real opportunity for us to not only fill a gap but make it contextually relevant right across the province and to give the right support. The IWK Health Centre will be providing support around that model, around the opportunity to provide continued information around programming, staff training, development, and those types of things, but it will be lived within the community and operate and be led by the community.

GARY BURRILL: Switching subjects, I'd also like to ask from the departments about the dimension of mental health relative to the report of the Mass Casualty Commission. The commission was very critical about the inadequacy of supports that it identified, and we understand that there have been responses that have come about that, including this call for proposals from more community-based services that's recently closed.

I wonder if you could update us on the status of that call, what are the kind of services that may be announced, and what we might be able to look forward in the near future to hearing about?

KATHLEEN TROTT: I'll start, but I'll pass to Dana, because she's been heavily engaged at the community level around meeting with folks there and helping to design things.

Yes, we've heard from the recommendation that the services we put in place did not meet the needs. We accepted that and are learning from that in how we can do better for community in the short term - in the now - but also in developing with community that longer-term program of what they need. It has been very interesting to be in community and hear from community around what their perception of mental health supports are - not always clinical, actually. I think folks here would understand that sometimes it's about having a space for men to gather and share their feelings in a way that's safe or natural, or getting folks out playing pickleball, for example - really getting community out together.

I think our response is absolutely all on the clinical side, certainly - I'll ask Dana to speak to that piece of it - but then also we're going to be looking at more community-development types of investments and putting the money into the hands of community for them to lead what they think they need to help their community heal and thrive.

I guess I'll ask Dana to . . .

DANA PULSIFER: Actually, this work, I would say - our approach is in line with everything that we've been talking about this afternoon about coming together with all levels of service care and support. That needs to happen across the continuum. That's what we've been hearing through our listening and engagement sessions.

As everyone is aware, we had to bring to the table by May 1st a proposal or a program, and we needed to do that with community at the centre and driving it. We've been, since that time, really engaging to hear what are the things that are required, what are the strengths of those communities, what are the supports that they are looking for? We have done many, many things. I'll just maybe share some of that.

We've been able to hire quite quickly into this process in Mental Health and Addictions three community-outreach workers. Those folks have been on the ground in communities since the end of April or early May. We've had a mobile unit with Public Health - primary health care and ourselves - visit the different communities early on in May to provide health care services and mental wellness types of services. We had an engagement team travel with that mobile unit, again, to gather input and feedback from community members and individuals at that time - what they were experiencing, what their needs were. That's a key part of the recommendation: really engaging community and hearing from them.

We're using that feedback to design an approach or a model of care or a program, as a recommendation terms it, for grief and bereavement services and mental wellness services that the community's needs are, and that can evolve as we learn more and as communities and individuals progress through these phases of grief and recovery and wellness.

Just to mention that recruitment is ongoing for a range of frontline and clinical positions. That will include a grief expert lead in the area, and that focus will be in the Northern Zone first, but we have a thought to expand scale and spread it throughout the rest of the province. As you know with the recent floods and wildfires, all of that is needed.

We're identifying - I think you mentioned - a community-based organization who will be a partner with us in that approach with a hub-and-spoke kind of approach to care, coordination of funding and grants, and hearing from other community organizations what their needs are.

What we've heard in our engagements so far is quite amazing, in fact. It was very clear that many folks and many community organizations know what their needs are. They made it very clear that they're not looking for health professionals to parachute in and to take care of things, but to help build capacity with those folks who already work in the community, have the relationships with other community members, and help them, for example, with mental health first aid.

I heard people speaking about this at the federal minister meeting that you chaired, and it really was quite amazing to hear that passion and dedication, the need that people have, but also to not overlook what they already have and what they want to build on, maybe through some support and capacity development through health providers in the system. We've also awarded the contract for the needs and impact assessment that's part of the recommendations through Davis Pier Consulting, and we're in a process of going through the information to provide them so that they can deliver that first report for 2023.

I guess I would also say that all along, what we're discovering is that primary health care, public health, mental health, sexual violence, folks are already on the ground doing their regular work - our health promotion teams and all of the community groups and organizations, and volunteers and individuals that are there. We want to be aware of that, we want to support that, and we want to fill in the gaps that they're suggesting are there. But I think the most important part is the approach in that we have to coordinate that - we have to connect it - so we're hoping that an example of an approach like a community hub model is going to help with the spokes - help keep people connected, not duplicate, but also fill in any of the gaps that are there.

We're learning a lot as we're going through this, and it's a very positive - out of a tragedy - positive experience to see how much strength there is, and also how much you can accomplish when you work together.

THE CHAIR: MLA Burrill, you have about 50 seconds.

