HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, February 17, 2016

RED CHAMBER

Department of Health and Wellness
Nova Scotia Health Authority

Mental Health Services, Programs and Strategy

Printed and Published by Nova Scotia Hansard Reporting Services

Public Accounts Committee

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[Mr. Terry Farrell replaced Mr. Iain Rankin]
[Mr. Stephen Gough replaced Mr. Brendan Maguire]
[Mr. Gordon Wilson replaced Ms. Margaret Miller]

In Attendance:

Ms. Kim Langille
Legislative Committee Clerk

Mr. Gordon Hebb
Chief Legislative Counsel

Mr. Terry Spicer
Deputy Auditor General

Ms. Evangeline Colman-Sadd
Assistant Auditor General

WITNESSES

Department of Health and Wellness

Dr. Peter Vaughan, Deputy Minister
Mr. Kevin Elliott, Chief Financial Officer
Ms. Tracy Kitch, CEO, Izaak Walton Killam Health Centre
Ms. Lynn Cheek, Executive Director, Mental Health Children's Services & Addictions

Nova Scotia Health Authority

Ms. Janet Knox, President and CEO
Dr. Linda Courey, Senior Director, Mental Health and Addictions

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, FEBRUARY 17, 2016

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Iain Rankin

MR. CHAIRMAN: I call this meeting of the Public Accounts Committee to order. This morning we have the Department of Health and Wellness and the Nova Scotia Health Authority to speak with us about mental health services. We'll start with introductions, beginning with Mr. Farrell.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: Thank you to everyone who is here this morning. Dr. Vaughan, I'll give you a chance to provide some opening comments.

DR. PETER VAUGHAN: Bonjour, tout le monde and good morning, it's good to be here. Thank you for the opportunity to talk to you today about an incredibly important issue for all of us - our own mental health and wellness.

We know that many individuals and their families across Nova Scotia are battling with and succeeding with their own personal mental health and addictions issues. We know that this is a reality right across our country and, in fact, around the world. Globally we are recognizing the importance of the diagnosis and treatment of mental health conditions and, I would add, the importance of mental health and mental wellness generally.

Stigma about mental health is eroding and we are seeing more people seeking treatment; this is a good thing. In many respects Nova Scotia has been ahead of the curve as it relates to mental health treatment. Three years ago our province released "*Together We Can*", a five-year mental health and addictions strategy. Since releasing the strategy, Nova Scotians are experiencing greater access to mental health assessment, treatment and care in their own communities. The trend is heading in a positive direction although we recognize there is more work to do.

People sometimes think of mental health care as primarily a service offered inside an institution like a hospital. The reality is actually very different. Today people are accessing care and support through early support programs, hospital outreach clinics, schools, homes and yes, coffee shops. The evidence suggests that most people benefit from mental health treatment in communities.

We are responding by building resilience and capacity in our communities, our schools, within supporting organizations and through our clinicians by offering competitive and comprehensive levels of care across the health spectrum from hospitals to home.

If people require in-patient care, they will receive it. No one will ever be turned away. As a provincial government we spend more than $270 million a year on mental health and addictions. These dollars cover doctors, social workers, drugs, program treatment, et cetera. Given the importance of this topic and its impact on Nova Scotians, we need to use evidence to drive decision making. For our strategy, this means tracking and monitoring our work so we are evaluating the strength of our programs.

Recently we released a progress update about the strategy highlighting what is working and where we need to do more in the future. The document is on the department website and I'm happy to share a copy if you need a hard copy.

There are a number of highlights I'd like to mention and a number of successes that we can point to and we can all be proud of. I will mention only a few of these highlights: the Strongest Families program, Certified Peer Support Specialist Program, the Mental Health Crisis Line that operates province-wide, SchoolsPlus that operates in every school board in Nova Scotia, mental health clinicians in First Nations communities, and significant reductions in wait times for community-based programming.

We recognize there is more to do, and we intend to do it. There is more to do in the care field as well as in the broader community. We know that mental health and addictions challenges are not just a Department of Health and Wellness issue. They're not just a Nova Scotia Health Authority and IWK issue. They're a community issue, they're a government issue, they're a business issue, and an each and every family issue. These issues include housing and community supports. We all have a role to play in ensuring a safe and welcoming community.

I'm encouraged by the new federal government's language around mental health and addictions, and I'm encouraged to see that mental health is included in the mandate letter for the new federal Minister of Health. This issue was discussed at our meetings of federal and provincial Health Ministers in Vancouver.

I look forward to your questions, and I'll ask Janet Knox, if I may, to say a few words.

MR. CHAIRMAN: Ms. Knox.

MS. JANET KNOX: Good morning and thank you for the opportunity to speak on this subject today. Over the past several years, through the efforts of many people and organizations around the world, there has been great success tackling the stigma around mental health and mental illness. Around the world, including here in Nova Scotia, people are more willing to talk about their mental health and to seek out services when they are in need. That is a welcome change. We'd much rather see people recognize the signs of depression, anxiety or other mental illnesses and ask for help in managing them, than let them try to cope silently.

Schools and employers are better equipped to accommodate the needs of students and employees, focusing on creating environments that foster good mental health. This is critical. We will never achieve true health in Nova Scotia if all our efforts focus on helping people only in times of crisis.

The Nova Scotia Health Authority and the IWK work closely with schools to help develop resiliency in young people and connect them to supports early. As CEOs, my colleague Tracy Kitch and I are part of a Workers' Compensation Board-supported effort focused on the importance of workplace safety, including mental well-being and the role it plays in our province's future.

Treatment for mental illness is also required of course, and services are seeing some increased demand as people feel more willing to access them. In Nova Scotia, we're working to improve access and better coordinate and distribute services according to need around the province.

As with all our services, we are constantly learning and seeking to improve quality. Globally, the understanding of mental illness and the evidence about the most effective care is shifting, and it would be irresponsible not to change our services in response. That task is more achievable today with the Nova Scotia Health Authority taking a provincial view, than it was when nine previously separate organizations working with the IWK were trying to align services.

Mental health and addictions care in Nova Scotia takes a comprehensive approach with a menu of services from broad health promotion and prevention functions targeted at

the general population to highly specialized in-patient care targeted to individuals with complex problems.

When hospital admission would provide the best care, we will always admit a patient, even if the demand at the time means the patient must be transferred to an available bed elsewhere in the province. However, evidence is telling us that treatment for more mental health and substance use disorders is more appropriately and effectively provided on an outpatient basis and must address the factors in the community that affect a person's health. Unnecessary or prolonged hospitalization can actually cause harm.

Many disorders have a chronic course and patients will have periods of greater and lesser need for care, requiring our services to be flexible and matched to a patient's need, including in-patient hospitalization.

Our focus is on the individual as a whole person, in the context of their family, their caregivers and their community. We offer the care that's right and most likely to be effective for them at the time. We must respect an individual's right to seek, to accept or decline services, save for specific circumstances in which they are legally unable to make those decisions for themselves.

We have referred to partners in our conversation here and there are many whose work is critical in the mental well-being of Nova Scotians. They include community organizations such as the Canadian Mental Health Association, the Schizophrenia Society of Nova Scotia and other not-for-profit groups. Other government departments are very important partners - Community Services, Education, and Justice as examples. Other parts of our health care system, such as primary care, emergency services, public health, continuing care and pediatrics, and other services and agencies such as our police forces and emergency health services.

Our vision at the Nova Scotia Health Authority is healthy people, healthy communities for generations. With the help of our partners, we are today better positioned than ever to build on what is in place in our province and develop a coordinated mental health and addictions services program of care for Nova Scotians. Thank you, we'll be happy to answer your questions.

MR. CHAIRMAN: Thank you, Ms. Knox. This morning I would like to ask everyone to ensure you're just within a few inches of your microphones when you speak, just to make sure that our audio-visual team can pick up on what we're saying. I will be recognizing - particularly our guests before they speak - to ensure that the correct microphone can be turned on so we capture your comments for the record.

We'll begin with Mr. Houston for 20 minutes.

MR. TIM HOUSTON: I was listening with interest to the opening comments. It sounds like a description of the ideal and I'm worried that the reality is pretty far away from that ideal.

I guess I would start off and ask Dr. Vaughan, who is ultimately accountable for the delivery of mental health services in the province? Where does the buck stop?

DR. VAUGHAN: I think as everyone realizes, in the structure of governance and the structure of government that ultimately the minister has responsibility for all health services delivery, including mental health services and addictions.

MR. HOUSTON: So he does have responsibility for that, in my view as well. He's not here as a witness today, but of the witnesses here today, would you agree that you have responsibility, he's your delegate here?

DR. VAUGHAN: We oversee and we monitor and we plan and we fund. While the minister and I do not see every patient in the province, we oversee and ensure that the services are in accordance with our requirements as government.

