HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, April 25, 2018

Legislative Chamber

Mental Health Strategy

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Public Accounts Committee

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Legislative Committee Clerk

Mr. Gordon Hebb,
Chief Legislative Counsel

Ms. Nicole Arsenault,
Assistant Clerk, Office of the Speaker

Mr. Terry Spicer,
Deputy Auditor General

WITNESSES

Department of Health and Wellness

Mr. Denise Perret,
Deputy Minister

Dr. Charmaine McPherson,
Executive Director - Risk Mitigation-Primary and Acute Care

Ms. Jennifer Heatley,
Project Executive - Risk Management-Health Promotion

Dr. Alexa Bagnell,
Chief - Department of Psychiatry,
Mental Health and Addictions Program,
Mental Health and Addictions
IWH Health Centre

Ms. Jocelyn Vine,
Vice President - Patient Care and
Chief Nurse Executive
IWK Health Centre

Ms. Maureen Brennan,
Director - Mental Health and Addictions
IWK Health Centre

Nova Scotia Health Authority

Ms. Janet Knox,
President and CEO

Ms. Lindsay Peach,
Vice President - Integrated Health Services-
Community Support and Management

Ms. Samantha Hodder,
Senior Director - Mental Health and Addictions

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, APRIL 25, 2018

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Gordon Wilson

MR. CHAIRMAN: Order. Good morning. 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 with us to discuss the mental health strategy, and I would ask everyone to place their phones on silent so we don't have interruptions this morning.

We'll begin with introductions.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: Thank you. We will have opening comments, I believe, from a couple of the organizations here at least. Who would like to begin - Ms. Perret?

Ms. Perret.

MS. DENISE PERRET: Good morning. Thank you very much for the invitation to be here on the topic of mental health and addiction.

Providing access for Nova Scotians to the health care services they need is a priority for this government and for the Department of Health and Wellness. Key in this priority is the government's goal and investment in strengthening and improving access to mental health and addiction programs and services.

For too long mental health has been the second cousin of the health care system and that's true for this province and throughout Canada, and we see the effects of it. There are challenges in the system, demand is high, wait-lists are too long in some cases, some specialists are hard to recruit, and people don't always know where to go for help. But this situation is starting to change. We are at a point as a country where there is a growing recognition that mental health needs to be valued and have the same priority as physical health.

The challenge is that mental health and addiction services have often been brought into the public health system in an incremental and often sometimes ad-hoc fashion - it's a bit like the prescription drug circumstance that we have a broad landscape of services that are publicly paid for, privately paid for that might be provided through employer benefit plans.

As we facilitate the move to a much stronger publicly funded system of services, we're focused on a number of things. We know we have to create larger capacity in the public system to facilitate and enable better access for all Nova Scotians. This includes hiring more clinicians and putting in place effective navigational services. We also want to connect and integrate with non-profit service providers because this expands system capacity and helps to build a more comprehensive and cohesive system.

We need to have a fulsome continuum of services from health promotion through early intervention and treatment through to addressing and treating complex mental health and addiction needs. An example of this effort to build the continuum are the steps being taken to facilitate connections between youth health centres, SchoolsPlus clinicians, and primary care services for children and youth.

As well, we need to determine how emerging virtual health technologies can play a role in this space because there are very interesting developments happening on the technology front, with encouraging outcomes and results. We need to ensure that we make the right investments in this area, that these investments give us positive outcomes, that they're safe, and they deliver the expected benefits.

There are many individuals and organizations that are part of this work to build a more comprehensive system, some are here today and others are in the community doing this work. Very briefly, the Department of Health and Wellness is the policy and funding arm of the system, and the minister's charge was setting the strategic direction for the health system. The two health authorities that are here today are responsible for organizing and delivering the health services. Two departments that play important roles that aren't here today are the Departments of Education and Early Childhood Development and Community Services.

There is also a tremendously important contribution being made by researchers and innovators, and we need to maintain and grow this connection. Two that you will be aware

of would be the work of Dr. Stan Kutcher, who provides important expertise and advice to the Minister of Health and Wellness; and also Dr. Patrick McGrath, whose work in establishing and growing the Strongest Families Institute has provided accessible and practical support to youth and families.

Nova Scotia is fortunate to have dedicated and skilled service providers in its non-profit sector, and in its public health authorities. We also have organizations like Laing House, MacPhee WorkShop, the Phoenix Centre For Youth, that provide service delivery models that merit support and possible growth. Finally, within all of these organizations, we have dedicated staff and workers who are on the front lines doing true public service, and I want to acknowledge their work in delivering quality mental health and addictions care to Nova Scotians.

So, again, we appreciate the opportunity to be here and to be part of this discussion.

MR. CHAIRMAN: Thank you. Ms. Knox.

MS. JANET KNOX: Good morning, and thank you for the opportunity to be here. This is a very important subject for Nova Scotians. Leading healthy, flourishing, and productive lives is a top priority for our citizens. Positive mental health and living a life free from the harms, risks, and injuries associated with substance use and gambling are fundamental to reaching this goal. Without mental wellness, hope, and the possibility of recovery, it's hard for people to live healthy lives and contribute to their community in a meaningful way.

The prevalence of mental health disorders and harmful substance use is high among Nova Scotians. In any given year, one in five people is living with a mental health problem. One in seven will experience a substance use problem at some point in their lives. When we include families, caregivers, and communities, every Nova Scotian is impacted in some way by these health conditions. We know some people and their families are waiting too long for the care and support they need. Sadly, many people who need services are either not getting the help they need, or may not ask for help at all, because of the pervasive stigma and discrimination that continues to exist.

Over time, we have seen changes in the people who use our services, the complexity of their needs, and how they may best respond to support. We are building ways to match those needs with strengthened community supports, technology to maximize access to specialists, and mechanisms to evaluate the impact on recovery and well-being. Our team is focused on improving the experience of patients, clients, and their families, while helping to support their road to wellness and recovery.

Historically, there have been some fairly fundamental differences in how mental health and addictions services are provided and supported across our province. Our task as a health organization has been - and will continue to be - to work with our leaders, with

providers, funders, and consumers to examine, implement, and evaluate the changes that are required in our system, so that it is better integrated around the needs of our people and promotes positive mental health and supports recovery for all.

The document we included in your packages, entitled *Milestones On Our Journey: Transforming Mental Health and Addictions in Nova Scotia*, is intended to serve as a framework to help further guide the development and implementation of a provincial model for promoting positive mental health care and support in Nova Scotia. In planning, we have reviewed the analysis of others, of mental health and addictions in Canada and across our province. We have taken the opportunity to ask profound questions about the people we serve: What services we should be offering, and how to ensure those services are based in evidence and responsive to the individual, to their families, and their community? The collective message is that the system change is long overdue, and we need to produce much better data in order to make decisions to improve our programs and results.

Our commitment is to ensure that people and their families have access to a fully-integrated continuum of high-quality services and supports from health promotion to intensive treatment and support. Movement within the continuum of care must be smooth, patient, and family centred, and our relationships with community strong to help people be well and stay well. People and their families have better and timelier access to a range of care and supports in their community and in our schools. We must focus on reducing stigma and discrimination, and we must focus on promoting positive mental health, hope, and recovery for our citizens.

The work we have begun will take time to do in the way that Nova Scotians deserve. We are making considerable progress, yet there is much more to do. We are and we will continue to move forward with a well-defined direction, excellent partnerships, and the drive to achieve excellence. Mental health and managing harmful substance use and gambling requires the attention of many sectors of our society. Beyond our services, it's clear that workplaces, our many partners, our communities, and many others can have a positive impact. I would say we want to make sure that our impact is purposeful, that our goals are clear. We all have a part in this to ensure success for Nova Scotians.

In closing, together with the IWK and the Department of Health and Wellness, we are designing a responsible, accessible, effective public system informed by evidence and one that must be easy to navigate while keeping the recovery, well-being, and positive mental health of individuals and their loved ones at the centre of all our work. Thank you.

MR. CHAIRMAN: Thank you, Ms. Knox. We have the Department of Health and Wellness and the Nova Scotia Health Authority, but we also have the IWK and we will have opening comments from them as well. We will hear now from Ms. Vine.

MS. JOCELYN VINE: Thank you very much for the opportunity to discuss the important topic of positive mental health and mental health and addiction services for Nova Scotians. Providing a supportive environment early in life is critical to healthy growth and development. In addition, early supports focusing on emerging mental illnesses should be readily available in ways that suit children, youth, and their families, and maximize their ability to stay engaged in positively functioning in their normal activities.

The needs of children and youth require particular attention, as demonstrated in the 2017 UNICEF Report Card on child well-being. The report highlighted that Canadian children are not doing as well as those of other wealthy countries, particularly in the areas of health, protection from violence, and overall well-being. Progress on poverty and food security is key to creating a healthy future for children, youth, and families. We recognize this challenge on a system level and work closely with government and community departments - such as community services, justice, and education - to respond to the needs of families.

The IWK mental health and addictions strategic plan has created extensive program transformation to redesign our internal services to ensure they provide well-coordinated and evidence-based continuum of care that is responsive and effective in meeting the needs of children, youth, and families. We have added a major focus on creating partnerships and opportunities to collaborate outside of our services and in partnership with other key community providers who work with children, youth, and families. Through strong collaboration, we've been able to expand our reach within the community and benefit from the expertise of other care providers to better meet needs.

The IWK works very closely with the Nova Scotia Health Authority realizing many opportunities within a provincial model of care for children and adolescent services. Through this work, we have endorsed a stepped model of care that matches service levels to the treatment need. As well, we work with our many community and government and health partners. The IWK is focused on working with children, families, and youth to design services that best meet their needs as close to home or school as possible. We are working collaboratively to strengthen the important connections to ensure smooth and safe transitions and to share opportunities to improve.

Inpatient and intensive intervention programming is available when needed. We are working closely with the Department of Education and Early Childhood Development on the recommendations from Inclusive Education and we welcome the opportunities provided through the shared focus on the needs of children and youth. Working together is the path to success.

The IWK has been making transformational and evidence-based changes to our mental health and addictions services and programs in close collaboration with NSHA to ensure that services for children and youth, not only at the IWK but throughout Nova Scotia, are the best they can be. These changes have been based on five key areas: the

principles and practices of patient- and family-centred care; the implementation of the choice in partnership approach, which works on the goals of the child and family; evidence and best practice for delivery of services; co-design of services in partnership with patients and families; and the principles of trauma-informed care.

