Come Together

Report & Recommendations of the
Mental Health and Addictions Strategy
Advisory Committee

March 2012
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Foreword

A Call for System Improvement

EVERY NOVA SCOTIAN HAS THE RIGHT TO EXPECT equitable opportunity to access mental health and addiction services. The Nova Scotia government has the responsibility to uphold that right through health and social policies. Despite the best efforts of highly qualified and dedicated professionals, care and service providers, and community groups, the current systems of mental health and addictions services are not meeting the needs of many people and families impacted by mental health and/or addictions issues in Nova Scotia. As a result, the health and well-being of individuals, families and communities is at stake and has a negative impact on the social fabric and economic foundation of this province.

The development of service delivery standards in the mental health and addictions services systems emerged from the broader trend in health care to improve quality of services to clients, ensure consistency of care, monitor outcomes and manage associated costs. In 2002, Nova Scotia became the first province in Canada to develop a set of standards for addictions services. These standards were updated in 2005.

In 2003, Nova Scotia was again first, this time with standards for mental health services. While intended to guide system development, the mental health standards have not been achieved. Despite dedicated efforts and targets to fund implementation of these standards, spending on mental health and addictions services is not sufficient or appropriately allocated to meet the standards or the needs of many. Indeed, spending on mental health and addictions as a percentage of overall health spending has decreased steadily over the past two decades.

The government elected in 2009 understood the scope and seriousness of this problem. In the March 2010 Throne Speech, the new government committed itself to action and announced that a Mental Health and Addictions Strategy would be developed. When implemented, the strategy would bring about “timely access to quality (mental health and addictions) services.”

In June 2010, Nova Scotia’s Auditor General reported that implementation of the Provincial Standards for Mental Health Care was lagging and called for greater accountability, transparency, and system-wide monitoring. As part of essential system wide change, the Ross Review of Emergency Care in Nova Scotia (2010) also called for improvements within the mental health system.

Other reports, media coverage and public inquiries into unfortunate and tragic events heightened awareness that, within the very system charged with serving a vulnerable and stigmatized population, numerous inadequacies and fragmentation were contributing to suffering and even death. Mental health workers joined their voices with the public in these reviews to highlight their concerns, dissatisfaction and their commitment to find solutions.

In September 2010, the Minister of Health and Wellness appointed the Mental Health and Addictions Strategy Advisory Committee (the Advisory Committee) to study this issue and report back with recommended solutions to address local and system-wide challenges within the current Nova Scotian mental health and addictions services systems. (Terms of Reference are included in Appendix A).
The Advisory Committee was made up of representative stakeholders with experience and expertise in mental health and addictions. The Nova Scotia Health Research Foundation (NSHRF) was enlisted to gather data required for the Advisory Committee’s work and to facilitate and oversee the process.

**How the Advisory Committee Worked**

From the outset, the Advisory Committee embarked on a consultative fact-finding mission to become acquainted with the current state of mental health and addictions services in Nova Scotia. Its members participated in education and information gathering sessions, consulted with experts in the field, participated in a workshop on models for integrated governance of mental health and addictions, and read a plethora of research reports and other relevant documents. Current mental health and addictions services in Nova Scotia, across Canada and in other countries — Australia, England, New Zealand, Scotland and the United States — and the work of the Mental Health Commission of Canada were examined.

Early in the process, the Advisory Committee identified three critical gaps in knowledge. The NSHRF called for proposals to gather information in these areas:

1. Current demographic, epidemiological information and the current state of service delivery related to mental health and addictions services specific to Nova Scotia.

2. Review of treatment approaches, services and existing mental health and addiction systems in the province related to specific populations and access to services (rural and urban).

3. Review of strategies (local, national, international) to address mental health and addiction service delivery to various populations across multiple settings.

These reports informed the Advisory Committee’s deliberations and are available from the NSHRF.

Issues and challenges were explored through a consultation process that invited the perspectives of many Nova Scotians, including:

- Focus groups with targeted populations;
- Consultation with the general public;
- Online and mail-in questionnaires.

More than one hundred groups were consulted. These included health professionals, mental health clinicians, addictions counsellors, psychiatrists, individuals who live with mental illness and/or addictions, others affected by mental health and addictions issues, non-governmental organizations (NGOs), First Nations, African Nova Scotian and Francophone/Acadian communities, District Health Authorities (DHAs), the IWK Health Centre, allied communities working with African Nova Scotians, forensic service providers, chiefs of police, and military families. A list of participants is included in the appendices.

The Advisory Committee met regularly to discuss the data, and identified themes that would form the foundation of this report. A population health approach was adopted to address issues and move individual members beyond their special interests to arrive at recommendations that meet the needs of all Nova Scotians.
Communications

A comprehensive plan was developed by the NSHRF to support the activities of the Advisory Committee. It included:

- Online availability of locations for consultations and up-to-date results; Advisory Committee meeting minutes; an overview of the Advisory Committee activities; and names and contact information of NSHRF staff who were actively supporting the Advisory Committee and who could respond to questions from the field.

- The development of a summary report regarding the current state of mental health and addictions services in Nova Scotia. This report remains available on the NSHRF website and was distributed to key stakeholders in the Departments of Health and Wellness, Community Services, Education, and Justice. It was reviewed for accuracy by representatives from each of the DHAs and the IWK, as well as by mental health and addictions personnel.

- Themes that emerged from the consultations were continuously updated to ensure robust dialogue and an iterative process for seeking and obtaining public input.

- The Minister of Health and Wellness and senior department staff were regularly informed about the work and progress of the Advisory Committee.

Report Presentation

The themes that emerged as a result of stakeholder consultations, review of academic literature, and review of provincial, federal and international reports on mental health and addictions were used to organize the Advisory Committee’s recommendations. Findings and conclusions are presented in the following format:

1. Identification of major issues, under the heading: What we heard.
2. Objectives for change.
3. Expected (or desired) outcomes as a result of implementation of change.
4. Recommendations.

Many key reports informed the Advisory Committee’s work. Some should be noted here because they proved particularly helpful in the development of our recommendations. These reports include:

- Fatality Inquiry into the Death of Howard Hyde by Hon. Judge Anne Derrick (2010).
The Patient Journey Through Emergency Care in Nova Scotia: A Prescription for New Medicine by Dr. John Ross (2010).

Report of the Auditor General, Jacques R. Lapointe (2010); and


Numerous other studies and reports have assisted the Advisory Committee and are cited in the appendices.

Despite these rich sources of information, up-to-date empirical data for Nova Scotia remained difficult to find. Some information is less current than would be ideal but, in the opinion of the Advisory Committee, retains validity because there has been little or no change in the health care service conditions that gave rise to the data. As noted in the Accountability section of this report, current systems to collect data, measure outcomes and evaluate interventions are inadequate, particularly for mental health services. Effective management, well-guided decisions and high quality service delivery require consistent, valid and reliable longitudinal data collection.

The Advisory Committee had access to a wealth of experiential knowledge of mental health and addictions services, issues, gaps and outcomes through public consultations, site visits, personal and professional experiences. In our opinion, this first-hand experience added critical and relevant information to the limited bank of empirical data.

Recommendations are organized under the following themes:

1. Wellness
2. Access and Intervention
3. Collaboration
4. Sustainability
5. Accountability
Introduction

The High Price of Inaction

BY 2030, MENTAL HEALTH AND ADDICTIONS ISSUES will be the leading cause of disability in Canada, yet Canada — including Nova Scotia — is a low spender on mental health services. This chronic underfunding may reflect and be a form of stigma in itself. The low priority is reflected in the relatively low investment of public dollars in these areas as compared to spending to address other common diseases.

There is mounting evidence that the growing cost to society of untreated or under-treated mental health and addiction issues is not sustainable. Indeed, the total cost to society could become greater than the entire cost of the health care system in Canada.

One in five Canadians will experience a diagnosable mental health issue this year. In Nova Scotia, that means nearly 200,000 people will experience symptoms ranging from problematic and chronic to acute and debilitating, most of which could and should be treated and relieved. Many will not.

Mental health issues and illnesses are the leading cause of short and long-term disability in Canada. The national economic burden of mental disorders was estimated at $51 billion per year in 2002, with almost $20 billion of that coming from work-related losses.

Nationally, one in four workers will experience a mental health problem in the next 12 months, and 500,000 Canadians are absent from the job every day for psychiatric reasons. Mental illness is associated with more lost workdays than most chronic physical conditions. While there is a high incidence of mental health problems among working Canadians, between 70 and 90 per cent of Canadians with serious mental illness are unemployed, unable to support families, denied opportunities to make a contribution to the economy, and therefore place pressure on social safety nets.

Likewise, the overall cost of substance abuse in Canada in 2002 was an estimated $39.8 billion. This includes the burden on health care and law enforcement services, and the loss of workplace productivity as a result of absenteeism, disability and premature death.

In Nova Scotia, hundreds of dedicated mental health and addiction treatment professionals work hard and their efforts are supplemented and assisted by a broad array of community and non-governmental organizations. But it is not enough. Far too many people who need treatment wait too long. Many others who fear the stigma that attaches to their illness do not seek treatment at all.

Health care professionals, and others who provide treatment and care for those with mental illness and addictions, work in a system that is poorly organized. It lacks integration because of bureaucratic divisions, and it has been under-funded for generations. It is misunderstood by people within and outside the health system and is unevenly accessible or responsive, often due to cultural, geographic, linguistic or racial factors.

Addressing such mental health and addictions issues and the social conditions that contribute to them is complex. The World Health Organization defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” Mental health is essential to
healthy living and quality of life. Good mental health is associated with better physical health, improved educational attainment, increased economic participation, and rich social relationships.

In a 2009 report, the Mental Health Commission of Canada said good health is not possible without good mental health. When individuals experience mental health or addiction issues, not only is their quality of life threatened, a ripple effect is created often impacting many others, including family, friends, coworkers, workplaces and communities.

The total economic costs of mental disorders have been shown to match the economic impacts of heart disease, diabetes and hypertension combined. Of the non-communicable diseases, neuropsychiatric conditions contribute more to the overall burden of illness than either cardiovascular disease or cancer.

Substance abuse and addiction add billions of dollars to the overall social and economic burden. Of the total costs related to substance abuse in Canada, alcohol accounted for 36.6 per cent, or $14.6 billion in 2002. In Nova Scotia, the relative costs of substance abuse are consistent with national figures. Social and economic costs of alcohol abuse totalled $419 million (2002) or 33.7 per cent of all substance abuse costs in the province. This substantially exceeded the annual profits ($158 million in 2002) returned to the Nova Scotia government from alcohol sales through the Nova Scotia Liquor Corporation. The costs of tobacco use, primarily to the health system, were $625 million (50.3 per cent of all substance abuse costs in the province); and illegal drug costs were $200 million (16 per cent of substance abuse costs in the province).

Addiction, as defined by the American Society of Addictions Medicine, is a primary chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual complications, which result in a pathological pursuit of reward and/or relief by substance use and other behaviours.

Addiction is characterized by an inability to consistently abstain from such substance use, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is generally progressive and results in disability or premature death.

Addictions services provided in Nova Scotia also focus on health promotion and prevention of substance abuse. Therefore, for the purposes of this report, addiction requires a broad definition and includes the spectrum of harmful behaviours related to problematic substance use and gambling.

Early intervention and easily-accessed, effective treatments for mental health and addiction issues improve both short and long-term outcomes, including the prevention or mitigation of symptoms of some disorders, reduction in disability, and enhanced civic and economic participation. Outcomes such as these have the potential to dramatically decrease the overall social and economic burdens of these illnesses.

But our mental health and addiction services systems require more than a focus on early, effective, and easily accessible treatments. Public awareness and other educational efforts are needed to reduce stigma and discrimination associated with these disorders. Health promotion plays a critical role and effective collaboration at and across all levels of service delivery and program decision-making is vital to effective treatment, services and positive outcomes.

All of this requires strong leadership to create change and accountability to ensure improved results. If a society wants a sustainable, high quality of life for its citizens, attention to mental health and addiction issues is not optional. It is essential.
The 1978 World Health Organization declaration of Alma-Ata that health is a fundamental human right — a state of complete physical, mental and social well-being; not merely the absence of disease or infirmity — is a major milestone in the field of public health. The attainment of the highest possible level of health was declared an important global social goal that requires action on the part of many social and economic sectors. There is no doubt that many Nova Scotians in need of treatment for mental illness or addictions lack access to treatment and therefore are denied this human right.

Although mental illness and addictions occur independently of social or financial status, the social and economic determinants — and the outcomes — of these disorders are predictable: poverty, low educational attainment, family distress, trouble with the law, isolation and increased risk of other health problems.

This report comes at a time when the Government of Nova Scotia is wrestling with serious financial issues. There is no doubt that the actions and recommendations advocated here will require additional spending in the areas of mental health and addictions services. However, it is clear that preventive measures, promotion, early intervention and treatment will reduce the overall social and economic costs the province currently bears from untreated and under-treated mental illness and addictions.

Nova Scotians expect that government will invest wisely and bring spending under control in order to ensure the province’s debt does not overwhelm us or our children. A strong case can be made for investment in mental health services and addiction treatment. This investment and management of services is intended to relieve the suffering and financial toll that thousands of Nova Scotians, their families and communities face as a result of mental health and addiction issues.

A Closer Look at Nova Scotia

In Nova Scotia, self-reported rates of overall mental health and substance use (cannabis and other drugs) are comparable with other parts of the country. However, the prevalence of alcohol misuse, binge drinking, daily smoking, and mood and anxiety disorders are significantly higher among adult Nova Scotians than other Canadians. Women have higher rates of poor mental health while substance abuse rates are higher among men.

Incidence of mental health and addiction issues is strongly associated with social determinants of health such as low incomes, being older, single, isolated and unemployed. The converse is also true. Positive emotional health is reported by younger people, who are in committed relationships, educated, employed and have higher incomes.

Most mental health disorders — an estimated 70 per cent — begin prior to age 25. They tend to be chronic and result in significant, negative outcomes in the short and long term. They lead to poor academic and occupational success, interpersonal and family difficulties, increased risk of physical illness, shorter life expectancy and economic dependence.

Despite the prevalence of early onset, those who report poor mental health are more likely to be within the 45–64 age range, unemployed and from a low-income bracket. The 2002 Canada Community Health Survey (CCHS) found 11.3 per cent of Nova Scotians accessed some form of mental health or addictions services that year, while an additional five per cent reported that their mental health care needs went unmet.

Just over one-quarter (26 per cent) of students in the province screen positive for elevated risk of depression, but between 10 and 20 per cent of those who wanted help for their mental health issues did
not receive it. Among students, females reported the highest rates of depression, as did students with lower Grade Point Averages, those from single-parent households, and those with less educated mothers.

Compared to the rest of the country, fewer Nova Scotians identify themselves as “regular drinkers” while more report “occasional drinking.” However, the overall rate of alcohol misuse in Nova Scotia is higher.

Substance use is fairly common among students in Nova Scotia, with almost 70 per cent of high school students reporting alcohol use in the past year and one-quarter of them reporting binge drinking in the past month. Eighteen per cent of youth reported the use of cannabis within the past 30 days.

The use of painkillers and illicit substances other than cannabis for recreational purposes is equally widespread. There is abundant anecdotal evidence that abuse of prescription medications, painkillers in particular, is a growing problem with sometimes tragic outcomes.

In Nova Scotia, the relative costs associated with substance abuse are fairly consistent with national costs. Heavy drinking in Nova Scotia begins to peak in early adolescence and usually tapers off through middle adulthood. Drinking is more often associated with urban males and may be associated with unemployment, single status and lower academic grades. Youth (18–24 years), males, and single individuals are more likely to report drug use as are students with lower Grade Point Averages, those from single-parent families, and those with less educated mothers.

Problem gambling accounts for 2.6 per cent of the costs of primary addictions treatment in the province, but the consequences are severe and can lead to loss of family, bankruptcy and sometimes suicide.

Approximately 23 per cent of Nova Scotians consider themselves smokers, with almost 19 per cent reporting daily tobacco use — a rate that is significantly higher than the rest of Canada. Nova Scotians are exposed to a higher rate of second-hand smoke coming from their home or vehicles than are other Canadians. Individuals who reported wanting help to stop smoking said they had difficulty receiving this support.

The development of provincial concurrent disorder standards is underway. Data on concurrent mental health issues and addictions is limited and difficult to extract from existing data sources. Nova Scotians were identified as being between one and two per cent more likely than other Canadians to experience co-occurring alcohol or drug problems and mood or anxiety disorders.

“My name is Karen. I grew up with an alcoholic father who was saved by a treatment program when I was young, and for many years I was actively involved with various family support groups. My daughter is an alcoholic and drug abuser. This has been ongoing for six years. She sought treatment several times in the past four years, but a three-to-five day dry out is not treatment. She has repeatedly asked doctors, detox staff and others for mental health help but has received none. She has lost several friends to addictions-related deaths.”