GARY BURRILL: Well, I wouldn't want to confine any of our guests to 45 seconds, so we'll please move to our Progressive Conservative friends.

THE CHAIR: All right, we'll move on to the PC caucus. Who would like to start? I see MLA Palmer; you have 20 minutes.

CHRIS PALMER: A wonderful discussion this afternoon. I think Nova Scotians, if they're tuning in, are learning a lot about how everyone works together to make sure that we're achieving better outcomes in mental health. Obviously, a system that's been stressed quite a lot over the last few years with COVID-19, Portapique, fires. We know what's been going on, so we know the stresses on the system have been probably greater than normal.

I just want to give Ms. Nichols a chance, because we've heard from a few of our panel today that data is very important. I was wondering if, Ms. Nicols, you would like to respond to my colleague across the table? I don't want to confuse the Nichols/Nicoll. You had some data - national data - that you thought would be relevant to the conversation. I'd like to give you an opportunity to share some of that, if you'd like.

KARN NICHOLS: In preparation for this conversation, what I do know about mental health is it touches everything. It's social determinants, it's housing, and food, and everything. I wanted to make sure that there was a clear understanding of some of the impact and the data that comes from the Summer research from Mental Health Research Canada, which is national, so I realize that - suggests and reflects a lot of what we're hearing on the streets.

[2:00 p.m.]

It suggests that financial concerns remain a major factor in negative mental health among Canadians, and 39 per cent of respondents feel that economic issues are impacting their mental health - no news there. Suicide ideation among Canadians experiencing financial challenges is alarmingly high with 41 per cent reporting having thought about suicide in the past year. Housing and food insecurity remain high, with 23 per cent of Canadians concerned about their ability to make rent or mortgage payments, 37 per cent struggling to feed themselves, and 29 per cent of Canadians citing an inability to pay as a reason for not accessing mental health care despite needing it. That's an increase from 11 per cent from the previous polls. I know it's national, but I think it's reflective of and mirrors the sentiment that's going on here in the province.

I don't know if you need to hear any more.

CHRIS PALMER: I wanted to give you the opportunity to share some of the data, so thank you for that.

My first question will be to you, Ms. Nichols, again. I represent a rural constituency, so a lot of my questioning might be around that rural lens a little bit. One thing we've learned today so far is the preconceived notion that it's just clinical practitioners that we deal with for mental health. It's clear that this is about the community. We are all part of the mental health system. I've had the fortune of attending a few sessions through the Kingston Greenwood Mental Health Association that they put on. Our office deals with Project H.O.P.E. on a regular basis.

I just want to maybe ask you a question regarding a $400,000 commitment from the Province for the rural mental health project. It looks to address a lot of the issues that we've been talking about. Could you expand on what supports are available in those areas for that?

KARN NICHOLS: Reframing that question is: You're wondering what's available in rural Nova Scotia for mental health supports?

CHRIS PALMER: Specifically to funding of $400,000 to the rural mental health project. Any rural supports would be fine.

KARN NICHOLS: You're probably referring to a number that might have been a compilation of a number of different funders, perhaps? The majority of our work is in rural Nova Scotia. The programming is very community based, as we've been talking about. It's based in the need in community. When we were talking about suicide prevention and intervention, we partner with a lot of organizations, as well, in rural Nova Scotia. For example, I partner with an organization called Roots of Hope NS, which is doing a pilot in northern Nova Scotia, and they focus on community-based education around suicide prevention and intervention. We have met with family members, for example, who have had youth who have died by suicide in the past little while, and coming together to provide support but also think about the system and how we can continue to support them.

Additional programs would be things like our peer support programming which exists all throughout Nova Scotia, particularly in northern Nova Scotia where we have a number of programs that are tied to women who are trying to control or take over their lives, and they have some agency in supporting others who are in difficult situations. We have newcomers in southwest Nova Scotia. What we try to do is we try to infiltrate the community but meet them where they are. Often their programming is designed to really have those conversations and grow the programming from there.

CHRIS PALMER: I'd like to maybe address my next question to Associate Deputy Minister Trott. I have a wonderful organization in my constituency called the Evangeline Club, and it's a great club. It's a social recreation club for vulnerable people, many facing mental health and addictions challenges, housing challenges, and they are just a great organization - really preventing isolation and working with individuals from that perspective.

Representing a rural community, not everyone has some of those organizations like that, but the government's launched some initiatives over the last couple of years regarding virtual or telephone services. Can you expand on those for people in rural Nova Scotia who might not have access to a practitioner very quickly? The access to those services?