[9:15 a.m.]

In addition, we have introduced significant investments in improvement methodologies within the program. We have been able to redesign processes based on what patients, families, and our teams tell us are needed. Through these project investments and the expertise of our teams, we have been able to significantly improve timely access to care, and we continue to spread those improvements across our programs and clinics.

Another important area of focus is ensuring that our team members are supported and have the learning and research opportunities they need to build successful careers right here in Nova Scotia. Our work is showing very positive results as we begin to improve access and the ease of navigation across the continuum of care so that children, youth, and families, can move smoothly across services and back to their everyday lives with the supports they need within the local mental health and addictions teams and within the school environment.

We must continue closing the gaps for children and youth across Nova Scotia. There is much work ahead for the IWK, the NSHA, and all of our partners. We are focused and committed to continue transformation toward positive mental health and excellence in care and services. Thank you.

MR. CHAIRMAN: Thank you. We will start with Mr. Houston of the PC caucus, for 20 minutes.

MR. TIM HOUSTON: Thank you for the introductory comments and for being here this morning.

Ms. Knox, the deputy referred to needing to expand capacity in the system - clinicians and doctors. I have to ask you off the top - why wasn't Nova Scotia represented at the recent recruiting seminar?

MS. KNOX: Are you referring to the education session for rural family physicians in Newfoundland and Labrador?

MR. HOUSTON: Yes.

MS. KNOX: We have a robust recruitment strategy for physician recruitment. What we have found in our work with residents and learners who are in medicine is that direct contact is the best approach. Our strategy was a personalized direct strategy with the

residents in Atlantic Canada, to be present with them alone. We went to Newfoundland and Labrador to meet with the residents two weeks before that session.

MR. HOUSTON: Okay, so you didn't see the value in that particular session?

MS. KNOX: The decision was made that our best value would be in independent, direct talk with them.

MR. HOUSTON: The Premier insinuated in the House here in Question Period that he was basically appalled that we weren't represented. Do you disagree with the Premier on that? Is he misinformed?

MS. KNOX: I would not comment on the Premier's views. What I would say is that we make the best decision that we can in terms of where we're going to get the best return. That was the decision that we made.

I truly do understand in terms of people wondering why we were not at every opportunity. We have a very robust strategy. Next month, we will be at another national meeting with three times the number of rural physicians, but also nurse practitioners and medical students go to that session in Ontario. So, you make your choices, so thank you for your question.

MR. HOUSTON: You maybe have a different strategy than all the other provinces, I guess. They were represented; we weren't. It's pretty close geographically, Newfoundland and Labrador. I guess, if I may, I'll just leave it at that. You had a different strategy than everyone else.

MS. KNOX: We do believe we need a different strategy than other provinces because we are actually in direct competition with the other provinces. You need to think about where you are, sitting next door to a province with all of them there or spending dedicated time with individuals to help them see how important they are to Nova Scotians and that we really want them to be with us. Those are the decisions you make.

MR. HOUSTON: One might argue that a personal contact two weeks before, and then a follow-up at a major conference might make sense too, but we'll leave it at that for now.

Wait times for adult mental health community-based services are pretty high. We are talking about services that can assist with anger management, anxiety and stress management, depression management and recovery, and the wait-lists are just too long for these.

You referred in your comments about the services that the province should be offering. I assume that these types of services would fit that category, that the province

should be offering these types of services. I see some nodding in agreement, so they should be offered.

I went to the website and picked up the wait times between July 1 and September 30, 2017, and these are the wait times; I want to read them off, if I may: Cape Breton Regional, 363 days; St. Martha's Regional, 215 days; Valley Regional, 114 days; Hants Community Hospital, 95 days; Aberdeen, 91 days; Cumberland Regional, 83 days; Cole Harbour Place, 63 days; and Inverness Consolidated, 52 days - I added that one for you, Mr. Chairman.

Pretty long wait times, in my mind. You referred, in your comments, that your commitment to the people is that families should have access to the services that they need. Are these wait times too long, and what is an appropriate wait time that would be acceptable to the Health Authority?

MS. KNOX: I'll start and I'm going to ask Sam Hodder to talk about the wait times because she has the data and the information.

Thank you for raising this issue. What we are talking about in terms of - we do need to understand what the needs of Nova Scotians are and we need to develop our services so that we can respond appropriately to those needs.

Across this province, as our deputy has said, our past has been an incremental offering or enhancing services, but not in a uniform way so that we can say that this service is uniformly available across the province for Nova Scotia. Hence, when you talk about different wait times for services, it's because our history has been not a plan that access would be the same across the province. I will ask Sam Hodder to talk about the wait times and what we are doing.

MR. HOUSTON: Sure, and are the wait times too long and what is the appropriate wait time?

MR. CHAIRMAN: Ms. Hodder.

MS. SAMANTHA HODDER: So the wait times are too long; I just want to acknowledge that. Particularly, we know that they are waiting too long and the Nova Scotia Health Authority, in collaboration with the IWK, are committed to changing those wait times.

What I would say is that wait times are one measure in terms of the overall performance of the system. Through our planning efforts that have been identified within the milestones report, we've made a commitment, as well as the Department of Health and Wellness has made that commitment, to invest additional resources into our community-

based clinics which are what those wait times are representing on the provincial wait time site.

I would like to speak specifically to the problem with the way the wait times were historically reported. They are very disjointed and variable across the province, meaning that the bands and the level of urgency or priority wasn't necessarily reported on, so those wait times don't distinguish between triage level or a person's need. They don't reflect urgent wait times nor do they reflect regular wait times. Our commitment is to look at the bands of the wait times and putting in appropriate benchmarks that are linked up to national level standards in terms of what those wait times should be.

We have made a decision to move to a two-band system which is in sync with where the IWK is, as well. Our urgent would be a seven-day wait and our regular would be a 28-day wait.

MR. HOUSTON: Seven days for urgent and 28 days. So, Aberdeen at 91 days; some of those people are urgent and they are waiting 91 days, right? That's what's happening right now? Is that true?

MS. HODDER: I'm not sure how you would know whether or not they're urgent.

MR. HOUSTON: So the information is not available. How long will it take to transition the system to this new wait-time system?

MS. HODDER: We've already started to implement actions in terms of identifying our information system to be able to record those wait times. There are many different ways that people across the province were registered, and the way that the wait times were input into our actual data system. However, there are also things that we need to improve on in terms of our system level change from a clinical perspective, and a triage perspective, for people who are accessing our service provision. Our target for reporting on those provincial wait times will be quarter one this year, and we will have those available in August.

MR. HOUSTON: Okay. Ms. Knox, have you read Todd Leader's book, *It's Not About Us*?

MS. KNOX: I have. I read fast.

MR. HOUSTON: I've read the book, and it seems like he makes some good points. We don't need to recreate the wheel. They were already doing some good things in certain areas of the province. Does his book have validity to your mind?

MS. KNOX: What I would say is that we are doing a lot of good things around the province and we want to maximize all of that. When we talk about evidence, we need to

be open to all evidence, use what others have learned and maximize that. That's our best resource.

Whatever good evidence is available - this is not about recreating. There is a lot of work done in this province and in Canada. Our issue here, as we've been saying, is that we need to have a plan that says all Nova Scotians should have access - it doesn't matter where you live - and use our best evidence to create those services across our province. So, yes, we use all evidence.

MR. HOUSTON: Do you use Todd Leader as a resource?

MS. KNOX: We have not consulted with Todd Leader recently.

MR. HOUSTON: The deputy referred in the opening comments to a much stronger publicly funded system. Ms. Knox, you referred to working with the funders to improve the system. Obviously, that's a big thing - who is going to pay and how much.

The Auditor General stated that the mental health budget is around $255 million. The Premier said that budget is $287 million. In Budget Estimates, when discussing it with the minister, it was indicated that the budget for mental health and addiction services totals about $206 million. It seems to be that you've got the Auditor General saying one thing, you've got the Premier saying different, you've got the minister saying something else different. Can you tell me how much the department is spending on mental health and addiction services?

MS. KNOX: I think that's a question for the Department of Health and Wellness. I would just say, our budget would refer to the services that we provide. As our deputy has said, mental health services are provided in schools, in communities, in hospitals across our province, so there are different budgets. When Nova Scotia Health Authority talks about our budget, it is about the budget that we have to provide the services for which we are accountable.

MR. HOUSTON: How much is that?

MS. PEACH: The budget for 2017-18 for the Nova Scotia Health Authority is $172,855,000, and that's for mental health and addictions.

MR. HOUSTON: $172 million. Okay, deputy, the Auditor General referenced a number of $255 million. The Premier called the number $287 million. The minister called it $206 million. We now know that the Health Authority believes their budget is about $172 million. As the deputy, how much is the province spending on mental health and addiction services?

MS. PERRET: The estimates - and I'll give you some of the component parts - the number would be $287,097,900, the budget for mental health and addiction services. Some of the larger items in that are in-patient, which is over $56 million. We have community mental health, which is over $96 million. We have physician services based on psychiatry, over $50 million. We have mental health pharmaceutical and drug costs and that's over $30 million, then it breaks down a bit further. But when you add those types of component parts together, it is just over $287 million.

MR. HOUSTON: I do want to go back to the community services element because that's where the wait-lists are so long. So, does the department or the Health Authority have - is $50 million enough, or how much do we need to spend to get those wait-lists down?

MS. KNOX: So, what the question probably is, is what do we need to do? I think we'll answer that question by talking about what our investments have been in the past year and what we've done with that, and I'll ask Lindsay Peach to start with that.

MS. LINDSAY PEACH: I think to answer that question - there are really two considerations. One is, how efficiently is the current system working in order to address the wait-lists; and secondly, what resources are actually required to meet the needs of the population. It's a two-fold approach that we need to take.

I think certainly, as we've spoken about already, the work that's happened as part of our health services planning to really plan for a stepped-care approach for mental health and addictions, so that we're able to provide the support to individuals who need that level of support, and also work with our community partners who are able to support individuals who maybe have a lesser level of need or are able to support themselves.

From a community clinic perspective, as Sam has indicated, the wait times don't reflect individuals in urgent need . . .

MR. HOUSTON: Well, we don't know that. Sorry, I just want to be clear on that, because what I took from Ms. Hodder's comments was that we don't know that. We don't know if people who have been waiting 91 days at the Aberdeen are urgent or not urgent. Are you insinuating that we do know that?

