House of Assembly
Nova Scotia

HALIFAX, TUESDAY, MARCH 28, 2023

SUBCOMMITTEE OF THE WHOLE ON SUPPLY

3:41 P.M.

CHAIR
Lisa Lachance

THE CHAIR: Order, please. The Subcommittee of the Whole on Supply will come to order. It is now 3:41 p.m. The subcommittee is meeting to consider the Estimates for the Office of Addictions and Mental Health.

E27: Resolved, that a sum not exceeding $306,855,000 be granted to the Lieutenant Governor to defray expenses in respect of the Office of Addictions and Mental Health, pursuant to the Estimate.

I will now invite the Minister responsible for the Office of Addictions and Mental Health to make opening comments, up to an hour, and if they wish, introduce their staff to the committee. Just a reminder that the minister can only be aided directly by two staff from the department.

The honourable Minister responsible for the Office of Addictions and Mental Health.

HON. BRIAN COMER: Thank you, everyone, for being here this afternoon. I'll introduce my staff to start off. To my right is Kathleen Trott, associate deputy minister; and to my left is Barry Burke, executive director of finance. Behind me, I have my senior advisor, Ken Carmichael - he does a lot of hard, hard work for many people; Francine Vezina; and Natalie Cochrane. Thanks to them for coming today.

Mx. Chair, I'm pleased to be here to highlight the work of the Office of Addictions and Mental Health to speak about the group, our priorities for the coming year. We have many exciting and critical projects planned for the year ahead that will build upon the accomplishments of the past year and provide more care for those in need. Budget 2023 helps move our province forward, investigating in health care and many of the things that are important to Nova Scotians. We will do whatever it takes and invest what it takes to fix health care and deliver the care Nova Scotia families need and deserve.

This budget builds on our work so far and moves us forward. Our investments will put us on a long-term path of growth so that we have a sustainable health care system, and more importantly, so that Nova Scotians can get the timely, reliable mental health services that they deserve. We have a real plan to fix health care, and it's working. We are making progress, but just as the issues did not emerge overnight, they will take some time to resolve.

Delivering universal mental health and addictions care is no small task, and it's not something that can be defined by one single action. We are addressing gaps in care. We are supporting critically important programs delivered in communities. We are testing new and better ways for people to get the help they need. These actions are providing more care for Nova Scotians today. They're also building a foundation of universal mental health and addictions care where all Nova Scotians, regardless of their income, have access to the support that they need.

Universal care is a made-in-Nova Scotia solution. It will be the first of its kind in the country. It will take time to put all the pieces in place. We have been quite open and honest about that since the beginning.

While we admit that there's still a lot of work to do, I don't want to give the impression that care isn't there for Nova Scotians today. I can assure you it is. There is tremendous care that is being delivered in every region of the province.

Nova Scotians should be encouraged and inspired by the incredible efforts we see from our frontline workers, from our community-based organizations, and many others.

During my time as minister as well as my time working on the front line of addictions and mental health care in Cape Breton, I have had the opportunity to see first-hand the tremendous work and dedication of so many who work tirelessly to help those living with mental health and addictions issues. I want to acknowledge the unwavering dedication of so many of those on the front lines and the difference they are making in the lives of so many people. Many Nova Scotians have found hope, strength, and success thanks to the care delivered by these dedicated workers.

We certainly know things aren't perfect. There are Nova Scotians who are still having trouble getting the care that they need. This is what still keeps me up at night, and

I know it keeps many other families up as well. I want to assure them and all Nova Scotians that we are there for them, and that we will not rest until the work is done. We will do more and go faster to deliver the health care that Nova Scotians deserve.

[3:45 p.m.]

I would like to take a couple of minutes to speak about how the Office of Addictions and Mental Health works. The office is responsible for setting the strategic direction and for funding the delivery of addictions and mental health care in the province. We maintain a strong connection within the Department of Health and Wellness and across the broader health system itself.

We work alongside our colleagues in the Departments of Education and Early Childhood Development, Justice, Municipal Affairs and Housing, and Community Services to network on solutions that make a positive impact on the health and well-being of Nova Scotians. The office also works closely with the Nova Scotia Health Authority and the IWK Health Centre to deliver a range of care for people living with addictions and mental health concerns. We also partner with numerous community-based organizations to support the delivery of important services in communities, services that promote mental wellness and help people overcome mild and moderate challenges that impact their mental health.

We are also responsible for ensuring Nova Scotians understand how to access the care that they need; that access to multiple services is streamlined, making the system easier to navigate; and that there is consistency in integration of practices across the four health zones.

None of what I just listed would be possible if not for the hard work and commitment of the team of employees within my office. They have definitely been working hard, and I would like to acknowledge all the work that they have done.

We have been delivered a significant and critically important mandate. I certainly speak for the team when I say that we are eager to continue our important work on behalf of all Nova Scotians. Over the past year, I have been to Yarmouth, to Sydney, and everywhere in between. It has been a privilege to travel the province and hear the unique needs of communities. There are certainly some significant challenges in the province but some significant opportunities. I certainly learned that communities have diverse needs. On my travels, I met with clinicians, community-based organizations, and staff and volunteers. The good mental well-being of Nova Scotians is a team effort.

In addition to having responsibility and oversight of Addictions and Mental Health, I also have responsibility for Communications Nova Scotia. I would like to acknowledge the deputy ministers, associate deputy ministers, and senior teams for the preparation that they do with this budget and submissions and their hard work throughout this past year.

Our budget for the Office of Addictions and Mental Health for 2023-24 is just over $300 million, a $38-million increase, or 14.2 per cent, compared to last year. The office's budget is focused on advancing our commitment to Nova Scotians to improve access to mental health and addictions care, as we have laid out in our Action for Health plan, including investments and projects to further advance universal care, projects that will build our mental health and addictions workforce, deliver culturally representative and responsive care, and test new and better ways of offering care.

Before I dive too deeply into the budget, I just want to speak a bit to our partnerships and investments. Care is delivered to Nova Scotians through health authorities, community, and private partnerships. Collectively, they help to promote individual mental wellness; support people experiencing mild to moderate health, substance use, or gambling concerns; and support for those who require more intensive care for more severe and complicated disorders. We have made investments over the past year to expand care in all these areas.

Recently, we provided over $7 million to support critically important community-based programs. Throughout the year, we hear from many organizations that are experiencing hardship. The cost of inflation has impacts right across the board. Higher operating costs, coupled with fewer fundraising dollars from Nova Scotians who are simply not in the position to give as they once did, has meant that these organizations, and more importantly, the people who rely on them need our help. Again, this year, we were grateful to be able to offer that help. For a second year, we have continued with an unprecedented investment of $3 million to the Mental Health Foundation of Nova Scotia for community grants. Last year, the foundation was able to support the important work of numerous organizations across the province, including a project by LOVE Nova Scotia that enabled 40 youth to build their capacity as positive role models in their communities and with their peers.

Grant funding also allowed Healthy Minds Cooperative to support members of the 2SLGBTQIA+ community in becoming safeTALK trainees. These trainees are now helping others within their community who might be struggling with thoughts of suicide.

Wabanaki Two Spirit Alliance was also supported through provincial grant funding administered by the foundation last year. Funding allowed these organizations to hold gatherings where two-spirit youths and young adults were able to share their thoughts on how best to address their mental health needs.

We will continue to support the delivery of community-based mental health and addictions programming, and we will seize the opportunities to further expand access to services for people who need less intensive support than is currently offered in the formal health care system.

Services like those, the recently launched Peer Support Phone Service, almost 400 Nova Scotians have already reached out for support since the line opened last Fall. Peer

support can play a critical role in helping Nova Scotians overcome addictions and mental health challenges. The line offers a safe space for Nova Scotians who are struggling. Being able to connect with someone who has been where you are and can relate with empathy can really build confidence and hope. Peer supporters are accredited and certified with national training. They provide social and emotional support, reassurance, and encouragement to people who are feeling isolated, alone, or anxious. They can also provide information about more formal services and supports that might help.

Another recently launched service that is helping Nova Scotians deal with mild to moderate mental health concerns is a program called Tranquility. Tranquility was a program actually founded by a Nova Scotian, Joel Muise. He was a financial planner initially. He started to have some mental health issues himself and worked with a psychologist in Nova Scotia to develop this innovative program coming from lived experience. It was a great partnership for a really well-utilized service.

The online program helps better understand emotions, thoughts, and behaviours, and build skills and coping strategies. People are supported by a coach who checks in on their progress and offers ongoing help and motivation. Almost 2,000 Nova Scotians have used the program since it launched in December, including one Nova Scotian who said he needed non-crisis anxiety management to help him tackle some professional and social hurdles in his life. For him, having direct human contact and personal accountability were key, as was the fact that he could access this program for free, something he says he otherwise wouldn't haven't been able to afford. In his own words, "My coach isn't a therapist, and I don't dump therapy-level stuff on them, but I'm finding it helpful just to have someone to talk me through my thought loops and challenge me, and to have a place I can write my struggles down and evaluate them rationally."

These same outcomes are being experienced by people who have used Access Wellness. Many of us at some point in our lives experience life stresses that challenge our ability to cope. It could be job loss, the loss of a loved one, separation or divorce, or family conflict. Having professional help readily available will keep us mentally well and help address problems early before bigger mental health issues develop.

Not only are Peer Support Phone Service, Tranquility, and Access Wellness universally available, Nova Scotians can access these directly without a referral from a family doctor or general practitioner. They are providing a level of support that Nova Scotians haven't previously had access to, support to help them through everyday life and challenges, and support that can keep people from potentially needing more-intensive supports. These services are addressing gaps in care. They are making it more accessible, and most importantly they are making a difference in the lives of Nova Scotians.

People who require a lower level of support aren't likely to benefit from the more intensive and specialized care that is delivered in the formal health care system. In fact, by labelling a person's distressing emotions as suffering in the face of real-life stressors as a

mental illness, sometimes we can do more harm than good. People who are struggling need support. They just might not need formal mental health treatment. That is the gap we're helping to address with these new services.

Mental health is certainly complex, and challenges require a wide range of care. While our community-based partners deliver care for Nova Scotians dealing with mild to moderate concerns, the Nova Scotia Health Authority and the IWK Health Centre provide care for people with more specialized and severe concerns. The care delivered by our health authorities includes in-depth diagnostic assessments; medications; psychotherapy; intensive interdisciplinary care involving occupational therapy, recreational therapy, and social work case management; as well as others. It's within this level of care that you will find in-patient care, intensive mental health and addictions day treatment programs, outpatient clinical services, and specialty care for illnesses such as eating disorders.

We need to continuously be looking for ways to improve the delivery of care and ensure we are meeting Nova Scotians where they are in the recovery journey. We know there are many people who don't require around-the-clock in-patient care, who can safely and successfully recover from mental health and addictions issues while remaining home and within their own community.

This year's budget also includes $4.9 million to enhance addiction medicine services, including further expansions of the province's recovery support centres to the Strait Richmond area, Sydney, Yarmouth, Truro, North Sydney, and Halifax. The four existing centres have already supported more than 1,000 Nova Scotians in their recovery. These centres improve direct access to support for people living with substance use and gambling disorders and provide a bridge to increased or decreased level of care based on their individual circumstances or needs.

Just as the recovery support centres provide outpatient care to those struggling with substance use and gambling addictions, the province's new Mental Health Acute Day Hospital provides a similar pathway to support for people requiring intensive mental health treatment. This year, I had the privilege of visiting the province's first Mental Health Acute Day Hospital here in Halifax. I had an opportunity to meet the dedicated team of clinicians who are excited to be part of this new model of care.

The new day hospital at the Cape Breton Regional Hospital will provide another level of access to patients on the Island. There's great excitement among local clinicians about this innovative model of care. We know that successful health outcomes depend on the ability of Nova Scotians to access appropriate supports and treatments. Before the opening of this hospital, the only pathway to intensive mental health treatment was to be admitted to an in-patient psychiatric unit, but not everyone needs around-the-clock hospital care.

The Mental Health Acute Day Hospital addresses this gap and provides another

way of delivering intensive mental health treatment while allowing patients to stay closely connected to their families and communities. Patients are supported by an interdisciplinary team of mental health specialists, including a newly hired psychiatrist, nursing staff, and social workers. They attend therapeutic group programs and receive psychiatric treatments during the day and continue their recovery at home in the evenings and on weekends.

In-patient day hospital psychiatric units in Nova Scotia are functioning with high occupancy rates. This means that some people can't get in-patient care close to their homes. Transferring patients to facilities in other zones places them further away from their families and support networks and places great strain on these facilities. These inter-facility transfers also reduce the number of ambulances available to respond to other health emergencies and other patient transfers. These impacts can be costly, inefficient, and most importantly, they aren't meeting the care of Nova Scotians.

Mental health day hospitals help to alleviate these pressures and free up in-patient psychiatric beds for those with more severe mental illness. This is why we are investing in an expansion of the day hospital, adding one in each of the remaining health zones across the province. This year's budget includes just over $2 million to support this expansion.

The services I have been speaking about are in place now. They are providing care to Nova Scotians today. We know our work isn't done. More needs to be done to give Nova Scotians the timely, reliable mental health and addictions care that they need.

A significant portion of this year's budget will be invested in testing new ways of delivering care, taking the best ideas and putting them into practice. More that $1 million will be invested to expand training opportunities for clinical psychologists and provide more access to clinical care for Nova Scotians. Students of Dalhousie University's clinical psychology program will work under the supervision of registered clinical psychologists. This will allow these students to enhance their training while also positioning them to deliver a range of clinical services to those who need help, ranging from assessment to clinical intervention and group psychotherapy.

The office budget also includes $306,000 to support a new pathway for Master of Nursing students into mental health and addictions care. Helping to expand the workforce will provide more care faster to Nova Scotians. The Dalhousie School of Nursing currently offers two streams for advanced practice: the nurse practitioner stream and the professional stream. By offering advanced practice in mental health and addictions we can train more nurses to work in the field to ultimately better support Nova Scotians who are dealing with mental health and addictions concerns.

Our budget also includes $250,000 to expand access to needed diagnostic assessments for ADHD and autism spectrum disorder through partnerships with private practitioners. This will help Nova Scotians to get important diagnoses and treatments sooner and allow us to test aspects of a universal care model, including compensation.

[4:00 p.m.]

This year's budget also includes just under $2 million to establish integrated youth services, providing youth with seamless care and better mental health supports. Eight locations will be set up across the province over the next four years. These locations will offer a single point of entry for young Nova Scotians and their families to support access and services that they need, including peer support, referrals, navigation, and direct connection to resources within their communities. Health care and social service providers will work together with youth and families to develop a care plan tailored to their unique and individual needs.

Now I would like to take a minute to speak about the importance of community, more specifically about the importance of ensuring that our own mental health and addictions services represent and respond to the needs of diverse communities. On several occasions, I have had the opportunity to meet with the executive directors and health directors of community organizations, community health centres, and various Mi'kmaw communities. I have also met with the staff at the Mi'kmaw Native Friendship Centre and with Tajikeimik to discuss mental health and addictions issues within Indigenous people and increasing resources within their communities. What these and other visits have taught me is the need to truly engage within the community.

This year, we will be investing in targeted work to design culturally specific services for African Nova Scotians. This work will be led by the African Nova Scotian community, with the aim of enhancing trust and confidence in mental health and addictions services; strengthening cultural representation, knowledge, and competence amongst our service providers; and improving community health. This investment will lay the groundwork for the development of supports that are guided by the cultural traditions of the people they are intended to help.

We know that the needs of diverse communities have been underserved in our health care system. We also know that the best ideas come from people who have experience. It is when people are faced with the barriers they see that they can see the solutions.