KATHLEEN TROTT: Those are through the EDs, I think, and then also support for the community clinics part of the Nova Scotia Health Authority. Francine, if you want to expand on those at all? They're less for that type of community-based organization.

But what I love hearing about a club like that is that's exactly what we're recognizing as being essential for community wellness. Community wellness, at its roots, is support for positive mental health and health and wellness.

We've been doing some interesting projects with the Department of Communities, Culture, Tourism and Heritage because of the role that they play in community work as well, and we're really seeing where we can come together on more of these. How do we keep people well, mentally and physically? That's that piece, but maybe over to Francine for the supports in rural.

CHRIS PALMER: Specifically for the internet, virtual, or telephone services that are available, please.

FRANCINE VEZINA: There's so much to tell you there, because there's actually a lot of - it comes in different forms. We fund community-based organizations that often provide services that are provincial, and they have virtual components - for example, our peer support online components or chat or whatnot. There are things like that. There are things like Kids Help Phone, which provides services provincially and virtually. We have MindWell U, Togetherall, Tranquility, Therapy Assistance Online. Dana, you'd probably be better poised for providing a bit more detail in terms of what each of those are and how they differ. But again, those are available to anybody across the province.

Whenever we provide the granting, and as we look at developing a community-based framework, we do look at ensuring that the distribution of supports is across the province. We do recognize that often, things can be a bit Central Zone-based or richer. We do pay a lot of attention to that, but the Mental Health Foundation of Nova Scotia also makes a critical effort in ensuring that the distribution of their grants - and it's a significant amount of resource - is also equally distributed.

Depending on what you want to hear next, either Dana for detail on those programs, or perhaps Starr could speak a little bit about the distribution of funds and what may be in the virtual space through their grants.

CHRIS PALMER: In the interest of time for my colleagues, maybe we'll just have one, if that's possible, and then I'll pass it on.

Anyone who would like to maybe just expand on one of those services - possibly Tranquility or anything like that that's available for those people.

DANA PULSIFER: I can add a little bit more. Just quickly going back to the COVID-19 time that we've gone through, we - IWK and NSHA - were able to pivot very quickly using virtual means to keep seeing patients. That included our SchoolsPlus clinicians in the schools. Schools were closed, but they still were able to make that connection. I think that investment and ongoing - in the rural and urban areas, of course - virtual care has been a really important advancement for us to use. It doesn't work in all rural areas, but for those areas that it does, it has been very good, especially during that time period.

We continue to have that hybrid approach, depending on what the presentation is, to make sure it's safe and also what the client is looking for. We've also been using it in our local EDs with our urgent care teams, after hours, and in order to not have to be physically present. Geography-wise, we're quite a big and rural area of Nova Scotia. I would also say that during COVID-19 and continuing on, I believe, we were receiving some funding from the Mental Health Foundation for phones and iPads to help our clients who couldn't afford the data and the phone package to stay in touch with us. That's been a really well-resourced strategy or approach.

I'm not sure if that answers it.

CHRIS PALMER: I appreciate all of you being here today. I'll pass it over to my colleague MLA Smith.

THE CHAIR: MLA Smith.

KENT SMITH: Just to echo some of my colleagues' comments, thank you very much for the work that you do and the work that your teams do to help Nova Scotians.

The topic today is implementation of additional supports for mental health and addictions, and I'm a guy who likes to stick on topic. I have two questions, both going to ADM Trott. The first one is going to be about mental health and the second one is going to be about addictions.

This morning, Minister Comer was involved in an announcement at Dalhousie University. I believe it was the Dalhousie Centre for Psychological Health. I'm wondering if you can share a little bit about this initiative and how it differs from other supports in the province.

KATHLEEN TROTT: We're very excited about this initiative and its potential. What we're doing is providing an opportunity for psychology students to get training as part of their program under the supervision of clinicians. The clinic is focused on serving those from underrepresented communities and those who have a hard time getting supports because they can't afford to go to a private practitioner.

It's really creating an opportunity to test a clinic. We're doing service code testing there that will help us as part of our mandate around introducing codes to have more clinicians from the private sector participate in providing services. There's a bit of testing happening there. We're super excited. Dalhousie really came to the table in a way that was different for us and saw the opportunity to play a role in helping to contribute to not only increasing services, because they're going to be actually serving people in the community, which is amazing, but helping us also to determine some of these pieces that we're trying to figure out as we move towards some of these other mandate items around service codes.

KENT SMITH: Like I said, I have one more question for you, ADM Trott, and it relates to the addiction side of things. Most of the conversation today has been about mental health, but you folks are doing important work with addictions as well. Specifically, during the research, we talked a little bit internally about the recovery support centres. I'm wondering if you can share what those initiatives are and how they're being helpful to Nova Scotians.