MS. PEACH: Sam can clarify.

MS. HODDER: I think you misunderstood my comment there . . .

MR. HOUSTON: It happens. (Laughter)

MS. HODDER: . . .because I wasn't saying that we don't know that. I was saying that to make the assumption that we don't know that, but you - that that's inaccurate.

Our central intake across each of our areas, or each of our zone management areas, has established significant triage criteria that distinguish people on their level of care needs. So they would be triaged in accordance with level of urgency, or level of priority based on the presenting problem and then matched with the appropriate level of care. That clinical decision would be happening at the clinical interview at the intake level, and that is currently happening right now.

MR. HOUSTON: Okay, and when did that start?

MS. HODDER: We had started that - it was a bit of a phased approach, but I can give you an example within Cape Breton, because of the pressures that were there in relation to the wait times. Last year, we actually looked at the system within the industrial Cape Breton area and implemented specific triage guidelines one year ago, borrowing from the Northern Zone and the work that they had commenced about six months prior to that, and identified the specific triage criteria there. We have made significant improvements in relation to the intake that's done in the clinical assessment, as well as the urgent care needs within Cape Breton.

MR. HOUSTON: Okay, I'll come back, but I want to - that's important so thank you.

The wait times that I found on the website were up to September 2017, so they're a little dated, for sure. They were Cape Breton Regional 363 days, so I guess since then the system has changed. What's the wait time at the Cape Breton Regional now at the various triage levels that have been initiated?

MS. HODDER: I can speak to that. It varies by clinic of service delivery, so people in Cape Breton weren't waiting too long. Right now, I had consulted with our colleagues in preparation for today's meeting and the standard of the urgent criteria within seven days after the clinical interview is conducted at intake, is being met.

MR. HOUSTON: Seven days? Okay, and…

MS. HODDER: For urgent level of care.

MR. HOUSTON: The standard for the 28 days, is that…

MS. HODDER: The standard for the 28 days is not being met in Cape Breton.

MR. HOUSTON: Okay, and do you have a number as to where we're at?

MS. HODDER: It varies between seven months and ten months.

MR. HOUSTON: Do you have similar numbers for the Aberdeen and such?

MS. HODDER: I don't have those.

MR. HOUSTON: Is that something you could get and provide to us? The Aberdeen you mentioned, when you said Northern was doing this even before Cape Breton Regional - I assume that's the Aberdeen.

MS. HODDER: Yes.

MR. HOUSTON: So they would have these numbers?

MS. HODDER: What I would say to that is our commitment going forward is to look at producing those reports for August in relation to our first quarter this year. There was a significant amount of work and action to think about that from a provincial perspective.

The other piece to this is around our access and navigation project which is requiring a provincial approach to conducting the triage and then matching the person's needs with the available services in the community.

MR. HOUSTON: Is it your belief that these wait times from September 2017 are much improved across the board?

MS. HODDER: I can't speak to that but when we do have the evidence to support whether or not they are being met or not met, we will provide that.

MR. HOUSTON: I have only a little bit of time here but which ones of these are using the new triage system? You say that Cape Breton Regional is - would St. Martha's Regional be using the new triage?

MS. HODDER: Yes.

MR. HOUSTON: And Valley Regional?

MS. HODDER: They're not.

MR. HOUSTON: Okay, and Hants Community?

MS. HODDER: They're not.

MR. HOUSTON: Aberdeen is. Is Cumberland?

MS. HODDER: The whole Northern Zone is, yes.

MR. HOUSTON: The whole Northern Zone is, okay. Cole Harbour?

MS. HODDER: Northern Zone and Eastern Zone, the two zones.

MR. HOUSTON: Inverness?

MS. HODDER: Yes.

MR. CHAIRMAN: You still have about 30 seconds, but if you'd like to finish there . . .

MR. HOUSTON: Thank you.

MR. CHAIRMAN: Thank you. We'll move to the NDP caucus and Ms. Roberts.

MS. LISA ROBERTS: My first questions are going to be to the deputy minister related to health funding and the transfer from the federal government. This year the increase in provincial health funding from the federal government was 3.5 per cent and we're expecting that will drop to a floor of 3 per cent annually for at least the next eight years.

According to a study conducted by the Institute of Fiscal Studies and Democracy at the University of Ottawa, the bilateral health funding deal that Nova Scotia signed is going to result in a loss in the long run because the macroeconomic health care cost drivers are expected to outpace the growth rate in the health transfer over the coming decade.

My question is, is there a written agreement that we can see where the details of that bilateral health deal are spelled out?

MR. CHAIRMAN: Who do you wish to ask the question to?

MS. ROBERTS: I'm sorry, that is to the deputy minister.

MS. PERRET: Thank you, an important question. The bilateral agreement is not yet public. We're still negotiating some of the terms with the federal government with respect to the projects being included in that. An important part of that, and you've heard the importance from earlier discussions here, is on measurement - how we're measuring, monitoring, and determining outcomes. That information will be out a bit later this year.

MS. ROBERTS: Can you explain why there are publicly available agreements and targets and commitments from New Brunswick, Newfoundland and Labrador, P.E.I., and the Northwest Territories, and yet Nova Scotia that signed a deal earlier is still negotiating the terms?

MS. PERRET: My understanding is that most of the provinces are still negotiating with the federal government on their individual bilateral agreements. Quite frankly, we

want to make sure we're using that investment money wisely. It gives us a space to try some of the new virtual technologies. It's going to be important that we have the right measurement and monitoring criteria in place.

MS. ROBERTS: How do we know even that this funding is going to continue at a particular level if there is no written agreement at this point?

MS. PERRET: The funding agreement itself was set out for 10 years. It's broken into two parts. The bilateral agreement will include - it's the identification of the projects and the outcomes anticipated by those projects in two five-year chunks. You have to reapply for those projects after five years, but the funding commitment itself has been set out and it's a 10-year commitment. We're not negotiating the amount of money; that has been determined at this point.

MS. ROBERTS: Do you have a date when we can expect a final agreement and when Nova Scotians get to see what we have committed to, what those commitments are?

MS. PERRET: I don't have a specific date. We would like to have that out as soon as possible, and the feds would like that out as soon as possible. Everyone is motivated to conclude this. The back-and-forth is actually quite constructive and instructive because, again, as you have heard, it's important to get some of the measurement tools right, and to make sure that we undertake projects that are going to have the outcomes that we're seeking for the population.

MS. ROBERTS: There was money that flowed to the province under that agreement this year, and for this budget year coming, correct? Can you provide a breakdown of how much of that targeted federal funding will be allocated specifically to mental health this year, and where it will be spent?

MS. PERRET: I don't have those figures with me today. We have those figures, and I can provide them. I will undertake to bring that information forward.

MS. ROBERTS: Can you give me an example, as you're negotiating, of what sort of performance measure we're looking at that would actually reassure Nova Scotians that we're moving towards positive change in the mental health system?

MS. PERRET: For example, and this is tentative, because it hasn't been approved, I mentioned earlier the work of Dr. Pat McGrath on the Strongest Families Institute. That work is expanding into caregiver support, and being done through virtual means and support groups. We're interested in whether we could incorporate that type of technology into the work we're doing to support people in the community.

We support caregivers financially. We want to expand those types of supports through technology that monitors people in their home or helps with lifting patients and

the like. Because caregivers have anxiety and depression, we're interested in how we can support them in that space as well.

These are the types of initiatives that are under discussion. Some of these initiatives are developmental. As I said before, the measures are how we know that it's an appropriate tool, that it's a safe tool, and that it gets the outcomes that we want.

MS. ROBERTS: Just to make sure that I understand things correctly, $287.8 million over 10 years is targeted to mental health. Is that mental health and addictions, both health authorities, I'm imagining?

MS. PERRET: I have to check the number, because I don't have the exact number before me.

MS. ROBERTS: Can you provide any insight into why the funding is not being distributed evenly over the 10 years?

MS. PERRET: I believe that the federal government came in on this and gave us a bit of start-up time before you sort of get to cruising altitude, as I would say. I think that's the primary reason.

MS. ROBERTS: Thank you. I reviewed, maybe not entirely in-depth, the Milestones report that was provided in our package; I guess it came from the NSHA. Part of me is just trying to understand how that relates to the work that engaged 1,200 Nova Scotians over years, which was the Together We Can mental health strategy.

As a relatively new MLA, this is one of my sources of frustration - that work done by one government can, with a change in government, seem to be irrelevant even though that work actually did not belong to the elected officials. It belonged to all the community agencies and the bureaucracy, the Public Service, which worked long and hard on that work, and was in service of Nova Scotians. It was not a Liberal report or an NDP report. It was a mental health strategy for Nova Scotians.

First, quickly, can somebody explain to me what the Milestones report is and how it builds on or relates to the Together We Can mental health strategy?

MS. PERRET: I really appreciate that question. I agree with you. I think too often really good work gets done and it gets shelved. The election cycle is disruptive in terms of building a system.

One of the decisions that we made in looking at the type of investment this government wanted to make and how quickly we could put that in play, and what policy and strategic documents were in place, is that this wasn't a time for people to go to their

cubicles and write another policy document. We need to look at the landscape we have and knit it together.

I want to say that documents like the Together We Can document is an extremely well-done document. When we looked at the principles and the values in that document, they are still relevant and they need to carry forward. We want that document to stay alive and, certainly, the front end of it to guide the work going forward.

[9:45 a.m.]

That work has been complemented by the efforts of both health authorities, and the department played a role in the Milestones document which gives you a stronger, in-depth look at what some of the current research is in the area, what organizations are in play, what the clinical structure is - they would call it the pyramid, the tiered system which I would call part of the continuum of care. It sets out in a much more specific fashion where we go off on those principles and values, and Together We Can, into a more structured clinical approach.

Then we have the benefit of the minister's Advisory Committee on Mental Health and Addictions which is still guiding the work of the department and the strategic view with both the recommendations it makes and it continues to advise the minister, and then Dr. Kutcher's report on Cape Breton which all plays into that.

So, if you have the mandate commitment for the minister and those documents, you really have the strategic overlay for the system.

