HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Tuesday, April 9, 2024

RED CHAMBER

Withdrawal Management Services

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HEALTH COMMITTEE

John A. MacDonald (Chair)
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[Hon. Kelly Regan was replaced by Fred Tilley.]
[Gary Burrill was replaced by Lisa Lachance.]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Nova Scotia Health Authority
Dana Pulsifer
Senior Director

Janah Fair
Director, Northern Zone

Dr. David Martell
Physician Lead, Addictions Medicine

Office of Addictions and Mental Health
Kathleen Trott
Deputy Minister

Dr. Sam Hickcox
Physician Consultant

Direction 180
Paula Martin
Program Manager

Ally Centre of Cape Breton
Jill Gardiner
Manager, Managed Alcohol Program

HALIFAX, TUESDAY, APRIL 9, 2024

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
John A. MacDonald

VICE CHAIR
Danielle Barkhouse

THE CHAIR: Order. I call the meeting to order. This is the Standing Committee on Health. I'm John A. MacDonald. I'm the Chair and the member for the Hants East.

Today we will hear from the Nova Scotia Health Authority, the Office of Addictions and Mental Health, the Ally Centre of Cape Breton, and Direction 180 regarding Withdrawal Management Services.

Just a reminder to put all your phones on silent. I will now ask committee members to introduce themselves by their name and their constituency, starting with MLA Barkhouse.

[The committee members introduced themselves.]

THE CHAIR: For the purposes of Hansard, I recognize the presence of Chief Legislative Counsel Gordon Hebb and Legislative Committee Clerk Judy Kavanagh.

I'd like to welcome all the witnesses. First, I'm just going to get you to introduce your name and your position, and then we'll get to opening statements. I'll start with Dr. Martell, please.

[The witnesses introduced themselves.]

THE CHAIR: I believe we have Janah Fair, director, Northern Zone, in the back. If called upon to answer questions, she'll take either Dr. Martell or Ms. Pulsifer's spot.

I just want to remind all the witnesses for opening statements to keep them around three minutes. We have four of them.

I believe the deputy minister is going to start. Am I correct?

Deputy Minister Trott.

KATHLEEN TROTT: I'll start, and then I'll ask Dr. Martell to speak, and then we'll have our community members speak, if that works.

Good afternoon. Thank you for the opportunity to join you here today to discuss withdrawal management. Substance misuse and overdose prevention have always been complex issues, and they have gotten increasingly more complex over the last five years. We have seen an increase in overdoses and deaths and an increasingly toxic drug supply, and we are responding.

We work with our health system partners and community-based organizations to address substance use and overdose in our communities and to support Nova Scotians experiencing addictions. We have been making investments to strengthen addictions medicine and increase access to supports and programs.

We are making progress on the implementation of the recovery support centres opening across the province. These centres offer one-on-one support and group treatment for people struggling with substance use or gambling. The team at these centres can provide harm reduction support, including naloxone kits and training, as well as more traditional services, like in-patient withdrawal management and opioid-use disorder treatment. We removed barriers by creating a walk-in service as part of this new model, so the service is there when people are ready to take their first step. There are now seven locations across the province, including the one in North Sydney that just opened last month, with more to come this year.

We are investing in harm-reduction approaches to help minimize the impacts of drug use. There are overdose prevention sites in Halifax and Sydney. The Take Home Naloxone Program has provided more than 43,000 life-saving kits through community-based organizations like Direction 180 and the Ally Centre and pharmacies across the province. We provide funding to community-based organizations offering needle exchange and disposal, peer support, opioid replacement therapy, and more. Additionally, opioid use disorder treatment services are available in every health zone, with 23 sites across the province, and there is no wait-list for this treatment.

In September 2023, we launched the province's first in-patient Addiction Medicine Consult Service at the Halifax Infirmary site to provide advice for physicians providing care to in-patient units and the emergency department.

When it comes to addictions, we need to meet people where they are. That means we need a range of services and supports - everything from harm reduction and overdose prevention on one end to treatment options and recovery support on the other. We have a lot happening in this space and we look forward to talking more about this today.

THE CHAIR: Did Dr. Martell have opening statements? Dr. Martell.

DR. DAVID MARTELL: Thank you so much for inviting us to this committee meeting. As the Chair mentioned, I am Dave Martell. I'm the physician lead for addiction medicine for the Mental Health and Addictions Program. We didn't properly introduce Janah Fair. She is the zone director for the Northern Zone, but she is also my partner in this addictions planning work, my co-lead; and Dana Pulsifer, senior director for the Mental Health and Addictions Program.

I'd also like to acknowledge our community partners. It's very important to have them at this table, representing the Ally Centre of Cape Breton and Direction 180. We have key partnerships that allow us to be very effective by having them present, and having them be part of our planning in the programs that we control.

I also want to take a minute to thank this committee for prioritizing this topic. Addiction doesn't get a lot of conversation at all times in health care or in society, and I think it's important that we have these discussions openly.

I also want to congratulate the members of the Legislature who have stood up and given their own personal narratives. It's always very meaningful when it happens. It helps humanize the face of addiction. It helps us to fight stigma, so thank you.

I want to start my comments by illustrating a little bit why this conversation is important. You heard Deputy Minister Trott talk about the deepening of the issues that are coming up with toxicity in the drug supply, and people dying unnecessarily from overdoses. That's only one part of it. Addiction issues and substance use account for perhaps a large majority of disability that happens in society. It's primarily responsible for most premature death in our culture. People live 10 or 20 years less than what is expected because of substance use and addiction.

We lost 73 people to drug toxicity last year, more than we usually do. We are expecting a trend where that increases as well. These are parents, children, siblings, co-workers. They are human beings. We should acknowledge their loss.

Addiction represents a complex set of problems for which there is no one solution, there is no one recipe. We have to individualize treatment. The complexity is normally what scares health care providers away from having a comfort level with providing care for people in this setting. We really have to co-operate to come up with plans and system-level planning to make for effective treatment for this population of people.

We work closely with the Office of Addictions and Mental Health and the IWK Health Centre, but also with collaborators in other parts of the Nova Scotia Health Authority, partners nationally in other provinces, and internationally. I serve some leadership roles across the country to that end.

What guides us? We are guided by the Action for Health plan. We want to deliver high quality, low barrier access to treatment. We are tasked now to come up with a realistic plan to implement universal mental health.

We're also guided by a framework that was developed seven years ago - the Opioid Use and Overdose Framework. It came out as part of the public health emergency to do with opioid overdoses - the same thing that we are talking somewhat about today. A lot of that framework still holds true. We need to be driven by data. There's a focus on prevention. There's a focus on treatment. There's a focus on harm reduction. There's a focus on enforcement. Coming at this problem from all different areas seems to be the most comprehensive way we can address it.

Things have changed since we came up with that framework. Here, seven years later, we are dealing with poisoning of the illicit drug supply. I think it is time for us to prepare for a worsening, perhaps, of this problem and to do another set of planning. I know there are discussions in the works about that.

I'd like to talk briefly about recovery support centres. These are hubs that we have developed where people can start on their pathway to addressing their addictive behaviour and making change, places where we try to rid people of the shame associated with their disease, where there is no judgement, where we show respect, where people can have individualized care plans made. There is no recipe to try to address an addiction issue. There is no cure for an addiction. We have group learning sessions that take place in these settings. We sit with people and make individualized plans for their care. We follow up with them. We form relationships. The engagement seems to be a key part of what makes this care effective.

We've also, in September of last year, developed a consult service at the Halifax Infirmary designed to try to help decision makers in the hospital, caregivers caring for people with very complex problems, to ensure that they stay in hospital and receive the care that they need. Too often, that doesn't take place when people feel shame or feel judged. Not getting the care that they need, sometimes with life-threatening conditions, can have major consequences. Our team has a nurse, a social worker, we're hiring a peer

worker. It's meant to be multi-disciplinary and holistic. We also have a telephone advice service that is part of this program where any nurse practitioner, physician, or pharmacist in the province can call asking for advice or guidance on complex problems.

THE CHAIR: Dr. Martell, I'm just wondering if you're almost done because you're at six minutes. (Interruption) Just a second. Dr. Martell.

DAVID MARTELL: In closing, thank you so much for providing this space for us to have this conversation, for us to talk about our vision. We appreciate it.

THE CHAIR: Thank you. Ms. Martin - sorry, Mrs. Martin.

PAULA MARTIN: I am very happy to be here today on behalf of Direction 180, a program of the Mi'kmaw Native Friendship Centre that directly supports people impacted by addiction in all of our communities. As I mentioned earlier, my name is Paula Martin, and I am the program manager for Direction 180 and the ReFix overdose prevention site.

