HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, January 13, 2021

Video Conference

Mental Health Services -
November 22, 2017 Report of the Auditor General, Ch. 2

Printed and Published by Nova Scotia Hansard Reporting Services

Public Accounts Committee

Keith Bain (Chair)
Keith Irving (Vice-Chair)
Brendan Maguire
Hon. Margaret Miller
Ben Jessome
Rafah DiCostanzo
Tim Halman
Lisa Roberts
Susan Leblanc

[Keith Irving was replaced by Bill Horne.]

In Attendance:

Kim Langille
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

Terry Spicer,
Acting Auditor General

Andrew Atherton,
Assistant Auditor General

Ashley Richardson,
Audit Principal

WITNESSES

Department of Health and Wellness

Dr. Kevin Orrell,
Deputy Minister

Vanessa Chouinard,
Senior Executive Director - Public Health, Mental Health and Addictions,
and Acute Care

Nova Scotia Health Authority

Dr. Brendan Carr,
President and CEO

Samantha Hodder,
Senior Director - Mental Health & Addictions

Dr. Andrew Harris,
Senior Medical Director - Mental Health & Addictions

IWK Health Centre

Dr. Krista Jangaard,
President and CEO

Dr. Annette Elliott Rose,
Vice President - Clinical Care and Chief Nurse Executive

Dr. Alexa Bagnell,
Chief of Psychiatry

Maureen Brennan,
Director - Mental Health and Addictions

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, JANUARY 13, 2021

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIR
Keith Bain

VICE-CHAIR
Keith Irving

THE CHAIR: Order, please. We'll call this meeting of the Standing Committee of Public Accounts to order. Good morning, everyone. My name is Keith Bain. I'm the MLA for Victoria-The Lakes and Chair of the Public Accounts Committee.

Before we do some housekeeping rules, there's one issue I want to bring forward. Mr. Maguire does not have video and will need the permission of the members, the consent of the members, to let him participate without video. With a show of hands, do you agree, committee members? Anyone opposed? Thank you for that.

As I say, my name is Keith Bain, and today's topic is mental health services. Before we begin, just a few reminders. The witnesses should keep their video on during the meeting. The members should also keep their video on during the meeting, just so we can watch for hands moving and to ensure we have quorum at all times. You're asked as well to keep your microphones muted until it's your turn to speak, and you'll wait until I as Chair recognize you to unmute your microphone.

One final reminder: anybody with cell phones, please put them on silent or vibrate.

I guess we'll begin by having the committee members introduce themselves, and we'll begin with Mr. Horne.

[The committee members introduced themselves.]

THE CHAIR: Thank you all. Again, as mentioned, on today's agenda, we have officials from the Department of Health and Wellness, Nova Scotia Health Authority, and the IWK Health Centre to discuss mental health services from the November 22, 2017 Report of the Auditor General, Chapter 2.

We'll now ask the witnesses to introduce themselves, beginning with Deputy Orrell.

[The witnesses introduced themselves.]

THE CHAIR: Thank you all very much. We'll begin by inviting Dr. Orrell to make his opening remarks. After Dr. Orrell is finished, we'll move to Dr. Carr and then to Dr. Jangaard. Dr. Orrell, the floor is yours.

DR. KEVIN ORRELL: Thank you, Mr. Chair and committee members. Good morning. We appreciate being invited to join with our colleagues from the health authorities to meet with you today. I am joined by Vanessa Chouinard, who introduced herself - our Senior Director of Public Health, Mental Health and Addictions and Acute Care. I am also joined by Dr. Carr and Dr. Jangaard and their teams.

We are happy to be here to discuss the progress of the nine recommendations on mental health and addiction from the Auditor General's November 2017 report. Despite the challenges of the pandemic, the department continues to make progress on our goals for mental health and addictions.

We are committed to ensuring better access for all Nova Scotians, better integration between service providers, and strengthening a continuum of care from health promotion and illness prevention to crisis services and treatment for complex issues.

Government's role is to set the strategic direction for mental health and addictions in this province. Government also funds the delivery of health care for Nova Scotians and makes additional priority investments where and when they are needed. This funding permits the health authorities to deliver the services and plan services across the province. They are also responsible for the recruitment and retention of the workforce.

The provincial budget for mental health and addictions is over $310 million for this fiscal year, 2020-21. We have increased the mental health and addictions budget by over $35 million since the 2016-17 budget year.

Services are also delivered by community-based not-for-profit organizations. Government funds many of these organizations through ongoing grants provided either directly by the department or through the health authorities. We know that the capacity

exists to build on the great work of some of these groups, and our plan forward includes a stronger role for community organizations.

This past year has been very challenging for many Nova Scotians. We fully recognize the impact on mental health on our citizens as a result of COVID-19 and many other events that took place in the province. To that end, information about the mental health system and its crisis support have been communicated in all of our briefings.

Mental Health and Addictions was a core component of Nova Scotia's public health response to COVID-19. Although we changed the way in which our services were offered, our commitment to patient care remains our top priority. How we thought about access shifted and the department boosted efforts in virtual care.

In terms of the Auditor General's recommendations, both the department and the health authorities have made considerable progress since 2017. From the department's perspective, we have completed all but one of the recommendations, the most recent one completed in December. This clarified the wait-time standards for initial and subsequent appointments.

[9:15 a.m.]

Following that, we launched our waittimes.novascotia.ca website which initially reported wait times for first appointments. We are proud of this work that improves transparency for Nova Scotians. We appreciate the recommendations the Auditor General made in 2017 to create a more consistent provincial approach to mental health and addiction services across the province. We are making progress, but there is always more to do. We will continue to work with our community partners and the health authorities to improve access to care for Nova Scotians in all parts of this province.

Thank you for the opportunity to appear before the committee today.

THE CHAIR: Now we'll turn the floor over to Dr. Carr.

DR. BRENDAN CARR: Good morning, Mr. Chair and committee members, and Happy New Year to all of you.

My name is Dr. Brendan Carr and I am the President and CEO of the Nova Scotia Health Authority. I am very pleased to be here today with my colleagues from our provincial Mental Health and Addictions Program: Sam Hodder, our Senior Director and Dr. Andrew Harris, our Senior Medical Director, whom you met just a few minutes ago.

We were very pleased to accept the recommendations of the 2017 Auditor General's Report. Since then, Sam and Andrew have led their team to complete the

recommendations relevant to the Mental Health and Addictions program, and the joint recommendations for the program, the IWK, and the Department.

For the wait-times-related recommendation, Nova Scotia actually has the most comprehensive wait-time data for publicly-funded mental health and addiction services in Canada. As a result of the implementation of multiple initiatives, the Mental Health and Addictions program now routinely meets the urgent care wait-time standard of seven days in every zone across our province. It has reduced non-urgent wait times by 42 per cent for adults and 43 per cent for children. On average, we see 79 per cent of adults and 75 per cent of children with non-urgent needs within the 28-day standard: 18 days for adults and eight days for children. Our work will continue until we meet the 100 per cent standard.

As COVID-19 impacted health care here and across the country, the Mental Health and Addictions program responded. We continued to offer high-quality care and support to patients, families, clinicians, and physicians in collaboration with our community partners.

The mass casualty and other tragic events affected many Nova Scotians deeply. In response, we put in place access to additional pathways: First Responders Assist, Psychological Support Session, crisis care pathways, and health care provider and physician support through Nova Scotia Compass - all promoted through social media and other channels.

Our SchoolsPlus teams stayed connected with communities after schools closed and throughout the Summer to support children, youth, and their families through virtual care and in-person visits when needed.

We launched a new mental health and addictions website and accelerated the launch of e-mental health and addictions tools. We continue to work with the Mental Health Commission of Canada to implement Stepped Care 2.0 through online self-help programs, peer- and coach-facilitated programs, and links to community-based supports and virtual visits.

Our provincial intake service line is a single entry point: a toll-free telephone number available 24 hours a day, seven days a week, 365 days a year answered by trained mental health providers. That means when calling, individuals can self-refer to Community Mental Health and Addictions clinics, withdrawal management services, and opioid treatment and recovery programs. In a typical year, that line manages roughly 20,000 cases. In 2020, because of COVID-19, it managed over 25,000.

Investments in child and adolescent care since 2017 have resulted in improved access to support for young people through their schools, community-based treatment, and adolescent outreach programs.

Significant investment in the treatment of harmful substance use has made possible the introduction of a physician lead in addictions medicine, implementation of the Opioid Use and Overdose Framework, piloting the addictions medicine consultation model, and the Nova Scotia Take Home Naloxone Program, and has drastically reduced wait times. This has resulted in the elimination of opioid-related wait-lists and often access to same-day care.

At any time, more than 2,000 people actively receive opioid treatment and recovery services: 1,038 unique clients received withdrawal management services last year. More than 15,000 naloxone kits were distributed through 300 distribution sites since 2017. We established a suicide risk assessment and inventory, with training and monitoring compliance that ensures we meet the standard set by Accreditation Canada.