MS. ROBERTS: Okay, thank you. At Public Accounts Committee on February 17, 2016, then-Deputy Minister Peter Vaughan said that Nova Scotians are experiencing greater access to mental health assessment, treatment, and care in their own communities, which suggests that evaluations of changes to the mental health system have already been completed. Is that true? Has there been evaluation of changes made under the mental health strategy?

MS. PERRET: So, the focus on measuring, and monitoring and measuring, is a really important point. I think probably what Dr. Vaughan was referring to, at least in part, was that the restructuring of the department after the consolidation of the health authorities was to focus on how we monitor the system, how we stop looking at inputs as much as we do, and start looking at outputs and outcomes.

That work is still in play. You heard the discussion on how we need to be much more diligent and have a robust more informative system of measures on wait times so that they actually have meaningful information for us. And so I would say it's not a measured system that's complete, it's still being built, in progress. The work on wait times is one example of that.

MS. ROBERTS: So, just to be clear, there has been no evaluation done of actions coming out of the Together We Can strategy - is that accurate?

MS. PERRET: I'm going to refer that to Dr. McPherson, if she wants to add to it.

MR. CHAIRMAN: Dr. McPherson.

DR. CHARMAINE MCPHERSON: I'm not quite sure what you're meaning in terms of evaluation, what level of evaluation. We have looked at the strategy and the various components in terms of whether they've been met - have we delivered on those, what's at play? We're looking at the entire strategy from an evaluation viewpoint in terms of reflection on the components and whether they've been brought into the public system.

MS. ROBERTS: I guess what I would be interested in is there an evaluation that has been shared with the minister. During the Committee of the Whole on Supply in conversation back and forth with the minister, when our Health and Wellness Critic asked about evaluation of the Together We Can mental health strategy, the minister said: When I talk about the review of the Together We Can strategy, it's really my review work that I was doing reviewing the document, not a formalized review - my assessment of the document.

So, it seems that there hasn't been - I mean, is there a review of the document or is there an evaluation of the work that has flowed out of the document and if there is such an evaluation, can it be shared with the public? Can it be shared back to the 1,200 stakeholders who participated in the development of the document?

MS. PERRET: I appreciate that clarity and the short answer is no, there isn't a formal evaluation document that we could share with you. It is the subject of much discussion and it informs a lot of the work that we do, but we are still building a system that's much more outcome-focused.

MS. ROBERTS: Okay, thank you. According to the master tracking dashboard of the Mental Health and Addictions Strategy, work on a sex, gender, and diversity review of mental health and addiction services had still not been started as of October 2017, nor had collection and monitoring of alcohol, drug, and gambling data.

Ms. Perret, could you provide some insight into why those aspects of the strategy have not been started?

MS. PERRET: The insight would be just the volume of work on our plate and priorities. Certainly it's not an indication of their importance. The reorganization of the department lagged behind the consolidation of the health authorities, and there has been

some work in staffing it up and orienting it and getting a new system in play, playing the role that hadn't been played in the past. So it is a lag time issue.

MS. ROBERTS: Last session the NDP caucus tabled legislation that would require the Health Authority to report publicly on several service delivery indicators. One of those was the number of days between an individual's first choice and partnership approach appointment and their admission into a community-based mental health program.

I wonder if someone could explain, first of all, what a patient can expect at a choice and partnership approach appointment.

MS. PEACH: Sure, I'm happy to answer that question. It's a great opportunity to provide some clarity. As we have indicated, with the wait times reporting, starting in the first quarter of this fiscal year, we'll be able to report on wait times to an urgent appointment; wait times to a regular appointment; wait times from referral to the first appointment, the choice appointment; and wait times from the first appointment to the second appointment, which is the partnership appointment. So I completely agree, and I will explain to you the difference between them.

The most simplified way of explaining it is, the choice appointment is really an opportunity for the individual to sit with a clinician and identify goals that they would hope to achieve through treatment and then, through a matching process, be able to match up with the best clinician to provide that support to them to achieve their goals. The partnership appointment is really the follow-up to that, which is an opportunity then to start on the work together to achieve the goals that have been established in the choice appointment.

MS. ROBERTS: Currently, do we have access to wait times between first presenting in some fashion to the system and that partnership appointment? I think what matters to people if you are in some sort of mental anguish is that that mental anguish is relieved. I am picturing that that really happens at that partnership appointment.

MS. PEACH: Yes. We recognize that as well, which is why we have also agreed and made the suggestion that we need to capture both points in the system. What we were identifying is that individuals may get into that first appointment quickly and then have a significant wait time to get to the second appointment. We want to make sure that we capture both so that we have a full understanding of the wait time issue and are able to focus our attention and efforts around that. Is it that people are waiting a long time to get into the first appointment, or is it that they are waiting a long time to get to the second? Right now the wait times just report the time from referral to that first appointment.

MS. ROBERTS: When can we expect to see a more meaningful reporting on wait times?

MS. PEACH: We'll be able to report on that for the first quarter of this year. We'll see those reports in August, as Sam had indicated.

MS. ROBERTS: Just drawing on the work in the Milestones report, the base of the pyramid, the fattest cohort of folks seeing some assistance who are less urgent - I don't know exactly who would be best to respond to this, but I'm struck by the fact that they are presenting to the system, in many cases, may be tied to living in poverty. Also in many cases, people living in poverty do not have access to the other services that people often seek out through employment assistance programs or through private insurance.

Would somebody just take that on in terms of the significant determining impact of living on low incomes?

MS. HODDER: I can take that. What you are referring to within the Milestones document is essentially what we're calling a tiered framework, or a tiered level of care, where that bottom base is actually representative of the general population. Our efforts to look at that would be around strategic approaches to healthy public policy and to look at the social determinants of health, keeping people well. Those folks in the bottom component of the pyramid wouldn't be seeking service provision from our mental health and addictions system.

MS. ROBERTS: So the base of that pyramid actually represents the entire population?

MS. HODDER: The base of the pyramid, what we refer to as tier one, would be that largest portion of the population. Those folks are not generally seeking help and could benefit from that strategic approach to reduce their harms, reduce the injuries associated with substance use, and promote positive mental health and well-being.

MS. ROBERTS: Okay, but when we were talking earlier about the current wait time reporting and how that includes folks who have been triaged, there would be a portion of people in that group who are experiencing distress. I'm thinking back to a constituent who said that she actually got into an appointment, and the clinician she spoke with identified that a significant contributing factor is the fact that she's living in poverty and that she's in constant financial stress. So she's not suffering acutely, she's not urgent, but she has life circumstances which are bad for her mental health.

MS. HODDER: So that would be a few steps up. That person that you are speaking about would be a few steps up in the actual pyramid. It might be helpful if we had a conversation about how that pyramid is actually structured and how we see that in terms of stepped care. I'm not sure if that would be helpful or not.

MS. ROBERTS: I think that would be fine. Am I out of time?

MR. CHAIRMAN: Yes, you are. Sorry.

MS. ROBERTS: I knew I was heading for 9:57 a.m. Maybe one of my Liberal colleagues will allow you to do that.

MR. CHAIRMAN: Ms. Lohnes-Croft.

MS. SUZANNE LOHNES-CROFT: Thank you for being here, and I'm learning a lot. There's good work going on, I can tell. There are some very bright people working to help in our mental health system, and I'm glad to hear that and to see that. You and your colleagues who work with you and do a lot of the work - I know it was a system that sort of didn't exist before, and you're trying to build it. Kudos to all of you who are bringing this together. It doesn't happen overnight, I realize that. It's going to take a lot of time.

I will ask you to do the pyramid after I ask an initial question. There was a lot of questioning about access and wait times. What do we do while we're waiting? I think that's an important message to get out to people while we're waiting.

I strongly believe in preventative health, mental health. There are things you can do. There must be resources in our communities now that exist. I know there's SchoolsPlus and other programs. I refer also to Pat McGrath's Strongest Families Institute.

What can we do while we're waiting? Some of the time periods seem really long. While you're waiting, surely there are community-based options or virtual - because I think that's where we're going. Our kids are accessing more and more online services, and so are parents. While we are waiting, what can we do? Maybe the pyramid comes in play in that. Whoever wants to respond to that, or maybe there's several people who want to contribute to that, what do we do while we're waiting?

MS. KNOX: I'm going to start, and Ms. Hodder will talk about what we're doing. It's a very important point you're making because all Nova Scotians need to hear that. While we understand the needs of Nova Scotians, we have to step in with the people who need help now. So it's a two-pronged process, planning to serve better now and into the future, and caring for the people who present now.

I'll ask Ms. Hodder to talk about how we do that.

MS. HODDER: There has been resource investment within the system that Nova Scotia Health Authority along with the IWK has begun to implement to answer that very question - models that are grounded in evidence and that we know are effective.

One of the examples would be our CaperBase Outreach team, which is really looking at early intervention and outreach services for youth at risk. The overall model started in Cape Breton many years ago - probably about seven years ago - and was

evaluated. It was funded originally through Health Canada under the Drug Treatment Funding Initiative. The robust evaluation was shared with the Department of Health and Wellness and they maintained the funding and sustainability of that program.

[10:00 a.m.]

When Dr. Kutcher did the visits and psych consultations in Cape Breton, part of the recommendation was about further enhancing and expanding that model of care - saw it as a value as well as the evaluation. So what we're doing and what the provincial approach to mental health and addictions allows us to do is scale and spread. We've enhanced the CaperBase Outreach Services in Cape Breton in response to that recommendation, so actually hiring people to be working in communities and schools for youth at risk.

We've also then linked up with the other areas across the province to be able to add additional resources and model that care. So within the Western Zone and within the Northern Zone, we are in the process of hiring youth outreach workers to be able to implement that framework and model of care to expand reach and access for youth at risk. That would be one example.

The other commitment that I would like to talk about in terms of actual resources is around our community mental health and addictions clinics, which will target and help with those wait times that we spoke about earlier, but we are adding additional mental health and addictions clinicians now to our complement. It started in Cape Breton because it was driven by need, and that's the whole lens that we're driving everything by - not just making decisions based on geographic location or history, but actually looking at the needs within the communities, and then targeting those resources to match those needs. So five additional clinicians have been targeted for Cape Breton from the last budget, and then this upcoming year we'll be hiring an additional 10 mental health and addictions clinicians across the province for resource investments.

The other piece is in relation to - and I think it speaks to that piece that we were talking about before around urgent care. We've looked at our crisis teams across the province and recognized that in order to better meet our benchmarks that we're setting in terms of our bands - because we're utilizing all of our key performance indicators to guide our resource investments as well - we've added additional complement to our crisis teams that will be armed from our crisis teams to be offering urgent care clinics within each of the areas.