Direction 180 is a community-based opioid treatment program located in north end Halifax. We have been in operation since 2001, supporting people with substance use disorders to reach their full potential through health and social programming. We are currently treating 465 patients with opioid use disorder.

Direction 180 also operates Atlantic Canada's first overdose prevention site. An overdose prevention site is a safe space for people to use drugs in our community. This safe space reduces the frequency of public drug use and the inappropriate disposal of drug use equipment, public intoxication, incarceration, the transmission of blood borne pathogens, unnecessary fatal drug poisonings, and most importantly, the opportunity to connect people who use drugs with other health and social services. Since January 2022, the ReFix overdose prevention site has supported a total of 399 Nova Scotians to use in a safe space, a total of 19,540 times. ReFix staff have successfully responded to seven opioid poisonings, preventing seven unnecessary opioid deaths in our community.

Direction 180 understands the importance of employing people with lived and living experience with drug use. Employing people with lived and living experience helps to ensure organizational policies, procedures, and services meet the needs of the population served. This reduces barriers and can increase service retention among people who use drugs in our community.

Thank you again for having me here today to share more about what our organization does to support Nova Scotians to reach their full potential.

THE CHAIR: Ms. Gardiner.

JILL GARDINER: Hi, everyone. I'm Jill Gardiner. I am the harm reduction manager at the Ally Centre of Cape Breton. The Ally Centre of Cape Breton aims to be a supportive and non-judgemental environment. We serve populations such as folks who use substances, those experiencing homelessness, sex workers, and individuals experiencing active mental health issues.

[1:15 p.m.]

Our programs are built on a person-centered, trauma- and violence-informed approach with direct access to wraparound supports. With harm reduction as a key element, we embrace those with lived and living experience both as peer mentors and employed staff. At the Ally Centre site located in downtown Sydney, we provide a long list of programs that address the physical, mental, and social needs of the participants we serve. Some of these include S.A.N.E., Sharp Advice Needle Exchange, drop-in services, health clinic, overdose prevention site, naloxone program, food bank, housing support staff, social workers, and peer navigators.

I'm here today to talk about MAP. The Ally Centre MAP is the second managed alcohol program in Nova Scotia. The program demonstrates best practices through a harm-reduction philosophy that targets individuals who are vulnerable to alcohol use, homeless or at risk of homelessness, and ready to engage in reducing the harms associated with their alcohol consumption.

MAP is a palliative program in which the focus is on preventing alcohol-related harms, including those related to survival drinking, non-beverage alcohol use, alcohol withdrawal, maintaining or reducing use, and harm reduction, wellness, peer mentor support, self-management, and safer-drinking education.

The Ally Centre MAP team provides wraparound support to MAP participants. This includes the clinical team - a MAP nurse and nurse practitioner - and a harm-reduction outreach team providing daily support. Individualized care is provided as the MAP team recommends.

MAP community partners are currently providing supportive housing. A referral form is provided to the community partner through our established partnership. This is followed up with various interviews with the individual and their supports to ensure that MAP is a fit for all. The Ally Centre MAP accommodates a maximum of 20 individuals in a supportive housing environment.

Supportive housing in Cape Breton: Due to the lack of harm-reduction-based supportive housing models in Cape Breton, we are really struggling to implement MAP. We have had some small successes with a scattered-site model - individuals who live in their own home or apartment. However, MAP is best delivered in a supportive environment with several touchpoints a day.

In Cape Breton we have zero harm-reduction supportive housing models. It hasn't happened yet. We at the Ally Centre have been working closely with New Dawn Enterprises to provide these severely needed models in Cape Breton. We have been met with community resistance, which has led to political movement halting the implementation of the Pallet homes. We were hopeful that the Pallet homes would be actively operating at this point and providing the much-needed supportive housing option that our many community members living rough need. MAP would have likely accounted for half of the Pallet home occupancies with participants who are at a palliative stage in their journey.

Supportive housing models, specifically in harm-reduction and palliative care, are the missing piece that we are faced with in trying to deliver MAP in Cape Breton. Harm reduction saves lives, yes, but it also offers an opportunity for folks who have been struggling their entire lives to be sober to finish their days in a supportive environment, recognizing that sobriety is not for everyone.

We feel at this time that it is very important to highlight the lack of movement on the systemic changes needed in Cape Breton. With the delay of the Pallet housing due to community and political protest, dozens of individuals will be denied programming. For some, a four-month delay will mean they will never settle into adequate supported housing in their lifetime.

THE CHAIR: As normal process here, each caucus will get 20 minutes. At the end of the 20 minutes, I'll divide by three to see what the next round is. If, at the end of the 20 minutes, you hear "order," it's not being rude. It's just to get it going along.

First will be for the NDP. Sorry, the Liberal Party - I'm looking right at you. It'll be MLA DiCostanzo.

RAFAH DICOSTANZO: First I want to start by thanking Direction 180 and the Ally Centre of Cape Breton for the amazing work they do. It really does make a huge difference in your communities, and I hear a lot about it. I just want to acknowledge and I'm very happy that you are here as well.

However, my first question is for the Nova Scotia Health Authority, probably to the deputy minister. The government promised recovery support centres throughout the province and they are so needed because the wait times are still very long. We know that in some clinics it is over 100 days. I saw one of them was 122 days for the non-urgent visits, and over a week - one of them, I believe, was over nine days for the urgent visits.

The Halifax site has been delayed in opening. Can you please give us an update as to when the Halifax centre will be opened and why there is such a delay?

KATHLEEN TROTT: I am going to pass it over to Dana Pulsifer, who leads that initiative.

THE CHAIR: Dana Pulsifer.

DANA PULSIFER: I was just trying to hear the entire question.

THE CHAIR: Yes, construction is not being nice. Do you need it repeated?

DANA PULSIFER: I think I pieced it together. I think your question is about the recovery support centres and the one in Halifax.

RAFAH DICOSTANZO: Sorry about that. Yes, we are still having very long wait times all across the province but some of them are - the numbers that I wanted to quote are - for the non-urgent are over 100 days - some of them are 120 that I looked at - and for the urgent it is still over one week, some of them are nine days. Specifically, we were supposed to have one in Halifax opened by now but there is a delay. Why is the delay? When is the expected time?

DANA PULSIFER: I'll answer. I think there are a couple of different questions in there. Then I will likely pass it over to Dr. Hickcox for a little more detail. I think some of the wait times you are quoting are related to the outpatient, community mental health wait times when you talk about over 100 days and the seven days.

Our recovery support centres, really, they are walk-in related or they can call the intake line to be given an appointment or they can call the actual recovery support centre in their specific location and arrange for an appointment and an assessment. Those wait times are really applying to our outpatient or our community-based mental health and addictions clinics.

For your second question about the delay, some of the recovery support centres that are to be launched and have had a bit of a delay typically are related to the construction and renovation timelines that keep being moved, unfortunately. Some of it is related to the hiring and recruitment of either addictions physician positions or some of our allied health care positions. I'll ask if Dr. Hickcox could relate to the specific question.

THE CHAIR: Dr. Hickcox.

DR. SAM HICKCOX: I think the reason they punted this to me is that I am the addictions medicine physician who is going to be working at the Halifax recovery support centre when it gets set up, so they did recruit somebody.

I've sort of been intimately involved with what's happening in terms of the delays and so on. I would echo what Dana is saying, that the majority of the delays are really due

to supply chain issues regarding the renovation of the existing space that's there, getting skilled labour to come in and put in the appropriate physical requirements of the space, like the electrical system, et cetera.

In the case of the Halifax recovery support centre, it has less to do with recruiting health care providers. They are really close to full complement, basically we're going to be having a conversation with a nurse practitioner on Friday with the aim to bring them onboard. Otherwise, they are pretty much at full complement and waiting for the space to be ready to be used, which is coming very soon.

RAFAH DICOSTANZO: Can you clarify "very soon"?

THE CHAIR: Dr. Hickcox, am I going to refer that to someone else?

SAM HICKCOX: No, no, it's okay. No, I know. (Laughs)

As of today, I've been told to show up on the 13th of May and start admitting patients that week. I think it's very credible that we'll be getting going in mid-May, for sure. It takes a while to roll out these things, to roll out all the services, of course, and get things rolling. Stay tuned for that.

Just a couple of things, like the space. I just get excited about the space itself because we're right next door to one of our universal mental health care pilot sites, the psychology clinic that's being run by Dalhousie's psychology training program. Their mandate is to address the needs of folks who are really struggling with being insecurely housed, or are unhoused, or living at the margins. We see an opportunity to provide collaborative, co-occurring care for people who normally can't afford a combination of psychological care and actual addiction medicine care. I just wanted to point that out.