KATHLEEN TROTT: I will get at one point. I'll probably have Dana jump in here with some more details, but I think it's a very good point. It's why the office name changed to the Office of Addictions and Mental Health, to make sure that that profile is happening there. In complex cases, there can be mental health and addictions, so you're really trying to treat both of those.

It's important to be in community to do this, so that's where the recovery support centres and that new model come into play. They're really working in communities. Their walk-in service - they have programming that goes on there. I'll ask Dana to speak more about what happens at those centres.

[2:15 p.m.]

DANA PULSIFER: There's a lot of renewed focus on the addictions part of the Mental Health and Addictions program of care. Recovery support centres are just one of them, and I can give you a bit of information about that. We also are really starting to emphasize more on concurrent disorders, which is folks who present with both. You really can't separate that out. I think that's something that is really important for us to think about in how we're advancing capacity for our clinicians. We have psychiatry with some expertise in that area, so we're doing a lot of training and developing a framework to help ensure that we can offer both of those things simultaneously when that's required.

As far as recovery support centres, I think there are 10 overall. Four to six - I always get this mixed up - are existing and changing over to the new model of care that's been in place for the last couple of years. I can just tell you that in the Central Zone, Dartmouth was opened in January 2022, New Glasgow was opened in February 2022, Middleton was an existing and moved to the new model of care in August 2022, and Lunenburg, same - was an existing centre but moved to the model in November 2022.

The additional recovery support centres that are scheduled to open in the Eastern Zone would be North Sydney, another one in Sydney - that's October for North Sydney, and within the next year for Sydney. Then a realigned recovery support centre in Strait Richmond Hospital - we're hoping no later than March 2024.

In Northern Zone, we have a new one in Truro to open in, we're hoping, December 2023, and Amherst within the next year. Central Zone has a new one in Halifax opening within the next year - no later than March 2024. Hoping I'm not missing any.

They're all providing that continuum of care in withdrawal management, face-to-face or sometimes online assessment to properly match their needs. They can call our intake line, as for any other presenting issue, or they can actually call the local recovery support centres directly, and we also have walk-in that can happen.

As with every other service in our program area, we really match the needs of that individual to the type of service or support that they require. When you think about the whole continuum of care for additional work, again, we're looking at partnering with AA and our stepped programs right up to in-patient withdrawal management. We're really trying to make sure we have our hands in access and navigate to all of those levels of care, which we don't all provide ourselves, but we partner with them in those areas. (Interruption)

Can I just quickly add - we're pretty pleased, Dr. Dave Martell is our provincial leader for addiction medicine, and I was getting an update from him on recruitment for addiction medicine physicians. We've really been focusing our energies as well in the physician field for addiction medicine. There aren't a lot of folks out there with that training and interest. We have 8.2 FTEs, and I'm really pleased to say that we've hired two FTEs already, which are three physicians in the Central Zone. They're doing interviews for four other physicians . . .

THE CHAIR: Order. The time for the PC caucus questioning has expired.

We have eight minutes for each caucus to do another round. I'll begin with the Liberal caucus.

BRAEDON CLARK: Obviously one of the big challenges in terms of achieving universal mental health will be having the people to give the care - the professionals across the board. A question for, I believe, Ms. Brennan and Ms. Pulsifer: One of the things we hear about from time to time is issues with HR and recruitment, so I'm just wondering right now, do you have the latest data in terms of what vacancies look like for psychiatrists at NSHA and at the IWK Health Centre?

MAUREEN BRENNAN: Recruitment is critical to mental health and addictions. In medicine, we have our MRIs. In Mental Health and Addictions, our equipment is our people. Ensuring that we're looking at recruitment and retention of our people is a critical area for Mental Health and Addictions. I can tell you that right now, within the IWK, we've reduced our vacancy rate down to 1 per cent for clinical positions, and we've done this through various recruitment initiatives to engage national psychologists to come into our program. We've hired four in the last three months - PhD psychologists - and continue to do various levels of recruitment.

The other component that we look at when we're thinking about our health human resources is to look at how we can optimize the scope of practice for those clinicians and

physicians to stick to that high-level end of work, and what other roles we can introduce. Can we create a team so that those needs can be met by various roles?

Identifying what new roles can do clinical work, we've also introduced a suite of new allied health roles, additional occupational therapists, additional recreation therapists, board-certified behavioural technicians, to actually support. We recognize there's an increase in complexity. Through those efforts, we're actually able to protect people to stay at the higher end of the scope and then bolster more FTEs through our clinical services.