So 13 FTEs have been targeted for that and I think we're over half staffed now to be meeting that urgent level of care needs. So at the same time that we're planning and projecting what the needs are, when needs are identified we're having those conversations - they're delivered and they're intentional - to meet our commitments to the Nova Scotia population and investing those resources where the needs are presenting.

Those are just some examples of what actions are being done to date while we're waiting to really facilitate that system transformation effort that we're talking about.

MS. LOHNES-CROFT: Following that, how is this being communicated to people who are accessing mental health and they're on the wait-lists? How are parents being communicated to on where to go for these resources?

MS. HODDER: I think that's a really great question because when we looked at our system and the access points - where do I call to get help when I need it - I started off when the Health Authority started in the Northern Zone, and we did a review over access points, and there were over 36 different ways to enter into the system, which is very complex.

MS. LOHNES-CROFT: Navigation.

MS. HODDER: Navigation. We were having conversations about hiring, and additional resources to navigate, when we should be just making the system easier for people to navigate. That's where our central intake - or Access Navigation is what we're calling it now - comes into play. That's a collaborative effort with the IWK as well, so we're adding additional resource investments and have a project team scoped out to create one number where Nova Scotians can call to get help.

So, it's "I need help", and then we'll help to do the sifting and sorting and help to identify if there's something we have within our system of service provision and care that best meets their needs and supports their recovery, or - in thinking about that stepped care model - is there something in community that would better meet their needs or match their needs? Is it a family doctor or within primary care that could help support or care for their needs, or is it something from the formal mental health and addiction system, or community organizations?

Getting that central access and navigation initiative up - and our target is next year, to have that up in place - I really think will help facilitate seamless delivery of care services for people within our system, as well as helping to facilitate access to other community-based services and supports for Nova Scotians across a lifespan.

MS. LOHNES-CROFT: So as an MLA - and I'm from rural Nova Scotia, so we can't always access IWK services like someone in HRM - I must say our mental health services have been fairly good. I know people don't know to say, put me on a cancellation list, because people get bumped up very quickly on the cancellation list.

As an MLA, I get parents calling me who just don't know how to help their child. I think we need to help parents, to empower parents. How do we go about doing that, empowering parents? They are probably the first person the child talks to. Parents themselves are stressed, they have so many stresses themselves, with work and raising

families, and some have financial issues as well. That's part of prevention, too, healthy bodies. We're reading more and more about less screen time for children, but then our education is encouraging screen time, using more tablets and iPads in the schools, so where are we going to get that balance?

I know children should be outside more, getting fresh air, good nutritious food, and then you have financial issues that sometimes prevent that. Would someone like to speak on that?

MS. PERRET: It's an important question. What I would say is that it's being addressed from a number of different streams. As Ms. Hodder said, you've heard some of the work that is going into building that core capacity in community clinics and to looking at how we systemize triage and get those most in need.

As well, we've got an initiative, and this has been guided by both the minister's Advisory Committee and Dr. Kutcher himself, on building out our Youth Wellness Centres so there is good information for youth, and that we are connected on the health prevention promotion basis. That needs to be, as Dr. Kutcher's directive, linked and connected into what we're doing in the SchoolsPlus, which is also being built out.

The mental health clinicians that support SchoolsPlus are connected to the 31 community-based clinics that we have throughout the province, and have access to additional resources. That's a very good connection for families and youth to make.

We've mentioned the Strongest Families Institute. I was talking to someone yesterday, a family with their child who had run through that program, who had nothing but good to say about how helpful it is in certain respects.

Another stream in early days, that will be growing, is through MyHealthNS, because what you want to have, and to your reference to people accessing tools on-site and supports on-site - Dr. Google, so to speak - we need to have a source of trusted health information, a source that parents and individuals can use to find mental health resources and other resources. Our platform for building that up will be through MyHealthNS as well.

Those are some of the initiatives that we are either growing or expanding or that are in play.

MS. HODDER: I would just like to add that one of the initiatives that we had committed to and started as a demonstration project, and you had mentioned it, was in relation to virtual care. I think that is a really exciting opportunity that we have for Nova Scotians, particularly those living in small towns and rural communities, in terms of enhancing or expanding our reach.

Last Fall, we did a demonstration project in relation to virtual care, utilizing a Medeo platform. We had 10 clinicians across the province participate. I believe just over 150 patients were identified as being appropriate to participate within that model of care. I believe there were 63 people who accepted an appointment, and then 49 actually completed the virtual care appointment. Most of those folks were from small towns or rural communities.

Going forward and thinking about innovative strategies, we need to be talking about virtual care. How does that enhance our reach? How does that help facilitate ease of access for a mom who is not able to get child care in place for her to attend a clinical appointment? How do we help someone who doesn't have access to public transportation in a small town or rural community or where the bus schedule for transportation means it's a day's event? Thinking about innovative and creative strategies to do that and to get our services out there, I think, is the way that we need to be moving forward. That's not to say that it is the only option, but it needs to be another option available for folks.

We had very good satisfaction rates, as well. We looked at implementing the evaluation which was talked about and commented on earlier. All of the initiatives that we are implementing have that process as well as an outcome evaluation component built into them because we want to know, going forward, if it's effective. Should we continue to spend our resources in this way? We had 94 per cent of folks who had participated say that they would utilize that service again, and 87 per cent said that they were, overall, satisfied with the level of care that they received during that virtual care visit.

The most common reason or issue as to why they were not satisfied was technical glitches. That's an opportunity for us to go back and look at how we educate folks and how we ease those technical difficulties so that we can make that experience 100 per cent positive for folks.

MS. LOHNES-CROFT: Who is most familiar with SchoolsPlus? When they first rolled out SchoolsPlus, it mostly involved the justice system and slowly has come about. It's growing, and it's growing in more areas and more schools. Can you speak about accessing it? I know it was a referral system within the school system, that the guidance counsellor or the principal referred to students to SchoolsPlus. Some people weren't aware of how it works. Can you give us some details on how SchoolsPlus works?

MS. PEACH: I can do that. I will start perhaps with a bit of a clarification that sometimes is not fully understood. The mental health clinicians who are part of the SchoolsPlus program are part of the Mental Health and Addictions program. They are mental health clinicians functioning in the school setting as part of a SchoolsPlus team.

As we mentioned earlier, one of the things that we quickly discovered, early in the days of the Nova Scotia Health Authority, was the extent to which some of the services varied, even though they were provincially implemented or initiated as a provincial

program. SchoolsPlus was one of those examples. How those clinicians were working was quite variable across the province.

We have undertaken work - together with our partners at the Department of Education and working with the IWK and the Nova Scotia Health Authority - to establish some clarity around the roles and responsibilities of those mental health clinicians, how they function within the school setting, and how they function as part of the SchoolsPlus team, and we're certainly seeing some of the success coming from that clarity.

[10:15 a.m.]

The other thing is, we've seen some significant investment in SchoolsPlus mental health clinicians over the last number of years. Just to paint a bit of a picture around the visits provincially, between 2014 and now in 2017, we've seen a 55 per cent increase in the total visits associated with SchoolsPlus. We're certainly able to reach children where they are and as Ms. Hodder had mentioned, through the CaperBase expansion initiative, we're also able to reach youth who aren't in schools.

So, it really is that combination of the two initiatives to build resiliency, to have early identification of individuals when they do require some more intensive support, and to be able to pick those individuals up early and refer them to other parts of the system when we need to.

MS. LOHNES-CROFT: Great. Do we have time to talk the triangle?

MR. CHAIRMAN: You have one minute remaining.

MS. LOHNES-CROFT: Well, can we do some work on the triangle?

MS. HODDER: I'll try to do it in a minute. Basically, what the pyramid does is it's what we're calling stepped care. The overall goal is to operationalize service delivery to ensure that there's access and transitions at each of those steps, and an overall engagement approach to patients and families when they need us.

Tier one is at the base of the pyramid and those folks likely don't need mental health and addictions-related care from the formal system. They're folks in the population that benefit from overall health, wellness, keeping people healthier, looking at healthy public policy - whether that's reducing alcohol-related harms, cannabis policy, all those sorts of things.

Tier two is really around the fundamental role of primary care and other community-based organizations. People may be experiencing mild . . .

MR. CHAIRMAN: Order. I'm sorry, time has expired for that round of questions. We'll move back to Mr. Houston of the PC caucus, this time for 11 minutes.

MR. HOUSTON: My colleague was talking about families and interaction with the system and I do want to acknowledge the work of the IWK with the Garron Centre and stuff, some terrific work. You'll notice you're not getting many questions - there's a reason for that, so keep up the good work there.

We're talking a lot about wait times and understanding wait times and that's good, I'm happy that that's being done. It's four years since the Health Authority started, so it's good that that information is getting assembled at this stage, but the question then becomes, what do we do going forward? Once we have the information, how do we get the services to the people? That's really what the question is now - what's the strategy?

What would the Health Authority do if 25 psychiatrists dropped down right now - would you have a plan? Would you send them back? Is it too many? Is it not enough? How many psychiatrists do you need to add to the system and do you know what to do with them if you have them?

MS. KNOX: I just want to say it's three years and not four. We do expect to see a very big difference in an additional 12 months of this very focused activity and, in terms of recruitment of psychiatrists, that's a major challenge for Nova Scotia and for across the country. Our goal is to be very focused and take as many as we can, and Lindsay Peach can tell you the numbers that we are looking for.

MR. HOUSTON: How many psychiatrists do you need to add to the system?

MS. PEACH: Current vacancies that we're recruiting for is 22.5. We do recognize we have significant challenges with psychiatry, and a number of things have happened over the last year that have created some situations with vacancies that were unanticipated. I would say as context to that, we also have two pieces of work that we're doing. We are doing work with psychiatrists to look at their role within the Mental Health and Addictions team, to really make sure that we are maximizing that resource within the team. So that's a piece of work that we're doing together with them.

The other thing that we've undertaken, particularly identifying the challenges with psychiatry vacancies - both in Northern Zone and in Eastern Zone, particularly in Cape Breton of Eastern Zone - we've done work with Central Zone psychiatry and have just recently started last week a tele-psychiatry option so that we do have psychiatrists in Central Zone that are providing that support through technology to support clients and individuals living in both Eastern Zone and Northern Zone.