A final piece: it's important to recognize that with our model of addiction care that we've conceptualized, the attempt is to take into account what's happening to people who are in the throes of addiction. When people are struggling with substance use, that really eclipses everything else in their life. It's very difficult for people to maintain an appointment for two, three, four weeks, six weeks down the road, right? Immediate walk-in access is what we're aspiring to. We're not there with all the RSCs yet, but that's the core of the model.

RAFAH DICOSTANZO: If you don't mind, if you can keep it to the timeline. I'm trying to figure out when will Halifax - and I'm very grateful. I've got an estimated and a very good time.

My second one was the hub for Southwest Nova Scotia. When will that be opened? If you can give me the other ones that have been promised and approximate times that you're expecting them to be open, I would really appreciate that.

DAVID MARTELL: The question, MLA DiCostanzo, was about Southwest Nova Scotia, recovery support centres in the southwestern part of the province. You're referring specifically to Yarmouth. There is also a recovery support centre in Middleton. The challenges that we've had in that part of the province to effectively stand up a service like this have to do, again, with the health human resources planning. We had great success through last year, recruiting a physician to work in that site. Then a family issue came up and the person had to back out. We're continuing our recruitment effort.

We've also, on top of that, developed a situation where we've had a flood in the Abbie J. Lane Memorial Building. Some of the staff who are working in the Yarmouth site have been seconded to help out with patients who had been in the Abbie Lane. I know that's temporary, but staffing going into other care settings can fragment the ability to build an RSC, and in Yarmouth that's what's taking place right now. We hope to have it back up as soon as we can, but there isn't a specific timeline.

RAFAH DICOSTANZO: For Southwest Nova Scotia, it is staffing rather than location? The location is ready, it's just that you're having a hard time to staff it?

DAVID MARTELL: Yes, that's correct.

RAFAH DICOSTANZO: And for Middleton? It's the same for both of them right now?

DAVID MARTELL: The situation with the recovery support centre in Middleton is a little different in that the space is not within a specific hospital setting and staffing issues are more in flux. We have the service up and running in the recovery support centre in Middleton at present. It's an active recovery support centre.

RAFAH DICOSTANZO: I don't want to spend all the time on this, but what other centres are you having a hard time with? How many more centres are you opening, and which ones are you expecting to have some success as the Halifax one?

DAVID MARTELL: The ultimate vision was to have 11; now we're thinking of 12, geographically distributed throughout the province. We have seven open at present; we have three more about to open within the next few months and are trying to put plans together to have all 12 open just as soon as we're able to have the recruitment piece, the staffing piece, in place. Those are the numbers.

RAFAH DICOSTANZO: Perfect, that's exactly what I was looking for. Thank you so much.

I heard from physicians who work in addiction and withdrawal management on how difficult it is to have successful continuum of care for patients living with addiction, because the management of opioids is - and they've actually sent an email, I believe, to the

deputy minister, to have an electronic medical record to help them with the continuum of care for patients.

[1:30 p.m.]

I'm just wondering: When will the withdrawal management and opioid clinics be able to transition to electronic medical records?

DAVID MARTELL: Thank you, MLA DiCostanzo, for asking that question. It's a question I, myself, have had about what our vision is for documentation and communication within addiction settings in the province.

We have undertaken a project, as you know, provincially to try to bring all of the systems into one system, called One Person One Record. We are hoping to blend the conversations about the development of that program into: What the needs are that we have within our mental health and addictions programs to communicate and to document that care. We are hoping that the development takes place at the same time.

RAFAH DICOSTANZO: The OPOR is a 10-year program or 10-year long time. What are they doing right now when they are struggling, honestly? What are they going to use? Meanwhile they are using paper - very archaic, and it's just very discontinued, especially now with not having a family doctor and going to virtual care or going to pharmacists. The information is all over the place and it's 10 times harder when you have an addiction that needs continuous follow-up for them.

These patients are truly struggling, and the doctors are struggling with this. OPOR is a 10-year thing, and also does not include family doctors. The investment that we just announced, or the new government announced, does not include family doctors, so it could be another 10 years after that. What are they supposed to do in the meantime?

DAVID MARTELL: MLA DiCostanzo, you are preaching to the choir. I am one of these physicians, and I struggle myself with the archaic nature of the way we keep track of notes. I think this might be an opportunity for one of our community partners to speak about their success with that physician piece. I'd maybe call on Paula Martin to talk about the use of electronic health records in the setting where she works.

PAULA MARTIN: At Direction 180, we do currently use an electronic medical records system. It has been a very useful tool, not only for our patients but also for physician transcribing. Physicians' handwriting can oftentimes be difficult to decipher. It has really enhanced the care we're able to provide through our clinic, as well as collaborating with other health and social services through the use of an electronic medical records system.

We were able to do this more easily because we are not positioned in a hospital. We are not a hospital-based program. I would expect that some of the challenges in the Nova Scotia Health Authority opioid recovery programs, if they are positioned or based within a hospital setting, that they would have to follow similar record-keeping mechanisms where they're positioned.

RAFAH DICOSTANZO: I thank both of you for the answer. How much time do I have left?

THE CHAIR: Just under six minutes.

RAFAH DICOSTANZO: I am going to pass it to my colleague, Mr. Tilley.

THE CHAIR: MLA Tilley.

FRED TILLEY: Thank you all for being here today. The first question I have is regarding an organization in Yarmouth. The leader of the party and MLA for Yarmouth wrote to the minister earlier this month about a longtime organization in Yarmouth called Laing House Yarmouth, a youth centre that provides peer support and programs for those living with mental health challenges. They were suddenly informed that they were being shut down.

No information was provided to the members of the organization behind this reason. In a time when we need more mental health and addictions supports for youth, why would the department shut down Laing House in Yarmouth?

KATHLEEN TROTT: The department didn't shut down Laing House in Yarmouth. It was a decision made by the Laing House board. We were notified after that had taken place.

We are working with the organization now to determine what led to that decision and how we can work together to support services for youth in Yarmouth. I understand that the Halifax Laing House is providing virtual support currently. We're working with the organization to determine what the path forward is.

FRED TILLEY: Another question I have is around in-patient beds for withdrawal programs across the province. How many beds do we currently have? Are they full? Are we fully staffed?

THE CHAIR: I'm seeing them all look at Dr. Martell. Am I correct?

DAVID MARTELL: Again, keeping track of exact numbers is challenging, because they're ever in flux. Just this past week, the same way in Yarmouth, we have had

to second some patients to the in-patient withdrawal-management unit at Simpson Landing.

We've only ever been able to have programs partially up and running, initially due to pandemic restrictions, but then due to health human resource staffing issues. We're still trying to emerge from that. Part of this conversation is also about the model of care - questions like should we be siloing care for people who have a medical complexity of their addiction such that they need to be hospitalized to help them come away from the substance? I think it's an opportunity that we have to not just reflect on beds but on the care itself and whether or not people who have that need, who require a hospital, should be allowed to get treatment in an actual hospital and not a withdrawal-management unit. I'm not speaking on behalf of the program in those words.

The other thing I'll point out is that we have a lot of conversations, often, about beds. That is how we keep track of the numbers of what we need and what our capacity is. I'd suggest that there is a hint there that the best way to treat somebody who has an addiction somehow involves them lying down. We need to look at capacity using other measurements and not just by how many beds there.

FRED TILLEY: Regardless of the number of beds - "across the province," I guess, would be a better way to phrase this. The level of service from Cape Breton to Yarmouth: Would it be consistent levels of service throughout all the regions, or are there one or two regions that have exemplary service, or would there be one or two regions that require more help and staffing?

DAVID MARTELL: That one is quite easy for me to answer, MLA Tilley. I live in one of the regions that doesn't have a designated in-patient withdrawal-management unit. We have a co-operation with another zone to try to provide that care when it is required, but because of the distance and the logistics, it often doesn't easily take place. We really need to reflect on the model. That inequity has to do with where these in-patient units historically were and their legacy.

FRED TILLEY: I guess, with probably 30 seconds left . . .

THE CHAIR: No, 55.

FRED TILLEY: Fifty-five seconds left. Very good.

Can you give a recommendation, then, of how we could improve this type of service for patients across Nova Scotia, in 55 seconds or fewer?

DAVID MARTELL: My recommendation: I alluded to looking at the model. The way I would reflect that back to you is that we have had very effective models of care where people really need sheltered care treatment in other parts of the country. Drawing

from that experience and taking the best of the examples in terms of their health outcomes for patients, I think, is the path forward. There are some index ones, like designated hospital wards in places like St. Paul's Hospital in Vancouver and the ARCH program, that have a co-operative effort with emergency departments in their area. They have swing spaces where they do more complex care. Drawing from those models, I think, is the solution.

THE CHAIR: Order. That's perfect. The 20 minutes are up. The NDP. MLA Leblanc.

SUSAN LEBLANC: Thank you all for being here. I just have a couple of quick questions before I pass it on to my learned colleague.