Tobacco smoking among patients with mental illness is common and exposes them to increased risk of smoking-related morbidity, mortality, and to detrimental impacts on their quality of life. The neurobiological and psychosocial links to smoking appear stronger in certain co-morbidities, notably depression and schizophrenia.

Individuals with mental health and addictions problems have significantly poorer physical health than those without. Physical health and mental health are not separate entities. However, there is often
a failure to provide adequate physical care to those with mental health and/or addictions issues. The inability to see beyond the symptoms of mental illness and addictions, inadequate understanding of mental health and addictions issues, discrimination and stigma all play a role in this oversight.

The Advisory Committee was distressed to hear the experience of an Aboriginal woman with a history of mental illness and substance abuse who presented at one of the province’s hospital Emergency Departments. ER staff knew her, but what they didn’t know was that she also suffered from diabetes. She was sober, but low blood sugar made her disoriented and uncoordinated. She was dismissed without examination. She hitchhiked home and was treated the next day by her family doctor.
Solutions for Nova Scotia

Shaping an excellent system of care in Mental Health and Addictions

The Advisory Committee developed and adopted vision, belief and mission statements, as well as a set of clear principles to guide its work and inform the development of recommended actions.

Vision Statement

All Nova Scotians will have effective access to an excellent system of care in mental health and addictions to improve well-being, address inequities, eliminate stigma and discrimination, and reduce the impact of illness. Making use of innovation, collaborative practice, longitudinal evaluation and leadership across Health and Wellness, Justice, Education and Community Services, this system will be efficiently coordinated and sustainable.

Belief Statement

The present system of mental health and addictions care can improve by becoming more accessible, coordinated, collaborative, non-stigmatizing and respectful of individuals, their family members and/or their network of support, as well as being sensitive to language, culture, race, ethnicity, sexual identity, and gender. This renewed system will promote wellness through education, prevention and health promotion, early and recovery-focused interventions, rehabilitation, and sound scientific research.

Mission Statement

To provide the Minister of Health and Wellness with a report and recommendations that lead to improvement and ongoing development of mental health and addictions services in Nova Scotia.

Objective

To create a mental health and addictions system that is accountable to the public, informed and guided by integrated, reliable and valid data measured within an information system that is standardized across the province and in which staff are appropriately trained and competent. There is consistent and timely knowledge transfer and translation from research to practice and these practices are based on scientific evidence or where this is lacking, on wise and promising practices.

People with a lived experience of mental health and/or addictions issues actively participate in the design, implementation and evaluation of the comprehensive mental health and addictions system.
Core Principles

As outlined by the World Health Organization (see appendices), a well-functioning health system responds in a balanced way to a population’s needs and expectations by:

- improving the health status of individuals, families and communities;
- defending the population against what threatens its health;
- protecting people against the financial consequences of ill-health;
- providing equitable access to people-centered care;
- making it possible for people to participate in decisions affecting their health and health system.

In addition to these, the Advisory Committee developed principles upon which the recommendations are based. These are:

1. Meet the mental health and addictions services needs of all persons in Nova Scotia, including those of jurisdictionally and historically-marginalized populations and under-serviced populations (such as Aboriginal and military families), linguistically and culturally diverse populations, and populations with specific needs.

2. Follow person-centered, family and natural supports-inclusive approaches to mental health and addictions care across the lifespan as appropriate, with attention to varied health literacy needs.

3. Use a population health approach and include social determinants of health.

4. Use a health promotion approach that is consistent with the Ottawa Charter for Health Promotion.

5. Ensure that access to care is timely and easy to navigate.

6. Support communication, collaboration and co-operation as well as coordination and integration of services to develop seamless and efficient care delivery.

7. Embed mental wellness and recovery-based approaches within services.

8. Ensure that health promotion, prevention, early intervention and anti-stigma/discrimination are essential components within services.

9. Apply provincial mental health and addictions standards to service delivery.

10. Incorporate best or wise and evidence-based practices and ensure knowledge exchange between scientific research and practice. The term "wise practices" refers to actions, tools, principles or decisions that contribute significantly to the development of

12. Ensure accountability. Utilize frameworks that evaluate services effectively and longitudinally to monitor progress. These measures should be comparable across the province for evaluation, accountability, quality improvement and sustainability. Engage stakeholders in the design, implementation and evaluation of the system.

A Call for Collaboration

Recommendations are organized under the themes that emerged from a synthesis of stakeholder consultations, academic literature reviews, provincial, federal and international reports, and other mental health and addictions strategies. To provide context for each recommendation, it is framed by a brief examination of what we heard, the objectives of the changes we advocate and the expected or desired outcomes. The Advisory Committee understands that implementation of its recommendations will challenge Nova Scotia’s fiscal resources and calls for a non-partisan collaborative partnership of all political parties to work together and engage in this process to leave a lasting legacy for the people of Nova Scotia.
1. Wellness

1.1 Social Determinants of Health

**WHAT WE HEARD:**
The evidence is clear: while mental health and addictions issues affect persons of all socioeconomic groups and all ages, when basic needs are not adequately met, health risks increase, the ability to access treatment is impaired, and chances of recovery are diminished. Unemployment, poverty and lack of education are among the key determinants of poor mental health and addiction among Nova Scotians.

The Advisory Committee heard from many Nova Scotians concerning the debilitating impact of poverty on the lives of those with mental illness and addictions. Poverty is clearly a determinant of these disorders as well as a frequent outcome. Positive outcomes from treatment are significantly diminished among people living in poverty.

Determinants of poor health are disproportionately evident among certain groups, including First Nations, racial, ethnic and linguistic minorities. Success in creating more effective mental health and addictions services and in improving outcomes from intervention will be diminished without a commitment to address the inequities in the social and economic foundations of good health. Income, employment and education all form part of the foundation but adequate and safe housing is essential.

For decades, persons with mental health and addictions issues have been unable to access appropriate housing options. Crisis, transition and recovery housing are frequently unavailable or inaccessible to these people, resulting in relapse, inappropriate housing placements and compromised recovery. Governments, working in good faith, have been unsuccessful in finding solutions, perhaps in part because of the division of responsibilities across various departments. While mental health and addiction treatment is a responsibility of the health system, responsibility for mitigating the harmful impact of the determinants of poor mental health or addiction more frequently falls to the Department of Community Services. The Justice Department is also frequently involved when persons with these issues are in conflict with the law.

The history of government departments working together suggests that they will struggle to come together effectively in response to the complex mix of issues and problems faced by persons with mental illness and addiction in need of housing options.

Adequate, safe and appropriate housing is a first vital step in recovery. Research indicates that provision of appropriate housing options is a cost-effective response. A joint effort of Simon Fraser University, the University of British Columbia and the University of Calgary found that each homeless person in British Columbia costs taxpayers $55,000 a year in health, corrections and social services. The report concludes that adequate housing supports could be provided to these people for $37,000 a year, resulting in $18,000 in annual savings per person per year. The cost of incarceration — too often the unhappy result when people with mental health and addictions problems are living on the street, or are inadequately housed — is $323 a day, or $117,895 a year.

A “Housing First” model is being explored by the Mental Health Commission of Canada with a major project located in New Brunswick. The research is to be completed in 2013. This is a promising approach...
to addressing homelessness and helping people get back into community life. The concept is sound, in that once a person has a place to live he or she can then concentrate on other personal issues. With a place to live, the person is offered a range of health and social support services, including help with routine tasks like shopping or getting to a doctor's appointment, securing opportunities for education, volunteering, and employment. Participants in the Housing First model pay a portion of their rent, meet with program staff once a week and are encouraged to make use of support services.

Housing alone is an incomplete response. Persons with severe and persistent mental health issues and addictions need meaningful daily engagement and employment opportunities, as well as programs to promote wellness, prevent relapse and enhance recovery. And, quite simply, the success of any efforts to deal with mental health issues and addictions will be limited without determined action to reduce poverty.

People recovering from mental illness and addictions need support in accessing education and employment, or simply adjusting to a return to everyday life. The “Clubhouse” model is an evidence-based example of psychosocial rehabilitation. Members are partners with staff in all aspects of running the Clubhouse, where programs provide opportunities to improve skills, find employment, take part in education opportunities, and make friends. Staff and members link with community organizations to encourage participation and involvement. The International Centre for Clubhouse Development has established standards, training and accreditation programs. It is a model that deserves wider consideration in Nova Scotia.

**OBJECTIVE:**

To maximize the effectiveness of improvements in mental health and addictions treatment and services, government will address the social determinants of health — specifically and as a priority, the housing and employment/purposeful activity needs of persons with these disorders. Adequate crisis, transitional and recovery housing appropriate to the recovery needs of people with mental health issues, illness and addictions (including those who have been in conflict with the law) will be available and accessible. Government will have organized itself so that this objective can be met through a single entry point avoiding the past problems created by ineffective cross-departmental efforts. A Housing First model will be effectively delivered through this single source.

**OUTCOMES:**

Expected and desired outcomes from the following recommendations include improved housing options in addition to increased opportunities for employment and purposeful activities. An overall decrease in poverty among persons with mental health and addiction issues offers them a better chance to live full and meaningful lives.

**RECOMMENDATIONS:**

1.1-1 Adopt a Housing First model that spans the Departments of Health and Wellness, Justice and Community Services. The client-centred Housing First model should ensure a single entry point for supportive housing. In addition to existing housing, the model should also meet the need for crisis, recovery and transitional housing for individuals with mental health and addictions issues in communities across the province.
1.1-2 Coordinated efforts are required across government to address and reduce poverty and its effects on persons with mental health and addictions issues. The provincial poverty reduction strategy should be acted upon.

1.1-3 Increase meaningful daily engagement opportunities, employment opportunities and programs (e.g., work/education transition, volunteerism supports, etc.) appropriate for individuals with mental health and addictions issues to promote wellness, prevent relapse and enhance recovery. In each DHA, supports for education and productivity within various environments must be available, including supportive programs (such as those following guidelines of the “Clubhouse” model). This could be partially achieved by supporting NGOs to foster social enterprise and/or by partnering with the private sector.

1.2 Knowledge, Education and Awareness

WHAT WE HEARD:
Gaps in awareness and knowledge about identification and treatment of mental health and addiction issues are evident across society — in workplaces, in schools and in government-provided services. Increased awareness and knowledge can result in significantly-improved outcomes, through a reduction in stigma and discrimination, and through early and more effective interventions.

There is a lack of accessible information and education — both physical access and access to appropriate literacy levels — on mental health and addiction issues. Individuals, families, other supporters and community-based groups, as well as health care and service providers from other government departments and agencies need to be better informed.

Ignorance breeds discrimination and adds to the burden of stigma attached to mental health and addiction problems. A lack of knowledge prevents those in a position to identify problems from taking action that would lead to early intervention.

OBJECTIVES:

- To promote awareness, knowledge and education related to mental health and addictions across the spectrum where there is need and where care is provided.

- To ensure that all health practitioners and front-line service providers of the Departments of Health and Wellness, Education, Community Services and Justice, as well as DHAs and the IWK have a core understanding of mental health and addictions issues and referral processes.

- To ensure that persons with mental health and addictions issues, their families and the public have easy access to information on these issues and the resources available for intervention.
OUTCOMES:
The following recommendations will foster improved mental health and addictions-related health outcomes, including mental wellness, empowerment of individuals with mental illness and their families, reduction in stigma and discrimination, early and appropriate interventions, improved physical health and an improved quality of the patient’s journey to recovery. Increased use of harm and risk reduction strategies and recovery-focused interventions in mental health and addictions services across all sectors is also expected. Recovery and wellness is the ultimate answer to stigma.

RECOMMENDATIONS:

1.2-1 Make mental health and addictions awareness and knowledge a core competency for health professionals at all service levels and for appropriate staff of other government services. Programs to enhance the competencies of staff in long-term care facilities should also be implemented.

This may be achieved through collaboration with university and college health care training programs to develop mental health and addictions curricula offered early in the training of medical students, nurses, occupational therapists, social workers, psychologists, teachers, child care workers and others who come in contact with individuals with mental health and addictions issues.

Evidence and best practice-based approaches should be used in mental health and addictions basic training and sensitivity awareness for provincial and DHA/IWK administrators, policy-makers and employees in the Departments of Health and Wellness, Education, Community Services and Justice. Training must include current information about community resources and supports for persons with mental health and addiction issues, basic human rights principles, empathy, anti-stigma awareness, communications, and listening skills.

1.2-2 Education supports must be available to individuals with a mental health issue or illness and/or addiction, as well as to their family and identified circle of care so that they understand the illness, its treatment and how they can build their capacity to contribute to its management.

1.3 Discrimination and Stigma

WHAT WE HEARD:
Stigma and discrimination marginalize persons with mental health and addictions issues and illnesses. They are contributing factors in maintaining the social and economic disadvantages that are an impediment to seeking services, supports and recovery. Not only are people suffering from mental health and addiction issues affected, so too are their families and service providers.

Lack of knowledge about mental illness and addictions is at the root of many forms of stigma, which include internal and external stigma, self-stigma, stigma by association and stigma across the lifespan of the affected individual. Stigma is real behaviour, not merely an attitude. That behaviour is organized through cultural and social routines and the policies that keep people with mental health and addictions issues on the margins.
Stigma and discrimination experienced by those with mental illness are distinct from that experienced by those with addictions. Stigma toward alcohol addiction is distinct from drug addiction. Stigma occurs in many environments including workplaces, educational facilities, health care settings and in the media. Stakeholders in the consultations identified the need for greater education in all mental health and addictions settings to address and reduce stigma.

Under-funding the mental health and addictions services is, in itself, a form of discrimination. It adds to the stigma attached to these issues.

Anti-stigma initiatives must be consistent with the initiatives of the Mental Health Commission of Canada, and best practices must be identified and developed into a provincial anti-stigma campaign.

The Province should support community initiatives and programs that promote an anti-stigma message or engage in positive stigma-reduction activities. Effective existing provincial initiatives should be incorporated. Anti-stigma initiatives will:

- Draw attention to the differences in how stigma is understood and experienced specific to addictions, mental health issues and illness and concurrent disorders.

- Target the Department of Health and Wellness and DHA/IWK administrators and policy makers, health care professionals, police and justice system personnel, Departments of Community Services and Education personnel, other service providers and the general public.

- Develop interventions that are culturally-relevant and accessible to marginalized groups and high-risk populations (e.g., seniors, children, youth, Aboriginal People, African Nova Scotians, Francophone/Acadians, immigrant populations, disabled persons, and street involved persons).

- Develop and use health promotion, health literacy and prevention-focused approaches in support of evidence-based anti-stigma campaigns directed toward addressing stigma among youth.

- Incorporate messages that are informed and/or delivered by persons with lived experience of mental health issues and illness and/or addictions and their families.

- Use social marketing techniques for dissemination of knowledge to promote awareness and take action against stigma and discrimination.

- Support the adoption across government departments and in the media of respectful language that is appropriate in identifying persons living with a mental illness and/or addiction.

**OBJECTIVE:**
To eliminate discrimination caused by the stigma associated with mental health and addictions issues in Nova Scotia through education, advocacy and by enforcing the principles within the Charter of Rights and Freedoms and provincial legislation, such as the Human Rights Act.
OUTCOMES:
To begin a process whereby people are treated with equity and without discrimination within families and communities, as well as in the health care, education, justice and community service systems. Reduction in the stigma attached to mental illness and addictions will lead to increased self-identification, early and timely intervention and harm reduction.

Education, health promotion and knowledge transfer will occur in community-based initiatives. These will be related to topics like suicide, mental health and addictions issues and will occur in all communities including those that are marginalized.

RECOMMENDATION:

1.3-1 The provincial government should commit to a multi-year, collaborative and inclusive stigma reduction initiative. By publicly committing to this, the government will demonstrate leadership in addressing discrimination, inequities and stigma associated with mental health and addictions issues.

1.4 Health Promotion and Early Intervention

WHAT WE HEARD:
Health promotion and early intervention in mental health and addiction issues are critical to a comprehensive strategy. Opportunities are too often missed for early identification of and intervention in mental health and addictions issues. There is a need to enhance efforts among youth in schools, and among adults in workplaces. A health promotion approach uses a strengths-based framework to build resilience among young people and build strong support networks among adults.

Kevin’s odd behaviour in and out of school was marking him as a social outcast from a very early age. Children often recognize differences in the behaviour of other children that adults miss or shrug off.

Kevin was fortunate. He attended school where a multi-agency, evidence-based program called BEST (Behaviour Education Support Treatment) offered help for elementary school children with behaviour and social challenges.

Bright and curious, Kevin took and hoarded in his desk at school and his room at home things that clearly weren’t his and some that he found, or belonged in the garbage. In his desk at school were his classmates’ erasers and used snack wrappers. At home, his mother found a stash of trash. She was even more worried, however, by Kevin’s severe agitation when she took it away. Kevin also hummed incessantly in school and his teacher worried about the social isolation his behaviour was causing.