MR. HOUSTON: So the oversight of the delivery rests with you, in terms of the witnesses here today. When I listened to the words of the opening comments and I mentioned the disconnect that I feel there is between what you're talking about and what's happening in the real world, it makes me wonder, in your capacity as having ultimate accountability for the delivery of services, have you been out talking to patients or even patient advocacy groups in the last, let's say, six months? Have you met with anyone who has actually had to deal with the system?

DR. VAUGHAN: I meet many individuals and receive correspondence from many citizens, many clients, many patients across the province, as well as clinicians. I know the minister has met with many groups. We've been out to parts of the province, myself and the two CEOs at this table have been out talking to many clinicians and individuals, so I have met everybody.

MR. HOUSTON: So you've been speaking to patients. I'm wondering if you - is it your personal opinion that patients in the province are being adequately served?

DR. VAUGHAN: I think that we in Nova Scotia, like many areas, have our challenges. I think patients are well served. We have good clinicians who are delivering care to patients and Nova Scotians every single day right across this province. I think to suggest that there's anything less than the best care going on would be a great disservice to the clinicians, I think, who are working very hard every single day to treat and meet the needs of those patients.

MR. HOUSTON: We're going to talk about it but what is a disservice to the clinicians and also the people of the province, I think, is the lack of support they have.

There's not enough clinicians - we're going to talk about that - people aren't getting access to the levels of care they deserve, despite what we might have heard here. I'll give you an example that was also repeated by Ms. Knox; you said that nobody will be turned away and Ms. Knox said that we will always admit. I just don't think that is true, not just at the Aberdeen but I've heard many stories from people in many parts of this province who have been turned away because there is no bed for them.

I certainly don't think that rests at the feet of the clinicians but I think it rests at the feet of the department for a lack of support for those clinicians who are - I mean I've talked to clinicians and heard about clinicians who are seeing people at eleven o'clock at night, after hospital hours, having private clinic hours at eleven o'clock at night, and with delays and travel and stuff, seeing patients at one o'clock in the morning. I would certainly not say that's a person who is underperforming, I would certainly not say that. That's a person who is over performing, but I would also say it's a shame that they have to see patients at that time of night because there are not enough resources.

There was a number here and this number has come up before, in the opening comments it was said that as a provincial government we spend more than $270 million on mental health and addictions. These dollars cover programs, doctors, social workers, drugs, programs. I wonder if we can get an actual - can I see that $270 million broken down in a spreadsheet? If not now, then I'd like to request that.

DR. VAUGHAN: Absolutely, we can get that information to you.

MR. HOUSTON: Is it available at the moment? Maybe as we talk we can find it.

MR. CHAIRMAN: Mr. Elliott.

MR. KEVIN ELLIOTT: I think that was provided in the package and if it wasn't, we'll make sure you get it.

MR. HOUSTON: Thank you. I wonder if you can tell me how many people sought mental health services last year in the province.

MR. CHAIRMAN: Dr. Courey.

DR. LINDA COUREY: I don't have the number of the actual unique individuals who sought treatment but I can tell you there were about 270,000 patient visits to outpatient mental health services in the year 2014-15.

MR. HOUSTON: Would you call those unique visits?

DR. COUREY: Those are separate visits. That means that every time a patient would see a mental health clinician, either through the emergency department or through an outpatient mental health clinic - that would be the number for the fiscal 2014-15.

MR. HOUSTON: Do you have a sense as to how many people that is?

DR. COUREY: All I can tell you, no, our information system for mental health and addictions is not established. We are able in some areas to make that determination but not consistently across NSHA.

I can tell you that in 2014-15 there were over 16,000 new patients who were assessed in the system.

MR. HOUSTON: I'm trying to reconcile these types of numbers to the common statistic of one in five Canadians. Have you done any work - maybe Dr. Vaughan - to see how Nova Scotia stacks up against that one in five statistic?

DR. VAUGHAN: We would be about the same as the national statistic.

MR. HOUSTON: Okay. I do want to talk about the situation at the Aberdeen Hospital because I actually think it's more representative of what's happening in many places across the province. The situation at the Aberdeen was that the people of that area were told that would be a temporary, three-month closure. It's still closed, it's much longer than three months.

The most recent thing that I've heard from this was, the Minister of Health and Wellness told reporters that the future plans for the short-stay mental health unit at the Aberdeen were with the Premier for review. To your knowledge, is the Premier reviewing plans for the short-stay unit at the Aberdeen?

DR. VAUGHAN: I'm not aware of that.

MR. HOUSTON: So the minister said the Premier is reviewing plans, which when I heard that, I had an understanding that the Premier himself was actually going to decide what would happen to the short-stay unit at the Aberdeen. Could that possibly be something that has happened without your knowledge? Would that normally go through you? If there was a proposal for the Aberdeen, would it normally not come from your desk?

DR. VAUGHAN: I could not speak on what the Premier is considering on his very large plate on a day-to-day basis, and I would not be able to comment on that. However, I can say that the health authority has been working hard to provide the right services for the citizens of Pictou. They'd be happy to answer that, I'm sure.

MR. HOUSTON: Would you be willing to comment or clarify as to whether or not, of the variety of things that might be on the Premier's desk, one of them would be something that you suggest should be there and that would be the short-stay unit? Or does that just not involve the Premier, in your mind?

DR. VAUGHAN: I couldn't speculate on what might be on the Premier's desk at this time.

MR. HOUSTON: Do you have any sense as to why the minister would say that something would be on his desk? Were you surprised to hear that he said that?

DR. VAUGHAN: I wasn't surprised either way - again I'm not . . .

MR. HOUSTON: Did you hear the Minister of Health and Wellness say that the Premier was reviewing plans for the Aberdeen short-stay unit?

DR. VAUGHAN: I don't recall him saying that, but if you say he did, I wouldn't dispute it.

MR. HOUSTON: And if he did, it wouldn't surprise you that the minister was making statements like that without you - I would have thought that as you being the person that's accountable for the delivery of services, that you might have had a say in what proposals would be put forward, but I guess it's possible that you didn't have a say in what proposals would go forward.

DR. VAUGHAN: Again, I think the health authority can tell you exactly what is going on with the provision of services.

MR. CHAIRMAN: Order, please. Mr. Stroink.

MR. JOACHIM STROINK: I would just like to refer back to the mandate of the Public Accounts Committee. The Public Accounts Committee is fundamentally concerned about matters of policy. The committee does not call into question the rationale of government programs, but rather the economy and the efficiency of their administration. I'm finding this kind of line of questioning is outside the parameter of the committee. It doesn't belong on this topic. You have brought up this topic numerous times in the House. This is an important issue. I ask that it stay on this issue and discuss the matters at hand that are here today with the members here. I ask the chairman to ensure that the questions stay within this.

MR. CHAIRMAN: Well Mr. Stroink, we have had this discussion a number of times. You have raised this matter a number of times. As chairman, it is very important that I be independent, that's why, since I've been made chairman, I've actually never sat down and asked a question on this committee. But you are also putting me in an awkward position because you are suggesting that I am not policing questions as they should be policed.

We have a legal opinion from our legal counsel that states members have the freedom to ask questions. I have heard questions from the government members of this committee that are not strictly to do with financial aspects - past expenditure of

government. I've heard questions from government members that could be considered cheerleading - to be making the department that's our witness for the day look good.

So it is difficult for me to keep addressing your request on this because we have a legal opinion. Mr. Stroink.

MR. STROINK: That's fine if you have a legal opinion. I just want to be clear that the mandate of the Public Accounts Committee is a written document here that we have and I'm happy to table it, but I think we need to either decide we're going to follow this or not. To my understanding, we're going to deviate away from this 100 per cent and we're just going to put it to the side and ignore it and do what we want to do here.

MR. CHAIRMAN: I'm familiar with the mandate. We have a legal opinion. If you lack confidence in me as the chairman of the committee, that's something you'll have to talk to your Premier about. I know it's the practice for the Leader of the Official Opposition to appoint the chairman to the committee. If there is an issue, perhaps you can put something in writing to our Leader and you can state the reasons why. But to have our meetings interrupted - I've ruled on this matter already and we're going to stop the discussion here for today . . .

MR. STROINK: One more comment.

MR. CHAIRMAN: No, because the clock is ticking. Okay, have one more comment. Mr. Stroink.

MR. STROINK: I asked that the questions pertaining to what the Premier thinks - you're reaching. That does not sit in the PAC mandate, so asking what the Premier thinks is not a fair question, do you not agree to that?

MR. CHAIRMAN: Mr. Stroink, if I have to get inside the mind of everybody on the committee, both government members and Opposition members, and try to understand what they are asking in each specific question, it's impossible. Members have to have the freedom, and our legal opinion is that members have the freedom. Each caucus has the same amount of time, they can ask questions. They may be asking a question to lead into something else.

It is true that members are supposed to focus on expenditure of government in this committee but it's not my place to start questioning members on their train of thought in their questions, whether they be government members or Opposition members - I've seen questions from the government members also.

Mr. Houston, the time on the clock is 9:27 a.m. You were interrupted at 9:23 a.m. so there will be four minutes added so that you will have your 20 minutes. Mr. Houston.