We have been engaging with African Nova Scotians and members of Indigenous and 2SLGBTQIA+ communities in our work to develop universal care. These engagements have been tremendously valuable in helping us to identify what's working and where our gaps are. The only way we can better meet the needs of these communities is by better understanding them. We will continue to work with these communities over the coming year and test new models of delivering care that are led by them and their needs.

I have talked a lot about mental health so far. I'm going to switch it up to talk about some addictions supports. I also want to clarify that the two are not distinctly separate. Quite often, people dealing with addiction concerns are also dealing with mental health

concerns, and sometimes people who are dealing with mental health concerns will turn to substance use as an escape.

Essentially, what we have been talking about today so far is the crossover between mental health and addiction. There are a few specific items in this year's budget that are uniquely focused on delivering care for people with substance use issues.

In addition to the expansion of the recovery support centres across the province, which I have already talked about, we also support several different types of harm reduction programs, including needle exchanges, overdose prevention sites, naloxone, and managed alcohol programming. This year's budget includes $1 million to support the managed alcohol program of the North End Community Health Centre and to expand the programming to the Eastern Zone. These programs provide essential supports to people living with alcohol use disorder, preventing alcohol-related harms, including withdrawal, which can be extremely dangerous and often life threatening. Organizations such as the Ally Centre of Cape Breton and Direction 180, which I had the opportunity to personally visit myself, do tremendous work for Nova Scotians.

This year's budget also includes additional investments in the Mobile Outreach Street Health program, which provides accessible health care services to people experiencing homelessness or who are insecurely housed. We will continue to look for ways of better supporting people on the road to recovery.

Everything I have spoken about today is delivering on our promise of working towards universal care, care that is available at the right time in the right place. This can sound very simple, but we all know that this is a substantial piece of work. We are breaking new ground. We don't have the luxury of leaning on lessons learned from other jurisdictions. We need to build this from the ground up, and that is what we have been doing since we came to office. We continue to work tirelessly to address gaps in care. We're supporting critically important programs delivered in communities. We're testing new and better ways for people to get the help they need. These services are building the foundation of universal mental health and addictions care where every Nova Scotian will have equal access to mental health and addictions care that they need, regardless of their situation.

Is there more work to do? Absolutely. We will not rest until it's done.

THE CHAIR: According to the practice as developed in this Legislature, each caucus has about one hour to start with questions, and I will take my seat on behalf of the NDP caucus at the end of your first hour. Only the minister may answer questions, of course. As well, caucuses are expected and encouraged to share the time fairly with the Independent member.

The Liberal caucus and the honourable member for Clayton Park West to start the

first hour of questions.

RAFAH DICOSTANZO: Thank you to the minister for the long speech - lots of information. I have a few questions, but I am going to start with the prepared questions, and if we have time, I'll go back to things that you said in your opening remarks.

I'm going to start with numbers, if you don't mind. I'm going to go line by line in the budget. My first question: We see that the salary and employee benefits line in the budget has increased from $2.2 million to $2.6 million with an increase of five FTEs - full-time equivalents. What were these positions for? If you can just give us a list of those.

BRIAN COMER: These three positions would be for a senior strategist, a coordinator, and a senior policy analyst. Their primary objective, I would say, goals within the office, would be to continue to work towards the mandate for universal access to addictions and mental health care.

RAFAH DICOSTANZO: These are three full-time positions. It says five, so there are two more? It shows five. It gives a number of extra positions, FTEs. It went from 19.4 FTEs to 24 FTEs.

BRIAN COMER: Estimate to estimate, there would be three new positions. I think the 19.4 would have been a pre-existing vacancy. It would be three new positions in total.

RAFAH DICOSTANZO: The second question: under operating costs there is an increase of $600,000. Can the minister explain what the increase is made up of? That's operating costs.

BRIAN COMER: The reason for that increase would be primarily inflationary pressures, so rental fees for clinical services, to deliver service, as an example. Increased inflationary pressures - there might be a small amount of wage increases amongst clinicians too.

RAFAH DICOSTANZO: Under grants and contributions, there was an increase of $13 million. Can the minister tell me what the grants are and who the contributions went to? If we can have some names of organizations as well.

BRIAN COMER: There's a variety of groups that would have received money. Just for clarification, you're talking about the annual core funding, organizations, or just the recently . . . (Interruption)

RAFAH DICOSTANZO: Just to clarify, if it is a long list, you could give us that information in writing but just read it quickly. I would like to take it home with me as well.

BRIAN COMER: I'll give a couple of examples of ones that we would do every

year and some other ones that would be newer, one-time examples, if that works?

[4:15 p.m.]

RAFAH DICOSTANZO: Do you have the list? If you have it, we would just like a copy of it by the end.

BRIAN COMER: I would like to acknowledge a couple of the groups, just because I think they're doing great work.

Aidaen's Place in Yarmouth is a great example of such an organization which provides services to youth in transition, to skill building for employment, for example, for suppers. That family specifically had a very sad story of the death of a child of their own from suicide. I know they do a lot of good work in the community.

The Ally Centre of Cape Breton is another organization that does great work with vulnerable populations in Cape Breton. They do everything from evidence-based harm reduction to managed alcohol withdrawal to employment services.

I think that's a couple of good examples.

RAFAH DICOSTANZO: Maybe I wasn't clear. If you can give us the dollar value to each organization - is that what you have? What I'm looking for is the dollar value out of the $30 million - who got what. If you have those, you can table them, and I will take that. That would be wonderful.

BRIAN COMER: There's a number of programs. You just want to receive the list with the amount? (Interruption) I can list them: Strongest Families Institute at the IWK Health Centre received $245,000; Kids Help Phone was $300,000. We can provide the list at a later date with the specific amounts.

RAFAH DICOSTANZO: I'm just going through the lines, and we'll go through it fast. General administration has decreased in cost. Can the minister tell me what the decrease consists of? Did we lose a staff member?

BRIAN COMER: There's a partial vacancy within the office itself. That would be where you would see that reduced cost.

RAFAH DICOSTANZO: I'm assuming this is going to be filled. This position is just vacant at the moment.

There's also $2.8 million for strategic direction and accountability. Can the minister tell us what this line item entails? Just a breakdown - I don't think we have had that before.

BRIAN COMER: This would be primarily the financial contribution for the Office of Addictions and Mental Health, the staff that carries the bulk of the mandate and the strategic direction.

RAFAH DICOSTANZO: This is salaries for a number of staff in the department. How many staff?

BRIAN COMER: This would be the 22 of the 24 FTEs within the office.

RAFAH DICOSTANZO: Could the minister explain what early intervention services are on the budget line item? What will the increase in monies cover?

BRIAN COMER: This would be primarily for the autism model and increases in EIBI - the Early Intensive Behavioural Intervention program.

RAFAH DICOSTANZO: So we have increased the money for EIBI. That's the 3-year-olds to 5-year-olds before they go to school through the IWK program, correct?

BRIAN COMER: EIBI is typically for the pre-school population. It would be maybe a bit earlier than the 3-year-old to 5-year-old range, but typically the 18-months to 36-months cohort.

RAFAH DICOSTANZO: Just for that, have we increased - that's a very important program that I have actually worked with as a medical interpreter, and I have watched it. I'm hearing a lot that they're unable to get their kids into it. Have we increased the budget for that program? If you can let me know, please.

BRIAN COMER: This isn't an increase, to the specific question. This is a transfer from the Department of Health and Wellness. We would have looked at our investments last year in the pre-school strategy. There would have been a significant increase. We just recently gave Pinwheel Wellness Centre, a facility in Bedford, a $600,000 investment - which is an incredible service geared towards autism as well. That would be comprised of clinical therapists, occupational therapists. Cynthia Carroll, with Autism Nova Scotia, is spearheading that service as well. This specific question isn't, but I would say there has been significant increased investment in autism.

RAFAH DICOSTANZO: I'm a little bit confused because I thought that was a program through the IWK Health Centre and it had a certain budget. Is the whole money here - what we just talked about - we called it early intervention services, $22.4 million to $28.6 million. There is an increase, which is around $600,000. That's the $600,000 that went to a Bedford group? I'm just trying to understand what is happening with this EIBI.

BRIAN COMER: From estimate to estimate, it's a $1.5-million increase, just for clarification. I do think it's important to give a brief overview with autism. There are a few

moving parts with this file specifically.

Last year, we did invest $12 million to implement a new model of care for pre-school autism services. That will be implemented over the next one to two years. These include interventions - it could be diagnostic testing, it could be supports for families. We recently just expanded QuickStart Nova Scotia. That's a parent teaching program to enhance coping skills for parents. That has been expanded across the province now. There are partners within the office, certainly within the IWK Health Centre, with Hearing & Speech Nova Scotia, within the Department of Education and Early Childhood Development as well. Autism Nova Scotia is probably one of our most significant partners on this file specifically.

I mentioned QuickStart Nova Scotia. Pinwheel Wellness Centre in Bedford is . . . (Interruption) Pinwheel Wellness, yes. That's in Bedford. I had a chance to stop by there last month. It's a fantastic place for families.

There's the Brief Intensive Outreach Service, which I think is another innovative service where a team of trained clinicians can actually go to the community, go to the household to intervene before things get to the point where families aren't left with a choice but to bring their child to the hospital setting. I think feedback from both the clinicians and families has been very positive thus far. I know we do have some preliminary data on the number of calls that that service has had so far. It has been very positive so far, the feedback we have been receiving. We did try to launch that service in Eastern Zone. It might have been before my time, I believe, in this position. There are issues with human resources capacity, but there has been success in Northern Zone with getting that service stood up. It was started here in Central Zone through the IWK.

The new model of pre-school autism service - that includes the QuickStart Nova Scotia expansion, which is intervention for parents - education for parents and families, a coaching where people don't need a specific diagnosis, they can just have a suspected diagnosis - sometimes that's certainly a barrier.

On a little bit of a - I don't want to say different topic, but one of the pilots in the budget, subcontracting with psychologists, is actually geared towards increasing capacity in the province to make more diagnoses, increasing the clinical capacity. That's where we would look at taking a private partnership to offer a free public service. There's a wait-list, as you mentioned, for diagnostic criteria.

We have increased annual funding from $300,000 to $400,000 for Autism Nova Scotia. There are nine autism resource centres across the province.

I just talked about the BIOS program. This helps health care providers and families handle emergency situations with children under the age of 19 with autism. This has expanded to allow the program to be piloted in the Northern Zone, the Northern Health

Zone in the province.

RAFAH DICOSTANZO: So this $600,000 wasn't just for early intervention. It was for multiple different - you said QuickStart and Pinwheel. Are we funding them? Or are these staff positions? The EIBI, they were staff positions within the IWK, and they go to the homes and help the children at their home to prepare them for school. I'm confused: are these positions or are these grants?

BRIAN COMER: The $600,000 for Pinwheel is separate. That was just announced, one of the one-time grant contributions. I think they were having some pressures there with operational costs. We certainly provide some core funding for Autism Nova Scotia as well. The actual service delivery of the BIOS program would be through clinicians, I think through the IWK, which would be part of the health authority and that sort of thing. It could be an occupational therapist or behavioural interventionist. They would have some contact with some psychologists, I believe. It's a variety of health care disciplines.

[4:30 p.m.]

RAFAH DICOSTANZO: I'm a little confused, but I'm still moving to Question 7. For addictions services, there's a slight increase in the budget. Can the minister explain what the increase represents? That's for addictions services. We just have one more line, and then I can move on to real questions.

BRIAN COMER: This would be primarily for wage increases. Also, it is part of the continued expansion of the Recovery Support Centre. I used to work at the Inpatient Withdrawal Management Unit in Sydney. That's going to be changed to be more accommodating to the recovery support centre model. We'll be changing some clinical programming for group programming, individual programming, these sorts of things. The site in North Sydney is actually going to be a new site for that community. It's going to be built from the ground up, essentially. I know there's a lot of excitement in North Sydney for that service. That's kind of a continuation of the further implementation of the recovery support centres, which can range from connection to inpatient withdrawal services to something as simple as coming by for the group program a couple of times a week, that sort of thing.

RAFAH DICOSTANZO: I think we have gone through most of the lines, just to get the details on that. In general, the World Health Organization recommends that governments spend at least 10 per cent of their health budget on mental health. We are spending 6 per cent of the total health budget here. Can the minister tell us why our mental health budget is not - still very small compared to what is expected or recommended? Do you expect it to go higher? Are you hoping to reach the 10 per cent?

BRIAN COMER: Yes, that's a good question. It's something I thought about a lot when I was working as a psychiatric nurse. I left that to come do this, essentially. I think

this year has been by far the biggest increase in mental health and addictions care in the history of the province - $38 million. I have been doing this for a little over a year and a half, and it has been increased by $65 million. I think that's pretty significant.

I wish it was as simple as getting more money to address this issue. They're very complex issues, for sure. If you look across the continuum, I think about what universal access means. It could mean anything from peer support right across the spectrum to hospital admission. Oftentimes, this process isn't linear, so sometimes people have to go back and forth along the continuum as they need help throughout their life. I think when you look at innovation, I would say, in the pilots, whether that's looking at clinical psychology programs or new nursing programs or the subcontracts with private clinical psychologists, I think there's a lot of exciting opportunities there, for sure. I think when you think of pilots, you look at innovation, evaluation, and scalability. When you're innovating, sometimes everything doesn't work. That's part of innovation. We're offering expansion of services, many of which are the first of their kind in the province.

I think when you look at the expansion of the mental health acute day hospitals to Cape Breton, to the Northern Zone, and to the Western Zone, it increases to more intensive services, for sure. I would say as we evaluate and as the pilots roll out, there's scalability. There's certainly willingness for me to advocate for increased funding. It's just not as simple as money.

RAFAH DICOSTANZO: I'm a little bit confused because you're saying we spend $65 million - we have increased it. But actually, the budget has come down. In 2020-21, the previous government - when the Liberals were there - the budget was at $336 million. We have actually gone down with your increase from $288 million last year to this year, $306 million. We're still down by $30 million. How do you explain that? We haven't increased it at all if you go back to 2020-21.

BRIAN COMER: If you look back to 2021-22, there was a budget of $247,983,000 for the Office of Addictions and Mental Health. There was also $94,591,000 million, which included physician services and pharmacology, so that would be your medications and physician services - your psychiatrists, your psychiatric medications. That gives a total of $342,574,000. Fast forward to 2023-24. The Office of Addictions and Mental Health is $306,855,000 plus $100,944,000, which is a total of $407,799,000. It has increased.

RAFAH DICOSTANZO: You have taken part of - the $336 million included $100 million of something else. Am I understanding it correctly? That is no longer part of your office budget?

BRIAN COMER: The way you presented the data from 2021-22 and the way I'm presenting the data is the same. There has been a significant increase to 2023-24. I don't know how else to say that.

RAFAH DICOSTANZO: The Canadian Mental Health Association of Nova Scotia issued 12 recommendations to the government on how they feel the money could be best spent, specifically when sufficient funding is given to community-based programs. My question is: Can the minister tell us how many organizations received increases in this year's budget and what percentage was the increase?

BRIAN COMER: Right now, we're just in the midst of completing an evaluation of funding for CBOs across the province. I'm sure as MLAs, we have heard from many groups who spend more time writing grant proposals than they do actually helping people. The Canadian Mental Health Association, specifically, we have done a good announcement in the Truro-Colchester-East Hants region lately, met with their executive director. They're going to be - actually, it's a pilot project within that CMHA branch. Some of the issues that they identified during our visit ranged from eating disorders to employability skills and these sorts of things.