Kevin was referred to the BEST Program when he was in primary. Assessment, consultation and therapeutic interventions from the local Mental Health Services child psychiatrist and the BEST team, including the School Psychologist were arranged. These clinicians consulted with each other, Kevin’s mother and school staff to plan and coordinate Kevin’s care.
Guidelines were developed regarding the items Kevin was allowed to collect. His mother checked his backpack each night and Kevin had to return anything that was not his. He was supervised more closely at school and was given a stress ball to keep and use in the classroom as he chose.

Two years after his entry in the BEST Program, Kevin was successfully using a number of the strategies he learned to deal with his compulsive behaviour. His social isolation was being reversed; he was being invited to birthday parties again and appeared to be fitting in with his peers. His mother felt comfortable with her son’s progress. These days, the support both she and Kevin receive is on an “as needed” basis only.

Fostering collaboration among diverse health care disciplines and across the public sector will help improve early detection of mental health and addiction issues, and increase treatment effectiveness. Early identification and intervention reduces the burden of illness and the impact on the individual, family and community. It reduces costs to society over the long-term. Given that up to 70 per cent of mental illnesses begin in childhood or adolescence, the Department of Education has a critical role to play in early identification.

Research suggests that the strongest return on investment in health promotion efforts is for programs focussing on children and adolescents. These programs might include increasing parenting skills, and primary health care screening for depression and alcohol misuse. Health promotion programs in schools might be aimed at reducing conduct disorders and depression, promoting anti-bullying and anti-stigma, and increasing suicide awareness and prevention. Nova Scotia has evidence-based examples that can serve as models.

Returns from mental health promotion and addictions prevention show up in different sectors from the one in which the investments are made. A ”mental health in all policies” approach should be considered. It should be noted Mental Health Services and Addictions Services must take different approaches when addressing health promotion, illness prevention and early intervention.

A formal link between reproductive mental health programs and the mental health and addictions services systems should be established. This could be accomplished via a specialty network to link DHA-based programs with the provincial IWK program, and through distance-based interventions.

**OBJECTIVES:**

- To enhance health promotion and early intervention initiatives in all settings, with specific attention on health care facilities and services, workplaces, and educational institutions.
- To use a population health approach to address mental health and addiction issues.

**OUTCOMES:**

The expected or desired outcomes of implementation of the following recommendations are:

- More mental health issues will be identified early so that treatment is more effective and the consequences of illness are not as severe. Fewer people develop addictions and begin using substances inappropriately, high-risk use is reduced and, further along
the continuum, a harm reduction approach is taken to minimize health and social consequences of addiction. The health of Nova Scotians is improved.

- A holistic approach to mental health and physical health assessment is utilized.
- Employees are protected from psychological harm and psychological well-being is actively promoted in the workplace.
- Employers experience enhanced organizational effectiveness as the result of reduced absenteeism/presenteeism; lower disability costs; reduced costs associated with high turnover and recruitment; higher levels of employee engagement and productivity, creativity and innovation; lower rates of error and physical injuries; greater marketability as an “employer of choice”; an enhanced reputation as a good place to work; and a reduced risk of legal issues related to psychological harm to employees. (Presenteeism is attendance at work when ill and generally non-productive.)

RECOMMENDATIONS:

1.4-1 Design a province-wide health promotion and early identification and intervention approach that:

- Aligns with other strategies (district, provincial, other jurisdictions, national);
- Targets the general population as well as specific population groups at risk;
- Addresses the specific needs of youth and young adults, including junior and senior high school and college/university students;
- Addresses the specific needs of seniors;
- Provides resourcing for province-wide, distance-based early intervention and self-management programs addressing mild to moderate mental health issues;
- Recognizes and incorporates the different approaches to prevention and promotion required for mental health and addiction initiatives;
- Collaborates with employers and unions to develop and implement workplace supports, opportunities for early identification of problems and linkages to appropriate interventions;
- Expands the reach and range of harm-reduction services that prevent and reduce the health, social and fiscal impacts of problematic substance use and problem gambling;
- Includes information on access to locally-available resources including alternatives to conventional treatment.

1.4-2 Integrate screening and intervention for mental health and addiction problems across the lifespan into primary health care settings, ensuring effective and timely referral and follow-up processes.
• Include an assessment of family supports and well-being in screening.

• Ensure training of health practitioners (e.g., primary care physicians, emergency physicians and Emergency Department staff, nurse practitioners, continuing care coordinators, home care, and long term care staff) in screening, identification, early intervention and referral.

• Ensure that the physical/medical assessment needs for persons with severe and persistent mental illness and addictions are addressed in primary care settings.

• Enhance screening for reproductive mental health, prenatal period, maternal addictions and maternal-newborn attachment issues.

• Integrate screening for early childhood developmental, behavioral and learning disorders, and family well-being into a province-wide screening program and ensure effective referral and follow up processes.

• Support evidence-based interventions to enhance early detection and management of illness for youth, adults and their families, taking into account the impact on education and employment, transition into school or the workplace, and support for pharmacological and behavioral management.

• Create a partnership between the Departments of Health and Wellness, Education, Justice and Community Services to coordinate a comprehensive approach to a range of parenting support for families in Nova Scotia dealing with mental health and addiction issues.

1.4-3 Advance psychologically safe workplaces in Nova Scotia (consider the standards under development by the MHCC). Publicly-funded workplaces should have evidence-based strategies and be a model for all workplaces in assessing and addressing risks to mental health and problematic substance use within the employment situation.

1.4-4 Use the findings and evaluations of youth health and wellness models established in some schools in the province to inform how broader access to these models could strengthen mental health and addictions services.

1.4-5 Alcohol misuse is a major health issue in Nova Scotia, with a broad impact felt well beyond those who are alcohol dependent. Evidence-informed population-based policies should be examined as ways to further reduce alcohol-related harms.
2. Access and Intervention

2.1 Access to Services — Response and Wait Times

**WHAT WE HEARD:**
Virtually all stakeholders identified accessing mental health and addictions services as a challenge. Wait times for outpatient services, major difficulties in accessing inpatient service, and lack of after-hours services were all cited as problematic. Long wait times for children and youth with symptoms of mental illness was a particular concern. Navigation of the system is difficult. There are disparities in services for marginalized populations and across regions or districts.

Nova Scotians who participated in consultations told us they want a system which can provide rapid and effective assistance to those with mental health and addictions issues — one where “every door is the right door” leading to easy navigation and access. Today, access for various sub-populations is uneven at best. These groups include children and youth, diverse (indigenous and immigrant) communities, incarcerated individuals, seniors, military families and individuals with severe and persistent mental illness.

Tele-health service is available in every hospital in the province but is not used to capacity. It was seen as a potential solution to some community access problems. Technology could provide a measure of equality of access, especially for rural populations, and could offer increased access to specialized mental health and addictions services. It is a reasonable alternative to travelling long distances, which is a barrier for many.

Nova Scotia has been a leader in the research on technology-aided interventions. Evidence suggests these interventions can provide timely access to assessment and early intervention for mild to moderate mental health issues. This would permit the more traditional delivery system to focus on those with more severe or complex mental illnesses.

A review is required of the feasibility of mobile crisis teams or on-call systems to meet the provincial Mental Health Standard: “A crisis and emergency response service (CRS) is available in a timely manner in the most appropriate environment in each district and includes a plan for 24-hour service, seven days per week.” Ultimately, however, government must ensure that crisis/early response service in each DHA is adequate to meet the needs of the population.

Tele-health and other forms of information technology and health informatics based approaches should be examined to determine their feasibility to provide services and enhance collaborative care. The Mobile Crisis Team (based in the Halifax Regional Municipality) could be supported to provide telephone crisis advice to all Nova Scotians from 5:00 p.m. to 9:00 a.m. and on weekends, with linkages to community/district crisis services, emergency departments and inpatient units. This type of service might be accessed through 811 Health Link and 211 Information and Referral Service, once operators are trained. Training for 911 operators and dispatchers is underway and should continue so that they can identify calls with mental health or addictions aspects so members of the mobile or other crisis teams and/or police officers with crisis intervention training can respond.

Training is an issue across the spectrum of service providers who can encounter persons with mental health and addictions problems. The Department of Community Services, for example, should review staff training and behavioral consultation supports in the facilities it funds. Nurse practitioners in
collaborative care practices should be trained to enhance their role in screening and basic interventions for mental health and addictions issues.

To expand services, the province should evaluate the feasibility of walk-in assessment and brief intervention services in the DHAs and, based on population and need, provide mental health and addictions consultations in a timely manner in Emergency Department settings.

Seniors can be a particularly vulnerable population due to difficult diagnostic criteria for mental illness and addictions, complex co-morbid diseases, frailty, difficult ambulation, living arrangements and lack of peer support.

Individuals with addictions or mental health concerns whose behaviour is deemed to be of concern are often not offered access to home care. The present system of home care does not have sufficient funding and education for providers to ensure home care is available for all persons with mental health and/or addictions issues who require it.

Communications and system navigation is a persistent problem. At the community or district level, a navigator/advocate system could be useful and relevant, particularly for specific and minority populations. These services may be able to address multiple health services beyond mental health and addictions services in some districts.

In addition, effective and efficient communication pathways with primary health care, community agencies and other referral sources should be established to ensure updated information on mental health and addictions services and referral routes is widely available.

Throughout its work, the Advisory Committee learned of an array of specific issues related to mental health and addictions that are creating gaps in access to service and service delivery, particularly for specific segments of the population. Too often, due to financial reasons, medications are not available to those in need. People with serious or severe mental illness fall through the cracks simply because they do not actively seek treatment.

Understanding the patient journey during illness can shed light on why those with severe illness do not seek services. The Province should explore ways of reaching people who, due to severe mental illness, do not seek services. These might include the use of peer support programs, assertive outreach teams, and enhanced public and health care provider understanding of the Involuntary Psychiatric Treatment Act.

Community-level supports are vital in order for recovered and recovering individuals to reintegrate into the workforce and their communities. These types of supports are uneven in their distribution and availability across the province.

The Advisory Committee heard concern about uneven access to provincial services. Patients who live in close proximity to the programs seem to access them with more ease than those farther away. The province needs to evaluate the utilization of provincial programs to determine that they are equally accessible to people in all areas.

Untreated and under-treated mental health issues and illness or addictions can contribute to behaviour that leads to self-harm and harm to others (e.g., threatened and completed suicide, drinking and driving, assault, being bullied). These require intervention through crisis response, acute care and community-based services to help individuals, families and communities. Intervention requires cross-jurisdictional collaboration and involves many elements, such as the justice system, involuntary hospitalization, community treatment orders, revoking licenses to drive or a license to own firearms, and privacy and
confidentiality issues in order to effectively intervene, prevent, postvent and manage risk of self-harm and harm to others.

OBJECTIVES:

- To develop a mental health and addictions system that connects people with the services they need in a seamless, timely and simple way.
- To improve treatment of severely-ill patients through a planned and managed approach to urgent care and hospitalization.
- To employ technologies and emerging best practices to improve access.

OUTCOMES:
Expected and desired outcomes from the recommendations in this section are:

- Mental health and addictions standards related to wait times are achieved.
- Early identification and intervention that will lead to better health outcomes and patient satisfaction, improved practitioner satisfaction and quality of work life for service providers.

RECOMMENDATIONS:
General Access

2.1-1 Mental Health and Addictions Standards should be revised to include a standard related to the urgency of addressing moderate to severe mental illness and/or addictions in a person who is a parent or guardian of children or youth, given the potential negative impact on children’s development and well-being. The triage category must be adjusted to reflect this status.

2.1-2 Resources need to be sufficient to meet the current mental health and addictions standards. Steps should be taken to further reduce wait times for children and youth. The following are suggested objectives:

- **Urgent level of priority.** Addictions Services Standards for children and youth must align with existing Mental Health Standards. Urgent referrals should be offered an appointment for assessment within seven calendar days of the date of referral (a change from "10 business days" in current Addictions Standards).

- **Semi-urgent.** Semi-urgent referrals of children and youth should be offered an appointment to be seen within 14 calendar days of the date for the referral (a change from 28 days in the existing Mental Health Standards).

- **“Regular” or “general” referrals.** Mental Health Standards should be revised to align with existing Addictions Standards. Regular/general referrals of children and youth should be offered an appointment within 21 calendar days of case
assignment (a change from 90 days in Mental Health Standards and consistent with Addiction Standard of 15 business days).

2.1-3 Telephone crisis intervention services should be expanded and offered province-wide, with trained staff available to respond.

2.1-4 Ensure that in each DHA there is access to a Seniors Mental Health/Addictions program with trained clinicians and consulting psychiatry for specialty service to seniors with late-onset mental illness or mental illness complicated by the aging process, addictions and multi-dimensional factors. Support and continuing professional education for these clinicians should be available through participation in the provincial Seniors Specialty Network.

2.1-5 Assessment and service for seniors should be available within the home, residential and long term care settings and during transition between settings. Collaboration with community agencies and services, along with DHA initiatives, should ensure that “a range of practical and social support services can be delivered in their homes to seniors living with mental illness” and that “there is a level of support to seniors living with mental illness that is, at a minimum, equivalent to the level of support available to seniors with physical ailments, regardless of where they reside.” (Kirby) Senator Kirby also recommended that consultation be available to long term care facilities to deliver psycho-education for clients and caretakers. The Advisory Committee supports that recommendation.

2.1-6 There should be one or more “stabilization units” within the province for patients with dementia who are exhibiting difficult or dangerous behaviour. Dementia care specialists working in these units could assess and treat such people over a limited time, before returning them to long-term care facilities closer to their homes with specific treatment plans.

2.1-7 Fund home care programs that specialize in managing people with mental health and addictions issues, especially those perceived to be “high risk” and those with severe and persistent mental illness.

2.1-8 Ensure that the health care needs of persons with severe and persistent mental illness (i.e.: schizophrenia, bi-polar disorder, and other psychotic disorders) and concurrent disorders are addressed through a comprehensive continuum of care. While this may be a comparatively small patient population, it has extremely high need for many complex services. In each DHA, a form of intensive community support service (e.g., Assertive Community Treatment) must be available for this population, reflective of demographics and need.

2.1-9 Navigators/advocates should be made available to help individuals and their families easily find their way to the appropriate service in the mental health and addictions systems.

2.1-10 Ensure that programs and services with a provincial mandate are clearly designated as such, and evaluate the use of these programs to ensure equitable access for persons from all parts of the province.

2.1-11 Develop criteria for and fund access to pharmacological treatments for mental health and addictions for individuals who demonstrate financial need.
2.2 Peer Support

WHAT WE HEARD:
The Mental Health Commission of Canada defines peer support as any organized support provided by and for people with mental health problems. Peer support is sometimes known as self-help, mutual aid, co-counselling or mutual support. Peer support also applies to addictions issues. A great deal of information on the benefits of peer support and advocacy is available, but qualitative and quantitative research data is generally lacking across Canada.

In April 2010, the Mental Health Commission of Canada (MHCC) launched the nationwide Peer Project to support the development of Standards of Practice and research the value of peer support and advocacy. In a recent MHCC study, people who had benefited from peer support reported better coping skills, better understanding of mental health issues and services, less isolation, better engagement at work and in their community, greater ability to reach life goals and experience a sense of accomplishment, increased quality of life, and fewer crises and hospitalizations. With peer support, people with mental health problems and illnesses and addictions, service providers, family caregivers and others become partners in the healing journey.

The three key objectives of the MHCC project are to produce:

1. National standards of practice for peer support;
2. A training curriculum and a certification process to provide peer support workers with nationally-recognized credentials (voluntary); and
3. Research to evaluate the efficacy of peer support programs.

RECOMMENDATIONS:

2.2-1 Establish a partnership with the Mental Health Commission of Canada (MHCC) and its "Peer Project" to collaborate in establishing national standards of practice for peer support. Develop a training curriculum and a certification process to provide provincial/local peer support workers with nationally recognized credentials, and research and evaluate the efficacy of these programs.

2.2-2 Review the variety of ways peer support and peer advocacy is being delivered now in Nova Scotia as it relates to mental health and addictions, reporting on the current state of peer support service delivery with recommendations for proceeding under the MHCC Peer Project model.
2.3 Diverse Populations

WHAT WE HEARD:
Mental health and addictions services must be able to meet the needs of diverse populations in Nova Scotia. Many in these populations have been under-served or not served by the existing system for generations. Diverse populations experience barriers to service resulting in a higher burden of illness and greater risk for mental health and addictions problems.

Programs currently in place often are not culturally specific, safe or relevant, and are not linguistically inclusive or responsive to the health literacy needs of diverse populations.

“I took my daughter to the local Emergency Department to see the psychiatrist because she was having thoughts of killing herself. When we got there a staff member in the mental health section made a comment that he didn’t think Black people tried to kill themselves. As members of the Black community who have a 200+ year history of living in the province, I would think that people who work with mental health patients would have a better awareness of providing support to non-white people. The racial comments made to my family speak to why Black people do not trust the system to help us. My daughter waited almost three weeks to see a therapist. That person was no better and made assumptions about where she lived. In short, she ended up not going to counselling there because of the lack of cultural awareness and poor treatment for her mental health crisis. We ended up contacting a Black social worker and getting her a private therapist who understood her cultural and mental health needs. In short the present system, as far as I can see, doesn’t work for Black people.”