MR. HOUSTON: Thank you, Mr. Chairman. Dr. Vaughan, are there any plans to reopen the short-stay unit at the Aberdeen Hospital?

DR. VAUGHAN: I would defer that answer to the Health Authority who would be in the best position to describe what is currently taking place and what the plans are.

MR. CHAIRMAN: Ms. Knox.

MS. KNOX: I'd like to start by talking about what that unit is and what we found. When we became the Nova Scotia Health Authority, we had nine organizations offering mental health and addiction services . . .

MR. HOUSTON: Mr. Chairman, if I may - with all due respect, in the interest of time, I understand what the unit was and I think most people certainly in Pictou County do. The unit is no longer there so whether one wanted to have an opinion on whether it was an outstanding service, an adequate service, a poor service - it was a service and it's a service that's gone.

I guess I would ask the question differently to you. When can the people of Pictou County and the people serviced by the Aberdeen Hospital expect to see new services added?

MS. KNOX: New services have been added. When the unit was closed because we did not have the staffing to run the in-patient unit, we enhanced the community-based services in that local area.

MR. HOUSTON: How so?

MS. KNOX: I'll ask Dr. Courey to describe that in detail. What I would like to say to you, however, before she does that, is that the unit, as it was, was not a mental health unit that met the standards so we would never open that unit as it was. We have to have the proper standards of in-patient care. I'll ask Dr. Courey to describe for you the services that we've put in place in the local area.

DR. COUREY: Since August 4th, we've been carefully monitoring the utilization of the emergency department and the need for in-patient hospitalization in that area. Once the unit closed, we created two additional nursing positions, mental health nursing positions, to be located in the emergency department to assist the team there with assessing and making treatment disposition decisions on the individuals who are coming in in crisis.

We've created an additional social work crisis response person to support individuals coming in crisis. We created quick access to follow-up, including mental health clinicians and psychiatry, for individuals who are discharged from the emergency department and deemed not to require in-patient hospitalization but did require more rapid follow-up than they would otherwise get.

MR. HOUSTON: How many people have needed that quick response access to psychiatry?

DR. COUREY: Actually I don't have that data. I don't have follow-up on the people who have required it. I do have data, however, on the number of people who have required voluntary admission to the Aberdeen since the closure on August 4th. We have seen 18 individuals since August 4th over a period of 178 days, who otherwise would have been admitted to the Aberdeen on a voluntary basis. That's about one patient in every 10 days requiring in-patient hospitalization.

We have been closely monitoring the need for an in-patient unit. We have become aware of the fact that the unit actually did not meet provincial standards for the running of a mental health unit . . .

MR. HOUSTON: So would it be your assessment that there are adequate services provided?

DR. COUREY: I would go further and say there are better services being provided at the moment because in the past people were being admitted - I would hazard a guess to say, unnecessarily - to that in-patient unit. Many people in our community equate mental health care with admission . . .

MR. HOUSTON: No, I don't believe that is true; we'll have to agree to disagree on that. I would suggest you come with me for a day and talk to people who are trying to access services. To hear the stories before this committee today - even the ones that make it to the media about a person who should be admitted driving to Sydney in a storm to be turned around and sent back to the Aberdeen to stay on a gurney in emergency rooms and hallways and stuff.

It's very offensive to me to hear you say that this is better than what was being provided before, and by extension of that, almost imply that it's better than what people should be getting. I think that's a very bold statement. I don't believe it to be the case that people are getting a better quality of service than they should be getting. Is it your opinion that they are?

DR. COUREY: It is my opinion, which is backed up by the scientific literature, that better care for people with mental health disorders is provided in the community. The other part of your question - if someone does need admission will they get admitted to an in-patient mental health bed? - we can say unequivocally that in Nova Scotia, if a psychiatrist assesses a patient as requiring admission, they will be admitted. I would say further though . . .

MR. HOUSTON: Okay, I think that . . .

MR. CHAIRMAN: Order, please. Mr. Houston, I would like Dr. Courey to have an opportunity to answer the question.

MR. HOUSTON: I'm satisfied with the answer I received on that, Mr. Chairman. In my last couple of minutes, I think what we're hearing here is if I look back - back in August there was a rally at the Aberdeen, and I'll speak to Dr. Vaughan specifically on this. There was a rally to protest the closure of the short-stay unit and quite a few people showed up from the community. I would say there were a few hundred people there because it's a grave concern to people in the community.

There was an internal email, which I assume is from a bunch of communications folks, and Dr. Vaughan, you're copied on it. It comes from a lady named Patricia and it says: Hi, perhaps you are already aware of this - I just wanted to make sure. So she is alerting everyone that there is a rally going on in New Glasgow.

At that time, Dr. Vaughan, your response was very succinct. It was a one-liner that said: Narrative needs to be around the mental health services that are available. So the narrative needs to be around what's available, and "narrative" is a word - I would use the word "spin". There would be other words for that too.

I think what's happening here is the narrative is staying around - and we heard it in the opening statements about the services that the department believes are available. What I believe to be the case is that there are absolutely services available, but they're failing. I was hoping today we could have a conversation about how we could address those failures, but unfortunately in my first 20 minutes, we've heard nothing except accolades for how successful the narrative has been. The narrative is talking about the services that are available, despite the fact that they're failing.

I guess in my last minute or so I'd ask you to maybe put mission accomplished on the narrative. The reality is that people are being left behind. Maybe if you can comment on whether you feel people are being left behind by the services that are available, or if everything is just fine.

DR. VAUGHAN: As I said in my opening remarks, there's a lot of good things going on, and there's a lot of things we can improve - I think that's true generally in health delivery everywhere in the world. Nobody has the perfect answer to all these important questions.

The comments around wanting to ensure that people knew what services were available in that community is an important one to communicate, so . . .

MR. CHAIRMAN: Order, I apologize, I do have to interrupt, we have run out time. We'll move to Ms. MacDonald of the NDP caucus.

HON. MAUREEN MACDONALD: Before I get into some of the substantive questions I have, I first want to say how happy I am to see the mental health strategy back on track and on the government's radar. Everything isn't perfect yet, we have lots of work to do but I am delighted, frankly. I have to say, as the minister who oversaw the development of the mental health strategy in the department, nothing upset me more than to see that strategy come to a halt and slip back. So now to see the progress report that was released in January and seeing the focus back on getting this job done makes me feel very happy, I have to say.

Now, having said that, I want to say that the mental health strategy was really just a first step. The mental health strategy we developed was just a first step and they were kind of baby steps. I need to acknowledge the work done before the mental health strategy around the provincial standards. Not only is the mental health strategy the first mental health strategy that the province had that we can be proud of, prior to that, under a previous government of the persuasion of my colleague to my left here, the mental health standards were developed for the province. We were the first province in the country to do that and we need to continue to work with those as well. Those are my opening remarks.

Having said that now, I want to really look at some things that concern me and that I need some clarification around. The first thing I want to ask for some clarity around is the finances with respect to investment in mental health strategy and the confusion I have with respect to the significant differences in what was budgeted in the provincial budget last year for the Nova Scotia Health Authority for mental health services and what the health authority has in their budget for mental health services. I can't understand the discrepancy.

Let me say this, last year when the provincial budget was introduced, the Nova Scotia Health Authority was given in the budget $111 million, approximately, for mental health services. But when I look at the business plan for the Nova Scotia Health Authority for this year, that $111 million doesn't show up. What shows up is $85 million. That leaves me wondering what has happened to a significant amount of revenue.

Now mind you, when I look at the Nova Scotia Health Authority's business plan in lots of other areas, there are pretty big discrepancies as well. The provincial budget that was tabled had $63 million for administration, but in fact, the health authority's business plan says $96 million for administration.

So something doesn't sit right with me around that. Monies that were allocated for mental health in the provincial Budget Estimates haven't appeared in your business plan. Can somebody explain this to me?

DR. VAUGHAN: I'm not clear what the question is. It's not uncommon for the budget and the business plans not to exactly line up. I'm not sure what the question is exactly.

MR. CHAIRMAN: Ms. MacDonald, would you like to clarify your question?

MS. MACDONALD: I don't know how I can make it any more clear. I have a page from the provincial budget for the fiscal year that we're in, 2015-16. This is the page from the budget for the Department of Health and Wellness for the Nova Scotia Health Authority for all of these categories: Administration, Operations, Inpatient Services, Ambulatory Care, yadda-yadda-yadda.

The estimates are $111,290,000 for Mental Health Services for fiscal 2015-16. I have in the package the Nova Scotia Health Authority Business Plan for the same year, same plan, same entity - Mental Health Services $85,699,939. That is a significant reduction from what the provincial government tabled in their provincial budget. I don't understand the difference. Why is there a difference?

DR. VAUGHAN: I will ask Ms. Knox to answer.