The CMHA branch in Halifax also received funding from us recently for an innovation project which is going to be geared towards seniors. This would be for vulnerable adults living with - it could be mental illness, or it could just be loneliness, working with Karn Nichols here in HRM. There are certainly some significant partnerships with CMHA. Most of these partnerships are the first time that any of these groups have received funding of any kind from any government. If you look at Bereaved Families of Nova Scotia, outside of palliative care in the hospital setting, there are essentially no resources for families that lose a loved one. I think that's another great example of a community-based organization that's doing great work. A lot of these groups are not just increases - it's the first time they have received funding from anyone. I think that's a good thing.

RAFAH DICOSTANZO: That's wonderful. If I may, this is the second list that I would love to have. I'm writing them down, and if we can have them - I actually did the same thing last year with the Department of Communities, Culture, Tourism and Heritage, and I've yet to get those lists. I'm going to ask if I can have it within 24 hours. We asked in Estimates last year, and we're still waiting for those lists. If we can have them within 24 hours - otherwise, we never get them back. I would really appreciate those - the names of the organizations and how much money they got.

A key commitment of the Houston government was to create universal access to mental health by creating a new billing code that would allow mental health professionals, like therapists and social workers, to be able to serve anyone who seeks a service, regardless of their socio-economic circumstances. My question is: Can the minister tell us where we are with this billing code? The billing code is very important for this big promise by the Houston government. Where are we, and when will we see that billing code?

BRIAN COMER: I think when you look at the budget and you look at the two pilots that are coming, with the Dalhousie clinical psychology training program and the

subcontracts with private clinical psychologists, those are two good examples of where that work will be undertaken. In my mandate letter, there were three disciplines mentioned specifically. The psychologists were the first one, so that's where we'll be laying the groundwork.

In the primary care sector, typically physicians - it's a term called shadow billing - you keep records of every patient that you see and these sorts of things. This is something we'll be doing with these two pilots, so we'll certainly have a thorough evaluation in place with that. Also, for the subcontractors, specifically the clinical psychologists pilot, this will be testing the product of public service integration for the first time. This will look at health and human resource recruitment, compensation for the private psychologists, and a big focus on making sure whatever we're doing is increasing access to service for Nova Scotians. These will increase provision of, for example, diagnostic assessments, so for testing for autism spectrum disorder, ADHD. There are equity-seeking groups that aren't getting adequate access to care and don't have private health insurance. This would be a free service, something I said right from the start.

I think these would be some of the comments I would make about that. The Dalhousie clinical training program pilot will be in partnership with the faculty there, focusing on community-based practising clinical psychologists. You essentially have licensed clinical psychologists who would supervise senior students in the clinical psychology program, actually providing services to people attending their clinic. This could also be a good example of how that work will be started.

RAFAH DICOSTANZO: That didn't answer the question of a billing code. Those are all pilots where you're trying to figure out how much money it will require or what kind of services so that you can arrange a billing code. It's almost two years, and we still don't have this billing code - a promise that was made. It was in your campaign. When will we see the billing code through MSI? That was the question.

BRIAN COMER: I would say that we're testing new models of care. It's very important that we increase access to service, but it's also important that we properly evaluate these services because it's the first time they have been done in Canada, certainly a very complex issue. I wish it was as simplistic as developing one billing code, but it could be potentially multiple billing codes. As we continue this work, it will be with other health care disciplines as well.

We will be doing a thorough evaluation to look at the billing codes specifically, but in the meantime, we have implemented a variety of new services - so your recovery support centres, your acute mental health acute day hospitals, Tranquility. These are services right across the continuum of care. We have always had our acute hospital-based system as well, for people who need help. There's help available. This is a new expansion of a new program.

[4:45 p.m.]

RAFAH DICOSTANZO: Is there a way that you can give me some timelines when - is the intention still to have billing codes, or are we finding different ways that we're going to offer services without it going through MSI? When will we see billing codes if we're still going to do that? Is the billing code still on the table, or have we found different ways we're going to do things?

BRIAN COMER: Yes, the billing codes are certainly still on the table, for sure. I'm very aggressive with my timelines as well. We would expect to have those specifics by the Summer would be my answer.

RAFAH DICOSTANZO: I'll be looking forward to the billing codes this Summer.

The PC platform estimates the cost of a new system to offer universal mental health care at $100 million per year. The next question is: Can the minister tell us where that money is allocated in this budget and if that $100 million will be added to the mental health budget?

BRIAN COMER: I would say that there has been a significant increase in the budget this year - $38 million. Certainly with these pilots, we undergo a thorough evaluation of scalability. I would have a very aggressive timeline for expanding services. As we evaluate these programs, talk to Nova Scotians and talk to clinicians to see what's working better than the other pilots, there would be an expectation that there would be an increased investment. I wouldn't venture to give a specific figure today, but there will be increased investment, yes.

RAFAH DICOSTANZO: So it's not in the budget for this year or next year or in 2023-24. We will not see universal access because you would have to budget for it in order to have it. I'm going to leave that question as it is because I'm hoping to hear something in the Summer, but I don't know where the money is coming from if it's not budgeted, the $100 million for the universal. It would be for the following year. Maybe that's why. I'm going to leave that with the comments.

The next question is the current government promised a dedicated three-digit telephone number for a mental health crisis line. Can the minister tell us when that will be happening, and will those costs be allocated to the Office of Addictions and Mental Health budget? How much will the federal government be contributing, as well?

BRIAN COMER: The 988 three-digit crisis line was something I was supportive of in Opposition and continue to be supportive of as minister. We have had multiple conversations with Kids Help Phone and different stakeholders. I was very glad to see the federal government also come on board with the initiative. We're working very closely with them on implementation. I don't have the cost figures here in front of me today. I

believe next Fall is the targeted implementation date. Once I do have the financial specifics, I would certainly follow up with the member.

THE CHAIR: The honourable member for Clayton Park West with a reminder that the time changes at 5:07.

RAFAH DICOSTANZO: I'm very happy that this is still coming. Don't they have this in other jurisdictions, so we know approximately the cost? We must have an approximate cost for this. Is it in the budget? Other jurisdictions have this number. What is the cost in other jurisdictions? What is the amount that the feds have said they would be contributing?

BRIAN COMER: I know the federal government has a significant contribution towards mental health in their campaign. I didn't get a chance to read the federal budget. I think it was tabled today. I have had several very productive conversations with Minister Bennett for sure. There's a lot of common ground there. I would say the Canadian Radio-television and Telecommunications Commission is sort of spearheading this implementation. I know a number of years back, they implemented a three-digit crisis line in the United States. They had a significant increase in call volume. There's no cost given by the federal government yet. We'll have to scale it up accordingly. We'll see what happens with the uptake.

RAFAH DICOSTANZO: Can you just give me a rough figure of the cost? It's in Ontario, I believe, and other provinces. Can you give us a cost in other jurisdictions so that we know how much this should be budgeted for?

BRIAN COMER: From our perspective, we already have a provincial crisis line in place now. It's a 10-digit number, but there are highly trained clinical staff who would answer those phone calls for crisis situations. We do have the clinical pieces in place in many ways already. Whether we have to scale it up depending on uptake of the service would be probably a question. We'll have to wait to see. The CRTC would certainly be responsible for any kind of infrastructure - physical infrastructure, telecommunications infrastructure - once the service is rolled out.

RAFAH DICOSTANZO: Mr. Houston, when delivering the platform on addictions and mental health, stated that he didn't want any Nova Scotian without coverage to do without mental health access. In fact, he stated, "I won't allow them to do without under my leadership, under our government." Can the minister tell us what talks have been undertaken with the Nova Scotia College of Counselling Therapists about covering their services under MSI to reduce the wait times for access?

BRIAN COMER: I would say everything we have done up to this point is about increasing access to free high-quality care for people - really identifying the gaps and getting rid of the gaps as quickly as we can. I think the Integrated Youth Services expansion

over the next number of years is probably a good example of that. This will be across the province for youth. That's a good example of an innovative expansion of services. I'm not sure if you're referring to registered counselling therapists, but they were part of our stakeholder conversations that have already taken place. I know the RCTs specifically have been in dialogue with the office. I know we probably have a list of practitioners, but I know it's quite extensive, the dialogue. There has been a heavy focus on psychologists, social workers, RCTs, occupational therapists, and many others - certainly some very active dialogue on that.

RAFAH DICOSTANZO: So we are going to have those therapists under MSI, correct? That's the intention? You're going through the talks. Is this the ultimate goal - the intention - that the therapists would be billing through MSI?

BRIAN COMER: As I mentioned previously, we'll be testing this through pilots. The psychologists will be the first group. I know we have had some good conversations with social workers and registered counselling therapists, occupational therapists. There are even some primary care providers. They oftentimes can be the first point of contact for mental health concerns in their own office. Those conversations are certainly ongoing, but I couldn't commit to that specifically today.

RAFAH DICOSTANZO: I have a good question here, I hope: If we have virtual mental health care services, why do we need the one session of one-on-one counselling that has been offered?

BRIAN COMER: Access Wellness - I have done a lot of interviews. I think this is filling a gap in care that didn't exist previously. This is meant for your mild to moderate people, that there are services embedded in their community that they can just walk in. There's also availability for telephone or virtual health options with the Access Wellness service - highly trained clinical therapists, social workers with advanced degrees, registered counselling therapists. There are 11 therapists who are working at these four sites. They're all from Nova Scotia - very high quality of care.

If someone comes into an Access Wellness service for example and their needs are too acute or too complex, there's an opportunity to connect them to the formal mental health care system - the Nova Scotia Health Authority program. It's not a linear process. You could access care a variety of different ways. I often try to explain to my constituents that there's no wrong door when you're looking to access mental health services. This service - you can go back more than once. The idea is you don't have a record of your assessment or your visit, but you are given a plan of care as you exit the appointment. That's just one of the new services, in addition to everything else, that we have been doing.

RAFAH DICOSTANZO: I'm sorry, I'm even more confused now. Those social workers, you're going to put them in different parts of Nova Scotia in communities, and you're giving them salaries or contracts? Is there a number of hours or dates? When is this

being offered? What does one hour do for anybody? You and I know about mental health. It takes five or six sessions before there's a proper relationship with your mental health service before they can even start treatment. One hour - it blew my mind. How can that be useful to anybody?

BRIAN COMER: I can speak to an example of the service in Sydney. The Access Wellness service we announced February 22, I believe, in Sydney. I used to work with one of the clinicians there who's a clinical therapist social worker. Does the one session benefit everybody who needs help? Maybe not. That's a fair assessment. Could it benefit people who need it, one-time help? I think it could, actually. This is not for acute mental health issues. These are for mild to moderate - if you have a domestic issue, if you have substance use issues. This is an opportunity to connect Nova Scotians with the formal system.

If you were in New Glasgow, and you went to Access Wellness - you were having some substance use issues - you could be connected with a recovery support centre, which we also just opened in New Glasgow. It's a connectivity point for people for help in their community. The four sites are embedded within communities. I think that's also important. You don't need a referral from a primary health care provider as well. Oftentimes, that can delay people - whether it's a consult with their family doctor or a psychiatrist or a psychologist. It cuts down on that bottleneck. It's definitely meant for a specific target population, as are many other services that we already provide.

I would be hesitant to be too negative on a new service that is providing help to people that they haven't had before. Is this the silver bullet for every single person? Absolutely not. Is it a beneficial service for some people? I think it is.

RAFAH DICOSTANZO: I'm still having a really hard time understanding. People will have to know - are you going to make a list? If you have this issue with your mental health, you can go in, but if you have this, this, or this, you can't go in for these services?

If you have serious issues and you get one hour and you're waiting for three to six months - if you're lucky - what happens to that information from that one hour? Where is that information going? They're meeting somebody new, so all that information has to be repeated - it's not the same person. It's a total waste of time for probably 80 per cent of the people who actually need mental health care. How can you triage who can go in and who can't? How can you triage who simply needs to talk? "I'm feeling down today, I need a chat." That's what you're providing the service for because if you have any serious issues, you should be connected right away and not be waiting.

That first contact - it takes a huge effort for somebody to open up. Mental health - you understand how difficult that is. You're giving an hour for somebody, and that information is lost somewhere. Where is that information going to be? If they're even connected 100 days later or something is serious, how are we going to get that connectivity that you're talking about. That money could have been used to hire more people so that

instead of 100 days, maybe we could have it at 50 days.

[5:00 p.m.]

BRIAN COMER: I would say there's no wrong door. If people aren't sure if they have to use the service, they should use the service. That's what it's there for. I made sure before the service was launched that there's a mechanism in place for what we call the warm handover or the warm transition in the health care system to the more formal service, whether that's the Nova Scotia Health Authority, or that's intake - there's a variety of formal services within the health care system.

I don't think I would agree that 80 per cent of the people who go there wouldn't need it or wouldn't benefit from it. I would be hesitant to make those sorts of claims. We'll obviously evaluate any new program. There's an expectation that it has outcomes that are helping people. That's our number one objective.

Tranquility is another example. We had over 950 people right now across the province using that service, the last time I checked. That's almost 1,000 people who are getting help that they probably weren't getting before, to be honest. I know this certainly isn't for everybody.

Something else I've seen in my time working in the health care system is that people actually won't go to the hospital for mental health help. It can be quite stigmatizing. If you're on Charlotte Street in Sydney, maybe you'll just walk by, or maybe you'll just walk in - I have known people who have done that - as opposed to going to the hospital or going to your family doctor. If you miss that opportunity to just get the help you need at that point, you might miss that window.

Certainly, I hear the concerns. I think there's some benefit to this as well.

THE CHAIR: The honourable member for Clayton Park West with three and a half minutes left.

RAFAH DICOSTANZO: I'm going to spend my time on this question because I just want to clarify. They go see somebody, and that information is going to be collected by whom? Let's say they need at least a psychologist or an assessment or they may need a psychiatrist because they need medication. That information, that serious information, who will be keeping it? Who is in charge of getting it to the next person they're going to see? Is that mechanism there?

BRIAN COMER: At the conclusion of an appointment, the patient will be given what's called a care plan. The patient would take the care plan with them. The individual clinicians who work at these sites would be no different from a social worker in a hospital. They would have to adhere to the standards of practice, with their regulatory body.

Confidentiality and all that stuff would still apply based on the professional standards. The patient would be given a plan of care that ultimately would be up to the patient what they want to do with their personal health information. Otherwise, the clinicians still have a responsibility to adhere to their standards of practice.

RAFAH DICOSTANZO: When are you going to evaluate this service? When does it start? When does it end? What evaluation is put in place for it?

BRIAN COMER: I requested an update on that this morning. We had 168 calls so far. It's a little over a month since the service was launched. Sixty-eight per cent of the calls are from those who identify as female. Typically, any program has a quarterly evaluation, for sure. Sometimes I ask for them more often than that based on the call volume. What we hear from the people utilizing the service will have a significant impact. We'll continue to look at that.

RAFAH DICOSTANZO: I'm hearing "calls", so this is not face to face. The 168 have all been calls, correct? Has anybody had face to face?

BRIAN COMER: It would be a combination of contacts. It could be calls, it could be in person, or it could be both.

RAFAH DICOSTANZO: Could the minister provide us with how many in-person and how many calls and which areas in this province are receiving this service? If we could have that information - so far. You only have one month, but just to see.

I thank you very, very much. I'm sure . . .

THE CHAIR: Order, please. The time has now elapsed, and it is the NDP's turn.

The honourable member for Halifax Citadel-Sable Island.

LISA LACHANCE: Thank you to my colleague for kicking off the discussion. What I might do is ask a follow-up question on that service. What are the outcomes being monitored for that service?