Our five public advisory groups - one provincial, and one in each of the four zones - include patient and family advisors and community support group leaders. They further enhance our quality framework and inform our response to patients and families, with more work to be done.

We appreciate the insight provided by the Auditor General, and we will continue to transform our services to meet the evolving needs of Nova Scotians with high-quality care. We would be very happy to answer your questions.

THE CHAIR: Thank you very much, Dr. Carr. Now we'll call on Dr. Jangaard for opening remarks as well.

DR. KRISTA JANGAARD: Thank you very much to the committee for the invitation for the IWK to participate in this discussion this morning.

As mentioned, I'm Dr. Krista Jangaard. I am the President and CEO of the IWK Health Centre, and you've met my team members: Dr. Elliott Rose, VP of Clinical Care & Chief Nurse Executive, and our co-leads for our mental health and addictions program, Dr. Alexa Bagnell and Maureen Brennan.

The specific focus of the IWK Mental Health and Addictions Program is to provide services for children, youth and families that best meet their needs as close to home or their school as possible, and to partner with other key community partners to strengthen important connections that ensure smooth, safe transitions and opportunities for improvements in service.

Through these strong collaborations, we've been able to expand our reach within the community, understand the needs of children, youth and families, and ensure a coordinated care approach to better meet their needs. The recent development of our learning link, for example, has supported expanded capacity building, consultative care, and closer-to-home services.

We know that providing a supportive environment early in life is critical to healthy growth and development. Working with both primary care and mental health clinicians across the province to support prevention and early intervention of emerging mental illnesses enables children, youth, and their families to maintain a positive functioning within their home communities and may prevent moderate to severe mental health issues that require our subspecialized and specialized services.

I am pleased to share with the committee that throughout the pandemic, the IWK Mental Health and Addictions Program continued to provide its full suite of emergent, urgent, and non-urgent programs and services. In addition, the team worked with the NSHA, as you've heard, and other system colleagues to respond to the specific mental health impacts of the pandemic.

At the IWK, in fact, the Mental Health and Addictions team was the very first to adopt and implement virtual services, offering families appointments in ways and times that worked for them, and actually improved access to services for some populations who preferred this approach. When barriers arose to accessing the equipment and technology that was required for this virtual care, the IWK - in partnership with the team - created an equipment loan program to help those families out.

In addition to the collaborative work within the Department of Health and Wellness, the IWK Mental Health and Addictions team has also partnered with the Departments of Community Services, Justice, and Education and Early Childhood Development to support Nova Scotian families. For example, prior to the return to school, the IWK Mental Health and Addictions team created a webinar series for Nova Scotian families providing strategies to support their children and youth. A similar webinar series was also created to support teachers and education workers.

I am happy to report that at the IWK, through the hard work of our teams, we continue to make significant strides in improving wait times. All the children and youth seen at the IWK regularly are seen within the seven-day wait time standard for urgent appointments, and 87 per cent of the children and youth within the 28-day standard for non-urgent appointments.

As always, there is much work to do, and the IWK, the NSHA, and all our partners will work together. We are focused and committed to improving access to care and patient outcomes.

My colleagues and I will welcome your questions. Thank you.

THE CHAIR: Thank you very much, Dr. Jangaard, and thank you all for your opening remarks this morning. We'll open the floor now for questions. Just one reminder to the committee members: I'm going to ask that you indicate who your question is to, because it will certainly make things a lot easier as we go forward.

We'll start the first round of questions, beginning with the PC Caucus for 20 minutes. Mr. Halman.

TIM HALMAN: Good morning, everyone. Deputy Minister Orrell, CEO Carr, Dr. Jangaard, all staff that are with us today, please know Nova Scotians are extremely grateful for the leadership our health care professionals have demonstrated. Please pass on our gratitude.

We today, however, have a number of questions related to, for me as an MLA, a key priority to the well-being of Nova Scotians, and that's access to our mental health services.

My first question is to Deputy Minister Orrell. This will simply require a yes or no response. Dr. Orrell, is the Department of Health and Wellness committed to giving the residents of Nova Scotia better access to mental health services? Yes or no will suffice.

KEVIN ORRELL: Yes.

TIM HALMAN: Deputy minister, is the Department of Health and Wellness committed to delivering mental health services more quickly to Nova Scotians?

KEVIN ORRELL: Yes.

TIM HALMAN: Is the Department of Health and Wellness committed to delivering mental health services that are closer to home for Nova Scotians?

KEVIN ORRELL: Yes.

TIM HALMAN: Fifteen years of teaching history taught me to compare and contrast texts. I was this morning reading your opening statements, which I certainly appreciate. The paragraph that indicates:

> "We know that the capacity exists to build on the great work of some of these groups, and our plan forward includes a stronger role for community organizations, giving people better access, more quickly, and closer to home."

This is the copy that I have, but I've received updated opening remarks, which you just read. In the opening remarks you just read, "giving people better access, more quickly, and closer to home" has been removed. Yet the text I have in front of me clearly states that we wish to give people "better access, more quickly, and closer to home."

Can you please account for why that was removed from the text?

KEVIN ORRELL: Quite simply, in our rehearsal for our opening remarks and the timing, we had gone over in my remarks and there was some abbreviation of that to meet the time limits that were dictated by the rules of the committee so the opening remarks were changed and subsequently submitted in the abbreviated form that met the time restraint.

Removing those remarks has very little to do with the discussion that can ensue and the discussion around exactly those topics.

TIM HALMAN: Certainly, deputy minister, there is no substitute for clarity. Your opening remarks certainly provide an opportunity to provide that clarity to Nova Scotians - that the Department of Health and Wellness is fully committed to better access in a timely manner and that's closer to home.

Obviously, I ask you this because it's talked about closer to home. I have the honour of representing East Dartmouth. On January 4th, CBC News reported that three sites that offer mental health services in Dartmouth are being relocated to Portland Hills in Cole Harbour. My understanding is there will be three mental health and addictions facilities housed in one area.

Cole Harbour is certainly an area I'm familiar with. I grew up in Cole Harbour. My understanding is that catchment area spans as far as Ecum Secum. From Dartmouth to Ecum Secum is well over 150 kilometres. We will have mental health services provided for an area of 150 kilometres.

How does the Department of Health and Wellness rationalize moving three facilities from the downtown core of Dartmouth to Portland Hills - especially in the context if you are committed to mental health services that are closer to home? How do you square that?

KEVIN ORRELL: In health care, there are many things that have taken place over many years that have necessitated some relocation and unification of services that are provided for financial reasons, for population reasons, geography, et cetera.

You could look at our emergency departments as one example when years ago - and this spanned my 30 years of orthopedic practice in Nova Scotia - the emergency departments were located in every community and we had human health resource issues with manning those, and with having them open on a consistent basis. It was necessary to adjudicate and to bring some emergency departments together to provide for a broader distance with a greater support and much more robust service.

This may well be the case with other aspects of health care delivery. Because we commit to having care closer to home does not mean that every neighbourhood is going to have access to mental health and addictions. I would then refer the question to my

colleagues who are with us today from the health authorities. Perhaps Sam Hodder would have more to say about that as an operational issue.

[9:30 a.m.]

THE CHAIR: Ms. Hodder.

SAMANTHA HODDER: All three of the outpatient locations that you speak of in Dartmouth have leases expiring in relation to those locations. One of the locations had a physical layout that actually did not match the service delivery model to meet the needs of the patients who were receiving care in that area.

The other two locations essentially predate the integration of a model of care in relation to mental health and addictions. The service offerings were siloed for addiction services and mental health services. This created an opportunity, essentially, to put out a request for proposal and integrate those services in one integrated space. This is about supporting patients and families and maximizing the collaboration in relation to care of clinicians. As we know, people are living with both mental health and substance use disorders.

We actually received one request of a response to the RFP location that fell within the geographical boundaries for the Dartmouth service provision. It is not in the downtown area, as you have noted, but it is centrally located adjacent to a Halifax Transit hub and frequently travelled bus routes.

The other important component is one of the three services, the Connections Halifax program. A big component of that program is actually an outreach arm. The teams that work within the Connections program actually reach out and engage patients and families in their home and in the community. That model of care and that component associated with the connections program will stay.

TIM HALMAN: I thank you, Ms. Hodder. Thank you, Deputy Minister, for your response. However, I've heard some concerns from members of my community. You've indicated in your opening remarks that you are committed to building a stronger role for community organizations.

Implied in that statement, I believe, is your desire to listen and to consult with stakeholders. It's my understanding that no consultation occurred with stakeholders. Is this true?

KEVIN ORRELL: I'm not aware that consultation did not take place. On a personal level, I've had many conversations with some of these stakeholders, who have contacted me directly to discuss some of their concerns and have made time to listen to those and address them with the branch.

I started my job in April, so I had large clinical experience in the health care system and was aware of some of the mental health and addiction issues that existed. I certainly cared for patients who were being managed through Mental Health and Addictions services. However, it was more one-on-one contact with some of the leaders and participants with these groups. I've always made time to speak with them.