Most of my questions are for the Ally Centre of Cape Breton. You've done a great job of talking about the work that you're doing, and we also know that the Ally Centre has an excellent track record of providing compassionate community-based care in Cape Breton. I'm just wondering: First, can you talk about the population demographics of who you're seeing at the centre lately? First of all?

JILL GARDINER: Sure. Actively homeless populations, typically. We have really seen that population grow in Cape Breton. It's a very visible population. I call it the Ally Centre magic. They have a really good relationship with this population. Oftentimes when we talk about programming and community-based programming, we develop the programs and then we find the participants. Well, at the Ally Centre, it happens the opposite way. We already have that relationship established, that trusting relationship. Many folks are actively homeless. Many folks may be using substances. Those are our folks - very vulnerable populations. Many are struggling with mental health issues that have never been addressed.

SUSAN LEBLANC: Are you seeing any changes in terms of age groups? More seniors, more young people, anything like that?

JILL GARDINER: It's an interesting question. It is a bit of a spectrum. We do have an aging population in Cape Breton, so there are many folks on the street who are palliative. Other than that, we know that substance use and living rough can take years off our life anyway. We are seeing - just because we're in Cape Breton, I believe, too, and that's the demographic that we have.

SUSAN LEBLANC: With the managed alcohol program, are there barriers? You've mentioned the housing piece, but are there other barriers that you've come up against in terms of providing support through MAP?

JILL GARDINER: Yes. A big piece is building those partnerships. I started this role a year ago - actually, this week - to develop the program. That was the easy part. The

big piece is developing the relationships within the community with other organizations, them understanding the program, trusting the program. That has been a big barrier. Also, you know, because we don't have a harm reduction model, supportive housing setting, it's sort of delivering new programming for our partners.

SUSAN LEBLANC: Well, I guess this is maybe a two-parter for you and for the department. I guess the big question is: What do you need from the Province of Nova Scotia in terms of ensuring the success of the centre, the programs? Is there enough funding for front-line workers? That kind of thing. Is there a big gap that you see or any gaps?

[1:45 p.m.]

JILL GARDINER: Yes: infrastructure. Right now, we're building the RHI. You may have heard of that $5 million project happening in north end Sydney. We're about January 2025, that should be ready - 24 units, harm reduction supportive housing. In the meantime, we're just making do. We have pulled together shelter. We have folks staying overnight at our shelter. I'm hearing that funding is running out soon, but the weather's nice.

SUSAN LEBLANC: I live in Dartmouth North and represent Dartmouth North. We have The Overlook in Dartmouth North. I just got a chance to take a really awesome tour of the facility and meet a bunch of the staff and meet some of the residents. It feels really good there. Is this RHI - is this a similar thing?

I guess the bigger question to the department is: Are we looking at other models like The Overlook for other areas of the province?

THE CHAIR: Ms. Gardiner first and then I'll go to the department.

JILL GARDINER: When I first started, I visited The Overlook. It was so exciting, definitely the model that we are following. They are doing some amazing things. Ideally, I would leave here today with a hotel so that we could do Overlook. Really, Overlook is exactly the model that we are looking at. We work very closely - MAP runs out of The Overlook. They actually met with the North End Community Health Centre's Managed Alcohol Program manager this morning and they have really made some great progress with their MAP at The Overlook.

KATHLEEN TROTT: We are absolutely looking at that model and working with the North End Community Health Centre on the work that they're doing there and evaluating. I think that we're seeing what they've laid the foundation for in this area. Really, they are matured in this area here, so we need to take what they are doing and help support them, support other organizations like this in other parts of the province that have these significant hot spots, needing these types of facilities. So yes, we are absolutely looking at other parts of the province.

SAM HICKCOX: I just wanted to say, I think you've heard even just one of the main challenges with setting up new services is less about investments in - necessarily just coming up with some money - but a huge component is just finding health care providers and other folks in the helping professions to do the work. Really of great import is ensuring that people who have the skills to not just use the buzz word "trauma-informed care" but actually have the capacity to provide trauma-informed care, to really understand what the components of harm reduction care provision would look like, particularly in populations of folks who are really living in chaos.

We know that even the majority of health care providers, the largest cohort of health care providers qualified to do so is in Halifax. The province has invested - through the Nova Scotia Health Authority and also in partnership with Doctors Nova Scotia - in a new program of harm reduction education for health care providers across the province, using a model of mentorship. It's through an organization within the Nova Scotia Health Authority's Mental Health and Addictions program, called the Atlantic Mentorship Network - Pain & Addiction.

We are really leveraging the expertise of some of the health care providers who actually work at The Overlook to try to extend, to expand the kind of orientation of harm reduction to health care providers across the province. That's an absolutely essential component here, not just finding health care providers but people who actually have the skills to do so. That's an important investment, I think, as we go forward. It would be pretty easy to stand up a bunch of buildings and then to have really inadequate capacity, right?

LISA LACHANCE: I wanted to ask a bit about - I think in Nova Scotia one of the things we're seeing is a shift, right? I think for a long time we have been a little bit isolated from the toxic drug supply that has plagued the rest of the country, and that is no longer the case.

At the same time, across the country there are various different ideas about supporting addictions and substance use and supporting withdrawal management. I wanted to ask you a question, I think probably Deputy pul to start but you can pass it amongst yourselves: Has there been any discussion about forced treatment plans, like we're hearing talked about in New Brunswick and in Alberta?

KATHLEEN TROTT: We're watching that quite closely. We do not have any plans right now to embark down that path. We'll be watching what Alberta and New Brunswick are doing there.

LISA LACHANCE: I was also wondering, again with this idea - the difference between the beds, which I took Dr. Martell's comment about people lying down for treatment, but that's not actually what people do, right? People live their lives and seek treatment at the same time. The recovery centres - I'm wondering if, at this point, you have some outcome data that compares - do you have a sense of the right pathways for the right

people at the right time, in terms of beds versus recovery centres? Do you have a sense of recovery centres for certain populations to be more effective than in-patient treatment?

THE CHAIR: Apologies, with the construction noise - I think you said Dr. Martell, but I wanted to make sure.

LISA LACHANCE: Whoever can answer the question.

DAVID MARTELL: I can have a go at that. I think what this speaks to is - we talked earlier about being data driven. We have these discussions around our leadership table, in that part of every program that we build also involves evaluation frameworks that allow us to inform whether or not we're having the kind of impact that we want to have. We are collecting data.

We're in a situation now with recovery support centres being a new model. The one that opened - the first opened only January 2022, so that data collection process is taking place. Trying to draw conclusions based on that limited dataset is difficult, but things do look promising.

It's also trying to figure out what the best ways are to measure success. Historically, and in the medical literature, the way that success is measured is by engagement in care. We prioritize that in these settings, keeping track of people who have been lost to follow up, or people who drop out. I think there are other important ways to measure success. Personally, I believe - there's a certain way we do this data collection through what's called routine outcome measures - taking stock of: What are the social indicators of their health right now? What might they be at X interval? - through a process of engagement with one of these centres. Introducing those tools to help us measure will be critical to understanding our data, but data collection is key to having this really be effective and to show it.

SAM HICKCOX: Thanks for the question; I think it's an important one. I think it's really nice that our entire Mental Health and Addictions program is aspiring to bake into any new program developments ongoing continuous quality improvement and outcomes-based measurement - so more to come.

The development of this model was based on available medical literature, a multi-country jurisdictional scan, and so on. But what we really came to learn is that there's no off-the-shelf model for addiction care and for withdrawal management. What the evidence really shows us, though, is that the traditional notion of people going for a very short period of time into an in-patient setting and going through withdrawal, so that they no longer actually have tolerance or withdrawal symptoms, and getting some initial counselling or other kinds of basic care - and then leaving, essentially, as a stand-alone intervention, is not particularly effective. It's effective for a small cohort of people who are highly motivated and would likely actually do well on their own as it is.

Substance-use disorders are chronic diseases. They require a chronic-disease conceptualization, which is really kind of - I know the eyes can glaze over quite easily, but I think it's important to recognize that the way we've tried to conceptualize and structure this program is to assume that. There are people who go now into our in-patient withdrawal-management units now. They meet the criteria for those. That's the care they need. Right afterwards - the day afterwards, they can go to the recovery support centres and actually get care. That's not to say that's all set up perfectly, seamlessly across the province. We still have work to do, but that is the model, right? People can go into care of a higher level of intensity or a lower level of intensity, as needed.

We do have well over five to six years of data, showing our initial model of ambulatory addiction care, which was started, actually, in Lunenburg. Dr. Martell was one of the two people who founded that initial program many years ago. It clearly shows that the number of people seeking treatment increases, the number of people actually staying engaged in treatment increases, the number of potentially high-risk medications that are used to support withdrawal management actually decreases, and the amount of time that people need to go through that intense, acute period of withdrawal management actually decreases as well with ambulatory care.