MS. KNOX: We can help you with the reconciliation and we can provide that. I can tell you that our cost centres are rolled up in defined buckets of information that is provided for us. We do know that in our Nova Scotia Health Authority, our budget for mental health and addictions is $159 million. That's what we're spending.

It may show up, as you remember, in different parts of a summary plan for a business plan, but our operating budget for Mental Health and Addictions for Nova Scotia Health Authority that Dr. Courey manages is $159 million. We're very careful about making sure that stays in mental health and addictions.

MS. MACDONALD: So I would very much appreciate seeing an up-to-date and very detailed breakout for your budget.

DR. VAUGHAN: We can certainly provide that for you.

MS. MACDONALD: We here in the Opposition have certain tools, and as my colleague often says, you have way more information than we do. When you have that kind of discrepancy in the information that is provided, then it raises concerns, for sure.

MR. CHAIRMAN: Ms. MacDonald, Mr. Elliott would like to make a comment, are you okay with that?

MS. MACDONALD: Yes.

MR. KEVIN ELLIOTT: In Dr. Vaughan's opening comments about one of the things we can do better - when there were nine organizations, there were often business plan and budget variances. We know that those are working documents that we constantly reconciled, but when you pull them together with one health authority, those differences become much more visible and much larger.

I think it was raised at our last session to do a better job at reconciling those two and we will be doing that. So that is part of our plan going forward, but we'll definitely get you that reconciliation.

MS. MACDONALD: The next question I have is with respect to the number of mental health beds we have in the province. The government is making a very strong point, and so is the health authority, about taking a provincial view. How many in-patient mental health beds do we have in the province, and where are they?

DR. COUREY: I can turn your attention to the presentation that was included with your package. Basically we have 234 non-forensic mental health beds in Nova Scotia, and there are additional forensic beds. Their distribution is located in the presentation with 28 mental health beds in the Western Zone; in Northern at the moment, Colchester is operating between about 10 and 14 beds; in Central, I mentioned that's about 140 beds but they are spread out and include offender health and forensic services. As well, in the Eastern Zone, there are 56 mental health beds. There are also in-patient withdrawal management units, as described in that presentation.

MS. MACDONALD: One of the items in the mental health strategy was to do a review of the mental health beds in the province. That review was scheduled to be done in 2012-13. I'm assuming that review has been done, has it not? Has that review been done? I think I see on the update to the strategy that in fact it has been done.

DR. COUREY: No, I would say that it has not been fully completed. With the creation of the Nova Scotia Health Authority, however, we are engaging in a planning exercise to review what services we are providing across the province for mental health and addictions, and their distribution across the province. That would include whether it's emergency department services or community-based, and will include a review of mental health beds.

The review of beds, though, has been part of work that has gone on in the Northern Zone. That was started I think in 2014, by the Northern Zone Advisory Committee. The completion of that review will probably be in the Fall of this year, 2016. As I mentioned, it's impossible for us to review distribution of beds without also providing a review of every other part of the mental health and addictions continuum because beds in isolation don't do very much for people. That provincial review is underway and, as I say, we anticipate by the Fall of this year to have a better sense of what the continuum of mental health and addiction services should look like, and where the services should be distributed.

MS. MACDONALD: I'm looking at the update to the strategy - I'm looking at all the different little items and the checkmarks and I'm seeing that the checkmarks indicate that work has begun or work has completed. So the beds review has a checkmark. What you are saying is this is not completed, it's under way.

DR. COUREY: It is in progress.

MS. MACDONALD: It's in progress. So what I'm going to do then - when I look at the progress report and all the checkmarks, they don't really tell me what's completed and what's begun. So I'm going to take you through that so we can see what's completed and what is in progress.

The 18-month developmental screening for all children - where is that? Completed? In progress?

DR. COUREY: Perhaps I can defer to the Department of Health and Wellness.

MR. CHAIRMAN: Dr. Vaughan.

DR. VAUGHAN: That is in progress. It involves a number of groups of people.

MS. MACDONALD: Where is it in progress? How far along is that?

DR. VAUGHAN: We have a pilot test currently, and the evaluation and feedback is coming back in to be able to evaluate that.

MS. MACDONALD: The province-wide telephone coaching for families.

DR. VAUGHAN: That is in place.

MS. MACDONALD: That's families first, is it?

DR. VAUGHAN: Strongest Families.

MS. MACDONALD: Mental health clinicians in schools.

DR. VAUGHAN: Yes, that is in place. We have mental health clinicians in every school.

MS. MACDONALD: Completed?

DR. VAUGHAN: Yes.

MS. MACDONALD: School policies related to mental health in substance use and gambling.

DR. VAUGHAN: That's currently in progress.

MS. MACDONALD: Collaborative care among primary health.

DR. VAUGHAN: Again, this is in progress. It's not one of those things that's probably ever complete, but it's in progress.

MS. MACDONALD: The education for EHS paramedics.

DR. VAUGHAN: Again, that's in progress.

MS. MACDONALD: Reduce mental health wait times to meet the standards.

DR. VAUGHAN: I would say it's in progress, but I say that it has had some success in certain parts of the province. One of the challenges that has been alluded to is when we've gone from nine organizations to one, there were some areas and some former districts that did very well at reducing wait times using the CAPA program and others less so. So now there's an opportunity to smooth that throughout the province - so yes, but in progress.

MS. MACDONALD: Wait times are certainly one of the things that people are most concerned about - with good reason. The chart I have would indicate that wait times are improving in terms of the initial assessment, but they are worsening around clinical care. Why is that?

DR. VAUGHAN: I'll make a comment and then I'll turn it over to the folks who have the details of the health authority. We have seen - as I said in my opening remarks - more people coming forward with issues around mental illness, there's a lot more people in the queue, if you will, and that has an impact on the ability to see people as fast as we would like them to be seen.

The good news is people are coming forward. We are having conversations. Stigma is being reduced. The challenge we have is to provide the services for the volume of people who are now coming forward. I'll turn over the rest of the answer to the health authority.

DR. COUREY: We are working very hard to standardize our approaches to people who come to us with mental health problems and addictions on an outpatient basis. That means we are looking to the evidence on what the best practices are so that we can treat people and produce better outcomes. We're looking at our efficiencies, which is standardizing how people are treated and seen and assessed and responded to in a consistent way across the province.

So we anticipate that over the next year or two, as we're able to properly implement and standardize our approaches, that we will see reduced wait times, but what we're most interested in is also appropriate use of services. Right now we are seeing many people in the mental health system who do not need our services, who would be better managed and supported by primary care or other organizations. We need to do a better job of being able to assess people's needs when they come to see us, properly match them to a trained clinician, measure outcomes so we know we're having an impact, and having good flow through our outpatient systems and services. That's going to take a fair amount of work again because everyone did business in different ways.

Our care providers, our primary care sector, and our patients and communities all have different expectations about what we should be doing. What we are doing in the next year is going back to evidence - what's the best care we can be providing? How do we ensure our clinicians are appropriately trained? How can we measure outcomes? How can we improve flow so . . .

MS. MACDONALD: I'm sorry to cut you off.

MR. CHAIRMAN: I also have to apologize, time has expired. We'll move to the Liberal caucus and Mr. Farrell.

MR. TERRY FARRELL: I'll begin by directing some questions to the NSHA team in terms of the nature of the unit at the Aberdeen that was called the short-stay mental health unit. I think in your earlier answers you were trying to give a little bit of background and history on what that was and how it came to be. I'd like to give you the opportunity now to explain what that was and how it evolved into what it was.

MR. CHAIRMAN: Ms. Knox.

MS. KNOX: To be precise and concise, I'll let Dr. Courey tell us the story.

DR. COUREY: I'm not familiar with the origins of that unit but I am aware that for the last very many years we have been aware that the unit, although it was called a mental health unit, in fact did not meet provincial standards for a mental health unit and did not actually function as a mental health unit. Patients were admitted to that unit by family physicians who could choose or not to consult a psychiatrist during the patient's admission, and patients would be discharged from that unit by family physicians.

There was no multi-disciplinary team, other than nursing and physicians. There was no security on the unit and, in fact, the unit was opened for an ambulatory care clinic - an ear, nose and throat clinic - where a clinic was operating in the middle of an in-patient unit.

The unit, unlike any other mental health unit in Nova Scotia, because of the unavailability of a psychiatrist to oversee the care of admitted patients, was unable to accept involuntary patients, patients who were considered involuntary under the Involuntary Psychiatric Treatment Act. Those patients always had to be transferred to other units.

It is difficult to reconcile that picture of the functioning of the unit with what exists in the mental health standards around what residents of Nova Scotia should expect, the care they should expect to receive while admitted.

That having been said, I don't want to appear disrespectful to the physicians and nurses who ran that unit and managed those patients and provided the best care they could with the resources they had.

MR. FARRELL: So the discussion appears to be around beds, though: there were beds and there aren't beds now. Can you comment on that in terms of how the service continues to be delivered and how those beds either being there or not being there, what the effect of that is on the service to the citizens of that area?