TIM HALMAN: Who are these groups, deputy, that you met with?

KEVIN ORRELL: There was the Ally Centre of Cape Breton group, there was the group for safe injection sites, opioid abuse, drug and alcohol abuse.

TIM HALMAN: Deputy, with all due respect, when I asked you if you're committed to having services closer to home - if the department is committed as you indicated, here's an opportunity to demonstrate that, especially to the residents of Dartmouth and Cole Harbour and Eastern Passage and all the way out to Ecum Secum.

Obviously, the big concern here is that we are going to increase barriers for those who require assistance, those who are dealing with the trauma of addiction. Do you believe that we are increasing barriers by the decision that's been made to relocate these facilities to Portland Hills?

KEVIN ORRELL: I do not believe we've created barriers. I think that Nova Scotia is a relatively small province and there are supports in place for people who have issues with transportation, so I don't think that this is a barrier. I think the state of all of health care is such that there is amalgamation of service in some areas that people become very familiar with and adapt to quite easily.

With respect to some of the issues about dealing with your constituents and other constituents, it is noteworthy that I did outline that I started the job in April, and this began at the height or the first wave of this pandemic. The department has been enormously focused on COVID, and we have been very occupied, if you will, with COVID issues and the management of the second wave. It is not possible to hold meetings with all stakeholders for every branch who provide service. I think that given the attention to COVID and the time that that's taken, we've made a remarkable effort to engage people from other aspects.

We've dealt with the mental health and addictions issue. Specifically, the priority has been to deal with the effects of COVID on mental health and addition, and that's been largely our focus since my time in April.

TIM HALMAN: Well, deputy, it sounds like you've consulted with everyone except those who require these services in downtown Dartmouth. If the department is committed to providing mental health services that are closer to home, behaviours will

reflect that. Behaviours reflect the overall vision, for vision is a priority; behaviours reflect that. I'm concerned that we're not seeing that play out in this particular case.

Deputy, switching gears, I'd like you or CEO Carr to clarify for Nova Scotians: Who is ultimately responsible for the reporting of wait times? Is it the Department of Health and Wellness or is it the Nova Scotia Health Authority?

KEVIN ORRELL: As you've been made aware of from the opening remarks, the operations are with the health authorities and they would be responsible for the assessment, evaluation, and calculation of wait times. The department would oversee that and we would want their input as an accountability issue. I will refer to Dr. Carr for further explanation.

BRENDAN CARR: Thank you for the question, Mr. Halman. These are important questions, and just to digress for a moment, really it is the responsibility of the Nova Scotia Health Authority to organize and deliver services, and the question of access and ensuring that we have built a model of care that can be consistently delivered that promotes access is, I would say, one of our highest priorities.

As you heard Ms. Hodder when she spoke specifically to the question you raised around these locations, we consider things like whether the location is physically prepared to offer the model of care, or if it is co-located with other services - because mental health doesn't exist in a vacuum. The people who need mental health services frequently interact with other social services, et cetera - are these services easily accessible?

These are literally the kinds of questions that we consider every day in looking at services. It would be fair and honest to say that we are continuously in a process of looking at services and changing locations to try to optimize these things for many people.

Equally, it would be fair to say that there's a considerable amount of consultation that goes on. I mentioned in my opening remarks that we have five community advisory groups across the province. I'm sure if Ms. Hodder were to speak to this, she could speak to the members and Dr. Harris and other people that groups have been engaged in dialogues around how we improve these services.

As it relates to wait times, the truth is we are all responsible for wait time data. We have a responsibility to collect that data as a function of the services that we're providing and provide that to the Department of Health and Wellness. That's something that we have done.

What's most important, as I said in my opening remarks - if you look at that data, we've made substantial improvements since 2017 where we are now consistently meeting standards for urgent visits and for the semi-urgent visits. We've made improvements of 42 to 43 per cent.

TIM HALMAN: To that point, Dr. Carr, that's my concern. When we use statements like "all are responsible", I think that leads to the Auditor General indicating these are being implemented haphazardly - there's no provincewide plan for mental health. All this is coming out of the Auditor General's Report. That's a concern. I think Nova Scotians want to know where the buck stops. Where is the scope of the responsibility?

According to the Department of Health and Wellness's website, wait time for non-urgent care can range from a nine-day wait in Colchester County to a 238-day wait at Cape Breton clinics.

In your opinion, is such a discrepancy in wait times - depending on where you live in Nova Scotia - acceptable? Yes or no is sufficient.

BRENDAN CARR: The answer is no. It's not acceptable and that's why we continue to work on this process across the province.

TIM HALMAN: I'm certainly a proponent of universal mental health care for our province. Do you agree that it shouldn't matter where you live in this province or if you have private medical insurance?

BRENDAN CARR: Yes, I do agree that it shouldn't matter where you live. These services should be publicly available.

TIM HALMAN: Do you believe that, as demands skyrocket for mental health services across our province, there needs to be a separate minister responsible for mental health and addictions? Could you explain?

BRENDAN CARR: In less than a minute, it would be very challenging to fully address that question. I would probably ask my colleague, Dr. Harris, to speak to this from a clinical point of view.

What I can say, having worked in senior leadership across three provinces and having seen a number of different approaches to mental health, what we've learned in the last 15 or 20 years is that mental health does not exist in a silo. There are some people with highly specialized mental health needs, but the majority of people's mental health issues interact with social, behavioural, and other issues. What's most important is whatever structure we put in place, that it promotes the integration and a holistic approach to care and good access, as you've pointed out.

I think if you look to the Province of Nova Scotia, as you said, in 2017 the Auditor General's Report raised some serious concerns and we are here today to say that we have substantively addressed those concerns. The concern that you're raising existed in 2017 and we are saying that those concerns have been substantively addressed. Are we perfect? No, but we will continue to improve. Perhaps Dr. Harris would like to speak.

[9:45 a.m.]

THE CHAIR: Maybe we can come back to that, unless the committee would like to hear from Dr. Harris first.

The time for the PC Caucus questioning is up. I'm going to turn it over to the NDP Caucus for 20 minutes - Ms. Leblanc, go ahead.

SUSAN LEBLANC: I am happy to hear from Dr. Harris, as long as it doesn't cut into our 20 minutes. Can we figure that out on the other end?

THE CHAIR: It all depends on how long his response is going to be. (Laughter)

DR. ANDREW HARRIS: My opinion is that we are better served by being closer to the entirety of the health care system as Dr. Carr has implied.

Psychiatry and mental health are a complex combination of neural behavioural disorders, some of which are based in brain dysfunction and some of which are based in social determinants of health. We have come a long way from the days when we used to institutionalize and saw psychiatry as a separate and distinct area of health care. My personal opinion is, it would be a step in the wrong direction to separate ourselves through the forming of a separate ministry.

SUSAN LEBLANC: I just want to follow up on this a little bit - go off my script a bit - and pick up on the relocation of the mental health services in Dartmouth to Portland Hills really quickly. Certainly, I share some of Mr. Halman's concerns. For me, it's not a question of combining those services under one roof. I totally understand why that's important and I think that's a really good move.

For me and my community in Dartmouth North, for us the issue is access. I understand that Connections does reach out to folks in Dartmouth North. Dartmouth North, as I've said many times, has parts of its community that are extremely vulnerable. I think we have the highest levels of social deprivation in the province. We have high unemployment. We have very low incomes. We have a lot of people who are accessing or need to access mental health and addiction services.

To ask those folks who are already leaving the community, which is a community in many ways at least in this area that we are in right now - the north end of the north end - who already find it difficult to get to downtown Dartmouth to get on a bus at 8 o'clock in the morning to get to Portland Hills, even though it's right next to a bus terminal, is actually quite a big ask. I know that community members here in Dartmouth North are very upset and worried that people are going to stop accessing the services they need.

I do have letters drafted for many of you on this call, actually, to talk about the possibility of satellite mental health services in Dartmouth North. I think it's possible. There is space available. I am ready and willing to work with all of you to make that happen. Wait for it. It's coming up for you.

Today, there was a report released by the Nova Scotia College of Social Workers - I don't know if you've seen it yet. It's on mental care and it's called *Repositioning Social Work Practice in Mental Health in Nova Scotia*. It's a culmination of in-depth research with mental health service providers, supervisors, and service recipients. It urges a critical change to the mental health care system and urges a broad social determinants of health approach.

One of the recommendations in the report is to increase the proportion of spending on mental health to 10 per cent of the province's spending on health. When we're talking about all of these issues, we can't deny that a lot of it has to do with budgets and spending and where we're allocating the dollars that we have. We shy away from this conversation sometimes, but we are a Public Accounts Committee, so let's talk about it.

The World Health Organization makes the same recommendation, but Nova Scotia falls well below the target of spending 10 per cent of the health budget on mental health. I'm wondering if you can talk about what would be possible if the budget for mental health care was increased to 10 per cent? I'd love to ask folks like Ms. Hodder and Dr. Harris, who are running the programs.