That's one example of a recruitment effort. I'm very happy. Right now, within our psychiatry division, we have one FTE within the IWK that is vacant and we're in active recruitment and interviews at this time.

DANA PULSIFER: Is the question about recruitment initiatives for psychiatry, or generally in clinical positions?

BRAEDON CLARK: Generally, but specifically I did also ask how many vacancies there are currently for psychiatry.

DANA PULSIFER: Our general clinical roles - I just had an update. Clinical social workers, psychology, OT, those who provide clinical care - our percentage of vacancy was 20.3 per cent in July of 2022, and unfortunately it has increased to 22.3 per cent just this past July. We continue to struggle in that area. I think as Ms. Brennan mentioned, we have many strategies and approaches under way to try to alleviate that gap in positions, and one of those, as she mentioned, is using all clinicians, including psychiatry's role, to top of scope of practice, meaning that there are other allied health professionals who can provide support and care. Our Bachelor of Social Work group can run groups and other supportive means that help leverage what we have. Despite an ongoing vacancy rate, we have been able to pool those types of positions to continue to provide the care that we need to provide in a high-quality way.

Vacancies for psychiatry, we've actually done some really great recruitment in the last year-plus, but we do have a few outstanding vacancies. In Central Zone, there are 1.8 FTEs still to fill. I think they're actively being recruited, however. Eastern Zone, I'm really pleased to say we have zero vacancy. There are no FTEs to fill. I think that's for the congratulations of the department head in that zone and all of their recruitment efforts and really selling the Cape Breton experience. We're hearing some great things coming out of Cape Breton and those in-patient units.

Northern Zone continues to have a vacancy of six FTEs. Five are adult and one is child, although I do believe there are some recruitment processes happening right now. It takes a bit of time to recruit and onboard, even when we have interested candidates. I'm just giving you the general numbers. In Western Zone, there are 1.2 FTEs. Again, we do a

really good job of trying to provide that care across the Western Zone. There is some virtual care that happens with psychiatry as well to try to fill in some of those gaps.

I did want to mention the Dalhousie Psychiatry Residency Training Program. Second-year residents do a rotation in Eastern Zone at the in-patient units. I think that's been a real positive in trying to keep our own within Nova Scotia - a really great recruitment area for us.

BRAEDON CLARK As you mentioned, Ms. Pulsifer, the vacancy rate has increased - by a little bit, but has increased - in the last year or so. A little more than one in five of these positions are vacant at this point. Why is it going, I guess, in the wrong direction, I would say? I'm sure there's a lot of work under way, but what is the biggest challenge in terms of filling those positions and getting that number moving back down in the opposite direction to where it is now?

THE CHAIR: Ms. Pulsifer? Or ADM Trott.

BRAEDON CLARK: Whoever can answer it.

KATHLEEN TROTT: Sure. I guess not unlike every other jurisdiction, we are having real challenges in recruitment. We are doing some things in addition around working with our colleges and universities to try to expand seats, but they're longer-term solutions, for sure. It is absolutely a challenge. We're up against our colleagues in the country and our colleagues internationally, but we are working on a strategy that we hope will help us really narrow in on what we need from a needs-based planning perspective.

As you've heard folks say, looking at the scope of practice . . .

THE CHAIR: Order. The time has expired for the Liberal caucus.

MLA Burrill with the NDP caucus, you have eight minutes.

GARY BURRILL: Ms. Nichols, I wanted to ask you a couple of questions about how some things look from the point of view of the CMHA world. I'd like to go back to the numbers you were talking about earlier about people connecting financial struggle with mental health issues.

We know there are a lot of people living in the space of this connection. I wonder if you could comment on some of the real impacts, as you see them in the people you serve, of the housing crisis and the affordability crisis on the mental health of the people who the CMHA is in touch with?

KARN NICHOLS: I think we all agree that housing is a social determinant of our health. Those who are living unhoused or at the risk of being unhoused are living with - if not mental illness, they are on that continuum and they're moving up toward crisis.

Every day, our folks who work on the ground, in particular with Project H.O.P.E., are meeting people who have stories. The things that they're noticing are that it's not just - it's everybody now. It's the elderly, it's the people - you know, last year we were dealing with a pregnant mother who we had to provide with a tent in community. There are no barriers to having to experience this sort of thing in community.

Mental health is absolutely impacted by virtue of the challenges that people receive. The work that we do really addresses not just the housing piece, but also the piece around providing them the supports and the resources to manage their mental health as well.

[2:30 p.m.]

It's also tied to so many other elements along that continuum. It's around eating well and finding connection within community. It's around having access to food. Those are some of the supports that we also provide when required, depending on the situation.