BRIAN COMER: There's a variety of outcomes. I think when you look at any of these new services - whether it's the mental health acute day hospital, for example - we were able to collect data on the impact that had on provincial bed in-patient occupancy rates. I think if you look at that just as one example - but I think there's a variety of factors that could be looked at as outcomes. Decreased visits to the emergency department for psychiatric presentation would certainly be an outcome that I would be interested in seeing. I think it's also very important to speak to people who are using the service. We have had significant focus with that as well. But I think if you look at any of these new services, the increased access to the system in effect takes pressure off the formal system

complementary to that.

LISA LACHANCE: I was going to ask you about the acute day hospitals and the decrease that you're seeing. That's at the output level. What I'm wondering about is the functioning level, the actual mental health outcomes.

THE CHAIR: Your microphone went off. The honourable member for Halifax Citadel-Sable Island.

LISA LACHANCE: I was just waiting for the chatter at the table to quiet down so I could hear myself think.

I'm interested in the mental health outcomes. I do have a question about the mental health acute day hospitals.

Continuing to focus on the telehealth program and the TELUS Health program, you talked about decreasing ER rates, which I think is really important, but that surely would only be correlation, not causation. You could never attribute a decrease in ER visits aside from someone's opinion - would you have sought access at the ER if you couldn't have accessed this? I was actually quite surprised to see, when I went back looking at the wait times data, that there had been an increase in wait times, certainly for non-urgent care, in most jurisdictions. I won't walk through them, but that was what I was seeing.

I'm wondering with the TELUS Health program, what are the mental health outcomes that you're measuring - not outputs, not numbers like bums in seats. What are you actually hoping improves, and how are you measuring that?

BRIAN COMER: As a part of the outcomes monitoring, I think you need to look at the treatment goals, if they're being met both from the client's and the clinician's perspective. Is the client progressing during therapy? It's difficult to ascertain that. You have to talk to the client and talk to the clinician. This is typically conducted from the patient's perspective, whether it's every session, every five sessions - it's at a regular interval.

There needs to be feedback given to us as well from both the client and the clinician, the provider of the care, to see how things are going. Is it doing what it's intended to do? Oftentimes, I have seen the clients have an increased awareness of their own progress, if they're starting to feel better, which is often an indication that it's successful. I think the clients and therapists review - has their decision-making process improved? Has their quality of life improved? Is it reliable data that we're seeing? Is it valid? It's quite complex to get a very accurate understanding, I would say, of an individual's mental health.

We certainly have outcomes measuring in place. I think the client voice is something I focus a lot on, to understand their perspective, whatever the program may be.

The clients are able to complete assessments wherever they're at, so that is helpful. Just as a general practice, I would say that the routine outcome monitoring within the office itself focuses on routine outcomes measurement, increased client improvement - they're feeling better.

LISA LACHANCE: Maybe we can go back to the Mental Health Acute Day Hospitals. I know that the intent was to gather quite a bit of data, especially from the first pilot. My question is: What outcomes were being measured there, and could you share the results of that?

BRIAN COMER: We have talked about the mental health acute day hospital before. We have addressed a gap in the current system for intensive treatment which doesn't require an overnight stay in the hospital, which I think is a good thing for people who are stable enough to go back home. Certainly there was very positive feedback.

I visited the one here in Halifax. Clinicians and patients, I would say, are very happy with the service. There was a young psychiatrist who decided to be - their full-time job now is there. He was very happy with that. It's also being used as a kind of recruitment tool. In terms of actual data, there have been 87 individuals discharged so far, and 92 would be acute cases. The average length of stay is somewhere between 14 and 26 days. Typically an acute in-patient psychiatric unit is a bit - up to a week is what I used to see. That's over 2,847 in-patient days that would be saved in the formal health care system. That's about 6 per cent of all in-patient acute psychiatric patient days provincially, 13 per cent of Central Zone's acute psychiatric patient days' capacity. I think that's quite remarkable statistics for in-patient acute system.

I don't think at this point we would be able to say that those same numbers will translate to Cape Breton or to the other two health zones because they're different parts of the province with different concerns. But I would say the preliminary data on the day hospitals has certainly been very positive. It really looks at having the patient heavily involved in their own care as well, so they can report to us on their own progress. It's more of a collaborative relationship with the clinician. I would say generally speaking, it's a much different field than the acute in-patient setting, which I think might be a good thing sometimes. I would say that it's very positive.

LISA LACHANCE: What are people saying specifically in terms of positive feedback? What are the aspects from clinicians' and a patients' points of view that are positive? Have there been any concerns expressed about the model from either clinicians or patients? Is that being collected in a formal way?

BRIAN COMER: When I made the announcement in Cape Breton, one of the speakers was a young guy from Cape Breton who has had some experience with substance use in the form of the health care system. He's probably one of the more impactful speakers that I have had at an announcement, for sure. He spoke from the heart, for certain. I think

he gave a very balanced perspective of why it's a very good thing.

[5:15 p.m.]

I think Dr. Sridharan here in the Central Zone was the lead clinician to get this first day hospital stood up. She would have extensive expertise from the U.K. - a very smart, smart person. She also works closely with Dalhousie to collect data and outcomes at least every three months. She was actually earlier than that for the first pilot. I think you rely a lot on clinicians with expertise in the area. Just talking to patients - the day I was there, they were just very happy with the service. They get to go home to their kids, their wife - it's just good.

There's also a way to transition whether it's to day programming or if you deteriorate and have to go back to in-patient admission - hopefully not, but sometimes it does happen. I would say both the formal and informal indications have been pretty positive.

LISA LACHANCE: Have there been any concerns expressed with the day hospital model in terms of barriers, maybe related to transportation or other barriers? How has the program supported folks?

BRIAN COMER: I would say transportation is not so much an issue in Central Zone. I know at the Aberdeen Hospital recovery support centre there, where they have a more rural target population, transportation certainly is an issue. Some people miss appointments because they can't get a drive. Sometimes it happens.

I know when I worked in the hospital system, we had taxi chits or transit tickets for people. Typically, that could be the difference of getting to the appointment or not sometimes. I certainly think transportation is a significant issue in rural parts of the province. We haven't heard that much specifically with the Central Zone pilot, I don't think. I think you see the recovery support centre even in Dartmouth - we try to put things along transit routes and highly accessible locations if we can. If you're in Yarmouth or northern Cape Breton, you have to have a different way of thinking. It's not going to be feasible. I wouldn't say transportation is an issue at this location, but it's certainly an issue in rural parts of the province.

LISA LACHANCE: I'm going to wrap up with a follow-up question and then ask a different question. Would the programs in rural areas or acute day hospitals that are set up, that are serving more rural populations - will offering taxi chits or figuring out transportation be part of the services? Then, I'm wondering what the psychiatric in-patient occupancy rates have been throughout the province and also if you know what the trend is in the province for ER presentations for mental health.

HON. BRIAN COMER: I think initially - I won't say post-COVID - when things

were really locked down, I think the presentations to ER were up around 30 per cent to 34 per cent. I think that has levelled off slightly to - we talked about this this morning. I'll get the specific number. I don't want to say a specific number and be wrong, but I think it's in the 20s, but it's still higher than it was pre-pandemic, for sure.

If you look at the rural parts of the province, we have seen success with virtual psychiatric care in ERs. St. Martha's was one of the pilot locations. There will be expansions of that service to the South Shore, for example. It's not always appropriate in the ER setting. Sometimes it can be, whether you need psychiatric medication adjusted. There are just times when I think it can certainly be valuable.

I think the active transit issue specifically is something that has probably been lacking, certainly in Cape Breton and other rural parts of the province. I know that giving decisions to people who are providing the services is probably the most efficient way to do that, whether it's taxi chits, these sorts of things. Having active transit is a conversation that I have with my colleagues because it's certainly an issue that I hear.

LISA LACHANCE: I'm wondering: Do you have access to data from the Maple public virtual services and what percentage of those calls or texts exchanged are for mental health issues?

HON. BRIAN COMER: I wouldn't have that because it's primary care. It's mental health oftentimes, but that would be more appropriate for the Minister of Health and Wellness.

LISA LACHANCE: I wanted to turn to talking about integrated youth services. As you know, this has been an area of my work and focus in my studies as well. I have been engaged nationally and internationally with different initiatives. I am glad to hear the words integrated youth services uttered in Nova Scotia. I think we were the last jurisdiction in Canada to really talk about it, so I'm also really interested in seeing that initiative develop.

In the discussions around the budget - when I got the breakdown of the $17.7 million and there was almost $2 million for Integrated Youth Services - I guess I was wondering, realistically, what's planned for this year? I was a bit concerned by the information provided on Budget Day, so I'm hoping you can elaborate a bit. I was concerned about the reference to folks being referred into Integrated Youth Services through other IWK services. There's a pretty well-researched and well-established IYS model that exists. The federal government provided millions of dollars more for IYS-Net after funding the Accessible Minds Network. There's a fairly good understanding of what the IYS model looks like, and one of the key tenets is actually removing the need for a gatekeeper or any kind of referral. You were saying "no wrong door", but idea is a young person, either online or in person can walk in and access a service when they need it.

I'm just wondering if you can talk a little bit about what this is looking like in terms

of the model in Nova Scotia and also provide an update on negotiations between IWK and Nova Scotia Health to ensure that we're actually implementing youth services for 12- to 25-year-olds that bridge the traditional child-to-adult transition at 18 years old.

BRIAN COMER: I certainly agree that Integrated Youth Services should have a very low barrier to access. I spent some time in Eskasoni - it was one of the first meetings I had after being in this position. The Integrated Youth Services model in Eskasoni is much different than the IWK, for example. Kids would come in to go fishing, to have lunch, or something. Then they might happen to talk to a clinician. It wasn't a formal system, which I think is probably a really good thing.

The whole thought process is you can just drop in - especially for youth or for the caregivers or the elders in the community. We're really focused on wraparound supports, navigation, outreach. I think when you look at the 12- to 25-year-olds, I have seen that myself as a clinician. You age out, so to speak - you're 18 or 19 years old, where people kind of have a difficult transition time. I know there have certainly been very active conversations with Nova Scotia Health and IWK about that specifically.

I think there would be an expectation that we try to do this as evidence-based but as quickly as possible. I think one of the challenges we face - not just in Nova Scotia but across the country - is the human resource aspect. We have to be very innovative in our strategies to properly staff these centres. I know that the department is certainly heavily involved in that work. I would think ultimately the community has to buy into the service in order for it to be effective. There's certainly a role for Community Services, Education and Early Childhood Development - in terms of the curriculum that we're developing - and Justice. This is a cross-governmental initiative.

The service specifically in Eskasoni has primary health care, dental care, activities, these sorts of things. The goal over the next four years would be to have them in all four health zones. Once we can get these models effectively implemented, there will certainly be an expectation that I would advocate to get them across the province as quickly as possible to get them to help kids.

I have had a number of conversations with my federal counterpart. Certainly there's some very common ground there. I'll see what was in the federal budget today. I haven't had a chance to see it yet. I know they had some significant commitments to mental health in their election as well. I think there's a collaborative partnership there, so I'm hoping we can expand that sooner than later.

LISA LACHANCE: Eskasoni, as part of the Accessible Minds Network, provides a really important model. Part of Accessible Minds was the intent to - how do you have standards based on evidence that then become culturally contextualized. How do you do that in communities? I think Eskasoni is a great example of how that worked.

In other jurisdictions, the Accessible Minds Network, which was early, but I'm also thinking of B.C.'s Foundry and the Youth Wellness Hubs Ontario. In that case, when the province committed to Integrated Youth Services, there was actually a significant commitment to rolling it out. Communities were invited to basically prepare themselves. It wasn't just about government. It was about community-based organizations and other institutions, and communities had to come forward with a plan. They had to kind of prove that they were ready to take on an integrated youth services.

In B.C. - I would have to go back and double-check the numbers because they're not off the top of my head - basically well over a dozen within three to four years. Youth Wellness Hubs Ontario quite similarly ask communities to come forward and have done two rounds of funding to expand the funding of Integrated Youth Services. I'm just wondering why the government of Nova Scotia hasn't chosen to go that route when it seems to be - I also think of Kickstand in Alberta, there's expansion in Manitoba happening. Why haven't we done this in Nova Scotia?

[5:30 p.m.]

BRIAN COMER: I think the IWK example has been in the process of being set up over the last year. Certainly the focus on youth mental health is something we focus on a lot, especially with the non-urgent wait times being what they ar. That's certainly a focus of mine. I think there's a real focus upon it for sure, the expectation that once we deem that these are effective services for youth, we would be scaling them up as quickly as we can.

I think there's a lot of uniqueness in different communities as well, especially with community that don't really trust the formal health care system, like in Eskasoni, for example. We need those community partners. Some will probably come forward with proposals. Some probably won't. There's an expectation that we really keep a close eye on the shared outcomes. I know there have been frequent conversations with leadership within the IWK with both national and international leaders in this space. I think we are part of the federation as well.

Why it didn't happen sooner in the province, I'm not sure, to be honest. But it's certainly a focus of ours, and we'll continue to focus on it.

LISA LACHANCE: Like I said, I despaired at seeing the previous government never mention Integrated Youth Services. I definitely see the commitment here, but actually, I think we can still go faster. I don't think there's a need to wait for the evidence. I think these models that consider community complexity and uniqueness exist, and we have a lot of data from other jurisdictions in Canada that have proven - Foundry, for instance, has centres in really diverse communities. I guess I would just really encourage rapid access. I think the evidence base is there. We don't need to wait.

Another step in Newfoundland is through Choices for Youth, which is a lead partner

working with funding through the Royal Bank of Canada. They actually went out and in their rural and remote communities - I gave you this report - did all this research. In really remote areas of Labrador, how does a walk-in service work? What does this look like, and what does the community need? Again, it was pre-COVID, so I think we're playing catch-up, and I would love to see us catch up sooner.

I also wanted to ask, when the department was running through the $7.7 million in investments, there was $1.576 million for what was described to me over the phone as police pilots, which I was a little bit concerned about. That's certainly not what people are talking about . . . (Interruption)

THE CHAIR: Order, please.

The honourable member for Halifax Citadel-Sable Island.

LISA LACHANCE: Thank you, Madam Chair. I guess I would just encourage - this is the second time I have been interrupted by the Minister of Agriculture in this setting, and I'm not pleased. This is hard work on this side too. I'm tired and hungry too. If you don't feel like being here, take a break. You're an adult.

I was wondering about what was called police pilots because across the country and around the world, there has been a lot of work looking at emergency response to mental health crises - the pilot in Toronto and Edmonton and elsewhere. It's really about getting police out of there or at least reducing the amount of police response and actually increasing greatly the amount of response by mental health professionals. I guess I'm wondering if we could talk about what these are and what's being looked at in Nova Scotia.

BRIAN COMER: This would be mental health and addictions crisis response - mobile crisis response - something I have been trying to push since my nursing days. There's certainly a great need for this probably across the province.

These could be a variety of complementary clinical make-ups. I'm not trying to sound too health care-ish. It would be to improve outcomes for those experiencing crises for both people living in more urban centres as well as rural. We did a thorough jurisdictional scan - I know you mentioned Alberta. There are some other jurisdictions that have done these sorts of initiatives. This will have to be done very carefully, in conjunction with the provincial crisis line, which will be 988, not too far in the distant future.

Increased training for first responders as well, with trauma-informed and culturally safe practice. I worked with the community outreach team in Cape Breton. This was a plainclothes police officer and either a psychiatric nurse or social worker. The issue with them is they had 9:00 a.m. to 5:00 p.m. hours, Monday to Friday. It was great for those hours, but a mental health crisis can occur outside of those hours.