DR. COUREY: I believe, as I have said previously, that by investing resources into community-based care and into support in the emergency department, that the residents of that area will be better served and are being better served in relation to their mental health needs.

There are in-patient mental health units between a half-hour and an hour's drive away in Antigonish and Colchester so individuals who do require in-patient hospitalization absolutely will receive that service. Again, there are times when people have to travel greater distances because the beds locally may not be available, but again, that is a fact of life for all of us in Nova Scotia, having to drive distances to receive specialized care.

So we are committed to improving service delivery throughout the province. This is not just about New Glasgow. This is about what is the best configuration of mental health and addiction services for the residents of Nova Scotia. The best configuration includes in-patient beds, but it also includes strong outpatient and community-based services, strong support from primary care, good access to safe, affordable, and accessible housing - all of those psychosocial determinants of health that impact people's mental health disorders and their addictions.

So again, we see in a microcosm in New Glasgow the issues around what is better care for people. What is better care is better care provided by competent professionals in the community with a range of services and supports and access to specialty care when they need it.

MR. FARRELL: So the overall goal then is fewer admissions, fewer people who have to receive in-patient mental health services?

DR. COUREY: I don't know what the proper number of admissions would be until I'm comfortable that we have all the other services and supports in place; until I'm comfortable that we have a mental health and addictions system that is being run in a consistent way across the province; when I know we're providing services efficiently; when I know we're able to measure our outcomes so that we're getting feedback all the time about what's working and what's not so we can improve our services - then I'll be able to answer more competently the questions about what the ideal number is of admissions to mental health units in Nova Scotia.

MR. FARRELL: So it sounds like it's an ongoing process in terms of assessing the nature of service and the need for service across the province - that's part of the formation, if you will, of the health authority and the level of service they're providing across the province.

DR. COUREY: We have a wonderful opportunity in front of us. For the first time we can take the time to look at the needs in the population and have that drive where we put our services, and we don't do it blindly - we assess and review what the practices are across Canada and other jurisdictions: what are the best practices, what does the evidence tell us? We're trying to establish a system that ensures that Nova Scotians, no matter where they live, can have access to good, quality, and safe mental health and addictions care.

MR. FARRELL: Thank you. I'll pass it on to my colleagues.

MR. CHAIRMAN: We will move to Mr. Wilson.

MR. GORDON WILSON: I would like to start by thanking the Opposition - the Leader for the NDP - for raising the comments around the mental health strategy and how it is an important day today that we are here speaking about it. Every time we do, it breaks down those barriers, so I respect that. I also respect all the Opposition on the floor of the House of Assembly when they passionately bring the discussion there. Sometimes I think their motives are a little bit maybe not quite what we're trying to get at here.

I'd just like to also state that witnesses when they are here are bound to speak the truth. This is like a court of law - sometimes it feels more like a court of law than it should, but the truth is spoken here and I respect what is being said. I appreciate the fact that Dr. Courey just had the opportunity to answer a question that she was asked earlier that she didn't get a chance to answer.

One thing that wasn't spoken about here today - I think it's a little bit of history. In some of my preparation to come here today, I do realize that the Auditor General did report three times, I believe, on the state of mental health and health delivery in that world and also the merging of interests between the Department of Health and Wellness and the health authorities in that regard.

I'd like to ask Dr. Vaughan if he could speak on what some of those comments were around the Auditor General's Reports - I believe we had three of them.

DR. VAUGHAN: The Auditor General commented on the lack of - he called it inadequate data and monitoring of performance back in 2010 in mental health services, in 2012 on addiction services in the Annapolis Valley District Health Authority and in 2015 on problem gambling; and in several other reports, that the role of the department was not adequately overseeing the data and the performance of those areas in mental health.

That's one of the reasons we've embarked on the redesign of the Department of Health and Wellness - to really focus on our role in new legislation, which is the performance and monitoring, rough performance, setting the objectives and prioritization. We're now going to be able to do that going forward. Change isn't easy, for sure, but those Auditor General Reports did guide us in our decision to change.

MR. GORDON WILSON: One last question in just a little bit of a different area, it was touched on, I believe, by the Opposition and by Mr. Farrell also, in regard to the number of beds. I think we focused a lot on health care delivery around how many beds we have or don't have. I do also understand the comprehensive service delivery model and number of beds don't match up. I'd ask either Ms. Knox or Dr. Courey - either one could answer - around what that means in the strategy of mental health delivery?

MS. KNOX: Our whole approach in providing services must be based on what the people need, so what are the needs of our population in terms of service. We very much want to be in a position where we look at the total continuum of support that is required for people with particular disorders, which also includes the health promotion.

It is our intense interest to not just focus on beds in any service we provide but beds are an integral part of that service, so it's very important. It is a change for us in Nova Scotia because we segmented our services - outpatients, just the use and we're still using it because that's what people understand. Really, to help people understand there's a variety of services that we need to provide and we need to look at them every time we're planning services.

As we go forward with Nova Scotia Health Authority we are planning from that perspective - a population perspective, based on the needs of particular individuals with particular disorders, then looking at how do we put together this continuum of services and support which includes how communities help each other.

The other thing I'd also like to say that Dr. Courey has talked about, it is really important that we understand particularly around issues of mental health and addictions that the health system is one part of the contribution here and how we work with our partners, the non-profit organizations, with other government departments, with communities, to create the kinds of communities that support people to live well in their local communities, that's a very important aspect. That is our work as we try to get a better system that supports people in their life, in their family, in their community.

MR. GORDON WILSON: So in saying that, still we're going to fall into the trap if we don't have something to count, sometimes that's important. Outcomes around comprehensive service delivery, I would assume, are part of the model. Can you give me just a couple of different parameters that would be indicators in that area?

DR. COUREY: I'm not entirely certain I understand your question. If you're asking how we would judge a good system, how we would judge when we get there, then to me, first of all focusing on how service is provided, is it efficient? Can people get to us in a timely way? Are we seeing the population that we should be seeing - that is, people with moderate to severe mental health disorders and not seeing those with mild disorders who could be treated or offered some brief intervention elsewhere in the system. Are we improving people's lives? We need a system to measure outcomes so we need evidence, and that will guide our continued improvement.

So are people who need our services getting our services in a timely way, having their lives improved? Are we also ensuring that the standards of care that exist in certain parts of the province are accessible right across the province, respecting that specialty services are always going to be located in perhaps one or two areas of the province? So access, safety, quality, the provision of evidence-based services - I could go on.

MR. GORDON WILSON: That was great, thank you.

MR. CHAIRMAN: Ms. Lohnes-Croft, you have about three and a half minutes.

MS. SUZANNE LOHNES-CROFT: First may I say how embarrassed I am by the way you've been treated this morning. I will not cut you off. You are not on trial. You can speak - I won't interrupt you.

I am always concerned about rural Nova Scotia, and in particular the way the many challenges there are in delivering services there. Why are rural communities suffering so much?

DR. VAUGHAN: That's a great question, and thank you for that. I'm very fond of rural areas, as you know, having worked there for the past eight years prior to taking on this assignment.

I think the challenge in rural areas - not just in Nova Scotia, but right across this big country - is really access in many ways. That really cuts across many of the challenges, not just within health care, but other social services, the justice system, et cetera - the challenges of distance and really being able to get to places.

On the positive side, Nova Scotia isn't that large compared to other much larger provinces that have much further to go to reach access to services. So the challenge that we have to balance in any health care system is being able to balance the access to the right services - not just any service, but the right service. What you've heard this morning in terms of mental health services, it's ensuring we have the right services clustered in areas where it is accessible and then having to realize that people may need to travel further for those highly specialized services.

So it's a balance that we all appreciate. We all love to have things close to home, but it isn't always possible to have the hyper-specialized services very close to home. But we live in a province fortunately that we don't have the great distances that some of our neighbouring provinces even - let alone other parts of the country - do have to travel. So the balance between access and appropriateness and the right services that people need within the reasonable period of time, of distance to travel, is what we're trying to evolve in this province.

MS. LOHNES-CROFT: One of the big issues I find when people come to my office is they don't know what's available. They don't know about SchoolsPlus - the number of

parents who do not know there is a mental health worker in their schools. They don't know that not all mental health care takes place outside of a hospital or a mental health unit; that there are women's centres that provide counselling and support, et cetera.

How can we do this better? How can we deliver our communications around how people can access? Some people don't even know they can directly call mental health to get an appointment, they do not have to have a referral.

So many people are tied up waiting to see their GP when their child is in a crisis, for example. Are we working on that?

MR. CHAIRMAN: Dr. Vaughan, we just have about 20 seconds.

DR. VAUGHAN: We absolutely agree that we need to better communicate what services are available. Many younger people are using mobile devices for everything. There are some jurisdictions that have mobile apps to help them with mental health, many of the challenges with depression and anxiety, that large groups of individuals just want some kind of access. We have to get better at providing those kinds of services where people are, rather than necessarily making people come to the service.