GARY BURRILL: I also wanted to ask about the impact of long wait times on the people that you serve. We know that wait times vary a lot across the province, particularly for non-urgent care. In some parts of Colchester County, it's pretty nearly a year. Can you comment on the impact on the people whom you serve of longer wait times for non-urgent care?

KARN NICHOLS: To be clear, we're not clinical. The type of support we provide is really community-based. When we're meeting with folks who are dealing with their challenges, the pillars that I spoke of are education and navigation.

A piece of what we would do would be to help them navigate the system to find maybe the right door into support for them. There may be a wait time, but there may be supports that are available in the short term that will help bridge them to get to where they need to get to, or it may be the solution, for all we know.

I think that there is tremendous opportunity to leverage a lot of these resources that are in community that will help mitigate the impact of the wait times along the way. I think that's where the work needs to be done as well.

GARY BURRILL: I wanted to ask the office and the department about yesterday's announcement, about the wait-lists for testing for autism spectrum and ADHD. With that $500,000 pilot and the way it works, what incentive is there for private practices - which are already loaded up - what incentive is there for them to take on those who will now have

funding for services through this program, rather than the paying customers they already have? How does it work?

KATHLEEN TROTT: Maybe I'll ask Francine to jump in here, but it's a pilot. We are exploring that very question, actually. We've been working with the association to determine the best approach on how to engage private psychologists and see what will entice them to be part of this.

I think there's an understanding out there with private clinicians of the challenges of the wait-list and a desire to contribute and a desire to be part of a solution. We are seeing an excitement in just these early conversations as we're forming the pilot. We're not sure how many will sign up and be part of the pilot. We're really hopeful, though, because for this particular challenge, the assessments for autism and ADHD, the wait-list is significant and not every psychologist can do that work. It's very specialized.

To be able to tap in more broadly to the private sector to bring to bear what they can, I think to drive this wait-list down will be very helpful. Also we'll be testing the service codes, how we engage with private practitioners going forward, not unlike what we do already in the health system with dentists and optometrists - and there are doctors. It's how we pay for service, but this is a new area because of how this system has been created over time.

GARY BURRILL: The announcement spoke of a wait-list of 1,600 or 1,700 people. The pilot envisions what kind of change in that?

KATHLEEN TROTT: In part, it tests service codes for our mandate around how we create a system to bring private practitioners in and compensate. We've got this wait-list sitting there. It's a perfect opportunity to take a service that we know - it's a specialized service that only specially trained psychologists can do. Let's test the billing codes, but actually bring folks into the system to help us solve a problem.

GARY BURRILL: The budget talked about a $500,000 study to explore universal mental health care. Has the contract been let?

KATHLEEN TROTT: I'm sorry?

GARY BURRILL: There's a study in the current budget with half a million dollars provided to study universal mental health care. I'm wondering if this is in the form of a contract, and is there anything more about the contract we should know?

KATHLEEN TROTT: Francine Vezina is going to respond.

FRANCINE VEZINA: There are a couple. I'm not quite sure which one that is.

THE CHAIR: Order. Time for the NDP caucus has expired.

We will move on to the PC caucus. I see MLA Taggart has his hand up. You have eight minutes.

TOM TAGGART: Before I start, just a couple comments, if you don't mind. I really want to thank you all for the work you do in what's a real challenge across Nova Scotia and across Canada, and I think probably the world. I really appreciate the job you do and the passion you've shown here today - the understanding you've shown here today.

I'm so very glad to hear so much talk about community today. ADM Trott will know where I'm going with this. I know from experience how hard it is and has been to get folks to come out and say: Hey, I need help. I need to see a clinician.

I really believe the place to start on recovery - where we need to go with mental health - is start right in the community. My community in West Colchester certainly had some challenges over the last - because of the tragedy, you know - and what they've done in that community to what I'll call revitalize it and become a community again. I strongly believe that that is where we need to go to get a handle on this whole mental health situation, start in the community and let people build pride in their community and pride in themselves.

I have some questions. I just had to say that, but I'm going to skip my question. MLA White has a really good question he wants to ask, and if there's time, I'll come back, okay? But I just had to say that. Thank you all very much.

THE CHAIR: MLA White.

JOHN WHITE: As a struggling PTSD victim and a current mental health professional - kind of both sides - I really want to thank you guys for coming in and all the work you're doing. To hear you speak about not parachuting into a community and repairing and leaving. As MLA Taggart was alluding to, communities go through traumatic events and they build resiliency, and it is post-traumatic growth, which is what we need. Although you guys didn't mention PTG, it is an actual thing that this community is going through right now.

I said that because I didn't want to leave MLA Nicoll over there talking about - the only one with a mental health issue here. I wanted to make sure she had company.