If there was a budget increase to 10 per cent of the health budget - I'm sorry I don't have those numbers in front of me, but maybe Dr. Orrell or Dr, Carr could give a sense of that - what would be possible? What could we be doing? Could we have satellite services in Dartmouth North and many other communities? Could the wait times come down drastically in Cape Breton for a second appointment? What would be possible in Nova Scotia?

BRENDAN CARR: I do want to hear my colleagues comment, but I do have one overarching comment I'd like to make, which is we absolutely should appropriately have resource mental health services in this province. I think, as the deputy said, there have been substantial investments made in mental health, and we will continue to do that.

Ms. Leblanc, having grown up in Dartmouth and living close to the north end, I completely agree with and support what you're saying. We should be able to look at things like satellite services and do that within our existing resources. Our challenge is, we have tremendous resources as a health system, and our first approach should be to say, how can we best use those resource to deliver the most value we can for our citizens?

That sometimes means thinking about how we redistribute resources from one program area to another. That is something that we are actively engaged in. I just think we need to keep that in mind, and we have tremendous opportunity to do that.

I'll turn it over to Ms. Hodder.

SAMANTHA HODDER: Just to note, over the last five years, we actually have seen, as it has been noted, substantial increase in relation to Nova Scotia Health Authority's operational budget for the Mental Health and Addictions program. Those investments have totalled up around a 21 per cent increase in our overall operational budget over the last five years. I'd just like to note that those investments have been under way and have been resourced.

As part of the Auditor General's Report, those recommendations were significant and we have made substantial changes in relation to those. Part of that was around needs-based planning, which was essentially the methodology that we utilized to plan for our overall program of care. It's based on an approach of community, Nova Scotia needs, local needs, as well as provincial needs. When we have identified gaps within our system, within our program of care, we have collaborated and consulted with the Department of Health and Wellness, and they've actually responded with significant investments in relation to where the identified needs have been identified.

Our access and navigation initiative and noting up and standing up our intake line, that has substantially increased access and availability of services. We heard from patients and families time and time again that our program - and when they had the courage to reach out and get help, or a family member was wanting to make a referral, they didn't know the first step to essentially take in relation to that. That is essentially what our intake line and standing up has done, has created sort of that centralized access point for mental health and addictions.

In terms of recommendations of future investment and where we're at, I think the performance - we've made some significant gains. I think we have a plan in place as a provincial system of care, and future investments should be made to support the work that has already been under way because of those gains and the momentum that we've actually made. It was pointed out in relation to wait times for the Cape Breton area and sort of the variation that exists in some of our areas across the province. We're very well aware of that, because of our robust data and information systems that have been essentially completely redesigned with new investment that has enabled us to essentially look at the variation and apply resource to where the needs are.

We've done just that, and virtual care has actually created a significant opportunity for us. I do need to highlight that, and sort of the opportunity there. The reasons why we do have some variation across the province in relation to wait, it's really about recruitment

of providers. We have some areas in rural Nova Scotia where we have left positions unfilled for years because we could not get qualified candidates for those positions.

Virtual care has actually created an opportunity for us, and we've actually stood up a clinical virtual care team in the Province of Nova Scotia with the investment from the Department of Health and Wellness to say, let's not leave these positions vacant any more. Let's recruit to a provincial virtual care position, and essentially those team members can go to where the needs are. We have recently just stood that up and created that opportunity.

The other thing with the Nova Scotia Health Authority that this has created is a shared resource strategy. What that means is that in areas like Cape Breton, where they were struggling in relation to that access issue, we actually have made significant improvements in relation to access in Cape Breton by utilizing resources in other areas across the province to provide treatment and care to people utilizing virtual technology. Actually the wait times that are published right now, it's important to note that that 90th percentile is actually a distribution of the maximum wait time that somebody would have been waiting for care within that quarter. It's actually not the average amount of time that somebody would be waiting.

The average amount of time that somebody would be waiting for care in the last quarter is 76 days. That's still too long, and we want to make sure that we're bringing that back into the standard. We actually reached in to our colleagues across the province and had a provincial approach to that. We actually took 70 people who were waiting for service in Cape Breton and actually had them serviced by other clinicians across the province to get better access.

Those are some of the opportunities I think that we have, is capitalizing on the framework and the foundation that has been established with the Nova Scotia Health Authority and in collaboration with the IWK in building on the current investments that have been made as we've made significant gains.

THE CHAIR: Ms. Leblanc, I'm going to ask if you still want Dr. Harris to comment.

SUSAN LEBLANC: I think I'm okay, actually. I'll move on, but I will say that after all my comments about how horrible the mental health situation is in Dartmouth North, I just want you to note that the sun is shining very brightly here. I'm being blinded by the sun, so it is actually an amazing place to be.

I'm going to switch gears and talk a little bit about youth mental health services. One of the recommendations from the 2017 Auditor General Report that was left incomplete as of October 2019 was that the Nova Scotia Health Authority should finalize policies for emergency mental health services and reflect a provincial approach to service delivery.

In my office, I often hear from parents whose teenage children are in crisis and who feel completely unsupported by the mental health care system. No one has to look very far to find a parent who has a story of being sent home with a child in crisis and told that they'll be checked in on in a couple of days.

Firstly, the Nova Scotia Health Authority responded that the implementation of the emergency admission policy is under way and completion was anticipated in the Fall of 2019. My first question: Is that complete?

THE CHAIR: Who are you …

SUSAN LEBLANC: Dr. Carr.

BRENDAN CARR: If it pleases the Chair, I think I'd like to ask Ms. Hodder to respond, if that is okay.

SAMANTHA HODDER: Yes, it is complete. That was done jointly for the youth policy in collaboration and jointly with the IWK and the Nova Scotia Health Authority, but it is complete.

SUSAN LEBLANC: Thank you, that's great. I'm wondering if possibly Dr. Jangaard could talk, or Dr. Bagnell or Ms. Brennan, could talk about how the assessment process works at the IWK. Is the experience described by the parents that I've referenced part of the admissions policy, or is it a capacity issue at the IWK?

THE CHAIR: Dr. Jangaard.

KRISTA JANGAARD: If it would be okay, I would ask that either Dr. Bagnell or Ms. Brennan would be answering that question, as they're closer to the actual processes on a day-to-day basis.

DR. ALEXA BAGNELL: Thank you for the question. As I understand, the question is around admission or assessment processes in the emergency room at the IWK. We have gone through a lot of work in looking at our processes, and we are in continuous improvement, so I do appreciate the question, and we have really had a lot of gains in our process of the emergency room, but as you'll hear, there is always work to be done.

We have a clear process when a family comes in. We have a fantastic emergency crisis team, which is the first point of contact with our emergency room. Then we have 24/7 psychiatry on call. About the half of the patients and families who come to the emergency department for an emergency crisis assessment do see psychiatry. About half of those patients are admitted to our in-patient unit.

[10:00 a.m.]

In terms of emergency room visits, we have youth come from across the province for emergency assessments. Probably about a third of our visits are from outside of the Halifax Regional Municipality's Central Zone.

In terms of questions around family feedback, we have at the IWK Health Centre a really robust feedback system where if a family is concerned about how the process went, they have an anonymous feedback, but also an individual feedback where we will follow up on that. We talk to families all the time and that is part of our continuous improvement process.

In summary, I would say - and I will then see if Ms. Brennan also has something to add - that we really have in the last five years changed our process a lot. It's a lot smoother. I think families have a lot more information when they come in. We also have fantastic services now very quickly afterwards. We have an urgent care service that sees families within two to three days of their visit, if an assessment in terms of admission to the hospital is not needed.

I'm going to finish my comments there and see if Ms. Brennan has something to add.

MAUREEN BRENNAN: Good morning and thank you for the question. Building on what Dr. Bagnell said, we've had tremendous opportunities to work in collaboration with the Nova Scotia Health Authority over the many years, working towards a vision for improved mental health services across the province.

The admission policy that has been created is a shared policy and it supports provincial admissions into child and adolescent in-patient services. It's also important to note that feedback is such an important part of our system of care and we learn so much and get so much value from patients and families and community partners. As a regular process, we have introduced over the last number of years clear processes where families contribute to the design into how we improve services. We accept and bring their ideas into the plan. That's in our standard way of working within the IWK.

Emergency services - again, because we have such a strong working relationship with Nova Scotia Health Authority, we sit as part of the provincial Mental Health and Addictions program where Dr. Bagnell and I have an opportunity to talk about how we can improve and standardize services across the province. We talk about opportunities to learn from one another and to ensure that we can support our communities across the province.

With that in mind, the example would be a shared assessment that was shared across the province for emergency departments to use that assessment, which would be the same assessment that's used in the IWK. That will ease and smooth the transition and admission

process for anyone from Cape Breton to Yarmouth or from Halifax to have a standardized way in which we're understanding the care and the needs for those families in crisis.

SUSAN LEBLANC: I'm going to ask a quick question about the Mental Health Mobile Crisis Team. We know that it aims to respond with a mental health clinician for people experiencing mental health crisis anywhere in the province, but I understand that it's not available at all times and in all parts of the province.