Mental health and addictions service providers require education about co-morbidity, concurrent disorders, and unique risk factors for the diverse populations they serve. There is a growing body of knowledge that indicates that unless senior administrators are consistently and deliberately educated about diversity and social inclusion/exclusion, the likelihood of longitudinal uptake in agencies and institutions is marginal at best.

Among our diverse populations, there are groups that warrant particular attention to ensure that their mental health and addictions service needs can be addressed effectively. Evidence-based and culturally specific prevention and health promotion programs to meet the unique needs of First Nations and Aboriginal Nova Scotians, African Nova Scotians, Francophone/Acadians, Immigrant and Lesbian, Gay, Bi-Sexual, Transgender and Intersex (LGBTI) communities should be developed. When working within diverse populations, the Department of Health and Wellness should ensure that a collaborative, community, participant-driven approach is practiced.

Mental health and addictions needs have been consistently identified as the highest priority by First Nations communities and Aboriginal organizations. Aboriginal individuals, families and communities suffer a significant burden of illness in these areas.

The Advisory Committee was distressed to hear the experience of an Aboriginal woman with a history of mental illness and substance abuse who presented at one of the province’s hospital Emergency Departments. ER staff knew her, but what they didn’t know was that she also suffered
from diabetes. She was sober, but low blood sugar made her disoriented and uncoordinated. She was dismissed without examination. She hitchhiked home and was treated the next day by her family doctor.

The profound impact of cultural and historical intergenerational trauma must be considered when planning and delivering services to this population. It is critical that services are culturally appropriate and culturally safe.

OBJECTIVE:
To develop mental health and addictions services that meet the needs of all Nova Scotians, including diverse populations and communities. The system will be culturally and linguistically inclusive, health literacy-based, culturally safe and accessible to all Nova Scotians.

OUTCOMES:
Expected and desired outcomes from the recommendations below include:

- Increased cultural competency among care providers;
- Increased cultural safety within all mental health and addictions services;
- Increased access to services for diverse populations;
- Timely access to interpreters and greater engagement of diverse populations as service providers and as clients of the system;
- Provider teams that reflect and understand cultural diversities of the communities in which they practice;
- Increased recruitment and retention of culturally and linguistically diverse practitioners.

RECOMMENDATIONS:

2.3-1 Work collaboratively with members of diverse populations and communities, including immigrant communities, to eliminate barriers and support initiatives that have been demonstrated to reduce health disparities, consistent with the Provincial Cultural Competence Guidelines.

2.3-2 Identify best/wise and evidence-based practices to meet the needs of specific diverse populations. Identification of such practices must take place in collaboration with identified community groups. Establish a DHAs and IWK Provincial Network for Services to Diverse Communities to support this process and the work of providers.

2.3-3 Provide interpreter and translation services (including sign language) as required in clinical settings.
2.3-4 Implement community-based mental health and addictions services for Aboriginal populations that are culturally competent and appropriate, support capacity development and strengthen relationships particularly between First Nations communities and DHAs/IWK mental health and addictions programs. Support initiatives aimed at increasing Aboriginal mental health and addiction service providers.

2.3-5 The DHAs and the IWK must develop meaningful partnerships with key stakeholders within the African Nova Scotian community to develop collaborative clinically-competent approaches to meet the mental health and addictions needs of the community across the life-span. The DHAs and IWK need to recruit, retain and promote African Nova Scotian health care providers. The Department of Health and Wellness must continue to work with the Office of African Nova Scotian Affairs and other departments to address a system-wide approach to meet the concurrent needs of the African Nova Scotian community.

2.3-6 Acadians and the Francophone population must have timely access to a range of linguistically-competent services. The province should be supportive of initiatives aimed at increasing French-speaking mental health and addictions service providers. In addition, English-speaking service providers need to be made aware of the availability of French service providers and French language resources to address mental health and addictions issues. Ultimately, service providers need the necessary training to provide the relevant mental health services linguistically. Further research is necessary to determine if there are culturally-specific treatments required to meet the needs of this population.

2.4 Incarcerated/Justice Involved Individuals

WHAT WE HEARD:
Approximately 50 per cent of provincial inmates suffer from mental illness, and 77 per cent report substance abuse problems. There are concerns that adequate mental health and addictions services, as well as adequately-trained staff, are not available to treat individuals in jail. There is also concern that some people may commit crimes believing they will have access to mental health and addictions services while incarcerated. The Advisory Committee supports recommendations in the Derrick report that address gaps in services for this population.

More work is required to research, develop and implement evidence-based approaches to mental health and addiction issues specific to individuals who are incarcerated or before the courts. Particular emphasis should be on young people with mental health and/or addictions issues who are in trouble with the law. All approaches should be gender, ethno-racial, cultural and linguistically supportive.

There are special challenges in supporting individuals as they transition from provincial correctional facility services to community-based mental health and addictions services. Protocols should be established to ensure gaps in treatment are eliminated.

The Advisory Committee supports the recommendation of Judge Derrick to expand the Restorative Justice program to include adults with low severity mental health and addictions issues to ensure they receive timely treatment interventions. As well, the Advisory Committee supports the Derrick
recommendation that the Departments of Health and Wellness, Justice, Education, and Community Services collaborate to provide mental health and addictions services to accused persons appearing in criminal courts.

The apparent success of the Mental Health Court now sitting in Halifax suggests an expansion should be considered. The province should determine if there is a need for a Mental Health Court in Sydney, and determine the possibilities for extending access to the existing Mental Health Court, or an acceptable alternative, to persons residing outside the Metro region.

Specific guidelines are needed to help police officers deal with someone in their custody suspected of having a mental health and/or addictions issue. If a mental health or addictions issue is diagnosed (in an Emergency Department or by some other means), measures must be taken to ensure follow-up when the person is released back into police custody or moves through the criminal justice system. This is particularly important for people who may be on psychotropic medication and who may not have access to their prescriptions while in custody. The lack of medication to control their symptoms or withdrawal from psychoactive drugs can be a threat to the person’s health, and would also likely have an impact on the outcome of any criminal proceedings against them.

Police point out that guidelines are also needed to assist with persons with suspected or diagnosed as having mental health and/or addictions issues, who are not in their custody for criminal offences but have no housing or natural supports. They are brought by police to Emergency Departments and subsequently discharged.

Specific guidelines should also be developed to ensure persons suspected or diagnosed with mental health and/or addictions issues have those issues addressed when taken into custody by the police.

OBJECTIVE:
To ensure that mental health and addictions services are easily accessible in a seamless manner to individuals who are incarcerated or involved with the justice system, as well as to their families.

OUTCOMES:
Law enforcement officials will have the knowledge and skills to recognize, intervene and cope effectively with the unique needs of individuals involved in the justice system and/or incarcerated individuals in need of mental health and addictions services. These individuals will experience seamless continuity of care and timely access to mental health and addictions services.

RECOMMENDATIONS:

2.4-1  Provide additional mental health and addictions services to ensure timely access and to meet the need for service within provincial correctional services. Review the space requirements for such enhancements and ensure sufficient and appropriate treatment space is available within correctional facilities.

2.4-2  Provide best practice anti-stigma education to health care providers, Emergency Department staff, police and corrections workers to establish a greater level of comfort and skill in dealing with individuals who have mental health and/or addictions issues, and are or have been in conflict with the law.
2.5 Mental Health Inpatient Care

WHAT WE HEARD:
Inpatient beds are the “critical care” end of the mental illness and addictions continuum. Here, acutely ill patients who need stabilization and whose crises cannot be safely managed in the community are treated. The aim of acute inpatient care is to relieve problems safely and rapidly in a structured environment that provides support and involvement with an emphasis on treatment, stabilization and transition back to the community. The stabilized patient is expected to access community programs. Without access to inpatient services, community programs and supportive housing can be overwhelmed by the needs of severely-ill patients.

The consequences of a shortage of beds, especially when combined with inadequate supportive housing and community supports, include: increased homelessness, the incarceration of mentally ill individuals, overburdened Emergency Departments, and increased violent crime. The right balance must be achieved between treatment within community-based services and inpatient services.

Currently in Nova Scotia, there are 20 psychiatric inpatient beds per 100,000 people. This number is low compared to other jurisdictions. Uneven bed distribution across the province creates barriers to access and frustrating searches for available beds. The shortage of supportive housing options, and the tendency to admit people with behavioural problems linked to dementia to psychiatric units, has reduced the capacity for inpatient care of severely-ill patients.

Over the past decade or more, the Executive Director of Mental Health, Children’s Services and Addiction Treatment of the Department of Health and Wellness, DHA Vice Presidents of Community Health, Chiefs of Psychiatry, Mental Health Directors and Psychiatric Unit Managers from the DHAs have frequently reviewed the serious challenges of access to inpatient psychiatric care. There is agreement that the current system does not provide effective and timely access.

When reconfiguring the adult inpatient psychiatric system, consideration should be given to the short stay inpatient needs for youth and children. It is important to continue to house the youth forensic population separately from the general youth inpatient services.

A number of challenges related to inpatient psychiatric care are identified below:

1. Small units are difficult to sustain due to:
   • Chronic shortages of psychiatric and nursing resources;
   • Small complement of staff with limited support for providing services;
   • Inadequate complement of psychiatric services for 24/7 coverage of units especially in non-urban settings;
   • Inadequate access to admission to meet 24/7 requirement of services; e.g. closure to admissions as early as 3:00 p.m. on weekdays and noon on weekends in non-urban units;
   • Partial shutdown of units during holiday periods;
• Lack of full continuum of care from short-stay crisis stabilization to medium stay psychiatric rehabilitation and subspecialty services; and

• Crowded environments.

2. Pressure on units to admit patients presenting for non-psychiatric disorders, such as brain injury, dementia, or who are difficult to manage on other medical units.

3. Utilization of beds by other patients, such as those waiting for placement in long term care facilities.

4. Insufficient development of intensive community supports which in turn places pressure on the inpatient system.

These challenges have led to:

• Chronic shortages of inpatient psychiatric services and beds;

• Significant difficulties for Emergency Department staff finding beds when hospitalization is essential for mental illness management;

• Lack of available inpatient resources to accept and manage patients certified under the Involuntary Psychiatric Treatment Act;

• Patients with severe psychiatric illness being held in unsafe, inappropriate and non-therapeutic settings, which exposes them to increased risk and sets dangerous precedents for staff and DHA managers; and

• Frequent out-of-district and out-of-province transfers with additional costs and fragmented patient care.

RECOMMENDATIONS:

2.5-1 Implement a provincial system of inpatient psychiatric bed management which includes consistent and clear admission criteria and policy. A provincial bed coordinator may facilitate access to inpatient beds across the province.

2.5-2 Provide adult inpatient psychiatric care in fewer, larger units strategically placed across the province. Each unit should provide a full range of services to patients and families from all areas and ensure success in the recruitment and retention of staff. The IWK should continue to house a child and youth inpatient unit. The numbers of beds in the province must not be reduced since Nova Scotia is already working with a small number of beds per capita. Services should include short stay crisis stabilization to medium and longer stay psychiatric rehabilitation and subspecialty services (which are currently unavailable in smaller inpatient units). All Nova Scotians should have equitable access to these units.

2.5-3 Establish a provincial/multi-DHA/IWK Mental Health Inpatient Services Committee to which all inpatient services would be accountable, to ensure appropriate utilization and accessibility.
2.5-4 Review the effectiveness of existing models of observation beds in psychiatric units that are accessible directly by emergency physicians or family physicians on-call to determine if implementation across all DHAs should become standard until such time as 2.5-1 and 2.5-2 are fully implemented.

"Models of observation beds in psychiatric units that were accessible directly by emergency physicians or family physicians on-call were noted to be effective in some districts. Some reported that 24 to 48 hour management of many of these crises outside of the emergency department and in an appropriate mental health unit often led to resolution of problems before psychiatry became involved." (Gass)

2.5-5 Ensure that short stay, crisis mental health and addictions service capabilities exist within the continuum of inpatient services for children and youth. It is vital that patients and their families have access to these services regardless of where they live across the province.

2.5-6 Establish one or two secure rooms within Emergency settings to meet the need for short term stays and emergencies in DHAs without in-patient services.

2.5-7 Examine the need for specialized, tertiary-level psychiatric beds and services for complex illnesses (e.g., psychogeriatrics, eating disorders, etc.). These are distinct from acute care psychiatric units.

2.6 Addictions Services

WHAT WE HEARD:
Currently, access to addictions services is voluntary, respecting the fact the individual must recognize a need for treatment. While this approach works for many people, it is difficult for family, friends and the community when the individual does not agree to treatment. More can be done to provide support and engage in efforts to encourage those who need treatment to receive treatment.

Access to opiate substitution treatment should be broadened. Those on evidence-based substitution treatment regimes should also have access to medical, pharmaceutical, and psychosocial supports. The alarming prevalence of opiate use, particularly among young Nova Scotians, suggests that the appropriate infrastructure to support treatment (generally methadone) programs should be available provincially. This will require the development of standards, laboratory testing of urines, recruitment and training in core competencies for health practitioners in primary care so they can undertake prescribing, managing and ongoing care of individuals that have been stabilized in supported programs.

The following challenges specific to addictions services access and intervention have been identified:

- Chronic shortage of withdrawal management services;
- Shortage of intensive residential and inpatient rehabilitation programs;
- Lack of supportive housing using a recovery model;
• High recidivism to withdrawal management; and

• Limited access to methadone treatment due to low numbers of practitioners competent in methadone management, lack of infrastructure to manage and monitor adherence to treatment, lack of community-based treatment and lack of funding.

These challenges have resulted in the following problems:

• Without appropriate access to withdrawal management and recovery care, individuals have lost family, housing, employment, and freedom due to incarceration. They have experienced deterioration in physical health. This all has a detrimental impact on the well-being of communities. The economic cost to health care programs, and the social cost to communities and individuals are increased when individuals are unable to be financially independent or are incarcerated.

• Without access to methadone treatment there is a higher chance of overdose and death. When people are stable on methadone, other health issues like Hepatitis C can be treated in a timely manner, avoiding subsequent serious medical consequences.

RECOMMENDATIONS:

2.6-1 Reconfigure addictions inpatient beds for withdrawal management, opiate stabilization and structured treatment according to evidence and best practice, utilizing alternative community-based approaches where possible.

2.6-2 Ensure that withdrawal management services for youth are available for management of addictions and concurrent (mental health and addictions) disorders. Ensure separate adult access to treatment for concurrent disorders.

2.6-3 Support the development of community-based supportive care for mental health and addictions within specific cultural communities in the province, and offer on-site care to populations that cannot, for a variety of reasons, access that care in clinical settings.

2.6-4 Increase access to evidence-based opiate substitution treatment.
2.7 Continuity of Care

WHAT WE HEARD:
In times of transition between services, the risks of gaps in service where people may “fall between the cracks” are significant. This can happen when youth transfer to adult services, when persons with concurrent disorders transfer between mental health and addictions services, and when patients are discharged from inpatient treatment programs to community-based or outpatient services.

The services receiving the new patients may not receive information in a timely way, or engagement of family or other supports may be lacking. Similarly, when persons are discharged from formal mental health and addictions services to community supports, transition and discharge planning could be improved to ensure continuity of care. This can also be an issue when incarcerated individuals with mental health and addictions issues are discharged to receive mental health or addictions services in the community.

The liaisons between child and youth and adult-focused mental health and addictions services should be strengthened to provide a timely and seamless transition for young people, their parents, guardians or caregivers. This will require collaborative consultation and care practices. Circumstances such as differences in the age at which various government departments define children or youth services, versus adult services, can cause significant gaps and disruption in service to an individual.

Efforts are needed to ensure seniors with mental health and/or addictions issues are cared for in the appropriate settings. For example, they should be transitioned from acute care to long-term care facilities, or other appropriate housing, when it is clinically appropriate to do so. As recommended by Senator Kirby, alternatives to hospitalization should be more widely available by creating affordable and supportive housing units for seniors living with mental health and/or addictions issues.

As Dr. Ross recommended, long term care facilities should have special care units with different staff ratios so they can take and care for higher-care residents, including those with mental health and addictions issues. This flexibility will free up acute care beds sooner and keep at-risk patients from Emergency Departments.

Essential supports need to be put in place for persons discharged from criminal justice programs and facilities back to the community. These should include supportive short-term housing, adequate longer term housing, home care, ready and regular access to appropriate mental health and addictions services, community outreach and intensive community support (including peer support) and medications as needed.

OBJECTIVE:
To create a seamless continuity of care with adequate transition support for persons as they move between programs and services and as they are discharged from services. Continuity of care is available in systems utilizing collaborative mental health care models.