Anyway, I wanted to tell you about the second mental health and addictions day hospital, in Cape Breton. As a councillor and as somebody who travelled that road myself, I know that when my psychiatrist was trying to work with me, I was fighting with him. Everything we do is how we make sense of our current events. Everything I did yesterday is how I make sense of today. It continues day by day, minute by minute. When I was into

the struggles of PTSD and depression, I wasn't making sense of a lot, and my self-talk was really bad. I am still challenged with that today.

But anyway, when I think of this day hospital, I think of that as the opportunity to teach strategies and have them go home and try them, and then catch it right away. Am I right on that? That's kind of what I want to know from you. I want to know what capacity that day hospital is, what's being done there, if anybody can help me with that?

I'll leave it to MLA Taggart after that.

DANA PULSIFER: You're talking about the day hospital? Yes. Absolutely, opportunity. As you know, the day hospital in Sydney just opened in late July. So far there have been about 19 distinct individuals and around 218 visits, so they're slowly getting their feet under them. All kinds of great work and potential great work that can come out of that approach or that model of care. As you know, a day hospital is twofold or more. Folks who are - who could be discharged from the in-patient unit or stable enough - they have a good home environment to help support, but maybe have additional work to do, they can step down into the day hospital setting, which provides that intensive coping and helping you live well in your community. Or we have clients and patients who may be receiving treatment and support in our outpatient clinics, but things are escalating, and they need something more intense. That's the other kind of avenue, or route, that day hospital is intended for.

The types of programming that happen there - we have pharmacy care, we have OT as part of the team, there's recreational therapy, there's your typical psychiatric assessment and medication and treatment protocols, social work, and psychology. I think, depending on what the individual's presentation or diagnosis is, that's what would dictate how the care plan or treatment plan, as well as education and supports and services, are all geared to that person's unique presentation.

TOM TAGGART: I'm not sure who to ask the question to, but are there plans? What plans might you have to expand these mental health day hospitals? I love the idea. Are there plans to go further with that?

DANA PULSIFER: Yes, we do. We have plans to expand into Northern Zone as well as Western Zone - we're hoping within the next year. As with many things right now, location of space and our HHR challenges keep us moving and hopping along. We have had a few delays, but we're in the middle of finding other strategies and approaches to be able to do that. We're hopeful to do that within the next year.

TOM TAGGART: If I could to CMHA and MHFNS - sorry - before I was elected, I served on local organizations in my community which were mental health focused. I can say from personal experience at that time that funding was very difficult to find. Recent investments around this province will serve many communities in providing this resource.

Again, ADM Trott referenced community-based organizations, and in your future in your work, or as you look ahead, what do you folks see, or where you value most - what community-based organizations moving forward? What type of role might you play in that? Whoever would prefer to speak to it.

STARR CUNNINGHAM: I think the role that the Mental Health Foundation of Nova Scotia would play is to raise the funding to let the people who are on the ground in their communities do the work that they know needs to be done. Our job there is to raise more money and to do it in a very timely fashion to get the money to work as quickly as possible in our communities.

THE CHAIR: Ms. Nichols, the time has expired. (Laughter) Sorry.

Again, thank you for all the questions from the committee. It's an opportunity now for witnesses to have closing remarks. Is there anybody who would have - I see Ms. Nichols has her hand up.

KARN NICHOLS: Thank you for your patience. I know that we've spoken a lot today about our mental health system in Nova Scotia, and I'd like to take just a few moments to end this conversation about the system that supports this system as well, the system that's within it.

At CMHA Nova Scotia, we're collaborators at heart. We are all, actually. I know that for a fact. The impact sector of over 6,000 organizations across the province pride themselves in being collaborative, but we're not always coordinated. I think that the opportunity is really understanding the capacity that we can hold to support the full system.

Additionally, we believe that in order to build a healthy community impact sector to serve the needs of the province, it's important to consider the needs of the sector. Many community-based organizations work with and hire people who are facing significant barriers themselves.

In order to implement the additional mental health supports from community-based organizations that we've been speaking of, we need to continue to look for ways to invest in the core and operational funding, which includes that we have enough resources to ensure people have a living wage, supportive accommodations, and a reasonable quality of life in their work. Without this, it will lead to further burnout and harm and likely make the crisis even worse by causing the helpers to have less capacity to help.

I'm just asking you to think a little more beyond the services we're providing in the community to the people who are providing the service for the community, because if that doesn't work, then the rest won't work.

[2:45 p.m.]