MR. CHAIRMAN: Order, thank you. We'll move to Mr. Houston, 14 minutes.

MR. HOUSTON: There has been lot of talk this morning about relying on community organizations and community services and all this type of stuff. On January 12th the department put out a press release saying, "The province is asking for interested community groups to apply for . . ." funding. That was on January 12th. That letter finishes with "Letters of intent will be accepted until Jan. 29 . . . After that, groups that qualify will be invited to submit . . ." an application. So a two-week window to basically submit a proposal, which will then be vetted to see if you can apply for funding or not.

Two weeks sounds - I don't know how many people on this committee have prepared proposals and submissions and stuff like that, but that can be incredibly stressful. Two weeks seems like a pretty short window for the department to say, get it in in two weeks or you can't even apply. What do you say to that? How do you reconcile that with the big focus on involved community organizations, push things to communities but you only have two weeks to tell us what you're going to do and whether we think it's worthy or not? Does it seem short to you?

DR. VAUGHAN: That was a request to submit a letter of intent, it wasn't the actual proposal. A lot of these organizations do already have a lot of background information ready, it's an annual kind of request. It was a letter of intent, not an actual proposal.

MR. HOUSTON: Yes, a letter of intent. After that, and presumably based on the letter of intent, certain groups that qualify will be invited to submit an application. There's

no difference between a letter of intent and a proposal in that context because if your letter of intent is deemed not worthy, you're not even going to be invited to apply.

I don't want to get too caught up in the language, let's talk about what's really happening. What's really happening is the department sent out a release that said you have two weeks to submit something to us that convinces us that you're worthy of us asking you to apply. It seems like a really short window of time and I'm wondering what the thought process behind that is.

DR. VAUGHAN: It wouldn't be unusual in any kind of competition that occurs nationally for individuals and groups to be requested to submit a letter of intent within a period of time such as that. That allows people to put together a letter, in fact. They would then be reviewed, and if there was merit to their proposals they would be submitting more information which would be required.

MR. HOUSTON: To your knowledge, were there any discussions with any of these groups beforehand? Was there a road show that went around and spoke to any of these groups and said this is what's going to happen?

DR. VAUGHAN: There was no road show. There were informal consultations taking place with individual groups.

MR. HOUSTON: There would have been?

DR. VAUGHAN: There were informal conversations.

MR. HOUSTON: So some groups had a sit-down chat and some didn't, but for everyone they received a press release that said you have two weeks to submit. I don't know if you see the inconsistency between that and we're going to rely on community groups to help us more, or if that inconsistency is not apparent to you. But it is apparent to me and it's the concerns I have with what we're hearing here today about all the services that are available and all the wonderful things that are happening, but when you scratch back just a little bit, how it's unfolding is different.

Dr. Courey talked a lot about establishing systems to improve flow and measurement of what people need and then giving them what they need. Well, most people are presenting in emergency rooms - 270,000 visits. I don't know how many of those were emergency room, but a lot of people - certainly in Pictou County - they're presenting at emergency room in many cases.

We can talk about the numbers of that, but when people present at emergency rooms, they're triaged to certain standards and they're triaged to the Canadian Triage Equity Score. Well there is nothing in the Canadian Triage Equity Score that speaks to mental health. So has any specific training been done to emergency room practitioners about how to triage somebody who presents with a mental health situation?

DR. COUREY: In fact, the triage scale does specifically refer to certain mental health presentations and, in fact, to my knowledge, they were revised two or three years ago - maybe longer - to better reflect the distress of individuals coming to the emergency department and the need for more rapid follow-up.

There has been a fair amount of work in various parts of the province providing education, back-up, training to emergency department staff - some are receiving mental health first aid training. Now it is part of the accreditation standards that emergency department staff are able to complete a suicide risk assessment and have an intervention plan. There is a pilot project in Cape Breton that involves training emergency department staff and physicians to deal with individuals presenting with addictions and concurrent addiction mental health disorders.

So I think there is widespread recognition that one of our contributions to people's improved mental health in Nova Scotia is building capacity in all of those front-line service providers - be it police, EHS, dispatch, emergency room physicians and frankly, primary care physicians - to be able to properly address those problems when people come for help.

MR. HOUSTON: So over the next few years that will roll out across the province?

DR. COUREY: It's happening now.

MR. HOUSTON: Is it rolled out across the province?

DR. COUREY: It's hard to say what is rolled out across the province in any aspect of care since we're such a new organization. All I can say is that we are working very hard to, first of all, do a good environmental scan to find out exactly what is happening across the province, and then we'll get to the standardization part.

MR. HOUSTON: You mentioned to my colleague that there has been a study of beds - a bed review for the northern district has been completed. Did I hear that right?

DR. COUREY: There was a review of the full continuum of services by the Northern Zone Advisory Committee. I think it was started in 2014 - initiated by the Department of Health and Wellness. That was not just a review of beds, because as I've said, we've all recognized that beds are connected to all the other services, so the number of beds that you need in a particular area is related to the number of community-based services and supports. You can't have one without the other.

So there was a review done. A consultant was hired, there were community consultations that were widespread that included care and service providers, as well as members of the community asking questions about, what sort of services do you feel you need if they're in crisis.

MR. HOUSTON: I'm trying to be respectful of your time, but I'd ask you to be respectful of my time as well - I have just a few minutes left. My question was if the review had been completed.

DR. COUREY: The review for the province has not been completed.

MR. HOUSTON: Okay, so it has not been completed. We know that the beds at the Aberdeen were closed. I was able to obtain a copy of an action plan for the Aberdeen through freedom of information. In that, it talks about exploring opportunities to increase in-patient bed capacity in Truro and Antigonish. You referenced it in your own comments and kind of said, well, there are units 30 minutes away, I don't know what the big deal is, was kind of my interpretation of your comments.

In this report it talks about adding four beds in Truro and two beds in Antigonish. Were the four beds in Truro added and were the two beds in Antigonish added?

DR. COUREY: I'm not aware of any reference to two beds in Antigonish but I can tell you that Colchester has been operating at 14 beds instead of the 10 beds that it had been funded for. We made an attempt to move some of the resources, some of the nursing resources that were associated with Aberdeen to create temporary nursing positions at Colchester, to help support those additional beds.

Unfortunately, because we could not post permanent positions, we've had a very difficult time trying to attract nursing staff who would be willing to take temporary positions. That having been said, Colchester and their team have risen to the challenge and have been operating with additional beds.

MR. HOUSTON: In your comments earlier you said there were 10 to 14 beds in Truro, do I now understand that it's 14?

DR. COUREY: As of the last few months it has been 14. Some days it goes up to 16 and other days it decreases a bit. They're trying to manage based on acuity and what the needs are and what the presentation is.

I'm not comfortable with managing an in-patient unit in that way but until we have a final decision around our resources that we can redeploy elsewhere, this is what we have.

MR. HOUSTON: It is what we have indeed, I guess, and we're all hopeful that we can get something better.

Dr. Vaughan, with the chat about in-patient versus in-community, can you give me a sense of what your ideal budget split on that is? Would it be 50 per cent towards in-community and 50 per cent towards in-patient admissions? What's the ideal budgetary split there that you would be striving towards?

DR. VAUGHAN: I'm not sure there is, Mr. Chairman, a right answer to that question. If we're building a system that's based on evidence need, then I think we have to be able to deploy the resource where there is evidence of need.

Arbitrary expenditure in community versus hospital base isn't really the kind of evidence-based planning and resource management that we would recommend in the future. It would be very much akin to deciding that we only want to have all of our snowplows in one part of the province, and that would be a very risky endeavour in a severe storm. We need flexibility, we need to be able to deploy resources where we see the trends. That is the approach that we're building, is looking at where we . . .

MR. HOUSTON: I guess I would challenge you on the analogy because the fact of the matter is there are snowplows all around the province right now. Sure, some get moved when there's a storm and when there's a need. I'm asking you, do you have your snowplows all around the province? What is your ideal assessment of in-patient versus in-community? What type of budgetary split would it be? If you need to react to move that in time, do you have a sense in your mind, given all the planning and effort that has gone into it, as to how these dollars should be spent? What is the ideal breakdown?

MR. CHAIRMAN: Dr. Vaughan, you have about 30 seconds.

DR. VAUGHAN: We do know from national and international studies that community-based care is the right care for the majority of people. There are some patients who do need in-patient care. Those resources are available in this province and we do need to build community care.

MR. CHAIRMAN: Thank you, Dr. Vaughan. The time has expired. We'll move to Ms. MacDonald.

MS. MACDONALD: I do want to go back to the strategy and deciphering where there's work in progress to where work is completed. Before I do that I want to talk again about budgetary issues. I know, Ms. Knox, you as the CEO had sent a directive across the system for a 1 per cent reduction in order to meet the budget of the health authority. Did that include mental health and addiction services?

MS. KNOX: It didn't include any care.

MS. MACDONALD: It didn't include any care.