MR. HOUSTON: Thank you. So 22.5 - is that just to kind of get to the base level? What's the real level that we could provide really good service to Nova Scotians?

MS. PEACH: That would be the number identified in the Physician Resource Plan.

MR. HOUSTON: What is that number?

MS. PEACH: The total number is 132.1.

MR. HOUSTON: Psychiatrists?

MS. PEACH: Yes - for the whole province.

MR. HOUSTON: That's what we should have? And we have . . .

MS. PEACH: We have 22.5 vacancies.

MR. HOUSTON: So the 22.5 - those are actual positions that people left?

MS. PEACH: Vacancies.

MR. HOUSTON: Those are positions that people left. So that assumes that we had enough, but what I'm asking is, did we have enough? In other words, if you have one psychiatrist and they leave you have zero, but maybe you needed two to begin with, but you only had one. So I'm trying to get to what the real . . .

MS. PEACH: The number identified in the Physician Resource Plan is 132.1, but as I mentioned earlier, the context around the role of psychiatry is work that we're doing - so what is the right number is planning work that we're undertaking with psychiatry.

MR. HOUSTON: So you don't know the right number then.

MS. PEACH: We know the number identified in the Physician Resource Plan.

MR. HOUSTON: But are you comfortable that that's the right number?

MS. PEACH: I think that's the number that was identified based on that planning, but again, we're doing work with psychiatry around the model of care and their role within it.

MR. HOUSTON: What year was the Physician Resource Plan updated that came up with the number of 132.1?

MS. PERRET: The Physician Resource Plan is updated every two years. You'll see a new update coming out shortly. We have Dr. Wilson working on that. He has travelled the province extensively, meeting with all the specialty practice groups. He is also looking at both the numbers that are projected - Ms. Peach made an important point - but also the

clinical setting and the clinical requirements because this is a Canada Health Act issue. Back in the day, you could access psychiatry resources for free - not so much in a community for psycho-social.

Part of the transition that's taking place in the country is appropriate care and getting the right care. It's an important point because we don't want to have health care profession shortages. We want to use health care professions to full scopes.

MR. HOUSTON: Dr. Wilson is updating the Physician Resource Plan. When do you expect a draft or something of the Physician Resource Plan?

MS. PERRET: It is near completion.

MR. HOUSTON: Have you seen a draft?

MS. PERRET: I have not seen the draft yet.

MR. HOUSTON: Has anybody with us today seen a draft? So near completion - what do you expect, within the month or when would you expect to receive that report?

MS. PERRET: I'm not sure if it's within a month. What Dr. Wilson is doing right now - and it wouldn't be unusual that people sitting at this table haven't seen the draft because he is working with the actual clinicians and the department heads in the field and reviewing the results with them and making modifications. They have the work done and they are fine-tuning it and doing a double-check.

MR. HOUSTON: The world changes; the environment has changed over the last two years. So two years ago, the indication was that we needed 132.1 psychiatrists in Nova Scotia. Would you expect that today, knowing what we know, that that number would be higher or that number would be lower? Do you have any expectation of what that would be?

MS. PERRET: That's why Dr. Wilson is doing the work he's doing. That's why it's not just a projection, but it's also the work he's doing with department heads to determine what the right clinical practice model is. It's also why we're making an investment in community psychology and social work because this is based on the social determinants of health and we want people to get appropriate care.

We don't always want to use the most expensive and scarce resource when it's not necessary, when it's not appropriate. This is part of the choosing wisely initiative, if you like.

MR. HOUSTON: So you don't have any sense as to whether if 132 were required two years ago, you don't have any sense of whether there would be more or less today?

MS. PERRET: I don't know that number today.

MR. HOUSTON: You don't have any gut feel as to higher or lower?

MS. PERRET: No, today I don't.

MR. HOUSTON: Ms. Knox, do you?

MR. HOUSTON: Okay. Ms. Knox, do you?

MS. KNOX: No, I don't, but I would like to reiterate what my colleagues are talking about. It's really about how the whole team works together. So revising one resource plan is really important but it's a plan that's the physician resource to this Mental Health and Addictions team and then there are all the other practitioners that we need to take into account.

That's our work as we go forward and I'm very encouraged that we're updating our work and really making sure that we're understanding what differences we're creating. It's a really important question you're asking because we have to be open to using the most important resource and making sure we have them then.

MR. HOUSTON: Yes, it is. Actually, what I'm trying to get to is a sense of how in touch the people running health care in the province are with the needs of the people. That's really what I'm asking. How in touch are the people that are responsible for spending $4.5 billion of money to deliver health care? How in touch are they and I'm asking what your sense is.

We know cannabis is coming; that's going to have an impact on mental health in the province. We know the stigma is reducing. More people are seeking out services. We know these things are happening. We know there's greater awareness of autism and we know - my sense is 132 is probably going to be higher. That's what my sense is, but I'm asking if you have a sense of that. If you do, you're not willing to share it, I guess is what I take from that.

MS. KNOX: I think these are all really good questions that you're asking and it's creating the opportunity for all of us together to really constantly be reviewing what the needs are of the population and be open to new models as we go forward. So, in our organization, we have 191 physician leaders. So, they'd be all the folks that Dr. Wilson would be talking about. So, we are encouraging and supporting them to do their work.

MR. HOUSTON: You must talk to them too, right.

MS. KNOX: I do but we will wait until they have their report. It will be all part of our work. In our planning for mental health and addictions, this is a multidisciplinary team

that works together across the three organizations. So it is really important that we are making ourselves available of all of the information and then the team members can debate what that means for them and how do they contribute the very best they can be. We have a lot of effort in . . .

MR. HOUSTON: Just in the interest of time, Mr. Chairman, if I may go back to where we started. You made a statement about working with the funders. The deputy talked about a much stronger publicly-funded system. Then we need to be honest about their needs, right?

So now we understand the wait times a little better. We're doing a two-year update of the physician resource requirements. We just passed a budget; the budget's passed. My expectation is 132 probably isn't going to be enough in today's terms. So in kind of assessing the budget for the year, you would have had to ask for more money if you thought it wasn't enough; otherwise, we're always going to be behind the eight ball. We're going to get a report and it is going to say . . .

MR. CHAIRMAN: Order, time has expired. We'll move to the New Democratic Party caucus and the honourable David Wilson.

HON. DAVID WILSON: Thank you. I want to return to an area that is concerning for me and I think for Nova Scotians and that's around the federal funding and an agreement - or not an agreement - being signed with the Province of Nova Scotia. I don't know what happened in December 2016. There was an announcement that there was an agreement but there is no agreement. I guess it was just a friendly, mutual pat on the back between the federal government and the provincial government, and that we're supposed to trust both levels of government to act in the best needs of Nova Scotians.

The federal government plays an important role in the province providing services in health care with the federal transfers and, for decades, we had the Health Accord and, of course, now, we're here today hearing that there is no agreement signed, that Nova Scotians can hold the current provincial and federal government to account. Is there any timeline on when that agreement would be signed between the Nova Scotia Government and the federal government?

MS. PERRET: Thank you for the question because I do want to clarify a point. There is an agreement that was reached on the overall funding amounts for the 10-year period, so that's not in question. What we're talking about is the bilateral negotiations that are under way as to an agreement as to how the money is spent, both in two categories - care in the community and mental health and addictions.

[10:30 a.m.]

There is, in the accord that was reached, certain criteria that the federal government had down, some of it which is a priority on children and youth and that type of approach, also looking at innovations and how we deliver care. You've heard a bit of the discussion on virtual care, so that's how we're looking at using that space.

Where we are now with the discussions with the federal government - they are constructive discussions because everyone wants this to work and to succeed. We're also having discussions with the Canadian Institute of Health Information, as is every other province and territory because that's how results and outcomes are going to be reported.

MR. DAVID WILSON: Is there any kind of timeline?

MS. PERRET: I can hear the minister's voice because I'm about to say the word "soon" and he has an issue with that word, but those discussions, negotiations, are well under way. I expect we will have information if not by late Spring, then by early summer.

MR. DAVID WILSON: Late Spring, early summer, because the emphasis is that this needs to be ratified. I think it's important for Nova Scotians to have something - they should know exactly what kind of agreement our province is entering with the federal government. It's really about accountability.

I think you mentioned election cycles are disruptive. Well we are a year and a half away from the next federal election - who knows what will happen? Maybe Justin Trudeau will take enough selfies that he'll get re-elected and everything will be fine, but I don't trust that and I think Nova Scotians don't trust that. There needs to be the ability to hold government to account and not just trust me. I'm very concerned that it's taking this long to get to that point.

I know that's not all on your plate and everybody's here, but I think those who make the announcements are the ones who may be gone; most of you will still be here to continue on. I know that elections are disruptive. In the 2013 election, we amalgamated district health authorities. It put a lot of things on hold until we could figure that out and we're just here, finally four years later, hearing about some of the positive things about the work being done. That's why I have concern that it's taking longer than anticipated.

When we look at the mental health budget - we heard it was about $287 million being spent on mental health and addiction services. How much of that funding comes directly from the federal government - are you able to give us a number? I know we try to go through this in Estimates, but there are a lot of numbers, there are a lot of components to it. With that $287 million, approximately how much does come from the federal government? There may be strings attached to it, there may not be, but are you able to provide any detail on that?

MS. PERRET: The Canada Health Transfer portion is really a question that is best addressed by the Department of Finance and Treasury Board because it's a revenue source. Within the budget, and referring to your comments earlier, I do want to assure you that the work we're doing with the federal government, there are early indications that we are on the same page. There's not going to be a lag and we're going to hit the ground running when the bilateral is signed.

I don't have a breakout of the $287 million, that would come from federal funding.

MR. DAVID WILSON: Just quickly, going back to that as I turn my page around, I'm just putting notes down - are there still opportunities for the Premier, for example, to live up to his commitment to Nova Scotians to recognize our demographic, the age of our province? He indicated he would not sign anything unless the federal government recognized that Nova Scotia has one of the most aging populations and that puts pressure on delivering services in the province. Is there still an ability to maybe have the federal government recognize in a final agreement that our age of our province is going to put pressure on our ability to provide services as we go forward, especially for a 10-year deal?

MS. PERRET: So, it's a two-sided coin. My assurance to you that there is an agreement on the funding over the 10 years, that is in place. The other side of the coin is no, that agreement is not going to be opened up for a different type of funding arrangement.