The best estimate we have is that approximately 80 per cent of people who need some kind of medically supervised withdrawal care are going to do well with that initial phase in an ambulatory setting, in an outpatient setting, like you'd find in the recovery support centres. Approximately 10 per cent probably need in-patient care, and then about 10 per cent probably could do withdrawal management either in a home-based setting or a non-medicalized kind of setting.

With that said, what's really key here is a model that allows people to get connected to ongoing care. That's the most important thing. The analogy I often use is if you have a young child who initially gets diagnosed with diabetes - type 1 diabetes - by actually presenting to the IWK Health Centre's emergency department in a state of unconsciousness, and it's very rapidly deemed that they need acute care to stabilize their blood sugar levels. So, they'll be admitted to the pediatric floor, perhaps for two or three days. They have an entire interdisciplinary team, a lot of diagnostic imaging, and so on. That person gets stabilized. Imagine, after that week or three to four days they get all stabilized. Everything's all good. They get their insulin doses, and then the team says, Okay, good. You can go out now. Try not to get high blood sugar again. We would just laugh at that, right? They need to be connected to ongoing care.

And that's really the way addiction care works, whether you have folks who are not contemplating stopping substance use and need more intensive harm-reduction interventions, such as managed alcohol for people whose goal is abstinence. There are people who will relapse and remit. There are people who - probably about 50 per cent of people, for example, with alcohol addiction - the first time they seek treatment, will go into remission for the rest of their life, which is comparable to other chronic diseases, actually.

Those folks are still doing chronic disease management. It might be actually managed by their family doctor, by less and less the medical system. In the same way that someone with hypertension that's really well controlled is actually going to be treating their hypertension with exercise and diet, right? They aren't necessarily going to need medical intervention. I think that's what's important about withdrawal management is that it's a component of addiction care. It's an important entry point. It's life saving in that sense, but it's really the beginning of the story of care for people.

LISA LACHANCE: I'll ask a quick question. In the government business plan for 2024-25, on Page 9 there is the statement, "We will continue to invest in harm reduction initiatives like managed alcohol programs, sobering and drop-in centres, and overdose preventions sites in 2024-25." Is there a plan to have additional OPSs open in this coming year?

KATHLEEN TROTT: I think we are looking at the context of what's happening and considering if there need to be additional sites. The other piece could be more products made available for self-testing as part of that. There are a few areas that we're looking at around harm reduction, yes, and . . .

[2:00 p.m.]

LISA LACHANCE: That was actually going to be one of my next questions - so maybe I'll just set that up, and we can come back to it either in the next round of questioning or when we come back here - around the idea of expanding the successful naloxone program to other supplies, like testing strips and that sort of thing, that are more available in the community.

KATHLEEN TROTT: That's exactly what we're looking at, even with naloxone kits in their current form. Is there a role for the spray kits as opposed to always the needle, for example, in certain environments? We're actively looking at all of those pieces. And even how do we - if we have a hot spot, an acute situation, how do we respond quickly to that community so that education is happening and folks are attached to the right supports?

THE CHAIR: Order. The time for the NDP has elapsed. Next it is to the PC Party for 20 minutes.

MLA Barkhouse.

DANIELLE BARKHOUSE: My first couple of questions are for the Office of Addictions and Mental Health. I'm just wondering: How do you address the unique needs of rural and remote communities in regard to withdrawal services?

SAM HICKCOX: I can give it a go. In part, we're in a different era of entry into addiction care compared to a decade ago, where essentially at that time if you were living

in a rural or a remote area, your options were usually to travel somewhere after waiting perhaps two, four, six weeks to then have a period of time in an in-patient unit outside your community.

Landing on 11 sites for the recovery support centres will increase the capacity of the entire system to provide care to more people, particularly those in rural and remote areas. We've learned so many lessons from the pandemic regarding virtual care and the provision of virtual care for withdrawal as well.

We have significant precedent outside of the province, as well as about a year of experience showing that health care providers can actually provide support for patients at a distance. There are, for example, settings where you may have shelter staff or nursing staff available but a physician or a nurse practitioner could actually be remotely connecting to the care team and providing withdrawal management services as well. We're looking to do that more and more.

We're hoping to potentially expand the Addiction Medicine Consult Service as well to provide more support for community hospitals so that those hospitals actually have the capacity to provide more withdrawal management even in their own small, rural emergency departments.

DANIELLE BARKHOUSE: How does the Office of Addictions and Mental Health collaborate with other government departments to provide holistic support?

KATHLEEN TROTT: We work very collaboratively with a number of government departments on this topic and many others. We definitely are working very closely on how we approach the increased need for the vulnerable population we're dealing with around addictions and mental health, including the DCS and the Nova Scotia Health Authority and others.

We are really trying to break down those silos and come together to co-develop ideas and approaches that we can deploy together. I think a great example might be The Bridge because that facility, although run by the DCS, we are all participating in and providing services and supports on site there, along with other departments. It's a really important effort that is happening around breaking down those silos. We're seeing in this work, we're seeing it in the response to the Mass Casualty Commission work, and so on, in particular, this core group of social departments that we're really working with closely together.

THE CHAIR: Before I recognize you, if everybody could make sure they speak into the microphones and a little louder, just because of the noise in the background.

DANIELLE BARKHOUSE: My next question is for Direction 180. I never preamble, I'm a to-the-point kind of lady. I just have to say for the Ally Centre of Cape

Breton and Direction 180, I 100 per cent understand what you guys do and offer and I am very happy to be here with you.

I am sure all of us have been touched by this. For me, as a family. I have The Helm in my constituency, which I adore. About six months before the election, I had a woman come to me. She is now almost three years, or a little over two-and-a-half years, clean because we found the money within the community. She was in my constituency, but we sent her out of the province, but still in Atlantic Canada, for a one-year program and it changed her life.

This is for Direction 180: I heard that Direction 180 has the first overdose prevention site in Atlantic Canada. Can you tell us more about the initiative?

PAULA MARTIN: At Direction 180, we have been operating the first overdose prevention site in Atlantic Canada since 2019. The service began operation through volunteers, people with lived and living experience, volunteering their time to operate this service.

It is a non-medical model, so there are no physicians or nurses on site. Everyone is trained with basic life support, an AED, oxygen, as well as naloxone. The reason our initiative started as a non-medical model was because we know that for a lot of our folks there's a lot of hesitancy, as well as a lack of trust, when it comes to health services. We wanted to ensure that our community's most vulnerable people who are using substances in unsafe ways felt comfortable accessing our services. That's how we began.

There was a little bit of funding through donations, community funding, crowd funding. We are now happily supported through the Nova Scotia Health Authority and Public Health. We've been a funded program since January 2022. They have graciously increased our funding this year as of January, so we have been able to - as Dr. Martell spoke about earlier - all of the data collection really shows that our service is working.

As I mentioned earlier, we have prevented seven unnecessary opioid drug poisonings in our community just by being open, by people feeling comfortable coming to our space to use some substances under the supervision of trained staff.

DANIELLE BARKHOUSE: You hit a lot of important things there, but that trust is very important. You need to have that. Could you just tell us some of the other programming you have?

PAULA MARTIN: The ReFix overdose prevention site is a program of Direction 180, and it is one of our larger programs. We provide a safe space for people to use substances so that they're not using in public, they're not disposing of drug use equipment inappropriately, whether that be in a park or on a trail or within a sheltered alleyway where a community member could potentially walk by and get poked by a needle unnecessarily.

We're also offering drug testing strips on site. We offer naloxone training, so not only are people coming to our space to use safely, they're leaving with the tools that are necessary to keep not only themselves but also their friends safe in our communities. As well, we have staff who are there solely to link people with health and social services when requested.

A big thing among our folks - a lot of our folks who access our service are precariously housed, so they need help securing a shelter bed, or getting into The Overlook for more wraparound supports and services or obtaining a room at The Bridge. We have people on site who can sit with them and help support them through that process because when you are in active addiction, it's extremely difficult to navigate the systems. It's extremely difficult for us sometimes, as staff, to navigate the systems. Being able to support people through that process really helps support connecting them with the additional health and social services that improve their overall health and well-being.

DANIELLE BARKHOUSE: I have a - with my last question, but before it I want to thank you all for what you do, but thank you for this.

Have you ever thought of or considered maybe expanding throughout the province? This could go to Direction 180, but also the Ally Centre because, yes.

PAULA MARTIN: Just a quick note: Every community should have a safe space for people to use substances. People are using substances in our communities every single day, and being able to help connect them with other health and social services is how Nova Scotians will thrive. The Province has expanded services into Cape Breton, so I'll allow the Ally Centre to speak to their overdose prevention site.