My question is, what proportion of people in crisis have an initial interaction with police instead of a mental health clinician? Also, many people will not feel safe calling the Mental Health Mobile Crisis Team because of the involvement of police. I'm wondering if there are any changes being considered to the service to improve this dynamic. I guess I will direct that to Dr. Carr.

BRENDAN CARR: I think it's an excellent question. I really can't answer that. Ms. Hodder could probably give you the best answer.

SAMANTHA HODDER: Thank you for the question. One important component around crisis is that we do have a provincial crisis line that is available 24 hours a day, seven days a week. That exists across the lifespan and for all Nova Scotia citizens to utilize. It's important to note that we track and trend the utilization in relation to the provincial crisis line as a key performance indicator for our program of care, and what we have noted is that there is a rise in relation to its uptake in utilization, as well as interventions. That rise in terms of utilization actually had commenced at the time when the state of emergency had been announced in our province.

One important thing is that we actually have a line that is available. It is answered by qualified mental health clinicians, it's available across the lifespan, and it is well utilized across the province. We've actually seen upwards, during the peak of the pandemic, of an increasing trend of 35 per cent from this time this year to previous years in relation to intervention.

I would like to note that we've actually been able to respond in relation to that increased demand or that surge in the crisis line. We have a standard where we respond within 30 minutes, and we've been able to continue to uphold that standard for the provincial crisis line.

The other thing that has enabled us to do that is that we have seen significant resource investment from the Department of Health and Wellness in our provincial crisis line as well as our urgent care services. That was an identified gap by the Auditor General, as well as we identified that as a gap within our overall system of care.

In Central Zone, we do have a mobile team as you had mentioned, but in other areas across the province, we have looked at utilization patterns over time and have made

investments to enhance the urgent care crisis teams that are located in those regional centres across the province. That's so if people do have a need and are presenting in crisis, we have qualified experts and clinicians and psychiatrists that are part of that overall care team as consultants to the emergency department to help support the patient need, and then also to help transition them to the appropriate level of care to meet their needs.

We've actually increased our budget in relation to our urgent care crisis response on an annual basis of about $1.5 million a year, and that equated to 13.5 full-time employees. That built on the existing framework that we had in place. There was a recommendation in the Auditor General Report around clarifying pathways, clarifying assessment tools, and helping to aid in relation to transitions for people, and we've been able to complete and accomplish all of the recommendations, as well as the associated training of our employees within those teams.

It does look a little bit different across the province in relation to our crisis response and urgent care; however, the quality and standard of care is the same.

THE CHAIR: The time for the NDP caucus has expired - actually it went over, but that's fine. We'll go now to the Liberal caucus. Mr. Jessome.

BEN JESSOME: Thank you kindly, Mr. Chair. Thank you folks for all those informative responses. It's clear to me that there has been tremendous consideration and hard work, for whatever my opinion is worth as a Nova Scotia MLA, as a non-health care provider. I truly value your expertise and positions and effort, truly. It's clear that the changes that are being initiated - in reaction to the Auditor General's recommendations - are being done based on what is clinically evident and valuable, which is what I think that we as legislators need to be mindful of.

We have an opportunity to bring forward the important considerations of our constituents that can add value to the decision-making protocols that take place, but I think we all need to remind ourselves of the importance of relying on our experts and the clinical evidence that supports this improved standard of care. That's my speech, and I'll go on to the question now.

Dr. Orrell, first one's for you. The allocation this year for mental health services is $310 million - an increase of, I believe, $35 million since 2016. Can you add some brief details as to whether or not this is the health-specific budget, or if this includes the budget allocated to community partners and other government agencies?

KEVIN ORRELL: Of the $310-plus million, $210 million is turned over to the health authorities for the services that they provide; $54 million dollars goes to physician services and psychiatry; $32 million is used for pharmaceuticals, for the drugs that are required to treat this population of people; and the remaining $10 million is held by the department to support those community not-for-profit groups that I referred to.

BEN JESSOME: Thank you, Dr. Orrell. I'll take that as an indication that there are separate budget items and separate departments - for instance, the Department of Community Services and the Department of Education and Early Childhood Development - that would have a collaborative impact on the mental health care of Nova Scotians.

Secondly, I'll move over to Dr. Carr, if I may. We've got the responsibility of bringing our constituents' issues to the table. Dr. Carr, you referenced on a couple of different occasions the inclusion of the five regional boards or advocacy entities with the Nova Scotia Health Authority. Can you provide us with some added context about how specifically their involvement plays into the decision-making on your end?

BRENDAN CARR: Thank you very much for that question, and if it pleases the Chair, I'd like to ask Ms. Hodder to respond.

SAMANTHA HODDER: As our colleagues at the IWK had spoken about earlier, patient, family, and community engagement is essentially built into the fabric of all of our planning, all of our design, our implementation, and our execution and evaluation for every single component of our mental health and addictions transformation. It's a principle that we had adopted early on within the Nova Scotia Health Authority, broadly as an organization, and we've applied that principle to all of the improvement initiatives that we undertake within our program of care.

That is multipronged. One of the prongs that we have is the public advisory groups that we have set up in each of the zones. They have cross-representation of not-for-profit organizations, patients, and families to share experience, get the pulse of what's happening in terms of the local needs, to take to them information about things that we're designing, ideas that we have in relation to get the response to whether this is going to meet the needs.

We also arranged check-ins throughout COVID-19 so that they knew how we were responding as program of care to maintaining access and continuity of our services for the citizens of Nova Scotia. We also do patient experience surveys on a routine basis as part of our requirements for accreditation, so they are essentially satisfaction surveys to find out and measure outcomes from a patient's perspective.

All of our projects, all of our planning that we have under way - whether it be our access and navigation project, or our improvement of our withdrawal management services - we build into an arm of either patient, family, or community representation to advise and assist and consult with us on a routine basis to essentially share their experience and let us know if we're missing the mark.

Another great example would be in relation to the standing up of our new website for Mental Health and Addictions and the online tools and resources. We co-designed that in relation to patients, families and community members. We did broad strokes in terms of surveys that were available for anybody to answer anonymously. We also did very specific

focus groups and engagement opportunities. It is a quality improvement cycle for everything that we're doing and so we need to continue to hear that feedback, those experiences, and let those be one part of the pie, so to say, in relation to how we design and implement high-quality services for mental health and addictions in this province.

BEN JESSOME: The next question I have - there was a reference to a new addition to the continuum of care that includes an enhanced suicide risk assessment and intervention training associated with that. Obviously, this is the worst case scenario that needs to be highlighted and addressed. Can either Ms. Hodder or Dr. Carr elaborate on what that new development is and what type of engagement staff can expect to have to go through or has gone through in order to meet those new standards?

SAMANTHA HODDER: As part of our requirements as an accredited program within the Nova Scotia Health Authority, we have what's called a required organizational practice around suicide risk assessment and intervention. We essentially have developed and implemented a policy, as well as standard operating procedures around suicide risk and the accompanied assessment tools associated with that.

We have also created training and education associated with that policy so that our providers have the knowledge, skills and abilities to essentially be able to work for, inform and do those risk assessments. That has been in place and we have 94 per cent of all of our providers trained in relation to the training associated with suicide risk assessment, as well as the policy and standard operating procedures associated with that as well.

The other piece is that we're partnering with our colleagues within the emergency department, as well as continuing care, long-term care in relation to suicide risk assessment within those areas. We have working groups that are essentially established around policy, protocol and risk assessment training in those care environments.

I'd also like to hand it over to my partner, Dr. Andrew Harris, to comment any further around suicide risk.

ANDREW HARRIS: Thank you, Mr. Jessome - I share your concern. This is certainly one of the most important areas of mental health - to prevent or avoid as best we can tragic events like suicide. I don't think I have very much more to add to what Sam said. We have taken this extremely seriously and we have a very organized approach to how we handle suicide risk. I think certainly the biggest part has been our ability through our training organization within mental health to bring up to speed all of our providers. We're at 94 per cent and we would hope to hit 100 per cent at some time in the near future.

BEN JESSOME: Dr. Harris, I'm just curious because I think this perhaps speaks to the level of hard-working consideration and importance that staff across the board have for this. When was the program initialized? We're at 94 per cent completion rate. That's fairly

impressive by most standards. How long has this program been available to get to 94 per cent completion rate?

ANDREW HARRIS: If you don't mind, I'll pass that over to Ms. Hodder.

SAMANTHA HODDER: In relation to the policy development and the implementation of training, we commenced that in the 2017-2018 fiscal year.

BEN JESSOME: Thank you. Very impressive. Ms. Leblanc had some questions related to families and their entry into crisis situations. I do hear things along those lines as well, so I appreciate that line of question.

There was a suggestion that there was collaboration with respect to admission standards that included the families and their assistance to design the model of bringing people in through that emergency scenario. I've heard on a couple of occasions at least that people were turned away at the hospital, so I'm wondering perhaps - I think one of my colleagues will get into the IWK in the next round of questioning, but at our other hospitals, how do families of patients who are in crisis have an impact on that acceptance into care at a point of crisis?