I will tell you that we interact with the federal government not only just in the traditional FPT space but through other mechanisms such as ACOA and the like. We work as an Atlantic Region, often to look at opportunities, and the federal government is quite responsive in wanting to work with us, and to recognize that this is an aging demographic in this area of the world, and I don't think the doors are closed entirely.

MR. DAVID WILSON: Just to go back quickly, I know Ms. Hodder mentioned around the new band system for wait times for mental health and the criteria, and it's being rolled out throughout the districts. I know my colleague read off some of the wait times around the province, and you indicated that certain areas were following the new criteria. When do you expect all regions, all facilities, would be implementing this new criteria when we're talking about wait times?

MS. HODDER: Our commitment is to have our access and navigation project implemented within this year, so it would be in April of next year that we would be live across the province. That doesn't necessarily mean that there isn't improvement at the local level and learning shared across a province, and that doesn't necessarily mean either that the model that is implemented in Cape Breton and Northern Zone isn't going to have significant improvements as well, based on the work, the research, and the evidence that's being implemented there.

We are looking to have a full provincial approach to access and navigation. With some of the components that we implemented, there was a recognition that in those areas, there was a need to take immediate action and address that. So as we're uncovering things within the new model of care, we're implementing and adding resources as the needs are coming up, but our plan is to have our access and navigation project for Nova Scotians implemented next year.

MR. DAVID WILSON: I know often, the measure of success for government is those numbers - the wait times - and I know it's complicated, but ultimately the public, that's what they see. We have websites, we hear numbers often, that's where we go to explain to Nova Scotians if things are going well, or if they're not going well in certain regions.

With the change in criteria, did you remove people off the list that were on the list maybe for some time, so the criteria changed enough where they were moved from that list? The reason I ask that is, there had been a change to the wait-list for long-term care, for example. The government uses those numbers often, but when you dive into the numbers you realize, well, the criteria changed so people were taken off because they don't meet the criteria, but the government tried to use that as a success, even though no additional money had been put in the budget to add long-term care facilities or beds in the province.

So, was there a criteria change that would just take people off that list? Hopefully, I'm kind of clear on why I'm asking the question.

MS. HODDER: I'm not able to comment on the piece around what government did or didn't do in relation to that. So, I can't comment on that. What I can comment on, because I was involved specifically within the system improvements within Cape Breton, is that every single referral that came in that was waiting had some contact by our service provision. The referral was reviewed and an attempt to reach out and actually speak to that individual, who was the referral, was made.

At some times, I can say that people weren't able to be reached, but that doesn't necessarily mean that we stopped there, because we also sent out letters that said to folks: we made an attempt to reach you, you weren't available, if you need us, here's how you can get back in touch with us.

I can speak to that specific experience within the Cape Breton area that there wasn't…

MR. CHAIRMAN: Order. I'm sorry, the time has expired. We'll move to the Liberal caucus. Mr. MacKay.

MR. HUGH MACKAY: Thank you for all the good news you've been sharing. There have been some tough questions, which we appreciate and have to ask, but out of

those tough questions we're hearing some really good news about things here in Nova Scotia.

I'd like to perhaps go back to the original question that was posed - and I think Ms. Knox addressed it - that we don't always follow the crowd. We have situations, opportunities, and challenges in Nova Scotia that are not necessarily met by just doing the same thing that everybody else is doing. We've got highly qualified professional health care workers here in Nova Scotia. We've got top-notch medical research facilities here in Nova Scotia.

While we obviously take best practices from elsewhere, from what I've heard today, we also develop our own unique solutions to approaching health care. That can be for doctor recruitment, but I think it also applies here in mental health. I guess I'd like to address the question, perhaps to the deputy - how are we doing relative in the overall Canadian situation, relative to other provinces?

MS. PERRET: I think generally speaking, all provinces and territories - and it's a reflection of the questions about the federal bilateral agreements - are focused on building a mental health and addiction system that really hasn't been a system per se.

As I said, I use the analogy to some of the discussions we're having on Pharmacare, that it has not been part of universal health care in the country, so we're starting a bit behind the game in building it. I think in that context - I've worked in three provinces and I've spent some time at the federal-provincial table - Nova Scotia is well-situated to respond to this challenge and to do some really good work.

Nova Scotia has invested in foundational elements that are in place. We have to grow them. We need to integrate, connect them. But just the system of 31 community health clinics throughout the province, the system of the SchoolsPlus hubs and how we're growing youth health centres - in many respects to have this foundation would be the envy of the other provinces.

MR. MACKAY: I'm going to go a little bit outside the box on my next one. It's regarding the holistic approach that the Nova Scotia Government is taking to mental health in so many aspects and through different departments. I'll ask my colleagues' indulgence a little bit on this one because it's something that my own family was impacted upon. One of my nephews went through the Mental Health Court system. Initially, I think there was some high concerns in our family about that, but the outcome was highly successful. We could not have been happier.

Since there's nobody here from the Department of Justice, perhaps to the deputy again. I'm just wondering, are there any comments on mental health courts and where they may be going, from your perspective - understanding it's not your department?

MS. PERRET: No, and I won't do the question justice, so I apologize on that point. I will assure you that on the social deputies and social ministers front, there's a real concerted effort to work across departments and to work in an integrated fashion. We consider these challenges to be government challenges that we all rise to address, and we don't work in silos.

MR. MACKAY: A holistic approach, and I think intergovernmental is working very well.

I think I'll address my next question to Ms. Vine, if I may. We've heard quite a bit from the Health Authority and the department. Like my colleague, the member for Lunenburg, I represent a primarily rural riding and I know the challenges faced in a riding such as my colleague the member for Halifax Atlantic's riding are quite different than what we have rural.

We speak of outreach, and one of the things I believe I heard was that lessons learned in maybe some of the other zones, perhaps within HRM, will be expanded to other parts of the province. In my case, that would be in the western part of the province. I'm just wondering if you could expand a little bit upon the IWK's participation in outreach to other parts of the province.

[10:45 a.m.]

MS. VINE: Certainly, I can make a few opening remarks and then I'll turn it over to my colleagues. I definitely think we have really worked to transform our services at the IWK, recognizing some of the specialty services that we are able to offer are not available within all community mental health clinics across the province. We take that role very seriously in terms of working very closely with our colleagues at Nova Scotia Health Authority in all aspects.

As we are developing a particular evidence-based program or approach, while we're training our own workforce, we're working on training the workforce of our colleagues within NSHA so that when they're working across systems, which we do all the time, they're speaking the same language and using the same evidence-based approaches. In general that's the way it would go.

I can pass it to Dr. Bagnell, who can talk about some of the consultation work that psychiatrists from the IWK regularly provide across the province.

MR. MACKAY: Please do.

DR. ALEXA BAGNELL: I think we have a really great opportunity because IWK is partnering with NSHA, and we're together at the provincial table forming a strategy and moving it forward. We're getting to know each other really well. We have created a lot of

great networks, and we have a child psychiatry network now in the province. We're not a big group, but we're a very cohesive group so we know who to call. One of the things that's clear is that we don't have child psychiatry coverage throughout the province right now. I'm sure people have heard about that. So how do we support those areas?

We have a telephone consultation service. We developed that a couple of years ago. It wasn't as well-used as we would have liked, so we promoted it more, and we have been having a lot more use. Physicians will call in and can get a telephone call consult with a psychiatrist within a couple of days. We have set times, it's booked, and then we call that physician. That has been really helpful for that immediate decision. What do I do next? What would you consider? Should I be referring? It's helpful just getting that started so that someone's not waiting in terms of a family physician or pediatrician not knowing what to do next.

Then the other piece is consultations directly to psychiatrists. We call them physician consults. A physician can consult us from anywhere in the province with a question. It's usually a one-time consult unless there's a serious mental illness that we feel needs to come into the IWK for intensive services. It really has been helpful because people don't wait as long. We can actually recommend evidence-based treatments that could be available in the province to help and connect people. Then we can remain as a resource to that physician as they're moving through the treatment. Those two things in psychiatry have been really helpful. We're hopeful that that will continue to build and grow.

MR. MACKAY: Good, and I think that that speaks to the fact that we are addressing the now and the future of mental health care across the province.

Speaking of what the approach is to mental health care on a provincial basis, I'm wondering, Ms. Knox, if you could comment on how the creation of the Health Authority has impacted our provincial approach to mental health care.

MS. KNOX: The Health Authority's mandate is to provide health services to all Nova Scotians in concert with our colleagues at the IWK for the services they provide. Ms. Hodder gave an example of one zone where there were 40 different ways to access services. Multiply that by four, and we're in the hundreds. I know four by 40 isn't - but there were many, many, many multiples of that around the province.

Planning together, bringing this Mental Health and Addictions team in the Nova Scotia Health Authority brings together the leaders from all across the province. They plan based on the people they're serving, and the implementation is local. We bring the best of our information, the best of our resources, together. Then the implementation of all of that benefit is at the local level, in the context of who people are living in their family in their community.

In three short years - I would say they were three long years of work - we're starting to see the benefit of that and really able to see how you can maximize expertise without having to duplicate it, quickly move it to where it needs to be, and replicate best practices.

The other thing I would like to say is that, as we came together using all the work that went before us, we made the commitment that we have to stand on the good foundation of all the work that went before us and then constantly use the best information in the world that is available to us now. We're very pleased with the level of practitioners we have in this province, and we should be celebrating them. We have the expertise, it is how we put people together in relationships and really stay very focused on who the people are.

So thank you for the opportunity for me to share that because I have been in this system as a CEO for more than 13 years and this is very different in terms of what we're able to do in saying that all Nova Scotians need to be treated with the same rights. Sometimes our strategies will have to be very different because of where they live or what their circumstances are but the treatment and the care they get has to be to their needs.

MR. CHAIRMAN: Order, time for questions has expired. We do have some committee business so we don't have a lot of time for closing comments but I would like to offer maybe just a quick 60 seconds to each organization with us today, starting with Ms. Perret.

MS. PERRET: Thank you, Mr. Chairman, and thank you to the committee. I think it's an important discussion and I think that the people of Nova Scotia know that we're at work and we want to improve the system and we want to remove the stigma in this area and make it a conversation we have throughout communities, so I thank you for this time today.