JILL GARDINER: We do have an overdose prevention site in Cape Breton at the Ally Centre. It's very busy. We were just chatting; we have about 200 registered participants in comparison to Direction 180 with around 400. We've been in operation since June; last June, we were one year. At our site, just to give you an idea, we have the overdose prevention site, we have a drop-in centre, we have a clinic downstairs, and now a shelter - for now.

DANIELLE BARKHOUSE: I'm going to pass the rest of my time down the road to MLA Palmer.

THE CHAIR: MLA Palmer, with eight-and-a-half minutes.

CHRIS PALMER: I, too, want to thank you all for being here, some for more than the first time and some for the first time. Welcome. We're definitely hearing lots of information today that's so important and vital for us as policy makers to hear and Nova Scotians to hear. We've heard a lot about collaboration amongst departments.

I guess my first question would be to Dr. Martell. In your opening statement, you talked a lot about collaboration with community organizations. That's why we're here together at the table. Can you expand on how you collaborate with community partners and how you enhance the withdrawal support between the two of you? Maybe I could ask Dr. Martell to give your perspective on that collaboration, and maybe I can ask Mrs. Martin or Ms. Gardiner to give your perspective on that collaboration as well.

DAVID MARTELL: I can speak to my own experience. I think it's also important, though, that we hear from someone like Janah Fair, who very directly has had involvement with these collaborations and can speak to the experience and the value of collaborating and how it takes place on the ground. Janah, can I get you to speak?

THE CHAIR: I love when a bunch of gentlemen get up for that. Janah Fair.

JANAH FAIR: Thank you for having me today. Partnership, as Dr. Martell mentioned in his opening remarks, is so important to our community. I think it helps to reduce stigma, and it helps us do more and reach more people. Some examples of how we have been working with community in Northern Zone: We noticed a need to spread the accessibility and information around harm reduction. We've been having community pop-up events since our initial ones in the Springhill community, where we partner with partners in the health system - primary health care, public health, and also partners in the community.

We've partnered with our local harm reduction agencies, Northern Healthy Connections Society, and many grassroots community organizations that have an interest in supporting their loved ones in care. Our take-home naloxone program, pharmacists: We are having events to allow the community or people with lived and living experience to access more information and support for harm reduction services.

I think that's how we solve problems, to include our partners. We're always looking for opportunities, as we design our systems of care, to build on those partnerships and work together.

THE CHAIR: MLA Palmer, was your question also to Direction 180?

CHRIS PALMER: Maybe I could ask Mrs. Martin or Ms. Gardiner if they'd like to maybe share from the community perspective, the collaboration with the department?

JILL GARDINER: We have some great partnerships with the offices. What we really struggle with in the community is confidentiality around other organizations. That can be hard when you are trying to advocate for individuals and you are not allowed to use their names. That is one barrier that we really see in working collaboratively with other organizations. To give you an example - which I think I can do - would be if somebody wants to stay at our overnight emergency shelter, they must not be allowed to stay at the

shelter up the street. We are not allowed to call and ask. The individual has to call and put it on speakerphone, and we have to listen.

[2:15 p.m.]

It does create those barriers in care when confidentiality is just too big. I wanted to make note of that. In terms of our partnerships with government, through funding, things are moving along in Cape Breton. But it really is just that piece around how do we help folks. There has been a lot of work around coordinated access, that they have really struggled with, and it's around that confidentiality piece.

PAULA MARTIN: In the community we collaborate a lot with the Nova Scotia Health Authority, the Office of Addictions and Mental Health, the Department of Community Services, all of those key stakeholders. It's extremely important that we have these ongoing partnerships, collaborations so that we're able to share what's going on on the ground when we're working with people who are struggling on a daily basis - that we can share that with policy-makers; we can share that with the system so that they truly understand the needs of the clients we are serving.

We also collaborate with the Nova Scotia Health Authority on a regular basis around the development of policies and guidelines that support people who use drugs. We are invited to the table, and we appreciate it. It works really well when we come together and work together.

CHRIS PALMER: Obviously this topic is vitally important in the addiction services. I think it was one of the priories of our government when we came into office to create a separate department for the Office of Addictions and Mental Health, with a designated minister, to put the focus on these issues. I think that was an important step in how we're moving forward.

A quick question about the opioid use. I represent Kings West, and we have the Western Kings Memorial Health Centre and an opioid recovery centre onsite there. I've had the minister visit with some of the staff there and met with someone who has gone through the program. Can you talk about how opioid use, from a societal perspective, has changed over time and how the government has been responding with centres, like the one that I discussed in Berwick?

SAM HICKCOX: Do I have, like, an hour? (Laughter)

THE CHAIR: One minute, 50 seconds.

SAM HICKCOX: We've been relatively spared from the worst ravages of the opioid poisoning crisis that has been sweeping across North America. I think it's safe to say that, bolstered by the enhanced surveillance that we've been awarded with through our

2017 Opioid Overdose and Response Framework, we've really seen a marked change in the last - it has been a bit gradual since the pandemic started, but we are relatively spared from marked increases in mortality.

The majority of opioids that have been used by people who are using opioids in non-prescribed ways has been - prescription opioids - has changed in the last year to a year and a half; it continues to change. We're seeing more fentanyl and its analogs coming into Nova Scotia - highly potent, very dangerous - and more crystal meth coming in and more non-prescribed highly potent benzodiazepines - tranquilizers.

This contamination of the drug supply has led to an unprecedented increase in mortality in this last calendar year. Our response to it is to address this as an emerging crisis. We're bringing together multiple government departments. We're going to be listening closely and doing our best to build trust and establish a relationship between people with lived and living experience, with health care providers across the province, and really learning from other jurisdictions what we may put in place. We have an opportunity here, and it's an opportunity to try to do our best to mitigate the kind of harm we've seen across the country.

It's going to be a really difficult time . . .

THE CHAIR: Order. The PC time has elapsed. The next round will be the Liberals, and it will be seven minutes.

RAFAH DICOSTANZO: I'm just going to take two minutes from the seven and leave the five for my colleague. This is just a bit of a burning question, but if we can go fast with the answer, what I'm looking for is: I'm sure you're aware of Clause 110 that was in the FMA that was very concerning to our party and the NDP - of the minister having access to people's health information. All you guys talked about is lack of trust of the patients, the confidentiality issue, the hesitancy to use services. Imagine if you tell them that your information is now in the department, and so many people have access to your name of using this information.

My question is: How do you feel about that and were you consulted? This is to the two organizations. Were you consulted about this clause?

THE CHAIR: MLA DiCostanzo, when you say two organizations, we have four here, so I'm just making sure. You mean Direction 180 and the Ally Centre of Cape Breton?

RAFAH DICOSTANZO: Correct. I apologize.

PAULA MARTIN: I was unaware of this.

JILL GARDINER: I was unaware as well. It probably would be something our board would be aware of.

THE CHAIR: MLA DiCostanzo, you have 30 seconds based on the two minutes you told your partner, so I'm just saying.

RAFAH DICOSTANZO: Maybe one minute more. How do you feel about it? Would you hand that information to the minister as an organization?

JILL GARDINER: That's a good question. I'm not sure. I'd need more time to think about that - what the benefits would be of sharing that information, what the negative consequences would be of that.

PAULA MARTIN: I would need a better understanding of specifically what information it is you're talking about, because there is the Personal Health Information Act. Are we sharing individuals' names, or are we sharing how many folks are accessing our services for a specific reason? I think it's important that we share that information to inform our funders. Are we being funded adequately or do we need more resources and services? The specific information, I would need to understand more.

THE CHAIR: MLA DiCostanzo, you're at four minutes and 18 seconds left.

RAFAH DICOSTANZO: I will speak to them after about it.

FRED TILLEY: Given the emerging crisis that we are experiencing here in Nova Scotia, this is a question to Direction 180 and the Ally Centre. What do you feel are the missing gaps in our public system that you as organizations see on a daily basis?

PAULA MARTIN: As I'm sure we can all see, the housing crisis that is currently happening across the province as well as the country, it's extremely difficult to support someone or even have a conversation about treatment when they are living outside. For many of our folks, they're just trying to survive. When we talk about treatment, it's extremely difficult to even think about treatment or accessing health services when you don't know where you're sleeping that night.

JILL GARDINER: Yes, I would agree - definitely appropriate housing models that are in an environment where we can run the programming that folks need. Public housing is not the place. That's what we're seeing in Cape Breton - a real push on public housing. It doesn't work for folks who need harm reduction programming.

FRED TILLEY: The next question I have is kind of for the whole panel. We are seeing 73 - I think was the number - drug toxicity-related deaths this year. Are we seeing a rise in younger clients, both at your system and through the addictions system itself? What can we do as a province to help stem that if we are seeing that?