OUTCOMES:
Persons with mental health and/or addictions issues and their families are appropriately supported during transitions between services and when discharged from treatment, leading to enhanced continuity of care, harm reduction and enhanced recovery.
RECOMMENDATIONS:

2.7-1 Implement effective plans for timely and seamless continuity of care between services and across the life-span (e.g., from youth to adult services or from adult to specialized senior services; from inpatient to community-based care). Plans for such transitions should include written discharge plans, briefing those who will provide care in the next step of treatment (family and other service providers including shelters and transition houses), case conferencing and other coordinating tasks as required.

2.7-2 Align the age of transition from youth to adult service across government departments, especially DHW and DCS.

2.7-3 Ensure the safe transition of patients who are medically cleared and discharged from Emergency Departments back into the community, when police have been involved, or when there is a lack of housing and family or natural supports for the person.
3. A Collaborative and Coordinated Approach

3.1 Collaboration and Coordination

WHAT WE HEARD:
The system needs to work more effectively across departments, care teams, between jurisdictions and among academics and clinicians that deliver, plan, research or fund some aspect of mental health and addictions treatment or support. There are too many silos. The lack of coordination makes it challenging for providers of mental health and addictions services trying to ensure they are offering the best care. Some silos are due to the way professionals are trained and their scope of practice. Some are due to the way resources are administered, even though inefficiencies are perpetuated. Others are due to the fact that a wide range of agencies, sectors and jurisdictions are involved in the lives of people who need mental health and addictions services — and the issues they deal with are complex.

Across Nova Scotia, there are examples of excellence in collaborative care from which the system can learn. These include collaborative care between mental health/addictions and primary care practices, between Mental Health Services and Addictions Services, and between Mental Health and Addictions Services and other agencies.

Having clear roles and accountabilities, guided by policies that make sense and programs that reflect them is fundamental. In the case of First Nations people living on Reserves, the jurisdictional maze is especially confusing. Federally-funded mental health services on-reserve are focused on prevention, promotion, education and short-term crisis intervention, and do not parallel or duplicate provincial mental health or addictions services. This leads to significant gaps in service delivery between hospital and home, and missed opportunities to improve access, quality and the patient experience. It is critical that the provincial and federal governments and service providers are clear on who is responsible for providing what mental health and addictions services, so that First Nations individuals needing care and support are able to get it. Military families can find themselves in a similar situation, denied services due to jurisdictional confusion over responsibilities. These barriers to care need to be removed.

Stakeholders want increased use of shared care and collaborative care to improve outcomes for individuals with mental health and addiction issues. A collaborative approach to concurrent mental health and addictions disorders is also required.

Issues identified include inefficiencies and inadequate care resulting from poor communication and coordination between and among:

1. Government departments;
2. DHAs and the IWK;
3. Various health care services;
4. The mental health and addictions services systems;
5. Teams and clinicians providing services;
6. The formal system; and

7. Services in the community.

Effective and efficient teams could maximize treatment and program effectiveness and ultimately enrich the work environment for practitioners. Staff teams in District/IWK Mental Health Services and Addictions Services will afford opportunities for case conferencing, case management, specialty consultation, interdisciplinary education/professional development, program planning, evaluation and quality assurance.

Interagency, interdisciplinary case management approaches to address the service needs of children and youth with serious behavioural and social challenges, as well as for their families, and also for persons with complex and multiple needs will bridge the gaps where too many of these people fall.

**OBJECTIVE:**
Improved communication, co-operation and continuity of services across sectors result in a collaborative approach to mental health and addictions services.

**OUTCOMES:**
Collaborative, shared care approaches to mental health and addictions services are evident within each DHA and the IWK, and involve health care providers, government (Departments of Health and Wellness, Justice, Community Services, Education) and non-government services.

**RECOMMENDATIONS:**

3.1-1 Develop and implement DHA and IWK approved guidelines for a collaborative approach to information sharing among teams of mental health and addiction service providers, as well as individuals identified by patients as supporting them in their recovery, without compromising the patient’s right to privacy and confidentiality.

3.1-2 Ensure that Mental Health and Addictions Services across the province work collaboratively with the Departments of Community Services, Education, Justice and Health and Wellness to create models of care that identify and support children and families at risk.

3.1-3 Develop a Memorandum of Understanding between DHAs and First Nation communities to clarify the responsibilities of the provincial government and federal government in order to have seamless access to necessary mental health and addictions services for First Nations communities. Strengthen relationships between DHAs/IWK and First Nation communities to build a shared understanding of mental health and addictions needs and how to address them most effectively.

3.1-4 Resolve confusion over federal and provincial health care mandates to ensure appropriate and timely mental health and addictions services are available to military families.
3.2 Person-centred and Family Inclusive

**WHAT WE HEARD:**
Persons with mental health and addictions issues must be empowered and supported to be actively engaged in their own journey to well-being. By definition, the recovery process is self-directed by the individual toward his or her own goals.

“I was diagnosed with schizophrenia in my second year of university. An honours student with hopes of a medical career, I was suddenly defined by my illness. I was not offered much hope or help from the provincial health care system. Instead I was offered a referral to community services for income assistance and a small, less than desirable apartment. My life was to be reduced to one of isolation, poverty, discrimination and illness.

“The healthcare system was satisfied to send me back to my family, who knew nothing about schizophrenia, without support or a discharge plan in place. Rehabilitation and recovery were never discussed and I was ready to accept my new reality. I was too sick to fight for myself.

“My family however had different plans and stepped in to educate themselves, advocate and support me in my journey to recovery. They firmly believed in recovery and could always see me not just my illness. To get my life back on track became a priority for them and with their help I got the medical care I needed and have now completed my education. I have a wonderful full-time job, a bright future and good mental health despite having a mental illness.

“In a perfect world everyone diagnosed with a serious mental illness will receive early intervention, treatment and rehabilitation and be given support and hope. I cannot understate the importance of my family and the need for family to be supported in their efforts.”

Stakeholders reported that within the formal system of health care, family members are sometimes prevented from playing a role in the care of persons with mental illness and/or addictions issues. The definition of “family” is based on the patient’s concept of family.

Stakeholders supported an approach that includes family and natural supports. It should be acknowledged, however, that in some circumstances this is either impossible or inappropriate.

Stakeholders also identified the importance of respite care being available to support caregivers. Caregivers take on an enormous burden and often put themselves at greater risk for developing health concerns related to the stress of doing so. Providing more support for caregivers could reduce the stress-related issues they often experience, and thereby reduce the burden on the health care system.

The non-profit and volunteer sectors support the mental health and addictions system and help build capacity in a cost-effective way. They, in turn, require the support of government and the community. Volunteer groups could help provide peer support initiatives, education programs, family group initiatives and self-help programs. Quality assurance could come through the development of certification and accreditation processes for self-help and peer support programs.
Case management offers a person-centred approach when the individual’s needs encompass many services and cross many agencies. A case manager coordinates services for mental health/addictions/justice clients, and is responsible for the assessment of need and implementation of care plans.

Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s holistic needs. It is implemented for individuals who require support in areas such as housing, mental health, justice, addictions, employment, social relationships, and community participation.

Care plans are developed in collaboration with clients and reflect their choices and preferences. The goal is to empower the client and ensure she or he is involved in all aspects of the planning and service arrangements.

The case management approach assumes that clients with complex and multiple needs will access services seamlessly from a range of service providers. Case management is described as a boundary spanning process to ensure service provision is client rather than organizationally driven.

**OBJECTIVE:**

A person-centred system of care that respects the privacy and confidentiality of the individual with mental health and/or addictions issues, and which takes into account the roles of family members and natural supports in caring for individuals.

**OUTCOMES:**

A common understanding of person-centered and family-inclusive care among providers, individuals and families should result in:

- Increased engagement of the person in treatment, increased self-empowerment and self-care.
- Flexible service models that integrate families and identified supports into care and development of communities as integral to wellness.

**RECOMMENDATION:**

3.2-1 Develop and implement province-wide person-centered and family-inclusive approaches to mental health and addiction services.
3.3 Collaboration between Mental Health and Addictions

WHAT WE HEARD:
For a number of years, there have been claims that the incidence and prevalence of co-occurring disorders is very high. This claim has become widely accepted and has contributed, at least in part, to a push for integration of Mental Health Services and Addictions Services. Evidence in the supporting document “Epidemiological and Demographic Analysis” (p.28) presents a slightly different perspective. (Note: Supporting documents are available from the Nova Scotia Health Research Foundation.)

As important as the epidemiologic data are for drawing attention to the overlap between mental disorders and substance use disorders in the general population, it should also be recognized that most people with substance use problems do not have co-occurring mental disorders, and vice versa. The significant, but not overwhelming, degree of overlap cautions us to maintain a focus, as appropriate, on the large majority of people presenting with single disorders.

It is also important to note that the rates of overlap in some subgroups are indeed substantial. For example, close to one-third of female illicit drug users met criteria for a co-occurring mood or anxiety disorder. But overall rates of co-occurring disorders in the general population are much lower than what has been observed in clinical populations.

It is essential to ensure that individuals impacted by concurrent mental health and addictions disorders and their families have timely access to quality collaborative care along a continuum of services and supports that best match their needs.

The Department of Health and Wellness is currently developing standards of care for concurrent disorders and these should be implemented.

RECOMMENDATIONS:

3.3-1 Prior to proceeding with any amalgamation of Mental Health Services and Addictions Services, an interdepartmental team should identify and critically appraise evidence pertaining to the need for integration at both the service and system level.

3.3-2 Promote the physical co-location of Mental Health and Addictions Services where feasible. Joint collaborative approaches to care should be undertaken.

3.3-3 Develop shared protocols and policies aimed at coordinating mental health and addictions services. These protocols should consider the following:

- A single access point for information on mental health and addictions for service providers and the general public;
- A coordinated intake and assessment process that uses common tools;
• Common data base and/or the ability to share information about patients across service providers;

• Boundary spanning positions (e.g., navigators, formal liaisons, case managers);

• A framework for evaluation that uses service indicators that measure success of collaborative interventions for concurrent disorders;

• Manage concurrent disorders by early identification and use of interventions that integrate mental health and addiction care;

• Develop expertise in management of concurrent disorders and ensure availability of such services across the province;

• Cross-train mental health and addictions services clinicians to promote a common understanding of both addictions and mental health;

• Ensure all clients are screened for mental health and addictions issues; and

• Support capacity building across the province with a Concurrent Disorders Network.

### 3.4 Collaboration with Primary Care

**WHAT WE HEARD:**
Collaborative mental health care and shared mental health care models have been developed, studied and documented in joint reports of the Canadian Psychiatric Association and the College of Family Physicians of Canada. This model of care is a required experience for psychiatry residency training programs accredited by the Royal College of Physicians and Surgeons of Canada. Some Nova Scotia communities approximate this degree of collaboration in some aspects of mental health care. It appears to be an excellent model to strengthen ties between primary care, mental health and addictions services.

The collaborative mental health and addictions primary health care model should include:

• Adoption of the principles of collaborative care as outlined in the literature.

• Effective methods for ongoing communication among providers and service recipients.

• Consultation based in collaborative mental health care approaches whereby:

  a) psychiatrists and other mental health/addictions professionals provide advice, guidance and follow-up to primary care providers to support care of individuals and families while sharing ongoing responsibility for care, and

  b) family physicians provide advice on the management of medical conditions in individuals with mental health and/or addiction problems.

• Coordination of care plans (including discharge plans) and clinical activities.
• Access to brief psychological therapies including motivational interviewing.

• Inter-professional educational programs including skill enhancement programs for primary care providers.

• Defined competencies (role clarity) and protocols.

When screening for mental health issues and illness becomes a routine practice in primary health care, early intervention and improved outcomes can be expected to follow. Routine screening is particularly important for people at high risk, such as those with chronic physical illnesses and physical disabilities. To put this in practice, educational initiatives for primary care physicians and other primary care providers will be needed.

Strong interdepartmental collaboration between the academic and practitioner communities is a way to enhance and support clinical activities, enrich teaching programs and generate collaborative research projects. This could include engaging academic departments to find ways of initiating and supporting outreach activities by psychiatrists to primary care providers and underserved communities (as has been the case by Child/Youth Psychiatry through Dalhousie University).

Family and emergency physicians play key roles in the management of mental health, physical health and addictions issues in community-based and institutional settings. Other providers of primary health care (e.g.: pharmacists, nurse practitioners, and family practice nurses), social workers, counsellors, psychologists, dentists, dental hygienists, law enforcement officials, first responders, legal aid providers and community based groups that deal with the public contribute to the management of issues related to mental health and addictions, and would benefit from collaborative linkages within the system of health care.

OBJECTIVE:
To create a collaborative care system where the appropriate care is given by the appropriate person at the appropriate place and time.

RECOMMENDATION:

3.4-1 Encourage greater uptake of the shared care model of collaborative mental health and addictions care. This could be supported by the establishment of a provincial Collaborative Care Network to share experiences around existing successful models in urban and rural environments, to support knowledge exchange and to partner with universities for evaluation of projects.
3.5 Privacy and Confidentiality

WHAT WE HEARD:
Greater clarity regarding the application of privacy and confidentiality in health care is urgently needed as it relates to collaboration and information sharing. Clear understanding is essential to ensure opportunities for co-operation, collaboration, and coordination of appropriate services can occur within the context of the Personal Health Information Act and the development of electronic health records.

The Province should take the lead in public education that ensures persons with mental illness and their families understand they have the ability to appoint substitute decision makers and make advance directives.

The development of standardized, transparent procedures to allow information-sharing between government departments (Departments of Health and Wellness, Education, Justice, and Community Services) should also be actively pursued.

OBJECTIVE:
To balance the right to privacy and confidentiality within collaborative care practices by addressing barriers to the effective communication of health information including legal and legislated protections.

OUTCOMES:
Effective information exchange among care providers, individuals and families that enhance a person-centered, family-inclusive approach to mental health and addictions care, while maintaining and respecting the individual’s right to privacy and confidentiality.

RECOMMENDATION:
3.5-1 Develop and implement a standard Authorization for Release of Confidential Information for use across the province for mental health and addictions services. Clarify its appropriate use for all staff (clinical, support and clerical) to ensure it is universally accepted and consistently applied across all DHAs and the IWK. In addition, develop a provincial policy that accommodates privacy and confidentiality of the individual within family-based, collaborative/shared care approaches. This should include clear direction for information sharing and exceptions. Also clarify the privacy and confidentiality guidelines as they relate to specific populations such as youth and seniors.

In standardizing the Authorization for Release of Confidential Information, consideration must be given to the following:

- Adopt consistent rules and guidelines, terminology and understanding of consent and liability, to address liability concerns among some professionals and professional organizations and governing bodies;

- Ensure there is clarity for individuals about what will be done with their information;
• Avoid duplication of assessment services (where the same questions are asked repeatedly);

• Incorporate existing privacy and confidentiality guidelines. For an example, refer to the new guidelines established in Capital District Health Authority (CDHA);

• Provide education and training about privacy and confidentiality for the public, health care service providers, and persons with mental health and addictions issues. Education and training should include clear and specific examples to users regarding situations when information can and cannot be released and to whom;

• Explore how privacy and confidentiality policies impact collaborative care and shared care initiatives;

• Review and revise relevant legislation to facilitate information sharing and standardization of formats; e.g., inclusion of the definitions of Circle of Care and collaborative care (see CDHA model) and provision to include allied professionals from other government departments in the Circle of Care. (Circle of Care includes individuals who are identified by the person living with mental illness and/or addictions to provide practical, caring, and emotional support, and includes parents/guardians of children).
4. Sustainability

4.1 Human Resource Issues and Care Provider Support

WHAT WE HEARD:
The health care system in general, and the mental health and addictions systems in particular, are only as strong as the people who work in it. They need to be supported, their health and safety must be assured and they should be provided with access to ongoing training and education.

In order to have a sustainable mental health and addictions system, recruitment of new staff as well as education and supports for current staff is essential. Creative, new efforts are necessary to attract and retain care providers across the province, to anticipate and plan for future attrition among service providers, and to attract people from diverse and under-represented groups into the mental health care and addictions treatment sectors.

Current data and information are insufficient to support adequate human resource planning for mental health and addictions services. There appears to be a perception of lack of transparency in human resource planning. Rural areas experience challenges in recruitment of health professionals.

OBJECTIVES:

- To create a sufficiently resourced and representative mental health and addictions system with a human resource plan that ensures service needs can be met throughout the province.

- To ensure the system is supportive of service providers and that health human resources are sufficient for provincial mental health and addictions standards to be met.

OUTCOMES:
The expected and desired outcomes are:

- More students in the health professions (including nurses, social workers, primary care workers, psychologists and psychiatrists) will be encouraged to seek placements in rural areas and have experience serving diverse and marginalized communities.

- Sufficient numbers of well-qualified professionals will be employed within the mental health and addictions systems in rural and urban areas to meet Mental Health and Addiction standards.
• Well-qualified professionals and support staff will be retained within all areas of the province.

• The numbers of care providers and professionals from diverse groups will increase.