This will be looking at a variety of clinical compositions. I have seen sometimes people do a wellness check, and there can be a weapon involved and psychosis. Things can kind of - there needs to be the police presence sometimes. Sometimes it makes it worse. These will look at a variety of compositions with teams as we move forward.

We have had significant conversations with the Department of Justice and a number of police organizations and clinicians across the province. Again, it's scalability, human resource capacity, and these sorts of things. There's certainly significant demand. I believe there was a service in HRM for mobile crises, but I don't believe it was 24/7. It's difficult, but that being said, I think if people could get this sort of option, it takes a lot of pressure off first responders, who are sometimes put in situations where they're not properly trained to handle the call.

I'm very excited for this as it moves forward. This is really about increasing the knowledge of mobile crisis response across the province and really, for the first time, having integration with justice and the health care sectors. There hasn't been that in the province traditionally, and really giving our front-line responders the proper training to know what to divert to a clinician or what-have-you.

We have had significant engagement to see where the desire is across the province. I know in Portapique, because there was obviously a significant tragedy for our province, we have hired a community liaison staff just recently to go into the fire department, go into the Legion - not your traditional "sit in my office, come and see me for an appointment" sort of set-up.

Oftentimes, when people set up formal services, people won't use the services. It's stigmatizing or they just don't use it. I think this is a very needed service. We just have to be very careful that it's rolled out safely. It could really create an alternative response to a mental health crisis, essentially. We'll certainly keep working on that. I think there's some potential there to help people with the service.

LISA LACHANCE: In this year, the $1.5 million that's committed - what will that be used for?

BRIAN COMER: The primary cost would be the health care human resource capacity for these teams. It could be registered nurses, social workers, or program/policy folks. It comes with a health care sort of budget. Obviously, this is contingent on human resource capacity. Sometimes you might have a social worker who works 60 per cent of their shifts in a day program. They could do 40 per cent - there are ways you can staff it a bit quicker. That's primarily for the health care clinical staffing aspect of it.

LISA LACHANCE: I'm wondering if you can clarify how many FTEs are foreseen within that $1.5 million. Then I'm going to switch us forward a little bit.

Health human resources is obviously a huge challenge everywhere. I'm wondering if you could talk a bit about it. What's the vacancy rate across zones? What are you seeing as the very specific challenges to filling those vacancies for addictions and mental health in Nova Scotia?

BRIAN COMER: We have had pretty good success lately speaking to psychiatry to start off. I just found out this morning that the federal government instituted the homebuyers ban and they didn't exempt health care workers coming to Nova Scotia. We got that figured out last night. I was very glad to see that happen because we have a lot of people coming from the U.K. or wherever to practice clinically.

I certainly think our post-secondary institutions play a very important role. If you look at Cape Breton University with the medical school and their Bachelor of Social Work - the Bachelor of Social Work doesn't get as much press, but I think it's a very important program for social workers. If you look in the budget here, with the graduate program at Dalhousie, that's six to ten seats with this program at Dal. Basically, a clinical (unintelligible) specialist would have a high level of training for addictions and mental health care.

I know we're in active conversations looking across other allied health care professionals, I would say. There's certainly some ability to grow our own, but I do think the immigration piece is significant. We have recently seen the ability for people in the United States - they wouldn't have to come here to go through the red tape for medical practice. That will indirectly impact psychiatry and other medical professions.

I do have some specific vacancy rates. Across the province, we have 123 psychiatrists, 648 psychologists, over 550 social workers, over 370 counselling therapists, 988 nurses - these would be nurses who work in the formal mental health and addictions system. These would be individuals registered with their regulatory bodies, which is just accessible online.

As of September 2022, the vacancy rate for all clinical positions was 24.9 per cent, which is down from 27.4 per cent from October 2021. Vacancies have gone up for counselling therapists and social workers. For counselling therapists, the most recent we have is 40 per cent; psychologists, 36 per cent; social workers, 22 per cent. In regard to clinical positions within the formal addictions and mental health care system - you just want the vacant FTEs? For psychologists, it's 33.7; social workers, 97 - that could range from clinical outreach workers, clinical program coordinators, patient access navigators; clinical therapists, 70; nurse practitioners, 5; registered nurses, 121; and LPNs, 32.

LISA LACHANCE: I can go back. Those numbers went by a little bit quickly. Perhaps that table could be shared. Obviously, it will also be in the transcript.

You talked a bit about some of the jurisdictional changes. Are there other key

challenges that you see in recruiting health human resources that you're hearing about from folks that you're trying to get into positions?

[5:45 p.m.]

BRIAN COMER: I have been to the four health zones. I don't think I've been to all the hospitals, but most of the hospitals across the province. The number one thing I hear about, honestly, is retention. I think the challenges of attracting new staff are certainly well established, but we have to keep the staff that we have. I do think the retention announcement recently was a very positive step, especially for nursing vacancies and other allied health care professionals. I think retention is probably the biggest thing that I have heard.

It has also been a tough time to work in health care, the last couple of years. There has been a lot of burnout and a lot of stressful circumstances. We're working with Nova Scotia Health to increase mental health supports not just for patients but also for the staff. I think retention is the biggest factor that I've heard about.

LISA LACHANCE: Earlier in the discussion, you talked about trying to establish a system where there's no wrong door. I think realistically in Nova Scotia, there are still lots of doors that aren't particularly open. If you call central referrals for IWK mental health, families and children are often waiting quite long waits. We hear a lot in our office from folks who cannot get the level of mental health care that seems to be what is needed or what might be effective for them. They are folks who are maybe not connected to primary health care or maybe are on a wait-list for their first intake appointment in counselling with Nova Scotia Health but are actively in crisis - so showing up in ERs, not being admitted, and really kind of existing in this space. They don't seem to be being picked up by the acute day hospital.

I have reached out to Ken before and asked about these situations. We have had them shared with us, and I have sat in the ER with a couple of families this year for very long periods of time and late into the evening. My perception, honestly, is that there is a risky gap around folks who are in high need and assessment not being needed to be admitted, which is good.

I see the urgent numbers are quite good in terms of wait times, but I'm wondering what your assessment is. My perception is there's a huge gap, and it's a dangerous gap. In my budget response, I shared three situations recently in HRM where folks were in pretty deep crisis, where they had family around them who were able to reflect and report on that. In two cases, the people died as a result. Their family attributes it to their mental health status.

I don't know how to ask a question about numbers because obviously, it's hard to count what doesn't happen, that sort of thing. If people aren't getting admitted, it's hard to

count folks in crisis. What would you say to that?

BRIAN COMER: There are certainly challenges. I think the cases you referred to are not quite crisis, but they're not quite non-urgent. It's a delicate window, I would say.

I think demand is probably up. It certainly is up in Nova Scotia based on our data. I think it's similar in other provinces. Having been to hundreds of Code Whites in emergency departments, it's a very challenging space for mental health patients. I know the IWK is doing some different work with the triage process itself of psychiatric patients. The new facility that's being built in Cape Breton has different dedicated space for psychiatric assessments, to that unit specifically. I think it is important to say that we're not perfect, but we do a good job of meeting our crisis targets for urgent mental health care. I think that can't get lost. That's very important.

Something I hear a lot about is that there still seems to be a bit of a misconception that everyone who has a mental health issue needs to see a psychiatrist. Sometimes they do, for sure, but sometimes they benefit a lot more from a highly accessible community-based resource, whether that's a peer support worker or whether that's going down to your CMHA and just having a coffee just to talk. We have a number of conversations with health care professionals to ensure that they're all working at the top of their scope of practice. With every scope, it's harder to find more people.

I think that we have had a pretty good dialogue with clinicians. In terms of expanding services, like the mobile crisis service, helping those people get to the ER would be my goal. The BIOS model we mentioned earlier is another option for people with ADHD or on the autism spectrum to get help at home. Sometimes those can be difficult situations at home. Sometimes they lead to hospital admissions where they're not even really in the right place - the child or the patient. I would say more definitely needs to be done.

A big issue that we have been discussing with clinicians is the medical clearance aspect for people in ER with mental health issues, because you have to rule out a biological cause for the issue to make sure it's not physical before you can then get the crisis assessment or the mental health assessment. We certainly have had conversations with clinicians about how to safely address that. It's a very delicate one because you can miss something physically. There are gaps. I think emergency departments are difficult places for people with mental health issues. It's something we'll continue to work on, but I do think all these community-based resources should hopefully - they won't help them all but should help a lot of these people out before they get there.

LISA LACHANCE: Integrated Youth Services is definitely founded on that model that that not everybody needs to see a psychiatrist, but when there also are wait times on the non-urgent side, then those more transient mental health issues can become more embedded or become more severe. Also, you get into a cycle around the social determinants of health. If your anxiety is preventing you from going to school, and then

you miss a semester, and then it starts to really impact how you feel about yourself - you know all this.

You talked about increased demand. Can you talk about what it looks like? What are the numbers year over year in terms of numbers of people on the wait-list? Would you attribute the increasing wait times to absolute increases of numbers, or what else is going on?

BRIAN COMER: I don't feel like I have a good answer for that question. Anecdotally - I'm not saying this is based on any data or anything - there's a lot that has happened in the world in the last couple of years. It's a tough time. We certainly have seen increases in presentation to emergency departments, increases to crisis lines. It has had an impact on some people's mental health.. We have also had significant population growth in the province. There's more pressure on the system. There wouldn't be one specific factor to that. Then you tack on inflation and everything else that's going on across the country. It's a tough time right now. I certainly wouldn't have a good answer for that question, I don't think.

LISA LACHANCE: I asked in the House today about the NSGEU grievance regarding the contract with TELUS Health. I would like to invite you to talk about the department's response and position to that issue.

BRIAN COMER: I have a lot of respect for front-line clinicians, whether they work in the public or private sector. That is a new service with Nova Scotia clinicians. I know there was a number of questions about the procurement and why it was TELUS Health. This would have gone through standing government procurement process, so it was outside of my control. I look at it as a way to help take strain off those working in the public system, as a complement, not as competitive.

We know the needs with non-urgent care and the pressure on our hospital system. I look at this as a partnership between the two, not as a competitive aspect. Oftentimes, I have known clinicians who work in both the public and the private sector at the same time. I don't see what's wrong with that, not as long as Nova Scotians don't have to pay for the service.

LISA LACHANCE: With that program and then with - I forget how much it was - the piloting for private assessments that's happening this year, what are you seeing in terms of the compensation model? What's the per-hour cost in the public system versus the per-hour cost happening in the private system?

BRIAN COMER: I would say that specific question would be part of the evaluation of the pilot, especially with the psychologists at Dalhousie University and province-wide. We have been meeting with them now for quite some time, especially with the psychologists. I would say we have a very collaborative relationship. As I mentioned earlier

- I think in the Summer - we would have more specifics to say on the compensation model. There would be an expectation that it's going to be available for people. I wouldn't look at the cost as a deterrent, if that's worth anything.

LISA LACHANCE: I think the cost is one portion of outcomes measurement, but I think building into the public system is really important, and if cost efficiency is part of what makes that a better investment, then that's an important thing to know.

[6:00 p.m.]

I have a broad question: Could you share with us the assessment criteria, the evaluation criteria, for contracts with non-profit organizations and community-based organizations? My specific example around that - the Pinwheel Wellness Centre that you were talking about through Autism Nova Scotia. Certainly there's a huge need, no question. I know they are oversubscribed by a lot, so I'm happy to hear that they have $600,000, but you know what one-time funding does. I know they could make good use of $600,000, but they could make probably better use of $600,000 if they knew that it was ongoing. Essentially if it's FTEs and you're asking an organization to staff up, but only with temporary people, then retention becomes an issue, and that affects clinical relationships - that whole cycle.

I'm curious to understand what we're asking organizations and what we're requiring for evaluation. How can initiatives like Pinwheel get off this one-year bump cycle?

BRIAN COMER: I see that there's a province-wide framework that we're developing. That should be developed in 2023-24, hopefully before then. That's my goal. I know Pinwheel, for example, when I was there, the uptake of the service exceeded their expectation, and they were actually servicing patients who didn't even have the need, but were assigned the service. How we navigate them to the formal health care system, these sorts of things.

I was certainly looking forward to when the framework evaluation is complete to get the core funding for all these groups. Being MLAs, we know there are often groups that can get a little bit from the Department of Community Services, a little bit from the Department of Health and Wellness, a little bit from Justice. It's very confusing for the people who are running these organizations. The idea would be to provide grants directly to the CBOs on a consistent basis.

There is a dedicated position that's going to be staffed in the Spring for a community liaison person within the office who will have direct contact with a lot of these CBOs across the province. When I came into this position, we didn't even have a list of the groups, to be honest. That was one of the first questions I asked. Some of them range from services for youth - I certainly think Autism Nova Scotia will continue to be a partner

of my office, for sure. You look at something like the Mental Health Foundation. They do a lot of great work across the province with grant distribution.

Any kind of money from the department that's given to a CBO will have an accountability framework with it. I don't have that in front of me but there would be specific criteria with the framework that we would check on.

LISA LACHANCE: Would you be able to follow up and share that accountability framework - obviously not a filled-in one, but just to give a sense of what's being looked for from non-profits?

You also talked about getting to the point of regularizing the type of funding. I'm wondering what your vision is around that. What kind of time frames would you be talking to organizations about? Is there a goal for percentage of the Office of Addictions and Mental Health budget that would then become focused on community - I guess transmitted through community-based organizations?

BRIAN COMER: I think the goal would be to have - when the framework is complete - sustainable core funding on an annual basis to these organizations. The framework isn't complete yet, so I would be hesitant to give a budget value or percentage at this point.

Generally speaking, one of my priorities in the department is to focus on community access for care, whether that's the Boys and Girls Club in Chester or the peer efforts in Yarmouth. I think they're undervalued historically in the province. Once that framework is complete, we'll certainly have specifics, but I would say that will be much more significant than it has been historically in the province. A lot of these were just one-offs historically.

LISA LACHANCE: Not to belabour the point, but we have had two years now of significant funding provided to community-based organizations, and I assume that there is an accountability agreement in place, maybe not the full framework. I am wondering if that can be shared - what's asked for in the reporting from community partners. I'm also wondering if the minister can table a list of contracts that are public-private partnerships, and also note which ones are pilot projects and which ones are permanent, if any.

BRIAN COMER: That was a couple of questions. I'll try to answer the first one. The CBO piece: Once we get the framework complete, we'll certainly have a very defined list, but I would say for organizations that receive one-time funding, there would still be an accountability framework provided to them. I can ask the department to provide the framework.

In terms of pilots, there's a number of them here in the budget. It ranges from mobile crisis to subcontracts with clinical psychologists. Then we have long-term

established services: in-patient mental health, withdrawal management, crisis intake, all these sorts of services. I think the initiatives would be - I would probably reference the pilots, both for the OAMH initiatives and the IWK initiatives. They would be the two main ones.

THE CHAIR: The honourable member for Halifax Citadel-Sable Island with 38 seconds.

LISA LACHANCE: Madam Chair, I was going to suggest a five-minute recess.

THE CHAIR: Let's take a five-minute recess.

[6:06 p.m. The subcommittee recessed.]

[6:12 p.m. The subcommittee reconvened.]

THE CHAIR: Order, please. The Subcommittee of the Whole on Supply will continue.

The time has elapsed for the NDP caucus. We will now go back to the Liberal caucus. I believe the intent is to share some of the time through the Liberal and NDP caucuses with the independent member.

The honourable member for Clayton Park West.

RAFAH DICOSTANZO: I have a couple of questions. If I may just go back to that last question, what I didn't ask for the one-hour session - I'm assuming it's a pilot. What is the timeline? When is it starting? When is it ending? So that we know when the evaluation - how many hours? What is the contract for that?