JILL GARDINER: That is interesting. I've often thought about doing some education in high schools, and did a little bit of research in our area around high schools, and if they are seeing needles disposed of. They're not, from what I'm hearing. I think that public education is starting to hit the next generation, so that's really good. I have only been at the Ally Centre a year, so I really can't speak to that. It really is a spectrum of individuals.

We don't see a lot of younger folks. If we did, we would be very concerned, but typically folks are 23 and up, in my experience.

PAULA MARTIN: Yes, we do see a younger generation coming through. When I say younger, I mean between the ages of 18 and 30. I suspect the reason for this is because the Nova Scotia Health Authority, as well as the Office of Addictions and Mental Health, have done an extremely wonderful job investing in addiction and mental health services.

Nova Scotians can access service when they need it, so there is no delay in treatment access. I anticipate that that's why we are seeing younger people access our services - because they can access the service when they need it, and they don't have to wait five to ten years until they have other health concerns that land them in hospital and then their addiction is treated. I see it as a positive thing that we are intersecting earlier with younger populations. Because as we know, people use drugs and they will continue to use drugs, so they should be able to access treatment when needed.

KATHLEEN TROTT: It's an example of the success that's come out of the 2017 Opioid Use and Overdose Framework. We have the data now; we are able to really watch the trends. Unfortunately, we actually had 128 deaths last year - 74 of which were from opioid toxicity. It was a little higher than what you had mentioned there. There are some pieces that we're seeing and in our last report we're seeing some more . . .

THE CHAIR: Order. That's the Liberal time.

LISA LACHANCE: Okay, I'm going to try to go through a speed round. We ended our round of questioning talking about some of the prevention and harm reduction work being done. I listened to *White Coat Black Art* (laughs) on the weekend, but there was a story about - in Ontario there had been a funded naloxone workplace training program. I'm wondering if we considered being able to roll that out in workplaces in Nova Scotia, and I would add community organizations and that sort of thing?

KATHLEEN TROTT: Yes. These are the pieces that we are looking at. I can share that Dr. Sam and I did a training session with deputies a couple of weeks ago actually. We think there are a number of large organizations out there that have staff who they know are facing addictions, and we want to make sure that in best supporting that employee their environment is as safe as possible, and that they can remain employed, and all of those things. So yes, absolutely we are looking at that.

LISA LACHANCE: I think the other piece, too, is obviously for customers and for people - sort of passersby and much like the AEDs that we have in public settings. Knowing where those are, having them marked, and having people being trained and being able to use them is really important.

[2:30 p.m.]

I know when we were talking before, you mentioned about nasal versus injection naloxone, and I also think that would be a good move. I know that lots of people are intimidated by giving a needle if you're not a medical professional. When I've had to break out my naloxone kit, it has been a moment actually, so nasal spray would be great.

I'm glad to hear the deputy ministers have - I usually make at least one member's statement during our legislative sittings about the naloxone program. I have a kit in my desk in the Legislature. I think it's very important to have as top of mind, especially as the drug supply changes.

I have two questions; I can't decide which to start with. I will start with what you're seeing in terms of different needs for withdrawal services for equity communities such as the 2SLGBTQIA+ community, Mi'kmaw and Indigenous communities, and the African-Nova Scotian communities, and how that's being addressed.

DAVID MARTELL: My one reflection is that we were very deliberate when we set up our hospital consultation service to have a way to be recognized as being an ally to those communities. You'll notice that I'm wearing a multi-coloured lanyard, and this is the reason. We chose this lanyard for - in those settings to have people know that we stand up for people in these more vulnerable populations. It's a signal that we can help; this is safe space. This was deliberate. I just wanted to highlight the lanyard. They cost a lot of money.

KATHLEEN TROTT: I also want to highlight the work we're doing with Tajikeimɨk. The office provided $2 million for Tajikeimɨk to work within the Mi'kmaw community to develop their mental health and addiction strategies. We're looking forward to that coming to fruition so we can work together on how we implement that. We agree we need to learn from communities how they're best served, and how we can really reach them and be there for them when they're ready.

LISA LACHANCE: I thought Dr. Hickcox might want to hop in on that, but maybe on the next question.

Speaking of ages and that sort of thing, one thing I've heard from parents and from young people is that sometimes overdose deaths (inaudible) reported as something else. So the number of people actually dying from opioids or other substance issues could, in fact, be higher is what family members would suggest. It's recorded as a suicide or an ATV accident or whatever it is.

I'm wondering, with the new Integrated Youth Services model being rolled out in Nova Scotia, how substance use services and withdrawal management will be integrated into those programs as well.

KATHLEEN TROTT: Because those Integrated Youth Services sites will be developed in partnership with local community, those areas that have that need - which we certainly know goes right across the province - will be integrated as part of the IYS sites, absolutely, yes. It's a key component for sure.

LISA LACHANCE: I'm going to go back to my first question, I think. Tajikeimɨk is one example of a partnership. That organization exists for the purposes of partnering around health in the province. With regard to the African Nova Scotian community or the 2SLGBTQIA+ community, how are you fighting and building competence in allies in community to do this work?

KATHLEEN TROTT: We actually have introduced a new position in the Office of Addictions and Mental Health whose focus is on building relationships with communities to ensure that, not only through funding agreements and things like that, but that we're bringing the right people together as we make plans and develop new services, or reflect on our existing services and how we can make them better.

We also have an advisory group as well that we are establishing that's going to play an important role as we continue to enhance services.

There's been a fair bit of conversation. The IWK Health Centre has been leading some really amazing work with the African Nova Scotian community to establish a clinic in community that meets the needs of youth and families, and it's a model that we think we're watching and learning from. It was built completely in partnership . . .

THE CHAIR: Order. The time for the NDP has elapsed. MLA White.

JOHN WHITE: I have so many questions for so many of you. I don't know where to start.

THE CHAIR: You have seven minutes.

JOHN WHITE: Seven minutes is not enough. I'll start with the Ally Centre, Ms. Gardiner, because I have worked with your group before. We've had you in to train, some naloxone training, with some students in a youth group of ours - stuff like that. I'm a huge supporter of you, I really am.

I have a question about - in your comments, your opening remarks, you mentioned the community hesitation for the Pallet shelters. I wanted to know what feedback you may

have received already and what you're doing to reach out and work with the community to help settle that.

JILL GARDINER: I can't really speak to that because my manager and my board would be dealing with that. We've also partnered with New Dawn Enterprises, and New Dawn has really taken the lead on that frontline role. I'm not sure I can speak to that.

JOHN WHITE: That's all right. I will be talking with Erika anyway. That's another great organization, New Dawn, absolutely. Let me ask you this. As a trained counsellor myself, I understand the importance of building trust with the client in a situation, and I understand meeting people where they're currently at. People are not motivated to change until their conditions in life are such that they are motivated to change.

With that being said, I'm curious about - I want to support the clientele that you're working with, but I also want to - there's a very real concern in the Sydney area, as you know, and I would be neglectful if I didn't speak about it today. I do want to ask you about it because I also believe that the people in the community and the business district and everything else, with all the things that are going on downtown that they're seeing, I want to know, being the trusting relationship that you have - and you talked about that already - I want to know if that is used, and if you have a client code of conduct. If not, are you developing one, and are they held to it?

This is where a lot of the community resistance is coming from. I really want to cut to the chase. Let's get to it. That's what we need to deal with, because we have two sides that we have to please here.

JILL GARDINER: One hundred per cent. We do have a client code of conduct and the sad thing is the only thing we can take from folks is us. We're all they have. We're the end of the line. So often a code of conduct means that folks are banned from our centre, and that works because they need us.

There are a lot of issues going on. We know that, unfortunately, with trauma comes violence. With this type of work comes a lot of grey areas where we need to be sure that we're supporting folks. The Ally Centre has been doing this for over 30 years and they're really good at it. That's one thing - that, unfortunately, the community doesn't see what happens inside. They only see what happens outside. Unfortunately, when folks are living on the streets, they're living their hardest moments for everybody to see.

Really, it's that lack of the supportive housing piece that is causing us to see so much chaos on the streets. If we had supportive housing that met people where they're at, they wouldn't be living their worst moments out on the streets.

JOHN WHITE: Absolutely, I understand that. Most people judge you by what they see in a current moment, whether that's a week, a month, or it doesn't matter. A current

moment, that's how we judge our encounters, not realizing that there is something that brought that individual to that point - trauma, whatever it may have been. I'm going to ask you about risk factors in a minute.

In the end, we do have to - I think you are in the best position because you have that trusting relationship and they're coming to you at a point in time when they need support and they're looking for it. I think that is the time to ask for acceptable behaviour, because we can't neglect the fact of what it's doing to a community in Sydney. That's where I'm at.