MS. KNOX: I just want to say thank you for your interest, this is very important work. We must not take our focus away from supporting Nova Scotians to be the healthiest and the best they can be. So thank you for your interest.

MS. VINE: Again, I would like to thank all of you for the opportunity to provide information to you. I really want to echo the comments from Ms. Knox about how fortunate we are to have the incredible workforce we have in Nova Scotia and how important it is that they hear from Nova Scotians about the great work they are doing. It's challenging work and they deserve our support and respect. Thank you very much.

MR. CHAIRMAN: Thank you to all of our witnesses for being with us today. We appreciate your presence and your ability to answer questions for us, thank you.

We have committee business, starting with correspondence. We had correspondence from the Department of Health and Wellness proposing an additional

witness for the May 9th meeting. The question before the committee is, do we wish to approve the additional witness?

Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried. Our clerk will make note of that.

The other piece of correspondence is from the Department of Environment and it has to do with information requested for our March 28th meeting. Information has been provided but the answer to one of the questions, it was suggested that the question was better asked of the Department of Transportation and Infrastructure Renewal. Does the committee wish to pursue that answer with the Department of Transportation and Infrastructure Renewal?

Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried. Our clerk will make note of that.

We have a record of decision from our subcommittee on future topics for our meetings. You have before you a list of topics. There are seven topics plus one, one being the Office of the Auditor General who has a report that he is delivering on May 30th. As I recall, we had already approved that for May 30th but there are seven other topics there and we need your approval on those. Mr. Houston.

MR. HOUSTON: Mr. Chairman, I make a motion that the committee approve these topics.

MR. CHAIRMAN: Mr. Gordon Wilson.

MR. GORDON WILSON: Yes, so we do have seven there. I'd like to note that there are three that we do have for the Progressive Conservatives in light of one of them that we thought would be one that would be dealt with better through the Auditor General's Office, which I do believe everybody knows has embarked on working on that. I think it would be a little bit pre-emptive of us right now at this point in time to approve that.

MR. CHAIRMAN: Can you identify the specific topic?

MR. GORDON WILSON: That would be Internal Services supplier contracts related to the FOIPOP breach.

MR. CHAIRMAN: Are you recommending that - so the motion before the committee is to approve all seven topics. Perhaps we will deal with that first.

Would all those in favour of approving all seven topics please say Aye. Contrary minded, Nay.

The motion is defeated.

Mr. Gordon Wilson, do you wish to make a motion to approve the six topics? I'll let you make the motion.

MR. GORDON WILSON: I'd like to make a motion that we approve the six topics, that would be: Community Services, funding for sexual violence; Department of Business, Rural Internet Middle Mile; Department of Seniors, Nova Scotia's Action Plan for Aging Population; Department of Health and Wellness, funding for home care; Nova Scotia of Immigration, immigration streams and programs; and Department of Health and Wellness, rural health care delivery.

MR. CHAIRMAN: Mr. Houston.

MR. HOUSTON: So Mr. Wilson's motion excludes Internal Services, supplier contracts related to the FOIPOP breach. I don't know if maybe Mr. Wilson cares to expand on why he has excluded that topic.

MR. GORDON WILSON: I think I explained that in my opening comments. I did, the fact that the Auditor General is looking into that at the time.

MR. HOUSTON: I'm not sure that I agree with the logic on that. The Auditor General operates separately from this committee, for sure. We respect the work of the Auditor General's Office and we often rely on it, but certainly this committee is not beholden to the Auditor General's schedule. We can call topics before this committee that we think are appropriate for discussion.

We did at one point in the past follow this path. We went down this road before with the IWK and the expense situation that was there at the time. The Liberal caucus said, hold on, we don't need to bring that before the Public Accounts Committee - the Auditor General is going to look at that. I think a year-plus has passed. I don't think we should use that; that's not a good precedent for this committee.

I would think that the Auditor General has many audits they're trying to do. They have a schedule out and they're looking at a schedule process for many things. If we continue down the path of allowing the government members to keep things away from the Public Accounts Committee because somebody else was looking at it - so insinuating that somebody else should look at it and this committee shouldn't, whether that be the Auditor General or an expert or whatever - I don't think that's a good precedent for this committee.

I think this committee should be focused on matters of importance to Nova Scotians, irrespective of who else is focused on them. In this particular case, we're talking about people's personal private information that was breached. That's a matter of importance for the government and I think this committee should consider it. I would like the member to reconsider his position in the interest of Nova Scotians - maybe put the interests of Nova Scotians before government interests, and say let this committee look at matters that are of importance.

I would ask the member to reconsider his motion and put the slate of topics that the subcommittee decided for scheduling and let the committee talk to people who know.

MR. CHAIRMAN: We do have another person wishing to comment. Is it the will of the committee to sit past the hour of 11:00 a.m., to extend the meeting for any further discussion?

Would all those in favour please say Aye? Contrary minded, Nay.

We will sit beyond 11:00 a.m., as necessary.

The honourable member for Sackville-Cobequid.

MR. DAVID WILSON: Quickly, I would concur with the comments just made by my colleague. I don't believe the Office of the Auditor General is actually doing a full audit. They're working and assisting with reviewing what happened. As was indicated, there is no other committee that is looking at this at the time. I would say that with the schedule, we're looking at our schedule going into September. Some of these witnesses would be in September, so if that's the case we could hold that topic to the end of our schedule. I, too, would ask if the members of the Liberal caucus reconsider and bring this topic forward.

MR. CHAIRMAN: The motion before the floor, put forward by Mr. Gordon Wilson, is to approve six topics - all of those except for Internal Services to discuss supplier contracts related to the FOIPOP breach.

Would all those in favour please say Aye? Contrary minded, Nay.

The motion is carried.

So those six topics are approved. The clerk has flagged for me - we do need to formally approve as a full committee the May 30th date for the Office of the Auditor General, at which point he will be bringing forth his Spring 2018 Report.

Would all those in favour of having the Auditor General as a witness on May 30th please say Aye. Contrary minded, Nay.

The motion is carried. Our clerk will make note of that.

[11:00 a.m.]

I just have a couple more items here. It won't take long - Ms. Roberts.

MS. ROBERTS: This may just be a point of housekeeping, but I noted that in our witness package for today, the IWK was not actually listed as a witness, and I think we could have gone in that direction, except we didn't actually know that they were going to be here as a witness. It was an opportunity missed.

MR. CHAIRMAN: Point noted. That is something we will watch to ensure that members are aware of all the witnesses who are appearing. Thank you.

The next item we discussed in our sub-committee meeting, and it is for approval here by the full committee, was distribution of meeting agendas. We came to an agreement that members and researchers for the caucuses will receive meeting agendas on Fridays before our Wednesday meeting the following week. The sub-committee also agreed that any information that is sent to members will be sent to researchers as well.

I want to issue a warning. If you have researchers in your office who leave your office, the onus is on committee members to ensure they are removed from the distribution list. Otherwise, we have information for the committee going outside of the committee's interest. That would be considered a breach, and we cannot have that onus put on the Clerk. That onus has to be on members.

So if we are agreeing to this, we are agreeing also to respecting that this information - if you have somebody leave your office who is a researcher, that you notify the Clerk.

Mr. Jessome.

MR. BEN JESSOME: Mr. Chairman, I think you just answered my question. I just wanted to clarify the appropriate medium of communication.

MR. CHAIRMAN: The answer to that would be, for your caucus, preferably through the member on the subcommittee for your caucus, to notify the Committee Clerk.

The honourable David Wilson.

MR. DAVID WILSON: Mr. Chairman, could I ask that you, as chairperson, reaffirm that and send a letter to each of the chiefs of staff for each of the caucuses, because the chiefs of staff work closely with - chiefs of staff and caucus chairs, if that's okay with the committee. That way we can make sure it is fully understood, the responsibility of each caucus and members of this committee?

MR. CHAIRMAN: Thank you. Good suggestion. We will send such a letter, as you have recommended.

The question put before the committee is to ensure that agendas are distributed on the Friday before the Wednesday meeting of the following week, and also to distribute agendas and research packages - any information being sent to members - to researchers in the caucus offices.

Would all those in favour of the motion, please say Aye. Contrary minded, Nay.

The motion is carried.

The next item we have - and for simplicity's sake, what was approved by the subcommittee on this issue has to do with briefings from the Auditor General. For simplicity's sake, any meetings that we are having with the Auditor General, in the case of the witness appearing in relation to a report that had been made by the Auditor General.

So picture a department coming in as a witness related to an Auditor General's report - before that meeting, we will have a 30 minute in-camera meeting with the Auditor General. Also, a 30 minute in-camera meeting in advance with the Auditor General, on days where the Auditor General is presenting a report, such as we will see on May 30th.

So it's a 30 minute, in-camera meeting with the Auditor General before meetings either associated with an Auditor General's Report they're introducing, or with a department who is a witness in response to report of the Auditor General.

Mr. Gordon Wilson.

MR. GORDON WILSON: I'm assuming also that the standard practice that we have put in place of having the reports come out on a Tuesday, and then the meeting on the Wednesday is part of that. I would also add the suggestion that my colleague had of adding this to that letter that will go out to the caucus chairs regarding formalities within - it would be nice to have that added to that, if you don't mind.

MR. CHAIRMAN: We will include that in the correspondence as you recommended, and the answer to your question is yes.

Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Our final item here is we do need the appointment of an Acting Chair for the May 9th meeting. Neither myself nor the deputy chairman of the committee can be here on that day. Would anybody like to - Mr. Gordon Wilson.

MR. GORDON WILSON: I'd like to suggest that Suzanne Lohnes-Croft fill that position that day.

MR. CHAIRMAN: Would all those in favour of Ms. Lohnes-Croft being the chairman for the May 9th meeting please say Aye. Contrary minded, Nay.

The motion is carried. We have an acting chairman for the May 9th meeting.

Our next meeting is May 2nd. We will have the Department of Finance and Treasury Board and the Nova Scotia Liquor Corporation to discuss listing of local products and new products.

Is there any further business to come before the committee?

From the Auditor General's Office, Mr. Spicer.

MR. TERRY SPICER: Can we assume those briefings will be in camera briefings?

MR. CHAIRMAN: Yes, they will.

MR. SPICER: Thank you.

MR. CHAIRMAN: Is there any further business to come before the committee?

Hearing none, this meeting is adjourned.

[The meeting adjourned at 11:06 a.m.]