BRIAN COMER: I announced this service February 22nd, so a little over a month ago. There are four physical locations in each of the four health zones. Service is accessible for people in those four communities in person, but it's also accessible via telehealth and virtual health if you live in a rural or remote region of the province. Typically, any kind of evaluation process would be every quarter within most frameworks. I don't have the details of the contract here in front of me, but I can certainly get the details and share it with you. I can check the details of the contract and follow up.

RAFAH DICOSTANZO: There's a beginning and an end for this contract, correct? It's not going to be every year for the $2.3 million.

BRIAN COMER: I would say that it's ongoing. I would be hesitant to say that we're going to do it forever without having the evaluation. Every number of months, we would undergo the evaluation process to see if it's doing what it's intended to do. The

investment this year would be for this fiscal year.

[6:15 p.m.]

RAFAH DICOSTANZO: For this fiscal year - so it's a one-year contract for $2.3 million. Do we know how many hours that totals?

BRIAN COMER: This service would be for this year, so it would be for the four locations and the clinicians, the clinical staff. Like any other program, there would be a thorough evaluation done to see if it will be continued. If it's not doing what it's intended to do, we would not support this service again. That's the investment that was announced in February. We'll continue to monitor the program.

RAFAH DICOSTANZO: Could I have that e-mailed to me? It's the contract, the date it's going to start, the date it's going to end, and when the evaluation is taking place, and how much per hour is the cost. Is that $2.3 million divided per hour that this company is going to provide? If you don't mind as well, how many of those hours are going to be virtual, and how many of those hours are going to be in person in different locations? I would just like a breakdown of what this service is all about and how you came up with this idea and the contract.

BRIAN COMER: I would say with any government service, there would be a request for proposal that would be issued for a service. This would go through the procurement process. The dollar figure would be to administer Access Wellness across the province as part of the RFP process. It's a package.

RAFAH DICOSTANZO: There was an RFP, so you have all the details of when is the start of this program, when is the end, how many hours, and the cost per hour, correct? If I could have that information, it would be wonderful. I'm glad there is an RFP and you have all that. It would be great to have that information.

The next thing I have is the Liberal caucus did a FOIPOP to find out how many vacancies there are in mental health staffing. I'm wondering how many vacancies of mental health and addiction professionals are there. Do you have numbers of what you're missing, vacancies that are available right now to fill?

BRIAN COMER: We do. Do you want me to read through them all, like I did before? Okay.

Registered counselling therapists, 39 per cent . . .

RAFAH DICOSTANZO: How many spots? How many positions, full-time employment?

BRIAN COMER: That would be 114 for RCT. Psychology vacancy would be 36.4 per cent, which equates to 60 FTEs. Social worker vacancy is 22.4 per cent, which equates to 248 RTEs.

RAFAH DICOSTANZO: I'm sure it's on Hansard. I wasn't able to write it fast enough.

The other question that I have is, we are facing an opioid crisis in this province, and I have heard from a couple of doctors who are working in mental health, and there is a treatment that doctors can use. It's available in Alberta and in P.E.I., but it's not available in Nova Scotia. That is Sublocade, and it's a monthly injection that can prevent people who are having to go every day to get medication - it's life-changing for a lot of them, but it's $200 per month per patient, and many of the people who need it have no way of paying the $200 a month. Do you know anything about this? Why does Nova Scotia not cover this medication?

BRIAN COMER: Sublocade is covered in the formulary of Nova Scotia. I was in North Sydney, for example - the Pharmacy Association of Nova Scotia is enhancing their scope of practice for primary care. Sublocade is covered under the provincial formulary. (Interruption) It is covered. Dr. Hickcox, who works in our office, is one of the leaders, I would say, in addiction medicine in the province, and Dr. Martell from Lunenburg. It is covered. If you hear anything different from a constituent, we would certainly be happy to connect you.

RAFAH DICOSTANZO: I will email you - we received it through an e-mail, and it's not covered, according to this person in Halifax.

In the business plan, it states that there will be more mental health day hospitals opened. I believe in your opening remarks, you mentioned there is one in Halifax and one in Cape Breton. My question is: What is the budget for all the day hospitals and where will they be? Maybe you can just describe what services are offered in a day hospital.

BRIAN COMER: The one we announced last year in Central Zone is the first day hospital. There's one that's going to be opening in Cape Breton. We're still trying to confirm the locations in the Northern Zone and Western Zone. I would say there's more to come with that.

In regard to cost, it's about $1 million per day hospital. That doesn't include psychiatric services. That's probably another $360,000, give or take. Medication dispensaries might be a little bit extra, generally speaking. In terms of service, you would need a referral from a primary care provider to the attending psychiatrist on the unit. The treatment would be very similar to an in-patient in a psychiatric unit minus the fact that you would stay there overnight. It could be pharmacology. It could be talking to a social worker for counselling. It could be group therapy, potentially. There's a variety of services,

but it's intensive treatment. You wouldn't be intended to stay there any longer than you needed to be without being clinically indicated to go to a lower-tier service.

RAFAH DICOSTANZO: Right now, there's one in Halifax, and I know I have a constituent who is trying to get help for her daughter. There were absolutely no beds - she wasn't successful at all to get her help overnight. Where is this one in Halifax, and how can I refer my constituent to this?

BRIAN COMER: I would say day hospitals aren't overnight anyway. A good place to start would be to contact intake, if they didn't already have a conversation with their primary health care provider if they have one. I would contact intake, and they would navigate them through the process if that's what they needed. I think intake would be a good starting point. You could also get a consult from your family doctor or nurse practitioner to psychiatry if it's needed. I don't know the specifics of the case. That would be the two routes that I would suggest.

RAFAH DICOSTANZO: Where is the day hospital in Halifax? She does have a family doctor. She has a referral, but she has not been successful. I will forward that email to your office, and hopefully we can help her. She is desperate for help, this mother. I'm sorry, did you mention where this day hospital is in Halifax? Is it at the Abbie Lane? It's at the Abbie Lane. Just a referral from your family doctor, correct?

BRIAN COMER: That would be the primary mechanism that I would use, but there's also 45 community mental health clinics across the province through Nova Scotia Health. These would be outpatient-based community clinics with a variety of clinical disciplines that would provide care. I don't know the specifics of the case, but these are some of the options that we could maybe explore for the constituent. I can't really say much else.

RAFAH DICOSTANZO: This is very complicated, and she has tried everything, and she has not received help at all. We will forward that to you and hope you can help us as well with that one.

There is a commitment to spend $2 million more to expand virtual mental health care - Nova Scotia Health, and the IWK. When will the service start, and what are the hours for care? How do you monitor this and quantify its success?

BRIAN COMER: During COVID-19, Nova Scotia Health and IWK, with mental health services, sped up the rollout of virtual mental health - not just mental health but I think primary care as well. We have a pilot that was very successful in the Eastern Zone for virtual mental health care in emergency departments. That's currently being expanded to other regions of the province.

There is a provincial Virtual Urgent Care Service that was implemented. That was

an increase of 3.8 FTEs. That was in 2022-23 to create this team. We're certainly in continual conversations with our emergency room physicians and our crisis teams within emergency rooms. Those pilots were virtual urgent mental health care emergency departments. Like I said, it was launched in Eastern Zone, and now it's expanding to Northern Zone. It provides virtual care in emergency room settings. Typically, they would have had to have been transferred to another facility for psychiatric assessment in person.

We have 22 FTEs that have been dedicated to support virtual care from our community mental health and addictions services teams that I just talked about, which are all across the province. All the uptake of the service, the service volume would all be tracked as well as wait times and outpatient appointments. I think as of last month, in February, there are three FTE vacancies which haven't been filled due to operational reasons.

I would say generally speaking, the feedback has been very positive for the virtual mental health care. There are certainly some challenges with recruitment, as previously mentioned. I think in 2022-23, approximately 13 per cent of all Nova Scotia Health appointments were virtual appointments. Over 27 per cent of appointments were conducted virtually during the third quarter across the IWK - so quite a bit higher for IWK services.

RAFAH DICOSTANZO: Virtual care - the total number of full-time staff we have right now is 22? The $2 million, what was the expansion spent on?

BRIAN COMER: The 22 FTEs would have been in addition to the previous staff complement, specifically for virtual care, across the province.

RAFAH DICOSTANZO: What was the total number of FTEs working in virtual care right now?

BRIAN COMER: I don't have that with me right now, but I can certainly follow up with the number.

RAFAH DICOSTANZO: I think I'm going to give my time to my colleague here. How many minutes did I use?

THE CHAIR: You used 20 minutes. Can we just pause for one second?

The honourable member for Cumberland North with an agreed-upon half an hour.

ELIZABETH SMITH-MCCROSSIN: I have some questions. I'll start off with a bit broader questions. How much money was budgeted for your office for the last year, the year that we're just finishing up?

BRIAN COMER: The amount for my office specifically would be $191,000, but

for the department, the estimate for 2022-23 would have been $268.631 million.

[6:30 p.m.]

ELIZABETH SMITH-MCCROSSIN: Just for clarification, $191,000 or $191 million for your office, and $268 million for mental health in general - that would include the Department of Health and Wellness? Maybe I'll just ask the minister to clarify the numbers.

BRIAN COMER: The general administration for 2022-23 for the office itself would be $191,000. The departmental budget for the Office of Addictions and Mental Health would be $268.631 million.

ELIZABETH SMITH-MCCROSSIN: Over the last year, did your office receive any additional funds than what was budgeted?

BRIAN COMER: We didn't, other than 2022-23 - which is the $20 million, which would have been for the health care retention, the staff within the formal mental health and addictions system.

ELIZABETH SMITH-MCCROSSIN: Can the minister let me know - do you have a specific budget for the Northern Zone?

BRIAN COMER: There's no specific budget for any zone, to be honest. I would say that there is expectation from myself that there are equitable services in each health zone, whether that's with the day hospital or that's with virtual care or community-based services. Each zone is certainly unique in its geographical makeup or challenges, whether it's rural or urban, that sort of thing. I think underlying a lot of these new programs that we have announced, there is a goal that all Nova Scotians should be able to access the service, regardless of where they live.

ELIZABETH SMITH-MCCROSSIN: Within the Northern Zone, can you share with us how many acute psychiatric beds there would be for Northern Zone? That would be Pictou, Colchester, and Cumberland Counties.

BRIAN COMER: This is the breakdown I have in front of me. I don't know if this answers your specific question, but I will see if it does. As of April 2022, there's a total of 361 in-patient beds - 164 would be acute beds, 74 would be specialty beds, 92 would be forensic beds, and 31 would be withdrawal management. In 2021-22, there were a total of 4,616 in-patient stays across the province. I don't have the specific bed breakdown, but we can get that and make sure we follow up with you.

ELIZABETH SMITH-MCCROSSIN: The reason I'm asking specifically is I believe there are only acute care beds in the Northern Zone at the Colchester East Hants

Health Centre. I'm wondering if the minister can confirm that, and if there are acute beds at Aberdeen Hospital to let me know. What would the occupancy rate be of the acute care beds for the Northern Zone area?

BRIAN COMER: Speaking from a provincial standpoint, typically the bed occupancy rate is quite high across our in-patient system, across the province. Historically, it has been the highest in Central Zone. That's why we chose there first for the day hospital, to try to take that pressure off the system. I know historically it has been between 95 per cent and 98 per cent for the other three zones. We don't have the specific percentage for Northern Zone here because we manage the in-patient bed system provincially. There will be an expansion of a day hospital in the Northern Zone. I just don't know the location at this point, but we'll certainly have some information to share soon for that.

ELIZABETH SMITH-MCCROSSIN: We have discussed this previously; I would have guessed that the occupancy rate was high. Has the minister and the department considered increasing the number of acute care beds for psychiatric patients based on the demand? The reason I'm asking that question is that we have had several continuing circumstances in our area where people are in need of psychiatric assessment and potentially in-patient psychiatric services, but unfortunately, there is no acute care bed available. It's very stressful for the emergency team - the physicians and the nurses.

What often happens is that the patient ends up not receiving the care that the medical practitioner would have liked because there's no availability of an acute care bed and sometimes a psychiatrist. What often happens is the emergency department staff simply end up discharging the person back into the community without them receiving psychiatric medical care.

Based on that, and I don't know if the minister's office would have stats or any data on how many patients would be discharged home without being seen - I don't know if that's even captured because it's not something from a legal liability standpoint that people would actually want to document. I know from hearing from our medical practitioners that that is, in fact, the practice. Based on all of that, I'm wondering if there has been any discussion about increasing the number of acute care psychiatric beds, specifically in the Northern Zone.

BRIAN COMER: There has been increased demand, I would say, in the in-patient mental health system across the province the last number of years. I think the data from the day hospital in Central Zone over the last year has been very significant.

There were approximately 2,847 days spent in the day hospital. It basically led to a 13 per cent reduction in in-patient beds in Central Zone last year. I don't think it would be fair to say that it would be the same for Northern Zone, Western Zone, or Eastern Zone per se, but I do think there's potential there. It should have a significant impact on the in-patient system.

I think there are also programs in the budget, such as the Mental Health Mobile Crisis Team, which would be another avenue to reduce pressures on the emergency departments - I think a lot of our services are really focused with community-based organizations, finding those kinds of champions within the community who can provide the lower-tier services. There's certainly increased demand for non-urgent services across the province, which has increased. I would say, generally speaking, it's something we'll continue to look at as we move forward.

ELIZABETH SMITH-MCCROSSIN: Certainly, every time somebody is not able to access care, we're always concerned. There's definitely a higher acuity of concern when people are in an acute state, when a medical practitioner deems it necessary for them to have an acute care bed and that's not available. Ideally, we would love it if there was someone looking at increasing the number of acute care psychiatric beds, definitely in the Northern Zone. I know there's demand there.

Would the minister have any numbers on the usage for Nova Scotia patients on the psychiatric services, mental health services - both in-patient and outpatient - in New Brunswick? For example, many patients in our community, when they're not able to receive care at Cumberland Regional, will go to Moncton. I'm often hearing anecdotally from patients about the superior psychiatric care that they're receiving there - that often they're seen and admitted for at least a one-week stay, seen by a psychiatrist versus trying to access mental health care through our regional hospital, where they're unable to see a psychiatrist and unable to receive psychiatric care.

Would the minister have any numbers of how much money Nova Scotia is spending on sending money back to New Brunswick for those services that Nova Scotians are receiving next door in our neighbouring province?

BRIAN COMER: I would say in terms of meeting our crisis targets in Nova Scotia, we do a pretty good job. It's not perfect, for sure, for mental health crises. There has certainly been an increase in non-urgent issues. Typically, non-urgent issues aren't seeing psychiatrists. That's typically for your higher-acuity, more complex care.

We wouldn't have that information about New Brunswick. I would have some correspondence from my colleagues about constituent cases, those sorts of things. We have had people come from other provinces to Nova Scotia too, for ECT or different services. I wouldn't have the New Brunswick information.

ELIZABETH SMITH-MCCROSSIN: I know that information is available. It may be available through the Finance and Treasury Board Department possibly. I'm not opposed to our people receiving care in New Brunswick, especially if it's not available to them here in Nova Scotia.

On that note, has there been any work with our neighbouring provinces - both New

Brunswick and P.E.I. - to work collaboratively to ensure that patients receive services? Has there been any collaboration from your office or department with the neighbouring province of New Brunswick?

[6:45 p.m.]