I'll leave you off the hook for a minute. I would ask a question, perhaps, to Dr. Hickcox about risk factors. When I think of such a - I don't want to say in particular - when I think of neurodivergent disorders and the need for stimulation - for stimulants, or whatever it may be - I want to know about at what point in a recovery is that considered? If we treat the current condition at a point in time, that's all we're doing. We need to treat what were the deciding factors to get into that position in the first place, and sometimes it could simply be a neurodivergence disorder that wasn't diagnosed.

THE CHAIR: Dr. Hickcox, with a minute-thirty.

SAM HICKCOX: Increasingly, the Nova Scotia Health Authority is putting their money where their mouth is with respect to investing in developing a high-quality concurrent-disorders care program. What does that mean? Concurrent disorder means providing care with specialized expertise in mental health - non-addictive mental disorders, including psychiatric care alongside addiction care at the same time.

We recognize that anyone who is using substances, whether or not it comes from something that happened in development, whether or not it comes from an undiagnosed or perhaps undertreated psychiatric disorder, at the time of treatment and entering into treatment, there are needs that are getting met by using substances. If all we do is take away the substances, and we don't address the unmet needs, whether they're physiologic - unaddressed chronic pain - whether they're psychiatric, whether they're emotional, based in unaddressed trauma - often alienation and disconnection from ourselves and from society, and a loss of meaning. If we don't really look at that entire person, and work to get those needs addressed over time, then that person's at risk of just going back to substance use, of course, like any one of us would. In general terms, that's absolutely essential . . .

THE CHAIR: Order. Sorry. That's the end of all the time.

I don't know if anybody has any closing notes or not, so I'm going to go backwards just to see. Does Ms. Gardiner have any closing comments? No. Mrs. Martin? No. Dr. Martell?

DAVID MARTELL: I'd like to just make a closing statement, because I think it's important that we end on a high note. There's a conception out there that people suffering

from serious addictions have no hope, or that they can't get better. I'd contest that. The data that we have suggests that these diseases are very treatable - as treatable as any other chronic condition. The treatment programs that we have in place speak to that, and we should really have that frame of mind when we talk about it: that these things aren't hopeless at all.

KATHLEEN TROTT: Just a comment. I've been spending a fair bit of time in community this last while, with community organizations and with our units and talking to folks. What I would say is, it's so amazing to see the people who work in this space really supporting people who are having such a terrible time in their lives, but the positive passion that these workers have, and dedication to these people and providing that hope that they can get better, is just exceptional. It is such difficult work, but we have the services and we don't want people to be left behind.

We're really excited that we had this opportunity today, because it's not an area that we get to talk about a lot. We really appreciate the opportunity today.

THE CHAIR: I'd like to thank you all for coming. That concludes your portion of it. We still have some committee business left. However, I will just give a three-minute recess to let them go out. In three minutes, we will be starting.

[2:45 p.m. The committee recessed.]

[2:48 p.m. The committee reconvened.]

THE CHAIR: Order. We've got a lot of community business. One thing I will start off with; MLA Lachance, you read from a paper. Was that part of a briefing note or separate? If it was separate . . . (interruptions)

LISA LACHANCE: This is - it's the government business plan, and I borrowed this version from the library, so I cannot table this.

THE CHAIR: Was it in the research briefing? Was it in the research briefing - the notes on it? If not, the Clerk has informed me that we will have to table that page - just the page or the whole thing?

LISA LACHANCE: We'll get - we can make a copy of it. We'll figure that out.

THE CHAIR: Thank you. You'll take care of it, and I trust it will be done.

LISA LACHANCE: I'm not using a prop. Sorry, folks.

THE CHAIR: Don't worry. If she doesn't trust you, I do. It's all good. Okay.

Correspondence: We received correspondence from the Nova Scotia Paramedics Union's president, Kevin MacMullin, in response to our request for information made on March 19th. It has been sent to members. Any questions regarding it?

I'll take that as a no. Okay.

Motion on the table: At the March 19th meeting, members discussed correspondence received from the Nova Scotia Government and General Employees Union regarding witness lists for that day. A motion was made. I will have the clerk read the motion.

JUDY KAVANAGH: "I would move that an explanation of the agenda-setting process and the witness selection practice of the committee be included, as well as a link to the January 9th Hansard report and the April 11, 2023 Hansard report highlighting the motion related to the topics that affected them, and that the Chair write a letter with those elements involved."

THE CHAIR: The meeting time ended before the motion could be put to a vote, and that's why it's on the agenda today. Is there any discussion on this? This motion was - well, technically, after a motion is made, it's the committee's. However, MLA Regan made the motion, and she did notify that she wanted it dealt with today, even though she's not here. At the meeting she made a remark of that, so that's why I asked if there's any discussion. Are we just going to vote on it? Any discussion?

SUSAN LEBLANC: Well, I'll just say it's a good idea. I think that committees have been receiving lots of correspondence from different organizations that would like to have a presentation at committee, or would be witnesses at committee, so I think it's very fair to write a letter outlining the process and thanking them for their interest, in fact, in the committee. That way, there is some official response back, which is important, I think, so people know that they've been heard and their issue's been discussed. That way we can move forward with people or organizations knowing the way the committee structure works, or the witness-setting works.

THE CHAIR: Any other discussion?

JOHN WHITE: This letter should have gone out long ago, but the problem I have with this is the same problem I had with it in March. The meeting took place - I think it was January, I believe - and the NSGEU sat here right in front of us while we discussed the idea of a letter. I really don't know what we're doing now. We're sending a letter out now in April for a meeting that took place in January, and people who sat here and heard us discuss in clarity the idea of - it was the Liberal topic, and we accepted all the witnesses that were posted. I think we explained it. I just don't know what we're doing right now. I feel like we're going back, just digging up stones. That's how I feel.

SUSAN LEBLANC: Well, just to clarify, I think there were two letters from the NSGEU. I think this letter that we're talking about actually was after that meeting where the NSGEU came and sat. I just think it should be a matter of course that if there are letters sent to the committee, this type of correspondence, then we should have a mechanism for replying. We would all reply if it came to our constituency offices. Why wouldn't we reply as a committee as well?

THE CHAIR: Any other discussion, or are you ready for the vote?

JOHN WHITE: Is the motion to send a letter to the NSGEU only, or is the motion to send a letter to everybody who applies?

THE CHAIR: The motion as read by the clerk is to be sent to the NSGEU, because that's who sent the letter to them. I'm looking at the clerk to nod. We would reply to the NSGEU, not everybody, yes? The clerk.

JUDY KAVANAGH: I can't speak to the motion.

THE CHAIR: If the motion passed, who would you write the letter to? You're saying you can't speak to that either?

JUDY KAVANAGH: I would write it to whomever the committee directed me to.

THE CHAIR: Perfect, thank you. The letter would be written to the NSGEU, who sent us the letter, explaining the process. I'm going to allow MLA DiCostanzo to speak first, and then I'll get MLA Barkhouse.

RAFAH DICOSTANZO: That's exactly what I was going to say. We reply to the person who wrote to us, or the organization who wrote to us, and we agree with our colleagues. We should be replying. We'd be happy to reply to them.

DANIELLE BARKHOUSE: Although, and you'll have to excuse me, I missed the last meeting, it was talked about while they were here. It was explained in the agenda, but with that being said, I'm not against sending a letter stating the process. I'd like to hear the motion one more time, but I'm not against sending a letter stating the process and whatnot.

THE CHAIR: The clerk.

JUDY KAVANAGH: "I would move that an explanation of the agenda-setting process and the witness selection practice of the committee be included, as well as a link to the January 9th Hansard report and the April 11, 2023 Hansard report highlighting the motion related to the topics that affected them, and that the Chair write a letter with those elements involved."

All ready for the vote?

JOHN WHITE: I don't want to talk out your motion, I want to vote on it, but I just want to say that I think this should be a practice for everybody that sends a letter in. I just don't understand why we're doing this for the NSGEU only. I want to let you have your vote.

THE CHAIR: Ready for the vote?

All those in favour? Contrary minded? Thank you.

The motion is carried unanimously.

One thing: right now, June 11th is looking at a meeting which will be agenda-setting. I'm just letting all the groups know now so that the caucuses can start getting their lists in. It is subject to change based on witnesses, but right now the clerk is letting me know - and at a previous meeting we discussed this - the more advance notice for everybody, the better.

Is there any other business? Seeing none, the next meeting is Tuesday, May 14, 2024, from the hours of 1:00 p.m. to 3:00 p.m. Witnesses: the Nova Scotia Health Authority, the Department of Health and Wellness, the Nova Scotia Health Coalition, the NSGEU, Doctors Nova Scotia, and the Pharmacy Association of Nova Scotia. The topic is Public-Private Partnerships in Health Care.

Meeting is adjourned.

[The committee adjourned at 2:56 p.m.]