THE CHAIR: And that question is to?

BEN JESSOME: Perhaps Ms. Hodder, I guess?

SAMANTHA HODDER: I'll start off with a response and then I'll pass it over to my colleague, Dr. Harris, for a conversation around the clinical decision-making that goes into that. At the Nova Scotia Health Authority, in relation to our adult services, we also have an emergency admission policy and associated protocol which essentially helps sort of set the criteria of needing an in-patient acute admission for Mental Health and Addictions. We had established that policy and the standards associated with that back in 2017.

What's important for folks to know on this call is that if people are needing in-patient mental health care, we provide that. There's no wait for in-patient mental health care, and if there is no bed available within the area or that the person or family is presenting to, we have a system in place in which we know at any given moment where all of the beds are in the province in relation to mental health care, and we will facilitate timely access to that level of care if it is needed for that person.

If somebody does meet the criteria and does need in-patient hospitalization, we do not turn people away. That is the most important decision that is made by the psychiatrist through their clinical assessment and in consultation with our crisis response team, but we do not turn people away who need hospital-based care.

Andrew, I'll turn it over to you.

ANDREW HARRIS: This is a very complex question and would really require me to get into some of the clinical care of people who present to services with self-harm. Suicidality is very common. Lifetime prevalence of suicidal ideation is between 70 and 90 per cent, meaning that it's actually normal. Each of us may at some point in our lives have this as a consideration. On its own, it is only one symptom of the person presenting, and as Sam has said, we do take it very seriously and as a systematized and careful assessment of risk.

Some people, if that risk is such that it would be modified by hospitalization, by admission, are admitted. For some people, that risk will not be modified by hospitalization and in some cases, the clinical decision is not to admit that person to hospital, but to organize urgent services and follow-up and supports in that person's community.

That may seem difficult to conceive of to people, and certainly for families in distress it seems like the wrong thing, but this is the accepted clinical management of people who present with complex disorders, which include self-harm, intent, or thoughts. I don't think this is the place to get into a substantive lecture on the management of suicidality, but in short terms, that's what it is.

BEN JESSOME: Ms. Hodder, you and others have referenced the AG Report's recommendations have been accommodated and met to some degree, and there is a plan for mental health care in the province. Is there a place where Nova Scotians can go to access that plan?

SAMANTHA HODDER: Our initial work in relation to our health services planning with Nova Scotia Health Authority produced a report titled *Milestones on our Journey*. That is available publicly on a website. I would encourage folks to look at that where we did essentially the initial gaps that were identified within our service provision, as well as the opportunities for future enhancements. I would encourage you to review that report, if you haven't already. It is available online.

We also did a report card of the progress that we made to date. That is also available online through our Nova Scotia Health Authority website. We also kicked off our own public website that has a lot of information for the public in relation to the work that is under way within Mental Health and Addictions. We finalized our key performance indicators for our program of care that we monitor on a monthly and quarterly basis that is accountable essentially to our executive within Nova Scotia Health Authority and our board. We also share those with the Department of Health and Wellness.

We just recently launched a new program plan called Direction 2025, which essentially outlines the next phases of our work in relation to future opportunities to support

access, high quality of care, transitions, and high level of patient, family and community engagement for better mental health care in Nova Scotia.

THE CHAIR: The time for the first round of questioning for the Liberal caucus has expired. Before we go into the second round of questioning, I want to ask the committee members - as we started six minutes late, if it's your wish, we will continue six minutes later on the other end. Just a show of hands from the committee members, if you're in agreement with that.

[10:30 a.m.]

It is agreed.

That's great so we'll go on. The next round is going to be about six minutes per caucus. We'll begin with the PC caucus - Mr. Halman.

TIM HALMAN: My question is for Dr. Carr. Would it be helpful to reduce wait times to allow private practitioners, including psychologists, counsellors, social workers, to bill the Province to provide care to those without private insurance?

BRENDAN CARR: I think I understand the question as would it be beneficial to allow private practitioners to bill the province for these services. My position would be, provided the services were being provided within the context of our overall public health system and that it was not creating a means for people to kind of jump in front of the queue - if we could think about that in a way that it created more access, managed within the scope of our provincial program, then that would be something that could be considered.

TIM HALMAN: Would a 10 per cent increase to the mental health care budget be helpful?

BRENDAN CARR: Just a point of clarification, because there was an earlier conversation around the notion of 10 per cent of the budget being allocated to mental health, which is not the same thing as a 10 per cent increase in health care . . .

TIM HALMAN: Let me clarify, Dr. Carr. The provincial budget spent on mental health care, seven per cent - if that were increased to nine per cent, by say $102 million, would that be helpful?

BRENDAN CARR: Certainly for mental health services, it could be helpful, and with a number of provisos. I'll be brief, but ensuring that we continue to keep a holistic view around mental health and ensuring that those funds went into the things that support mental health broadly - such as social programs, justice, many things other than just specialized health care services - I think that there could be tremendous value.

As a province with finite resources and as a health system with finite resources, we really should also look at what would be the trade-off, because if we were going to direct that much more funding to mental health, what other things would we not be able to do, and would those trade-offs make sense for us? That would be, I guess, the thought process that we should go through.

TIM HALMAN: Dr. Carr, do you agree with the Canadian Mental Health Association's executive director for Nova Scotia, Pamela Magee, that we need to re-evaluate the mental health care system here in Nova Scotia?

BRENDAN CARR: I would suggest that we have been in the process of doing that, and I think the Auditor General's Report 2017 provided us with a very strong signal that we needed to do that in a very earnest way. Given that I can't take credit for most of that work, having joined the organization just within the last year, I think it would be fair to say that that report has been taken very seriously, that there has been a substantial overhaul of the system, that we are in the process, as my colleague Ms. Hodder says, of transforming the system.

If you look at the data that we've provided here today in terms of improvements in access and the quality of service, the range of services, our ability to integrate different service lines such as virtual care, reach rural parts of the province, and work together with providers, we are on a path of substantial improvement, and we should continue on that path.

TIM HALMAN: Thank you for your response, Dr. Carr. Does Nova Scotia Health Authority believe there should be a dedicated mental health crisis line similar to 911? I'm certainly a proponent of creating a 24/7 mental health crisis line by dialing 988. Would you be able to respond to that, perhaps Ms. Hodder or Dr. Carr?

SAMANTHA HODDER: I just would like committee members to be aware that we do have a provincial crisis line in place. It is available 24 hours a day, seven days a week, and is staffed by experts in mental health and addictions-related care. That is in place, and we are responsive 24 hours a day, seven days a week in relation to that toll-free number.

TIM HALMAN: Again, Dr. Carr, you said opening up the building codes has to be looked at within the context of our overall public health system. Could you outline two or three benefits that you clearly see that we would gain by opening up those building codes?

BRENDAN CARR: I'm not sure that I can off the top of my head, Mr. Halman, and with respect, we would need to look at this through the lens of how many practitioners we're talking about and where those practitioners currently are practising. Many of our practitioners practise within the public system and sometimes have some private clinic or work.

It's actually quite a complex question, and I would be very hesitant to try to offer you a response without the benefit of further analysis.

THE CHAIR: The time for the PC caucus for the second round of questions has expired. We'll go now to the NDP caucus, and Ms. Roberts.

LISA ROBERTS: Thank you for this opportunity. I'm going to speak quickly because I have more than six minutes of questions, I think.

I have heard from both a psychiatrist and a social worker working in in-patient mental health care here in Halifax that the shortage of affordable housing and the lack of support for Housing First, added to inadequate income assistance rates, are impacting the health budget and the provision of acute mental health services in Nova Scotia.

I'm wondering, Dr. Harris or Ms. Hodder, could you comment on whether you are currently tracking or accounting for this problem - keeping data on how many nights of in-patient care within your area are actually people who are over-housed in mental health care settings because they can't be discharged into homelessness without obviously greatly impacting their recovery from perhaps from some initially acute mental health crisis.

SAMANTHA HODDER: One of the things that we do track in relation to our in-patient stays is something called alternative level of care. Essentially what that is, is when a person is on our unit and ready for discharge from a mental health and addictions perspective in relation to their treatment goals, and there is a lack of flow-through to that other level of care for them.

We do track that actually on a monthly basis right across the entire province. It has been actually tracked for some time within Central Zone. Then through our redesign of our information systems, we actually have been able to extend that to also track the alternative level of care across the entire province.

I will say that through COVID-19, we have struggled in relation to patient flow in relation to people who wanted an alternative level of care besides acute mental health. However, in the recent months, we actually have made significant gains in working with our partners at the Department of Community Services and long-term care in relation to facilitating access and flow-through into community. That has been a significant gain for us as a partner within that through long-term care, Department of Community Services, and the Department of Health and Wellness.