**RECOMMENDATION:**

4.1-1 Focus efforts on recruitment of mental health and addictions professionals from diverse communities and for work in rural areas.
5. Accountability

5.1 Accountability and Evaluation

**WHAT WE HEARD:**
Accountability for services and supports delivered, and for funding received, is a key component in the mental health and addictions systems. Accountable parties must know their roles and responsibilities, set performance expectations and achieve their stated and measured outcomes. Organizations and professionals must be accountable for the services and supports they provide. There must be transparent ways for all stakeholders to identify and address challenges and problems in the system.

Knowing how well the system is performing, and how it can be improved, requires access to the right information. Nova Scotia’s health care system is behind the times when it comes to the efficient, reliable and timely collection and sharing of information. The current information systems in place to collect data, measure outcomes, and evaluate interventions are inadequate for mental health and addictions services uses a different system altogether. This compromises the quality of policy development, program planning and service delivery to clients. It can result in missed opportunities for system improvements, lost time and wasted money. There can be breakdown in communications that disrupts care and sometimes prevents people from getting services at all.

Health informatics-based approaches will ensure that services are meeting the needs of all Nova Scotians. The collection of expanded demographic, social and ethnic data on provincial health records is necessary to ensure that efforts to reform and improve the system are working to reduce health inequities and discrimination where they exist. Linkages to population epidemiologic health data and administrative health records through individual health cards (where respondents have given permission) may offer a rich source of data on the population.

Knowledge transfer and translation from scientific research to practice is often inconsistent and delayed. Expansion of capacity and opportunities for applied clinical research in addictions and mental health would be appropriate. Involvement in clinical research increases an organization’s capacity for knowledge translation (e.g., identifying knowledge best suited to one’s own context and for adapting evidence to one’s own context).

Service provider expertise in some areas of practice is inconsistent and core competency standards do not exist. Professional development and clinical supervision and mentoring are inconsistently supported. The utilization of best/wise and evidence-based practices must be ensured, while supporting the use of promising, new practices.

Scientific research, knowledge exchange and evaluation need to be integrated into practice to create a culture where research and evaluation become an integral aspect of service delivery. The capacity and opportunities for applied clinical research in addictions and mental health should be expanded. Research partnerships should be created with universities, academics, and stakeholders.

To guide curriculum development in related university and college-based programs, core therapeutic evidence-based approaches commonly used in prevention and treatment of mental health and addictions
should be identified. In collaboration with universities and the community college, core competency training should be included in all relevant programs. Over time, this will decrease the need for provincially-organized training.

Specialty service networks provide an avenue for province-wide collaboration, knowledge and best/wise practices transfer. Sufficient resources are required to ensure participation by each DHA and IWK in specialty services networks including, but not limited to:

- Autistic Spectrum Disorder (ASD)
- Eating Disorders
- Early Psychosis
- Seniors Mental Health and Addictions
- Sexually Aggressive Youth
- Neuro-developmental Disorders
- Concurrent disorders
- Diverse populations
- Addictions
- Collaborative care
- Reproductive Mental Health.

Importantly, persons with lived experience of mental health and/or addictions issues have much to offer as active participants in the design, implementation and evaluation of comprehensive mental health and addictions systems. The inclusion of these persons on this Advisory Committee and on previous planning committees is applauded.

**OBJECTIVE:**
To create a mental health and addictions system that is accountable to the public, informed and guided by integrated, reliable and valid data measured within an information system that is standardized across the province and in which staff are appropriately trained and competent. There is consistent and timely knowledge transfer and translation from research to practice and these practices are based on scientific evidence or where this is lacking, on best practice or wise and promising practices.

People with a lived experience of mental health and/or addictions issues actively participate in the design, implementation and evaluation of the comprehensive mental health and addictions system.
OUTCOMES:
There is:

• Province-wide use of a standardized information system that is reliable, valid, consistently applied, and appropriately supported to collect data, measure outcomes, and quality of care indicators in mental health and addictions services. There is consistent use and evaluation of reliable data to monitor compliance with mental health and addictions standards.

• Use of health informatics to facilitate linkages between service provision, administrative and management systems, financial decision-making and epidemiologic data systems that inform policy.

• An accountable system with well-trained and supported service providers, including providers from diverse communities, utilizing interventions based on scientific evidence and best practices, and informed by persons with lived experience.

• An interdepartmental accountability system to evaluate the integration and coordination of mental health and addictions services with housing, employment support, community and social services, transportation and other required services.

RECOMMENDATIONS:

5.1-1 Develop a consistent system to monitor compliance with mental health and addictions standards, and for regular evaluation of the effectiveness of mental health and addiction programs and services.

5.1-2 Implement standardized information systems across all DHAs and the IWK. These systems — or system — should capture data on clinical activities and health outcomes, improve linkages between health services data and financial management information, and collect data on key indicators such as recovery, wellness, and quality of life.

5.1-3 Expand and integrate research and knowledge exchange and evaluation, ensuring utilization of wise/best practices and scientific evidence-based therapeutic approaches across the system.

5.1-4 Develop core competency standards, along with province-wide, mandatory, targeted and funded professional education for existing and new mental health and addictions services clinicians. An environment of continuous learning should be created by strengthening the role of education, clinical supervision and funding of professional development.
Conclusion

This report and recommendations reflect what the Advisory Committee heard and learned through consultation and by considering the best evidence available. Our report and its recommendations will not be universally embraced or applauded. It is understood that those who contribute to these kinds of fact-finding missions have, in many cases, experienced the weaknesses of the system. Few come forward to laud its strengths or give credit for the excellent work that goes on in the system now. The report and recommendations are faithful to those who came forward to tell of their experiences. It is based on the evidence of what approaches are most likely to be successful, and builds on significant areas of work that are underway — some of which began while our Advisory Committee was still deliberating.

This report comes at a time when the government of Nova Scotia — as is the case with most governments in this challenging economic climate — is wrestling with serious financial issues. Nova Scotians expect that government will invest wisely and bring spending under control in order to ensure the province’s debt does not overwhelm us or our children. A strong case can be made for investment in mental health services and addiction treatment. This investment and management of services is intended to relieve the suffering and financial toll that thousands of Nova Scotians, their families and communities face as a result of mental illness and addiction.

Some things that we recommend will certainly require more money. Others challenge us to work in different ways. Better communication, more effective coordination, breaking down silos, streamlining processes and using distance-based technologies are a few examples.

Health promotion, early intervention and treatment will reduce the overall social and economic costs the province currently bears from untreated and under-treated mental illness and addictions.

We end our report with a caution: Nova Scotia cannot afford the cost of not acting on our recommendations. The current and future well-being of all Nova Scotians and our communities is at stake.
Mental Health and Addictions Strategy Advisory Committee

Co-Chairs

Michael Ungar, PhD (Halifax), has been a social worker and family therapist for more than 25 years, working with children and families in child welfare, mental health, educational and correctional settings. As a professor at the School of Social Work at Dalhousie University in Halifax, he leads an international team of resilience researchers that spans more than a dozen countries on six continents. In addition to his research and writing interests, he maintains a small family therapy practice and participates in a committee working on a national mental health strategy.

Joyce McDonald (Truro) worked for the Colchester East Hants branch of the Canadian Mental Health Association for 24 years, including as Executive Director. She has a background in psychiatric nursing and is working as patient rights advisor for the Empowerment Connection. She has developed supportive housing programs, social and recreational programs, employment programs and peer led groups.

Members

Ajantha Jayabarathan, MD, FCFP (Halifax), has an innovative family medicine practice in Halifax, Nova Scotia. She is an Assistant Professor in the Faculty of Medicine at Dalhousie University. She has been a frequent contributor to local and national media on health care issues. She also co-leads the advocacy coalition, Healthynovascottians.com

Chief Frank Beazley (Halifax) was appointed to the position of Chief of Police for Halifax Regional Police in 2003. Chief Beazley joined the Halifax Police Department in 1970 and has worked in many divisions and sections during his policing career. He is a recipient of the Police Exemplary Service Medal and Queen's Golden Jubilee Medal. He is an active member of the Nova Scotia Chiefs of Police Association and the Canadian Association of Chiefs of Police (CACP).

Dr. Simon Brooks, MA, MB, ChB, FRCPsych, FRCPC (Bridgewater), is a specialist in Psychiatry and has Fellowship qualifications from both the Canadian Royal College of Physicians and Surgeons and the UK Royal College of Psychiatrists. He has been actively involved in the Canadian Psychiatric Association and has published articles on medical ethics, mental health legislation and in a number of other areas. Currently, Dr. Brooks is Chief of Psychiatry at the South Shore District Health Authority and has a small private practice in Bedford. He is also an external consultant to the Department of Health and Wellness, and a clinical assistant professor in Dalhousie’s Department of Psychiatry.

Andy Cox (Halifax) is the Mental Health Advocate with the Mental Health and Addictions Program at the IWK Health Centre. His role consists of individual advocacy, systemic advocacy, navigation of systems and community resources. Andy created the position and started in January 2004. Before the IWK, Andy worked primarily in the community educating students in schools around mental health and mental illness. He also was an employment counselor for youth with mental health disorders. He sits on various boards and committees dealing with the issues of mental health and mental illness including the board of The Mental Health Commission of Canada (MHCC).
Paul d’Entremont, BA, BEd, DES (West Pubnico), has been involved in improving French language health services for the Acadian and Francophone population of Nova Scotia since 2002. He is a founding member of Réseau Santé — Nouvelle-Écosse, and has been its Executive Director since 2003. He worked as an educator and in educational administration in the public school system in Nova Scotia for 30 years. He collaborated on many Atlantic educational projects and initiatives, especially in the field of social sciences. He has been involved in Acadian tourism product and cultural development initiatives throughout his career in his local community, provincially and at the Atlantic regional level.

Daphne Hutt-MacLeod (Eskasoni, Cape Breton) is the Director of Eskasoni Mental Health Services and the Coordinator of the Tui’kn Partnerships Case Management and Mental Wellness Teams. She has been working with Cape Breton First Nations communities for 22 years as a Psychologist, Clinical Therapist, Case Manager, Director of Mental Health, and Director of Health & Wellness. As one of five members of the well known Tui’kn Initiative/Partnership with the other four Cape Breton Unama’ki Bands, she participated in projects and committees related to the implementation of programs to address Fetal Alcohol Spectrum Disorder, Suicide Intervention, and Mental Health.

Jessica Inkpen (Halifax) is a young woman who has struggled with anorexia for many years. In 2006 she was accepted at the Nova Scotia College of Art and Design, but deferred her acceptance in order to seek treatment for her illness. Her experience with the mental health system has given her insight into many problems in the system and obstacles to treatment.

Lana MacLean, MSW, RSW (Halifax), is a member of the African Nova Scotian community and is a community leader in the area of health. She is a Halifax-based social work clinician who provides comprehensive mental health and addiction counseling to individuals, youth and families. She uses her clinical and advocacy skills to address culturally specific health needs of the African Nova Scotian community.

Cecilia McRae (Merigomish, Pictou County) is President of the Schizophrenia Society of Nova Scotia. Since 2004, she has been a member of the Creative Wellness Project and Friendship Corner in Antigonish. She has been caregiver of a family member with a mental illness since 1999.

Patti Melanson, RN (Halifax), is a community health nurse who has spent her career working with marginalized groups in Halifax. She is currently coordinator of the North End Clinic’s Mobile Outreach Street Health Program, which brings health services to homeless and street-involved persons. Previously, she was Health Services Coordinator at the Phoenix Youth Program in Halifax.

Kathleen Thompson (Halifax) is retired from a career in civil service with the Province of Nova Scotia. She is the mother of a young woman whose life is on hold as she battles an eating disorder. Her family’s involvement with Nova Scotia’s mental health system goes back more than 13 years.

Catherine M. Thurston, MA (Tidnish Bridge, Cumberland County), is a Child Psychologist. She was Director of Mental Health Services for the Cumberland Health Authority prior to her retirement in 2009. Earlier in her career, she was Director of Mental Health Services in Cumberland, Colchester/East Hants & Pictou districts under the Northern Regional Health Board, and was Psychology Department Supervisor for the Atlantic Provinces Resource Centre for the Hearing Handicapped (APSEA) in Amherst. She has published in the fields of attention deficit hyperactivity disorder and treatment of child behavior disorders, and is Co-Investigator for CIHR-funded partnership with IWK/Dalhousie University Strongest Families Program, a distance-based early intervention program for children with mild to moderate mental health disorders and their families and for women with post-partum depression.
Glossary and Terms

The following is a partial list of terms and words frequently referred to in the deliberations of the Mental Health and Addictions Strategy and Advisory Committee. Many of the terms have more than one definition depending on the source. For the purpose of this report the definitions are offered as a lens to assist the reader in understanding the Advisory Committee’s frames of reference formulating their recommendations.

Access: The ease with which individuals can connect with a service in order to obtain assistance.

Accountability: The obligation of service providers and/or their organizations to accept responsibility for their actions.

Acute Care: As a key component of the continuum of health services in Canada, acute care in a hospital based setting provides necessary treatment for a disease or severe episode of illness for a short period of time, with the goal of discharging patients as soon as they are deemed healthy and stable.

Addiction: A recurring compulsion by an individual to engage in some specific activity, despite harmful consequences to that individual’s health, mental state or social life. The term is often reserved for drug or alcohol addictions but is sometimes applied to other compulsions, such as problem gambling, impulse buying or shopping, and compulsive overeating. Many factors are suggested as causes of addiction including genetic, biological/pharmacological and social factors.

Advocacy: The act of helping people receive available services and influencing providers to improve existing services and provide new ones as the needs arise.

Assertive Community Treatment: Assertive Community Treatment (ACT) is a client-centered, recovery-oriented mental health service intended to facilitate psychosocial rehabilitation for persons who have the most serious mental illnesses and have not benefited from traditional programs (Canadian Mental Health Association of Ontario).

Assessment: A comprehensive, systematic, and frequently inter-disciplinary examination of all aspects of a person’s life including physical, medical, psychological, emotional, financial, educational, vocational, social, housing needs in order to determine a treatment plan of care. Additional information is gathered with particular emphasis on the person’s individual strengths, areas of deficiencies, and their cultural and health-related values and beliefs.

Alzheimer’s Disease: A disorder of the brain that causes a decline in cognitive functioning resulting in progressive loss of intellectual and social skills.

Alternative Medicine: Any healing practice that does not fall within the realm of conventional medicine and is based on historical or cultural traditions rather than scientific evidence (retrieved from the internet http://en.wikipedia.org/wiki/Medicine).

Best Practice: A superior method or innovative practice that contributes to the improved performance of an individual or organization that is usually recognized as “best” by peer groups or organizations. It implies accumulating and applying knowledge about what is and what is not working in different situations and contexts. It requires the continuing process of learning, feedback, reflection, and analysis.

Capacity Building: A supportive, educational process that promotes individual, community, and service provider (stakeholder) management of sustainable capabilities and competencies.

Caregivers: A broad range of individuals who provide care and support to family and friends requiring assistance due to chronic physical, mental or cognitive disabilities. Caregivers range in age from children to seniors (as defined by Caregivers NS).

Case Management: With the goal of assisting the person to achieve accessible and successful community living, a process of assessment, planning, implementation, evaluation, and advocacy is coordinated among and assigned to specific service providers to meet the individual and family’s comprehensive mental health and/or addictions service requirements.

Clinical Nurse Specialist: A registered nurse with a minimum of master’s level preparation with a high proficiency in interpersonal skills, the nursing process, and a sound knowledge of psychological, somatic, pharmacological, and milieu therapies.

Community: A social, religious, occupational, or other group sharing common characteristics or interests and perceived or perceiving itself as distinct in some respect from the larger society within which it exists.

Community Based or Community Support Systems: Service organizations developed by communities to reach those in need and as close as possible to where people live. They include but are not restricted to mental health centers, government and non-government agencies, private, voluntary, and outreach services specializing in mental health. Examples include crisis-response teams, rehabilitation services, housing, protection, and advocacy.

Circle of Support: Individuals who are identified by the person living with mental illness and/or addictions (or a guardian of children/youth or adults formally declared incompetent), to provide practical, caring, and emotional support.

Cognitive Behavior Therapy (CBT): An evidence-based psychological approach to therapy, practiced by a range of professionals that is problem focused and goal oriented, dealing with issues in the here and now. CBT helps clients to analyze their patterns of thinking, emotional reactions, and behaviors with the goal of assisting them to attempt new approaches to change existing patterns (Sheldon, Brian, 1995 and 2011).
Collaboration: An approach to working with others toward patient centered shared goals, using a process that incorporates planning, decision-making, problem solving, with an assumption of accountability and responsibility for actions that support the client/patient’s needs.

Collaborative Mental Health Care: Bound by a shared vision for the future, mental health and addiction primary care practitioners, together with the person and their self-defined network of family support work together to ensure a responsive, seamless, and timely access to the individual patient/client service needs. Successful collaboration utilizes local resources, services, and solutions and is grounded in personal and professional relationship built on mutual respect and trust, evidenced informed practices and the ability to respond to the changing needs of the patient/client. The five components of collaborative care are effective communication, consultation, coordination, co-location, and integration.

Community Outreach: Services that actively “reach out” and provide help to those who would not otherwise look for support in the community.