.My background is in business, and I can safely say that running a non-profit is way more complicated than running a comparable-sized business. When the for-profit entity finds a way to create value for a customer, it has found its source of revenue, which is the buyer. When a non-profit finds a way to create value for the beneficiary - providing community-based mental health support, in our case - it has not identified its economic engine to support that. The beneficiary cannot cover the cost of the service. We must find the funds to provide the service through other means, which is a separate, additional step.

Achieving sustainability in the non-profit funding model is therefore critical for the delivery of the social safety net of the valued programs and services that are not covered by other pillars in our society. Traditional funding models allocate money to specific projects, sometimes constraining how the money is spent, and it sometimes leaves a little bit of difficulty for the flexibility in how we serve the community, which means that sometimes we're just surviving, because the core funding is not really addressing our operational needs.

Some of the ways that we would suggest addressing the systemic challenges would be to increase the funding cycles. There are simple solutions that maybe we need to reconsider as well in order to support the overall system.

At CMHA, we're keen to work with the government, our sister organizations, all of our other funders, and most importantly our communities, to ensure that we have mental health for all. I really thank everyone in the room for the opportunity today, as well as the people who are sitting with me at this table.

THE CHAIR: Are there any other closing remarks?

STARR CUNNINGHAM: Our tag line at the Mental Health Foundation of Nova Scotia is "changing the way people think." I believe that that's what we're all working toward here at the table: changing the way people think about their own mental wellness, the recovery through mental illness and addiction, and what it means to be part of a community. We have great data at our fingertips because every application we receive for a community grant identifies the needs in a community. They're telling us what the gaps are, what pieces are missing, what they need help with.

What we've done is we've looked over all of our applications over the last 12 months, and we've identified six priority areas. I don't think they'll be a surprise for anyone here: diverse communities, vulnerable populations, addictions, youth, suicide prevention, and mental health literacy.

I just wanted to end my comments today by talking about mental health literacy. There is a huge appetite among Nova Scotians to learn more, and I believe we are in a

position where we can help Nova Scotians understand what it means to triage mental health, to understand when they do need to see that psychiatrist or when they can go to a student youth centre in their school. There are so many programs out there: safeTALK and Applied Suicide Intervention Skills Training were mentioned, mental health first aid, Mental Health and Wellness in the Workplace. We've seen an increase in people asking for that information, so let's work to give it to them. Let's educate Nova Scotians and help them not just navigate the system but navigate their own mental health and their families' mental health - their teammates', their colleagues', their neighbours', their children's. Let's give them the information they need.

It's not awareness anymore. We're all aware there is a serious problem. It's about educating now. It's time to put some meat on the bones.

KATHLEEN TROTT: I won't keep us, but I just really wanted to say thank you. This really was a great opportunity for us to share the big pieces of work that we're working on. I'm so proud of how far we've come and how we're working together as a team across the system and in partnership. We've got a lot left to do, but I think that we're really proud about where we are right now and the important role that is ahead around how communities and organizations work in partnership with us across the system to create that much stronger system to deliver care.

THE CHAIR: Thank you, ADM Trott, and on behalf of the committee, thank you to our witnesses for being here today.

This concludes our question-and-answer period. We're going to take a short two-minute recess to allow our witnesses to leave, and then we have at least one item of committee business. Two minutes.

[2:50 p.m. The committee recessed.]

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

THE CHAIR: Order. Thank you, members. We're going to get into committee business.

On committee business, we have one item: some correspondence both on August 6th and August 16th, emails from Matt Casey re "Nova Scotia Health Using Dirty Surgical Instruments on Patients." These were forwarded to members when they were received, and again yesterday.

Is there any discussion?

CHRIS PALMER: This side of the table, we believe it's important to recognize Mr. Casey's concerns and his correspondence. I'd like to move that the Standing Committee on

Health write a letter through you, Mr. Chair, to the Department of Health and Wellness requesting an update on the concerns outlined in the correspondence from Matt Casey.

THE CHAIR: Do we have any discussion on that item?

Hearing none, I'm going to ask for a vote.

All those in favour? Contrary minded? Thank you.

The motion is carried.

Is there any other business from committee members here today?

Seeing none, our next meeting is scheduled for Thursday, October 19th, from 9:00 a.m. to 11:00 a.m. As we've all been informed, I think, the House will be sitting at that time. The topic will be Mental Health Supports for First Nations Communities. Witnesses will include Tajikeimɨk - Mi'kmaw Health and Wellness; the Mi'kmaq of Nova Scotia Health Directors Committee; Nova Scotia Health Authority; IWK Health Centre; and the Office of Addictions and Mental Health.

With that, I will say we'll conclude business today. The meeting is adjourned.

[The committee adjourned at 2:55 p.m.]