It still continues to be a challenge for us, but to answer your question in relation to alternative level of care, we do track that and monitor that on a routine basis, specifically around housing. I'll pass it over to anybody else - it's a significant determinant of health and it is something that the citizens of Nova Scotia - Housing First strategy and homelessness are all key determinants in relation to good health outcomes, including

mental health outcomes. It does pose a significant challenge for people accessing our services.

THE CHAIR: Ms. Chouinard.

VANESSA CHOUINARD: I guess I would like to reassure the panel that we at the Department of Health and Wellness work closely with not only the health authorities on issues like this, but also with the Department of Justice, the Department of Community Services, the Department of Municipal Affairs and Housing. We work really closely with them to look for solutions and actually ensure that people have safe places to go and that they aren't sitting in an alternative level of care bed, like Ms. Hodder described.

For example, during the pandemic, we provided funding to open up an additional 30 homeless shelter beds, for example, to ensure that people were safe and they weren't being over-housed in the current shelter environment or having to go elsewhere. I just wanted to point that out.

LISA ROBERTS: Given the time constraints, I'm going to jump to a different question and topic. A number of other provinces have implemented same-day, next-day mental health services, and I know there's been at least one pilot project in Nova Scotia completed by the North End Community Health Centre.

Particularly in the context of the IWK, where we do see this tracking of urgent care and non-urgent care trending down, the fact that those stats and that data shows that people are getting care in a more timely fashion can't ensure us that the outcomes of that are also positive. We're tracking how the system is doing against the benchmark, but we don't know if the benchmark is resulting in the best outcomes.

I'm wondering if there is any consideration of that sort of same-day, next-day mental health service, particularly thinking of the 18- to 25-year-old group which can fall between systems and who are not in school and therefore not accessed by the SchoolsPlus programs.

KRISTA JANGAARD: Thank you very much for the question. It's a very important one, although we do not currently care for youth up to the age of 25. Certainly those 18-year-olds and 19-year-olds who require transition into services so that those services can continue is really important.

With respect to your specific question around same-day, next-day services, I would turn that over to Ms. Brennan for a discussion about where we are and how we have used not only the tracking of are we meeting the wait times, but what is happening with the patients, to explain that more formally - if I may, Mr. Chair.

THE CHAIR: Ms. Brennan, can you do it in a minute?

MAUREEN BRENNAN: I'll try my best. Thank you for the question. It's very important that the coordination of care is responsive and in step with each other, so anyone coming through the door in a crisis obviously is seen by our emergency mental health and addictions team immediately. If they require next-day service, we have the ability to provide that appointment through our urgent care service or our follow-up next-day service, which actually is an outreach program that can go into that particular home.

What's important to note here is that that service doesn't happen within a silo; it's then a warm handover to our community mental health and addictions clinics for that continuous follow-up.

You asked about outcomes. That's incredibly important, because how do we know our services are effective or making a difference or meaningful? We have multiple ways that we're engaged in the IWK at looking at that. We do pre-measures for every service called the Strengths and Difficulties Questionnaire, which is an evidence-based measure for child and adolescent mental health, and we do follow-up measures within the services right across our full suite of services that are appropriate to the level of intervention happening.

We have a research and evaluation outcomes team that actually look at that, provide regular quarterly reports, and look at the feedback, both from the effectiveness of symptom reduction and improved function, as well as feedback from families through our experience questionnaire, and we look at those to make adjustments to services and ensure that we're making a difference and that people are getting better and well and able to successfully leave our system to function without being engaged in our mental health and addiction system.

THE CHAIR: The time for the NDP Caucus round of questions has expired. We now go to the Liberal caucus, starting with Ms. DiCostanzo.

RAFAH DICOSTANZO: My question is actually about virtual care for the IWK, but I also had a small comment or a short question for Ms. Hodder. When my two colleagues from Dartmouth were speaking about the location, I actually have worked many times in Dartmouth as a medical interpreter. As you guys were speaking, the first thing that came to mind is how many times I arrived late because I couldn't find parking, and that happened to the patients as well.

I know it's important to get all of the different mental health services together, that is the most important, but was parking one of the issues for the relocation from downtown Dartmouth?

THE CHAIR: That was for Ms. Hodder?

RAFAH DICOSTANZO: Yes, please.

SAMANTHA HODDER: When we worked with our colleagues in facilities management as part of the Nova Scotia Health Authority, part of the request for proposals, or RFP, we identified all of the requirements in relation to service provision and appropriate location, and that was a consideration.

RAFAH DICOSTANZO: My question is in regard to virtual care and it's to Dr. Jangaard. I know how important it is and how fast, apparently, the IWK switched to virtual care. I'm thinking of a couple of programs that I worked with, and they're amazing programs for children when it comes to mental health. I'm trying to remember - early prevention program, EBIB, or something like that.

KEVIN ORRELL: EIBI.

RAFAH DICOSTANZO: EIBI. I apologize. For a couple of the children, it was a huge thing for them to get on the bus to get to the appointment. I'm sure virtual care has been an amazing thing for them. On the other hand, I'm thinking, part of the interaction is to get close with the child. How did the interaction of virtual care help, and what kind of programs are you using? Just tell us how this virtual care is going to help us in the future. I'm really excited to hear about that.

KRISTA JANGAARD: Thank you for your kind words. I give all of the credit to my amazing Mental Health and Addictions team, who actually have been working on virtual care as an augmented way to increase access to our services for some time, even before the pandemic, and the pandemic afforded us the disruption to actually make things move very quickly.

If I understand your question, you're talking about the whole suite of virtual care, not just the ones for EIBI? Is that correct?

RAFAH DICOSTANZO: Yes, correct. What programs have benefited from that?

KRISTA JANGAARD: I would love to hand this over to Dr. Bagnell and Ms. Brennan - whoever would take the lead on this. They've done some exciting work both in service delivery and in research and to talk about some of the ways that those are helping our patients.

MAUREEN BRENNAN: I'll start, and then if Dr. Bagnell would like to jump in, that would be great. Yes, we were very excited with the quick, swift turnover to virtual services. What that essentially did is support the staff in a way that was helpful and meaningful to them, as well as make sure that we're able to provide flexible options for our families and patients in ways that are meaningful to them.

The quick, swift work with the Department of Health and Wellness approving our Zoom for Healthcare license was an essential part of that. The system moved in light years,

which provided amazing opportunities for us to move on that. Zoom for Healthcare was critical because when anyone new is coming into the system, it's really important that you have a facial and visual recognition so that you can properly engage with and assess that new patient or family. It's also important to note that, embedded within our central intake system, we provided options that we felt if it was clinically necessary to see someone face to face, those services continued. It was provided in ways that were meaningful.

Virtual services then provided multiple ways for us to change our service delivery. We have five in-patient services that support the province and the Maritimes with specialty in-patient services, and because of the pandemic and the lack of travel, they weren't easily able to come into our system. The teams very quickly moved to changing our full suite of in-patient rehabilitated treatment service to virtual care so that services could continue across the province and that we could Zoom into families and provide family therapy, to Zoom into the youth and into the community, and to Zoom into various places that would then overcome that distance. That was super helpful.

Through that opportunity, we started to realize newer opportunities of how we could strengthen and support transitions. Kids who are coming to Halifax for an in-patient treatment, travelling back and transitioning back to Cape Breton or Yarmouth, there are opportunities for us to do a shared formulation with a community team back home in a Zoom for Healthcare way that would share the treatment with both the local community team, as well as the Halifax team. We started seeing new opportunities, which were much more strengthened in the idea of having a team with video conferencing than it would otherwise be by teleconference.

We were successful in getting several grants to actually do some research on how effective our virtual care is and we're in the midst of research now. It's being led by the IWK, in collaboration with the Research Chair of Adolescent Mental Health, Dr. Leslie Anne Campbell. We're really looking at virtual services and to see how effective they are, what the opportunities are that we can learn from them, and how we can permanently embed those within our suite of mental health and addictions services, which we are committed to and continue to do.

The last thing I'll mention before I will pass it over to Dr. Bagnell will be that upon central intake, we do a survey and we engage our families and our youth. We actually have an evaluation process by which we're assessing families' interest, effectiveness, and outcomes through the virtual care. We have some really positive data that I believe Dr. Jangaard spoke to earlier about the preference of virtual services, improving access, reducing barriers.

For example, a youth with chronic anxiety that might not otherwise come into the clinic, we're able to Zoom in and engage in treatment in meaningful ways, that a family couldn't get their son or daughter for six months out of that particular room. We're seeing all kinds of interesting opportunities for us to improve services as well.

THE CHAIR: The time has expired for the Liberal caucus, unless Dr. Bagnell, you very briefly want to make a response.

ALEXA BAGNELL: I think Ms. Brennan did an excellent job in our overview. I will just say that one of the really amazing things that has happened with the virtual care transformation is the connections across our province and working really closely between the two health authorities, and having people together collaborating on clinical care but being able to be in their local communities. We have seen so much benefit to our patients and families. I know families have appreciated it and our colleagues across the province. That's all I'd add.