MS. KNOX: I think you're probably referring to our discussions in the third quarter of our year. As we are entering the third quarter we are very determined to meet our budgetary requirements. We have a large organization and we've asked people to - let's all take, including me and our cost centres, a minus 1 per cent. So in my instance, that would be monitoring travel really closely. That's the kind of strategy that was.

MS. MACDONALD: Just for clarification then, mental health and addictions services across the province under the authority of the Nova Scotia Health Authority, they would not have felt any impact from a 1 per cent reduction - is that what you're indicating?

MS. KNOX: What I'm saying is, the provision of service to the clients would not have felt an impact, but they could say we're having our meetings using teleconference, if they chose to do that. All parts of our organization were not able to do that. This was just a management strategy to say, let's give ourselves a challenge and see where it takes us.

MS. MACDONALD: But in other words, mental health and addictions services, as a division if you would - I know it's not a division - was not exempt from having to find that 1 per cent reduction.

MS. KNOX: No, they were not.

MS. MACDONALD: The reason I ask that is - I did sit in the chair and had to make similar financial decisions and we did, in fact, exempt mental health and addiction services when those decisions were made because the reality is they're already operating on a very disadvantaged, I guess in some ways, over the remainder of the system - not a lot of top-heavy management in mental health and addiction services.

Are there clinical vacancies in mental health and addiction services across the province? If so, how many clinical vacancies are there?

MS. KNOX: We will constantly have vacancies across every program area. That's the nature of our work with people coming and going and retirement and those kinds of things. The actual numbers, I'll ask Dr. Courey to talk to.

DR. COUREY: I don't have those numbers, sorry, but we can get that for you. We do have numbers of vacancies, particularly but not exclusively in rural areas. Recruitment in rural areas continues to be a challenge, but we are working very hard to do the best that we can - going to professional conferences, using whatever resources we have at our disposal to do proper recruitment, and then retention because we have to be able to provide the clinicians that we can attract with supports that they need to keep them.

MS. MACDONALD: I want to go back to the number of beds in the province for mental health and addictions. You indicated that you had provided in our package - is this what you were talking about in the package?

DR. COUREY: Yes.

MS. MACDONALD: Okay, thank you. What I would say is that, in fact, this is not all that helpful, I'm sorry to say, but it really isn't all that helpful. You indicated that there were 234 mental health beds in the province, and when I try to take this chart and figure it out, it doesn't really add up. So what I'm going to request is a better description of what

we have in the province and where. I would also like the committee to be provided with the information with respect to children and adolescent mental health beds and other specialty services, if that's okay, and we can deal with some of those issues at a later date, I suppose.

I want to go back to the mental health strategy and I want to continue to probe what has been completed in the strategy and what is in progress. So far we have a number of things in progress, we have a few things completed, but we have a lot of work underway.

Expanded peer support, completed or in progress?

DR. VAUGHAN: Completed.

MS. MACDONALD: So in other words, the intention is not to expand beyond nine peer support persons, is that the department's intention?

DR. VAUGHAN: We are constantly evaluating the need and we'll be looking at expansion based on evidence of need, but right now that element is completed.

MS. MACDONALD: I'm disappointed to hear that. Skills training and support for families, completed?

DR. VAUGHAN: That's ongoing.

MS. MACDONALD: The partnership with the Schizophrenia Society, my understanding is that's the program that was cut, the funding to the Schizophrenia Society was cut for that program in the current budget.

DR. VAUGHAN: As you know, we have fiscal challenges in this province and everyone is asked to contribute to that. We did look at the Schizophrenia Society and I believe they do have the funding they need.

MS. MACDONALD: For that program?

DR. VAUGHAN: For that program.

MS. MACDONALD: They did take quite a significant cut in their operating budget. Which program would have been impacted by that cut?

DR. VAUGHAN: I'd have to look at what specific program you're referring to and I don't have that at my fingers. I think they were looking at some public health programs and some relationship with DCS, but I'm not exactly sure. I'll have to get that information for you.

MS. MACDONALD: So the skills training and support for families is in progress.

DR. VAUGHAN: It's ongoing, yes.

MS. MACDONALD: The expanded opiate replacement treatment, I think that was partially in the news yesterday, perhaps, is that completed?

DR. VAUGHAN: It is technically completed but I would probably describe it better as ongoing. That's not an issue that is going to be finished at any particular time with the challenges that we face, not just in Nova Scotia but across the country in opiate addiction.

MS. MACDONALD: I know the province-wide, toll-free crisis line is in place, that's completed, and the review of mental health and addictions beds is ongoing. Specialty care networks, completed?

DR. VAUGHAN: I would say that's in progress.

MS. MACDONALD: Have there been any speciality care networks introduced under this government?

DR. VAUGHAN: I don't think there have been any new specialties introduced.

MS. MACDONALD: Has there been any expansion of existing?

DR. VAUGHAN: I'll ask Dr. Courey.

DR. COUREY: No, in fact, this is one of the purposes of the provincial planning that we're doing right now, to determine the continuum of care. That includes then what specialties we do offer. Then that will result in what the speciality networks are that need to be operating to support them.

MS. MACDONALD: The concurrent disorder training for care providers, complete?

MR. CHAIRMAN: I'm sorry - just for the record.

DR. VAUGHAN: That's completed.

MS. MACDONALD: The awareness of the problem gambling help line?

DR. VAUGHAN: That is up and running, that is completed.

MS. MACDONALD: Complete?

DR. VAUGHAN: Complete, yes.

MS. MACDONALD: Better information systems for mental health and addictions, I know the Auditor General is really quite concerned about this in one of his more recent reports. Where does that stand?

DR. VAUGHAN: I would say that is in progress.

MS. MACDONALD: The information sharing guidelines?

DR. VAUGHAN: That would be complete.

MS. MACDONALD: With respect to the Aboriginal community and other diverse populations - this is one that I certainly have a very significant concern about, particularly when it comes to people who suffer the impact of racism. I see this fairly frequently in my constituency and the need to have appropriate services for people from diverse populations. Could you tell us where the various aspects of the strategy are here - complete or in progress? First of all, just working with the diversity groups on mental health and addictions programs and services?

DR. VAUGHAN: This is a work that is in progress. We are one of the first provinces and territories to have mental health clinicians in First Nations communities - seven communities with one full-time and six part-time individuals. We're the only province or territory to develop a cultural safety training in partnership with First Nations people. We are the only province or territory to have learning modules developed by the African Nova Scotian community for mental health and addictions clinicians.

We have funded 36 unique community projects throughout Nova Scotia - developed to make life better for those living with mental health problems and illness and/or addictions. Over 16 municipalities across the province have participated in projects related to reducing the harms of alcohol in their communities through the Municipal Alcohol Project.

MS. MACDONALD: I note that there is no checkmark on undertaking work to increase the diversity elements in addictions. Can you explain why that is?

DR. VAUGHAN: I think it's a work in progress. It's ongoing.

MS. MACDONALD: The recruitment of French-speaking professionals?

DR. VAUGHAN: That was really around clinicians and that's ongoing work.

MS. MACDONALD: There also appears not to be any movement on seniors' mental health and the addictions needs for care providers.

DR. VAUGHAN: For seniors mental health? We do have some activities with seniors mental health. (Interruption) We're working with our colleagues in the long-term

care sector to look at what the needs are and it becomes part of the dementia strategy, which is ongoing.

MR. CHAIRMAN: Order, time has expired. We'll now move to the Liberal caucus. Ms. Lohnes-Croft.

MS. LOHNES-CROFT: We didn't have much time to talk about how we can go about getting the communication piece out of what is available for mental health services. You mentioned technology and the telephone services that are available. How else can we improve, or what is there that we just don't know about?

DR. VAUGHAN: There is a lot of activity that we can do to communicate better in terms of what services are available. The key with the targeted communication is looking at who we're trying to reach. One size doesn't fit all so we need multiple channels, if you will, to communicate to different groups across the province. What works for the younger group may not work for the seniors group, so multiple channels. The opportunity that we have here today to talk about mental health is an important part of communicating.

We are in the schools; community groups. We've seen in newspapers in the past few days prominent business people talking about mental health in the business community. It's not just about the health care sector. It's really talking across our entire society - in schools, in the justice system, in the business sector. The Mental Health Commission of Canada encourages everyone to become much more knowledgeable and aware of mental wellness, not just when you are sick, of course, we need help but also what we can do to keep ourselves and our families and friends mentally well.

It's not just the health care system's job, we're sort of the ones people come to when they are most acute but the opportunity to have these conversations in the general media today is a great step forward to help us be able to make people aware of what services are available, as well as in the schools and you've talked about that.

MS. LOHNES-CROFT: Well I've certainly found it challenging, as a former home and school president who tried to deliver information to parents with information sessions on anxiety and depression with children and just not a good turnout of parents. It's frustrating to put that much time and effort into an event and then have a very low show of parents.

As a parent, I think one of our biggest fears always is suicide of our children. We're hearing so much about suicide rates with our young people, why is that? We seem to be paying more attention, there's more information, we're saying we're providing more services - what's happening with youth and suicide rates?