Concurrent Diagnosis: Refers to the co-existence of substance abuse and mental health disorders within the same person.

Core Program Standards: Core programs delivering comprehensive mental health and addictions services are characterized by the following standard aspects of care: promotion, prevention and advocacy; outpatient and outreach services; community supports; inpatient services; and specialty services.

Cross-jurisdictional: Activities that cross the boundaries of authority, particularly between provincial, federal and municipal governments.

Cultural Competence and Safety: An evolving and largely complementary framework that addresses the diverse mental health needs of people living in Canada. Service providers regardless of their cultural background are encouraged to communicate and practice in ways that respect and take into account the cultural, social, political, linguistic and spiritual realities of the people with whom they are working. Cultural safety has its origins in the indigenous experience of colonization, and draws attention to issues of power and discrimination, as well as to structural barriers that can limit access to appropriate care for people from diverse backgrounds. Approaches that build on cultural competence emphasize the necessity and urgency of addressing these vital aspects of service provision.

Culturally Diverse Populations: Like all people, individuals from culturally diverse populations have differing skills, knowledge, and values. It is important to understand people as individuals within the context of cultural competence.

While culturally diverse populations often experience barriers in accessing primary health care or feelings of exclusion in general, it cannot be assumed that all people within these groups experience the same reality. The form of exclusion experienced may not be the same across groups of people (Government of Nova Scotia).

Culturally Safe Practice: An approach that reflects the recognition that health, illness, and the meanings they hold for people are shaped by their social, cultural, family, community, historical and geographical contexts, and gender, age, ability and other personal factors. All ethnic-cultural backgrounds are respected, empowered, and safe enough that the person is able to communicate their unique realities of their situation and actively collaborates in the management all aspects of their health and well-being (Government of Manitoba).

Dementia: Dementia is a clinical state of which there are 70 to 80 different types and characterized by loss of function in multiple cognitive domains. The most commonly used criteria for diagnoses of dementia is the DSM-IV (Diagnostic and Statistical Manual for Mental Disorders, American Psychiatric Association). Diagnostic features include: memory impairment and at least one of the following: aphasia, apraxia, agnosia, disturbances in executive functioning. In addition, the cognitive impairments must be severe enough to cause impairment in a previously higher level of functioning including social and occupational.

Diversity and Diverse Needs: Diversity and diverse needs refer to the variety of ethnicity, backgrounds, experiences, and needs of an individual or circles of support that has a bearing on the person's engagement with an individual, system, or organization and the quality and effectiveness of the care or service they receive.

Dependence (Psychological): Psychological dependence occurs when a person feels he or she needs the drug to function or feel comfortable (e.g., needing to drink alcohol to feel relaxed in social situations, or needing to be high to enjoy sex). Some people come to feel they need a substance just to be able to cope with daily life.

Dependence (Physical): Physical dependence occurs when a person's body has adapted to the presence of a drug. Tolerance has developed, which means that the person needs to use more of the drug to get the same effect. When drug use stops, symptoms of withdrawal occur.

Disabilities: ‘Disabilities’ is an umbrella term, covering impairments or limitation in physical, cognitive, mental, sensory, emotional, developmental, or a combination of these reflecting an interaction between features of a person’s body and features of the society in which he or she lives (World Health Organization).

Early Intervention: Early intervention refers to specific measures undertaken for populations identified as being at risk for or already engaged in harmful behaviors or practices. Early intervention services identify and assess early signs and symptoms of mental illness, provide early intervention to prevent progression to a diagnosable illness, refer diagnosed mental illnesses for treatment and support, reduce the impact of mental illness, and foster hope for future well-being.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives, and
are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Evidence Based: Information based on the best available scientific evidence.

Families: The Mental Health Commission of Canada states that families can be made up of relatives, such as spouses, parents and siblings, or people drawn from a person’s broader circle of support, which may include extended family, close friends, health care professionals, peer support workers, and other concerned individuals.

Family Inclusive: Refers to the circle of individuals whom the patient/client defines as “family” and consents to their participation in the treatment and recovery process.

Follow-up: The maintenance of contact with or re-examination of a person (as a patient/client) usually at prescribed intervals following diagnosis or treatment.

Forensic Psychiatry: Refers to sub-specialty of psychiatry and an auxiliary science of criminology. It encompasses the interface between law and psychiatry. A forensic psychiatrist provides services such as determination of competency to stand trial to a court of law to facilitate the adjudicative process. Forensic psychiatrists evaluate an individual’s competency to stand trial where defenses are based on mental diseases or defects (e.g., the “insanity” defense) and sentencing recommendations. The two major areas of criminal evaluations in forensic psychiatry include Competency to Stand Trial (CST) and Mental State at the Time of the Offence (MSO).

Framework: A broad overview, outline, or skeleton of interlinked items which supports a particular approach to a specific objective, and serves as a guide that can be modified as required by adding or deleting items.

Health Human Resources: Addresses competency, training, and resource gaps in the provision of health service delivery.

Health Promotion and Illness Prevention: Mental health promotion aims to foster mental health in a positive way for all people in Canada, regardless of whether they are living with a mental health problem or illness. Prevention focuses to the greatest extent possible, on measures to prevent mental health problems and illnesses. Promotion and prevention efforts can both be directed at the population as a whole to prevent the development of mental health problems and illnesses. It focuses on people and communities at risk, vulnerable populations, and those with emerging problems in order to increase opportunities for early intervention, prevent the progression of a mental health problem or illness, and improve recovery. Efforts are additionally directed toward people living with mental health problems and illnesses contributing to their ability to achieve their full potential (Mental Health Commission of Canada).

Holistic: An approach that incorporates mind, body, and spirit in planning and implementing individualized care of an individual, system or community.

Holistic Recovery: Embraces all aspects of life such as housing, employment, education, mental health, healthcare treatment, and services; complementary and naturalistic services; addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person.

Hope: Recovery provides the essential and motivating message of a better future where people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process (Substance Abuse and Mental Health Services Administration, SAMHSA).

Housing First Approach: Refers to a client centered approach which holds to the belief that before someone can break the cycle of homelessness a safe and secure home, is necessary, with support services readily available.

Human Resources: A term used to describe the individuals who make up the workforce of an organization.

Human Rights: Human rights are “basic rights and freedoms that all people are entitled to regardless of nationality, sex, national or ethnic origin, race, religion, language, or other status.” Human rights are conceived as universal and egalitarian, with all people having equal rights by virtue of being human. These rights may exist as natural rights or as legal rights, in both national and international law (Wikipedia).

Individualized Care: Care that is planned to meet the particular needs of an individual patient/client, as opposed to a routine applied to all patients/clients suffering experiencing an illness or health problem.

Individuals/Persons with Disabilities: A person who may have a physical, cognitive, mental, sensory, emotional, developmental or some combination of these.

Informal Services: In economic terms, informal services refer to, “Any exchange of goods or services involving economic value between people outside the scope of ‘normal and formal’ business. With reference to healthcare, care that is performed outside of the formal system or organization may differ from the prescribed, official, or standard way and is typically provided by family and/or friends. Informal services as related to mental health and addictions could refer to any supports involving value to the person with mental illness/addictions. This type of informal care can include transportation, education, peer support, or family/friends engaged in a circle of collaborative care.

Informed Consent: A legal procedure to ensure that a patient or client knows all of the risks and costs involved in a treatment. The process of informed consent includes informing the client of the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment. In order for informed consent to be considered valid, the client must be competent and the consent should be given voluntarily.

Involuntary Treatment: The delivery of clinical treatment, usually in the context of a mental illness, to which the patient has not given consent.
Integration System/Service: The process of opening a group, community, place, or organization to all, regardless of race, ethnicity, religion, gender, or social class.

Interdisciplinary and Intersectoral: An activity that incorporates all relevant disciplines and sectors of society.

Intervention: The action or process of intervening; within healthcare intervention refers to action taken to improve a medical disorder.

Involuntary Psychiatric Treatment Act of Nova Scotia (IPTA), 2005: According to the legislation defines the conditions under which a person may be detained, assessed, and where indicated treated for mental health issues without their consent.

Knowledge Exchange: The act of closing the gap between research outcomes and information and those who use the research to inform policy, professional practice, decision-making, researchers, consumers, and service providers.

Memorandum of Understanding (MOU): An agreement to collaborate between two organizations that stipulate the expectations of each participant.

Mental Health: A state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community (World Health Organization, WHO).

Mental Health First Aid: The help provided to a person developing a mental health problem or experiencing a mental health crisis. For over four years the program has taught Canadians how to respond to mental health emergencies, enabling them to better manage potential or developing mental health problems in themselves, a family member, a friend or colleague (Mental Health Commission of Canada).

Mental Health Promotion: Building the capacity of individuals and communities to improve their mental health by collaborating with many sectors of society.

Mental Illness: Clinically significant patterns of behavior or emotions that are associated with some level of distress, suffering or impairment in one or more areas such as school, work, social and family interactions or the ability to live independently. Examples of mental illness include Major Depressive Disorder, Bipolar Disorder, Schizophrenia, and Eating Disorders (Mental Health Commission of Canada, Toward Recovery and Well-being: A Framework for a Mental Health Strategy for Canada).

Mental Health Commission Of Canada: A catalyst for transformative change whose mission is to work with stakeholders to change the attitudes of Canadians toward mental health problems and to improve services and support. Their goal is to promote mental health and assistance to those people who live with mental health problems or illness so that they may lead meaningful and productive lives.

Mental Health Court: A voluntary offender-based program for adults (persons 18 years of age and over) who have been charged with a criminal offence and have a mental disorder but are competent to participate in the criminal justice system.

Methadone Treatment Program: A best practice treatment for opiate addiction where methadone is prescribed and monitored by a physician.

Natural Support: An individual, family member, friend, clergy or any other person or group who plays a significant role in offering support to an individual living with mental health problems or mental illness. A natural support is not necessarily a part of the formal care system and is not paid for offering this support.

Navigation: A process by which an individual (the Navigator) guides persons seeking assistance through and around barriers in the health care system to help ensure timely assessment and treatment. Barriers to quality care fall into a number of categories that include: financial and economic; language and cultural; system complexities; communication; transportation; and fear.

Navigation helps ensure that person receives culturally competent care that is also: confidential, respectful, compassionate, and mindful of the patient’s safety (Oncol Issues, 2004 and Freeman, 2001).

Non-Linear Recovery: An aspect of the recovery process that involves continual growth, occasional setbacks, and learning from experience. It begins when an individual becomes aware that positive change is possible and fully engages in the work of recovery.

Non-Traditional Services: Individualized services provided to meet the needs of each client and family and includes a variety of resources including mentoring, traditional healers, alternative medicine/practices(s), sports/recreation/art/performing arts, faith and/or culture-based initiatives/programs. These non-traditional services may be administered outside of the traditional clinical setting, in community-based places such as schools.

Person-Centered Care: ‘A system where patients can move freely along a care pathway without regard to which physician, other health-care provider, institution or community resource they need at that moment in time. This system is one that would consider the individual needs of patients and treat them with respect and dignity’ (Ross report). Characteristics of person-centered care include respect for patients’ values, preferences and expressed needs; coordination and integration of care; and Information, communication, and education. Foundational to the provision of person-centered care is physical comfort; emotional support, involvement of family and friends and delivery systems that provide for caring transitions between different providers and the phases of care.

Participatory Process: A consultative process that seeks input from identified stakeholder individuals and groups in order to collect data and inform a potential strategy to address a particular issue or concern.

Patient Confidentiality: The right of an individual patient to have personal and identifiable medical information kept private; such information should be available only to the physician of record and other health care providers and will not be disclosed to others unless the patient has given informed consent.

Person- and Family-centered Care: Person- and family-centered care is an approach to the planning, delivery, and
evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families (The Institute for Patient-and Family-centered Care).

Peer: A peer is defined as a person of equal standing. In the context of providing peer support, the word peer is used in a broader sense to refer to people who share in common a mutual lived experience. In the field of mental health education peer is defined as “someone who is either a co-worker or person who works in a similar organizational background, or someone of the same generation or cultural background who has suffered the effects of mental illness.” This more precise definition takes into account the significance of a “power differential” in a relationship in attempting to achieve the emotional resonance required to successfully transmit the understanding that people suffering from mental illnesses are “just like you and me.”

Peer Support: Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another’s situation empathetically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are ‘like’ them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to ‘be’ with each other without the constraints of traditional (expert/patient) relationships (Mead, 2001).

Peer Based Services: Informal peer support has always been provided by friends, family and peers. Formal peer support services have been provided by grassroots community organizations and groups in Victoria for more than 30 years. Over the last 10 years, however, the sharing of lived experience has been increasingly recognized as an integral, complementary part of the recovery journey in mental health. Formal recognition has led to increasing numbers of paid peer support roles and a diverse range of terminology, services, activities, practices, protocols, research and resources. These have been developed by individuals, community and special interest groups, health professionals, government departments and support agencies, all aiming to harness the power of peer support for consumers of mental health services and their families/carers. Peer support services can be provided in a variety of ways including: One-on-one or in a group; by volunteers or paid employees; peer-led or facilitated by a health professional (for example, a psychologist or psychotherapist); in person, on the phone or via the internet; through workshops or social activities; and in ad hoc or ongoing formats.

Person with Lived Experience: Anyone who lives, or has lived with a mental health problem or a mental illness.

Population Health Approach: The health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations (Federal, Provincial and Territorial Advisory Committee on Population Health (ACPH), 1997).

Primary Health Care: Is based on practical, scientifically sound, and socially acceptable method and technology, universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination (WHO and UNICEF, 1978). Primary health care shifts the emphasis of health care to the people themselves and their needs, reinforcing and strengthening their own capacity to shape their lives. Hospitals and primary health centres then become only one aspect of the system in which health care is provided. As a philosophy, primary health care is based on the overlap of mutuality, social justice and equality. As a strategy, primary health care focuses on individual and community strengths (assets) and opportunities for change (needs); maximizes the involvement of the community; includes all relevant sectors but avoids duplication of services; and uses only health technologies that are accessible, acceptable, affordable and appropriate. Primary health care needs to be delivered close to the people; thus, should rely on maximum use of both lay and professional health care practitioners and includes the following eight essential components: education for the identification and prevention / control of prevailing health challenges; proper food supplies and nutrition; adequate supply of safe water and basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases using appropriate technology; promotion of mental, emotional and spiritual health; provision of essential drugs (WHO and UNICEF, 1978). The greatest difference between primary care and primary health care is that primary health care is fully participatory and as such involves the community in all aspects of health and its subsequent action (Anderson & MacFarlane, 2000; Wass, 2000; WHO, 1999).

Promising Practices: A program, activity or strategy that has worked within one organization and shows promise during its early stages for becoming a best practice with long term sustainable impact. A promising practice must have some objective basis for claiming effectiveness and must have the potential for replication among other organizations.

Protective Factors: Individual or environmental safeguards that prevent or reduce vulnerability (e.g. availability of social support; healthy methods of coping with stress); increase chances of positive results; protect people from risk factors.

Problematic Substance Use: Reflects potentially risky levels of alcohol or other drug use.

Provincial Mental Health Standards: A set of systemic and legislated requirements for the delivery of mental health services. These standards are intended to provide guidance for quality service delivery and reduce variations across the province, while maintaining flexibility to adapt approaches to unique district, community and organization conditions. Nova Scotia has the first such set of legislated standards within the Canadian public system, implemented in 2003, revised in 2009. Numerous system stakeholders were involved in reaching consensus on standards based on the best available information regarding effectiveness and/or best practice, balanced by the perspective of consumers, expert practitioners and educators. Input continues to be sought and revisions are to take place every five years to keep pace with best practice evidence.
Psychiatrist: A medical doctor trained and qualified in the area of psychiatry and mental health care.

Psychologist: A self-regulated professional trained to assess and diagnose, and treat problems in thinking, feeling and behaving using a variety of approaches directed toward the maintenance and enhancement of physical, intellectual, emotional, social and interpersonal functioning. Psychologists may work with individuals (child, youth, adult), families, couples or organizations.

Psychological Health: Our ability to think, feel and behave in a manner that enables us to perform effectively at work, at home, and in society at large.

Psychological Safety: "Psychological safety describes the individuals' perceptions about the consequences of interpersonal risk in their work environment. It consists of taken-for-granted beliefs about how others will respond when one puts oneself on the line, such as by asking a question, seeking feedback, reporting a mistake, or proposing a new idea. One weighs each potential action against a particular interpersonal climate, as in, "If I do this here, will I be hurt, embarrassed or criticized?” An action that might be unthinkable in one work group can be readily taken in another, due to different beliefs about probable interpersonal consequences” (Health Force Ontario, Edmondson).

Psychosis: A category of health problems that are distinguished by regressive behavior, personality disintegration, reduced level of awareness, great difficulty in functioning adequately, and gross impairment in reality testing.

Psychosocial Rehabilitation: A process that promotes personal recovery, successful community integration and satisfactory quality of life for persons affected by mental health and/or addictions issues.