BRIAN COMER: I would say there are regular meetings with the FPT, the federal-provincial-territorial representatives from each of the regions. I think when you see the recent announcement with Atlantic Canada with licensure for physicians to cut down on red tape from whether you're in the United States - I think it's a positive step forward. Certainly I have had conversations with my colleagues in the other Atlantic provinces - very interested to see what was in the federal budget today, for mental health and addictions care because I will be taking a close look at that tonight. Those FPT meetings are certainly regular and ongoing, as well as conversation with the federal minister. I would be open to any kind of dialogue with my colleagues.

ELIZABETH SMITH-MCCROSSIN: I believe certainly in Cumberland County we would benefit greatly from more collaboration with New Brunswick. The bottom line is we want to make sure that people receive care when they need it and wherever it is the easiest to access - I guess is what's best for the patient.

Before I finish on that note, I want to just emphasize that this is not anything new that I've brought up. I have brought this up before, but just to emphasize that we have a dire need for acute psychiatric beds in the Northern Zone. I don't know if the minister would ever have time to come up to Cumberland to meet with, specifically, the emergency room physicians and the emergency room nurses, because they are the ones who are faced with assessing a patient who comes in but not having the ability to access those psychiatric services. It's really one of the only specialties.

If they have a cardiac event, there are internists who share a 24/7, seven-days-a-week call. We have radiologists who are on call 24/7. We have obstetricians on call for delivering babies. We have surgeons. Really, just about every specialty - although you could say there's a psychiatrist available 24/7 in Truro, the fact is when our emergency room physicians try to access, they're often told there's no bed available, and the patient is not able to be seen. That often comes after spending hours on the phone.

What the actual result of that is, in a very busy emergency department, is often the emergency room physician will say, "I don't have time. I don't have time to get on the phone and try to convince a psychiatrist in Truro or in another area of the province to take this patient who needs psychiatric care." Often, the patient gets discharged home without receiving the care that they need.

The fact is, if it was any other type of condition - cardiac, or they broke their leg and they needed an orthopaedic surgeon - there is a place where they could receive the

care. We're really seeing huge deficiencies in accessing acute care - I'm talking about very serious medical acute psychiatric care. I just want to make sure that the minister is aware of that.

Our psychiatrists, I would say, the ones who are serving that area, are aware of it to a degree. The people who are acutely aware are the emergency room physicians because they're the ones who are faced with a patient in need, and they simply have nowhere to send the patient.

I want to move on to another topic, to ask the minister about education. Is there any collaboration with the Minister of Education and Early Childhood Development on trying to meet the mental health needs of students - specifically the psych-ed assessments that I'm being told from parents there's about a two-year wait time? I'm wondering: Are there discussions with your department of the two departments working together to try to get students in much faster?

BRIAN COMER: A couple of things with Education and Early Childhood Development specifically: Look at SchoolsPlus, for example, and the youth health centres. I think most of the high schools in the province were also working together to develop a curriculum with the Department of Education and Early Childhood Development. That is well under way. I know that's not far off.

In regard to assessments, one of the pilot subcontracts with a private clinical psychologist will be used for diagnostic assessments for autism spectrum disorder or ADHD - if you're on the wait-list for EIBI, for example - typically your pre-school, elementary chronic issues.

I know we've given Education and Early Childhood Development some increased resources for education around mental health literacy, both for staff and students. We have seen increased utilization of the health centres at the schools, usually with nurses and social workers. Most of the increase has been with mental health and sexual health. These are the two big things that have increased the last couple of years. We're always looking at whether that's the appropriate number of FTEs in the school system. I think there's a variety of partnerships with Education and Early Childhood Development.

Historically, if parents can't get the diagnosis, they can't afford to pay for the private diagnostic assessment. We're trying to pull that into the public sector with our private partners. They have been very receptive so far, I think I would say. Some may be working both private and public, depending on what their professional desire is. Conversations are certainly ongoing.

We do have an actual map of where every psychologist is in the province, which I think is important. There's a lot of potential with virtual care but sometimes it doesn't work for everyone. I think there's a number of things with Education and Early Childhood

Development that we are keeping an eye on. I would say the elementary school system is somewhere I would identify where there has been a lack of mental health resources. Certainly some collaborative conversations are going on there, even with food security and all that these things impact. There are some conversations there that are definitely ongoing.

ELIZABETH SMITH-MCCROSSIN: What I'm being told is that in New Brunswick all the psychoeducational assessments are being done by private contractors, and it has helped to shorten the wait-list, for whatever reason. I don't know if the minister is aware of that or wants to speak to somebody in our neighbouring province to see how they've done it. I guess they have really shortened the wait-list there. It is definitely an identified need that has come up through our office in Cumberland.

The minister mentioned one area around the increased demand for sexual assault counselling. I'm losing track of time; it was definitely pre-COVID. The former CEO, Dr. Kevin Orrell, actually allocated a significant amount of funding for sexual assault counselling not within schools but within Cumberland, because he was aware of some very high-profile and some large number of victims of sexual assault.

We don't have any specifically sexual assault counsellors in Cumberland. We have Autumn House, which is a place where women can flee from family violence. But there are no specific counsellors for sexual assault.

At that time, Dr. Kevin Orrell did look for community partners that would be able to take this funding and make it very clear that people could go to a specific centre for sexual assault counselling. Unfortunately, he was not able to find a partner. That money ended up getting folded into the Cumberland mental health budget, but the people in the community didn't know that, and there was really no advertising that you could call - people who were victims of sexual assault, they would just call the regular number. There was nothing that identified that there was specific funding there for that.

I'm wondering if that's something that the minister's office would be willing to look at. I don't have the data in other areas of the province, but I can assure the minister that there has been a large number of victims who have not come forward to police because of fear of public persecution, fear of shaming, all those factors. But they are in desperate need of counselling, of support, and of healing.

I'm wondering if the minister might be able to dig into that a little bit to see where that money went. Since then, I have spoken to a couple of the community partners that might be willing to be that non-profit support organization that could make available these counselling services for sexual assault victims.

BRIAN COMER: It's certainly something I would be looking into. I wasn't aware of Kevin and that funding, to be honest. Last year, we did announce a new sexual violence trauma-therapy province-wide program. That's kind of being led by the Avalon Centre.

There are clinicians who work in Colchester, Antigonish, and these places, who are still going to be part of the new program - I think the same program, specifically through Nova Scotia Health. They have some highly trained clinicians. They usually work in the hospital system.

I can certainly have a conversation. Hopefully we can find a community-based organization in the area, if we can. It's certainly something I would be open to looking at. I think something I have seen in different regions of the province is that human trafficking is a real issue in Nova Scotia, whether it's in the tri-counties or Northern Zone. Nova Scotia has a real problem in that regard. I know the folks at the Department of Justice are working on that as well, but with the counselling piece, we can certainly do all we can to help with that.

ELIZABETH SMITH-MCCROSSIN: I can connect the minister with some local non-profits. It would be great to have more support for these victims in our community.

I can't remember the exact number, but it was a large amount of funding. I don't know if it continued or if it was just for that one year. It was very much appreciated, but I don't think it actually got to the victims because of the lack of ability to find a local partner. Victims who do come forward - there is a counselling centre in Truro, but the fact is not a lot of people are able to travel that hour and don't have the transportation available to go there.

My last question for the minister is more targeted around psychiatrists. I'm wondering if the minister could answer a couple of questions about that. What is the funding allocation for psychiatrists specifically to the Cumberland Regional Health Care Centre? I was a little surprised that at the last NSHA Physician Recruitment and Retention Advisory Committee meeting that I went to, they actually did not have psychiatrists on their list of physicians that they were working to recruit. I was surprised by that. I'm wondering if anyone is working on recruiting more psychiatry for Cumberland Mental Health Services.

BRIAN COMER: I've had a number of conversations with the zone medical lead and the chief of psychiatry for that zone. It's certainly something on their radar. I don't have the specific number here, but I know that in each of the four zones, there's a dedicated FTE allotment. There's an expectation that there's money there for those FTEs until they're filled. It wouldn't be for lack of trying or lack of resources or funding available.

It's surprising to hear that it wasn't brought up at that meeting, for sure. I know in conversations with the chief there, they were discussing a number of positive people coming to the area at that time. This was probably six months ago that I would have met with the chief there. There was some positive momentum, I would say, in recruitment for that zone specifically. I'm not sure if it was Cumberland. I know primary care and psychiatric care are certainly something that the team is looking at.

THE CHAIR: I just want to confirm that the member for Cumberland North is finished with her questioning. Thank you.

The honourable member for Halifax Citadel-Sable Island.

LISA LACHANCE: In the $17.7 million that's allocated for universal mental health access, there was $562,000 allocated for MAiD. I'm wondering what that's for and what specifically will be done this year because, of course, the federal government has decided to delay the enhanced provisions of MAiD for a 12-month period. What is that allocation for?

[7:00 p.m.]

BRIAN COMER: This specific amount would be to help address increased demand for MAiD for non-mental health issues in the province. We certainly have been following the federal situation very closely and the Canadian Psychiatric Association telling them to slow down, which I'm glad that they did. We have to be ready as a province, depending on what the federal government does. We'll continue to monitor that. That specific number would be for non-mental health increased demand in the province.

LISA LACHANCE: Minister, could I ask you to repeat that answer, what the $562,000 is for?

BRIAN COMER: There's a high demand for MAiD in the province, not for mental health. This would be to help keep up with that increase in demand.

LISA LACHANCE: Is it FTEs? I'm wondering specifically how that money is being used to respond to the increased demand.

BRIAN COMER: This would be for FTEs. There would be eight FTEs in total: 2.5 for nurse navigators; 2 for nurse practitioners; 1 for a mental health nurse; 1 for a social worker; 0.5 for a psychiatrist; and 1 for a clinical lead - so it would be for clinical staff.

LISA LACHANCE: Given that staff component, it sounds to me like a team. Is that team responding to MAiD requests - or analyses or assessments - being asked for across the province? How is that team working?

BRIAN COMER: This would be a provincial team offering services across the province.

LISA LACHANCE: Can you describe a bit about how they're going to work? Would they be available virtually? The navigators - will they be providing in-person services? How is that all going to work?

BRIAN COMER: I don't have that information here with me, but I would be happy to follow up with the member.

LISA LACHANCE: As well, from that $17.7 million, there was $1.2 million for Trauma Informed Care through the IWK. This has been a fairly long-standing commitment from the IWK. What is the new allocation of an additional $1.2 million is being used for in this fiscal year?

BRIAN COMER: I think the member mentioned that back in 2015, the IWK did start its process of becoming a certified Trauma Informed Care organization. Part of that is developing a comprehensive training series, looking at their own current policies and how to improve them.

This specific $1.9 million to support Trauma Informed Care will create a provincial system where trauma is recognized and addressed so they can better meet the needs of clients, family, staff, and physicians. The three remaining objectives would be to increase trauma-informed education training across our service delivery providers, provide a comprehensive framework and support system for staff and physician wellness as well - so also looking at a trauma-informed lens looking at the staff, not just the patient population. We're really trying to do a better job strengthening and engaging with community partnerships, whether that's with vulnerable populations or other important members of the community.

LISA LACHANCE: Again, it sounds like some FTEs, particularly to offer training and training hours. The community partnerships, will there be direct transfers to community partners from this funding?

BRIAN COMER: It looks like it's primarily for clinicians - FTEs - ranging from clinical educators to social workers to zone leads to wellness coordinators. I don't have the specific information about these positions - if they would be people without experience, those sorts of things, for example. I'm sure we could find that out. The total for that would be 50 FTEs.

LISA LACHANCE: Maybe I'll ask one more follow-up question on that and then continue on. Is that a permanent increase of $1.2 million per year in Trauma Informed Care for the IWK?

As well, from that $17.7 million, there was $441,000 allocated for African Nova Scotian children and youth mental health. I'm wondering if you can tell us a bit about that project.

BRIAN COMER: The first answer is yes, it is permanent.

On the second question, surrounding the $441,000, this is under the IWK initiatives.

I mentioned in my opening remarks about the formal Nova Scotians who have historically had difficulty accessing services.

This would involve having Africentric services delivered by representatives within their community as part of the universal mental health care framework. We have had consultations with 92 different members of the African Nova Scotian community, from virtual platforms to community visits. We would have met with throughout this process with the African United Baptist Association; the Association of Black Social Workers; African Nova Scotian educators; the Nova Scotia Brotherhood Initiative; mobilization teams; a variety of young children in the community ranging from the age of 12 years old to 30 years old; African Nova Scotian elders; and African Nova Scotian clinicians.

Throughout these consultations, a variety of key topics came up: inclusiveness, representation, and continuity of care within the community. The idea is to let the community lead this relationship and actually set up a clinic within the community staffed by individuals of African Nova Scotian descent.

A number of the key functions for this service would be enhancing services for the African Nova Scotian community, improving engagement and flow for African Nova Scotian patients, and building cultural capacity and competency within the community, and hopefully build trust with service delivery.

LISA LACHANCE: I'm actually going to pass the questioning to my colleague for Cape Breton Centre-Whitney Pier.

THE CHAIR: The honourable member for Cape Breton Centre-Whitney Pier.

KENDRA COOMBES: My first question to the minister is: What are the Cape Breton mental health wait times for first visit?

HON. BRIAN COMER: I think Nova Scotia was the first jurisdiction in the country to start publicly reporting on mental health and addiction wait times, both from a non-urgent and an urgent perspective.

From an urgent perspective, across all four health zones, we do beat the target within seven days of treatment - just for clarification, the urgent is not crisis. Crisis is different than urgent, so crisis would be seen immediately. It's 98 days right now for non-urgent in Eastern Zone, which is an improvement from 126 days.

We do have the Mental Health Acute Day Hospital that's slated to open in Cape Breton this Spring. Speaking to senior leadership there, everything looks like it's going really well for a timeline - we recruited three psychiatrists, which is the first time in probably 10 years that there's people coming there instead of leaving for psychiatry, which is good. There are certainly challenges with non-urgent wait times for both kids and adults.

I think this is something that the integrated youth services expansion should help with.

KENDRA COOMBES: What is the average length of time between a first visit and second visit for mental health in Cape Breton?

BRIAN COMER: Typically, with non-urgent appointments specifically - I think that's what you're referring to - the first choice appointment would be a long, extensive assessment, essentially, with a clinician and an individual. We wouldn't have, I don't believe, the data from the first to second. I can certainly follow up to see if I can get it for you.

KENDRA COOMBES: I appreciate that - if you can get back to me with that.

My other question is regarding youth and mental health. Has virtual mental health through the IWK been implemented at the regional hospital, or is it being looked at?

BRIAN COMER: Yes. I'll just use an example. Dr. Vhari James is a child analyst and psychiatrist up here in HRM, but she does locums in Cape Breton. She doesn't physically see the kids at the hospital. She sees them in Sydney at an office off Charles Street, I think it is. She does a variety of virtual appointments with kids from across the province. Then for the more acute patients, she will come to Sydney to do the assessments. I think she's the first child analyst and psychiatrist we have had in - I don't know the date, but it has been a long time, which is good.

It has been really positive, the feedback with virtual care - certainly not for all kids but beneficial for most, that I've heard from families. That's ongoing right now. They wouldn't be doing that physically at the hospital. They would be doing that at almost an outpatient clinic setting in Sydney. She does do locums.

KENDRA COOMBES: My question is - I'm just wondering because we mentioned - is she a psychiatrist or a psychologist? How many psychiatrists and psychologists do we have in Cape Breton who specialize in youth? Or is she the only one?

BRIAN COMER: I wouldn't have that in front of me right now. Psychologists - I think we have a very good understanding where most of them are but not every single one. Typically, they're all regulated through their regulatory body. We can certainly see if we can find that out. I would say there's an adolescent outreach and outpatient mental health service in Cape Breton too, which would have its leadership team. They would probably have a lot of metrics and that data. I can certainly check with Nadine to see what I can find out about that.