THE CHAIR: Thank you all very much. Again, a big thank you to everybody for participating in today's discussion. I'm sure we could probably spend more time talking about today's topic.

What I'll do now is invite the witnesses, if they want to make any closing remarks. I'll first ask Dr. Orrell if he'd be interested in making closing remarks.

KEVIN ORRELL: Thank you, Mr. Chair, and committee members. As I referenced a couple of times, I began my work here in the department in April. As you can imagine, the learning curve has been very robust and very interesting for me to learn more about the health care system than I knew as a 31-year experienced orthopaedic surgeon.

Prior to taking the job, I did meet with the psychiatry group and the mental health group in Cape Breton because I knew they were struggling and I knew they had some significant concerns. What has impressed me is the collaboration that the health authorities have had with the department. The work they've done in a very short time amidst a pandemic to provide a system and a care delivery that I think is outstanding and I think serves our Nova Scotian population extremely well. I'm very grateful for them for the organization that they've taken on to do this as well as it is currently done. I think the Auditor General's recommendations have been well addressed.

As we all stated in our opening remarks, there is much to do, but I'm very confident, given what I've learned in preparation for this event. The health authorities are well focused on delivering this care and making it better all the time.

THE CHAIR: Thank you. Dr. Carr, would you like to make some brief closing comments?

BRENDAN CARR: Thank you to the committee members for their very thoughtful questions and discussion today. This is an incredibly important topic in every jurisdiction in our country and certainly in Nova Scotia, and it will continue to be important and probably become more important as a society. We value the opportunity for the scrutiny and for the accountability here.

I do want to acknowledge our colleagues in the Auditor General's Office, and, I think, the thoughtful audit that was done in 2017 that has prompted a tremendous amount of very good work in the system. The only thing that I would like to just underscore is something that my colleague, Sam Hodder, said earlier. There was a nuance I just want to clarify.

In a province like Nova Scotia, our objective is to ensure that there's equity in terms of accessibility of services, and that is not the same thing as saying that the same service will be delivered the same way every place. We need to take advantage of the resources that we have, but also tune our services to the unique need. A crisis response approach in one part of the province might look a little bit different than it does someplace else, and our commitment is that service will be available to people everywhere across the province. It just might not look and feel exactly the same, depending upon where you are.

This is an important theme for many services in health care, so I just think that it's important for us to underscore that. But thank you very much for the opportunity to be here with you today.

THE CHAIR: Thank you, Dr. Carr. Dr. Jangaard, would you be interested in making some closing comments?

KRISTA JANGAARD: I won't reiterate what my two colleagues have said, although I do agree with everything that they have brought forward. What I'd like to underscore is the strength of Nova Scotia and the strength of the service delivery in Nova Scotia. It's based on the relationships we build, the collaborations that we have, both within our health care organizations with the Department of Health and Wellness, but also with our other organizations and other departments, such as the Department of Community Services, the Department of Education and Early Childhood Development, and others where our families live, work, and do their business at school.

We are dedicated to the thought that we need to continue our improvement to address the issues of mental health and mental wellness in our families, and certainly starting off well and addressing these as early as we can in childhood and youth sets us up for a healthy future for all Nova Scotians moving forward.

Thank you for allowing me to come and speak today and for listening to my team, who I think are great, and we look forward to continuing to work together to move this forward.

THE CHAIR: Thank you all so very much once again, and to all the staff who have joined you today as well. That concludes the questioning of the witnesses, and the witnesses and any staff who wishes can leave the meeting at this point.

We do have a couple of committee items to look after. Thank you all once again, and we'll just get into the committee business in about two seconds.

TIM HALMAN: Mr. Chair.

THE CHAIR: Mr. Halman.

TIM HALMAN: Permission to introduce a motion.

THE CHAIR: Permission granted. Go ahead, sir.

TIM HALMAN: On Tuesday, January 5th, Dr. Robert Strang provided an update on the province's COVID-19 immunization plan. The update indicated that all eligible Nova Scotians would have the opportunity to be vaccinated. It further indicated that the government has set a target of 75 per cent of the eligible population of Nova Scotia to be immunized by September 30th of 2021.

This is the most ambitious immunization plan in the history of our province. Therefore, Mr. Chair, I move that the Standing Committee on Public Accounts brings the topic of COVID immunization at the earliest possible date in order to understand the details of the plan entirely in order to clarify the process. Appropriate witnesses should be from the 11 members of the immunization committee, the Department of Health and Wellness, and of course the Nova Scotia Health Authority.

[11:00 a.m.]

Just a few comments to that motion, if I may. The purpose of the motion is to understand the process. The purpose of the motion is to seek clarity. Yesterday at the 3:00 p.m. press conference with Dr. Strang and the Premier, there were a lot of questions. I've certainly received questions from constituents. Just yesterday, I received a very straight-forward question from a resident of East Dartmouth: How will my elderly parents be contacted by Public Health when we begin that phase to immunize our seniors in the general population?

We know Nova Scotians want clarity. Even yesterday, Dr. Strang at the press conference - and this quote is coming from allNovaScotia from yesterday, January 12th at the 3:00 p.m. press conference: "While it may look like it's taken a little bit of time, this is the biggest, most complex health care initiative we've ever done in this province."

I know we all agree that the scope of this committee - a part of its mandate is to investigate public administration and the execution of public administration. I believe this motion is appropriate and I believe it's in the public interest of Nova Scotians to have this at our committee.

THE CHAIR: Is there any discussion? Ms. Leblanc.

SUSAN LEBLANC: I agree with Mr. Halman that this is an extremely important topic, but - and I can't quite believe I'm saying this - I actually think this is a better topic for the Health Committee. I would like to make an amendment to the motion that the topic of the vaccine roll-out should be referred to the Standing Committee on Health as soon as possible. The Chair of that committee is sitting with us right now, so he's aware of what's going on.

Maybe we can write a letter to the Chair of the Health Committee to ask that this be added to the agenda at the earliest possible moment. I do agree that it is really important. I just don't see how it is actually a subject for the Public Accounts Committee.

THE CHAIR: Before we go further, I'm going to ask Gordon Hebb if he could give a ruling on that because I believe the amendment defeats the purpose of the motion in the first place. Am I correct in assuming that?

GORDON HEBB: Yes, it doesn't strike me really as an amendment. Maybe a more appropriate motion, depending on what happens with the original motion.

THE CHAIR: So your advice is that we vote on the original motion and then see where it might go from there. Is that correct?

GORDON HEBB: That's correct, Mr. Chair.

THE CHAIR: Is there any further discussion on Mr. Halman's motion?

TIM HALMAN: Mr. Chair, just one final comment. Respectfully to the member for Dartmouth North, I do believe this to be a topic appropriate to public health, despite the changes made by the Liberal caucus in the Fall 2018. I maintain that any topic that relates to the public expenditures, to the execution of public administration is appropriate to the Public Accounts Committee.

Certainly, as member of the House, I remain determined to keep pushing to make sure those topics that are in the public interest come to the Public Accounts Committee.

That being said, I'm happy to move to a vote. I call for a recorded vote on this.

THE CHAIR: Mr. Jessome.

BEN JESSOME: Just for the record, I would like to note for the benefit of the committee and anybody watching, it might not have been the last update, but Dr. Strang was pretty clear on the capacity of our efforts to get vaccines out to Nova Scotians as quickly as the stock of available vaccines is available to us. There is capacity within our

human resources to distribute the vaccine. There is not a question of the operational side of it, but rather our access as a province to the available allotment of the vaccine that's available.

I would add that Dr. Strang and the Premier have been in front of the camera and answering these types of questions on a completely regular basis. There are regular updates on novascotia.ca/coronavirus. We all have our own avenues to field questions from constituents. I've received a great deal of positive feedback with respect to my regular updates on social media, and I just wanted to add that piece for the record that the consideration for rollout of vaccinations to people who choose to receive it has only to do with our limitations related to the amount of vaccines that are actually allotted to Nova Scotia. I thought that was important to include.

BRENDAN MAGUIRE: Mr. Chair?

THE CHAIR: Just one second, Mr. Maguire. Ms. Roberts is first, okay?

BRENDAN MAGUIRE: Mr. Chair, time has expired for the committee. It's 11:06 a.m.

THE CHAIR: The time for the committee meeting has expired, so we could either agree to extend the meeting . . .

BRENDAN MAGUIRE: You can't have a vote after time expires.

THE CHAIR: Okay.

RAFAH DICOSTANZO: I'm sorry, Mr. Chair, I have another appointment at 11:15 a.m. and I have to -

THE CHAIR: Having said that, the meeting has adjourned. Our next meeting is going to be February 10th, and no doubt it will be via Zoom again, and it will be the Department of Health and Wellness concerning Managing Home Care Support Contracts, November 22nd, 2017 report of the Auditor General, Chapter 3 and Homes for Special Care: Identification and Management of Health and Safety Risks, from the June 16th report of the Auditor General, Chapter 1.

Since we have gone over time, the meeting stands adjourned.

[The committee adjourned at 11:08 a.m.]