Planning, Evaluation, Monitoring: Processes to ensure proper accountability for policies and programs. This may include standardized data collection systems, provincial quality improvement mechanisms, and appropriate governance and reporting structures.

Resilience: The ability to thrive, mature and increase competence, even when faced with negative circumstances or risk factors; ability to bounce back from stressful events and move forward.

Recovery Oriented System: Emphasizes self-determination and self-management by those with lived experience of mental health problems and illness. The fundamental underpinning of a recovery-oriented approach is hope and the key values are respect, dignity, and choice.

Recovery: A deeply personal and individual process in which people living with mental health problems and illnesses are empowered and supported to be actively engaged in their own journey of well-being. Recovery builds on individual, family, cultural, and community strengths and enables people to enjoy a meaningful life in their community while striving to achieve their full potential. Recovery does not necessarily mean 'cure', although it does acknowledge that 'cure' is possible for many people. The principles of recovery include hope, empowerment, self-determination and responsibility. Although relevant to anyone experiencing mental health problems or illnesses they must be adapted to the individual's realities across the lifespan (World Health Organization).

There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Recreational Therapist: A clinician who provides recreation activities to individuals with illnesses or disabling conditions to improve or maintain physical, mental and emotional well-being.

Registered Nurse: Self-regulated health-care professionals who work autonomously and in collaboration with others. RNs enable individuals, families, groups, communities and populations to achieve their optimal level of health. RNs coordinate health care, deliver direct services and support clients in their self-care decisions and actions in situations of health, illness, injury and disability in all stages of life. RNs contribute to the health-care system through their work in direct practice, education, administration, research and policy in a wide array of settings.

Rehabilitation: Psychosocial rehabilitation (also termed psychiatric rehabilitation, or PSR) promotes personal recovery, successful community integration and satisfactory quality of life for persons who have a mental illness or mental health concern. Psychosocial rehabilitation services and supports are collaborative, person directed, and individualized, and an essential element of the human services spectrum. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice and include a wide continuum of services and supports (Psychosocial Rehabilitation Canada).

Relapse: In the course of illness, relapse may occur when symptoms return after a period of time following a period of being symptom free (Encyclopedia of Mental Disorders, retrieved from the internet: http://www.minddisorders.com/Py-Z/Relapse-and-relapse-prevention.html).

Respect: An attitude in a relationship that conveys caring, valuing and acceptance of an individual without qualification, discrimination, or stigma. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Respite: Respite literally means a period of rest or relief. Respite care provides a caregiver temporary relief from the responsibilities of caring for individuals with chronic physical or mental disabilities. Respite care is often referred to as a gift of time.

Respite Care: The provision of short-term, temporary relief to those who are caring for family members who might otherwise require permanent placement in a facility outside the home.

Responsibility: The action of consumers participating in their own self-care and journey of recovery where taking steps towards achieving their goals may require great courage. Consumers assume responsibility when they understand and give
meaning to their lived experiences and identify coping strategies and healing processes to promote their own wellness.

**Risk Factors:** Individual or environmental factors that increase the likelihood of negative results linked to diseases, illness or injury; can be cumulative, increasing the harmful effect (e.g. social isolation or low economic status).

**Self-Direction:** The ability of the consumers to participate in and exercise control determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

**Self-stigma:** Occurs when people with mental health problems or mental illness internalize negative attitudes about their own condition potentially leading to embarrassment that can cause them to hide the symptoms or avoid treatment.

**Service Delivery:** The process that engages the client/patient in a collaborative process of care delivery, utilizing a range of approaches and services that may include assessment, treatment, evaluation, discharge planning, follow-up and community support.

**Service Level Integration:** The active management of all elements of the continuum of health and care services required by individuals and communities in order to achieve a seamless care pathway for the individual or client group (adapted from: NHS, Dept. of Health, 2001).

**Severe Persistent Mental Illness (SPMI):** A psychiatric diagnosis found in Diagnostic Statistical Manual (DSM-IV-TR 2000). It refers to those with a disability in one or more of the life domains such as social relationships, independent living, employment and duration, defined by an extended period of time receiving intensive mental health services such as hospitalization or supervised group living (Schinnar, Rothbard, Kanter, & Jung, 1990).

**Shared Mental Health Care:** Shared mental health care is a process of collaboration between the family physician and the psychiatrist that enables responsibilities for care to be apportioned according to the treatment needs of the patient at different points in time in the course of a mental health problem and the respective skills of the psychiatrist and the family physician (CFPC-CPA joint position paper on Shared Mental Health Care in Canada, 1997).

**Social Determinants of Health:** Key factors affecting people’s health including income and social status, social support networks, education and literacy, employment and working conditions, physical and social environments, biology and genetics, personal health practices and coping skills, healthy child development, health services, gender or culture.

**Social Marketing:** The planned, systematic application of researched and well-designed media initiatives that target specific issues, population segments, forms of knowledge or belief, and that aim to influence attitudes or intentions, or individual and cultural norms and behaviors. Social marketing approaches may be used to promote health and well-being, or to ameliorate health-related problems, or to reduce risks and harms.

**Social Inclusion:** A socially inclusive approach includes recovery-oriented practice, an emphasis on social outcomes and participation, and attention to the rights of people with mental ill health, as well as to citizenship, equality and justice, and stigma and discrimination (Royal College of Psychiatrists).

**Social Worker:** Professionals who promote social change, problem-solve in human relationships, and promote the empowerment and liberation of people to enhance the well-being of individuals and groups. Utilizing theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work (International Federation of Social Workers).

**Standards:** A standard is an agreed upon, repeatable way of doing something. It is a document containing criteria designed to be used consistently as a rule, guideline, or definition. Standards help to make life simpler and to increase the reliability and the effectiveness of service provision. Standards are created by bringing together the experience and expertise of all interested parties such as the individual, family and the community to facilitate participation in decision making, planning, evaluation and the delivery of mental health care.

**Strengths-based Recovery:** An approach that focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave behind life roles that are no longer effective and engage in new life roles and ways of being. In this way, the process of recovery moves forward through interaction with others in supportive and trust-based relationships.

**Stakeholder:** An individual or group having a significant interest in a specific area of concern that is currently under active study or consideration.

**Standard:** A document, established by consensus and approved by a recognized body that provides, for common and repeated use, rules, guidelines or characteristics for activities or their results, aimed at the achievement of the optimum degree of order in a given context (ISO/IEC Guide 2, Clause 3.2).

**Stigma:** Negative judgment, attitude or value based on a personal trait (e.g. mental health problem or illness) promotes prejudice and discrimination.

**Strengthening Local Identities:** The activity promotes and strengthens a sense of belonging and self-reliance.

**Substance Abuse/Use:** Overindulgence in or dependence on an addictive substance, especially alcohol or drugs.

**Supported Housing:** Supportive housing is housing that is safe, secure, and affordable. It is not treatment, but allows the individual to focus on recovery. Levels of support should vary and range from live in 24/7 support that assists with meals, organization and day to day concerns. The other end of supported housing spectrum is to provide consistent supports that are not live in, but rather those on as needed basis and assist with appointments, crisis management and maintain routine and wellness. Supported housing offers opportunity for individuals to grow and realize their potential and gain independence.
**Sustainability:** The capacity to endure. For humans, sustainability is the long-term maintenance of well being, which has environmental, economic, and social dimensions, and encompasses the concept of stewardship, the responsible management of resource use (Wikipedia).

**System Level Integration:** Multiple systems, such as justice, child welfare, mental health, medicine and other services working together in ways that make transitions between services seamless for the people using them.

**Tele-psychiatry:** The practice of psychiatry from a long range distance, facilitated by the use of technology such as telephone conferencing, video conferencing, and the internet.

**Transitional Care:** A comprehensive plan of care that includes a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or levels of care within a system.

**Treatment:** The management and care of a person or the combating of disease, disorder, issue or addiction.

**Voluntary Treatment:** Voluntary treatment occurs when a person willingly consents to engage in treatment for an existing problem or issue such as a mental health and/or addiction.

**Wellness:** The optimal state of health for individuals and groups; there are two focal concerns: the realization of the fullest potential of the individual physically, psychologically, socially, spiritually and economically and the fulfillment of one’s role expectations in the family, community, place or worship, workplace and other settings (Nutbeam, 1986).

**Wise Practices:** Actions, tools, principles or decisions that contribute significantly to the achievement of environmentally sustainable, socially equitable, culturally appropriate, and economically sound development.

**Withdrawal Management:** A medial protocol established to assist client to detox from substance use (drugs, alcohol or gambling) in a staff clinical environment.

**Woman-centered Care:** A philosophy of care within the overall health care system that gives priority to the wishes and needs of the user, and emphasizes the importance of informed choice, continuity of care, user involvement, clinical effectiveness, responsiveness, accessibility, policy and program development and design. The fundamental principles of woman-centered care focus on the women’s changing health care needs across the lifespan. This philosophy considers the cultural and political construct of women’s lives, and acknowledges how women have historically valued women’s-only programs to meet and create a safe place for wellness.

**Youth:** The Government of Canada has extended the age definition of youth for several of its programs as the implications of delayed youth transitions were considered in policy development. In 2006-07, the Policy Research Initiative (PRI) initiated several studies, 4 examining youth transitioning, particularly for at-risk youth, on provincial and federal youth policies and practices across the country. The areas of focus, employment, education and marriage and parenthood, align with the core youth transition areas.

**Youth:** The United Nations defines youth as being between the ages of 15 and 24 years. The age definition of when someone is legally deemed an adult varies amongst countries but tends to align with the legal age of majority usually at 18 or 21 years. However, internationally more and more countries are extending the age limits for youth in their government services into the mid-20s or early 30s.

**Glossary References**


Appendix A: Terms of Reference

Purpose

The Mental Health Strategy Advisory Committee will provide advice and guidance in the approach and development of the mental health strategy for the province.

Mandate

The Advisory Committee will provide advice to the Nova Scotia Health Research Foundation (NSHRF) on the following:

- The proposed approach to the development of a mental health strategy.
- Evidence needed to support the development of the Strategy.
- Sources of evidence that need to be considered in the development of the Strategy.
- The consultation process and format.
- Feedback on the various iterations of the Strategy.

Decision-making

The ultimate decision-making authority rests with the Minister of Health. The Advisory Committee will provide guidance and advice to the NSHRF who will coordinate the development of the strategy.

Reporting Structure

Co-Chairs will report on the progress of the development of the Strategy to the Minister/Deputy Minister.

Membership

Membership for the Advisory Committee has been identified by the Minister of Health. Members are appointed as individuals with expertise in mental health and will not represent their individual organizations, institutions or other affiliations directly.

Tenure

Members are appointed for a duration of 12 months, or until the strategy is submitted to the Minister of Health.
Appendix B: Ottawa Charter for Health Promotion


First International Conference on Health Promotion
Ottawa, 21 November 1986 — WHO/HPR/HEP/95.1

THE FIRST INTERNATIONAL CONFERENCE ON HEALTH PROMOTION, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.

This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization’s Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

HEALTH PROMOTION
Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

PREREQUISITES FOR HEALTH
The fundamental conditions and resources for health are:

- peace,
- shelter,
- education,
- food,
- income,
- a stable eco-system,
- sustainable resources,
- social justice, and equity.

Improvement in health requires a secure foundation in these basic prerequisites.
**ADVOCATE**
Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

**ENABLE**
Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

**MEDIATE**
The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health. Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

**Health Promotion Action Means:**

**BUILD HEALTHY PUBLIC POLICY**
Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

**CREATE SUPPORTIVE ENVIRONMENTS**
Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance — to take care of each other, our communities and our natural
environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment — particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

**STRENGTHEN COMMUNITY ACTIONS**

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities — their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

**DEVELOP PERSONAL SKILLS**

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

**REORIENT HEALTH SERVICES**

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

**MOVING INTO THE FUTURE**

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have
control over one’s life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members. Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

COMMITMENT TO HEALTH PROMOTION
The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

CALL FOR INTERNATIONAL ACTION
The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

* Charter adopted at an international conference on health promotion.

* The move towards a new public health, November 17–21, 1986 Ottawa, Ontario, Canada

* Co-sponsored by the Canadian Public Health Association, Health and Welfare Canada, and the World Health Organization
Appendix C: Selected Works Reviewed

In preparation of this document a plethora of information was reviewed by the Advisory Committee. Sources of information include peer reviewed literature, gray literature, government reports and legislative documents. The list of references below provides a selection of works used to support the Advisory Committee’s work.


Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978


Finding hope in the words and support of those who have lived with mental illness: BRINGING THE PEER PROJECT TO LIFE-THE ROAD TO SUSTAINABILITY. Mental Health Commission of Canada. Aug 2011 draft


Guidelines for comprehensive mental health services for older adults in Canada, Mental Health Commission of Canada, 2011


Roberts, G. & Grimes, K. Return on Investment: Mental Health Promotion and Mental Illness Prevention, Canadian Policy Network at the University of Western Ontario March 2011

Shared Mental health Care in Canada. 2000, College of Family Physicians of Canada and Canadian Psychiatric Association. 3.1 7

The Canadian Centre on Substance Abuse (CCSA)(2006). The Costs of Substance Abuse in Canada 2002,


WHO. Key components of a well functioning health system. May 2010


Consultations

The Advisory Committee consulted with over 100 individuals, groups and organizations representing more than 1,200 Nova Scotians.

In addition to these consultations, the Advisory Committee received written submissions and had information meetings with a variety of stakeholders. All of the information provided through the consultations, written submissions and information meetings was considered by the Advisory Committee in the development of their recommendations.

The following is a list of the individuals, groups and organizations that participated in the formal consultations.

- Allied community members who work with members of the African Nova Scotian community
- East Coast Forensic Hospital
- Acadia University
- Nova Scotia Legal Aid
- Nova Scotia Disabled Persons Commission
- Canadian Federation of Mental Health Nurses
- QEII Eating Disorder Team
- Health Association Nova Scotia
- Halifax Chamber of Commerce
- Nova Scotia Early Psychosis Program
- Pictou County Health Authority
- Guysborough Antigonish Strait Health Authority
- Cumberland Health Authority
- Cape Breton University
- Nova Scotia School Boards Association
- Chiefs of Police
- St. Francis Xavier University
- Colchester East Hants Health Authority
- Specialty Mental Health Services
- Schizophrenia Society
- IWK Health Centre
- Halifax Military Family Resource Center
- Saint Mary’s University
- Mount Saint Vincent University
- Chiefs of Psychiatry of the district health authorities
- DHW Directors, Mental Health Planning Group
- Association of Psychologists of Nova Scotia
- Department of Community Services
• Transgender Group
• Contemplative Practices in Mental Health Care
• Physical Activity, Sport and Recreation
• Nova Scotia Department of Health and Wellness
• Self Help Connection
• Direction 180
• Nova Scotia Residential Agencies
• Affirmative Industries
• Celtic Community Homes
• Annapolis Valley Health
• Metro Community Housing
• Family and Caregivers Group
• Workers Compensation Board
• Graduate Class, School of Social Work, Dalhousie University
• Provincial Suicide Prevention Strategy
• President and VPs, Dalhousie University
• School of Social Work, Dalhousie University
• Nova Scotia Health Boards
• First Voice
• Cape Breton District Health Authority
• South West Nova District Health Authority
• Alzheimer’s Society
• Seniors Mental Health Team, CDHA
• Directors of Addiction Services, DHW
• Service Provider Consult — Yarmouth
• Service Provider Consult — Dartmouth
• Public Consult — Greenwood
• Connections Halifax
• Service Provider — Truro
• School of Occupational Therapy, Dalhousie University
• Public Consult — Amherst
• Public Consult — Sydney
• Service Provider Consult — Port Hawkesbury
• Service Provider Consult — Antigonish
• Digby Clare Mental Health Volunteers
• Kings Chapter of the Schizophrenia Society
• Public Consult — Halifax
• Dual Diagnosis, NS Hospital
• IWK Health Centre
• Community Action Homelessness
• Public Consult — Bridgewater
• South Shore District Health Authority
• Eating Disorder Action Group

• Provincial Seniors Mental Health Group

• Engagement with Eskasoni First Nation Community

• Nova Scotia Advisory Commission on AIDS

• Centre for Emotions and Health, Dr. A. Abbass

• Mental Health Leadership Council

• Saint Leonard’s Society of Nova Scotia

• Immigrant Settlement & Integration Services

• Allied Healthcare Group

• Public Health Components, DHW

• Caregivers Nova Scotia Association, CCANS and staff from various home care and nursing home facilities

• Public French Language Consultation

• Canadian Mental Health Association, Nova Scotia Division Board of Directors and staff

• Mental Health Consumers

• Suicide Strategy Steering Committee

• Eating Disorder Focus Group

• Mental Health Day Treatment Program

• Wagmatcook First Nation Community

• Peer Support

• Frontline Shelter Staff

• LGTI Group

• Follow Up Consultation with Annapolis Valley DHA

• Childhood Obesity Prevention Strategy

• Acadian Community

• Concurrent disorders subject matter experts