KENDRA COOMBES: Forgive me if this was already asked. I wasn't here for the whole thing. I'm just wondering outside of adolescent and youth, how many psychiatrist and psychologist vacancies are there in Cape Breton, if any?

[7:15 p.m.]

BRIAN COMER: We can get the zonal breakdown. Speaking as having worked there, eight or nine years ago, we had 15 or 16 psychiatrists in Cape Breton. When I left, we had six. I think we had two from the U.K. and one just came from Egypt, so we're back up to nine. I'm not sure - not doing the math - but typically there would be some more FTEs that we need to fill. There have been three new hires. We have a new hire for the day hospital too. I would say it has been very positive momentum.

We have, I think, five clinical assistants there too. They can essentially do almost everything that a psychiatrist can do except deem someone voluntary or involuntary. They can do call schedules, they can do medication, pharmacology, and they see people on the unit. They can do most of what the psychiatrists can do. For whatever reason, they can't get full licensure in Nova Scotia or Canada sometimes, but they have certainly been a big asset, I would say, to Eastern Zone.

KENDRA COOMBES: How much time do I have?

THE CHAIR: It is 7:17. We're looking at 29 minutes and 30 seconds.

KENDRA COOMBES: Thank you. This is the last question I actually have, and then I'll be passing it on to my Liberal colleague. This past year, we saw B.C. was granted the exemption to the Controlled Drugs and Substances Act in a move to decriminalize drug possession. I'm wondering if the minister could provide an update on safe supply and decriminalization work.

BRIAN COMER: It's something we're keeping a close eye on in British Columbia. I think their exemption actually just started to take practice this January. So it's very early days, I would suspect. It's certainly something that we would keep a close eye on.

We do have a variety of harm reduction services in Nova Scotia. We have two overdose prevention sites, one here in HRM and one in Sydney. There are more supports for them here in the budget ranging from needle exchange programs to managed alcohol programs. We'll definitely keep a close eye on that.

Compared to other jurisdictions, I would say we have a very strong opioid framework across the province in terms of clinical services. I know that was a significant piece of work with Dr. Hickcox and Samantha Hodder and the rest of the team over the last 5 or 10 years - a real shift, the community-based service for people.

We'll certainly continue to support harm reduction services, whether that's the naloxone programs - we do have a new service starting this year within the hospital system where if someone is being seen in the hospital, they have the ability to refer to an addiction medicine specialist for the first time on a consultation basis. That's also new. We'll

continue to monitor that to see how it's going. I think you need to have that strong foundation of clinical services. Otherwise, decriminalization - we'll see what happens.

KENDRA COOMBES: Just to do a follow-up on decriminalization, is it safe for me to assume that there's no work being done to decriminalize drug possession in Nova Scotia from your office?

BRIAN COMER: We have no formal request to the federal government right now.

KENDRA COOMBES: Chair, just to formalize this, I will be giving the rest of our time to the Liberal member.

THE CHAIR: The honourable member for Bedford South.

BRAEDON CLARK: Thank you to the member for Cape Breton Centre-Whitney Pier for the generous offer of the time. Thank you to the minister and staff for being here. I know we're into the waning hours of what has been a long afternoon-early evening. I appreciate that.

I did have a few questions I wanted to touch on here. Last year, Minister, you stated that there had been an investment of $433,000 into a gambling strategy for prevention and treatment of gambling, harms that can result from gambling. I'm just wondering if this investment has been made, what kind of impact it has had. Are there any metrics or tracking to assess how well it's working?

In my view, I think that gambling addiction in particular can be a bit misunderstood and not quite as open, or folks might not be as willing to discuss that as they would with alcohol or drugs, for example. I'm wondering, has that investment been made? What kind of impact has it had over the last year?

BRIAN COMER: We're trying to track down specifics of that question right now, but I think it's also worth talking about the Recovery Support Centre because they're specifically geared not just for substance use but also gambling supports. We have opened a number of them, and the expansion will continue across the province. There will be 10 in total as things continue.

Gambling can be quite stigmatizing, I think, to seek treatment sometimes. I think these recovery support centres are good because with the one in Dartmouth, for example, you can just walk in off the street. I do think there has been significant uptake with Tranquility and these other online applications. I don't have the data to support this, but typically, that would be a very good anonymous way to seek help for a variety of mental health concerns. It's certainly concerning to see the prevalence of sports betting - it has just increased in our culture. It's certainly something we'll continue to keep an eye on, but I will try to find a specific answer to that question.

BRAEDON CLARK: The minister actually kind of touched on my next question, which is the really rapid rate at which sports betting in particular has taken off. I love sports. I watch something pretty much every day, and it's hard to get through a commercial break without something for DraftKings or FanDuel or all these different groups. I imagine it would be very, very difficult for anyone who's dealing with any kind of gambling addiction to see that on a constant basis.

For such a long time, that was such a taboo. There was nothing worse than gambling on sports - not just within the sport, but it was illegal just about everywhere. Now, just in the last couple of years, that has changed dramatically. How do you manage that when there's another arm of government through Atlantic Lottery and so on that deals specifically with gambling in that sense? I guess it's a bit of a two-part question: How do you deal with this increased prevalence of gambling within society at large? How do you balance that with other elements of the government that are actively involved in that business?

BRIAN COMER: I think with what happened in other jurisdictions, especially with single-game sports betting - that's where a lot of this probably started, I think. I have had a number of conversations with the Minister of Finance and Treasury Board about the regulated online gambling here.

Historically, there are hundreds of non-regulated gambling sites that people have access to. I think my input and my role would be to ensure that the people who are using it, that there's adequate resources on the website with contact information, supports for minors, education, mental health literacy and these sorts of things - make it as safe as it can possibly be, in terms of regulated options. It's certainly challenging, with the way culture is going now.

As a former clinician, someone who's in this role, I always come at it from the angle of worrying about people. I want to offer them support. I think with the recovery support centres and Tranquility, we do have a lot of options where people can seek help if they do need help. Dr. Hickcox and I have had a number of conversations about this in terms of addiction tendencies in Nova Scotians. Those are ongoing. That's certainly on our radar.

BRAEDON CLARK: We know that the school of medicine at Dalhousie has added addiction medicine training to the curriculum, and doctors are helping to train medical residents at the Ally Centre of Cape Breton's collaborative clinic. This is a great initiative. We would like to see this expanded as well. I would like to ask the minister if there are plans to continue to expand this program in this coming year and then beyond as well.

BRIAN COMER: I would say the CEO of the office is an addictions specialist and primary care as well. Certainly addiction medicine specialists are hard to come by. There's not a lot of them across the province. Dave Martell is another. He's one of the leaders in

the country in addiction medicine, someone I talk to quite frequently. He's from Lunenburg. He does a variety of leadership roles in Canada for addiction medicine - certainly something we would do to support in any way that we could.

There wouldn't be a specific dollar figure I could give you right now, but there will be a new service within our health care system where primary care providers can consult with an addiction medicine specialist within the health care system, which is new. I don't think the average primary care provider realizes the complexities sometimes of people coming into hospital for surgery who aren't forthcoming on their pre-op checklist, and they're withdrawing after surgery. These things happen more than people think in the hospital setting.

It's certainly something we would be willing to support, but I wouldn't have a specific dollar figure for that today.

BRAEDON CLARK: I'm going to go to something that I'm sure was asked earlier, so I apologize in advance for being repetitive, but it's useful for me and important as well. I wanted to ask about the universal mental health care program. At the time - great concept, certainly was something that's attractive to lots of people. There are countless people who are dealing with other mental health issues themselves personally or have a close family member or friend who's dealing with it as well. I can understand the excitement and the interest around the program. I felt the same way as well.

I'm just curious if the minister could update us on when we might see that program in effect and what that would look like. If you're a person dealing with a mental health issue and universal mental health care is in place, what does that actually look like?

BRIAN COMER: At a high level, every Nova Scotian would have access to high-quality care regardless of their ability to pay. That's at the core of it. I think if you look at the increases in the budget, which get a lot of scrutiny, which is understandable - that's why I'm here, to answer questions. There's $65 million in the first two budgets. There's a variety of pilots in this budget specifically - the province contracts with psychologists, the Dalhousie clinical psychology training program. We're going to start looking at the billing codes aspect to bridge that private-public intersection.

If you look across the continuum of care, it ranges from your peer support telephone line to your acute mental health hospital in-patient setting. There's lots in between. There's lots of going forward and going backward. I think as we scale these up - whether it's mobile crisis, whether it's having clinical psychologists come in to publicly do assessments for the autism spectrum that families don't have to pay for - it's increasing the access in getting rid of those gaps that have historically existed in the province.

There are certainly challenges, whether it's human resources, whether it's rural regions of the province. It's a very difficult task. I've never really disputed that. We're

certainly seeing a lot of things now, I think, in the province that we haven't seen before. It's not just me tooting my own horn. It's a fact. Even something like expansions of mental health day hospitals, recovery support centres - all these things lead to universal access.

[7:30 p.m.]

It's not like a light switch. This is a cumulative impact that will take a number of years to implement. Specifically with budget increases and with billing codes, this stuff will all be happening within the next fiscal, and people will see the meat of what they want to see, hopefully.

BRAEDON CLARK: I am curious about the billing codes and the cost calculation of this too. I'm certainly no expert on this kind of thing, but in my mind, at the time, I was thinking, Well, if you're a private psychologist or psychiatrist, and you charge $150 or $200 an hour or whatever the case might be, and someone's going to come through the universal program, presumably the vast majority of people don't have the means to pay that by any means. I assume, then, the model is that the government will be picking up that tab - if and when. I shouldn't say if - hopefully when this program is operational. Is that the idea?

BRIAN COMER: The billing codes with mental health clinicians specifically is a new concept for the province. Typically, you have your primary care provider, your GP, a dentist, for example, who could do the fee-for-service kind of model. We're taking the shadow billing, which is a pretty well-established mechanism in health care for other providers and applying it to these providers, essentially. At the end of the day, people won't have to pay for the service. That's the gist of it.

BRAEDON CLARK: I wanted to ask about the program that was started under the previous government, the Bloom Program, which at the time was first of its kind in Canada and was designed to increase and improve mental health and addictions care for Nova Scotians. Right now it exists in 47 pharmacies. I'm just wondering if there are plans to expand that list. How much is allocated in this budget for this particular program?

BRIAN COMER: I have had a lot of positive feedback, especially from a couple of pharmacists, specifically in Cape Breton, who speak very highly of this program. There's nothing allocated in this specific budget, but it's something I would be open to considering. It's certainly a very positively viewed program.

BRAEDON CLARK: Just to clarify, Minister - my apologies - there's no new funding allocated for this program in this particular budget?

BRIAN COMER: I believe that's with the Department of Health and Wellness, because it's with pharmacies specifically, but we can make the connection with the department and follow up.

THE CHAIR: The honourable member for Clayton Park West.

RAFAH DICOSTANZO: Just to continue on that, I met with the pharmacist who is doing it in Clayton Park, and apparently, the uptake has really gone down because they're not paid very much for it. I had all the information, but I don't have it with me. They're only paid a very small amount per month, and the intake for this program has gone down.

The pharmacists, now with the increased scope, are so busy that they don't have the time for this. For the amount of money that we are paying them, it is not worth it for them. That's what I got from it. She's happy. She has done it for a few years, but it's on the decline. It's not doing as well just because the pay for it is just not worth their time. They're overworked. They have too much on their plate. This doesn't make sense financially for them.

BRIAN COMER: I believe this is with the Department of Health and Wellness. We can certainly take that to my colleague and follow up.

RAFAH DICOSTANZO: This is the last question, I guess. The government is creating a new advanced certificate program for mental health and addictions. Can the minister please let us know when that will start and how long the course is? Is it being offered to all nurses? How is that being distributed, the education part?

THE CHAIR: The honourable Minister of Addictions and Mental Health, with a reminder that we have a hard four-hour stop at 7:46 p.m.

BRIAN COMER: That would be a graduate program - graduate studies faculty. I think they offer two streams already. One would be the nurse practitioner stream. The other, I think, is the thesis-based stream, so this would be a third stream.

Typically, most criteria for graduate nursing programs - you need your undergraduate nursing in good standing with the College of Nursing within Nova Scotia. Other than that, it would be up to the institution to dictate the admission criteria. I'll double-check the start date for you.

RAFAH DICOSTANZO: We don't know how long these courses are? It's offered at the Dalhousie Nursing School, correct? Who prepared the curriculum for those courses? How long are they? Do the nurses, once they take this, get an increase in pay? What's the incentive for nurses to take this?

BRIAN COMER: The faculty of nursing at Dal has been asking for this program. Typically most graduate nursing programs are two years in duration. When they graduate, if there are different classifications of nurses - RN 2 up to RN 6, I think - there would be a little bit of a pay increase depending on your classification. You would be getting increased salary based on your increased education and qualifications.

THE CHAIR: The honourable member for Clayton Park West.

RAFAH DICOSTANZO: How long do I have?

THE CHAIR: We have a hard stop at 7:46 p.m.

RAFAH DICOSTANZO: I'm just trying to understand this, how it came about. It's Dalhousie that came to you and wanted to offer this as part of the curriculum? Or is this for other nurses who can come back to school and upgrade? How is it going to be offered?

BRIAN COMER: I would say this would be for any nurse who wants to advance their education with addictions and mental health care. I know that Dalhousie, Nova Scotia Health, and the IWK, in partnership with the Department of Advanced Education, have had a number of conversations with us as well. It was a collaborative partnership. The actual health authorities - Nova Scotia Health and IWK - identified it as a need to increase clinical capacity within the system.

RAFAH DICOSTANZO: Just for the few minutes that we have left, to understand - Dalhousie came to you? Is this in the budget this year? What is the cost of this certificate?

BRIAN COMER: It is in this year's budget. It's $306,000.

RAFAH DICOSTANZO: It's definitely worth it. I'm just hoping that it is - you're going to give me how long is this course and as many of the nurses who can take it. I think it would be an amazing thing to encourage as many nurses in the past who graduated to upgrade because mental health is so important. I don't know - how well are we promoting it so that they get this?

BRIAN COMER: I think the program to start is between 6 and 10 students, but the goal is to expand it to 20-plus students in future years. I certainly would agree there's definitely a need there and certainly something we'll be looking at.

RAFAH DICOSTANZO: I just want to say thank you to the minister for answering all the questions we bombarded him with, and thank you, Chair.

THE CHAIR: You're welcome. We have now five minutes. I would like to hand it over to the honourable Minister responsible for the Office of Addictions and Mental Health for his closing statement.

BRIAN COMER: Thank you, everyone, for the thoughtful questions. It feels good to be in the hot seat because it forces you to know your department, which I think is important, so it's good. I'm going to keep it short and sweet and just read my resolutions if that's okay.

THE CHAIR: Shall Resolution E27 stand?

The resolution stands.

Resolution E16: Resolved, that a sum not exceeding $7,189,000 be granted to the Lieutenant Governor to defray expenses in respect of Communications Nova Scotia, pursuant to the Estimate.

THE CHAIR: Shall Resolution E16 carry?

The resolution is carried.

I would like to thank you. The time is now 7:43 p.m. That concludes the subcommittee's consideration for Estimates for today. The subcommittee will resume consideration when the House again resolves into Committee of the Whole on Supply. Please return to your seats in the Legislative Chamber. The Committee of the Whole on Supply must rise and report before the House concludes its business for the day.

I would like to mention one more thing. We are about 15 minutes ahead of the legislative room, so you have 15 minutes to cross the road.

[The Subcommittee adjourned at 7:43 p.m.]