DR. VAUGHAN: I'll ask Dr. Courey to comment on that. It's a challenge we face right across this country and in fact globally, the incidence of suicide increasing, it worries

all of us. There's not a family that hasn't been touched by this, I don't believe, across this great country.

I'll turn it over to Dr. Courey in terms of what the evidence would be from the psychiatric profession.

DR. COUREY: Suicide is a tragedy, there's no doubt about it. We work - the "we" meaning not just within Nova Scotia but certainly across Canada and internationally - trying to understand what the factors are that are contributing to rates of suicide that we're seeing. There are cultural factors, there are the determinants of health issues, there are also unfortunately undiagnosed mental health disorders that contribute to people killing themselves.

Our way to address this is two-fold: to decrease stigma so to increase people's willingness to talk about suicide, but to talk about depression and other mental health disorders that are likely to contribute to someone making that decision to end their lives. We also work to build capacity throughout the system - primary care, emergency departments, our own staff - to be able to properly assess risk so that we can do our best to determine if someone is at high risk for suicide and to put proper intervention plans in place to minimize the risk.

We are seeing increased rates of hospitalization of young girls, either in relation to suicide attempts or other acts of self-harm, and that's happening across North America. There are all sorts of factors at play, some over which we have jurisdiction and some we don't.

Our efforts locally are around improving mental health literacy and comfort, talking about mental health issues. We've worked with the Department of Health and Wellness around media reporting guidelines that do help the media do a better job at reporting incidents that come to the attention of the public, but in ways that are not disrespectful to people who live with mental health disorders.

Again, we have to do whatever we can to ensure that people who need our services seek out our help. Anything, as Dr. Vaughan alluded to, that increases the conversation that has people talking in a knowledgeable way about their own mental health problems or being able to notice that someone else could be - a young person in a school is suffering and then to be able to say, let's go talk to someone because you obviously need some help. We have, as a community, to do more to ensure that conversation happens.

MS. LOHNES-CROFT: When you mention a cultural component, would that reach out to First Nations youth as well?

DR. COUREY: The LGBT community - we are becoming more and more aware that these young people are at higher risk for suicide, so we have to look at the factors that might be contributing to that and encourage, for example, the - I was going to say Gay

Straight Alliances in schools, but the language has changed - Gender Sexuality Alliances in schools to help increase young people's sense of being accepted for who they are, at the same time working on improving access to mental health services in schools so that kids can access them. Again, really, this is about changing our whole culture. This is beyond just mental health and addiction services.

MR. CHAIRMAN: Mr. Stroink.

MR. STROINK: I guess Ms. Kitch over there in the corner hasn't said much today so I'd like to throw some questions towards the great things that are happening at the IWK, and I guess it would be a great note to end on: the positiveness that you and your team are doing specifically with the Garron unit and what is coming out of there and the achievements that you guys have coming out of there.

MS. TRACY KITCH: Certainly framed from the mental health strategy that was developed provincially, the IWK took the opportunity in 2012 to develop a strategic plan aligned to that strategy and we're very proud of the progress we've been able to make. The strategy had five pillars to it. Certainly enhancing the effectiveness and the efficiency of service delivery was number one. The transformation of the Garron Centre, our in-patient unit, is an environment that has allowed us to make those inroads.

Certainly we've seen increased access to care in the unit with certainly performing better on length of stay when compared to our national peers, and an environment that has completely transformed the experience of care for children, youth and families. That has happened, I think, as a result of the call to action in this province and the support of many donors in this community to make that happen.

It's a 16-bed unit and it is completely connected across the province so children and youth that need access to care across Nova Scotia will be referred to the Garron Centre. Although we see many of our referrals from the Halifax region, based on the population and the demographic, approximately 30 per cent to 40 per cent of our admissions come from other parts of the province and throughout Nova Scotia.

The strategy also included really thinking about mental health and mental illness in a much more integrated way and so we've also improved some of our services. Certainly you heard earlier about the CAPA program - the choices approach to treatment - and we've seen great success within our community programs where children and youth and families can self-refer and access to that model of care within the community. As Dr. Courey said, we hope to see that and we intend to see that expanded across the province. With that, we've seen an increase of referrals by about 25 per cent and a decrease in wait times by about 63 per cent over the last three to four years as that has been initiated.

We've taken inroads with the strategy to work in a much more integrated way across sectors and with schools, and you've heard that mentioned today with the

SchoolsPlus program and some of the capacity-building that we've done with teachers and Dr. Stan Kutcher in the school environment.

One of the things we're most proud of, in addition to those pillars of the strategy is, as we said earlier, the need to focus on research, data, evaluation and outcomes. We can make a lot of inroads in terms of how our children and families access care, but the big question is - is it making a difference? With the generous donation of the Sobey family, we just introduced the Chair in Child and Adolescent Mental Health Outcomes, and that's held by Dr. Leslie Anne Campbell. She has started to work across this province with our mental health clinicians and with schools to really think about what those outcomes are, the data we need to look at to know that what we're doing and the care we're delivering is making a difference. We believe that's really going to help also change the conversation, not just are we able to access care, but is the care we're delivering adding value and having an impact on the children and youth and families we serve in this province.

MR. STROINK: I guess one of the exciting things, my understanding is that the length of stay, based on the new clinic that you've created in the IWK, has decreased. Can you share those numbers just a bit?

MS. KITCH: Yes, I have them with me and I can share those numbers. Originally on the in-patient unit we would have seen a length of stay anywhere from 10 to 16 to 24 days. That would be an average length of stay. We recognize that an admission to hospital for youth is not where they want to be, they want to be back out in their communities with their families and their schools. Over the last number of years that length of stay has decreased to an average length of stay of about eight days.

The idea there is they are admitted, they are quickly stabilized from their acute care experience and then transitioned out into the community where we can really put the supports around them to ensure they have the ongoing supports they need, which is often not just an acute experience of mental illness but a chronic trajectory where we want to support the mental health of our children and youth.

MR. STROINK: Listening to you speak it's pretty remarkable what you have accomplished in your short time there. You're very fortunate to have such a strong team with you to develop this program and to make sure that our youth are supported in our communities across Nova Scotia, not just in Halifax.

I guess a lot of that is changing as technology plays an aspect of mental health. More and more kids are using their phones or their iPads to source out help. How are you guys dealing with that?

MS. KITCH: That is an area where we've identified we could be doing a lot better, how do we become much more mobile-connected with our youth? As Dr. Vaughan mentioned earlier, we have used technology with access to community services and the booking of the CAPA-based clinics. We have identified over the next number of years, as

our strategy transitions in 2016 in sunsets, we would like to do a lot more to ensure that we're using technology to help navigate and coordinate care with our children and youth, not just locally but . . .

MR. CHAIRMAN: Order, thank you. I'm sorry to have to cut you off, we are running very short on time. I just want to mention that we have an in camera briefing with the Auditor General's Office immediately following this meeting.

We had a piece of correspondence from the Nova Scotia Health Authority, that was information requested from the January 27th meeting. Our next meeting is February 24th with the Department of Finance and Treasury Board to discuss Chapters 2 and 4 of the Auditor General's November 2015 Report.

I would like to give the department - we have less than a minute left, Dr. Vaughan, if you'd like to provide some quick closing comments.

DR. VAUGHAN: Mr. Chairman, in closing, I want to acknowledge that the burden of mental illness takes a heavy toll on many lives in Nova Scotia. We also know though that there is hope. We know that Nova Scotians live with these health conditions every day. They succeed in their lives living with mental health issues. For many it is a chronic condition.

Our job is to use the best available evidence, the most accurate evidence to drive decision making so we can support people in living healthy, productive lives. As a province, we are getting better at delivering programs and enhancing care. By working with our partners and communities across the province we continue to provide the supports and services to people who need them.

I leave you with one final quote from Michael Porter from Harvard, published in *The New England Journal of Medicine* this month, "The arc of history is increasingly clear: health care is shifting focus from the volume of services delivered to the value created for patients, with 'value' defined as the outcomes achieved relative to the costs." Thank you for your attention today.

MR. CHAIRMAN: Ms. MacDonald, we've pretty much run out of time. If it's very short, I'll permit you to make a comment.

MS. MACDONALD: Thank you. If you will just indulge me, I appreciate it, and I know members of the committee will as well. I just want to thank Lynn Cheek for all of the work that she has done. I don't know if members of the committee are aware, but the reorganization of the department has meant that the position that Lynn currently is in is no longer there, and she has been really a key piece of having a mental health strategy in Nova Scotia.

We rarely get an opportunity to publicly acknowledge and thank the officials who do the heavy lifting in the department, so I would like to take that opportunity to thank Lynn and wish her very well in whatever lies in front of her.

MR. CHAIRMAN: Thank you, Ms. Cheek, for your work for the people of our province. With that, we will take a short recess.

[The committee adjourned at 11:01 a.m.]